

**Maryland's
Results for Child Well-Being
2010**



**Maryland Children's Cabinet
and
Governor's Office for Children**

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

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Executive Director



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CHILD WELL-BEING IN MARYLAND

RESULTS AND INDICATORS 2010



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MARYLAND CHILDREN'S CABINET AND GOVERNOR'S OFFICE FOR CHILDREN

Vision

Children's Cabinet: All Maryland's children will be successful in life.

Governor's Office for Children: Maryland will achieve child well-being through interagency collaboration and state/local partnerships.

Mission

The Children's Cabinet, led by the Executive Director of the Governor's Office for Children (GOC), will work collaboratively to create and promote an integrated, community-based service delivery system for Maryland's children, youth, and families. Our mission is to improve the well-being of Maryland's children.

Children's Cabinet

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

Secretary Sam Abed
Department of Juvenile Services

Secretary Theodore Dallas
Department of Human Resources

Secretary Eloise Foster
Department of Budget and Management

Secretary Catherine Raggio
Department of Disabilities

Secretary Joshua Sharfstein
Department of Health and Mental Hygiene

Interim State Superintendent Bernard Sadusky
Maryland State Department of Education

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Note: Data used in this report are analyzed at the State and jurisdictional levels, but data included in this publication is primarily State data. Jurisdictional data is available at <http://www.goc.maryland.gov>.

Dear Friends,

Recently, *Education Week* announced that Maryland's public school system ranks first in the nation among all 50 states for the third year in a row. Strong public schools, world-class teachers and administrators, and a workforce with the skills necessary to compete in the 21st Century are essential for Maryland to come through this national recession stronger and more quickly than other states. Together, we've chosen to protect this priority, funding public schools for the second year in a row at a record level of \$5.7 billion. A record \$4.9 billion in direct education aid will be distributed among Maryland's twenty-four jurisdictions in order to maintain and build upon the progress we've already made. As a winner in President Obama's "Race to the Top" competition, this budget proposal prioritizes innovative reform efforts to help boost student achievement, reduce the achievement gaps, recruit and retain world-class teachers and students, and turn around struggling schools.

The O'Malley/Brown Administration has identified 15 strategic and visionary goals to improve the quality of life in Maryland. The priority areas are generally focused on four areas: skills, security, sustainability, and health, and demonstrate the dedication and commitment of our administration to improving the outcomes and results for children, youth and their families in Maryland. Improving student achievement, and school, college and career readiness by 25% by 2015, ending childhood hunger by 2015, and reducing infant mortality by 10% by 2012 are exemplars of what we are doing to improve the lives of Maryland's families.

To prepare for my second term as Maryland's governor, I convened forums around the key issues effecting Marylanders. These forums included Jobs and the New Economy, Skills and Education, Sustainability, and Children and Health. Each forum provided the opportunity to hear from citizens and the issue experts and discuss our progress and future goals. Many of those goals are reflected in our Results for Child Well-Being report.

It is of paramount importance that we continue our work to maintain and improve the quality of life for our youngest Marylanders and their families. The O'Malley/Brown Administration has made this a priority and through the collaborative work of the Children's Cabinet coordinates the child and family focused service delivery system by emphasizing prevention, early intervention, and community-based services for children and their families. Realizing how crucial it is to count and gauge the progress of children in several areas, for more than ten years Maryland has chosen eight target result areas and developed statewide indicators to measure and report on child well-being. This information is utilized by the State and each jurisdiction to measure well-being for its children, develop strategic plans for children and family services, and communicate the successes and challenges of its efforts to reach the overall vision that all Maryland's children will be successful in life.

I am proud to say that the Maryland Results for Child Well-Being is among the longest, continuously reported results and indicators for children and families in the nation. This is a reflection of our state's long-term commitment to the success of its citizens and is reflected in the 15 priorities of this administration.

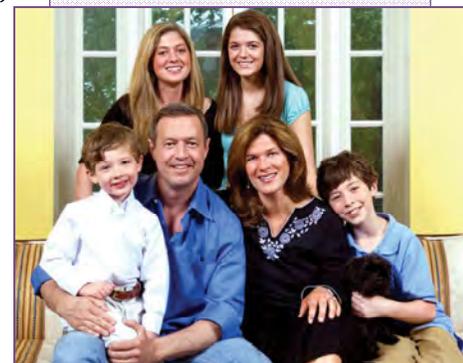
Thanks to each of the state agencies, organizations, families, and interested citizens for all you do to support the success of our children and their families in Maryland. Each of us benefits from a well educated, economically stable Maryland. With a state government that is working for citizens, we are making progress for Maryland families, but there is much more work to be done. Our great challenge is to redouble our efforts; doing all that we can to stand up for Maryland families and to power through the other side of this recession ahead of every other state.

Sincerely,



Martin O'Malley
Governor

FROM
GOVERNOR
MARTIN
O'MALLEY



Dear Citizens of Maryland:

On behalf of the Governor's Office for Children (GOC) and the Children's Cabinet, I am pleased to present the 2010 Results for Child Well-Being for the State of Maryland. The Governor's Office for Children serves as the coordinating entity for the six child-serving agencies of the Children's Cabinet: Department of Budget and Management, Department of Health and Mental Hygiene, Department of Human Resources, Department of Juvenile Services, Maryland Department of Disabilities, and Maryland State Department of Education. Our office utilizes results accountability to select, monitor, and measure the desired outcomes for children and families in our state-wide community. The Results and Indicators are utilized to support our collaborative efforts to provide a coordinated system of care for Maryland's children and their families. These Results and Indicators guide us as we chart progress, study trends over time, evaluate the current status, set priorities, and develop effective programs to meet the demonstrated needs of children, youth, and their families in Maryland.

Over the past year, a dedicated group of individuals from the state and private sector have critically reviewed the Results and Indicators that have been utilized in previous years to gauge their use and effectiveness for child-serving agencies today. This workgroup was convened by the Governor's Office for Children on behalf of the Children's Cabinet and included state agencies, family support organizations, and Local Management Boards. As part of their activities, the workgroup reviewed Maryland's alignment with the national indicators of child-well being. In addition to having the longest continuously reported set of Results and Indicators, we are also able to state with confidence that our Results and Indicators are aligned with the national child well-being priorities.

The workgroup developed a new framework, which was adopted by the Children's Cabinet, for reporting Maryland's Results for Child Well-Being. The 2010 Results and Indicators are reported in 3 overarching themes: Health, Education, and Family and Community Environment and afford us the opportunity to highlight connections among the various Results and Indicators. The workgroup has also replaced a number of the current Results and Indicators with stronger measures that most accurately reflect progress made over the years to improve the quality of both statewide and national data collection and analysis. The 2010 report reflects these changes to the Results and Indicators, and, where new indicators replace those that were historically reported, a retrospective presentation of the new data is used to establish a current baseline of no fewer than 3 years.

The Secretaries and Superintendent of the Children's Cabinet agencies continue to demonstrate an exceptional degree of cooperation and collaboration on child and family issues. In coordination with community partners and stakeholders, the Children's Cabinet continues to review and revise the implementation plan for *The Maryland Child and Family Services Interagency Strategic Plan*, which guides the work of the Children's Cabinet to effectively meet the needs of at-risk children and their families.

Through the use of the results and their associated indicators, as well as Governor O'Malley's administrative priority to strengthen the ranks of our citizens, improve public safety, and advance public education, we all continue to work together to improve the lives of Maryland's children, youth, and their families. Under the leadership of Governor O'Malley, this is our mission and unity of purpose as we work to make State government work for the people we serve.

Sincerely,



Rosemary King Johnston

Executive Director

Governor's Office for Children

FROM
EXECUTIVE
DIRECTOR
ROSEMARY
KING
JOHNSTON



INTRODUCTION TO MARYLAND'S RESULTS FOR CHILD WELL-BEING

What are themes, results, and indicators?

What is an Indicator?

Information and data that demonstrate Maryland's progress toward meeting a Result. Maryland has selected 28 Indicators for the eight Results.

What is a Result?

A goal that Maryland has established for its children, families, and/or communities. Maryland's Children's Cabinet focuses on eight Results for child well-being. Each Result describes the general well-being of Maryland's children and families in an area known to affect a child's ability to grow up healthy and secure.

What is a Theme?

Maryland has defined three overarching themes that encompass all of the Maryland Results for child well-being.

Maryland's Three Overarching Themes

Health



Education



Community Life



Maryland's Eight Results for Child Well-Being

Babies Born Healthy



Healthy Children



School Readiness



School Success



School Completion



School Transition



Safety



Stability



STATEWIDE EFFORTS TO IMPROVE OUTCOMES for CHILDREN AND YOUTH

The Children's Cabinet and the Governor's Office for Children are committed to improving outcomes for children and youth in Maryland. In addition to fulfilling Agency-specific mandates, Maryland's child-serving agencies also work together through the Children's Cabinet to coordinate policies, evaluate statewide needs, track progress on outcomes, and oversee funding to local jurisdictions to provide services which directly impact children's well-being. The Governor's Office for Children supports this work by:

- Convening the State Agencies, local partners, and community stakeholders to develop policies and initiatives which reflect the priorities of the Children's Cabinet and the Governor;
- Managing the Children's Cabinet Interagency Fund, which provided approximately \$46.2 million in State Fiscal Year 2009 to Local Management Boards (through Community Partnership Agreements) to provide needed services to children and families;
- Partnering with the Local Management Boards in each Maryland jurisdiction to plan, coordinate, and develop comprehensive systems of care, and fund and monitor the delivery of integrated services to children and families; and
- Informing the collective and specific work of the Children's Cabinet by developing and supporting an interagency data management system, collecting and analyzing data, and reporting to the Governor, the Children's Cabinet, the General Assembly, and other stakeholders on the progress of Maryland's children.

Maryland's eight Results for child well-being reflect the priorities of the Children's Cabinet and the Governor, and provide structure to the work of Maryland's 24 Local Management Boards (LMBs). The LMBs in each jurisdiction are comprised of representatives from the Children's Cabinet's local agencies, as well as local business and community members. Each LMB leads these and other stakeholders in a comprehensive needs assessment and prioritization of results and indicators based on the jurisdiction's needs. Funding from the Children's Cabinet Interagency Fund is used by the LMBs to develop and deliver services which address the eight Results areas.



USING MARYLAND'S RESULTS AND INDICATORS

The Children's Cabinet, in collaboration with the local jurisdictions, strives to meet the needs of Maryland's children, families, and communities. Through this collaborative approach, each jurisdiction identifies and focuses on results and indicators that are priorities in their community. The information in this publication assists in tracking and evaluating the well-being of children across the State and in each local jurisdiction.

Indicators are used to:

Assess and understand the current status of children and families and how trends emerge over time:

- Examine data for population subgroups, including race, sex, and age, to identify major differences across the groups and ensure that all children and families do well.
- Analyze trends to identify where results have changed on a local level in ways that are inconsistent with state-wide trends. This assists local jurisdictions with focusing resources on potential priority areas.
- Provide stakeholders and communities with the information and resources they need to understand the data and trends related to children in their communities.

Select priority areas and set goals for the improvement of child and family well-being:

- Use the indicators to identify troubling trends, choose strategies to address the problem area, and measure progress toward set goals; Compare and collaborate with other jurisdictions to identify potential shared strategies,
- Choose intervention strategies that are reasonably calculated to achieve progress toward the goals,
- Use indicators as part of strategic planning,
- Help stakeholders and communities to be informed and involved in setting goals for improvement in their communities, and
- Monitor progress toward goals in comparison with invested resources made in selected programs, services, and initiatives. Indicator data will help assess intervention strategies.

Results Accountability

The work of the Governor's Office for Children and the Children's Cabinet is accomplished using the Results Accountability framework. This approach focuses planning, decision-making, and budgeting on desired results and outcomes. In planning and developing stages, the Results Accountability model focuses on identifying a result to achieve, selecting indicators that act as proxy measures for the result, understanding the data and the "story behind the data", identifying necessary partners and effective strategies, and then developing an action plan and budget. In evaluating programs, this approach focuses on evaluating data through three main questions: How much did we do? How well did we do it? Is anyone better off?

DESCRIPTIVE GUIDE TO THE RESULTS AND INDICATORS

Information on each Indicator is organized as follows:

Indicator

A brief description of the Indicator.

Definition

A detailed description of the Indicator.

Significance

A brief discussion of the importance of the Indicator and how it relates to child and family well-being.

Baseline Data

Where available, multi-year State and national data are presented.

Data Source

The source for the most recent data presented and a brief description of the breakdowns that are available.

Considerations

Information about the source, the significance, or other aspects of the Indicator that should be considered when interpreting the data, using the indicator, to track trends, or setting performance goals.

Related Measures

If they exist, other measures that relate to the Indicator will be listed along with the source of data.

Story Behind the Data

A brief overview of the trend that exists for this Indicator, factors that may be impacting the trend, and additional background information.

A GUIDE TO STATISTICS

The following is a brief description of two key statistics used throughout this guide (percent and rate), a word of caution about their use, and instructions on how to calculate the rate-of-change statistic in order to track trends.

Percent: Percent means per 100. For example, 15% means 15 out of 100, 75% means 75 out of 100.

Percent = (Number in sub-group) ÷ (Number in whole group) x 100

Example: Percent of babies born at low birth weight (LBW), CY2002

Percent = (Number LBW) ÷ (Total number of births) x 100

= 6,623 ÷ 73,250 x 100

= 9% of births in 2002 were less than 2,500 grams (5.5 pounds)

Rate: The easiest way to understand a rate is to think of a percent as a rate per 100. (Note: Many indicators are presented as rates per 100,000.) In the example above, 9% of babies born at low birth weight could also be expressed as “9 babies per 100” are born at low birth weight.

Rate = (Number in sub-group) ÷ (Number in whole group) x MULTIPLIER

Example: Rate of youth (ages 10-17) arrested for violent crimes per 100,000 youth (ages 10-17)

Rate = (Number arrested) ÷ (Number of youth ages 10-17) x 100,000

= 3,037 ÷ 567,678 x 100,000

= 535 per 100,000 youth ages 10-17 were arrested for violent crimes in 1998

Rate of Change: It is often helpful to see how an indicator has changed over time. The rate of change refers to the magnitude of the change from one time frame to another (e.g. from 1995 to 1998). Rate of change is expressed as a percentage. A positive percentage indicates an upward trend while a negative percentage denotes a downward trend.

Rate of Change = {[(Recent year number) ÷ (Prior year number)] - 1 } x 100

Example: Rate of change in the rate of out-of-home placement, FY02 to FY03

Rate of Change = {[(FY03 rate of placement) ÷ (FY02 rate of placement)] - 1 } x 100

= {[10.9 ÷ 11.2] - 1 } x 100

= -2.7% is the rate of change in the rate of placement from FY02 to FY03.

Caution Needed When Using Percentages or Rates with Small Numbers of Incidents: Caution is necessary when using percentages and rates with small numbers of incidents. If the item to be measured has less than 5 occurrences (e.g. infant mortality in a given jurisdiction for a given year) then a percentage or rate should not be produced. One or both of the following methods can be employed to create a more stable percentage or rate:

- Multi-year averaging, which involves using a longer time period to produce the rate (e.g., using 3 or 5 years data); or
- Enlarging the geographic area (e.g., using a region containing several jurisdictions).

Both of these methods increase the number of observed events and hence the stability and reliability of percentages or rates calculated.

Theme I: HEALTH



Result 1—Babies Born Healthy



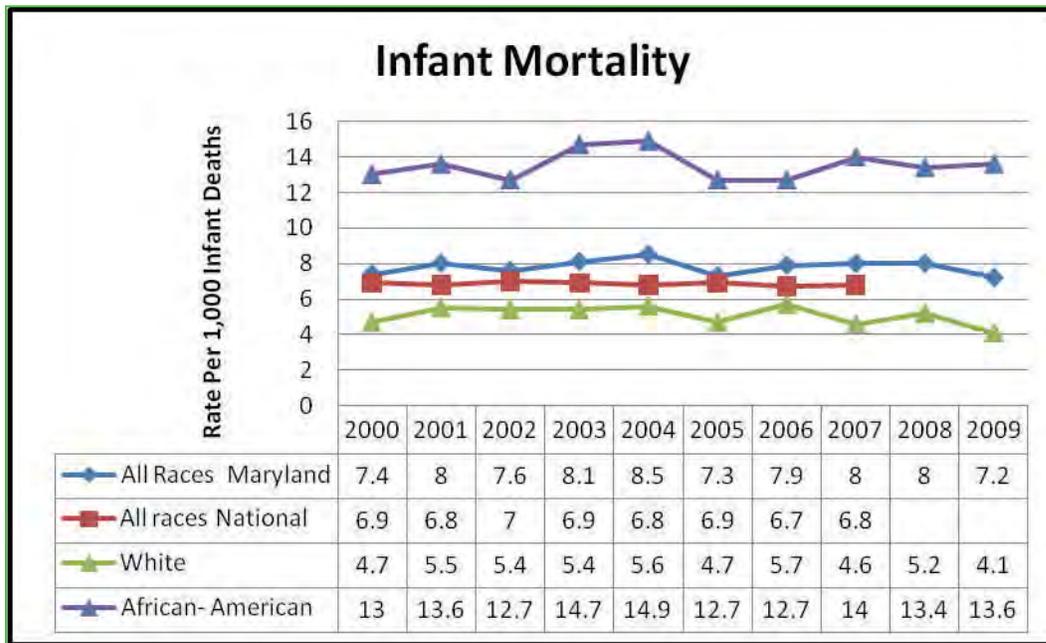
Result 2— Healthy Children



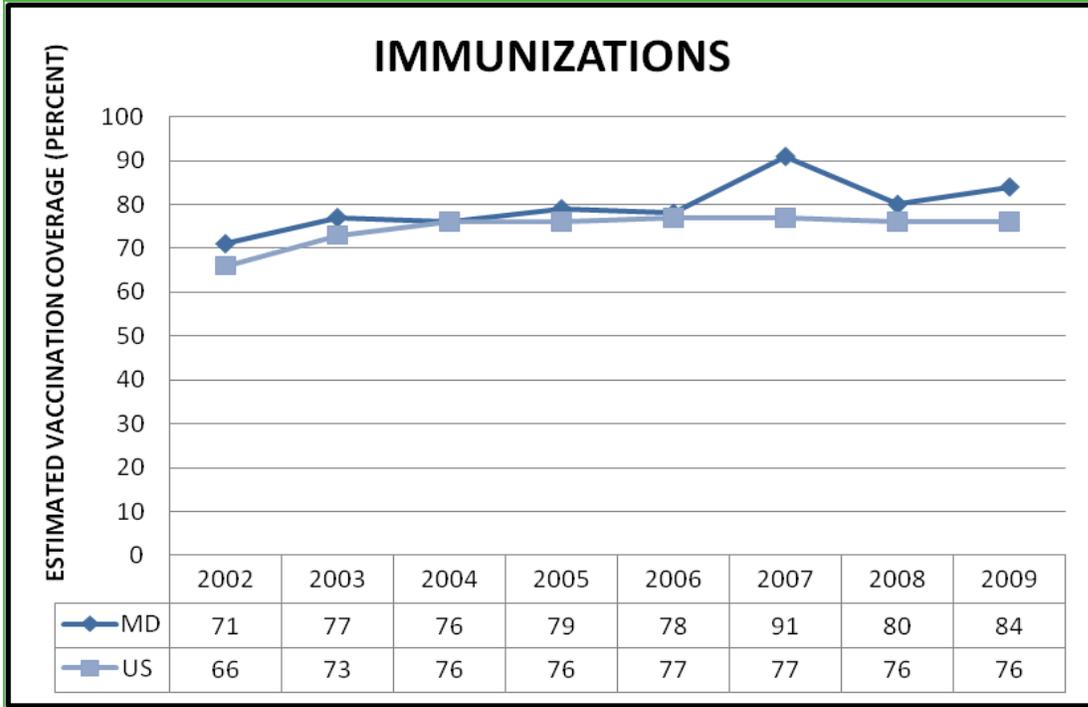
Theme I: Health

Maryland seeks to improve its performance through Statewide initiatives and policy goals. Among Governor O'Malley's strategic goals and priorities for Maryland are initiatives focused on children's health. It is fair to say that the importance of children's health cannot be overstated. Without a comprehensive strategy that ensures the health of children from the prenatal stages into adulthood, gaps in care can leave children at-risk for poor health outcomes. Children's health outcomes reflect a society's ability to provide for the most vulnerable, and often highlight where the most significant policy changes are needed. Maryland seeks to use the significant combined resources of State agencies, hospitals, non-profits, a vibrant health care community, and families to make forward moving strides in children's health goals and position Maryland as a national leader in children's health.

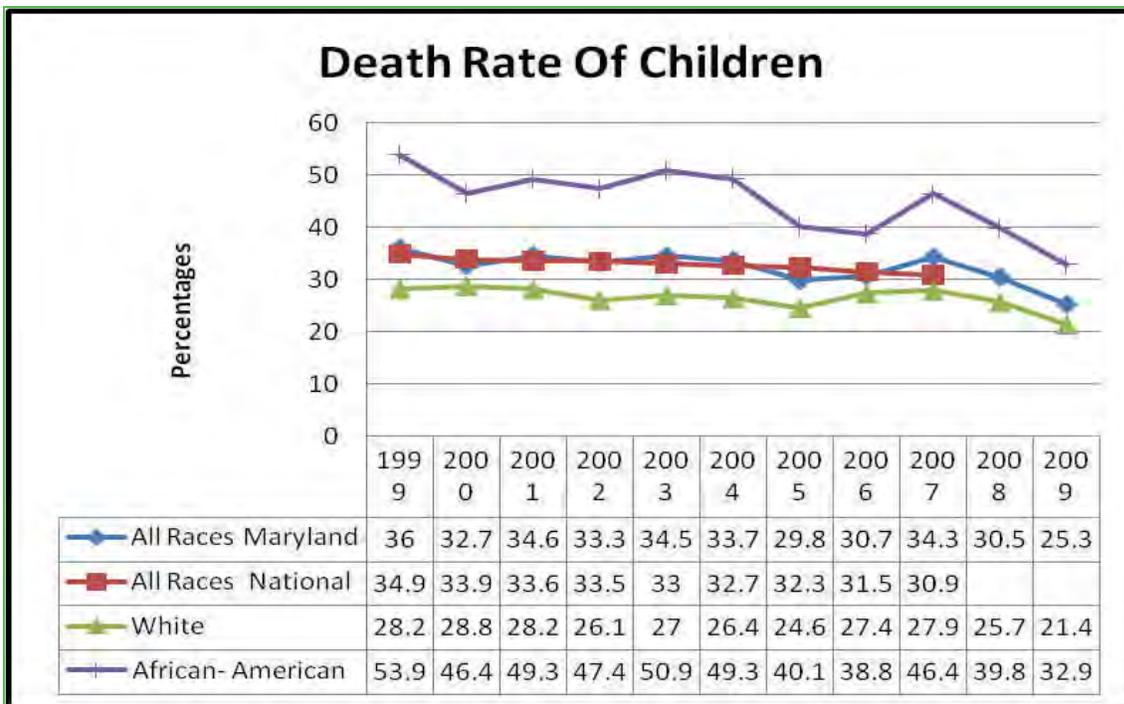
Major Developments in Health



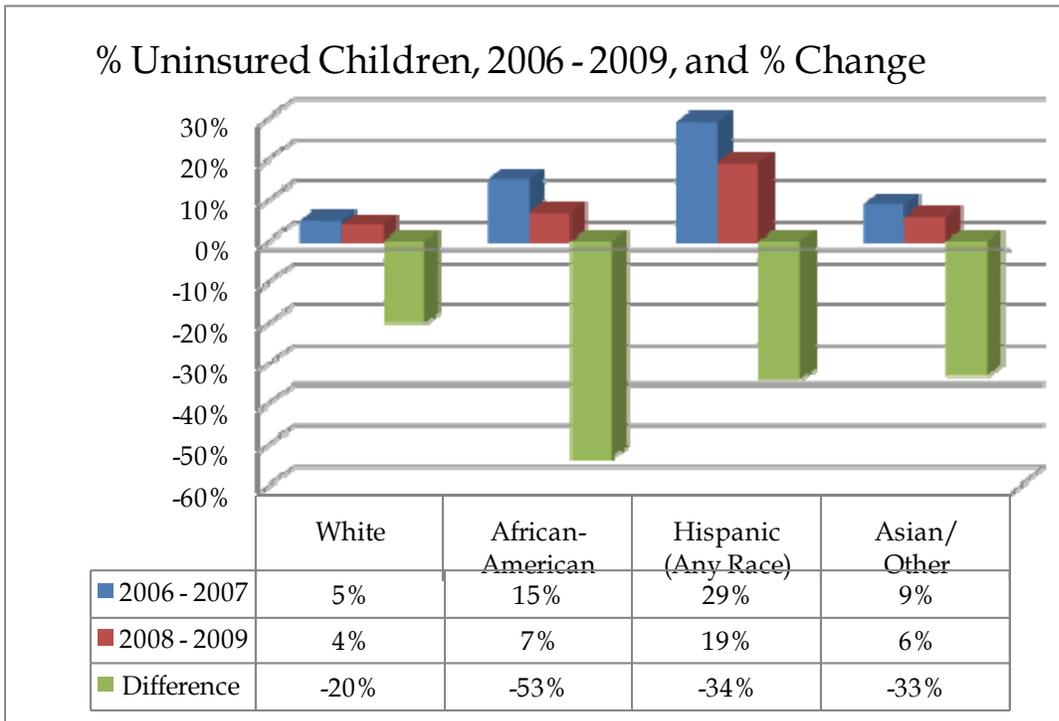
Between 2008 and 2009, the average Maryland infant mortality rate decreased by 0.8 infants per 1,000. This decrease may be attributable to a number of factors including decreasing numbers of births to teen mothers, fewer uninsured children, or more screenings of children for lead exposure. However, the rates over the past decade have been fairly stable, ranging from 8.5 in 2004 to 7.2 in 2009, indicating that 2009 had the lowest rate of infant deaths. The infant mortality rate of African-Americans as compared to Whites in Maryland is considerably higher. The rate of African-American infant deaths per 1,000 exceeds White infant deaths per 1,000 by 9.5 in 2009, reflecting the largest disparity between races in a decade.



In 2009, Maryland (along with Iowa) had the highest rate of immunizations for children ages 19 to 35 months of any state in our nation. Since 2002, the immunization rate has increased 13 %, from 71 to 84%. Updated data systems that track children’s health records and make those records available to providers help doctors and hospitals keep up to date with children’s vaccines and contribute to Maryland’s capacity to increase the percentage of children who are vaccinated and protected from childhood diseases.



Maryland’s average child death rate has decreased since 1999 by 1.07 percent. From 2008 to 2009 the rate decreased by 5.2 deaths per 1,000. However, despite the decrease, the rate of African-American child deaths has consistently been higher than White child deaths with the difference in rates per 1,000 deaths ranging from 25.7 in 1999 to 11.4 in 2006. The lowest rates for either race were observed in this most recent year. This decrease may be due to the increase in health coverage among children in Maryland in 2009.



Since CY2006 through 2007, a large percentage of children have become insured in Maryland. The rates of children’s health coverage increased among all races. The largest increase in health coverage was an increase of over 50% in the African-American population. From 2007 until 2010, nearly 118,000 children were added to Medicaid coverage. This may account for the sharp increases in children’s health coverage.

What Maryland Is Doing

Important Actions:

- The **Maryland Health Care Reform Coordinating Council (HCRCC)** was established by Governor O’Malley through Executive Order 01.01.2010.07 to assess and address the significant issues in federal health reform legislation and their impact on Maryland .
- The **Working Families and Small Business Health Coverage Act** was established to help working families with Medicaid enrollment. Coverage is provided to families with low family income and subsidized insurance premiums for workers and eligible relatives in small, low wage businesses.

- **Reducing infant mortality in Maryland by 10% by 2012.** This initiative is one of the Governor’s priorities and aims to improve the health of infants by assisting mothers and health care providers. Among the changes implemented through this initiative are trainings for obstetrician-gynecologists and expanded services for substance abuse, mental health, and developmental disabilities. Also, any women who seek enrollment at behavioral health or disabilities programs must be admitted within one business day.

Initiatives:

- Establishment of the Statewide **Health Information Exchange (HIE)** ensures the universal adoption and utilization of electronic health records. This plan includes formulating a comprehensive, multi-stakeholder-driven network including reliable electronic Maryland records and utilizing federal resources. \$10 million in funding has been appropriated to be disbursed annually to ensure implementation of the Statewide HIE.
- Maryland conducted a state-wide needs assessment to identify communities “at-risk” and in greatest need of expanded home visiting services through the new, federally funded **Maternal, Infant, and Early Childhood Home Visiting Program**. Based on the needs assessment, Maryland submitted a comprehensive state home visiting plan that accounts for the capacity and readiness for new or expanded home visiting programs at the local level. Local planning efforts are now well underway in all six jurisdictions with the highest risk communities.

Workgroups and Teams:

- The **School-Based Health Centers Policy Advisory Council** is charged with coordinating interagency initiatives to ensure and sustain quality school-based health centers in Maryland. State Agencies, organizations, and community representatives contribute to this goal.
- Maryland’s **State Health Improvement Plan (SHIP)** is currently under development by Maryland’s new DHMH Office for Population Health Improvement and partners across Maryland. The Plan is designed to improve population health in Maryland through increased accountability, making investments that are focused and evidence-based, and through increased collaborations that produce results.

Maryland Public Schools. http://www.marylandpublicschools.org/MSDE/divisions/studentschoolsvcs/student_services_alt/school_based_health_centers/docs/SBHC+Policy+Advisory+Council.htm (accessed 27 July 2001).

- Maryland convened groups of experts to examine issues critical to infant health, including the **Maryland Infant Mortality Epidemiology Work Group** and the **Secretary's Advisory Panel on the Use of Crib Bumper Pads**. The Infant Mortality Workgroup was charged with assessing risk factors associated with infant mortality in Maryland and identifying interventions most likely to enhance the state's ability to achieve its goal of reducing infant mortality rates in Maryland, particularly among African-Americans. The Advisory Panel was appointed to consider information documenting the risks and/or benefits to infants associated with the use of crib bumper pads.

What We Need to Do

Decrease the infant mortality rate, particularly among African-Americans.

- While infant mortality rates in Maryland have decreased slightly on average, conversely, the rate of African-American infant deaths has increased.
- More information is needed to understand why infant deaths remain high, to identify common causes, address racial disparities, and suggest possible solutions.

Increase the use of health care record-keeping networks.

- Electronic records networks allow doctors and hospitals to comprehensively look at the medical services a child needs.
- This information could assist in completing immunizations, identifying medications that may conflict with other prescriptions, and diagnosing conditions before they become immediate risks.
- Hospitals should continue to be encouraged to adopt these systems to increase the network base.

Continue to decrease the rate of births to teen mothers.

- The rate of births to mothers ages 15 to 19 has dropped for both White and African-American races from the rates in CY2000. In 2009, the rates for 15 to 19 year old mothers were the lowest since 2003 for Whites and since at least CY2000 for African-Americans.
- The rate of births to teen mothers is correlated with a lower rate of high school graduation and a lower rate of employment.
- Both high school graduation and employment rates are factors that can cause families to lack important economic and social resources that are of great benefit to young children, such as health care, adequate income, and educational services.



Result 1: Babies Born Healthy



Why is it important for babies to be born healthy?

Sound prenatal health care and a positive family environment are factors that often result in the birth of a healthy baby. The health of an infant is such a strong predictor of health later in life that it becomes imperative for babies to be born as healthy as possible. Humans grow more, physically and developmentally, in the first year of life than at any other time, making it critical to get a healthy start.

Research has shown that children of adolescent mothers are at risk for many negative outcomes including developmental delays, low birth weight, and poverty. Birth weight is also directly related to development and health. By measuring infant mortality, infant birth weight, and the rate of teen pregnancy, it is possible to gather an understanding of babies' health in Maryland. Each of these factors are predictive of the future health and development of the child.

How do we measure the health of babies?

The health of babies is measured using three indicators that are strongly associated with the future health and development of a child. Infant mortality, low birth weight, and births to adolescents each represent risk factors for babies.

Indicator 1-Infant Mortality:

A measure of how many infant deaths occur in the first year of life in proportion to the number of live births.

Indicator 2-Low Birth Weight:

The percentage of babies born with a birth weight of less than 5.5 pounds.

Indicator 3-Births to Adolescents:

The number of children born to adolescent mothers.

What does the data say?

- Infant mortality occurred at an average rate of 7.2 infants per 1,000 in the State of Maryland overall.
- 9.2% of babies born in Maryland weighed less than 2,500 grams.
- 3.12% of adolescent females between the ages 15 to 19 years old gave birth to infants in 2009.

Indicator 1: Infant Mortality

Indicator: The rate of deaths occurring in infants under one year of age.

Definition: The number of deaths occurring in infants under one year of age per 1,000 live births, for all infants, and for infants in selected racial groups.

Significance: This indicator is associated with family and prenatal access to health care as well as prenatal, family, and environmental risks to a child's healthy start.

Baseline Data: The number of deaths occurring in infants under one year of age per 1,000 live births, for all infants, and for infants in selected racial groups.

Rate of Infant Deaths per 1,000 Live Births by race and calendar year, Maryland and National										
Maryland	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	7.4	8.0	7.6	8.1	8.5	7.3	7.9	8.0	8.0	7.2
White	4.7	5.5	5.4	5.4	5.6	4.7	5.7	4.6	5.2	4.1
African-American	13.0	13.6	12.7	14.7	14.9	12.7	12.7	14.0	13.4	13.6
National	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	6.9	6.8	7.0	6.9	6.8	6.9	6.7	6.8	N/A*	N/A*
White	5.7	5.7	5.8	5.8	5.7	5.7	5.6	5.6	N/A*	N/A*
African-American	14.1	14.0	14.4	14.0	13.8	15.2	13.3	13.2	N/A*	N/A*
*2008 and 2009 National Data not available										

Data Source: Maryland Data: DHMH, Maryland Vital Statistics Annual Reports.

Available at: <http://vsa.maryland.gov/html/reports.cfm> National Data: National Vital Statistics Reports, Vol. 58, No. 19, May 2010. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf

Considerations: For Maryland data, racial groupings were determined by the race of the mother. The calculation is based on Number of Infant Deaths divided by the Number of Births.

Related Measures: A "service delivery/utilization" Indicator related to infant mortality is the percent of births for which prenatal care was initiated during the first trimester. Other related measures include neonatal and post-neonatal death rates. Data (on these measures) for Maryland jurisdictions are reported in the Maryland Vital Statistics Annual Report 2009 (Department of Health and Mental Hygiene). The percentage of infants born with low birth weight is also related to infant mortality .

Story Behind the Data: The infant mortality rate (IMR) in Maryland has been variable from year to year and trends in IMR over several years are more meaningful than year to year comparisons. A comparison of the five year average rates between 2000 through 2004 (average IMR 7.9) and 2005 through 2009 (average IMR 7.7) shows infant mortality in Maryland has fallen only slightly over the past decade. A racial disparity persists in infant mortality in Maryland, with the African-American IMR 3.3 times higher than the rate for white infants in 2009.

The leading causes of infant death in 2009, as in 2005 through 2007, were:

1. Disorders relating to short gestation and unspecified low birth weight;
2. Congenital abnormalities; and
3. Sudden Infant Death Syndrome (SIDS).

Notably, racial disparities are apparent in each of the leading causes of infant death. In Maryland, an African-American infant is 1½ times as likely to be born prematurely as a White infant, nearly twice as likely to be born at low birth weight, and nearly 2½ times as likely to die of SIDS.

The top three causes of death among African-American and White infants are included on the chart below (“1” being the leading cause):

	<u>African-American Infants</u>	<u>White Infants</u>
Disorders relating to short gestation and unspecified low birth weight.	1	2
Sudden Infant Death Syndrome (SIDS).	2	3
Congenital abnormalities.	3	1

Maryland Vital Statistics Annual Report 2009, Vital Statistics Administration, Department of Health and Mental Hygiene, Table 34a, page 127.

Maryland's overall IMR remains above the national average. The most recent national data (2007) by race show infant mortality rates in the United States for all races; Whites and African-Americans were 6.8, 5.6 and 13.2, respectively, as compared with rates in Maryland of 8.0, 4.6 and 14.0.

The Healthy People 2010 goal is to have no more than 4.5 infant deaths per 1,000 births (all races). (Healthy Maryland Chart book, Family Health Administration, Department of Health and Mental Hygiene, May 2007, pg. 45, http://www.fha.state.md.us/pdf/ohpp/Healthy_Maryland_Chartbook.pdf).

Indicator 2: Low Birth Weight

Indicator: The percentage of babies born weighing less than 2,500 grams (approximately 5.5 pounds).

Definition: The percent of all births and births in selected racial groups with birth weight less than 2,500 grams (approximately 5.5 pounds).

Significance: Infant birth weight is associated with infant survival, health, and overall development. Infants weighing less than 2,500 grams are more likely to have physical and developmental problems, including learning difficulties, mental retardation, cognitive impairment, disability, visual and hearing deficits, and chronic respiratory problems.

Baseline Data: Low Birth Weight (reported by calendar year)

++Percent of Babies Born Weighing Less than 2,500 Grams, by Mothers Race, by Calendar Year, Maryland and National										
Maryland	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	8.7	9.0	9.0	9.1	9.4	9.2	9.4	9.1	9.3	9.2
White	6.4	7.0	7.0	7.1	7.4	7.1	7.4	7.1	7.2	7.0
African-American	12.9	13.0	13.3	13.1	13.2	13.2	13.4	12.9	13.2	13.0
National	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	7.6	7.7	7.8	7.9	8.1	8.2	8.3	8.2	8.2	N/A*
White	6.5	6.7	6.8	7.0	7.2	7.3	7.3	7.2	7.1	N/A*
African-American	13.0	13.0	13.0	13.5	13.7	14.0	14.0	13.8	13.4	N/A*
*2009 National Data not available										

Data Sources: Maryland Data: DHMH, Maryland Vital Statistics Annual Reports Available at: <http://vsa.maryland.gov/html/reports.cfm>.

National Data: National Vital Statistics Reports, Vol. 59, No. 1, December 2010. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf.

Notes: Calculated as the number of babies born weighing less than 2,500 grams divided by the total number of births.

Considerations: For Maryland data, racial groupings were determined by the race of the mother.

Related Measures: A "service delivery/utilization" Indicator related to low birth weight is the percent of births for which prenatal care was initiated during the first trimester. Other related measures include neonatal and post-neonatal death rates, the percentage of infants born prematurely, and the number of plural births. Data for Maryland jurisdictions on these measures are reported in the Maryland Vital Statistics Annual Report 2009 (Department of Health and Mental Hygiene). The infant mortality rate is also related to low birth weight.

Story Behind the Data: Low birth weight (LBW) is a significant factor driving infant mortality rates. Infants born with LBW are also at increased risk of developmental delays. Babies born with LBW may be born either prematurely (before 37 weeks gestation) or full term (37 to 41 weeks gestation) and small for gestational age. In 2009, 10.4% of all births in Maryland occurred at less than 37 weeks gestation. (Maryland Vital Statistics Annual Report 2009, Vital Statistics Administration, Department of Health and Mental Hygiene, Table 24, pg. 115.)

The overall percent of infants born with LBW in Maryland continues to be higher than the national average. In Maryland and nationally, the percent of infants with LBW has been increasing. The rate of increase, however, has been slower in Maryland than nationally. The percent of White infants with LBW in Maryland has been very close to the national average for White infants. The percent of African-American infants with LBW in the State has been below the national average since 2003.

Infants of plural births (twins, triplets or higher order) have a significantly higher risk of being LBW than single births. In 2009, only 7.2% of all single births in Maryland were LBW, compared to 59.3% of plural births. (Maryland Vital Statistics Annual Report 2009, Vital Statistics Administration, Department of Health and Mental Hygiene, Table 22, pg. 113.)

Additionally, lack of prenatal care or late prenatal care (beginning in the third trimester) is related to both low birth weight and infant mortality. In 2009, 80% of births in Maryland were to mothers who received prenatal care during their first trimester and 4.7% to mothers who had received late or no prenatal care. (Maryland Vital Statistics Annual Report 2009, Vital Statistics Administration, Department of Health and Mental Hygiene, Tables 19A and 19B, pg. 107-108.)

One of the Healthy People 2010 goals is to reduce low birth weight births to 5.0% of all live births. (Healthy Maryland Chartbook, Family Health Administration, Department of Health and Mental Hygiene, May 2007, pg. 45, http://www.fha.state.md.us/pdf/ohpp/Healthy_Maryland_Chartbook.pdf.)

Indicator 3: Births To Adolescents

Indicator: The rate of births to adolescents, ages 10 to 19.

Definition: The rate of births, per 1,000, to adolescent females ages 10 to 14, ages 15 to 17, ages 18 to 19, and ages 15 to 19.

Significance: Adolescent mothers are more likely to drop out of high school, experience unemployment, or, if employed, earn lower wages than women who begin child-bearing after age 20. Children born to teen mothers face increased risks of low birth weight, prematurity, infant mortality, developmental disabilities, and poverty.

Baseline Data: Birth to Adolescents (reported by calendar year)

Rate of Live Births per 1,000 Women, ages 10-19- by calendar year, Maryland										
Age	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
10-14	0.9	0.8	0.7	0.6	0.7	0.6	0.6	0.5	0.6	0.5
15-17	23.3	20.9	19.9	18.2	18.0	16.8	17.5	18.1	17.3	16.3
18-19	69.8	65.2	61.5	59.0	56.6	56.9	60.5	64.2	56.1	52.7
15-19	41.2	37.8	35.4	33.3	32.4	31.8	33.6	34.4	32.7	31.2
Rate of Live Births per 1,000 Women, ages 10-19- by calendar year, National										
Age	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
10-14	0.9	0.8	0.7	0.6	0.7	0.7	0.6	0.6	0.6	N/A*
15-17	26.9	24.7	23.2	22.4	22.1	21.4	22.0	22.1	21.7	N/A*
18-19	78.1	76.1	72.8	70.7	70.0	69.9	73.0	73.9	70.6	N/A*
15-19	48.7	45.3	43.0	41.6	41.1	40.5	41.9	42.5	41.5	N/A*
<i>*2009 National Data not available</i>										

Data Sources: Maryland Data:
Births: DHMH, Maryland Vital Statistics Annual Reports
Available at: <http://vsa.maryland.gov/html/reports.cfm>

Female Population: Maryland Department of Planning. Available at:
http://www.mdp.state.md.us/msdc/Pop_estimate/estimate_00to09/CensPopEst00_09.shtml

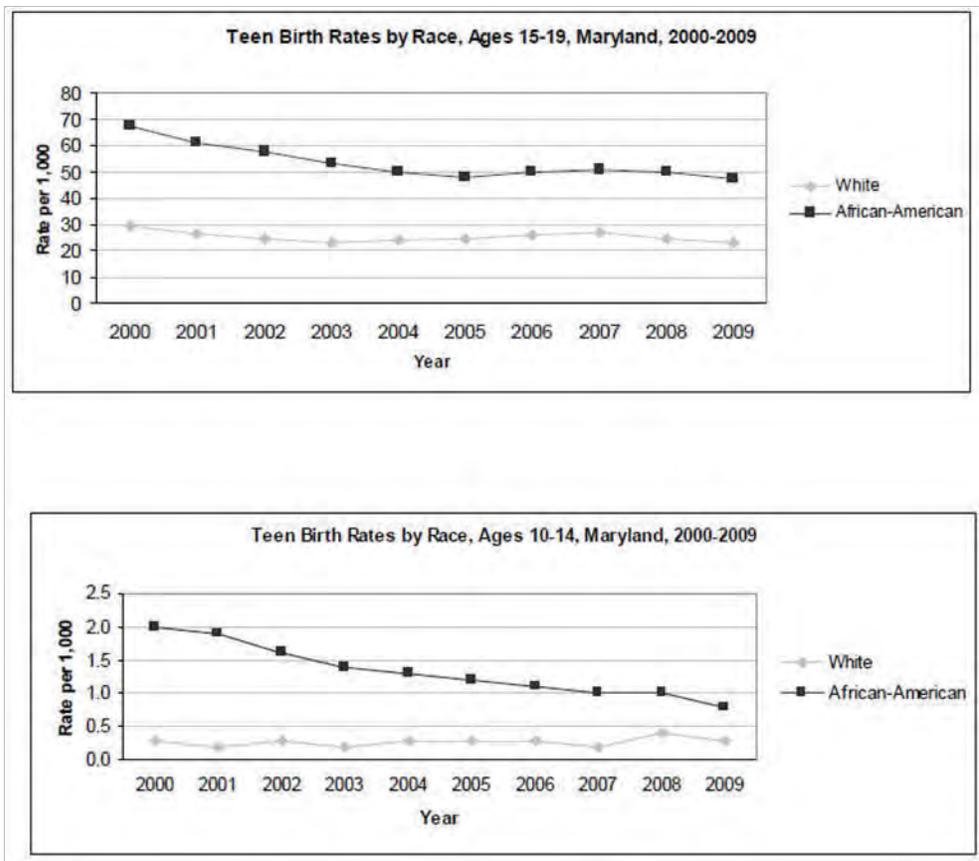
National Data: National Vital Statistics Reports, Vol. 59, No. 1, December 2010.
Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf

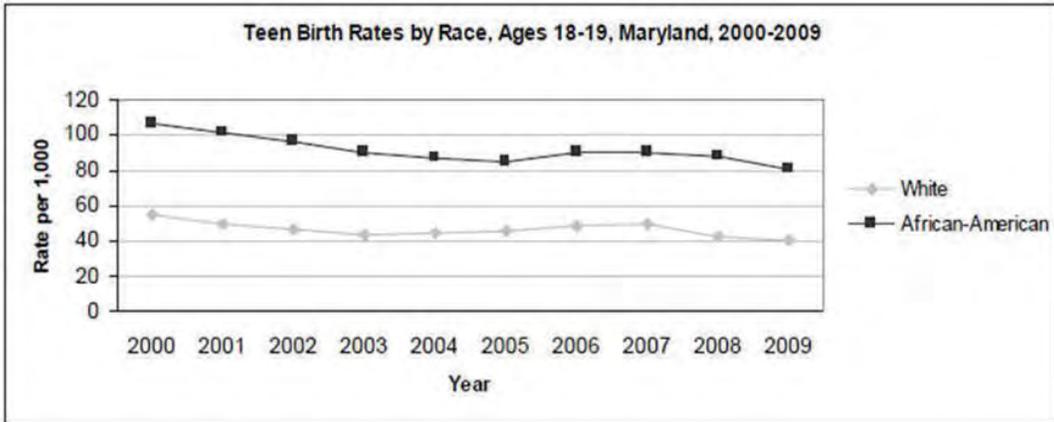
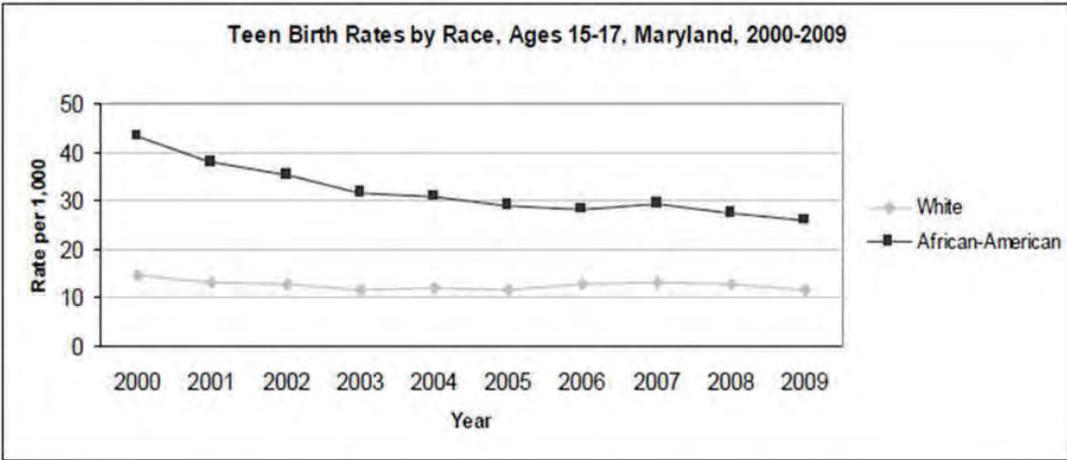
Considerations: As pregnancies between ages 10 and 14 occur at a much lower rate than in age groups 15 to 19, there is greater variability between reporting years in the 10 to 14 year datasets. The 15 to 19 year datasets show more consistency and have, accordingly, been used to calculate the jurisdictional rates. Births to Females under 15 are not included in the Birth Rate of Females Ages 15 to 19, nor are they included in the Children's Cabinet's Birth Rate to Adolescents Indicator. Teen birth rates are calculated by the number of live births to adolescents in the specific age group divided by the female population in the specific age group.

Related Measures: Births to adolescents are associated with low birth weight, infant mortality, and late onset of prenatal care.

Story Behind the Data: The birth rate to mothers ages 10 to 14 years, which declined over the past 10 years in Maryland, has remained essentially unchanged among Whites since 2005. Among African-Americans, the rate decreased to 0.8 in 2009, as compared to 1.2 in 2005.

After a decade of steady decline, Maryland's birth rates to mothers ages 15 to 17 and ages 17 to 19 increased slightly in 2006 and 2007. These increases were similar to increases seen in the national data. Maryland 2009 data, however, show another decline in birth rates to adolescents in both age groups. Maryland birth rates for both age groups are below the national averages.





Result 2: Healthy Children



Why is it important for children to be healthy?

Healthy children become healthy adults. Being healthy means more than avoiding diseases, injuries, and death. It also implies that children have healthy exercise and eating habits, are provided with preventive care, and learn how to avoid risky behaviors. Children who are healthy also demonstrate higher self-esteem and are more prepared to deal with daily challenges.

How do we measure the health of children?

Indicator 4-Health Insurance Coverage:

The percentage of children with health insurance coverage.

Indicator 5-Immunizations:

The percentage of children that have received all recommended immunizations.

Indicator 6-Hospitalizations:

The rate of hospitalizations per 1,000 children and ages 0 to 21.

Indicator 7-Substance Abuse:

The percentage of public high school students that report using alcohol, tobacco, or illegal drugs in the last month.

Indicator 8-Obesity:

The percentage of Maryland public high school students who are obese, describe themselves as overweight, or are trying to lose weight.

Indicator 9-Asthma Prevalence:

The percentage of school-aged youth (elementary, middle and high) with a asthma.

Indicator 10-Deaths:

The rate per 100,000 children that die before the age of 19.

What does the data say?

- 42% of children required inpatient hospitalization during 2009 for unintentional injuries.
- 93% of children in Maryland had some kind of health insurance in 2009.
- 84% of children ages 19 to 35 months old have received all of the recommended immunizations as of 2009.
- Of the Maryland public school students from 9th to 12th grade who were surveyed, 27.9% were overweight or obese (as measured by the BMI) in 2009.

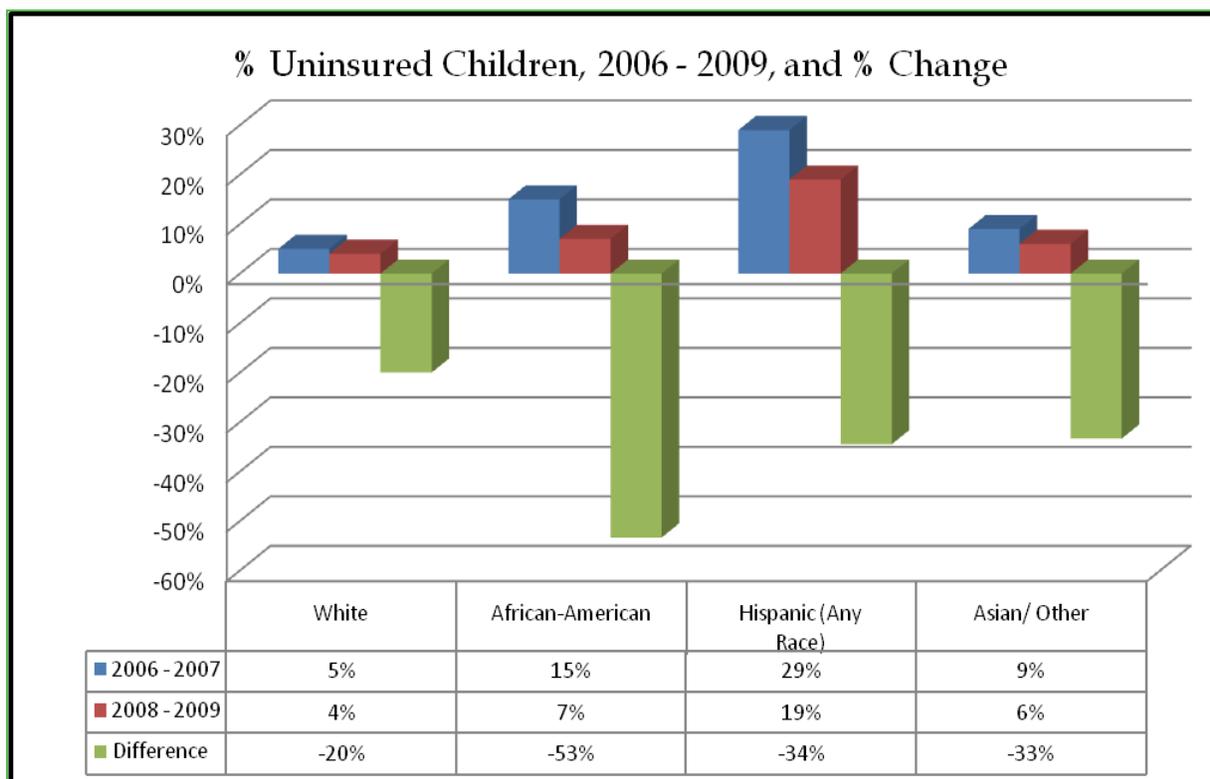
Indicator 4: Health Insurance Coverage

Indicator: The percentage of children and youth with health insurance coverage.

Definition: The percentage of children in Maryland ages birth through 18, compared to federal rates of health insurance coverage. Uninsured rates represent the percent of people who do not have health insurance for four (4) months or longer during the year.

Significance: Health coverage is a major indicator of a family’s preparedness to take care of their children’s physical well-being. In the absence of health insurance, families are less likely to take their children to the doctor especially for preventive care like routine check-ups. As children who visit the doctor less frequently, uninsured children are at an increased risk of obesity, disease (for lack of immunizations), and death.

Baseline Data: Children’s health insurance coverage rates are available from CY2006 to CY2009. These statistics show an increase in children’s health insurance coverage from CY2006 to CY2009 from 90% coverage to 93%. After more yearly data are collected in the future, a more reliable baseline trend will be established.



“Hospitalized Children Without Insurance Are More Likely to Die, a Study”. [Findshhttp://prescriptions.blogs.nytimes.com/2009/10/30/lacking-insurance-hospitalized-children-more-likely-to-die/](http://prescriptions.blogs.nytimes.com/2009/10/30/lacking-insurance-hospitalized-children-more-likely-to-die/). “Compared with insured children, uninsured children faced a 60 percent increased risk of dying, the researchers found.”

Data Source: Data is available by jurisdiction from the US Census Bureau, Small Area Health Insurance Estimates (SAHIE) for CY2006 through CY2007: <http://www.census.gov//did/www/sahie/data/index.html>. Children’s health insurance data based on categories such as age, race, income, and family work status can be found in the reports of the Maryland Health Care Coalition (MHCC), *Health Insurance Coverage in Maryland Through 2007*, and *Health Insurance Coverage in Maryland Through 2009*.

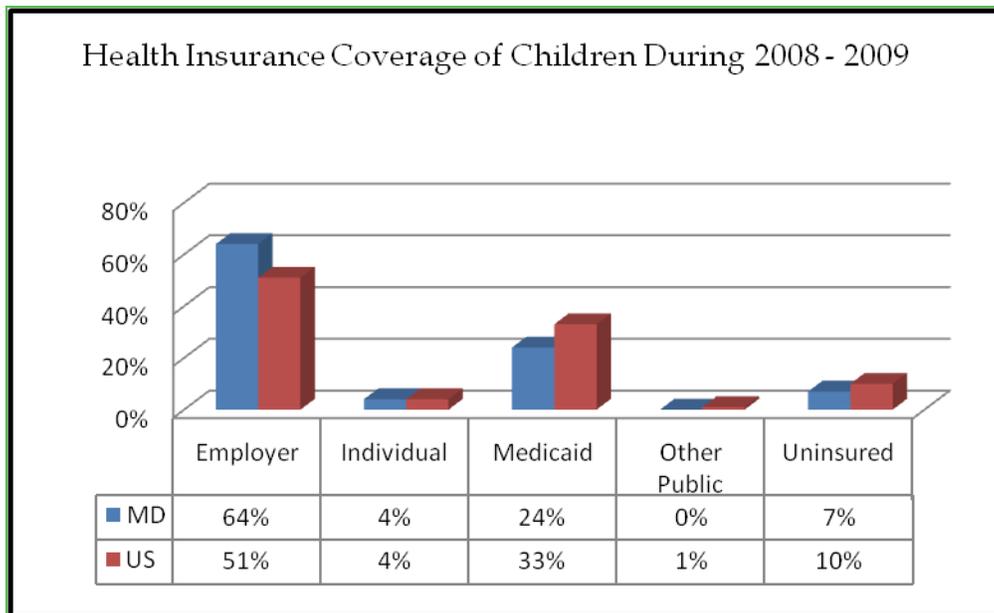
Considerations: Paired-year measures (i.e. 2006 through 2007, 2008 through 2009) represent an average of the rates of insurance coverage for each pair. Surveys are conducted annually through a random sampling of people who live in Maryland. The larger the size of the sample, the more each survey will represent the characteristics of the total population. Because sample sizes from yearly surveys are somewhat small, yearly data are paired and averaged to double the accuracy of the statistics.

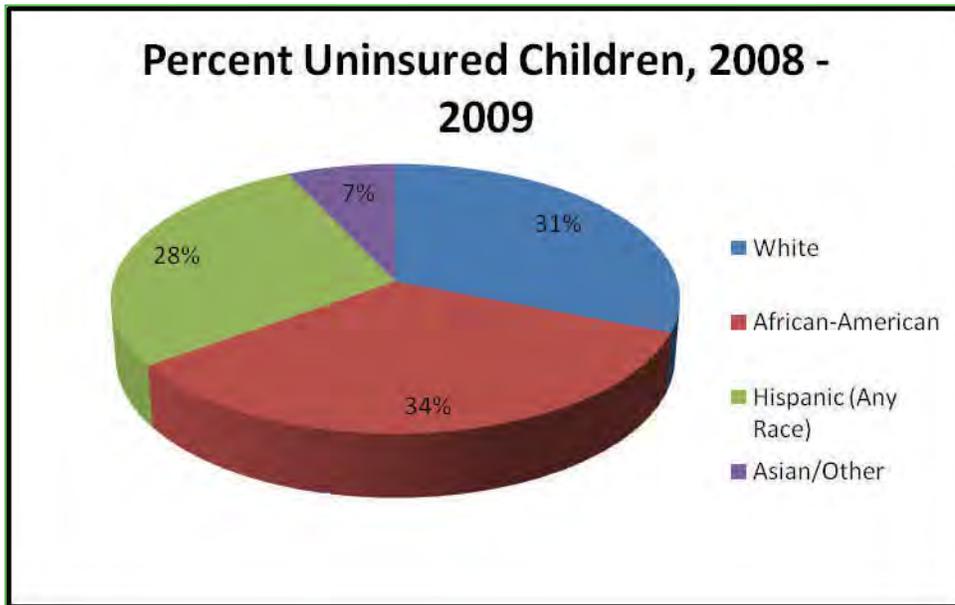
Related Measures: Employment rates are positively correlated with the rates of insurance coverage because the majority of people who have health insurance in Maryland are insured through their employer. As, “Almost half of those in families in which the adults did not graduate from high school are uninsured,”³ educational attainment is also related to insurance coverage. Another positive indicator of health insurance coverage is income, which means that an individual is more likely to be employed and have health insurance through his/her employer or is more likely to be able to afford health insurance.

Story Behind the Data: Overall, health coverage has increased from 90% in 2006 through 2007 to 93% in 2008 through 2009 for children ages birth through 18. As of 2009, Maryland exceeds the national average for the percent of children covered by health insurance. This may be attributable to Maryland’s unemployment rate only having increased by 2.6%, as opposed to the national average of 3.5%, because of the high percentage of people who have health insurance through an employer. Significant increases in insurance rates were observed among all races in 2008 through 2009 from 2006 through 2007 (as seen in the graph above). The sharpest increase of insurance coverage was for African-American children, increasing more than 50% from 2006 through 2007.

³ Maryland Health Care Coalition (MHCC), *Health Insurance Coverage in Maryland Through 2007*. P. 5.

However, disparities exist between races, with Hispanics representing 28% of children without coverage while only comprising 10% of the child population in Maryland (2008 through 2009). African-American children represent the majority of children without health insurance at 34%, but in 2006 through 2007 48% of uninsured children were African-American. Although White children are 31% of those lacking health insurance, only 4% of all White children in Maryland are uninsured.





It is positive to note that a significant increase in the rate of health coverage was observed for families who were below the Federal Poverty Level (<100%) from a rate of 22% uninsured in 2006 through 2007 to 11% uninsured in 2008 through 2009. This is likely attributable to the increase in the number of Maryland residents receiving Medicaid from January 2007 to December 2010 by almost 250,000 people – 118,000 of which were children. Similar decreases of uninsured children occurred in families with low levels of educational attainment and particularly in families with no adult workers (from 24% to 10% in 2008 through 2009), while there was no change or only small decreases of uninsured children in families who had higher educational and income levels. This data may indicate that lack of coverage is strongly related to low income and might further explain why the Governor's expansion of Medicaid corresponded to a sharp increase in the rate of insured children.

Indicator 5: Immunizations

Indicator: The percent of Maryland children fully immunized at age two.

Definition: The percent of children ages 19 through 35 months who have received the full schedule of recommended immunizations: 4 doses of diphtheria vaccine, 3 doses of polio vaccine, 1 dose of measles-containing vaccine, 3 doses of haemophilus influenzae type b (Hib) vaccine, 3 doses of hepatitis B vaccine, and 1 dose of varicella vaccine (4:3:1:3:3:1 series).

Significance: The immunization status of young children is a positive predictor of avoidance of death, disability, or developmental delays associated with immunization-preventable diseases.

Baseline Data: Immunization coverage of children ages 19 through 35 months:

National Immunization Survey: ESTIMATED VACCINATION COVERAGE AMONG CHILDREN-BETWEEN THEN AGES OF 19 MONTHS THROUGH 35 MONTHS, SURVEY YEARS 2002-2009, Maryland and National Data

	2002*	2003	2004	2005	2006	2007	2008	2009
Maryland	71	77	76	79	78	91	80	84
National	66	73	76	76	77	77	76	76

**Data prior to 2002 is not available*

Data Source: National Immunization Survey of children ages 19 through 35 months. Data for 2010 are not yet available.

Considerations: For 2009 data, the 95% confidence interval was $\pm 4.9\%$ for Maryland, compared with $\pm 1.1\%$ for the national data, indicating that Maryland data may not reflect immunization coverage as accurately as the national data.

Related Measures: The 2009–2010 Report on the Immunization Status of Students Enrolled in Maryland Schools is an annual survey of public and private Maryland schools. To comply with the Code of Maryland Regulations, schools must report the number of fully vaccinated students enrolled in Kindergarten. From 2003 to 2010, 99% or more of Kindergarten students had been fully vaccinated.

Story Behind the Data: Maryland's 2009 immunization rates were above the national average for children ages 19 through 35 months. The Centers for Disease Control and Prevention (CDC) reported that, at 84%, Maryland (along with Iowa) had the highest vaccination rates among states, 8 points above the national average. ImmuNet, Maryland's online immunization registry for children and adults, annual quality assurance visits to vaccine providers, strong local health department support, community efforts, and parents are credited with Maryland's continued above-average immunization rates.

Although child immunization rates are high, the Department of Health and Mental Hygiene (DHMH) Center for Immunization seeks to increase these rates to better safeguard children's health. Expanding the enrollment and use of ImmuNet among healthcare providers is a key strategy toward this end. Significant upgrades to ImmuNet were launched in April 2011 to make participation even more attractive to vaccine providers. ImmuNet now has electronic data exchange capabilities that can automatically capture data from electronic health records or other computer-based files, making direct data entry into ImmuNet unnecessary. Improved administrative options for users and convenient online training for registered providers are additional enhancements.

See www.mdimmunet.org. For more information on the work of Maryland's Center for Immunization, visit: <http://ideha.dhmh.maryland.gov/IMMUN/>.

Indicator 6: Hospitalizations

Indicator: The rate of child injuries that require inpatient hospitalization.

Definition: The number of injury-related inpatient hospital discharges (by jurisdiction and children's race) per 1,000 children, ages birth to 19 years, in three broad injury categories: unintentional injuries, assaults, and self-inflicted injuries.

Significance: Childhood injuries requiring inpatient hospitalization present risks of long-term illness and disability. Not only are the injuries themselves traumatizing for the child and family, the cost for care is high to public and private medical insurance.

Baseline Data: Child Injury Related Inpatient Hospital Discharges (reported by calendar year)

Rate of Child Injuries per 1,000 Children Ages 0-19- by calendar year, Maryland												
Unintentional injuries	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	3.4	4.0	3.8	3.8	3.8	3.9	4.2	4.1	4.4	4.4	4.3	4.2
White	3.8	4.1	3.9	3.7	3.9	4.0	4.2	4.2	4.7	4.2	4.0	3.9
African- American	3.2	3.9	3.9	3.8	3.7	3.8	4.1	3.9	4.2	4.6	4.7	5.0
All other races	3.3	3.8	2.6	3.8	5.1	5.0	5.8	6.0	5.0	5.1	4.8	4.2
Assaults	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	0.4	0.3	0.3	0.3	0.4	0.4	0.3	0.4	0.5	0.4	0.4	0.4
White	0.9	0.8	0.8	0.7	0.8	0.87	0.8	0.9	1.0	0.1	0.2	0.1
African- American	0.2	0.1	0.2	0.1	0.2	0.1	0.1	0.1	0.2	1.0	0.9	0.8
All other races	0.4	0.2	0.1	0.2	0.4	0.3	0.3	0.4	0.3	0.3	0.4	0.2
Self-inflicted injuries	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4
White	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.4	0.4
African- American	0.3	0.3	0.4	0.4	0.4	0.3	0.3	0.4	0.3	0.3	0.2	0.3
All other races	0.3	0.3	0.2	0.5	0.3	0.6	0.6	0.7	0.4	0.4	0.1	0.5

2009 Data Source: 2009 Source: Derived from HSCRC 2009 Hospital Discharge Dataset Population Estimates: Prepared by the Maryland Department of Planning, Planning Data Services 2009 Source: Census 2000 Modified Race data (MR(31)-CO.txt) prepared by the U.S. Census Bureau, June 2010 http://www.mdp.state.md.us/msdc/Pop_estimate/estimate_00to09/by_age_race_sex/county/CNTY_PopEst_2009.xls.

Considerations: These data refer to actual encounters with the healthcare system, not to individuals or to incidents. Recurring visits, either for the same injury or for subsequent injuries, were counted separately. Injuries for which medical care was sought outside of Maryland or not at all are not included in the data. Accordingly, the data may not be the best estimate of child injury-related hospitalization in jurisdictions adjacent to other states or to the District of Columbia and the injury rates may be underestimated for children without access to proper health care.

The rates of unintentional injury reported here are inconsistent with those in DHMH's Annual Injuries in Maryland reports. Due to the inclusion of codes corresponding to the adverse effects of medical care, the estimates of unintentional injury reported here are higher than those reported elsewhere.

It is important to note that these data do not indicate whether a child injury was related to abuse or neglect and the rates reported here are not direct estimates of the incidence rates of child injuries. Rates are not calculated for counts less than 20 because of unreliable and unstable statistical estimates. Caution should be used when interpreting small numbers.

Related Measures: Data from the Maryland Health Services Cost Review Commission (HSCRC) is also used by the Family Health Administration of DHMH to produce annual reports in an effort to provide injury professionals better information for designing programs to reduce injuries to Maryland residents (http://fha.maryland.gov/pdf/ohpetup/2008_Injuries_in_Maryland.pdf). Additional injury-related data can be found at the Family Health Administration of the DHMH (<http://fha.maryland.gov/ohpetup/publications.cfm>) and at the web-based Injury Statistics Query and Reporting System (WISQARSTM), operated by the CDC (<http://www.cdc.gov/injury/wisqars/index.html>).

Story Behind the Data: Injuries may be the result of unintentional or intentional events. Most unintentional injuries are related to motor vehicles, falls, fires and burns, poisonings, choking suffocation, and drowning. Intentional injuries include assaults and self-inflicted injuries.

In 2009, there were 6,317 total inpatient hospital discharges for unintentional injury, 555 discharges for injuries due to assault, and 540 discharges for self-inflicted injuries among Maryland children ages birth to 19 years. Compared to White children, African American children and children of other race groups had statistically significant higher rates of hospitalization for unintentional injury and injury due to assault. This suggests that in Maryland there may be racial disparities in unintentional injuries and injuries due to assaults among children.

Among White children, the highest rate of hospitalization for unintentional injury was reported in Kent County in 2009. The lowest rate was reported in Prince George's County in 2009. The ability to evaluate the differences across counties in injury-related hospitalization among African-American children and children of other racial groups was precluded by small numbers. Please note that the rates by jurisdiction may also be influenced by the geographical distribution of hospitals.

In the United States in 2009, the top five leading causes of nonfatal injuries for children ages birth to 19 years were unintentional fall, unintentional struck by/against, unintentional overexertion, motor vehicle accidents, and unintentional cut/pierce (data source: WISQARSTM (<http://webappa.cdc.gov/cgi-bin/broker.exe> accessed on June 22, 2011)).

Statewide programs such as Kids in Safe Seats, which provide free inspection of car seat installations and free car seats to those in need, and Smoke Alarms for Everyone (SAFE), which provide community grants to provide fire prevention materials, education and installation of smoke alarms, are examples of initiatives designed to prevent child injury and deaths due to injuries. Both programs are administered by the DHMH Center of Health Promotion and Education (<http://fha.maryland.gov/ohpetup/eip.cfm>).

Indicator 7: Substance Abuse

Indicator: The illegal use of alcohol, tobacco, and other drugs (ATOD) by Maryland youth.

Definition: The percent of Maryland public school students surveyed, in grades 9 through 12, who described themselves as having used or currently using alcohol, tobacco, and other drugs.

Significance: Use of ATOD poses many health risks for youth. Early use of some substances (e.g. alcohol, tobacco, and marijuana) is associated with later drug use and the prevalence of high-risk behaviors.

Baseline Data:

Alcohol Use - Percentage of Maryland public school students in grades 9 through 12 who:	2005	2007	2009
Have ever had a drink of alcohol.	73.1	72.9	67.2
Had a drink of alcohol before age 13.	24.8	23.5	24.5
Are current drinkers (at least one drink of alcohol on at least 1 day during the 30 days before the survey).	39.8	42.9	37.0
Are binge drinkers (five or more drinks of alcohol, within a couple of hours, on at least 1 day during the 30 days before the survey).	20.8	23.9	19.4

Tobacco Use - Percentage of Maryland public school students in grades 9 through 12 who:	2005	2007	2009
Ever tried cigarette smoking.	48.5	50.3	43.5
Smoked a whole cigarette before age 13.	13.7	13.4	10.8
Are current cigarette smokers (smoked cigarettes on at least 1 day during the 30 days before the survey).	16.5	16.8	11.9
Are heavy cigarette smokers (smoked more than 10 cigarettes per day on the days they smoked during the 30 days before the survey).	7.4	7.4	4.4
Are current smokeless tobacco users (used chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey).	2.9	4.2	5.4
Are current cigar smokers (smoked cigars on at least 1 day during the 30 days before the survey).	11.6	11.0	12.7

Marijuana Use - Percentage of Maryland public school students in grades 9 through 12 who:	2005	2007	2009
Have ever tried marijuana.	38.2	36.5	35.9
Tried marijuana for the first time before age 13.	8.9	8.6	8.1
Are current marijuana users (used marijuana one or more times during the 30 days before the survey).	18.5	19.4	21.9

Other Drug Use - Percentage of Maryland public school students in grades 9 through 12 youth who ever used the following drugs one or more times	2005	2007	2009
Cocaine (including powder, crack, or freebase)	6.9	5.5	6.3
Methamphetamines	4.0	3.0	4.3
Heroin	2.6	2.4	4.1
Ecstasy	5.0	6.3	6.4
Steroids (pills or shots without prescription)	3.6	2.5	3.9
Inhalants (glue, aerosol cans, paint)	12.5	12.9	11.0

Data Source: The Maryland Youth Risk Behavior Survey (YRBS) is part of the Youth Risk Behavior Surveillance System (YRBSS) developed in 1990 by the CDC to monitor behaviors that affect morbidity (disease) and mortality (death) among high-school-age youth. The YRBS monitors several categories of health-risk behaviors among youth. In the spring of 2009, the YRBS was administered to students in a representative sample of Maryland public high school classrooms. A total of 1,644 students in 30 Maryland public high schools completed the survey, representing a 78% response rate. The 2009 YRBS results are representative of all Maryland’s public school students in grades 9 through 12.

Considerations: The YRBS data are presented by combined grade levels, 9 through 12. The data presented in the formal report are not disaggregated by race, grade level, jurisdiction, or school. They are representative of Maryland’s public high schools.

Related Measures: The CDC also conducts a national youth health risk behavior survey every other year. The 2009 YRBSS included a national school-based survey conducted by CDC, 47 state surveys, four territory surveys, two tribal government surveys, and 23 local surveys conducted among students in grades 9 through 12 from October 2008 to February 2010. More information on the purpose, components, and use of the data is available at <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>.

Story Behind the Data: Although alcohol is the most commonly used drug among Maryland youth, the percentage of Maryland youth who have ever had a drink of alcohol decreased significantly between 2005 and 2009. Still, two-thirds of Maryland youth have drunk alcohol, and approximately one in five is a binge drinker. Other indicators of alcohol use remained unchanged.

Cigarette and cigar use decreased significantly or remained unchanged between 2005 and 2009 while smokeless tobacco use increased significantly. For females, smoking a whole cigarette before age 13 and current smoking decreased significantly.

Early marijuana use, current marijuana use, and current cocaine use did not change significantly between 2005 and 2009. One in five Maryland youth uses marijuana.

Between 2005 and 2009, males reported a significant increase in ever having used heroin. Current cocaine use among 9th graders increased significantly during the same period.

Indicator 8: Obesity

Indicator: The percentage of Maryland youth who are obese, describe themselves as overweight, or are trying to lose weight.

Definition: The percentage of Maryland youth who are obese, describe themselves as overweight, or are trying to lose weight for students in high school grades 9 through 12.

Significance: Overweight and obesity are defined as medical conditions in which excessive body fat accumulation may lead to increased health problems. The most widely accepted method used to screen for overweight and obesity is the body mass index (BMI), which is a measure of a person's weight in relation to his/her height.

Baseline Data:

Percentage of Maryland public school students in grades 9 through 12 who:	2005	2007	2009
Are overweight or obese (measured by the BMI).	28.7	28.3	27.9
Describe themselves as overweight.	27.4	27.5	27.5
Are trying to lose weight.	42.5	42.6	43.7

Weight Loss Methods Used:	2005	2007	2009
Exercise	58.4%	57.1%	60.1%
Dieting	38.6%	38.8%	36.4%
Fasting	10.3%	11.5%	10.7%
Diet Pills	5.5%	5.7%	5.4%
Vomiting/Taking Laxatives	3.2%	6.5%	5.9%

Data Source: The YRBS is part of the Youth Risk Behavior Surveillance System (YRBSS) developed in 1990 by the U.S. Centers for Disease Control and Prevention (CDC) to monitor behaviors that affect morbidity (disease) and mortality (death) among high-school-age youth. The YRBS monitors several categories of health-risk behaviors among youth. In the spring of 2009, the YRBS was administered to students in a representative sample of Maryland public high school classrooms. A total of 1,644 students in 30 Maryland public high schools completed the survey, resulting in a 78% response rate. The 2009 YRBS results are representative of all Maryland's public school students in grades 9 through 12.

Considerations: The YRBS data are presented by combined grade levels, 9 through 12. The data presented in the formal report are not disaggregated by race, grade level, jurisdiction, or school. They are representative of Maryland's public high schools.

Related Measures: The Centers for Disease Control and Prevention (CDC) also conducts a national youth health risk behavior survey. The 2009 YRBSS included a national school-based survey conducted by CDC, 47 state surveys, four territory surveys, two tribal government surveys, and 23 local surveys conducted among students in grades 9 through 12 during October 2008 through February 2010. More information on the purpose, components, and use of the data is available at: <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>.

Story Behind the Data: The prevalence of obesity among adolescents ages 12 to 19 more than tripled from 1980 to 2006 (from 5% to 17%). Obese youth are at risk for factors associated with cardiovascular disease (e.g., high cholesterol or high blood pressure), bone and joint problems, sleep apnea, and poor self-esteem. Obese youth are at increased risk of becoming obese adults, and therefore, are at risk for the associated adult health problems, such as heart disease, type 2 diabetes, stroke, cancer, and osteoarthritis.

The percentage of Maryland youth who are overweight or obese has not changed significantly between 2005 and 2009. One in four Maryland youth is overweight or obese. While there are significantly more overweight or obese males than females (31.4% to 24.1%), significantly more females describe themselves as overweight (32.5% to 22.5%) and are trying to lose weight. Despite its relatively small preference as a weight loss method among Maryland youth, the use of vomiting/taking laxatives has increased significantly between 2005 and 2009.

The MSDE supports programs in Comprehensive Health Education and Physical Education. Both of these content areas address the health and wellness of Maryland's students. MSDE works closely with the Maryland Association for Health, Physical Education, Recreation, and Dance, an organization that supports teachers across the state. MSDE specialists staff the Health and Physical Education Advisory Council, which is composed of health and education leaders from across the state. MSDE also supports local wellness policy initiatives, has created a number of resources, and has convened annual meetings to assist local implementation of wellness policies.

Indicator 9: Asthma Prevalence

Indicator: Percent of school-aged youth that have been told by a doctor or nurse that they have asthma.

Definition: The percentage of school-aged (middle and high school) youth with asthma in selected racial groups, by grade and jurisdiction.

Significance: Asthma is a chronic disease of the bronchial tubes, the air passages leading to and from the lungs. Although asthma cannot be cured, appropriate management can control the disease and enable people to enjoy a good quality of life.

Baseline Data: Asthma prevalence (reported by selected calendar years)

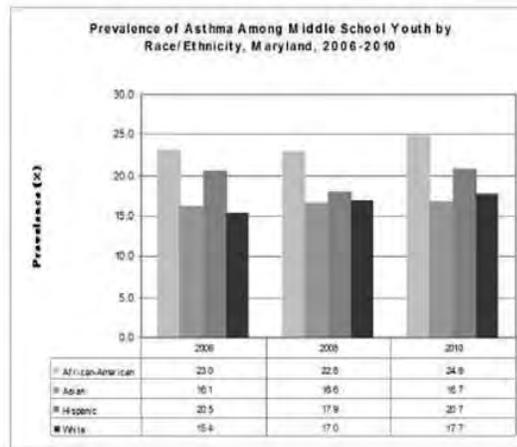
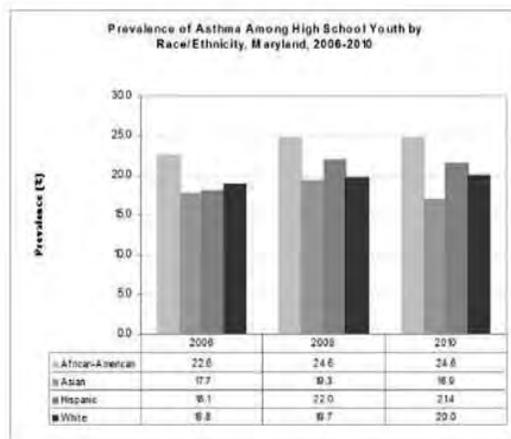
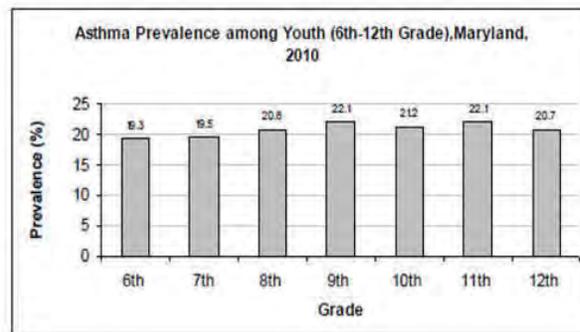
Prevalence of asthma among Maryland youth by calendar year and Grade			
Grade	2006	2008	2010
Middle School Youth	18.6%	18.7%	19.9%
High School Youth	19.9%	21.2%	21.5%
Prevalence of asthma among Maryland High School youth by calendar year and race/ethnicity			
Race/Ethnicity	2006	2008	2010
African-American	22.6%	24.6%	24.6%
Asian	17.7%	19.3%	16.9%
Hispanic	18.1%	22.0%	21.4%
White	18.8%	19.7%	20.0%
Prevalence of asthma among Maryland Middle School youth by calendar year and race/ethnicity			
Race/Ethnicity	2006	2008	2010
African-American	23.0%	22.8%	24.9%
Asian	16.1%	16.6%	16.7%
Hispanic	20.5%	17.9%	20.7%
White	15.4%	17.0%	17.7%

Data Source: DHMH Maryland Youth Tobacco Survey. Response based on the question: “Has a doctor or a nurse ever told you that you have asthma?”

Considerations: These data are from a survey of randomly sampled Maryland public middle and high school students. Prevalence is based on child self-report of asthma diagnosis by a clinician and may represent an underestimate of actual asthma prevalence due to lack of access to healthcare or to lack of awareness by the child.

Related Measures: Additional information on children's asthma is available through the Maryland Asthma Control Program's surveillance reports and briefs, available at: http://fha.maryland.gov/mch/asthma_surv.cfm.

Story Behind the Data: Asthma rates increased in Maryland between 2006 and 2010 among middle school and high school youth in all racial and ethnic groups. In 2010, approximately 1 in 5 Maryland youth was affected by asthma. African-American youth consistently report higher rates of asthma than other racial and ethnic groups. In 2010, 24.9% of African-American middle school youth reported having an asthma diagnosis compared to 16.7% of Asians, 20.7% of Hispanics and 17.7% of Whites. Among high school youth, 24.6% of African-Americans reported having an asthma diagnosis compared to 16.9% of Asians, 21.4% of Hispanics and 20.0% of Whites. Information on the Maryland Asthma Control Program's Action Plan is available at: http://fha.maryland.gov/pdf/mch/Asthma_Action_Agenda.pdf.



Indicator 10: Deaths

Indicator: The rate of deaths among children ages 1 to 19 years.

Definition: The number of deaths per 100,000 children ages 1 to 19 years, by age and race.

Significance: This indicator measures the worst health outcome for children. Comparisons of death rates may indicate potentially increased risks for children of specific age groups, racial/ethnic backgrounds and residential jurisdiction.

Baseline Data: Number and Rates of Child Deaths by Age and Race (reported by calendar year)

Rate of Child Deaths per 100,000 Children Ages 1-19, by Calendar Year, Maryland and National											
Maryland	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	36.0	32.7	34.6	33.3	34.5	33.7	29.8	30.7	34.3	30.5	25.3
White	28.2	28.8	28.2	26.1	27.0	26.4	24.6	27.4	27.9	25.7	21.4
African- American	53.9	46.4	49.3	47.4	50.9	49.3	40.1	38.8	46.4	39.8	32.9
All other races	19.7	9.6	16.4	24.1	18.1	13.5	21.0	15.6	28.0	25.7	21.5
National	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All Races	34.9	33.9	33.6	33.5	33.0	32.7	32.3	31.5	30.9	N/A*	N/A*
White	32.7	32.1	31.9	31.9	31.5	31.0	30.4	29.4	28.9	N/A*	N/A*
African- American	48.2	45.2	44.0	43.7	42.4	43.0	43.3	43.2	42.7	N/A*	N/A*
All other races	26.9	26.0	27.5	27.0	28.1	26.1	26.1	25.6	24.7	N/A*	N/A*
*2008, 2009 National data not available											

Data Sources: Maryland data sources: Child Deaths: DHMH, Vital Statistics Administration
Population: DHMH, MATCH

National Data Source: National Center for Health Statistics, Center for Disease Control and Prevention, accessed through the “CDC WONDER” online database:
<http://wonder.cdc.gov/mortsql.html>.

Considerations: It may be desirable to compute multi-year averages, particularly for small jurisdictions and subgroups. Rates are not calculated for counts less than 5 because of unstable statistical estimates. Caution should be used when interpreting small numbers. Calculation based on the number of child deaths (1 to 19 years) divided by the population of children (1 to 19 years).

Related Measures: The Center for Maternal and Child Health at the Department of Health and Mental Hygiene produces an annual report from the Maryland State Child Fatality Review Team, available at: http://fha.maryland.gov/mch/cfr_home.cfm, as well as a Child Death Report, available at: http://fha.maryland.gov/pdf/mch/cfr_Child_Death_Report_2008.pdf.

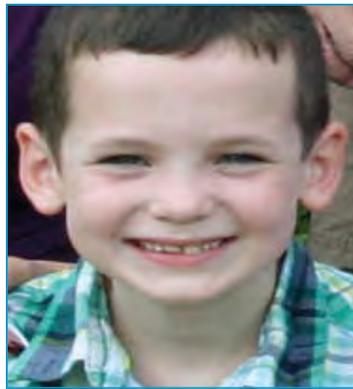
Additional child mortality related data can be found at the Maryland Assessment Tool for Community Health (MATCH), available at: <http://fha.maryland.gov/match.cfm> and the Leading Causes of Death Reports by the CDC, available at: <http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html>.

Story Behind the Data: Maryland's child death rate has generally decreased over the past decade. In 2009, 365 children between the ages of 1 and 19 years died. 21% of these children were age 1 to 5 years, and 70% were age 11 to 19 years. The overall mortality rate among children ages 1 to 19 years in 2009 in Maryland was 25.3 per 100,000 children. African-American children had significantly higher death rates (32.9 per 100,000) than those of White children (21.4 per 100,000).

In Maryland from 2007 to 2009, the top 3 leading causes of death for children ages 1 through 17 years were unintentional injuries, homicides, and malignant neoplasms.

Each of Maryland's 24 jurisdictions has a Child Fatality Review Team which meets regularly to review unexpected deaths of children living in their area. The purpose of these reviews is to identify changes in systems, policies, or practices at the local level which might reduce child deaths in the future.

Theme II: EDUCATION



Result 3—School Readiness



Result 4— School Success



Result 5— School Completion



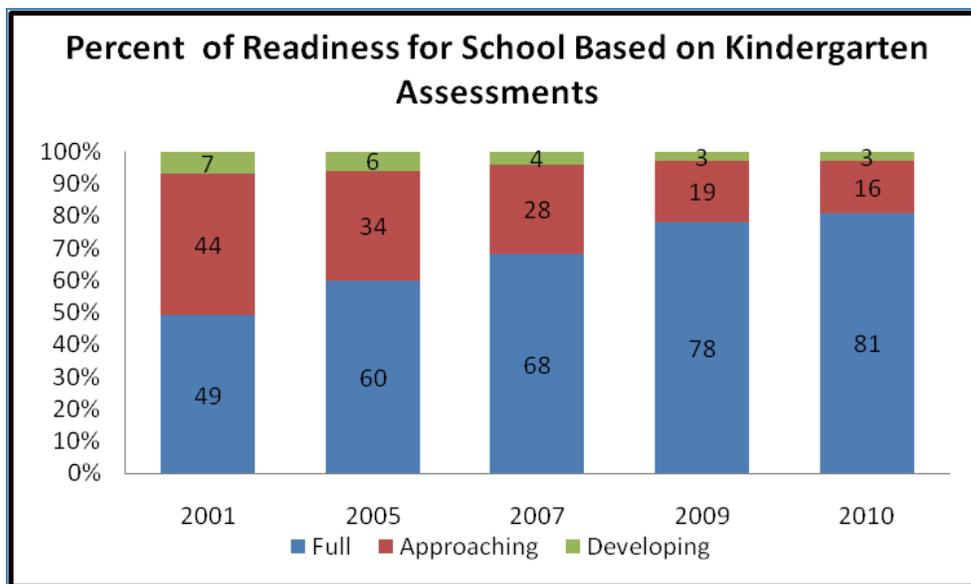
Result 6— School Transition

Theme II: Education

Maryland has a long standing commitment to building a world-class education system, won \$250 million for schools from the federal “Race to the Top” grant, and has been rated as the #1 public school system in the nation for the third year in a row by *Education Week*. In order to maintain Maryland’s long-term economic well-being in a changing world, Maryland’s schools strive to continue to build upon its successes. The Governor’s Forum on Skills and Education, convened in January 2011, identified strategic goals for how Maryland’s schools, educators, and families can meet the needs of all students, whether they are starting or completing school, or preparing to enter the workforce. Governor O’Malley has committed to improving student achievement, and school, college, and career readiness by 25% by 2015. Maryland seeks to accomplish these goals by increasing accountability through clear, measurable goals and holding the education system to the standard that all children can succeed in school.

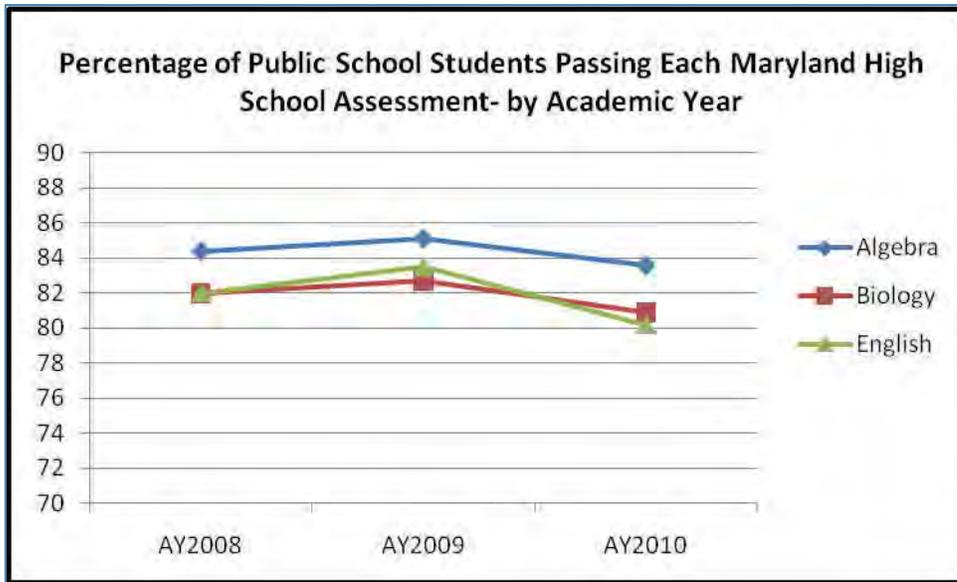
Major Developments in Education

Maryland’s educational goals for children encompass the years before and after school, and everything in between. It is a comprehensive strategy to ensure the ongoing well-being of Maryland’s school children. After all, a child cannot be considered to have received a quality education if he or she is not prepared for the next step in life.

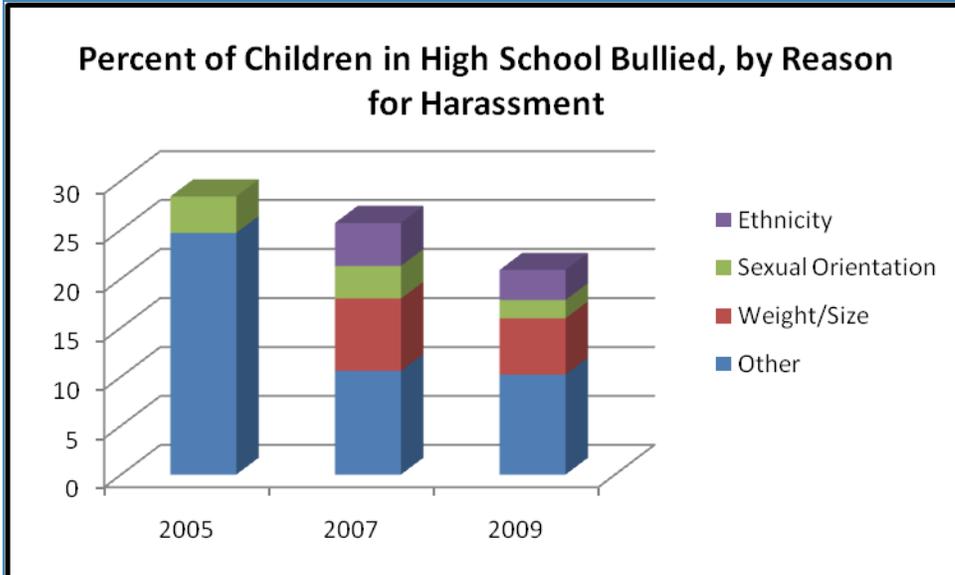


The 2010 school year results reflect the highest percent of children tested using the Maryland Model for School Readiness (MMSR or “Kindergarten Assessment”) who scored “Fully Ready” to enter Kindergarten. The test gauges children on developmental skills including language, social-emotional skills, problem-solving ability, and motor skills. The rate of children who score “Fully Ready” has increased 32% since 2001, however, the rate of children who score “Developing Ready” has only decreased 4% since 2001.

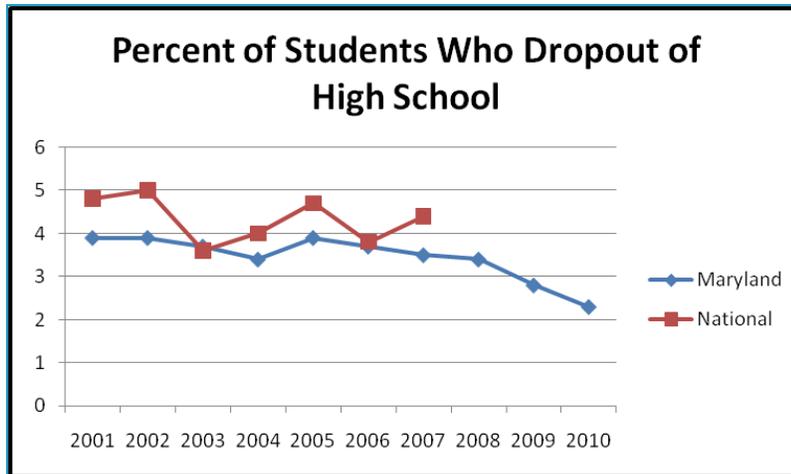
“Quality Counts 2011: Uncertain Forecast,” Education Week, January 11, 2011.



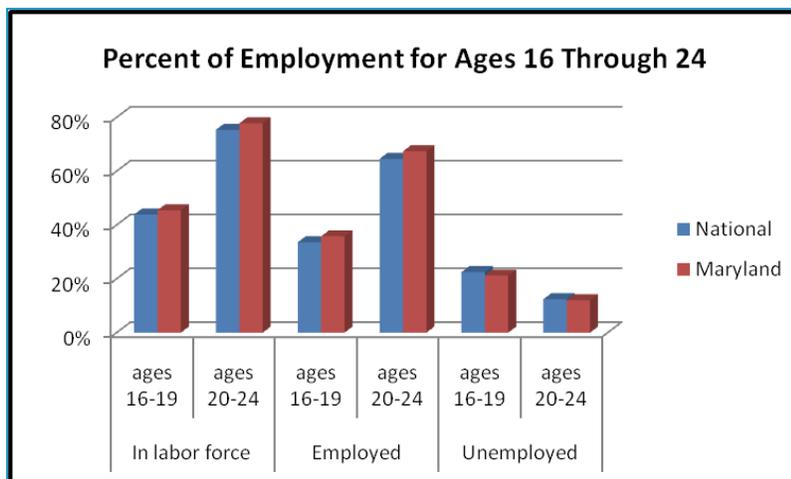
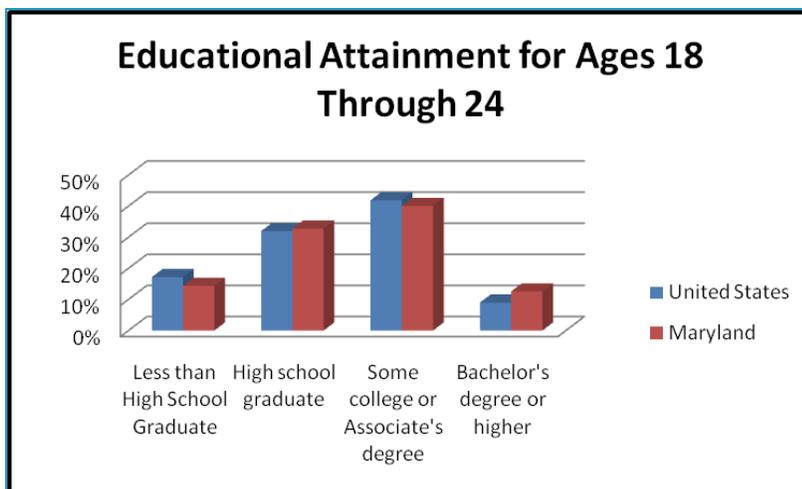
The Maryland High School Assessments test students on four (4) core areas of study: Algebra, Biology, English, and Government and can be a useful indicator of how much public school students in Maryland are learning. Each test is designed to cover 60% of what is learned in classes. Average passing rates decreased since the 2009 school year by about 2% in each subject. Government passing rates were not available for the 2009 and 2010 years.



Bullying can have a tremendously negative effect on individual student success and creates an unstable learning environment. It should be noted that the rate of children who have been bullied in school has decreased since 2005. According to surveys of public high school students, reasons for harassment based on Ethnicity and Weight/Size were not included in the 2005 data because the survey questions were posed differently in later years.



The Maryland average for high school dropout has been lower than the national average and has been decreasing since 2005. While this rate captures the percent of Maryland public high school students who have dropped out of school, it does not reflect the number of students who drop out before high school begins (prior to 9th grade).



Educational attainment and percent of employment for young adults are two clear indicators of how successful young people are in their transition from childhood to independence. Successful outcomes are higher levels of education attained by Maryland youth and higher rates of employment. Both outcomes show Maryland exceeding the national average in the percent of young adults attaining a bachelor's degree and who are employed.



What Maryland Is Doing

Important Actions:

- The **State Advisory Council on Early Childhood Education and Care** was created by the Governor through Executive Order 01.01.2008.09 in July 2008 and directs early child care programs to communicate with each other and coordinate funding so that families can have access to the most comprehensive and affordable child care resources possible. It allows for early assessment, identification, and intervention of children for developmental challenges and informs parents about how they can be their child's first teacher.
- The **Education Reform Act of 2010**, introduced by Governor O'Malley is designed to accelerate efforts to improve Maryland's public school system through a series of measures that poised the State to successfully compete for federal *Race to the Top* Funds.

Initiatives:

- The **Quality Rating and Improvement System (QRIS)** is a system that rates early and school-age care and education programs based on a series of defined standards. This assists parents in making well-informed decisions about where their children can receive care and develops accountability standards for programs. Many programs have been encouraged to participate during the last year through reimbursements for participation.
- The **Extended Option** is a program that provides families of eligible children the opportunity to remain on an Individualized Family Service Plan (IFSP) after age three. This has been remarkably successful in providing continuity of developmentally appropriate services for children during the transition from early child care and education into Kindergarten.
- **Career and Technology Education (CTE)** is available to Maryland public high school students. This initiative prepares students to graduate with a certification or industry recognition in a major trade. The skills involved in CTE are the skills most needed in the growing American workforce today and students who graduate through this program are better prepared for work, career, and higher education.
- **Skills2Compete Maryland** focuses on developing the Maryland workforce by working with local Workforce Investment Boards, community colleges, and State Agencies to bring businesses into Maryland and skills to people seeking quality employment.
- The **Maryland Transitioning Youth Website** (www.mdtransition.org), created by the Governor's Interagency Transition Council for Youth with Disabilities, is a new website for transition age youth with disabilities and their families. The website includes information on a variety of topics including transition planning, higher education, employment, health care, transportation, housing, and much more.

Workgroups and Teams:

- The Governor's **Interagency Transition Council for Youth with Disabilities (IATC)** works to ensure effective interagency planning and delivery of services for children with disabilities to exit high school, with a focus on higher education and employment. This work begins as early as middle school, educating parents and youth about their opportunities through life skills training, career and college counseling, and organizing a team of family, educators, and community supports.

What We Need to Do

Increase the percentage of early and school-age care and education programs that take part in the QRIS.

- Parents make better decisions about the care their children receive when they have ample information about quality care and are aware of their options.
- Child care programs benefit from a clear set of standards to accurately measure their success.
- Incentives increase buy-in from child care programs to participate in rating and ultimately assist programs in demonstrating to families what the programs have to offer.

Increase the percentage of students graduating with CTE certification.

- Jobs that require science, technology, engineering, and mathematics skills are growing.
- Students who exit school with special training are more attractive and employable to potential employers and educators.

Decrease the truancy rate:

- The truancy rate has decreased by .8% since the 2007-2008 academic year, with fluctuating rates between 11 and 14% over the past decade.
- Truancy can result from poor grades, behavioral problems and low parental involvement and often results in dropping out of school.
- Truancy can lead to school-aged youth becoming disengaged and participating in dysfunctional or criminal activity for lack of viable employment options.

Increase the average educational attainment of Maryland students.

- Maryland young adults from age 18 to 24 years have an average high school graduation rate of 85.6% and bachelor's degree attainment rate of 19.6%. Although both of which are above the national average, Maryland ranks third place when compared to the neighboring states of Delaware, Virginia, and Pennsylvania in both categories. This is indicative of Maryland's regional competitiveness and its ability to provide the highest quality education.
- Higher educational attainment is an indicator of better jobs and higher employment rates that give back to the economy by increasing the workforce and generating higher consumer revenues within the local community. An educated workforce leads to a vibrant economy.

Result 3: School Readiness



Why is school readiness important?

A child's mind is constantly active even before the day he or she is born, taking in new information, learning new skills, forming the foundations of knowledge and experience the child will use the rest of his or her life. During this time period children learn to move and crawl and walk, they learn to communicate both through language and non-verbal cues, and they explore their environments and begin to problem-solve. To children, the world around them is an ocean of question marks and mysteries, yet to be discovered. The majority of neurological connections are created during the early childhood years, which is why the first years of a child's life are the most crucial.

It is critically important that this time is wisely used to foster the child's development, partly because a child who is active early in life is more prepared to learn as he or she enters school. As a result, children who are prepared for school are better able to succeed in school. Early childhood programs like childcares, preschool, and home-visiting programs can have a tremendously positive effect on children and their families. Through programs such as these, children can experience a stimulating environment and parents can learn from early childhood professionals about how to continue the learning at home. Studies have shown that communities benefit as children grow, through increased success in school, increased employability, and reducing the social and economic costs of crime and poverty.

How do we measure school readiness?

Accessible and high-performing educational resources for families are essential to prepare children for school. Families need to know how to choose the highest quality early childhood programs and to know what skills their children need to develop. In Maryland, two assessments have been instrumental in assisting families to decide what is best for their children.

Indicator 11 - The Maryland Model for School Readiness (MMSR):

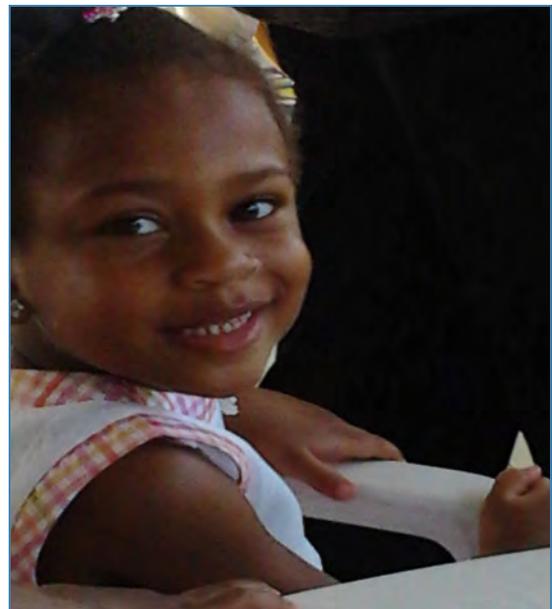
An assessment system that helps teachers and parents document and evaluate children's development in a variety of areas including language, social skills, mathematical thinking, and physical development.

Indicator 12 - (Future Development) The Quality Rating Improvement System (QRIS):

A rating system designed to improve the quality of early child care services, focused on a number of child care standards to increase accountability and performance-measurement.

What does the data say?

- MMSR scores for overall school readiness increased by 3% from the 2009-2010 academic year.
- From AY2001-2002 to AY2010-2011, children living in low-income families improved their overall MMSR scores by 39%.
- Since 2001, 212 child care centers and family child care providers have participated in the reimbursement incentive program tied to QRIS 87 participated in FY2010.



Indicator 11: Kindergarten Assessment

Indicator: The annual MSDE Kindergarten Assessment – known as the Maryland Model for School Readiness (MMSR) reports scores on language and literacy, mathematical thinking, scientific thinking, social studies, the arts, and physical development.

Definition: The Maryland Content Standards and Maryland State Curriculum (SC) are included in the MMSR Framework and standards defining early learning standards and indicators of what children should know and are able to do before they begin formal education. The MMSR includes as its assessment component a customized WSS®, which is a portfolio-based assessment system that helps teachers document and evaluate children’s skills, knowledge, behavior, and academic accomplishments across a variety of curricular areas.

The WSS® domains which are part of the school readiness information are:

1. Social and Personal Development;
2. Language and Literacy;
3. Mathematical Thinking;
4. Scientific Thinking;
5. Social Studies;
6. The Arts; and
7. Physical Development and Health.

Reporting of the scores reflects the percentage of students who have reached one of the following levels of readiness:

- **Full Readiness:** Students consistently demonstrate skills, behaviors, and abilities, which are needed to meet Kindergarten expectations successfully.
- **Approaching Readiness:** Students inconsistently demonstrate skills, behaviors, and abilities which are needed to meet Kindergarten expectations successfully and require targeted instructional support in specific domains or specific performance indicators.
- **Developing Readiness:** Students do not demonstrate skills, behaviors, and abilities, which are needed to meet Kindergarten expectations successfully and require considerable instructional support in several domains or many performance indicators.



Each student's composite score is derived from the student's individual domain scores and represents the student's overall readiness level. The following outline shows the process by which domain and composite scores are determined:

- Each student is rated on 30 separate items. Each item can be proficient (coded as 3), in process (coded as 2), or needs development (coded as 1).
- The 30 items are grouped into domains: social and personal, language and literacy, mathematical thinking, social science, art, and physical development. Each domain has 4 items, except language and literacy, which has six. If any one item is missing, no score is computed for that domain.
- For the four item domains, the possible range for each is from 4 to 12, a range of 9. Nine is divided into 3 equals, yielding the following: 4, 5, or 6 is rated as developing readiness; 7, 8, or 9 is rated as approaching readiness; and 10, 11, or 12 is rated as full readiness.
- For the six-item domain, language and literacy, the possible range is from 6 to 18, a range of 13. In this case, the range is divided into 3, with the "extra" item in the middle, approaching readiness, yielding the following: 6, 7, 8, or 9 is rated as developing readiness; 10, 11, 12, 13, or 14 is rated as approaching readiness; and 15, 16, 17, or 18 is rated as full readiness.
- The composite score is calculated only if all 30 items are present. All 30 item scores are added together, giving a possible composite range from 30 to 90, a range of 61. This is divided into three parts, with the extra item going in the middle category. A composite total of 30 to 49 is considered developing readiness; from 50 to 70 is considered developing readiness; and 71 to 90 is considered full readiness.
- The scale for all of the domain scores and composite score is: 3 = Full Readiness; 2 = Approaching Readiness; and 1 = Developing Readiness.

Significance: Research shows that children who have access to high quality early learning experiences are more likely to complete high school, go to college, or pursue gainful employment. Additionally, national studies show that for every \$1 spent on early childhood education, society saves as much as \$16 in remedial and corrective services. Ensuring that children are ready to enter school provides the best opportunity for propelling children toward success in school and in life. Kindergarteners who are ready to succeed when they begin school are less likely to require targeted support or special education services, be involved in the juvenile justice system, drop out of school, or perform poorly in their adult jobs. MSDE's Kindergarten Assessment process provides an effective tool to measure school readiness.

Data: National data on school readiness measurements that can be meaningfully compared to Maryland’s Kindergarten Assessment process are not available. Maryland Statewide readiness level data for the period FY2002 through FY2011 are included in this Narrative Outline:

Full Readiness (Statewide): FY 2002 - FY 2011										
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Social/Personal	55%	60%	62%	63%	63%	68%	68%	71%	75%	78%
Language and Literacy	36%	42%	45%	48%	50%	56%	58%	62%	67%	71%
Mathematical Thinking	40%	44%	49%	54%	56%	63%	63%	67%	72%	75%
Scientific Thinking	24%	29%	32%	35%	38%	45%	47%	54%	63%	68%
Social Studies	32%	37%	41%	44%	46%	54%	57%	63%	69%	73%
The Arts	51%	58%	62%	63%	64%	70%	71%	75%	79%	83%
Physical Development	60%	66%	70%	72%	74%	78%	79%	82%	85%	88%
Composite Score	49%	52%	55%	58%	60%	67%	68%	73%	78%	81%

Approaching Readiness (Statewide): FY 2002 - FY 2011										
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Social/Personal	36%	33%	31%	30%	30%	26%	27%	24%	21%	18%
Language and Literacy	50%	46%	44%	41%	40%	35%	35%	32%	27%	23%
Mathematical Thinking	47%	43%	40%	36%	35%	30%	30%	28%	23%	20%
Scientific Thinking	59%	57%	55%	53%	52%	47%	45%	40%	32%	27%
Social Studies	55%	52%	50%	47%	45%	39%	38%	32%	27%	22%
The Arts	42%	36%	34%	32%	32%	27%	26%	22%	18%	15%
Physical Development	35%	30%	28%	25%	23%	19%	19%	16%	14%	11%
Composite Score	44%	41%	38%	35%	34%	28%	28%	24%	19%	16%

Developing Readiness (Statewide): FY 2002 - FY 2011										
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Social/Personal	9%	8%	7%	7%	7%	6%	5%	5%	4%	4%
Language and Literacy	14%	12%	11%	11%	7%	9%	8%	6%	6%	6%
Mathematical Thinking	13%	12%	11%	10%	9%	8%	7%	6%	5%	5%
Scientific Thinking	17%	14%	13%	12%	11%	8%	7%	6%	5%	5%
Social Studies	13%	11%	10%	9%	8%	5%	6%	5%	4%	4%
The Arts	7%	6%	4%	5%	4%	3%	3%	2%	2%	2%
Physical Development	4%	3%	3%	3%	3%	2%	2%	2%	2%	2%
Composite Score	7%	7%	6%	6%	6%	5%	4%	3%	3%	3%

Data Sources: MMSR data are collected each year by the 24 LEAs and submitted to MSDE where the results are analyzed, validated, and prepared for publication by the Division of Early Childhood Development. MMSR data can be aggregated and sub-aggregated by any combination of assessment domains, geographic location (Statewide and jurisdictional), and student demographic information (race/ethnicity, gender, prior early care, special education status, English language learner status, and status of enrollment in the FARMs program).

Considerations: Kindergarten teachers are trained to conduct student observations and review student work samples in order to develop student readiness determinations in accordance with established MMSR procedures. Through ongoing observation, recording, and evaluation of everyday classroom experiences and activities, teachers gain a better understanding of what their students know and are able to do, and what support is still needed.

Kindergarten teachers use the WSS® with all children throughout the school year. For the MSDE School Readiness Report that is published annually each spring, Kindergarten teachers provide information on students' skills for the first (fall) grading period. Teachers use portfolio-based assessments to document their students' classroom performance during the first eight weeks of school. The fall assessment ratings are done on 30 WSS® performance indicators. These indicators reflect the skills and abilities that can reasonably be expected from children upon entering Kindergarten. The 30 WSS® indicators represent the seven domains listed above.

Student readiness assessment information reflects scores for each of the seven domains and the composite score of all domains. Assessment information is also analyzed for each of the seven domains and the composite score by the following demographic information:

- Race/ethnicity;
- Gender;
- Prior early care;
- Special education;
- English Language Learners (ELL); and
- Enrollment in the free and reduced priced meals program (FARMs).



MMSR data provide a snapshot of Statewide and jurisdictional school readiness levels of children entering kindergarten in the fall of each year. The school readiness information is designed for purposes of instructional accountability, which means that the data should inform practitioners and policymakers of how to improve the learning opportunities for young children and to begin the discourse for improving the quality of early childhood education. In general, the information can be used to:

- Develop jurisdictional needs assessments regarding the skill levels of children entering Kindergarten;
- Target federal, State, and local funds to address identified jurisdictional needs;
- Develop forums for partnership building; and
- Modify curricular and intervention programs and to identify resources for Kindergarten.

Interpreting readiness level data for specific groups should be evaluated as a way to track progress over time for each domain and each demographic category. For instance, the trend for the Language and Literacy domain should be tracked over time by comparing the results from year to year. Any progress is measured at the 95% confidence interval. The same measure applies, for example, in determining any significant changes over time for Language and Literacy using specific prior care categories, such as pre-Kindergarten or child care center. Caution in interpreting information is warranted when relatively small numbers of children are involved.

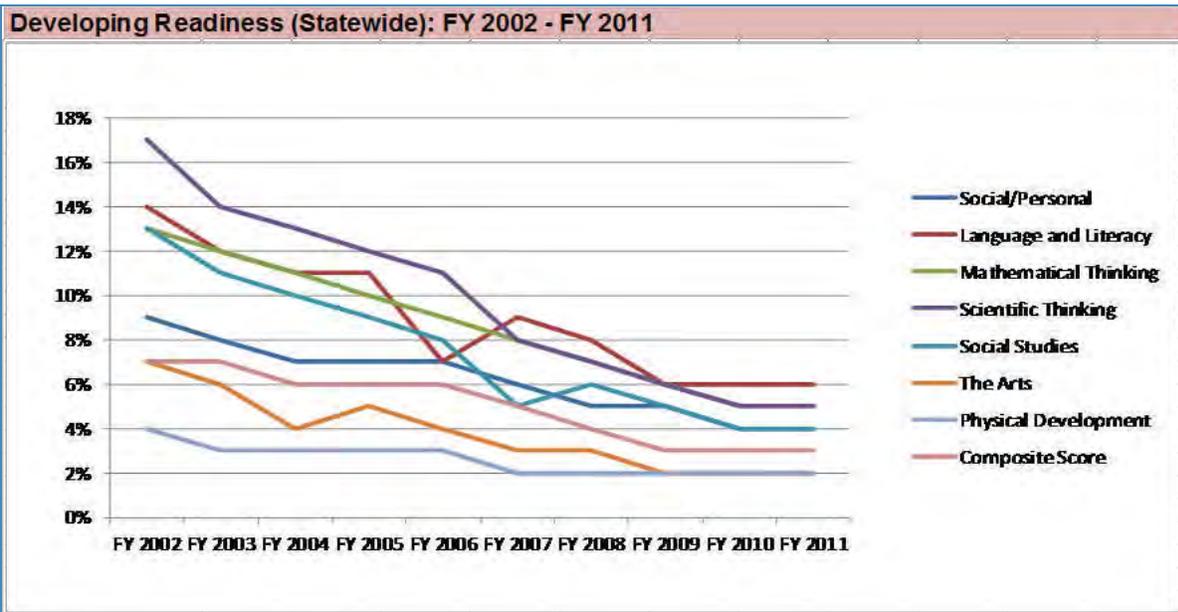
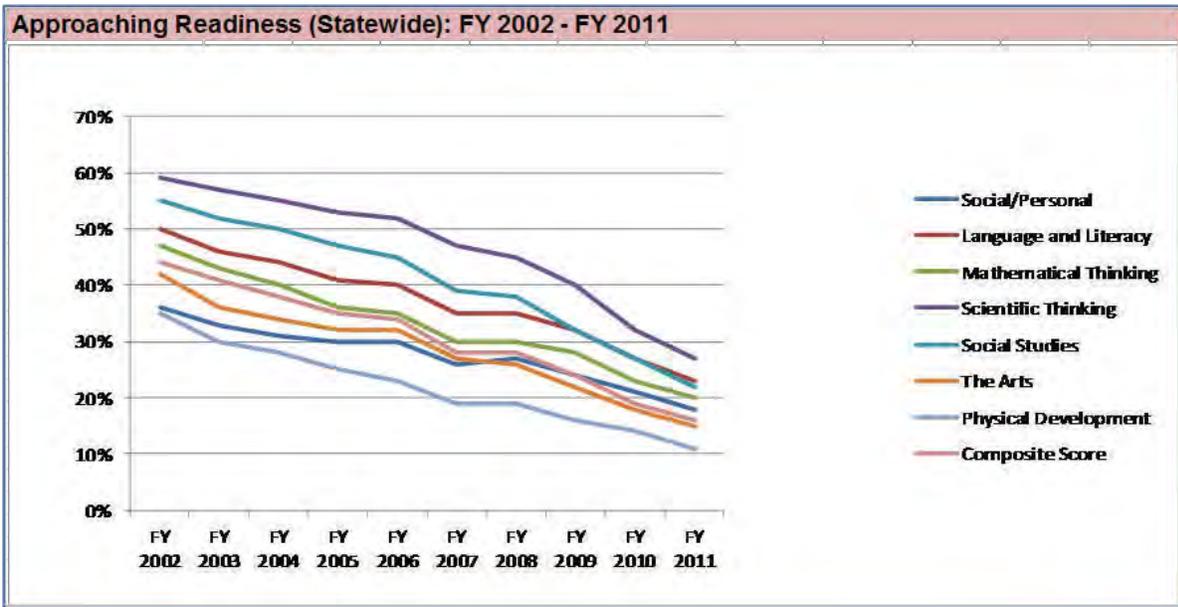
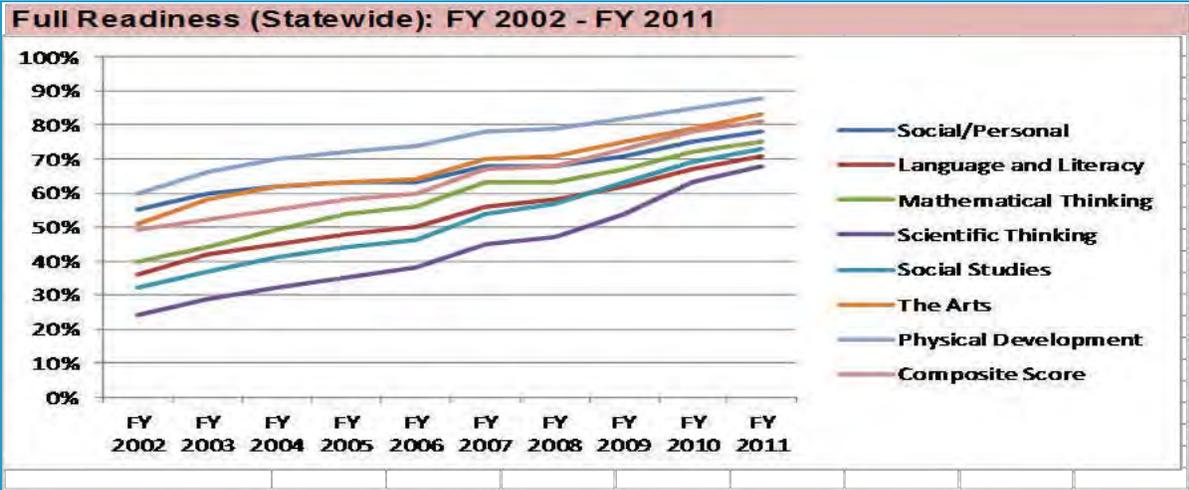
Since Kindergarten teachers use a portfolio-based assessment to evaluate their students' skill levels, concerns about the subjectivity of the teachers' evaluations must be addressed. The school readiness information is based on formative and summative evaluation protocols. The summative evaluations in the fall include the students' observed and documented records of their skills, behavior, and knowledge in response to the introduction of the Kindergarten curriculum. Teachers are trained in the use of specific guidelines which define fall benchmarks of Kindergarten expectations for each of the 30 WSS® indicators of learning.

The indicators for the domains of Language and Literacy, Mathematical Thinking, Scientific Thinking, Social Studies, and The Arts are aligned with the Maryland Content Standards, the state's Voluntary State Curriculum, and the MMSR Framework and Standards. Any sampling error of the results is eliminated by implementing census administration of the WSS®. Each local school system oversees the administration of the Kindergarten assessment. Additionally, the MMSR data are analyzed and verified by an independent vendor on contract to the Division of Early Childhood Development who provides reliability analyses for State and jurisdiction data sets.

Story Behind the Data: MMSR results for FY2011 indicate that Maryland students entering Kindergarten this school year were better prepared than those in the past. The cohort of Maryland's students entering Kindergarten in AY2010-2011 improved its overall school readiness skills by 3% compared to students who entered Kindergarten in the 2009-2010 school year. The percentage of incoming Kindergartners rated by their teachers as "fully ready" increased from 78% last year to 81% this year. The increase from the baseline year of 2001-2002 to this year is 32%.

The upward trend is a significant shift from AY 2001-2002 and reflects the Statewide efforts of improving the early learning opportunities for young children as they begin their school career. The results for the domains of Language and Literacy and Mathematical Thinking are even more pronounced. According to the teachers' assessment of emergent reading and writing skills, 35% more children were rated "fully ready" compared to youngsters who entered Kindergarten in 2001-2002. 35% more children were also rated "fully ready" in the domain of Mathematical Thinking as compared to children who entered Kindergarten in AY2001-2002.

The upward trend from AY2001-2002 is evident for all subgroups. The improvement in the composite score among low-income children and children with disabilities was significant, with an increase of 39% and 26%, respectively. The increase for English Language Learners (ELL) from AY2001-2002 is 33% for the composite score and 31% in the Language and Literacy score.



Indicator 12: Quality Rating and Improvement System (QRIS)

Indicator: The Quality Rating and Improvement System (QRIS) is a systematic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs. Similar to rating systems for restaurants and hotels, QRIS awards quality ratings to early and school-age care and education programs that meet a set of defined program standards. Through participation in the QRIS, programs embark on a path of continuous quality improvement. Maryland's QRIS, which will be called "Maryland EXCELS", will have five levels, represented by 1 star through 5 stars, through which licensed child care centers and family child care providers can progress as they meet successive quality benchmarks. Maryland's QRIS will be implemented on a pilot basis in various locations in Maryland by the end of 2011.

Definition: Over the past several years, a number of states have developed similar QRIS programs in an effort to enhance child care services and improve children's readiness to learn. While the details of these programs vary from state to state, they have five elements in common:

- *Standards:* QRIS standards are built on the foundation of child care licensing requirements and add multiple steps between licensing and higher quality standards, such as those associated with accreditation.
- *Accountability measures:* Accountability and monitoring processes are used to determine how well programs meet QRIS standards and to assign ratings.
- *Program and practitioner outreach and support:* Support for providers, such as training, mentoring, and technical assistance, are included to promote participation and help programs achieve higher levels of quality.
- *Financing incentives:* Financial incentives, such as tiered subsidy reimbursement, which pays a higher reimbursement rate to providers who care for children from families who receive CCDF subsidies and meet standards beyond minimum licensing, are awarded to programs when quality levels are achieved.
- *Parent/Consumer education efforts:* Most QRIS award easily recognizable symbols, such as stars, to programs to indicate the levels of quality and inform and educate parents.

Since 2001, a tiered reimbursement program has been in place in Maryland for licensed child care centers and family child care providers that participate in the State's child care subsidy program. The tiered reimbursement program, which provides higher subsidy rates for programs meeting quality of care standards, is a rudimentary version of QRIS that is open for participation only by child care subsidy providers.

In 2008, MSDE began planning a full-scale QRIS that would replace the tiered reimbursement program and would be open to participation by all licensed child care programs, also on a voluntary basis. The new QRIS will incorporate each of the five elements listed above and will show to the public the various quality initiatives a family child care provider or child care center participates in and undertakes. Additionally, QRIS will provide public recognition of child care providers and centers for their accomplishments.



MSDE, in cooperation with the Johns Hopkins University Center for Technology in Education, will launch Maryland's QRIS program – Maryland EXCELS: Excellence Counts in Early Learning and School-Age Child Care – by the end of 2011. At that time, a geographically diverse group of child care providers consisting of licensed child care centers and family child care providers will begin participating in a pilot version of the new QRIS. The purpose of the pilot will be to test all aspects of the new system, including online application processes, materials, technical assistance, management systems, and the time commitment for programs as they move from level to level. The pilot project will continue for at least one year before Maryland EXCELS is available for full statewide participation.

The QRIS quality standards developed by MSDE for licensed child care centers and family child care homes cover the following categories:

- Licensing and Compliance
- Rating Scale and Accreditation
- Developmentally Appropriate Learning and Practice
- Staffing and Professional Development
- Administrative Policies and Procedures

Significance: A QRIS program provides a clear, equitable, and systematic method for assessing, improving, and communicating the level of quality in early care and education and after-school settings. There are many benefits to QRIS including:

- Programs and educators use one streamlined set of standards, which are connected to supports and fiscal incentives to help them meet and maintain the standards.
- Programs receive feedback and are involved in continuous quality improvement.
- Policymakers understand where and how to invest additional resources.
- Parents have easily accessible information about the quality of early care and education programs.

Data: At present, approximately two dozen states have some form of QRIS program. Most of these states have separate sets of QRIS standards for child care centers and family child care homes. The standards are either in separate documents or in one document, with a clear delineation of which standards apply to centers and which apply to family child care homes. Some states have QRIS standards specifically for school-age programs, while others have standards for different types of programs (e.g., Head Start and license-exempt facilities).

Since its inception in 2001, 212 child care centers and family child care providers have participated in Maryland's tiered reimbursement program. 87 of these participated during FY2010.

Evaluations of state QRIS programs show that it is an effective strategy to improve the quality of care provided to children. Research shows that QRIS:

- *Provides reliable indications of quality:* In Pennsylvania, Oklahoma, Indiana, Kentucky, and North Carolina, researchers have found that QRIS ratings correlate with independently assessed program quality scores on environmental rating scales (ERS). Programs with high QRIS ratings in Kentucky also tended to have high scores on early language and literacy assessments. In North Carolina, programs with high ratings had lower rates of teacher turnover and higher staff salaries.
- *Helps to improve program quality over time:* Studies examining Pennsylvania, Indiana, Tennessee, Washington, and Missouri have shown that average program ratings increase over time as more programs receive higher QRIS ratings and move out of low ratings.
- *Increases low-income children's access to quality:* A 2005 Oklahoma study found that 76.5% of children receiving subsidies were enrolled in programs at the top two quality ratings, up from 45.8% when the QRIS began two years earlier. This success is largely due to a state policy that prohibits children receiving subsidies from enrolling in programs with the lowest quality rating.

Data Sources: Data concerning participation in Maryland's tiered reimbursement program is maintained by the MSDE Division of Early Childhood Development's child care automated tracking system (CCATS). These data can be aggregated by type of care, jurisdiction, and accreditation status. Because data are maintained only for participating programs, individual data such as age, race, and gender are not available.

Considerations: No data other than basic statistics concerning participation are maintained for Maryland's tiered reimbursement program. By contrast, extensive datasets will be created and maintained for the new full-scale QRIS program that relate to participation rates as well as to provider demographics, child populations served, performance issues such as compliance and license enforcement actions, staff qualifications, staff turnover, and geographical relationship to schools.

Related Measures: Not currently available. New QRIS program to begin by end of 2011.

Story Behind the Data: Not currently available. New QRIS program to begin by end of 2011.

Result 4: School Success



Why is school success Important?

School should be a place where children can be challenged to learn and grow in ways that will benefit them for the rest of their lives. Students who exhibit low academic performance are at a greatly increased risk of dropping out of school. School success is more than just getting good grades and test scores. It is also about learning positive socialization skills and treating others with respect. No child's experience in school can be a good one unless that child feels safe and accepted.

How do we measure school success?

Children need a comfortable learning environment in order to get the most out of their education. There are several ways to measure how successful Maryland school students are. One of the most effective ways to measure how much children are learning in school is by using standardized tests. These tests show more than grade point averages alone can illustrate by supplying a uniform baseline for how much children have been learning across the entire state and providing a basis for comparing the success rates of individual schools and school districts.

Truancy rates are another measure of success because they can tell us how many children are or are not regularly attending school. Additionally, understanding the amount of bullying that goes on in schools helps us better understand how we can make school environments more conducive to learning.

Indicator 13-Academic Performance:

1. The Maryland School Assessment (MSA): Gauges Maryland school 3rd through 8th grade students' aptitude in reading and mathematics skills.
2. Maryland High School Assessments (HSA): Gauges high school students' aptitude based on general education requirements.

Indicator 14- School Truancy:

Tracks the percent of children who have been absent from school for more than 20 days of the school year.

Indicator 15- Bullying & Harassment:

Youth Risk Behavior Surveillance (YRBS) measures rates among Maryland school students for bullying behaviors that occur on school property for reasons of victim's weight/size, perceived sexual orientation, or ethnicity.

What does the data say?

- During AY2010, 11.2% of Maryland students were absent from school for over 20 days as compared to 11.3% during AY2009.
- 20.9% of school students who were surveyed reported that they had been bullied by another child in some way during AY2010 school year.
- During AY2010, public high school students in Maryland passed the High School Assessments at a rate of 80.2% in English, 80.9% in Biology, and 83.6% in Algebra.
- 3rd through 8th grade public school students scored in either the “Proficient” or “Advanced” levels between a rate of 90.2% to 65.4% in Math, and between 89.4% to 80.4% in Reading, during AY2010



Indicator 13: Academic Performance

Performance Measure: Maryland School Assessment

Indicator for MSA: The percent of public school students in 3rd to 8th grades scoring proficient or advanced on the Maryland School Assessment (MSA).

Definition for MSA: The percent of public school students in 3rd to 8th grades performing at or above proficient levels in reading and mathematics on the MSA.

Significance for MSA: The MSA requires students in 3rd to 8th grades to demonstrate their knowledge of reading and mathematics. The test produces a score that describes how well a student mastered the reading and math content specified in the Maryland Content Standards. Each student receives a score in each content area that categorizes his/her performance as basic, proficient, or advanced. This data provides parents, caregivers, teachers, and school administrators with objective information on how each student is progressing academically.

Baseline Data for MSA: Percent of 3rd to 8th grade students scoring at basic, proficient or advanced levels on the MSA (reported by academic year).

Percent of Public School Students Scoring Basic, Proficient, or Advanced on the MSA - Academic Year 2008-2009, Maryland						
	Reading			Mathematics		
	Basic	Proficient	Advanced	Basic	Proficient	Advanced
3 rd Grade	15.1	63.0	21.9	15.7	55.5	28.8
4 th Grade	13.4	59.9	26.8	10.8	44.3	44.9
5 th Grade	10.5	29.9	49.6	18.8	56.1	25.1
6 th Grade	16.6	43.3	40.2	24.0	47.0	29.0
7 th Grade	18.3	38.1	43.7	28.0	49.0	23.0
8 th Grade	19.8	43.3	36.9	34.2	37.1	28.6
Percent of Public School Students Scoring Basic, Proficient, or Advanced on the MSA - Academic Year 2009-2010, Maryland						
	Reading			Mathematics		
	Basic	Proficient	Advanced	Basic	Proficient	Advanced
3 rd Grade	16.0	62.8	21.2	14.0	51.9	34.1
4 th Grade	12.6	57.9	29.5	9.8	43.6	46.6
5 th Grade	10.6	36.1	53.3	16.9	57.9	25.3
6 th Grade	13.9	42.8	43.3	20.2	50.1	29.7
7 th Grade	18.2	36.8	45.1	27.4	49.2	23.4
8 th Grade	19.6	35.5	44.8	34.6	35.9	29.5

Data Source for MSA: MSDE, Maryland State Report Card: <http://www.mdreportcard.org>.

Considerations for MSA: The MSA was established in 2002 to meet the requirements of the federal No Child Left Behind Act (NCLB). Students with severe cognitive disabilities where substantially simplified content is required based on their Individualized Education Program (IEP) take the Alt=MSA, Maryland's alternative assessment.

Related Measures for MSA: Results for the Alt-MSA are also published in the 2007 Maryland Report Card, which can be found at <http://msp.msde.state.md.us/index.aspx>.

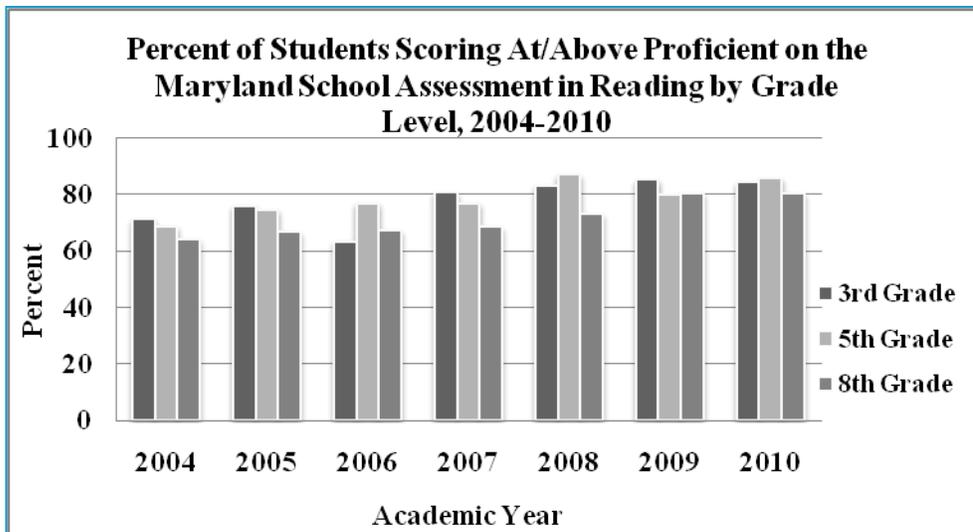
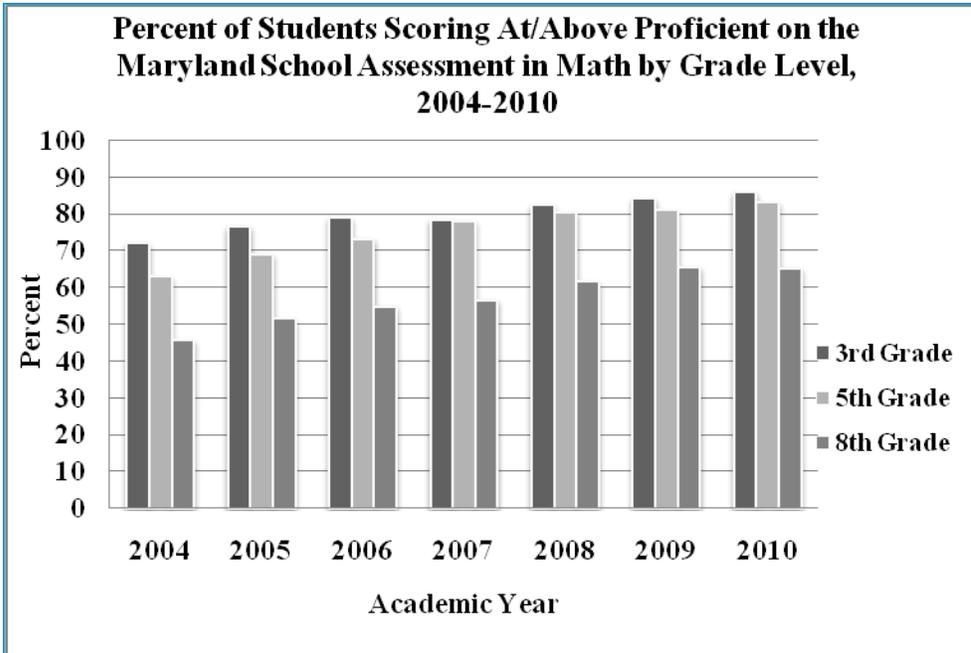
Story Behind the Data for MSA: NCLB requires Maryland to monitor school progress, report the results to parents, and take action when schools are not making Adequate Yearly Progress (AYP). Each year, schools must meet performance goals in the category of All Students and in each student subgroup category in order to make AYP. There are a total of eight subgroups: five racial groups, students receiving special education services, students with limited English proficiency, and students receiving Free and Reduced-Price Meals. The performance goals for schools will increase each year until 2014, when the goal will be that 100% of students demonstrate proficiency (or higher) in reading and math.

Achievement information for schools, school systems, and the State is published annually in the Maryland Report Card (www.mdreportcard.org). This report provides AYP charts for each public school and local school system and shows the school/system's progress on each of the NCLB performance goals.

In order to achieve AYP, a school must meet all its performance goals. A school that does not meet AYP goals in the same subject for two consecutive years will be identified for State School Improvement, which provides an opportunity for the school to work on improving the performance of one or more subgroups of students.

Comparing the percentage of youth scoring in the **Proficient** level from 2008 to 2010 across each grade level, it appears that there was an increase in 5th grade (6.2%) in Reading, and there were increases in 5th grade (1.8%), 6th grade (3.1%), and a very slight increase at 7th grade (.2%) in Mathematics.

Similarly, comparing the percentage of youth scoring in the **Advanced** level from 2008-2010 across each grade level, it appears that there were increases in 3rd grade (.7%), 6th grade (3.1%), 7th grade (1.4%), and 8th grade (7.9%) in Reading, and increases in 3rd grade (5.3%), 4th grade (1.7%) in Mathematics. There were also slight increases in 5th grade (.2%), 6th grade (.7%), and 7th grade (.4%) in Mathematics in the percentage of youth scoring at the Advanced level between 2008 and 2010.



Indicator 13: Academic Performance

Performance Measure: High School Assessment

Indicator for HSA: The percent of high school students demonstrating basic skills at the passing level on each of the four Maryland High School Assessments (HSA).

Definition for HSA: The percent of public school students in grades 9 through 12 performing at the passing level in four core subjects of the Maryland (HSA): Algebra, Biology, English 2, and Government.

Significance for HSA: The achievement of minimum academic standards affects graduation, adult achievement, future academic pursuits, and life skills.

Baseline Data for HSA: HSA – Percent of public school students scoring at the passing level for each of the four assessments (reported by academic year).

Percentage of Public School Students Passing Each Maryland High School Assessment - by Academic Year, Maryland				
Subject Area	AY2007	AY2008	AY2009	AY2010
Algebra	63.5	*84.4	85.1	83.6
Biology	70.3	*82	82.7	80.9
English	70.9	*82	83.5	80.2
Government	73.5	91.9	**	**
* Data Updated from Community File Submitted 7/2011 **Data unavailable				

Percentage of Public School Students Passing Each Maryland High School Assessment- by Academic Year 2009, Maryland				
Grade	Algebra	Biology	English	Government
10 th	84.4	82.3	76.9	85.3
11 th	87.3	84.1	81.9	90.7
12 th	88.8	85.5	86.6	93.2

Data Source for HSA: MSDE, Maryland State Report Card
<http://www.mdreportcard.org>

Considerations for HSA: Students take each test at the completion of the corresponding course. Accordingly, students may take these exams during any high school grade. The English 2 HSA replaced the English 1 HSA in Academic Year 2005.

Related Measures for HSA: As these assessments are required for graduation, high school graduation rates are a related measure. Data on high school graduation can be found at www.mdreportcard.org.

Story Behind the Data for HSA: In 2004, the State Board of Education ruled that, beginning with the class of 2009, public school students must pass the HSA to graduate.

There are two ways to pass the HSA to graduate:

1. Pass all four HSA tests with the scores listed below; or
2. Earn a combined score of at least 1602 on all four HSAs. This combined-score option allows students to offset lower performance on one test with higher performance on another.

For each HSA subject area, the range of possible scores is 240 - 650. The passing scores for each assessment are:

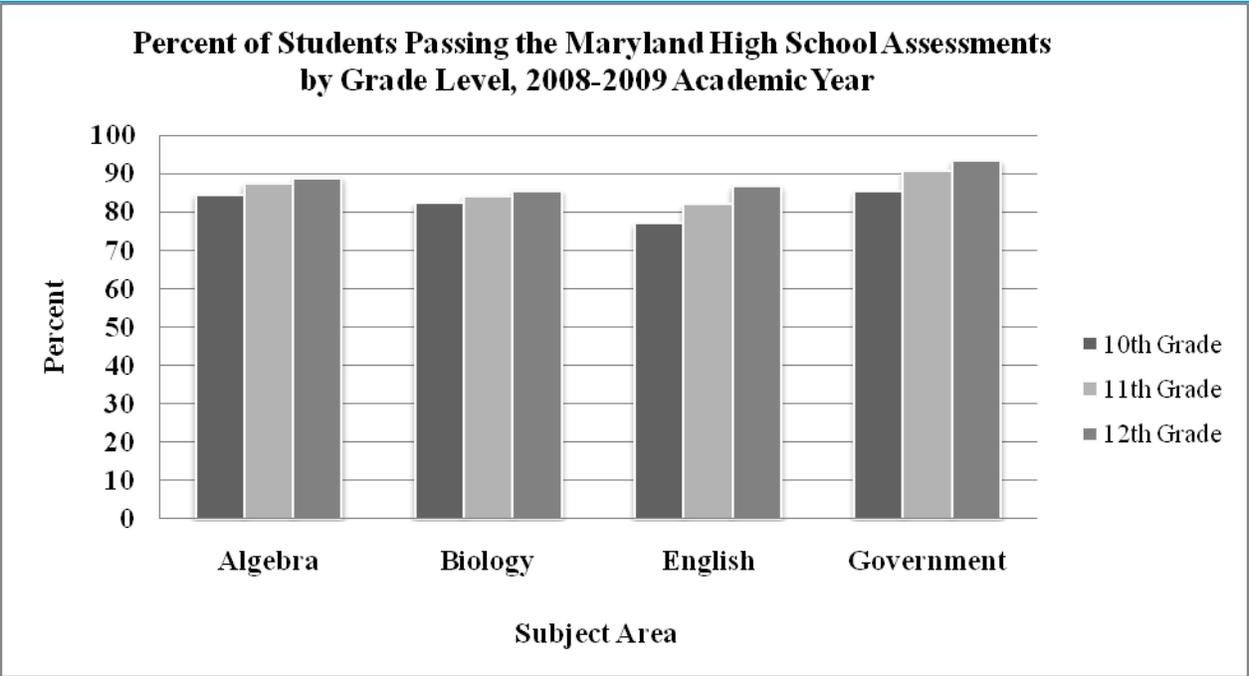
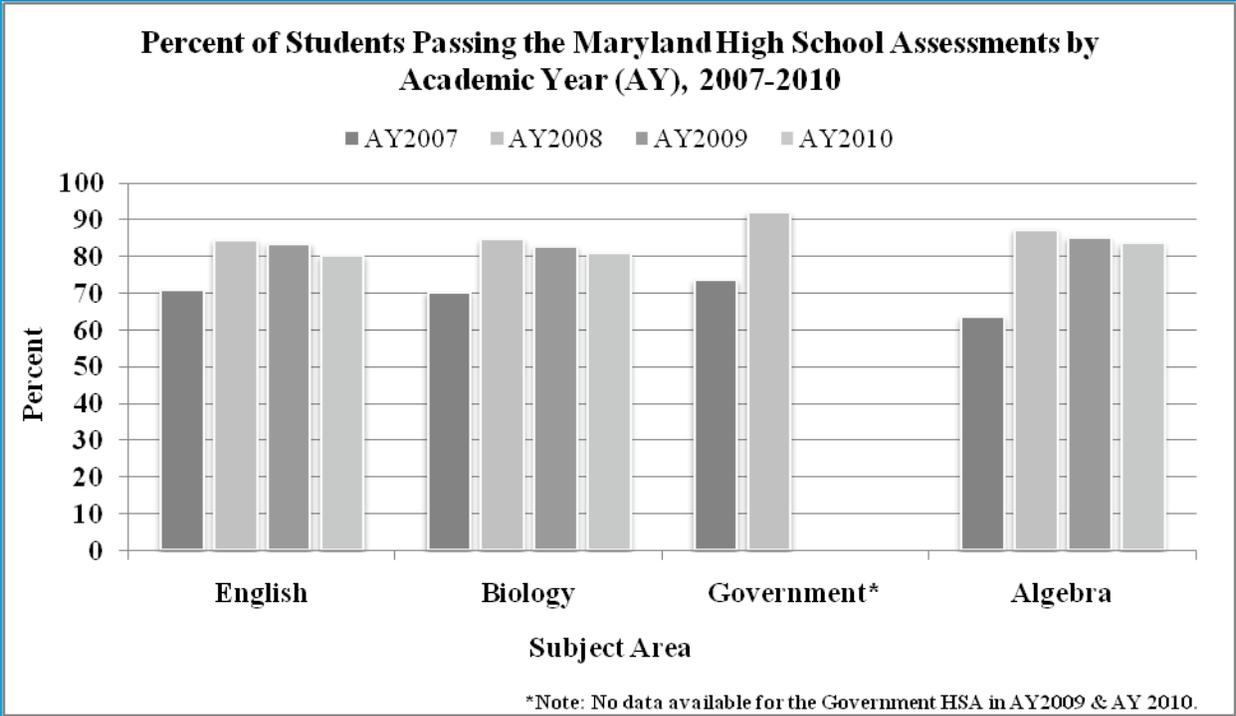
<u>HSA Test</u>	<u>Passing Score</u>
Algebra/Data Analysis	412
Biology	400
English	396
Government	394

Each assessment test contains both selected and constructed response questions and covers about 60% of a course's content. Each HSA takes approximately three and one-half hours to complete.

In 2010, the percentage of students passing in each subject area decreased slightly from the 2009 percentage of students passing the HSAs.

For students who do not pass the HSA, additional instruction is available through the local school system, and students may retake the assessment multiple times. For students unable to pass the HSA after two attempts, the Bridge Plan for Academic Validation offers alternatives to the assessment (note: academic eligibility requirements must be met for this program).

Additional information and sample tests can be viewed by going to www.hsaexam.org or www.marylandpublicschools.org/msde and clicking on Testing/High School Assessment.



Indicator 14: School Truancy

Indicator: Absence from school.

Definition: Percent of students in all grades (public schools) absent more than 20 days of the school year (excluding summer school). School attendance data is calculated as the percentage of students present in school for at least half the average school day throughout the school year. This measure is consistent with the MSDE standard that students attend 94% of school days.

Significance: Absenteeism and truancy represent a loss of learning opportunities, and have negative long-term consequences for students and communities. High levels of school absence are associated with a higher risk of school failure, high school dropout, delinquent behavior, substance abuse, and other high-risk behaviors.

Data:

1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002	2002 - 2003	2003 - 2004	2004 - 2005	2005 - 2006	2006 - 2007	2007 - 2008	2008 - 2009	2009 - 2010
13.7	12.3	12.3	11.3	13.0	13.1	13.4	13.0	11.7	12.0	11.3	11.2

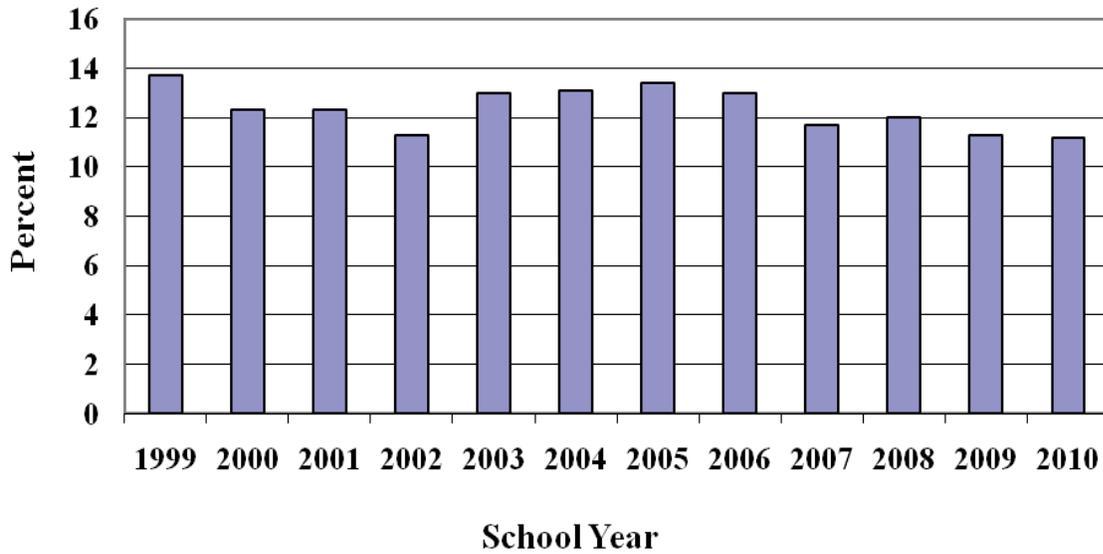
Data Source: Percentages based on data from: Maryland State Department of Education, 2010 Maryland Report Card, <http://msp2010.msde.state.md.us/index.aspx>.

Considerations: The current data reporting system is structured to collect statistics for absences of more than 20 days. It is important to note that these data do not differentiate between students with “excused” versus “unexcused” absences. Included in the reasons listed by MSDE as a “lawful cause of absence” are death in the immediate family, illness of the student, hazardous weather conditions, observance of a religious holiday, suspension, and lack of authorized transportation, among others. The principal or vice principal should speak with the student’s parents or guardian to determine whether an absence is lawful or unlawful. Local school systems maintain detailed data on reasons for absences. Additionally, this measure does not include students enrolled for fewer than 91 days during the school year.

Story Behind the Data: Maryland educators appreciate the significant role parents play in their children’s education. Absentee rates from school are one measure of parent-school collaboration. Between 1999 and 2010, the percentage of students absent 20 or more days decreased from 13.7% to 11.2%.

Adopted in October 2001, the MSDE family involvement policy is supportive of the fact that when schools, families, and community organizations work together to support learning, children tend to do better in school, stay in school longer, and like school more. This comprehensive family involvement policy is committed to encouraging parents to become involved in their children’s education.

Percent of Maryland Public School Students Absent More than 20 Days of the 2009-2010 School Year



Indicator 15: Bullying and Harassment

Indicator: School Success: Bullying and Harassment

Definition: Bullying is a form of aggression between a more powerful antagonist and his/her victim. Bullying can be physical, verbal, and/or psychological, and can be direct or indirect. Chronic victims may experience mental health problems such as anxiety, academic difficulties, poor concentration, and withdrawal. Bullying occurs across all age groups and includes sexual harassment, dating violence, gang attacks, domestic abuse, child abuse, and elder abuse.¹

Bullying and harassment also have negative effects on bullies as well as bystanders.

The YRBS survey questions focus on Maryland youth who have been bullied on school property, teased because of weight/size, harassed because of perceived sexual orientation, and teased because of ethnicity. The results are presented as percentages by grade level (9 through 12) and race (all races) as indicated in the Data Section.

Significance: The 2009 YRBS results are generally consistent with the results from the survey in 2005 and 2007. These cumulative responses provide trend data that may be used to monitor health risk behaviors among Maryland’s youth and young adults. The YRBS findings in the area of bullying and harassment will help MSDE, educators, State and local agencies, businesses, students, parents, and other stakeholders develop and refine initiatives targeted to improve the health and well-being of Maryland youth.

Baseline Data:

Percentage of youth who have been:	2005	2007	2009	Trend
Bullied on school property	28.4	25.7	20.9	↓
Teased because of weight/size*		28.7%	27.5%	•
Harassed because of perceived sexual orientation	13.1%	13.0%	8.9%	•
Teased because of ethnicity*		17.1%	14.7%	•

*A comparison with 2005 results is not possible because the wording for this question was altered beginning with the 2007 YRBS.

Data Source: The Maryland YRBS is part of the Youth Risk Behavior Surveillance System (YRBSS) developed in 1990 by the CDC to monitor behaviors that affect morbidity (disease) and mortality (death) among high-school-age youth. The YRBS monitors several categories of health-risk behaviors among youth. In the spring of 2009, the YRBS was administered to students in a representative sample of Maryland public high school classrooms. A total of 1,644 students in 30 Maryland public high schools completed the survey, resulting in a 78% response rate. The 2009 YRBS results are representative of all Maryland’s public school students in grades 9 through 12.

Considerations: The YRBS data are presented by combined grade levels, 9 through 12, and race (all races). The data presented in the formal report are not disaggregated by race, grade level, jurisdiction, or school. They are representative of Maryland's public high school classrooms.

Related Measures: The *Bullying, Harassment, or Intimidation in Maryland Public Schools*

Report is a report developed annually (March 31 of each year) by the Student Services and Alternative Programs Branch of the MSDE. It is comprised of data directly related to bullying, harassment, and intimidation that was reported in the State's 24 public school systems for the entire previous school year. The data are presented in the 11 categories required by law. Each category is represented by a chart, comparing three school years information with a narrative description of each chart. The **11** categories are:

1. Number of reported incidents, by local school system;
2. Locations of the reported incidents, Statewide;
3. Descriptions of the reported incidents, Statewide;
4. Ages of victims, Statewide;
5. Ages of alleged offenders, Statewide;
6. Descriptions of alleged motives reported by investigator, Statewide;
7. Methods used to investigate incidents reported by investigator, Statewide;
8. Corrective actions taken;
9. Number of days missed from school by victims;
10. Number of days missed from school by offenders; and,
11. Number of false allegations, by local school system.

The March 31, 2011 *Bullying, Harassment, or Intimidation in Maryland Public Schools Report* may be accessed on the MSDE web-site at www.marylandpublicschools.org on the Bullying Prevention link of the Student Services and Alternative Programs page.

Story Behind the Data: The data from the past three YRBS results for bullying indicate a downward trend in the number of incidents of bullying on school property, teasing because of weight/size, harassing because of perceived sexual orientation, and teasing because of ethnicity. Consideration must be given to the fact that the YRBS is administered only to high school students. Elementary and middle school grades are not included. The report does not disaggregate data by age/grade, jurisdiction, or motives of the offenders nor does it include other categories of incidents such as physical aggression, rude or threatening gestures, excluding a student, or electronic communication. MSDE continues to assist local school systems as they implement system-wide and school-wide programs of prevention and intervention to address bullying, harassment, or intimidation. In 2009, MSDE adopted the Model Policy to Address Bullying, Harassment, or Intimidation, which targets the problems associated with bullying and sets a state-wide definition of bullying.

The State policy defines bullying as any intentional conduct that creates a hostile educational environment by substantially interfering with a student's educational benefits, opportunities, or performance, or with a student's physical or psychological well-being; prohibits bullying on school property or at school-sponsored functions or by the use of electronic technology at a public school; sets forth ideas for preventing improper behavior and methods to intervene in bullying situations, noting the importance of professional development for educators; and suggests consequences for students who persist in bullying.

Each of the 24 local public school systems has specific policies in place to address bullying and harassment that are based on the MSDE Model Policy. The school systems also provide bullying prevention programming for their students, staff, and volunteers. Incidents of bullying and harassment may be reported to the school administration by students, their parents or close adult relatives, and school staff by using a standardized reporting form. The information obtained from these reports and subsequent investigations is regularly reported to designated personnel in each school system who in turn report system-wide information to MSDE on a yearly basis.

Result 5: School Completion



Why is school completion important?

Education is truly the gateway to success in an increasingly specialized and competitive economy. Students who complete high school have more opportunities for employment and future educational pursuits. For those students who do not obtain a high school degree, whether because of failing grades, truancy, or lack of emotional, mental, or physical support, achieving economic and social stability can be a nearly impossible task. The unemployment rate of high school dropouts is actually 63.8% higher than the unemployment rate of individuals whose educational attainment is a high school diploma, and dropouts earn a yearly average of \$9,634 less than individuals with a high school diploma. The overwhelming difficulty of achieving independence without education creates a tremendous strain on the society that must help provide for that individual, as well as for the individual who is disconnected from society.

How do we measure school completion?

Indicator 16 - High School Dropout Rates:

Percentage of 9th through 12th grade students who withdraw from school without transferring, including summer, evening, and alternative high school programs.

Indicator 17 - High School Program Completion:

The percent of public high school graduates who successfully completed the minimum course requirements needed to enter the University System of Maryland, to complete an approved Career and Technology Education program, or who completed requirements for both.

Indicator 18 - Graduation/ School Completion of Students with Disabilities:

The percentage of children with disabilities who graduate from or complete high school.

What does the data say?

- 78% of Maryland students with disabilities either graduated or completed high school in FY2009.
- 2.3% of Maryland public high school students dropped out of school during the 2010 academic year.

<http://www.all4ed.org/files/Volume9No17.pdf>. Alliance for Excellent Education. "The High Cost of High School Dropouts: New Alliance Brief Says Dropouts from the Class of 2009 Represent \$335 Billion in

Indicator 16: High School Drop Out Rate

Indicator: The percent of students in grades nine through twelve who drop out of school in a single year.

Definition: The percent of public school students, grades 9 through 12, who withdrew from school before graduation or before completing a Maryland-approved educational program during the July to June academic year and are not known to have enrolled in another high school program during the academic year. This data includes students who drop out of summer, evening, and alternative high school programs.

Significance: The percent of public school students, grades 9 through 12, who withdrew from school before graduation or before completing a Maryland approved educational program during the July to June academic year and are not known to have enrolled in another high school program during the academic year. This data includes students who drop out of summer, evening, and alternative high school programs. Failure to complete high school is closely linked with decreased employment opportunities, low pay, and limited paths to advancement.

Baseline Data: Percent of students completing High School can be found at www.mdreportcard.org

Percentage of Public High School Students who Drop out of School - by Academic year, Maryland and National										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Maryland, Grades 9-12	3.9	3.9	3.7	3.4	3.9	3.7	3.5	3.4	2.8	2.3
National, Grades 9-12	4.8	5.0	3.6	4.0	4.7	3.8	4.4	*	*	*
*2008 and 2009 National Data is unavailable										

2010 Data Sources: Maryland Data Source: MSDE, www.mdreportcard.org.

2007 National Data Source: U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "State Non-fiscal Survey of Public Elementary/Secondary Education," 2006-07 and 2007-08, and "NCES Common Core of Data State Dropout and Completion Data File," 2006-07; and unpublished tabulations. (This table was prepared November 2009.) http://nces.ed.gov/programs/digest/d09/tables/dt09_106.asp

Considerations: National data is based on surveys of individuals ages 15-24 who dropped out of grades 10 through 12 from October to the following October. State data, however, represents the actual percentage of enrolled students who dropped out during the academic year. Dropping out is defined as leaving school without a high school diploma or equivalent credential such as a General Education Development (GED) certificate. This includes only graduates for whom race/ethnicity was reported. Race categories exclude persons of Hispanic ethnicity. Event dropout rates measure the percentage of public school students in grades 9 through 12 who dropped out of school between one October and the next.

Related Measures: Local school systems have data on the various reasons students drop out of school. These reasons often include expulsion, pregnancy, and parenthood. Additionally, the U.S. Census Bureau collects two related measures: people ages 20 through 24 who have not completed high school and teenagers ages 16 through 19 who are not enrolled in school and are not high school graduates.

Story Behind the Data: In 2007, Maryland ranked 23rd in the nation for the percent of teens, ages 16 through 19, who were assumed to be high school dropouts (not enrolled in high school and not high school graduates); the percentage for both Maryland and the nation was 7%. (The Annie E. Casey Foundation, Kids Count Data Center, <http://www.kidscount.org/datacenter/>)

Although Maryland's 2007 percentage of teens age 16 through 19 was the same as the national percentage for teens who were high school dropouts, the percentage of high school students who drop out of school has been slightly lower than the national average for the past decade. It is important to be cognizant of the different populations represented by these statistics. The previous data includes all teens ages 16 through 19 and those students originally enrolled in school.

The larger population of teens 16 through 19 includes both adolescents who have recently dropped out of school and those who have been out of school for several years. This diverse group will have a wide variety of needs and learning skills which could impact their ability to reenter high school and/or enter a GED or alternative learning program or trade program. Further data analysis would be needed to tailor services to specific target populations.

The smaller proportion of students who drop out during a specific school year, however, may be amenable to programs targeted at reentry into high school, especially when targeted at addressing the immediate causes of drop out. School systems may have the most success in reenrolling these students as opposed to students who have been out of school for a longer time period.

In 2008, the percentage of public high school students who dropped out of high school declined slightly from 3.5% in 2007 to 3.4% in 2008. This continues a general downward trend demonstrated since 1998. In 2010, Maryland continues to make positive strides with school drop out rates decreasing to 2.3%.

Indicator 17: High School Program Completion

Indicator: High School Completion

Definition: The percent of high school graduates who successfully completed the minimum course requirements needed to enter the University System of Maryland, to complete an approved Career and Technology Education program, or who completed requirements for both.

Significance: The completion of program requirements indicates students' potential readiness for post-secondary education and/or employment.

Baseline Data: Percent of graduates who complete the various post-secondary requirements (reported by academic year)

Percentage of Public High School Graduates Completing Post-Secondary Requirements- by Academic Year, Maryland			
Academic Year	University System of Maryland	Career & Technology Education Programs	Both
1999	58.3	14.3	8.7
2000	57.7	14.2	9.7
2001	57.8	14.6	10.7
2002	52.2	15.9	11.3
2003	54.1	15.3	10.8
2004	55.7	14.7	10.3
2005	57.0	13.5	12.0
2006	57.6	12.3	12.5
2007	55.7	12.7	13.2
2008	59.5	11.9	10.7
2009	55.3	10.3	9.6
2010	55.3	9.9	NA

Data Sources: MSDE, Maryland State Report Card <http://www.mdreportcard.org>

Related Measures: Data regarding high school graduates' plans for further education, work, and military is reported by Maryland State Department of Education.

Story Behind the Data: Between AY2007 and AY2010, the percentage of graduates who completed the minimum requirements for the University System of Maryland has remained mostly consistent at 55%, except for AY2008, when the percentage increased slightly to approximately 60%. In contrast, between AY2007 and AY2010, the percentage of graduates completing the minimum career and technology program requirements has declined slightly each year. Cumulatively, between AY2007 and AY2010, the percentage of graduates meeting requirements fell almost 3 percentage points, from 12.7% in AY2007 to 9.9% in AY2010.

Indicator 18: Graduation / School Completion of Students With Disabilities

Indicator: Percent of children with disabilities who graduate from or complete high school.

Definition: Percent of children with disabilities who exit special education by graduating or completing school. The denominator does *not* include those students with disabilities who exited the program to return to general education or to transfer to another program. The denominator does include those students who reached maximum age, dropped out, or exited with a diploma or certificate.

Significance: High dropout rates among youth with disabilities are a serious national concern. States are striving to build, implement, and sustain special education programs with best practices that will yield positive results in dropout prevention, reentry, and school completion for students with disabilities (National Dropout Prevention Center for Students with Disabilities, 2011). Maryland is one of 48 states that are currently engaged in targeted evidence-based activities to improve graduation/school completion rates for students with disabilities, including: Positive Behavioral Interventions and Supports, literacy initiatives, Response to Intervention, mentoring programs, transition supports, and recovery and reentry programs for youth with disabilities (National Dropout Prevention Center for Students with Disabilities, 2008).

Baseline Data: Graduation Completion Rate - Exit data: percent of students with disabilities (reported by calendar year).

Percent of Students with Disabilities Graduating/ Completing School (by Fiscal Year- July 1st through June 30th, 2005-2009, Maryland and National)					
	2005	2006	2007	2008	2009
Maryland	72.00	72.00	74.00	75.00	78.00
National	73.53	74.20	75.31	77.53	*
*National Data unavailable					

Data Sources: 2009 Maryland Data: Unpublished data provided by MSDE (State totals include students in non-jurisdictional agency placements). The formula used for the Percent of Students w/Disabilities Graduating or Completing School is: (Diploma + Certificate + Aged Out)/ (Diploma + Certificate + Aged Out + Dropped Out). Calculations completed by MSDE.

2010 National Data: Students ages 14 through 21 with disabilities served under IDEA, Part B, who exited school, by disability category, exit reason and state: Fall 2005- 2008, <http://www.ideadata.org/PartBExiting.asp>

Considerations:

Growth in Specific Disability Categories

In reporting this Indicator, consideration must be given to the number of children identified with Emotional Disabilities, Autism, and Specific Learning Disabilities, as these are the most rapidly growing disability groups in Maryland. Students within these disability subgroups demonstrate great need for services and supports related to attendance, challenging behavior, discipline, and academic achievement. While a number of these youth receive school and community-based wraparound supports and services, these students also comprise the majority of youth placed in non-public special education facilities (MSDE, 2010).

Students with Emotional Disabilities

High school graduation/completion is an indicator of adequate functioning for children with mental health concerns. Mental Health America reports that children with Emotional Disabilities have the highest school dropout rate of any group of children with disabilities (The National Mental Health Association, 1993). More recent research has found that over half the adolescents in the United States who fail to complete their secondary education have a diagnosable psychiatric disorder. The proportion of failure to complete school that is attributable to psychiatric disorder is estimated to be 46% (Stoep, Weiss, Kuo, Cheney & Cohen, 2003, abstract). In Maryland, the graduation/completion rate for students with Emotional Disabilities remains significantly lower than that for other disability subgroups, with only 57% of students, with Emotional Disabilities completing school in 2010.

Disproportionate Identification of Minority Youth

National data indicate that students from racial and ethnic minority groups are twice as likely to be identified as having disabilities requiring special education and related services than are their Caucasian peers. 42 states cite disproportionate identification of minority students in these disability categories (OSEP, 2011). Congruently, African-American youth are consistently over-represented in special education in Maryland, having higher rates of identification despite the fact that they comprise a smaller segment of the total student population. The over-identification of minority youth as disabled has distinct implications for:

- impeding students' access to their least restrictive environment and limiting their access to the most rigorous academic curriculum;
- negatively impacting achievement, attendance, discipline, educational placement, school climate, stigma, access to services, and graduation and completion rates; and
- having more global implications for quality of life as it relates to transition to adulthood beyond the school years (MSDE, 2011).

Related Measures: Several factors must be considered regarding graduation and school completion for youth with disabilities. States must conduct comprehensive, longitudinal review of data to identify youth who are at risk for dropping out, and target this population of students for specific intervention. Among the data to consider for the special education subgroup are those for attendance, discipline, and academic achievement (National Dropout Prevention Center for Students with Disabilities, 2011).

Story Behind the Data: The percentage of students with disabilities who graduated/completed high school has been steadily increasing since 2005, when the percentage of youth with disabilities who graduated with a high school diploma was 35%, to 2010, when 40.91% of youth with disabilities earned a high school diploma. Additionally, the number of youth with disabilities exiting the school system with a certificate of attendance has demonstrated consistent increases from 5.35% in 2005 to 6.63% in 2010. In an effort to increase the graduation rate for students with disabilities and to enhance quality of life for students and their families, MSDE has taken a number of steps to provide comprehensive support to families, school systems, and communities. These steps include: assisting local school systems in the education of children and youth with disabilities, fostering improved interagency collaboration, providing technical assistance to local school systems and state-operated programs to promote the dissemination and employment of evidence-based strategies and interventions to improve academic, social, behavioral, and vocational outcomes for students with disabilities, and implementing workgroups focused on identifying critical issues and making recommendations for meeting the unique needs of students with specific disabilities (Specific recommendations can be found in a number of reports including the Report of the Steering Committee on Students with Emotional Disabilities, the Autism Task Force Report). More information can be obtained at www.marylandpublicschools.org.

Many of Maryland's schools have adopted a framework for enhancing the implementation of a continuum of evidence-based interventions to achieve important academic and behavioral outcomes for all students. Positive Behavioral Interventions and Supports (PBIS) is a three-tiered model which follows the public health approach to prevention by providing more intensive supports for students not responding adequately to a universal system of support. PBIS provides systems for schools to design, implement, and evaluate effective school-wide, classroom, non-classroom, and student-specific discipline plans. Implementation of school-wide, universal PBIS is designed to reduce disruptive behavior problems, enhance school climate and create safer, more effective schools for all students by targeting staff behavior and teaching students agreed upon behavioral expectations while promoting a shift from reactive, punitive practices to prevention and promotion of positive behaviors. This approach assists schools in moving toward school-wide behavior systems that address the entire school and student population, including individual students with challenging behaviors. Since 1999, 821 schools have received initial training in the implementation of school-wide PBIS, which represents over 55% of the public schools in the State. PBIS is viewed as a complement to individual behavioral plans for those children and youth with more intensive needs (National Technical Assistance Center on Positive Behavioral Interventions and Supports, 2011). Maryland has the fifth highest number of schools trained in universal school-wide PBIS in the country and is considered a national model for State implementation.

Result 6: School Transition



Why is school transition important?

The transition from high school to college and into the professional world is an important time in a young adult's life. Young adults are learning to be independent, "productive, and successful citizens. Post-high school planning is a critical predictor of the well-being of young adults. Maryland's system of career guidance encourages high school students to plan for the future and exhibit readiness to be a part of the workforce by continuing into higher education. Those who have attained higher levels of education are more likely to qualify for a broader range of jobs and earn higher incomes. Not only does college prepare young adults to be a part of the workforce, but it also serves as an incentive for high school students to do their best before they go to college.

How do we measure school transition?

What happens in the years following school indicates how prepared students are to face the world, achieve positive outcomes, and be independent. Continuing education and employment are among the activities showing that Maryland's youth are prepared. Surveys of high school students are key to gathering information about students' plans after high school, and census information provides estimates of educational attainment and employment among America's youth.

Indicator 19 - Post Graduation Plans:

All Grade 12 Maryland public school students are asked to complete the MSDE Pre-Graduate Questionnaire, which collects information about students' plans for the year following their high school graduation.

Indicator 20 - Educational Attainment:

The American Community Survey's five-year estimates track the percentage of young adults who complete various levels of education, ranging from less than high school completion to Master's degrees and higher.

Indicator 21 - Youth Employment:

The American Community Survey's five-year estimates track the percentage of young adults who are employed in Maryland.

What does the data say?

- Of the students who took the MSDE Pre-Graduate Questionnaire, 97.1% reported having plans for college, employment, or military in the year following graduation.
- The percentage of employed young adults in Maryland is 35.8% for ages 16 to 19 and 67.4% for ages 20 to 24.
- An average of 85.6% of young adults ages 18 to 24 years old during the years 2006 through 2008 had attained a high school degree or higher .

Indicator 19: Post Graduation Plans

Indicator: Post Graduation Plans – The percentage of graduating seniors indicating post-graduation plans in categories of education, employment and military service.

Definition: All Grade 12 Maryland public school students are asked to complete the *MSDE Pre-Graduate Questionnaire* within 45 days prior to high school graduation. Students respond to questions regarding plans *in the first year following graduation*, including:

- A Do you plan on attending college?
 - Part-time or Full-time?
 - Four-year College, Two-year Community College, or Career/Technical School?
 - Maryland College or Out-of-state College?
- B *Do you plan on working?*
 - Part-time or Full-time?
 - Employment Related to High School Program?
 - Employment Unrelated to High School Program?
 - Military / Reserves?
 - Apprenticeship Program?
 - Supported Employment (individuals with a disability)?

Significance: Post high school planning is critical to the successful transition of youth from high school to continuing education, advanced training and/or employment. Maryland’s system of career guidance and advisement includes a framework of standards for guidance and advisement at each learning level (K through 12) to successfully transition students.

Baseline Data: Based on student responses to the *MSDE Class of 2010 - Pre-Graduate Questionnaire*

Class of 2010 – Post High School Plans						
Total	College	College	Career / Tech. School	Work	Military	Other / No Response
	Full-time	Part-Time		Full-Time	Full-Time	
52,131	37,457	6,505	2,248	6,885	2,244	2,214
	71.90%	12.50%	4.30%	13.20%	4.30%	4.20%

Data Source: The *MSDE Pre-Graduate Questionnaire* is administered within 45 days prior to high school graduation. The response rate for the Class of 2010 was 87% with 52,131 of 59,772 Grade 12 students responding. Questions regarding plans *in the first year following graduation*, included plans for college, advanced training, military service, and employment. Students were also asked to indicate full-time or part-time status for college and employment.

Considerations: The *MSDE Pre-Graduate Questionnaire* includes student self-reported plans for college, training, employment and military service. These responses are collected prior to high school graduation and are not confirmed in terms of actual placement in college or employment following graduation.

Related Measures: The Maryland Longitudinal Data System (MLDS) is currently under development and will allow for the calculation of placement rates for Maryland graduates in higher education, workforce and the military. Data from the Class of 2011 will be compared with National Student Clearinghouse data to confirm enrollment of Maryland graduates in any institution of higher education in the United States. Through administrative record exchange, the MLDS will also calculate the rate of employment and military service for the Class of 2011. This data is expected to be available in November 2011.

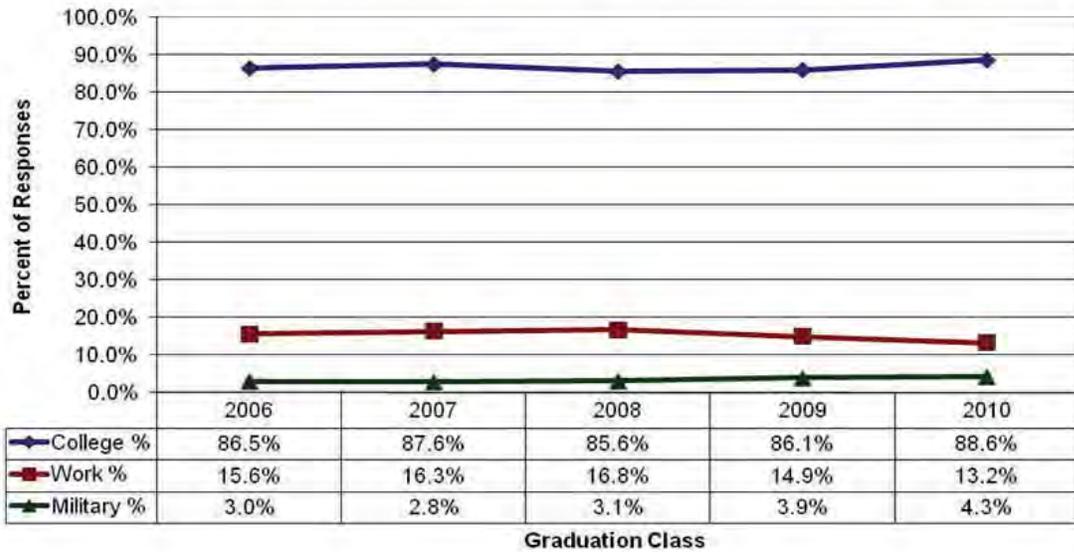
Story Behind the Data: Many students plan on attending college (full-time or part-time) and working in the first year after college. There are many pathways to advanced training and education, including 4-year colleges, two-year community colleges and specialized training schools. Just over 88% of Maryland's graduates plan on advancing their education and training in the first year after high school. While 13.2% of graduates plan on working full-time, only 3.9% plan on working without attending college or advanced training. More than one-third (36% of graduates plan on some combination of working and attending college or advanced training programs).



The Maryland State Department of Education supports implementation of the *Maryland Career Development Framework* standards, including opportunities for K through 12 students to engage in career exploration and career development activities leading to informed decisions about college and career success.

Additionally, MSDE supports all students completing the academic and technical courses to meet entry requirements for the University System of Maryland as well as a Career Technology Education (CTE) program of study.

Percent of High School Graduates Planning on College, Career Entry, or Military Service Immediately Following High School 2006-2010



Indicator 20: Educational Attainment

Indicator: The percent of young adults 18 to 24 years old that have reached educational milestones

Definition: The percent of young adults 18 to 24 years old who have attained a high school diploma, associate's degree, bachelor's degree, or higher degree by age groups, state, and jurisdiction.

Significance: Educational attainment is a dominant predictor of well-being. Young adults who have accomplished higher levels of education and schooling are more likely to achieve economic success than those who have not. In addition to qualifying for a broader range of jobs, completing more years of education can protect one against unemployment. Also, higher levels of educational attainment frequently lead to higher wages and income. Adults with higher levels of education also report being healthier and having higher levels of socio-emotional well-being.

Baseline Data: Population 18 to 24 years old, highest level of education attained by jurisdiction in Maryland

	Total	Less than High School Graduate	High School Graduate	Some college or Associate's Degree	Bachelor's Degree or higher
National	29,838,236	17.20%	32.00%	41.90%	9.00%
Maryland	532,517	14.40%	32.80%	40.10%	12.60%

Data Sources: U.S. Census Bureau, American Community Survey (ACS) five-year estimates; National Center for Education Statistics, Digest of Education Statistics

Considerations: Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90% margin of error. The margin of error can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to non-sampling error (for a discussion of non-sampling variability, see Accuracy of the Data). The effect of non-sampling error is not represented in these tables.

Related Measures:

Educational attainment of persons 18 years and older: 2006 through 2008 (three year average):

Location	18 to 24 year-olds who completed High School	Bachelor's degree	Graduate or Professional Degree
United States	82.90%	17.30%	9.10%
Maryland	85.60%	19.60%	15.70%
Delaware	81.90%	19.9	14.90%
Virginia	86.50%	19.70%	13.60%

Number of persons 18 and older, by highest level of education attained: 2005 through 2010 (national data):

	Total	High school completion	Some College	Associate's Degree	Bachelor's Degree	Master's Degree
2005	217,334	69,308 (31.9%)	41,647 (19.2%)	1,7587 (8.1%)	36,456 (16.8%)	12,902 (5.9%)
2006	219,849	69,401 (31.6%)	42,412 (19.3%)	18,146 (8.3%)	37,332 (18.8%)	13,184 (5.9%)
2007	222,722	70,108 (31.5%)	42,349 (19.0%)	18,237 (8.2%)	38,924 (17.5%)	13,755 (6.2%)
2008	224,703	68,480 (30.4%)	44,168 (19.7%)	18,589 (8.3%)	40,070 (17.8%)	14,893 (6.6%)
2009	226,973	70,044 (30.8%)	44,241 (19.5%)	19,303 (8.5%)	40,276 (17.7%)	15,260 (6.7%)
2010	229,240	71,172 (31.0%)	44,354 (19.3%)	19,740 (8.6%)	41,289 (18.0%)	15,357 (6.7%)



Story Behind the Data: Governor Martin O’Malley has specific goals intended to increase educational attainment, including maximizing the funds provided to the state for education, raising standards to better prepare Maryland students for college and professional life, and improving transitions to higher education. These plans have resulted in Maryland’s status as having the highest ranked public school systems for three years in a row, according to Education Weekly, as well as average rates of educational attainment that fall above the national averages.

The American Recovery and Reinvestment Act (ARRA), provides a total of \$98.2 billion in funding for education programs, giving states and school systems an unprecedented opportunity to make momentous changes to strengthen and improve all levels of education. Governor O’Malley’s goal is to maximize the \$589 million awarded to the state by establishing and using pre-K-through-college and career data systems to track progress and foster continuous improvement, and making progress toward rigorous college- and career-ready standards and high-quality assessments.

Forty-nine states and territories have joined the Common Core Standards Initiative. The Initiative is focused on developing a common core of standards that are internationally benchmarked, aligned with the expectations of employers and post-secondary education institutions, and inclusive of the higher order skills necessary to prepare our students for global competition. Governor O’Malley’s strategy for Maryland is to develop and adopt college and career ready “Core Standards” so that all Maryland public high school graduates obtain a college- and career-ready diploma by 2012.

Maryland has a history of strong collaboration between the K-12 and higher education segments regarding the alignment of the curricula for mathematics and English composition. Nevertheless, gaps remain. Governor O’Malley is focused on closing the “college readiness gap,” by working to provide our high school students with the skills they need to succeed in higher education and to access jobs throughout the state. Maryland’s Career Development Framework is designed to provide these skills by giving individuals an understanding of their career aspirations and learning styles and providing information about choices for education and career paths driven by standards from National Career Development Guidelines.

Indicator 21: Youth Employment

Indicator: The percent of young adults who are employed.

Definition: Percentage of young adults who are employed by age groups 16 to 19 and 20 to 24 and jurisdiction.

Significance: Youth employment represents the number of youth employed in Maryland but also exhibits the opportunities and readiness of young adults to be a part of the workforce.

Data: Employment Status by Age

Youth Employment- The percent of young adults in the civilian labor force who are employed.								
By age groups 16 to 19 and 20 to 24								
Employment Status 2005-2009 American Community Survey 5-Year Estimates (Table S2301)								
	Total Population		In labor force		Employed		Unemployed	
	ages 16-19	ages 20-24	ages 16-19	ages 20-24	ages 16-19	ages 20-24	ages 16-19	ages 20-24
National	17,267,273	21,163,659	43.90%	75.40%	33.60%	64.60%	22.50%	12.40%
Maryland	325,458	371,990	45.50%	77.80%	35.80%	67.40%	21.20%	12.00%

Source: U.S. Census Bureau, American Community Survey (ACS) five-year estimates (Table S2301.)

Data Sources: U.S. Census Bureau, American Community Survey (ACS) five-year estimates CY2005 through CY2009 Employment Status (table S2301)

Considerations: Data are based on a sample and subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90% margin of error. The margin of error can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to non-sampling error. For a discussion of non-sampling variability, see Accuracy of the Data. The effect of non-sampling error is not represented in these tables.

Related Measures:

National employment status of the civilian non-institutional population 16 to 24 years of age, July 2007 to 2010:

Employment Status	2007	2008	2009	2010
Civilian non-institutional population	37,443	37,506	37,586	37,944
Civilian labor force	24,339	24,429	23,691	22,938
Participation rate	65.00%	65.10%	63.00%	60.50%
Employed	21,717	21,021	19,304	18,564
Employment-population ratio	58.00%	56.00%	51.40%	48.90%
Unemployed	2,622	3,408	4,387	4,374
Unemployment rate	10.80%	14.00%	18.50%	19.10%

Source: U.S. Bureau of Labor Statistics



Story Behind the Data: The percentages of employed young adults in Maryland is 35.8% for ages 16 to 19 and 67.4% for ages 20 to 24. Both are higher than the national averages of 33.6% and 64.6% respectively. However, the summer employment of 16 to 24 year olds has declined about 10 percentage points over the past four years and is at the lowest July rate on record for the series which began in 1948. July employment rates are an important indicator of youth employment because most youth employment occurs during the summer months when school is out of session.

Some of this decline may be attributable to the difficulty of the current economic times. However a steady decline from the peak in July 1989 can be attributed to a lack of education and job-readiness. There is a growing gap between the needs of the current job market and the skills of young people. The fastest growing job sector is in science and technology, requiring some level of post-secondary education or training, more young people are entering the workforce without basic academic and occupational knowledge.

In the spring of 2008 the Governor's Workforce Investment Board (GWIB) established the Emerging Workforce Committee. The committee, comprised of representatives from business, state and local government, education, organized labor and community and nonprofit organizations, was tasked with providing recommendations to ensure all Maryland youth successfully transition to college, careers, and productive adulthood. The report recommends that Maryland ensure that public schools, higher education and community providers prepare young people to be workforce-ready through engaging learning and real-life experiences.

A GWIB recommendation stated the need for Maryland to re-engage disconnected youth to academic and industry-recognized credentials. Ready By 21™, an initiative of the Governor's Office for Children that is led by the Department of Human Resources, is a five year action plan focusing on the successful transition of youth into adulthood. The goal is that all Maryland youth will be prepared for school, work and life by the age of 21, focusing on those transitioning out of the public system (e.g. foster care, juvenile services, etc.) MSDE's Career Clusters is a key component to preparing Maryland's young people for the workforce.

Partnering with GWIB, MSDE redesigned the Career Technology Education (CTE) program, which provides high school and community college students the opportunity to pursue programs leading to advancement in a career field, with the addition of Career Clusters. Career Clusters guide students through a wide range of career options by applying academic and technical skills. MSDE, in collaboration with the GWIB, identified ten clusters focused on core functions across many industries in Maryland. This program is providing the connection between classroom learning and the real-life application to careers that young people need to be successful in today's workforce.

Theme III: FAMILY AND COMMUNITY ENVIRONMENT



Result 7—Safety



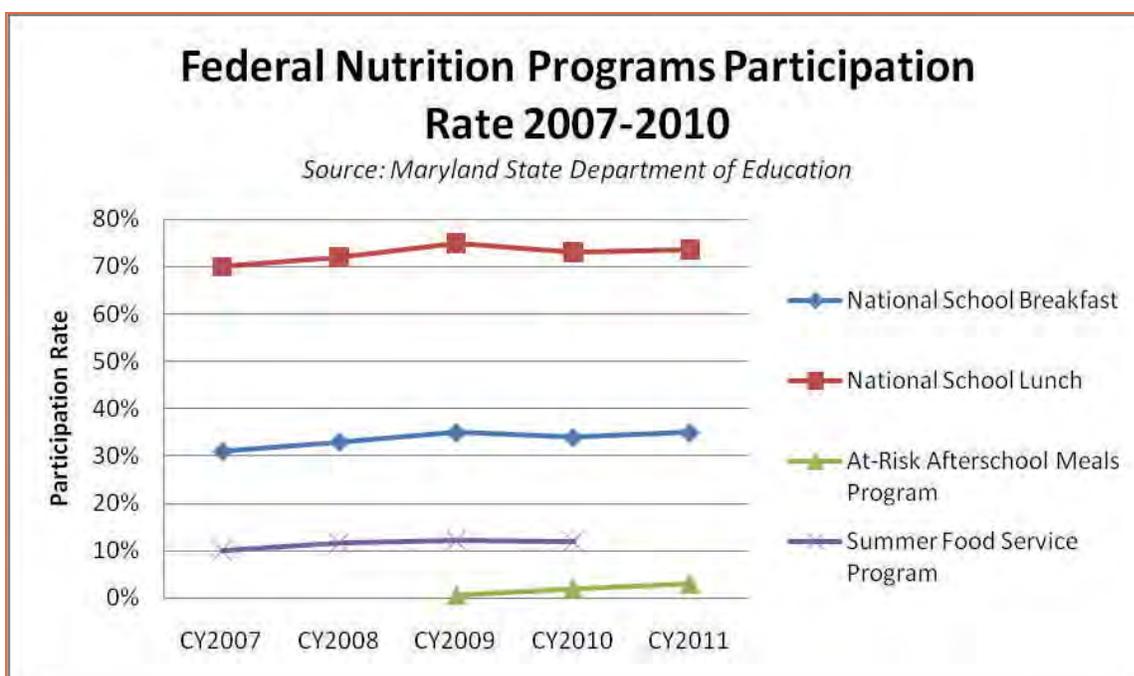
Result 8— Stability



Theme III: Family and Community Environment

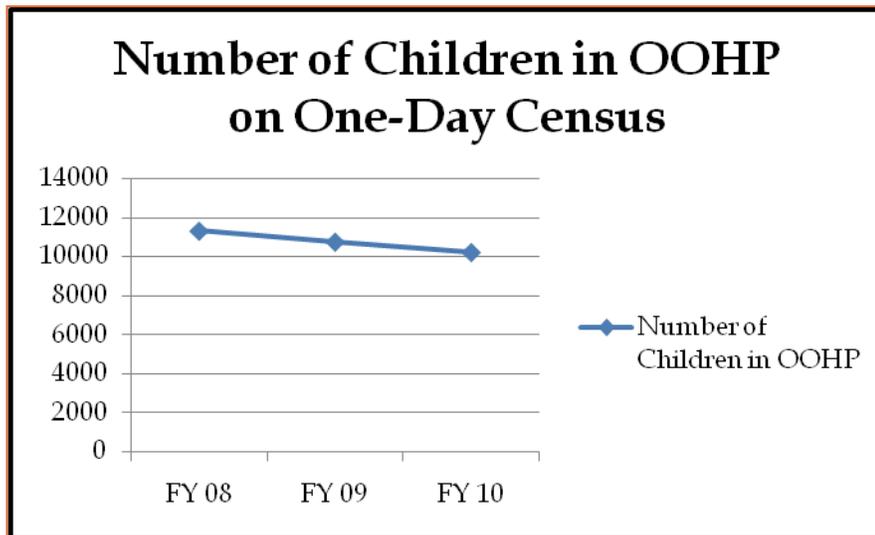
Family and community environment describes a child's surroundings as they grow and develop, both inside and outside the home. The environment in which one lives influences his or her priority on education, health and well-being, and overall success as an individual. Children need safe and nurturing environments to achieve positive outcomes in life. When those needs are put at risk, Maryland seeks to provide families with resources to redirect children from uncertain or harmful outcomes. Families need alternatives to hunger, crime, and community disengagement, to envision a better life.

Major Developments in Family and Community Environment

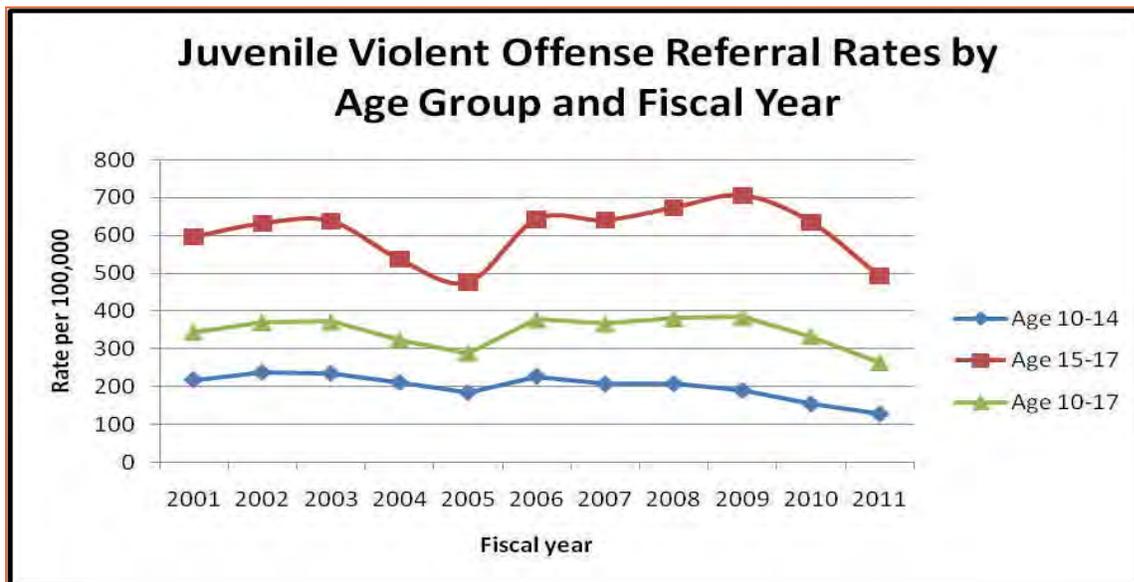
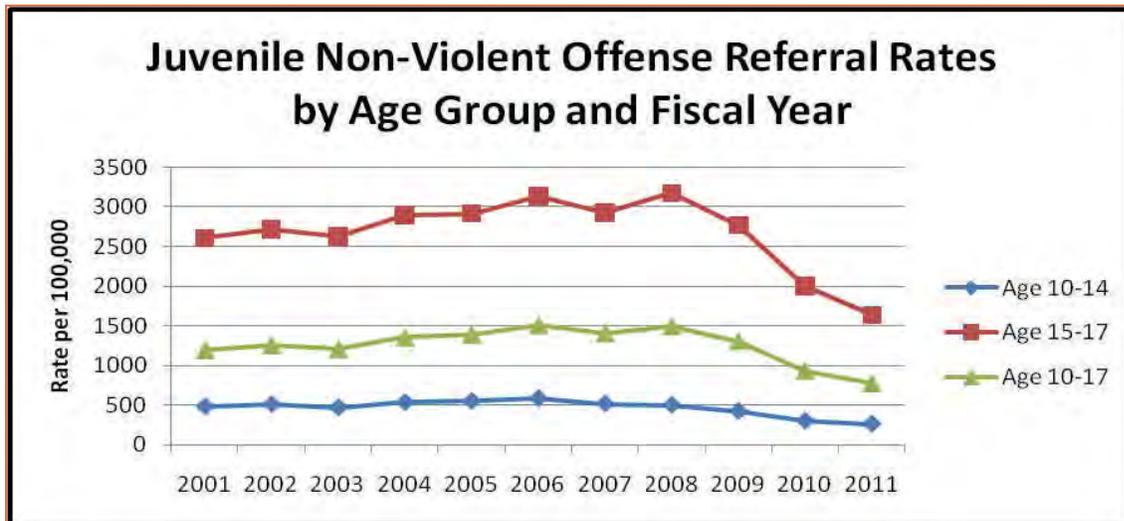


Participation rates in CY2010 for federal nutrition programs are comparable to those of CY2009. While the participation rates in CY2010 in the National School Breakfast, National School Lunch, and Summer Food Service Programs are slightly lower, yet still comparable, to those of CY2009, the rates are still higher than in CY2007. With Maryland's commitment to the Partnership to End Childhood Hunger led by the Governor's Office for Children in collaboration with community, foundation, and faith-based partners, newer programs, such as the At-Risk Afterschool Meals Program may offset the participation rates of other, older programs.

The percentage of children and youth enrolled in Maryland public schools who are homeless has increased again in the 2009-2010 school year since the steep incline during the 2008-2009 school year. While the percentage of homeless students has steadily increased since 2004, MSDE is working to distribute funds to local school systems to support the education of homeless students.



Department of Juvenile Services (DJS), designed to support the majority of children in OOHP, to decrease placement, and its associated cost. These initiatives, in addition to efforts to place children in homes that are suited to meet their individual needs have contributed to an average 4.9% yearly drop in the total number of children in OOHP since FY2008.



The rate of juvenile non-violent and violent offense referrals has dramatically decreased since the 2009 fiscal year for the 15 through 17 age group, and has decreased less sharply for the 10 through 14 and 10 through 17 age groups. The root causes of offense referrals can be correlated to many other issues, such as academic failure, lack of protective factors, such as adult involvement, gang involvement, and other early adolescent problems. As these issues are dealt with through statewide initiatives to better the overall family and community environments of youth, the rates of violent and non-violent offense referral rates follow the patterns that many of these issues follow.

What Maryland Did

Important Actions:

- Governor O'Malley is the first Governor in the nation to commit to ending childhood hunger in Maryland by 2015. Since 2007, there has been a 27% increase in meals served through the Summer Food Service Program and a 13% increase in average daily participation in the School Breakfast Program.

Initiatives:

- **Operation Safe Kids (OSK)** is a system of intensive community-based case management for high-risk youth, with the goal of preventing youth from perpetrating or being victims of violent crime. The program offers counseling and a variety of services to help youth with education, employment, recreational activities, substance abuse, reentry and legal services, and family issues.
- **Place Matters** is a DHR initiative that has been successful in reducing the number of children in out-of-home placement, placing children, instead, with relatives and family whenever possible. Children achieve permanency faster on average when they are placed with family and their outcomes are better because of the stability that a familiar and permanent home provides.



Workgroups and Teams:

- **Local Management Boards (LMBs)** serve as the neutral conveyor of collaboration for local child and family services. They bring together local child-serving agencies, care and service providers, clients of services, families, and other community representatives to assist and support local stakeholders in addressing the needs of and setting priorities for their communities. There are 24 LMBs, one in each county and Baltimore City.
- **Care Management Entities (CME)** serve as an entry point for children, youth and families with intensive needs so that they can achieve the goals of safety, permanency, and well-being through intensive care coordination using a Wraparound service delivery model and the development of home- and community-based services.
- **Local Care Teams (LCT)** are jurisdictional boards with representation from local agencies that are a forum for families of children with intensive needs to receive assistance with the identification of individual needs and potential resources to meet those needs.
- **The Advisory Council for Children**, established by Executive Order Executive Order 01.01.2005.34, is comprised of representatives of State Agencies, family organizations and other stakeholders to provide recommendations to the Children's Cabinet on methods for meeting the policy goals of the State.
- **Evidenced-Based Practices (EBPs)**. The Children's Cabinet is committed to an array of services for children and families, including an expanded implementation of EBPs. Through the GOC, the Children's Cabinet has contracted with the University of Maryland Child and Adolescent Innovations Institute to assist in achieving this goal by supporting jurisdictional and provider readiness efforts, organizing and facilitating required training and coaching, and providing outcomes and fidelity monitoring for an array of EBPs in Maryland.



What We Need to Do

Decrease the number of homeless students.

- The percentage of homeless children enrolled in Maryland public schools has increased from .66% to 1.55% between the 2003-2004 school year and the 2009-2010 school year.
- Prevention programs and outreach about shelters can help reduce the number of families with school-age children who are homeless.
- When students are homeless, they are more likely to have academic problems and will not progress as easily in school.

Reduce the crime rate of young individuals.

- Utilize EBPs to curb the factors contributing to juvenile reoffending such as academic failure, lack of family engagement, and neighborhood safety.
- A focus on preventing crime among young adolescents is necessary to ensure that teen crime rates continue to fall.

Reduce out-of-home placement.

- African-Americans are overrepresented in out-of-home placement, making up 69% of the adolescents placed in Maryland.
- A study to correlate demographical characteristics such as age, geography, gender, and race would give further insight into the factors that contribute to placement.
- Support the identification, development and implementation of community-based services for children.

Reduce child poverty.

- While Maryland's rate of low-income families is significantly lower than the national average, more can be done to prevent families from dropping below poverty levels.
- Advancements in employment would improve child poverty rates as adult unemployment is a major factor in child poverty.
- Continue to focus on school and summer meal programs that have been successful in ensuring that children do not go hungry throughout the day.

Decrease child maltreatment.

- The rate of child maltreatment has increased through FY2010, with neglect standing out as the most substantial factor in the increasing trend.
- The number of neglect investigations rose 24.2% from FY2008 to FY2010.

Result 7: Safety



Why is safety important?

Abraham Maslow's hierarchy of needs, proposed in his 1943 paper A Theory of Human Motivation, is often depicted in the shape of a pyramid, with the largest and most fundamental needs at the bottom, and the need for self-actualization at the top. The need for safety is the second level of needs, right above physical needs, such as air for breathing, food, and water. A person must feel safe in the home, community and within the family. If this need is not met it becomes more challenging for an individual to adequately satisfy higher levels of need, such as love and belonging through relationships, self esteem and confidence, and finally self-actualization through creativity, morality and problem-solving.

Feeling safe in the home, in the community and with family members is integral to the development of children and youth. Without that safety, children live in uncertainty and often with fear for their own well-being. This is not a conducive environment for children to grow, thrive, and succeed.

How do we measure safety?

Measuring the amount of child abuse and neglect shows the safety of the home environment and juvenile offense show the safety of the community. Three assessments have been integral to providing these answers:

Indicator 22-Child Maltreatment:

The rate of child abuse or neglect for children under age 18.

Indicator 23-Juvenile Serious Non-Violent Felony Offense Referral Rate:

The rate of referral for serious non-violent felony offenses for ages 10 through 17.

Indicator 24-Juvenile Violent Offense Referral Rate:

The rate of referral for violent felony offenses for ages 10 through 17.

Recidivism Rate (future development):

Each fiscal year, released youth are followed-up within one, two, and three years after release. Recidivism rates are compiled by committed youth program type using both juvenile and adult systems at re-referral or arrest, re-adjudication or conviction, and re-commitment or incarceration levels. Recidivism rates will be featured as an indicator in the 2011 Results book.

What does the data say?

- There is a 13.8% increase of indicated and unsubstantiated child abuse investigations from FY2008-FY2010.
- Neglect is the most substantial factor in the rising trend, increasing by 24.2% from FY2008 – FY2010.
- The Juvenile Serious Non-Violent Offense referral rates have seen a declining trend from FY2009 for all age groups, with FY2011 having the lowest rate of all previous reporting years.
- The Juvenile Violent Offence referral rates have seen a steady decline for all age groups from FY2007 to FY2011.



Indicator 22: Maltreatment

Indicator: Rate of child abuse or neglect per 1,000 children under age 18.

Definition: Child Protective Service (CPS) investigations are ruled “indicated” where credible evidence is not satisfactorily refuted, or “unsubstantiated” where insufficient evidence is found to support a finding as either indicated or ruled out.

Significance: The indicator measures the extent to which adults threaten children’s security. Child abuse or neglect can result in physical harm, developmental delays, behavioral problems, or death. Abused and neglected children are at greater risk for delinquency and mistreatment of their own children.

Baseline Data:

Rate of Child Protective Services Investigations, per 1,000 children under age 18 by Fiscal Year, Maryland										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Indicated	5.8	5.5	5.3	4.6	4.4	3.8	N/A	4.3	4.7	4.7
Unsubstantiated	6.0	6.3	6.1	5.5	5.4	4.1	N/A	4.3	4.7	4.7
Total	11.8	11.8	11.4	10.1	9.9	7.8	N/A	8.5	9.4	9.4
*2007 data is unavailable due to conversion to MD CHESSIE										

Data Sources: 2010 Maryland Data Sources: Department of Human Resources (DHR), State Stat data on the number of investigations.

US Census Bureau, Population Division, Table 1: Estimates of the Population by Selected Age Groups for the United States, States, and Puerto Rico: July 1, 2009 (SC-EST2009-01), <http://www.census.gov/popest/states/asrh/tables/SC-EST2009-01.xls>.

Considerations: For several reasons, it is likely that the data presented represents a high estimate of the true incidence of abuse and neglect in Maryland. There are always a number of cases of abuse and neglect that are unreported, but increased community awareness, protection and services for victims, and anonymity for reporters maximize the odds that an incidence of abuse or neglect will be reported. Additionally, those cases that are determined to be “unsubstantiated” are cases which lack sufficient evidence, however, they are taken into account in this measure because it is still possible that abuse or neglect occurred.

Related Measures: Additional information on child maltreatment can be found in the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4: <https://www.nis4.org/nishome.asp>). The NIS gathers information from multiple sources to estimate the number of children who are abused or neglected, provide information about the nature and severity of the maltreatment, the characteristics of the children, perpetrators, and families, and the extent of changes in the incidence or distribution of child maltreatment during the time since the last national incidence study.

Story Behind the Data: The rate of indicated and unsubstantiated investigations decreased through FY06, increased slightly in FY08, and appears to be on an upward trajectory for FY10. Closer inspection reveals that, for the period from FY08 to FY10, there is a 13.8% increase in the overall number of indicated and unsubstantiated investigations. Among the types of maltreatment, from FY08 to FY10 physical abuse decreased slightly, by 2%; sexual abuse increased by 3.1%; and mental injury abuse and neglect has more than doubled (although these represent 1% of all investigations - 151 in FY10). Neglect stands out, however, as the most substantial factor in the rising trend. The number of indicated and unsubstantiated neglect investigations rose by 24.2% from 6,335 in FY08 to 7,867 in FY10.

Child abuse and neglect is affected by many family factors, the most common being substance abuse, mental health issues, and poverty. While Maryland has not experienced as much economic hardship as other states, it nonetheless experienced unemployment rates ranging from 4% during 2007 to over 7.5% during 2010 (Maryland Labor Statistics: <http://dlr.maryland.gov/lmi/laus/maryland.shtml>). The economic downturn in Maryland, and the rise of unemployment, may be a factor in the rise of both indicated and unsubstantiated neglect investigations.

Accordingly, effective services must address these issues as well as the immediate safety risks to the family's children. Since July 2007, the DHR has implemented its child welfare initiative, Place Matters, that is focused on the following goals:

- Keeping Children in Families First
- Maintaining Children in Their Communities
- Reducing Reliance on Out-of-Home Care
- Minimizing the Length of Stay in Foster Care
- Managing with Data and Redirect Resources

As part of Place Matters, DHR has implemented a Family-Centered Practice model, which uses service plans based on comprehensive assessments and increases families' capacity to protect their children. Family Involvement Meetings encourage family participation in decision-making about the need for children's placements, decisions about reunification, or making permanent exits from foster care, including guardianship or adoptive placements.

Although the number of children entering foster care increased during the last few years, DHR, through its Place Matters efforts, has minimized the length of stay and moved children to permanency more quickly than in the past, thereby reducing the total number of children in out of home care. DHR's efforts to implement the Family-Centered Practice model often result in the identification of relatives and other community resources for families struggling with child maltreatment. DHR anticipates continued success with the Family-Centered Practice Model that is currently being implemented and becoming institutionalized in the agency's practices. Consequently, although the rate of investigations has increased, the rate of children placed in foster care in Maryland has decreased during these same years, from 6.4 per 1,000 (ages 0 to 21) in FY2007, to 4.7 per 1,000 in FY2011. In human terms, the number of foster children shifted from 10,331 in June 2007 to 7,549 in April 2011, representing a 27% decrease in the number of children placed in foster care.

Indicator 23: Juvenile Violent Offense Referral Rate

Indicator: The rate of intake referrals to the Maryland Department of Juvenile Services (DJS) for youth ages 10 through 17 for violent offenses.

Definition: The rate of referrals, per 100,000 youth ages 10 through 17, for violent felony offenses. Offenses included in this category are: murder, non-negligent manslaughter, forcible rape, first degree sex, second degree sex with force or threat, robbery, and aggravated assault.

Significance: Involvement in violent offenses increases the risk of injury or death and continued criminal activity into adulthood. Risk factors for juvenile delinquency include a lack of educational and job training opportunities, poverty, family violence, and inadequate supervision. Poor school performance, including absence from school and falling behind by one or more grade levels, increases the likelihood of involvement in delinquent activity.

Baseline Data: Juvenile referral rates for violent offenses include murder, non-negligent manslaughter, forcible rape, first degree sex, second degree sex with force or threat, robbery, and aggravated assault. Data covers the fiscal year which spans from July 1 through June 30.

Rate of Referrals to DJS Per 100,000 Youth Ages 10-17, for Violent Felony Offenses by Fiscal Year, Maryland											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Age 10-14	218	238	235	211	184	227	206	207	190	154	127
Age 15-17	596	632	637	537	477	643	640	673	705	635	493
Age 10-17	344	371	372	324	288	378	366	381	384	333	262

Data Source: Juvenile intake referrals: DJS’ automated data system, known as ‘ASSIST.’

Source for Population Estimates: Maryland Office of State Planning, Public School Enrollment Projections, 2010 – 2019, published in September 2010.

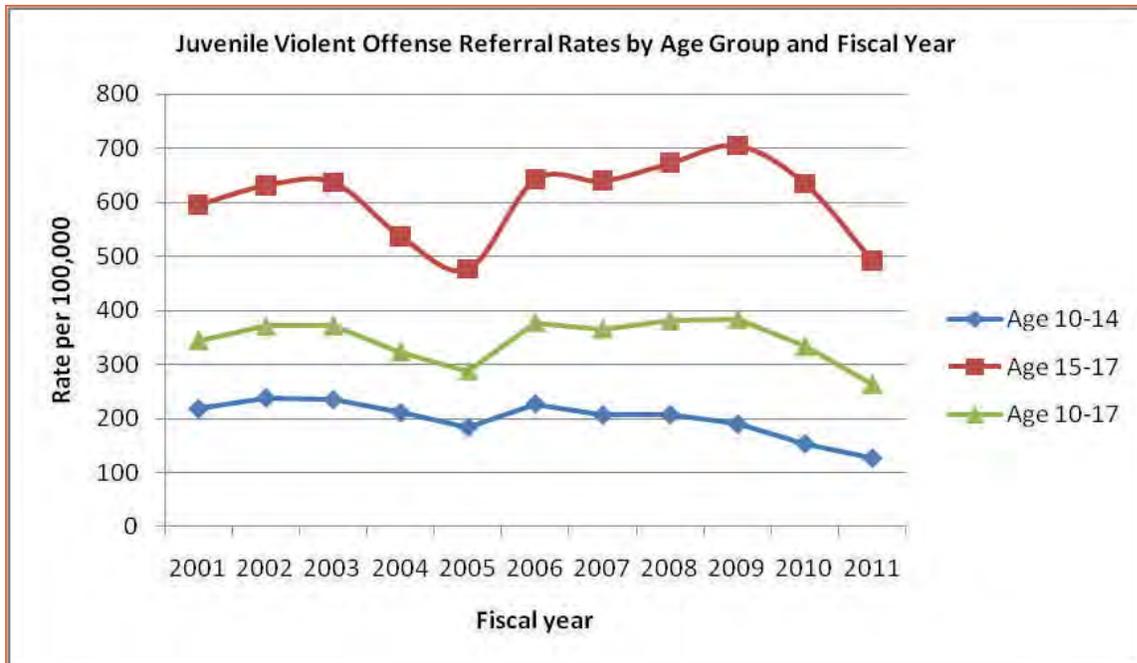
Considerations: Population data to calculate the FY2010 and FY2011 rates were based on the past five fiscal years (2005 to 2009) actual public school enrollment percentages for age groups 10 through 14 and 15 through 17. For example, for age group 10 through 14, 5 year average percentage was 87.2% and the private school accounted for the remaining 12.8%. FY2010 and FY2011 rates are estimated based on the projections of public school enrollments and applying the remainder for private schools. Projections are provided by grade for each of Maryland’s counties and Baltimore City. The public school enrollment projections use the Maryland Department of Planning’s population projections by age and gender for each jurisdiction. These data are available at: http://www.mdp.state.md.us/msdc/Schenroll/School_Enroll_Projection.shtml. Violent offenses are limited to DJS referrals only and do not include those that were referred to the adult system unless they were waived back to the juvenile system.

Related Measures: Violent offenses are automatic referrals to the adult system if a youth is age 14 or older for murder, rape and sex first degree charges and age 16 or older for robbery and aggravated assault. The rates given above include any youth waived back from the adult to the juvenile system and do not include youth who were arrested and not waived back to the juvenile system. Adult arrest data is available from: http://www.mdsp.org/downloads/RIME_IN_MARYLAND_2009_UCR_REPORT.pdf

Story Behind the Data: The juvenile violent offense referral rate for all three age groups (10 through 14, 15 through 17, and 10 through 17) has been decreasing each year from FY2007 through FY2011. The rates remained about the same in FY2002 and FY2003, and fluctuated between FY2004 and FY2006. In FY2010 and FY2011, the rate of juvenile referrals for youth ages 10 through 14 significantly decreased. The rate of referrals for youth ages 15 through 17 significantly increased from FY2008 to FY2009 and decreased significantly in 2010 and again in FY2011. The lowest referral rate for all age groups was reported for FY2011. Overall referrals have been declining nationwide which is the case in Maryland as well. Careful study of the juvenile referral rates and related measures over the next few years may be predictive of whether the recent decade’s slight downward trend will continue and is the beginning of a trend which would warrant further analysis of data and services.

Root causes of juvenile criminal behavior include:

- Early adolescent problems;
- Lack of protective factors, such as adult involvement;
- Academic failure;
- Increase in risk factors—community, family, social, peer, individual;
- Lack of family engagement;
- Gang involvement; and
- Severe unmet mental health and/or educational needs.



Indicator 24: Juvenile Non-Violent Felony Offence Referral Rate

Indicator: The rate of intake referrals to the Maryland Department of Juvenile Services (DJS) for youth ages 10 through 17 for non-violent felony offenses.

Definition: The rate of referrals, per 100,000 youth ages 10 through 17, for non-violent felony offenses. Non-violent felony offenses include breaking or entering, theft, motor vehicle theft, controlled and dangerous substance (CDS) distribution and manufacturing, assault on police officer, third degree sex with or without force, arson first and second degree, destructive devices and conspiracy to commit any felony offense.

Significance: Involvement in serious non-violent offense increases a youth’s risk for further criminal activity and violence both during adolescence and as an adult. Risk factors for juvenile delinquency include a lack of educational and job training opportunities, poverty, family violence, and inadequate supervision. Poor school performance, including absence from school and falling behind one or more grade levels, increases the likelihood of involvement in delinquent activity.

Baseline Data: Juvenile referral rates for Non-Violent felony offenses include breaking or entering, theft, motor vehicle theft, controlled and dangerous substance (CDS) distribution and manufacturing, assault on police officer, third degree sex with or without force, arson first and second degree, destructive devices and conspiracy to commit any felony offense. Data covers the fiscal year which spans from July 1 through June 30.

Rate of Referrals to DJS Per 100,000 Youth Ages 10-17, for Non Violent Felony Offenses by Fiscal Year, Maryland											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Age 10-14	483	509	470	537	551	586	518	502	424	301	263
Age 15-17	2607	2718	2624	2898	2915	3138	2929	3174	2767	2001	1639
Age 10-17	1194	1256	1205	1354	1391	1512	1406	1497	1307	934	772

Data Source: Juvenile intake referrals: DJS’ automated data system, known as ‘ASSIST.’

Source for Population Estimates: Maryland Office of State Planning, Public School Enrollment Projections, 2010 – 2019, published in September 2010.

Considerations: Population data to calculate the FY2010 and FY2011 rates were based on the past five fiscal years (2005 to 2009) actual public school enrollment percentages for age groups 10 through 14 and 15 through 17. For example, for age group 10 through 14, 5 year average percentage was 87.2% and the private school accounted for the remaining 12.8%. FY2010 and FY2011 rates are estimated based on the projections of public school enrollments and applying the remainder for private schools. Projections are provided by grade for each of Maryland’s counties and Baltimore City.

The public school enrollment projections use the Maryland Department of Planning’s population projections by age and gender for each jurisdiction. These data are available at: http://www.mdp.state.md.us/msdc/Schenroll/School_Enroll_Projection.shtml

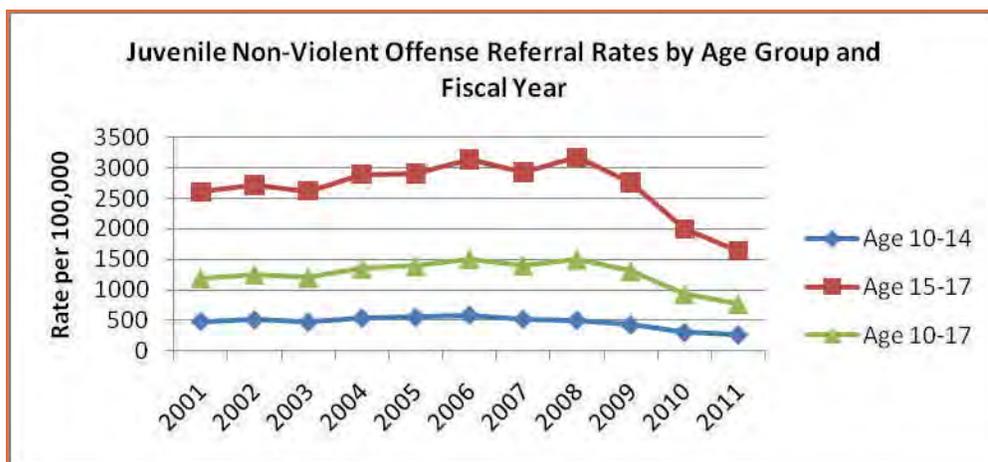
Although the majority of non-violent felony offenses are referred to DJS, referrals that were initiated in the adult system and not waived back to the juvenile system are not included. Additionally, the number of youth adjudicated, found responsible for the alleged offense, is an important correlate to juvenile referral rates

Story Behind the Data: The juvenile non-violent offense referral rates fluctuated slightly from FY2001 through 2005 for all age groups and declined sharply in FY2007. FY2008 saw another large increase for youth ages 15 through 17. It has been a declining trend from FY2009 for all age groups with FY2011 seeing the lowest rates of all fiscal years reported.

Causes of non-violent juvenile criminal behavior are often the same as the causes of violent juvenile criminal behavior and include:

- Early adolescent problems;
- Lack of protective factors, such as adult involvement;
- Academic failure;
- Increase in risk factors—community, family, social, peer, individual;
- Lack of family engagement;
- Gang involvement; and
- Severe unmet mental health and/or educational needs.

While the distinction between violent and non-violent crime is important in the legal system, a more important distinction in treating juvenile offenders is *their risk of re-offending*. This may be high for a youth who committed a non-violent crime but low for a youth who committed a violent offense. This is due to the sanctions provided for violent offenses which are more severe than those given for non-violent felony offenses. Also, youth committing violent offenses are generally older and are sent to the adult system for hearing. This determination can only be made through a thorough assessment of the youth’s criminal history as well as social, economic, educational, physical, family, substance abuse, psychological, and other needs and strengths.



Assessing these criminogenic factors and risks of reoffending, tracking data on the needs of youth, increasing family engagement, and utilizing results-based and evidence-based programs are key components of Maryland’s strategy to work with juveniles with both violent and non-violent arrests and adjudications.

Result 8: Stability



Why is stability important?

Having a place to call home is a key ingredient for both the well-being and success of a child. The reliability of a permanent and stable residency also creates reliability and permanency in other aspects of a child's life, including school and relationships. For transient children and youth, the focus is shifted from education and healthy relationships to securing a safe place for the night. This uncertainty creates an added stress and barrier to success. In turn, families cannot achieve economic self-sufficiency without stable housing.

Children who do not achieve permanency are positively linked to increased rates of delinquency or criminal activity, low educational attainment and school dropout, mental health and substance abuse disorders, and homelessness.

How do we measure stability?

Indicator 25 - Child Poverty:

The percent of children under age 18 whose families have incomes below the poverty level.

Indicator 26- Childhood Hunger/Food Insecurity:

The percentage of children ages 0 - 17 in food-insecure households.

Indicator 27 - Homeless Children:

The percentage of children enrolled in the public school system and defined as homeless: lacking a fixed, regular, and adequate nighttime residence.

Indicator 28 - Out-of-Home Placement (OOHP):

The number of children who are placed in out-of-home placement. The term "out-of-home placement" means: (1) the removal of a child from the child's family; and (2) the placement of the child by a cooperating department or court in a public or private residential child care program or treatment foster care home for more than 30 consecutive days.

What does the data say?

- Since AY2004, the percentage of enrolled children and youth who are homeless has steadily increased from 0.66% in AY2004 to 1.55% in AY2010.
- While the rate of entry into OOHP since the start of FY2008 has increased at an average of 3%, however the number of children in OOHP at the end of each fiscal year has decreased by 12% since FY2008.

Indicator 25: Child Poverty

Indicator: Percent of children under 18 whose families have incomes below the poverty level.

Definition: Related children under 18 whose families have incomes below the US poverty level, as defined by the US Office of Management and Budget
Percentage of children under 18 whose families have incomes below the U.S. poverty level, as defined by the U.S. Office of Management and Budget. (*Small Area Income and Poverty Estimate [SAIPE] statistic*)

Significance: Children who grow up in poverty are more likely to have unmet nutritional needs, live in substandard housing, experience crime and violence, lack basic health care, and have unequal access to educational opportunities.

Baseline Data:

Percent of Children Whose Families' Incomes are Below the Poverty Level- by Calendar Year, Maryland and National											
Maryland	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Single Year	6.5	6.6	7	7.3	10.3	10.9	13	6.9	10	9.8	9.9
3-year Average	8.9	6.7	6.7	7	8.2	9.5	10.4	12.2	10	9.6	9.9
National	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Single Year	16.3	15.6	15.8	16.3	17.2	17.3	17.1	18.3	17.6	17.8	18.2
3-year Average	17.9	16.7	15.9	15.9	16.4	16.9	17.2	19.1	17.9	17.8	17.9
Small Area Income and Poverty Estimates (SAIPE)- Percent of People under the age of 18 living in poverty											
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Maryland	10.1	10.7	9.4	10.1	11.5	11.1	10.9	10.1	10.6	10.4	11.8
National	17.1	16.2	16.3	16.7	17.6	17.8	18.5	18.3	18	18.2	20

Data Sources:

First Table of related children:

CY1998-CY2006 Current Population Survey (CPS) and CY2007-CY2009 American Community Survey (ACS)- Percent of related children under the age 18 in poverty:

http://factfinder.census.gov/servlet/STTable?_bm=y&-context=st&-qr_name=ACS_2009_5YR_G00_S1701&-ds_name=ACS_2009_5YR_G00_&-tree_id=5309&-redoLog=false&-caller=geoselect&-geo_id=04000US24&-format=&-lang=en

Second Table of Children Under the age of 18:

Small Area Income and Poverty Estimates (SAIPE)- Percent of People under the age of 18 living in poverty: <http://www.census.gov/cgi-bin/saige/saige.cgi>.

Considerations: Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90% margin of error. The margin of error can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to non-sampling error (for a discussion of non-sampling variability. The effect of non-sampling error is not represented in these tables.

“Related children” in a family include children under 18 years old in the household who are related to the householder by birth, marriage, or adoption. The count of related children in families was previously restricted to never-married children. However, beginning with data for CY1968 the Bureau of the Census includes never-married children under the category of related children. This change added approximately 20,000 children to the related children category in March of 1968.

Related Measures: Additional measures of child poverty include enrollment in programs such as the Free and Reduced Price Meals or the Food Supplement Program (FSP). Related measures include single parenthood, low educational attainment, and part-time or no employment. The National Center for Children in Poverty offers alternative methods for measuring poverty at:

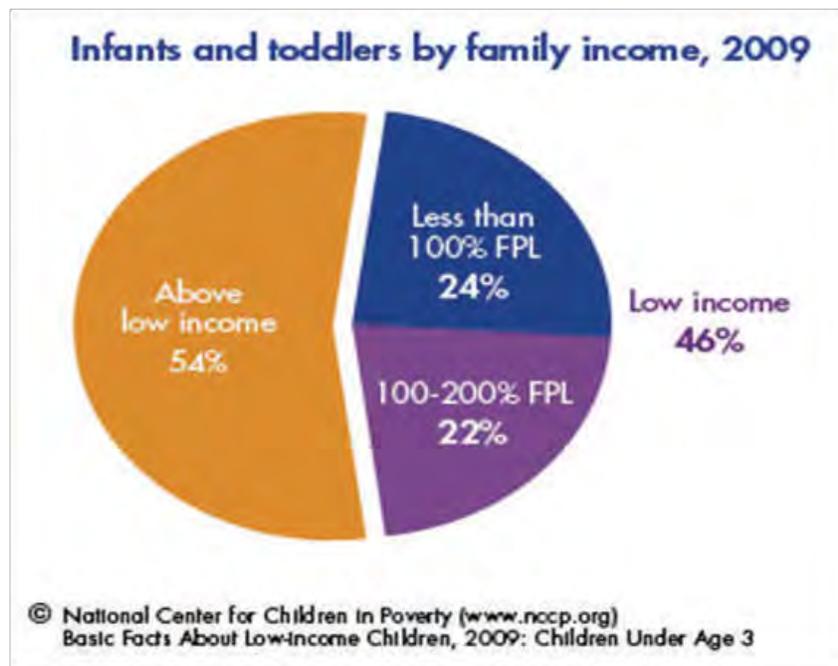
http://www.nccp.org/publications/index_date_2009.html.

Story Behind the Data: The official federal poverty level for a family of 4 in CY2006 was \$20,614; for CY2007, \$20,650; for CY2008, \$21,910; and for CY2009, \$22,050. Available research suggests that children whose families are “near poor” (i.e. 150 - 200% of the federal poverty level) suffer significant disadvantages in comparison to children in families who are in better financial conditions.

According to the National Center for Children in Poverty, “Children represent 25% of the population. Yet, they comprise 36% of all people in poverty. Among children, 42% live in low-income families and nearly one in every five live in poor families. Our very youngest children, infants and toddlers under age 3, appear to be particularly vulnerable with 46% living in low-income and 24% living in poor families”

(http://www.nccp.org/publications/pub_971.html).

After several years of relatively low joblessness, a significant factor bearing on child poverty is Maryland's rising unemployment. On an annual basis, Maryland was below the U.S. average in unemployment since CY2000. Starting with 3.6% average unemployment in CY2000 (compared to the national rate of 4.2%), the average rate increased to 4.2% for 2005 (compared to 5.1% nationally), and rose to 7.1% in CY2009 (compared to 9.3% nationally). This may be correlated to Maryland's levels of related children under 18 years old in poverty, which have been, on average, 8.1% below the national average between CY1999 and CY2009.



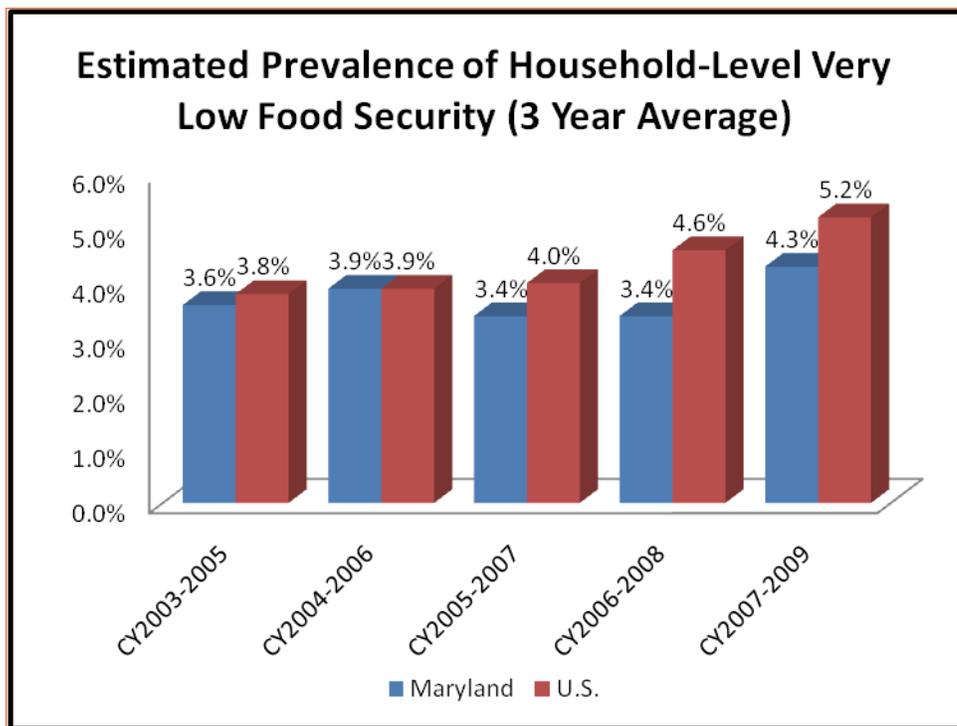
Indicator 26: Childhood Hunger and Food Insecurity

Indicator: The percentage of families who are food-insecure.

Definition: The United States Department of Agriculture (USDA) defines food insecurity as a measure of lack of access, at times, to enough food for an active, healthy life for all household members; limited or uncertain availability of nutritionally adequate foods.

Significance: Hunger affects the lives of children beyond not having the access to enough food. Hunger affects the ability for children and youth to attend and perform in school and raises greater health concerns as well.

Baseline Data:

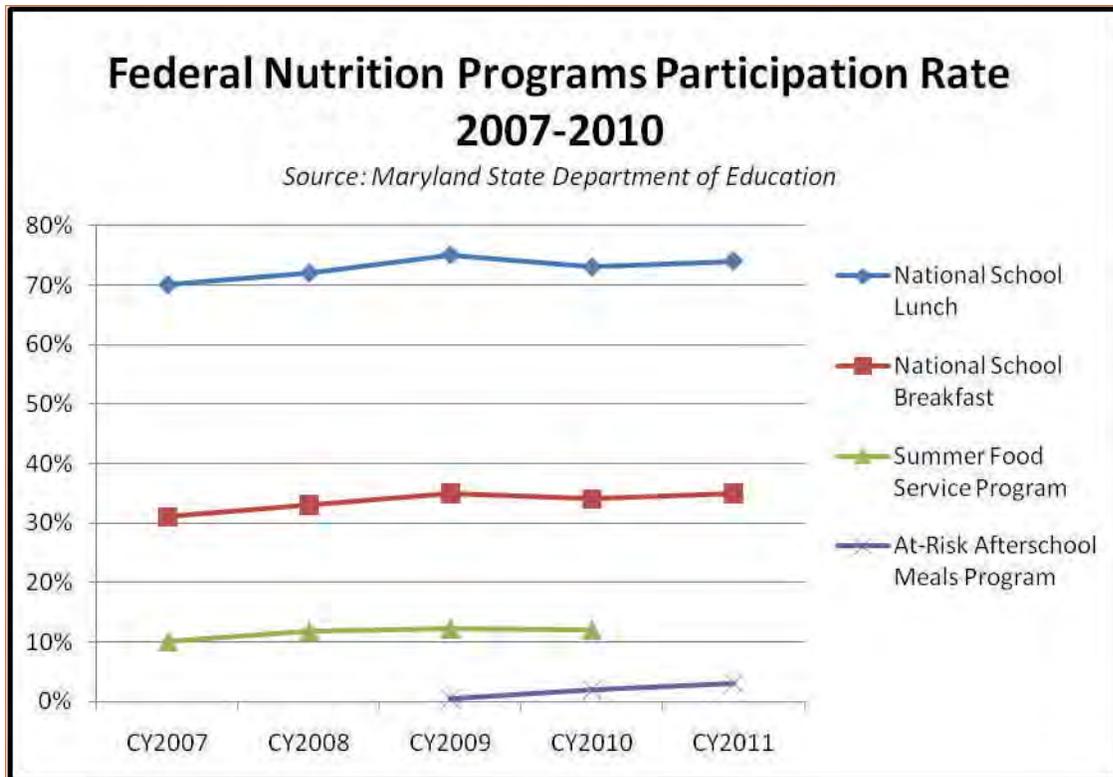


Data Sources: 2011 publication of the Governor’s Office for Children Managing for Results (MFR), D18A18.01

Considerations: The Economic Research Service, U.S. Department of Agriculture, compiles and analyzes data for this indicator from an annual survey conducted by the U.S. Census Bureau as a supplement to the monthly Current Population Survey (CPS). In December of each year, after completing the labor force interview, about 50,000 households respond to the food security questions and to questions about food spending and about the use of Federal and community food assistance programs. The households interviewed in the CPS are selected to be representative of all civilian households at State and national levels.

Paired-year measures (i.e. 2003–2005, 2004–2006) represent an average of the rates of food insecurity for each pair. Surveys are conducted annually through a random sampling of people who live in Maryland. The larger the size of the sample, the more each survey will represent the characteristics of the total population. Because sample sizes from yearly surveys are somewhat small, yearly data are paired and averaged to double the accuracy of the statistics.

Related Measures: The participation rates of federal nutrition programs (National School Breakfast, National School Lunch, At-Risk Afterschool Meals, and Summer Food Service Program), Food Supplement Program (FSP), and the Women, Infants, and Children (WIC) Program are related to food insecurity.



Story Behind the Data: As a result of the current economic difficulties, more families, including working class families, are facing food insecurities. The face of hunger is not just an image of starvation, but of lacking an adequate amount and access to food. Although Maryland is the wealthiest state in the country and home to three of the richest Counties in the nation (Howard, Montgomery and Calvert), 11.6% of households in Maryland (1 in 10) face a constant struggle against hunger. Childhood hunger is caused by a combination of three deficits: resources, access, and information. The high costs of housing, transportation, health care, and other necessities combined with low incomes limit the resources available to keep food on the table. However, even when families have the resources, they are often unable to provide healthy food for their children, due to a lack of access to fresh produce in many of the poorest neighborhoods. While programs like the Food Supplement Program (known federally as the Supplemental Nutrition Assistance Program (SNAP) and formerly known as Food Stamps) or School Breakfast Programs offer help to families, many families are unaware that these programs are available to help them.



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Governor O'Malley is the first Governor in the nation to commit to ending childhood hunger by 2015 and has made this commitment a priority of his administration. To carry out this priority, Governor O'Malley, the Governor's Office for Children, and Share Our Strength announced the creation of a Partnership to End Childhood Hunger in the fall of 2008. This five-year initiative emphasizes prevention, early intervention, and community-based services for children and families in Maryland. This public-private partnership comes together every other month and includes non-profit organizations, state agencies, local leaders and representatives from the faith community. Multiple workgroups have formed around school breakfast, afterschool meals and summer meals and meet regularly to address awareness efforts and challenges with program implementation.

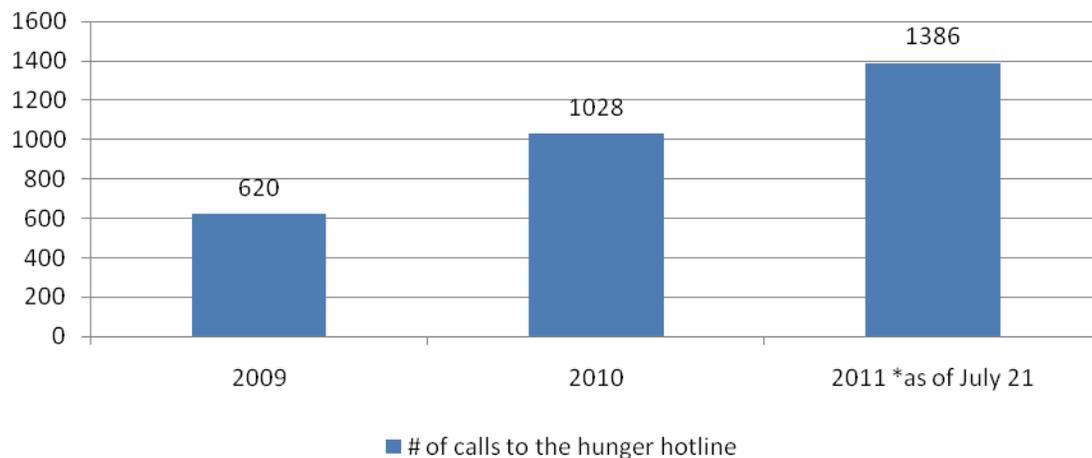
The most effective way to reduce childhood hunger in Maryland is to improve the number of eligible families participating in these already-established programs. The Partnership to End Childhood Hunger (Partnership) is working with community and faith based organizations across Maryland to reach out to families eligible for SNAP benefits and to ensure that those who are eligible can easily apply for benefits through the use of Maryland's web-based application tool, SAIL (Service Access and Information Link). Training community and faith-based organizations to help families apply for benefits is also a goal of the Partnership. Partnering with local faith communities throughout Maryland, the Partnership has conducted six faith-based hunger summits in Baltimore City, Frederick County, Mid-Shore, Lower Shore, Prince George's County and Southern Maryland and is planning two additional summits in Montgomery County in September 2011 and Western Maryland in 2012. Expanding awareness for the WIC program is through material distribution in WIC-eligible populations and educating new mothers about WIC eligibility requirements and benefits.

The Partnership is also increasing the awareness of and encouraging the use of federal nutrition programs including the School Breakfast Program, the Afterschool Meals Programs and the Summer Food Service Program. Prior to the end of the school year, the Partnership sent postcards to families in target counties. Every principal in those counties received a letter from the governor informing them about the Summer Nutrition Programs and postcards that should go out to every student in their schools. In the summer of 2009, almost 187,000 postcards were sent, in the summer of 2010, 432,736 postcards were sent and in the summer of 2011, 442,712 postcards were sent targeting 16 counties and the City of Baltimore. Each of these jurisdictions have an open summer food service site. These programs provide meals to children at critical times during the day when children need food. Through the Partnership's efforts, each of these federal nutrition programs has seen a steady increase in participation.

Maryland has created innovative ways of providing outreach and access to food and nutrition programs. In collaboration with MSDE, the Partnership created a Hunger Hotline to provide information regarding open summer meals sites and additional resource information, including SNAP and WIC. During the first month of hotline operation for summer of 2011, more calls were received than during the entire summer of 2010. The Partnership plans to expand the use of the hotline beyond summer and operate throughout the year.

Number of Calls to the Hunger Hotline 2009-2011

Source: Governor's Office for Children



Number of Caller Requests from Different Zip Codes, 2009-2010

Source: Governor's Office for Children



Working with the Family League of Baltimore City, the Partnership piloted a “mobile meals” delivery system for the Summer Food Service Program. The mobile meals delivery is a way to provide meals to children in areas of high need that have no existing program or site in place. This model allows the food providers to meet the children and youth in centralized and easily accessible locations. This is a solution to the barrier of transportation and travelling to sites. It also addresses the recent challenges of high summer temperatures and heat advisories closing existing meal sites. The mobile meal vehicle can continue to provide meals to children and teens throughout the summer month, regardless of heat closures

Finally, the GOC on behalf of the Partnership received a two-year USDA Food and Nutrition Service Hunger-Free Communities Grant. Catholic Charities, the Maryland Department of Human Resources (DHR), Maryland Food Bank, Maryland Hunger Solutions, MSDE, and the SHARE Food Network as sub-grantees of the Partnership, will implement strategies proposed in the *Plan to End Childhood Hunger in Maryland by 2015* and tailor implementation to the specific needs of targeted communities. The eight target Counties are Allegany, Anne Arundel, Caroline, Carroll, Dorchester, Frederick, Garrett and Montgomery. The three areas of focused work are:

1. Increasing access to and information regarding the Food Supplement Program;
2. Increasing participation in school and out-of-school time nutrition programs;
3. Expanding access to nutritious food for families with children.



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Indicator 27: Homeless Children

Indicator: Percentage of children and youth enrolled in the public school system defined as homeless.

Definition: The percentage of children enrolled in the public school system that lacks a fixed, regular, and adequate nighttime residence. The number and percentage of homeless children and youth enrolled in the public school system in School Year (SY) 2010: 13,158 of 848,412 (1.5%)

Significance: Families cannot achieve economic self-sufficiency without stable housing conditions. Children and youth who are homeless tend to have poorer health and experience more developmental delays than children who are adequately housed.

Baseline Data: The number and percentage of all children and youth enrolled in the public school system who are homeless at any time during the school year. This is not a “point in time” count.

School Year	Number Enrolled Homeless	Sept 30th Total Enrollment	Percent homeless
2003-2004	5,704	869,113	0.66
2004-2005	6,750	865,561	0.78
2005-2006	7,821	860,020	0.91
2006-2007	8,457	851,640	0.99
2007-2008	8,813	845,700	1.04
2008-2009	10,676	843,861	1.27
2009-2010	13,158	848,412	1.55

Data Source: The data for these counts are collected annually and submitted to the MSDE Division of Accountability and Assessment (DAA) via flags in the Attendance Data Collection. The Homeless Coordinators at every school system work with the Local Area Coordinator (LAC) to provide accurate counts to MSDE for accountability and to meet the federal reporting requirement. These data are submitted to the federal level via the Consolidated State Performance Report (CSPR) and the Education Data Exchange Network (EDEN) on an annual basis. The data are located in Part I of the CSPR, section 1.9. These can be located on the MSDE web-site at the following link:

<http://www.marylandpublicschools.org/MSDE/programs/esea/?WBCMODE=PresentationUnpublishe%25%25%25/>.

Considerations: The data reported for this indicator focuses only on children enrolled in a Maryland public school at some point during the 2010 school year. Approximately 848,412 children and youth were enrolled in a Maryland public school during 2010, 1.55% of whom were homeless. Since the 2004 school year, the percentage of enrolled children and youth who are homeless has steadily increased from .66% in 2004 to 1.55% in 2010.

Related Measures: DHR also tracks demographics of shelter-users. Of all the homeless people served in shelters as individual and family members (42% and 58%) respectively; 26% were under age 18; and 38.7% of shelter-users were women in FY2009. Also, the count of bed nights (the number of nights each shelter bed was occupied) is used as a measure to study the utilization of homeless shelters. In FY2009, a total of 1,941,722 bed nights (emergency shelter, transitional housing and motel placements) were reported.

In Maryland there was a decrease in bed nights (occupancy of one person, one night) during the period 2007 (1,857,026) and 2008 (1,547,434) while other variables that are related to homelessness, (unemployment, lack of affordable housing, foreclosures, etc.) increased during this period. The decrease in bed nights despite these trends may be attributable to the closing of some shelters at the beginning of the fiscal year. However, by the end of the year, new shelters opened, so that by the end of the counting period, it resulted in a lower overall count of bed nights. This phenomenon is substantiated by the bed night's figure of FY2009, which show an increase in the number of shelter bed nights (1,941,722).

Story Behind the Data: In addition to offering Title I services, MSDE distributes funds to local school systems through a competitive grant process under the McKinney-Vento Homelessness Education Assistance Improvement Act of 2001. The McKinney-Vento Act ensures that all homeless children and youth have equal access to the same free, appropriate public education provided to other children and youth. State and local school systems are required to develop, review, and revise policies to remove barriers to the enrollment, attendance, and success in school of homeless children and youth. All children and youth experiencing homelessness are eligible for Title I services in Title I schools, non-Title I schools, and other settings in which they reside.

Under the McKinney-Vento Act, local school systems may be granted funds to provide programs for homeless children and youth, including supplemental instruction, transportation, professional development, and referrals to health care. If a school-aged child becomes homeless, the McKinney-Vento Act allows for the child to either continue at the "school of origin" for the entire time s/he is homeless or until the end of the academic year in which s/he moves into permanent housing, transfer to a school nearest to the child's temporary shelter, or is sent to a school other than one the child's parent/guardian has requested.



Indicator 28: Out-of-Home Placement

Indicator: Children who are placed in out-of-home care.

Definition: The term “out-of-home placement” (OOHP) means: (1) the removal of a child from the child's family; and (2) the placement of the child by a cooperating department or court in a public or private residential child care program or treatment foster care home for more than 30 days. All OOHPs can be grouped into one of these categories:

1. *Family Home Settings:* Relative (Kinship) Care, Foster Care, Treatment Foster Care, Pre-Adoptive (Adoptive) Care, Living Arrangement- Family Home, and Individual Family Care
2. *Community-Based Residential Placement:* Independent Living, Living Arrangement -Community Based, and Residential Child Care Programs (RCCPs)
3. *Non-Community-Based Residential Placement:* Residential Treatment Centers (RTCs), Adult Corrections, Juvenile Detention and Commitment Centers, Substance Abuse and Addiction Programs, Residential Educational Facilities, Diagnostic Evaluation Treatment Program, Living Arrangement- Non-Community Based, and Non-Secure/Non-RTC
4. *Hospitalization:* General Hospitalization, Psychiatric Hospitalization and In-Patient Private

Significance: OOHP is utilized after other, less restrictive, interventions have been unsuccessful in keeping a child safe in their home environment. Often, children’s safety is at risk because they exhibit the most intensive needs. For this reason, multiple services and placements may be necessary for these children and can result in children not connecting with permanent caregivers. Outcomes for children in OOHP who do not achieve permanency are positively correlated with rates of delinquency or criminal activity, low educational attainment and school dropout, mental health and substance abuse disorders, and homelessness. This may be attributable to both a lack of constant family support and the challenging needs exhibited by children in OOHP.

Baseline Data: Each jurisdiction reports on the total number of placements that are initiated each year, displayed below as the “rate of entry” from FY2008 to FY2009. The listed rates are based on number of placements per 1,000 children in each jurisdiction, including the change in rate of entry across the most recent three years. On average, OOHP in Maryland has increased by 3% each year since FY2008.

Jurisdiction	Rate of Entry - FY08	Rate of Entry - FY09	Rate of Entry - FY10	Two Year Change	Average Change	One Year Change
Maryland Statewide Average:	10.2	10.8	10.8	5%	3%	-1%

Data Source: Data on OOHP comes from the *State of Maryland Out-of-Home Placement and Family Preservation Resource Plan: Fiscal Year 2010*. The report was compiled by the Governor’s Office for Children on behalf of the Children’s Cabinet and tracks OOHP data from FY2008. Data is available by jurisdiction, gender, race, age, agency, and placement category.

Considerations: Two types of data on placements are used in this report. “Rate of entry” data is based on the number of placements that were started in each FY listed. “One-day” data are gathered by census each year on January 31st, the mid-point of the FY.

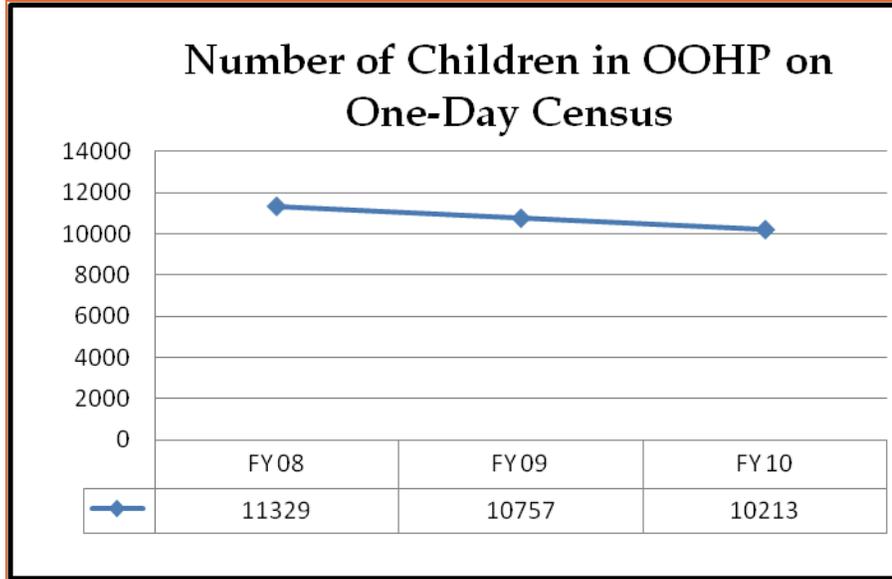
The included data does not perfectly represent the number of children in OOHP because numbers of placements are reported by each agency and some children are served by more than one agency. Previous years’ data have shown that approximately 3% of children are served by more than one agency. Accordingly, the total number of children in Maryland who are in OOHP may be estimated as 3% less than reported. “Rate of entry” data are a reflection of the number of children admitted to OOHP each FY. The actual data captures the number of placements started, but because some children can be placed more than once in a year, the “rate of entry” may be higher than the rate of children entering placement.

“One-day” data reflect the numbers of children placed by each agency. This measure provides a snap-shot of providers’ population capacities and the ratios of children served at any one time based on demographic.

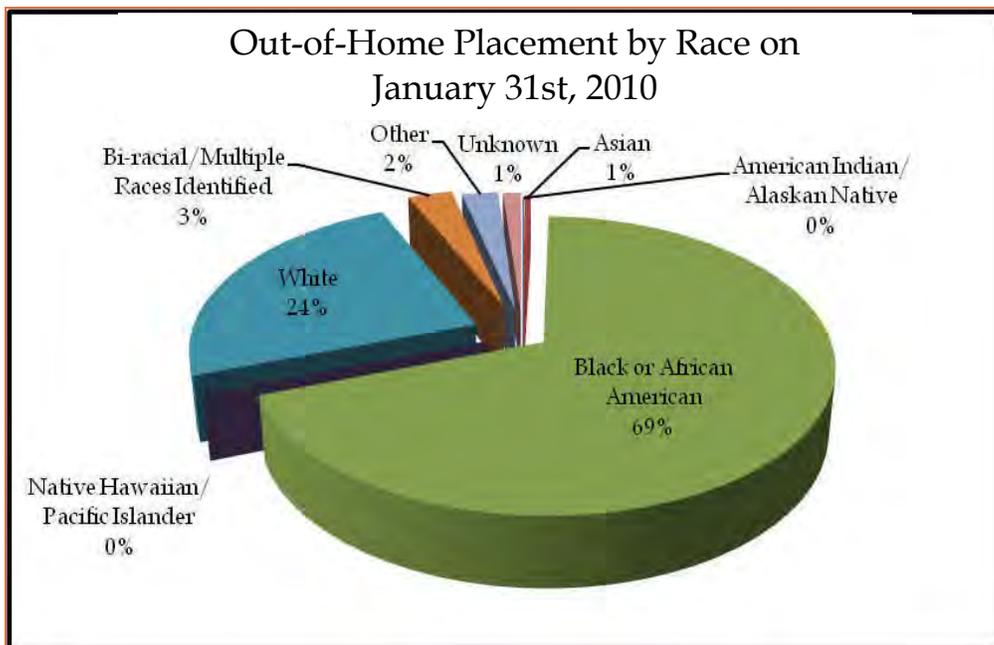
Related Measures: OOHP data is related to the outcomes of children who are raised in a variety of family units: nuclear and extended, single and two-parent households, and children raised by relatives. A large percentage of children in OOHP require educational, mental health, and legal services, so outcomes for children with these needs relate to the possible outcomes for children in OOHP. Additionally, the outcomes of families who require financial assistance, health care, substance abuse, and ex-offender services may provide useful information for children in out-of-home care because children in placement often come from families who exhibit these needs.

Story Behind the Data: Children in OOHP are placed in the custody of the state when their needs cannot be provided for by their parents or other immediate caregivers without the intervention of state services. This may occur when a child is determined to be in need of assistance, supervision, is delinquent, or when a family voluntarily places their child(ren) in custody to utilize services to which they otherwise would not have access. It is an asset for services to be available to families and children so that children's needs may be met early in life and prevent negative future consequences. However, children need permanent homes with loving, stable families to cultivate a sense of security and consistency as they mature and grow. Outcomes for children in OOHP are associated with lower educational and economic success, as well as correlated to higher disconnection from their communities and high-risk behavior. Ultimately, the goal of the Children's Cabinet is to reduce the rate of children who enter OOHP while ensuring that children and families have an array of community based services necessary to achieve positive outcomes.

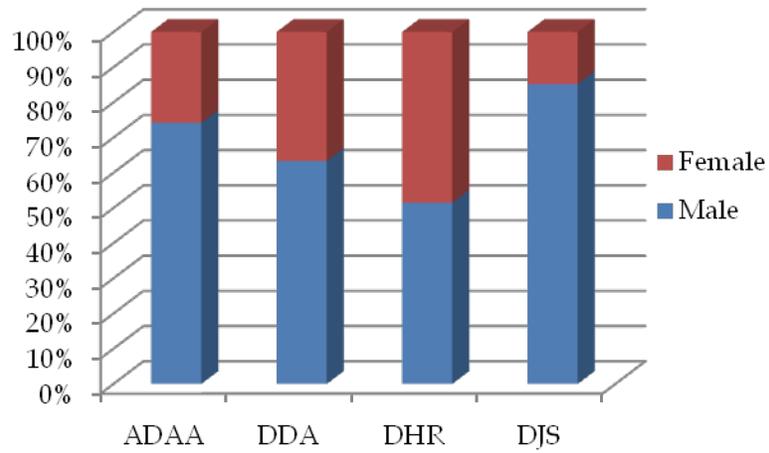
The number of children in OOHP has declined since FY2008 due to the continuing efforts and initiatives focused on serving families in their homes and preventing the need for placement. The Department of Human Resources (DHR) and the Department of Juvenile Services (DJS), which serve 92.5% of the total population of children in OOHP, have implemented programs to divert children from placement. These efforts have contributed to more stable families and significant cost savings. DHR has reduced the total number of children in OOHP by 12% (based on one-day data) since FY2008 and costs for OOHP have decreased concurrently, from \$290 million in FY2008 to just over \$250 million in FY2010. These results have been supported by the *Place Matters* initiative that aims to prevent children from entering care, making efforts to place with relatives if such action is necessary, and reducing the amount of time a child is in care. DJS reduced the total number of children in OOHP by 4% from FY2008 to FY2010. This has been accomplished through the use of evidence-based therapies and the Maryland Comprehensive Assessment and Service Planning tool, designed to place children more effectively in programs to suit their individual needs. Efforts such as these have contributed to an average 4.9% yearly drop in the total number of children in OOHP since FY2008. Reductions in the total number of children in OOHP do not reflect a corresponding reduction in the number of children being placed, however. The rate of entry since FY2008 has actually increased annually at an average of 3% for the State of Maryland. This may indicate that while more children are being admitted to OOHP, these children are remaining in OOHP for shorter periods of time. Many agencies have, congruent with this finding, reported a decrease in the number of children served at the end of the FY in comparison to the beginning of each fiscal year. More timely identification of permanent homes for children more quickly assists with the gaining of a sense of stability and achievement of better outcomes. This success could be a result of increased efforts to place children with family. More information will be needed to ensure that children who achieve permanency do not recidivate in the future.



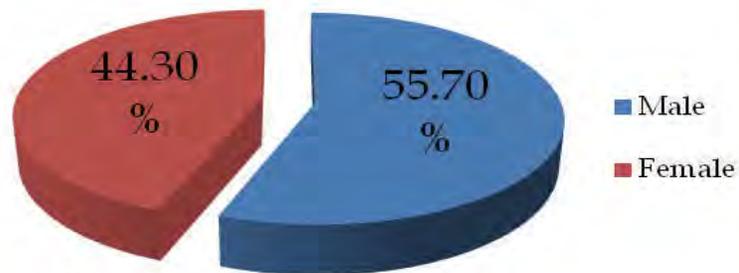
African-American males are currently overrepresented in OOHP, although the number of African-Americans in OOHP has decreased since FY2008 from 7904 to 7038, at a rate of 5.5% per year (based on one-day data). This rate of decline is slightly greater than the overall decline in the number of children placed in Maryland since FY2008, which means that African-Americans make up a lower percentage of children in OOHP than they did in FY2008. More information is needed in the future to show the reasons why children are placed, so that those indicators can be correlated with demographical characteristics such as age, geography, gender, and race. Such a study might be useful in focusing on the factors that contribute to placement, overrepresentation in placement, and effective strategies for reducing placement.



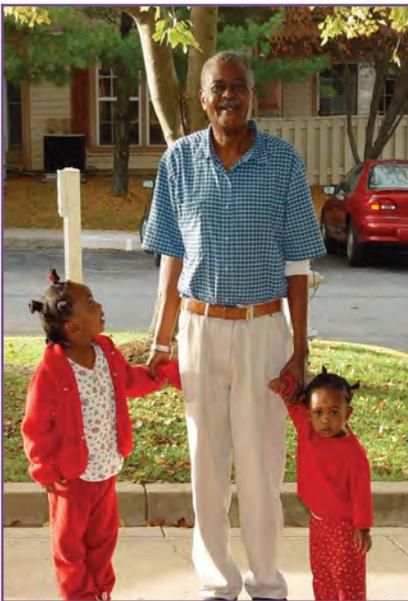
Gender Ratios by Agency on Jan 31st, 2010



Gender Ratio on Jan 31st 2010



APPENDICES



History of Maryland's Results and Indicators

In 1996, the Governor's Task Force on Children, Youth, and Families Systems Reform was created in response to a growing desire by local jurisdictions to ensure a strong local role in setting policy that affects children and families. Additionally, the Task Force considered the differing and individual needs of Maryland's jurisdictions as they recommended policies and procedures for the systems reform initiative. The need for a results-based system was a strong theme throughout the work of the Task Force and was reflected in the public hearings held by the Task Force throughout the State.

The Task Force's Program Subcommittee originally proposed nine results. Each result area and its proposed indicators underwent intensive review and discussion by the Subcommittee and in 1997 by the Program Subcommittee's successor, the Results Workgroup. Both groups had representation from the State and local levels, public and private members, including county public health officials, county social service employees, local school system staff, local management board members, advocates and State agency staff.

In the fall of 1998, the Outreach Workgroup was formed to gather further public opinion about the proposed nine results. Following this review, one result (Healthy Adults) was dropped due to insufficient data demonstrating its direct connection to and impact on child and family well-being. In January 1999, the remaining eight results were adopted, forming the basis of Maryland's Results for Child Well-Being.

The chosen results capture the quality of life for children and families in Maryland. Progress toward each result is determined through selected indicators which specifically measure segments of each result area. By monitoring the indicators, the State and local jurisdictions are able to evaluate the effectiveness of service delivery to children and families. In order to uniformly assess the usefulness of suggested indicators, the Task Force developed the following criteria to select Maryland's twenty-five indicators:

- The indicator is directly related to the well-being of children, families or communities in each specific result;
- The indicator is well measured. In other words, it applies to all or most of the relevant population and is collected in ways that support data reliability and validity;
- Data on the indicator are readily available from public sources; and
- Data on the indicator are available at the State and local level.

Across the nation, three to five indicators are usually accepted as a manageable number of measures per result area. The number of indicators is crucial. Other states have shown unsuccessful shifts to results-based accountability, in part, by selecting too many indicators. As other indicators are considered in the future, the task of monitoring and analyzing them will continue with public input. It is the intent of the Children's Cabinet that the core set of indicators will be modified as necessary. By adopting the results and indicators featured in this book, Maryland is able to move forward with the national trend of utilizing results-based accountability for programs and services.

Maryland's effort has been part of a national movement toward result-based services and accountability for outcomes. Using Maryland's Results and Indicators, the Children's Cabinet, in cooperation with local jurisdictions, strives to meet the needs of Maryland's children, families, and communities. Through a collaborative approach, each jurisdiction identifies and focuses on results and indicators that are priorities in their community. The information in this publication assists in tracking and evaluating the well-being of children across the State and in each local area.

In 2009, the Children's Cabinet convened a workgroup that reviewed the current Results and Indicators to assess their continued accuracy in measuring child well-being in Maryland. During this process, data for the current Results and Indicators were reviewed, along with data for potential new results and indicators. The workgroup has developed revised Results and Indicators that have been adopted by the Children's Cabinet. The workgroup has replaced some of the current Results and Indicators with stronger measures, to reflect the progress that has been made over the years to improve data collection and analysis, both statewide and nationally. Where possible, data for Transition Age Youth (18-21) was added. Whenever possible, there will be a new feature to "Hot link" the GOC website section on results and indicators to the online agency source. This will afford users the opportunity to disaggregate original data to meet their informational needs. There will also be a shift from Current Population Survey, SAIPE, and American Community Survey (ACS) (one and three year estimates) to a single source of ACS three-year averages. The 2010 report will reflect these changes to the Results and Indicators, and, where new Indicators replace historically reported Indicators, a retrospective presentation of the new data from no fewer than five years will be used to establish a current baseline.

Maryland's results and indicators provide a framework for accurately measuring the well-being of children in Maryland. Without clear and quantifiable indicators, there would be no evidence that Maryland is meeting its goals for children. And without the participation of all Marylanders who care about children, our understanding of how Maryland is doing would be incomplete. For this reason, State and national stakeholders including child and family-serving agencies, non-profit organizations, community-development partnerships, educators, faith communities, and parents and children are integral to shaping a vision for Maryland's children.

The Maryland Results for Child Well-Being is not designed to be a static or conclusive document. Instead, it is meant to be a process of continuous renewal and re-use. The results do not only describe what has already happened in Maryland, but they also provide guidance for what needs to be done. Throughout the year, the Children's Cabinet plans to utilize the wealth of information collected through the efforts of government agencies and non-profit research groups, and assisted by the input of community members, to direct the State's work with children and families. In 2011, the Governor's Office for Children will convene a series of workgroups to assess the progress of Maryland's child outcomes to date, what needs to be done to improve those outcomes in the coming years, and how the Maryland Results for Child Well-Being 2011 report can be presented for the use of child welfare practitioners and laypersons alike.

Acknowledgements

The following State partners were integral to the development of the *2010 Maryland's Results for Child Well-Being*, through data collection and analysis. Their efforts make outcomes measurement possible in the State of Maryland.

Department of Juvenile Services (DJS)

<http://www.djs.maryland.gov>

Department of Human Resources (DHR)

<http://www.dhr.maryland.gov>

Department of Budget and Management (DBM)

<http://www.dbm.maryland.gov>

Department of Disabilities (DOD)

<http://www.mdod.maryland.gov>

Department of Health and Mental Hygiene (DHMH)

<http://www.dhmh.maryland.gov>

Maryland State Department of Education (MSDE)

<http://www.marylandpublicschools.org/msde>

Thank You



Thank you to the many State and community partners who produced, analyzed, and disseminated the data reported in this book.

Thank you, also, to those individuals who assisted in synthesis of the data and results, provided photographs, and helped to update this year's *Maryland's Results for Child Well-Being*.