Maryland
Results for Child Well-Being
2011

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Governor

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Lieutenant Governor

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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

Sam Abed, Secretary
Department of Juvenile Services

Theodore Dallas, Secretary
Department of Human Resources

T. Eloise Foster, Secretary
Department of Budget and Management

Nancy S. Grasmick, State Superintendent of Schools
Maryland State Department of Education

Catherine A. Raggio, Secretary
Department of Disabilities

Joshua Sharfstein, Secretary
Department of Health and Mental Hygiene

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A MESSAGE FROM GOVERNOR MARTIN O'MALLEY

Dear Friends:

I'm pleased to introduce *Maryland's Results for Child Well-Being* presented by the Maryland Children's Cabinet and the Governor's Office for Children.

Maryland's public schools have been ranked first in the nation by *Education Week* for four consecutive years, and we know that we must continue to invest in our children if they are to compete and win in this changing global economy. In order to meet these new challenges, we have set goals to improve student achievement, and school, college and career readiness by 25% by 2015, end childhood hunger by 2015, and reduce infant mortality by 10% by 2012.

The Children's Cabinet is committed to prevention, early intervention, and community-based services to ensure that our children and families' needs are being met. For over ten years, Maryland has tracked eight target areas and developed statewide indicators to measure and report on child well-being to inform decisions by State and local partners. This report is among the longest, continuously reported results and indicators for children and families in the nation and reflects our commitment to our State's long-term success.

There are some challenges so large that we can only hope to tackle them together, and making the best choices to protect the dignity of every child is one of them. Thank you to our government agencies, community partners and engaged citizens for your commitment to Maryland's children and families.

Sincerely,

Governor

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TTY Users Call Via MD Relay

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 2011 *Maryland Results for Child Well-Being*. The GOC serves as the coordinating entity for the six child-serving agencies that constitute the Children's Cabinet whose members are the Secretaries of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Services, Disabilities, as well as the State Superintendent of the Department of Education.

Our office uses results accountability to select, monitor, and measure well-being outcomes for the children and families of our statewide community. Since 2001, these measures of well-being, results and indicators, have guided the Children's Cabinet's efforts as we have charted progress, studied trends over time, evaluated data, set priorities, and developed and supported effective and evidence based programs to meet the demonstrated needs of Maryland's children, youth, and their families.

As a state, we are proud to note that Maryland's Results for Child Well-Being are the longest continuously reported set of statewide results and indicators for children and families in the nation. In addition to longevity, we are able to state with confidence that these results and indicators are aligned with national child well-being priorities as well as those of the O'Malley-Brown administration.

In 2010, the publication was reviewed and redesigned. The results and indicators are reported in three foundational themes: Health, Education, and Family and Community Environment. This themed approach affords the opportunity to draw connections among the results and indicators, highlight the alignment with administration priorities, and utilize strong measures that accurately reflect progress made over the years.

Within each theme, the 2011 publication includes an additional section that reports "New Perspectives." The narratives of these sections provide information about newly adopted indicators currently being monitored, measured, and reported and have at least 3 years of data.

The leadership and staff of the Children's Cabinet agencies demonstrate an exceptional degree of cooperation and collaboration on child and family issues, policy, and practice. The Children's Cabinet, with input and guidance from the Children's Cabinet Advisory Council, applies the principles of results based accountability and continuous quality improvement to review and revise the implementation plan for *The Maryland Child and Family Services Interagency Strategic Plan*. This plan guides the work of the Children's Cabinet in its ongoing efforts to effectively meet the needs of at-risk children, youth, and their families.

The utilization of these results and indicators in conjunction with the Interagency Strategic Plan, align with and support Governor O'Malley's commitment to strengthen families and communities, improve public safety, and continue public education's performance as #1 in the nation. The Children's Cabinet agencies, families, and stakeholders continue to collaborate to move forward as a state and improve the lives of Maryland's children, youth and their families. With the leadership of Governor O'Malley and in unity with families we work together to ensure state government works for the people we serve.

Sincerely,

Rosemary King Johnston

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

Introduction to Maryland's Results for Child Well-Being

About the New Look…

The 2011 Results book looks different than the previous annual publications of the *Maryland's Results for Child Well-Being*. Although the rigorous analysis of Statewide child well-being trends hasn't changed, the ease of accessing information has improved.

The eight results for child well-being have been grouped into three overarching domains: Health, Education, and Community. This assists in the identification of commonalities among Maryland's intended goals to help children grow up happily and successfully. The 2011 Results book allows the reader to utilize the tabs on the side of the page to locate specific results.

Another difference with this Results book is that each indicator focuses the reader's attention on two of the most important details in trend analysis: the baseline and the story behind the data. Whereas earlier publications exhibited the majority of information under several subtitles (significance, related measures, considerations, etc.), that information is now included in the "Story Behind the Data," which is an analysis of the progress to date with regard to the indicator. Statistical considerations and data limitations are featured in notes at the end of each section. This highlights the information that is most relevant to demonstrating the progress made in achieving our goals.

An additional section has been included in the 2011 Results book, entitled "New Perspectives." It emphasizes indicators that Maryland has researched in the last decade as they have an effect on children's overall well-being. Many of the data for these indicators have only been obtained for three or four years, and in many cases the data is obtained by survey on a bi-yearly basis. For these reasons, some information is less current than other indicators but is still critical and representative of the efforts of Maryland's child-serving Agencies and non-profit partnerships as they work to improve these indicators.

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 the 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 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? And is anyone better off?

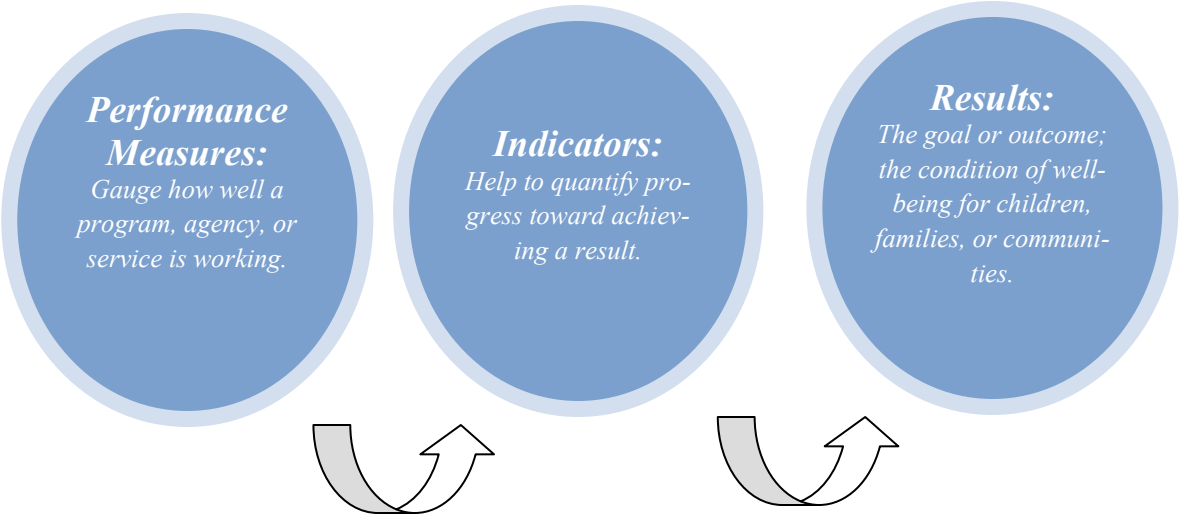
Results and Indicators

What is a Result?

Maryland's Children's Cabinet focuses on eight results for child well-being. A result is a goal that Maryland has established for its children, families, and/or communities. 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 an Indicator?

Maryland has selected 29 indicators for the eight results. Indicators are information and data that demonstrate Maryland's progress toward meeting a result.



Choosing Strong Indicators

To provide indicators that are reliable, important, and will ultimately inform the work of various stakeholders across Maryland's communities, we asked these questions:

Communication Power
Does the indicator communicate to a broad range of audiences?

Proxy Power
Does the indicator say something of central importance about the result? Is it correlated to the Result?

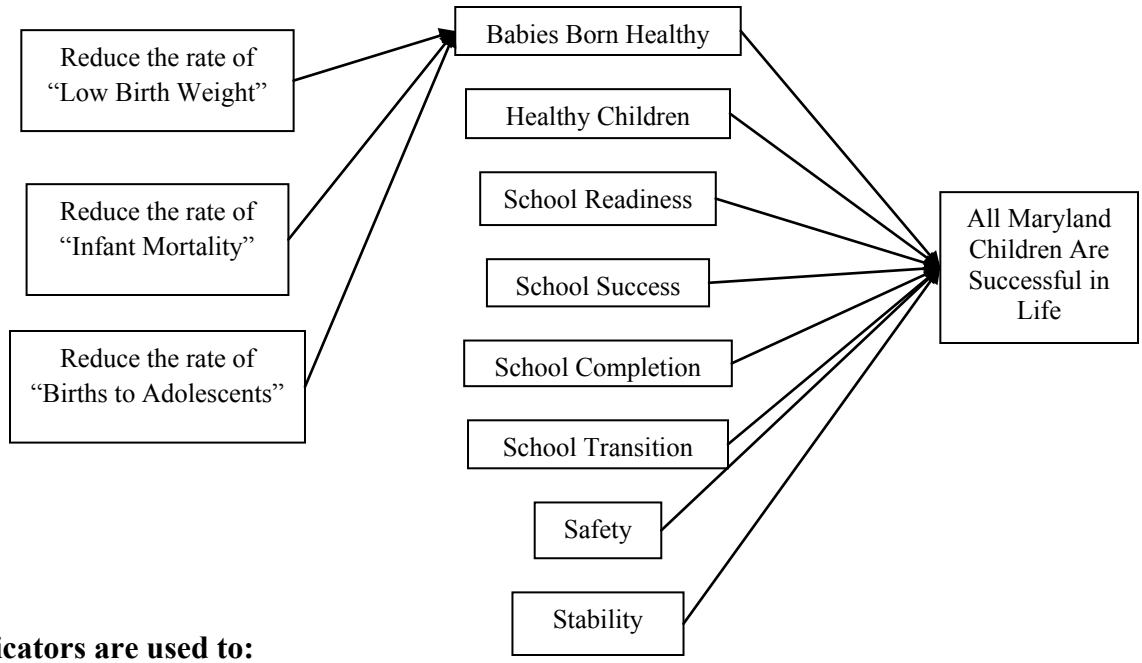
Data Power
Is the data reliable? Is it available on a timely basis?

Indicators are most useful in helping stakeholders identify children's needs and evaluate trends when:

- The data comes from automated systems like health or social services records which are **recorded consistently and updated constantly**;
- The indicator is measured nationally, so that Maryland's **trends can be compared** to other states'; and
- The indicators have been **measured for many years**, which yields an analysis of trends over time that is less susceptible to outliers and fluctuations.

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's Local Management Board (LMB) identifies and focuses on results and indicators that are priorities in its 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:

<u>Assess and understand the current status of children and families and how trends emerge over time:</u>

- Examine data for race, gender, and age, including population subgroups, 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 to focus resources on potential priority areas; and
- 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 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 resources invested in selected programs, services, and initiatives. Indicator data will support the assessment of intervention strategies.

Statewide Efforts to Improve Outcomes for Children and Youth

Maryland's eight results for child well-being reflect the priorities of the Children's Cabinet and the Governor's administrative priorities, and provide a structure for the work of Maryland's 24 LMBs. The LMB in each jurisdiction is composed of representatives from the Children's Cabinet's local agencies, as well as other stakeholders including local business and community members. Each LMB conducts a comprehensive needs assessment and prioritization of results and indicators based on the jurisdiction's needs. Funding from the Children's Cabinet Interagency Fund (the Interagency Fund) is used by the LMBs to develop and deliver services which address the results and indicators that have been prioritized for the jurisdiction.

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 LMBs that provides services directly impacting children's well-being. The Children's Cabinet includes the Secretaries of the Department of Budget and Management (DHMH), the Department of Disabilities (DoD), the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), the Department of Juvenile Services (DJS), and the State Superintendent of Schools and is chaired by the Executive Director of the GOC. The Interagency Fund is administered by GOC on behalf of the Children's Cabinet.

The key goals of GOC are to:

- work with LMBs and other State and local stakeholders to increase the capacity of communities to meet the specific needs of their jurisdictions' children and families;
- use data and technology to continuously monitor and evaluate outcomes;

- improve fiscal efficiency and accountability of programs that serve children and families, particularly those funded through the Interagency Fund;
- provide support and assistance to the Children's Cabinet, the Children's Cabinet Results Team, the Interagency Licensing Committee, the State Coordinating Council, and other interagency committees; and
- develop Statewide prevention plans and policies for transition-age youth, youth at risk of out-of-home placement, and other high-need populations.

The key goals of the Interagency Fund are to:

- use a collaborative, results-oriented accountability framework to track and evaluate the well-being of children across the State and in each jurisdiction through eight identified results for child well-being; and
- work collaboratively to ensure a safe, stable, and healthy environment for children and families though coordinated policy recommendations to the Governor.

History of the Results and Indicators in Maryland

In 1996, the *Governor's Task Force on Children, Youth, and Families Systems Reform* (the Task Force) 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 also 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, and included 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* report.

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 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 that 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 levels.

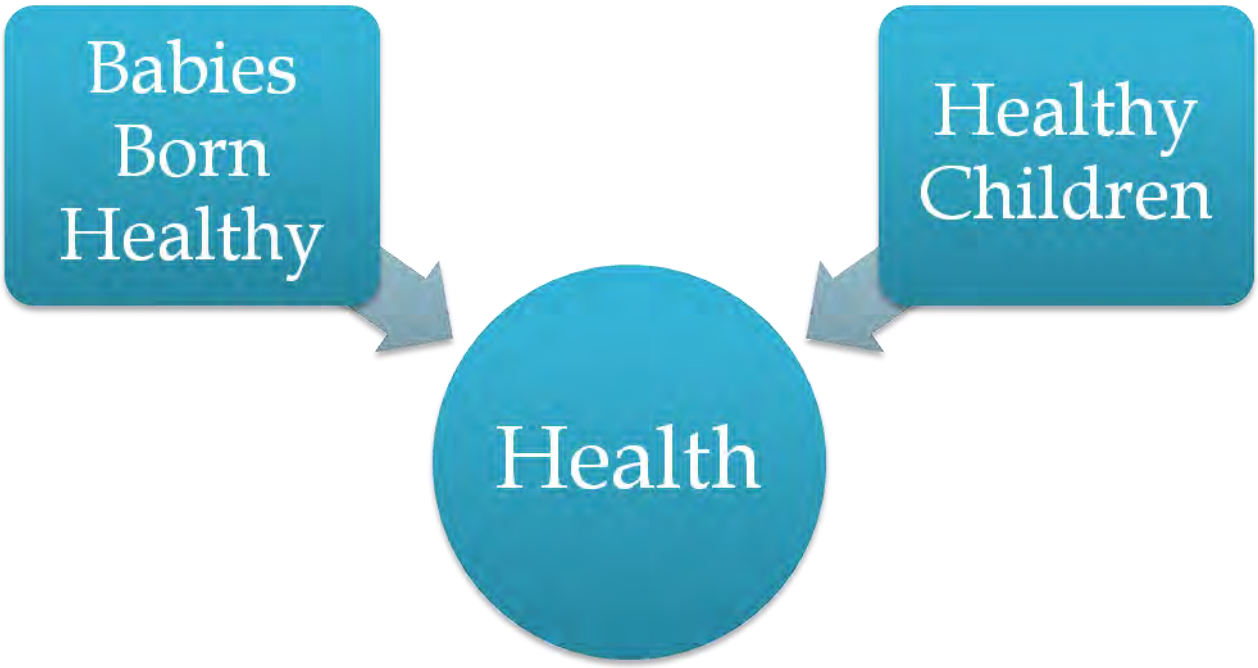
Across the nation, three to five indicators are usually accepted as a manageable number of measures per result area. The number of indicators is crucial. Other states have shown unsuccessful shifts to results-based accountability, in part, by selecting too many indicators. As other indicators are considered 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 in alignment with the national trend of utilizing results-based accountability for programs and services.

In November 2011, GOC held the Results for Child Well-Being Forum to assess the progress of Maryland's child outcomes for the previous year, determine what needs to be done to improve those outcomes in coming years, and assess how the *Maryland Results for Child Well-Being 2011* report can best support the work of State and local partners who serve Maryland's children. Beginning in mid-December of 2011, GOC convened workgroups to make recommendations for the 2011 Results book. The workgroups included a variety of State, local, and non-profit stakeholders. The priority of the workgroups was to agree on indicators to serve as a standard for the well-being of all Maryland children by improving the measurement of existing indicators and suggesting additional indicators. In keeping with the publication's history of featuring time-tested trends as well as new perspectives, the workgroups' recommendations emphasize the consistency of the widely-accepted/traditional indicators while providing an opportunity to include indicators that are creative and lend a fresh viewpoint.

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. 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 the well-being of Maryland's children.

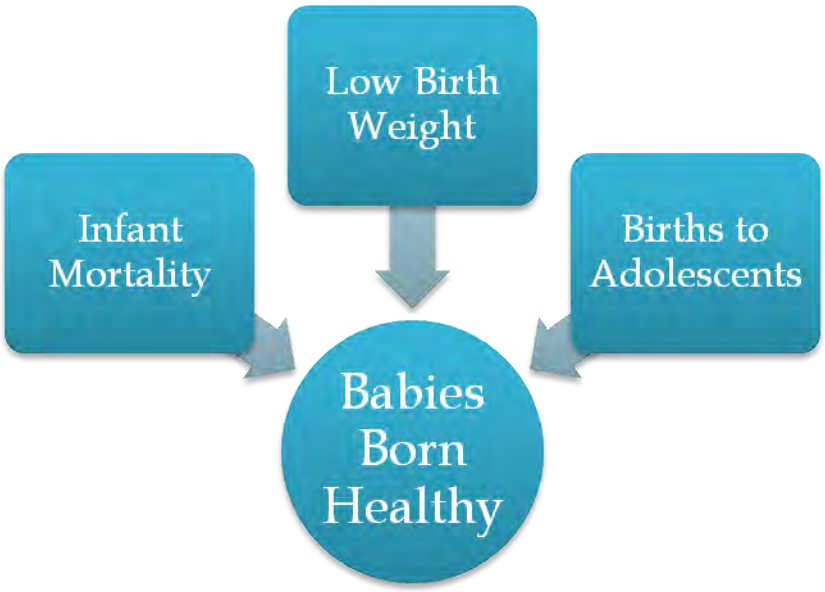
Babies Born Healthy
HEALTH
Healthy Children

Health


Babies Born Healthy
Healthy Children
Health

HEALTH
Babies Born Healthy
Healthy Children

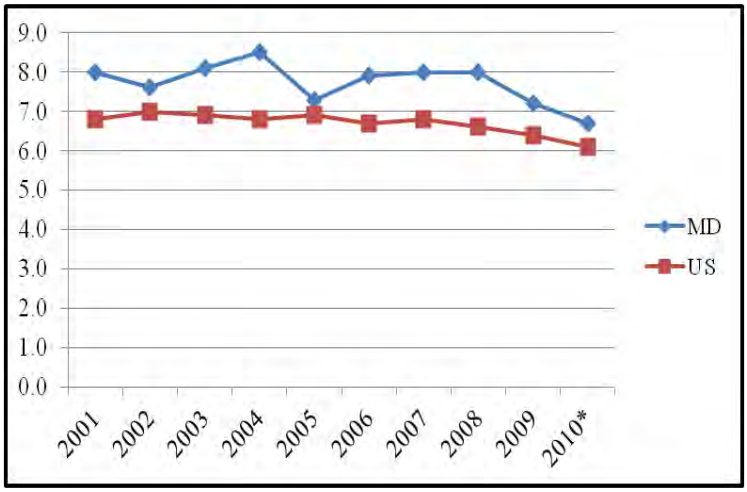
Result 1: Babies Born Healthy



Indicators:	Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Infant Mortality	The number of deaths occurring to infants under one year of age per 1,000 live births.			
	↓	-1.7%	-6.9%	-0.5 per 1,000
Low Birth Weight	The percent of all births with birth weight less than 2,500 grams (approximately 5.5 pounds).			
	↓	-0.3%	-4.3%	-0.4%
Births to Adolescents	The rate of births to adolescent females ages 15 to 19 years, per 1,000 of the population.			
	↓	-3.5%	-12.8%	-4 per 1,000

Infant Mortality

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



Infant Mortality Occurring per 1,000 Live Births, Under One Year of Age										
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010***
MD	8.0	7.6	8.1	8.5	7.3	7.9	8.0	8.0	7.2	6.7
US	6.8	7.0	6.9	6.8	6.9	6.7	6.8	6.6	6.4	6.1

* U.S. data for 2010 are preliminary

Data Source: MD DHMH, Vital Statistics Administration Annual Reports

Story Behind the Data: In 2010, Maryland's infant mortality rate fell to 6.7 per 1,000 live births, which was the lowest rate ever recorded in Maryland. It represents a decline of 16.3% since 2008. The reduction was notable for a 13% decline in the rate of deaths among Black infants between 2009 and 2010.

The leading causes of infant death in 2010 were:

- Disorders relating to short gestation and low birth weight;
- Congenital abnormalities; and
- Sudden Unexplained Infant Death Syndrome (SUIDS).

Racial disparities exist in the leading causes of infant death. In Maryland, Black infants are 4 ½ times more likely to die of SUIDS than White infants. They are also nearly 4 ½ times more likely to die from preterm and low birth weight.

Maryland's overall infant mortality rate remains slightly above the national average. The most recent national data by race from 2009 show infant mortality rates in the US for all races. Whites and Blacks were 6.4, 5.3, and 12.7, respectively, compared with rates in Maryland in 2010 of 6.7, 4.1, and 11.8. One of the *Healthy People 2020* objectives is to reduce infant mortality to 6.0 per 1,000 live births (Healthy People.gov). [ii]

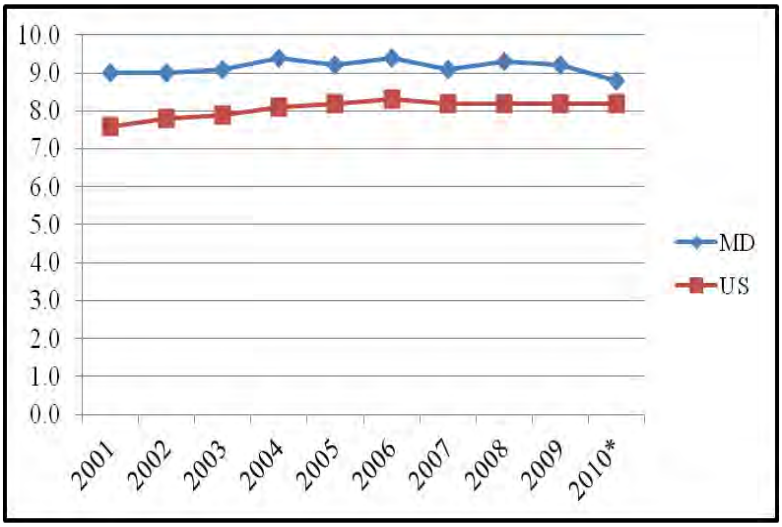
Babies Born Healthy

HEALTH

Healthy Children

Low Birth Weight

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



Percentage of Low Birth Weight (<2500g) Infants										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010*
MD	9.0	9.0	9.1	9.4	9.2	9.4	9.1	9.3	9.2	8.8
US	7.6	7.8	7.9	8.1	8.2	8.3	8.2	8.2	8.2	8.2

* U.S. data for 2010 are preliminary

Data Source: MD DHMH, Vital Statistics Administration Annual Reports

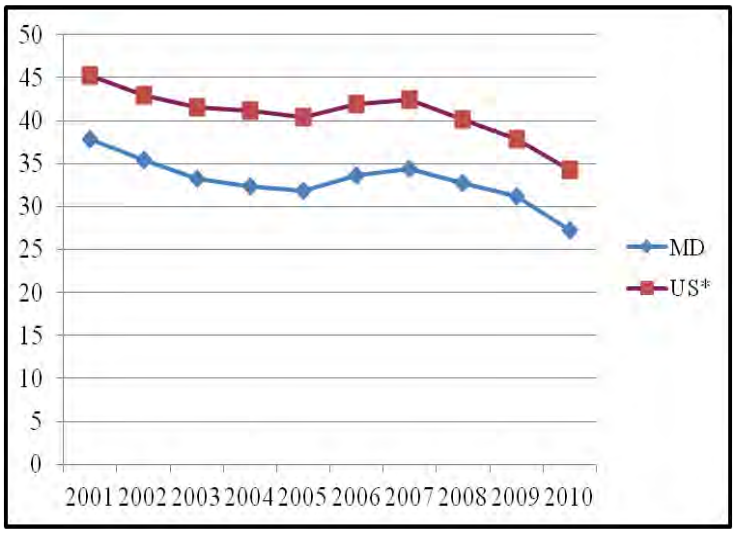
Story Behind the Data: Low birth weight is a significant factor driving infant mortality rates. Infants with low birth weight are also at increased risk for developmental delays. Babies who are born with low birth weight may be born either prematurely (before 37 weeks gestation) or full term (37 to 41 weeks gestation) but small for gestational age. In 2010, 10.4% of all births in Maryland occurred at less than 37 weeks gestation. (*Maryland Vital Statistics Annual Report 2010, Vital Statistics Administration, Department of Health and Mental Hygiene, Table 10)*

The overall percentage of infants born in Maryland with low birth weight was 8.8%, which continues to be higher than the national average of 8.2%. While the percentage of infants with low birth weight increased both in Maryland and nationally between 2001 and 2006, since that time the rate has plateaued nationally and declined in Maryland. There are substantial racial disparities in low birth weight births. Black infants are nearly twice as likely as White infants to be born underweight. Key maternal risk factors for low birth weight include chronic disease, smoking, obesity, unintended pregnancy, late or no prenatal care, and maternal age.

Infants of plural births (twins, triplets or higher order) have a significantly higher risk of having low birth weight than single births. In 2010, only 6.9% of all single births in Maryland were low birth weight, compared to 56.1% of plural births. (*Maryland Vital Statistics Annual Report 2010*, Vital Statistics Administration, Department of Health and Mental Hygiene, Table 22) One of the Healthy People 2020 goals is to reduce low birth weight births to 7.8% of all live births (Healthy People.gov).

Births to Adolescents

Definition: The rate of births to adolescent females ages 10 - 14, 15 - 17, 18 - 19, and 15 - 19 years, per 1,000 age specific population.[iv]



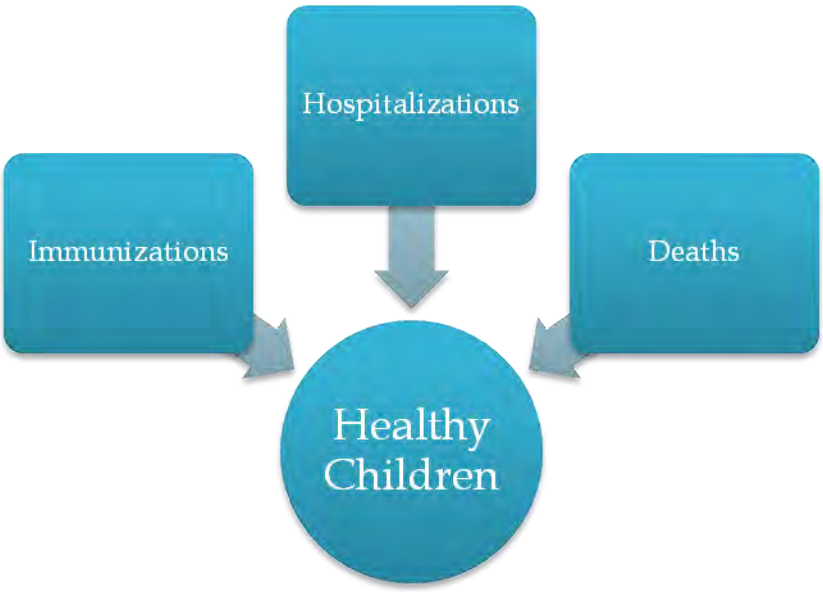
Adolescent Birth Rate per 1,000 women (ages 15-19 yrs), Maryland, U.S., 2001-2010										
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
MD	37.8	35.4	33.3	32.3	31.8	33.6	34.4	32.7	31.2	27.2
US*	45.3	42.9	41.6	41.1	40.4	41.9	42.5	40.2	37.9	34.3

*US data for 2010 are preliminary
Data Source: MD DHMH, Vital Statistics Administration Annual Report 2010

Story Behind the Data: Maryland's teen birth rate has declined by 28% since 2001. In 2010, the birth rate to adolescents ages 15-19 reached its lowest rate in 10 years, at 27.2 per 1,000. The rates among White non-Hispanic, Black non-Hispanic, and Hispanic teens also reached their lowest points in 10 years, at 16.1, 40.5, and 52.7, respectively. Maryland's adolescent teen birth rate has been substantially lower than the national rate over the last ten years.

Maryland's teen pregnancy prevention efforts focus on clinical and educational programming. Adolescents are served Statewide in family planning clinics and school based health centers. Services include family planning, reproductive health services, and counseling. State Personal Responsibility Education Program (PREP) and Abstinence Education programs provide curriculum-based programs for adolescents and their parents/caregivers at school, after school, and in community settings. The target population for educational programs range from age 10 through the early 20s.

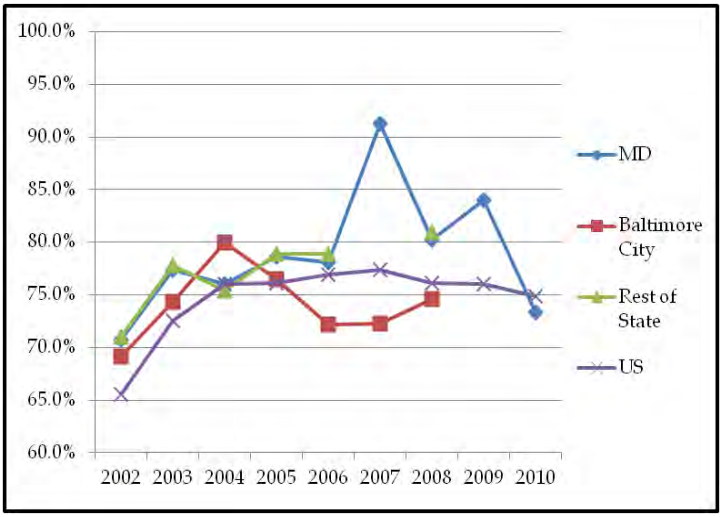
Result 2: Healthy Children



Indicators:	Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Immunizations	The percent of children aged 19–35 months who have received the full schedule of recommended immunizations.			
	↑	0.9%	-12.7%	-10.7%
Hospitalizations	The rate of nonfatal injury hospitalizations to children ages 0-21 years per 100,000 of the population.			
	↓	-5%	-12.5%	-32.2 per 100,000
Deaths	The rate of deaths to children ages 0-21 years per 100,000 of the population.			
	↓	-5.6%	-8.7%	-5.5 per 100,000

Immunizations

Definition: The percentage of children ages 19–35 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 Hib vaccine, 3 doses of hepatitis B vaccine, and 1 dose of varicella vaccine (4:3:1:3:3:1 series).



Estimated Vaccination Coverage Among Children Between the Ages of 19 Months - 35 Months, Survey Years 2002 - 2010[v]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
MD	70.7%	77.4%	76.0%	78.6%	78.1%	91.3%	80.2%	84.0%	73.3%
Baltimore City	69.1%	74.3%	80.0%	76.5%	72.2%	72.3%	74.6%	**	**
Rest of State	71.0%	77.8%	75.4%	78.9%	78.9%	**	81.0%	**	**
US	65.5%	72.5%	76.0%	76.1%	76.9%	77.4%	76.1%	76%	74.9%

** Data come from the National Immunization Survey, which are unavailable because the sample size is not sufficient to disaggregate further beyond the state level.
Data Source: National Immunization Survey

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

Maryland's 2010 immunization rates were below the national average for children ages 19–35 months.[vi] The reduction in rates for 2010 may be attributable to a national Hib vaccine shortage. Maryland's rates and the nation's rates were both impacted by the shortage. The shortage was considered resolved in late 2010 and a Hib vaccine catch-up program was implemented. The *2010–2011 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 report the number of fully-vaccinated students enrolled in kindergarten. From 2003 to 2011, 99% or more of kindergarten students have been fully vaccinated.

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

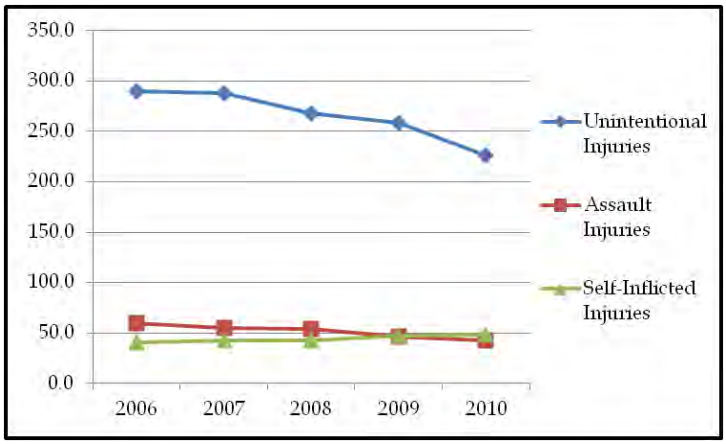
Babies Born Healthy

HEALTH

Healthy Children

Hospitalizations

Definition: The rate of non-fatal injury hospitalizations[vii] to children ages 0-18 years, 19-21 years, and 0-21 years per 100,000 age-specific population for selected categories of injury (unintentional,[viii] assault, self-inflicted).



Nonfatal Injury* Hospitalization Rate among Children (0-21 yrs) per 100,000					
	2006	**2007**	**2008**	**2009**	**2010**
Unintentional Injuries	289.5	288.3	268.5	258.2	226.0
Assault Injuries	59.4	55.4	53.9	46.3	42.7
Self-Inflicted Injuries	40.9	42.6	42.7	47.3	48.6

*Selected injury categories

Data Sources: MD HSCRC Inpatient Hospital Discharge Dataset, Population: MDP

Story Behind the Data: 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, but also, the cost to public and private medical insurance for care is high.

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

In 2010, there were 3,785 total inpatient hospital discharges for unintentional injury, 715 discharges for injuries due to assault, and 814 discharges for self-inflicted injuries among Maryland children aged 0-21 years. Non-Hispanic Black children had the highest rate of assault injury hospitalizations at 92.4 per 100,000, which was more than 4 ½ times higher than the rate among non-Hispanic White and Hispanic children. Non-Hispanic White children had the highest rate of self-inflicted injury hospitalizations.

Over the period 2006 through 2010, the rate of hospitalizations due to unintentional injuries among children 0-21 years has declined by 22%. The rate of hospitalizations due to assault decreased by 28% over this period. The rate of self-inflicted injury hospitalizations increased 18% over this period.

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 two examples of initiatives designed to prevent both child injury and deaths due to injuries. Both programs are administered by the Center of Health Promotion and Education (http://fha.dhmh.maryland.gov/ohpetup/SitePages/eip.aspx).

With the support of funding from Maryland's *Rape and Sexual Assault Prevention Program (RSAPP)*, a number of the State's local rape crisis centers have conducted educational sessions with children and youth covering topics such as healthy relationships and have begun implementation of child abuse prevention programming. Additionally, this funding has supported participating local school systems in purchasing curricula and providing prevention-based education to students on topics such as bullying, teen dating violence, and healthy relationships.

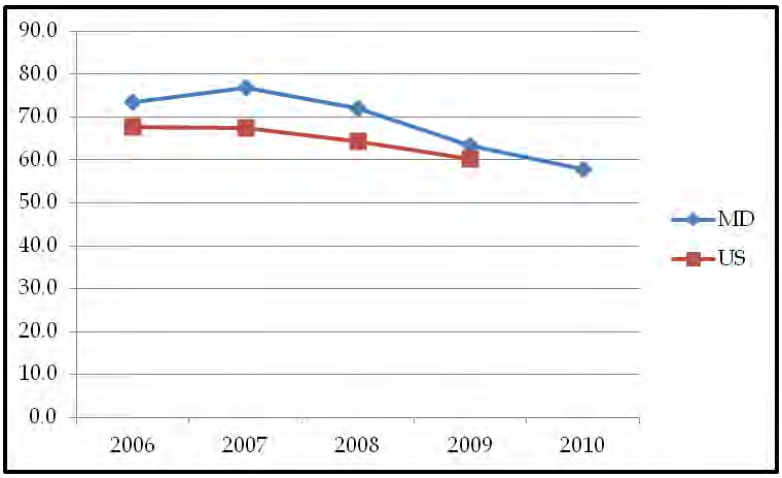
Babies Born Healthy

HEALTH

Healthy Children

Child Deaths

Definition: The rate of deaths to children ages 0-18 years, 19-21 years, and 0-21 years per 100,000 age-specific population.[ix]



Child (0-21 yrs) Death Rate per 100,000					
	2006	**2007**	**2008**	**2009**	**2010**
MD	73.4	77.0	72.1	63.4	57.9
US	67.8	67.5	64.3	60.2	*

* U.S. data for 2010 not yet available
Data Sources: MD DHMH, Vital Statistics Administration, Population: MDP Population Estimates
U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder Online Database.

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

Maryland's child (0-21 years) death rate has decreased by 21% in the last 5 years. In 2010, 970 children between the ages of 0 and 21 years died. The death rates were higher among children 19-21 years old, 80.0 per 100,000, compared to children 0-18 years, 54.2 per 100,000. The overall mortality rate in 2010 among children 0-21 years was 57.9 per 100,000, and was highest among non-Hispanic Black children, 95.7 per 100,000.

Maryland's child (0-21 years) death rates have consistently been higher than national death rates for the last 5 years. In 2009, the last year for which U.S. data are available, the Maryland child death rate was 63.4 per 100,000, while the national rate was 60.2 per 100,000 children.

Maryland's jurisdictions each have a Child Fatality Review Team which meets regularly to review the 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.

New Perspectives in Children's Health

Health Insurance Coverage

Definition: The percentage of children in Maryland ages 0 – 18, compared to federal rates of health insurance coverage.

Percentage of Children with Medical Insurance Coverage			
	2007	**2008**	**2009**
MD	90.5%	94.5%	94.7%
US	88.8%	90.3%	90.9%

Data Source: US Census Bureau, Small Area Health Insurance Estimates (SAHIE)
County-level data is available for the US Census Bureau, Small Area Health Insurance Estimates (SAHIE) for CY2006 through CY2007:

Why is Children's Health Insurance Coverage Important to Children's Health?

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 preventative 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.

Employment rates are positively correlated with rates of insurance coverage because the majority of people who have health insurance in Maryland are insured through their employer. As "[a]lmost half of those in families in which the adults did not graduate from high school are uninsured,"[xi] educational attainment is also related to the rate of insurance coverage. A 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.

Percentage of Insured Children, 2006-2009		
	2006-2007	**2008-2009**
White	95%	96%
Black	85%	93%
Hispanic (Any Race)	71%	81%
Asian/Other	92%	94%

Data Source: Maryland Health Care Coalition (MHCC), *Health Insurance Coverage in Maryland Through 2007*, and *Health Insurance Coverage in Maryland Through 2009*.[xii]

Disparities exist between races, however, with Hispanics representing 28% of children without coverage while only composing 10% of the child population in Maryland (2008 through 2009). Hispanic children have the highest uninsured rate at a staggering 19% (Black children are the next highest at 7%). Black children represent the majority of children without health insurance at 34%, but in 2008 through 2009, represented a third of the population. Although White children are 31% of those lacking health insurance, only 4% of all White children in Maryland are uninsured.

The number of Maryland children with medical insurance coverage remained higher than the national average in years 2007, 2008, and 2009 with an increase of 4% from 2007 to 2008. Additionally, 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 78% insured in 2006 through 2007 to 89% insured in 2008 through 2009. This is likely attributed to the increase in the number of Maryland residents receiving Medicaid from January 2007. Of this increase of nearly 250,000 people, 118,000 of whom were children, these data may indicate a strong relationship between lack of coverage and low income. It may further explain the correlation between the Governor's expansion of Medicaid and a sharp increase in the rate of insured children.

In October 2011, DHMH began reprogramming the Medicaid computer system for the expansion expected to occur on January 1, 2012. Through the Medicaid expansion, women who are below 200% of poverty and under 51 years of age are eligible for family planning services. Previously, women were eligible for services after the birth of their first child. The State is expecting to enroll more than 31,000 eligible women, representing a 177% increase in program enrollment.

Obesity

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

Percentage of Maryland public school students in grades 9-12 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%

Source: MD Youth Risk Behavior Survey (YRBS)[xiv]
Note: the most current YRBS for 2011 data will be available in June 2012.

Why is the Issue of Obesity Important to Children's Health?

The prevalence of obesity among adolescents ages 12 to 19 more than tripled from 1980 to 2006 (from 5% to 17 %). Obese children and youth are at risk for factors associated with cardiovascular disease (*e.g.*, cholesterol or high blood pressure), bone and joint problems, sleep apnea, and poor self-esteem. Obese children and 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 children and youth who are overweight or obese has not changed significantly between 2005 and 2009. One in four Maryland children/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 minor role as a weight loss method among Maryland children and youth, the use of vomiting/taking laxatives has increased significantly between 2005 and 2009.

MSDE supports programs in Comprehensive Health and Physical Education. Both of these content areas address the health and wellness of Maryland's students. MSDE also 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 convened annual meetings to assist local implementation of wellness policies.

Substance Use

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

Alcohol Use - Percentage of Maryland public school students in grades 9-12 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 9-12 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 9-12 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 9-12 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: MD YRBS [x]
Note: the most current YRBS for 2011 data will be available in June 2012.

Why is the Issue of Substance Use Important to Children's Health?

Use of ATOD poses many health risks for children and 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. Alcohol is the most commonly used drug among Maryland children and youth. The percentage of Maryland children and youth who have ever had a drink of alcohol decreased significantly between 2005 and 2009. Other indicators of alcohol use remained unchanged. Still, two-thirds of Maryland children and youth have drunk alcohol and approximately one in five is a binge drinker.

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 children/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.

While substance use prevention must be addressed by all stakeholders, MSDE continues to assist local school systems in developing, implementing, and sustaining scientifically-based research programs to prevent and reduce ATOD use in and around schools. Substance use prevention education is taught as part of comprehensive health education in kindergarten through 12[h] grade in all Maryland public schools.

Asthma Prevalence

Definition: Percentage of school-aged youth (middle and high school) that have been told by a doctor or nurse that they have asthma.[xv]

Prevalence of asthma among Maryland youth by calendar year and Grade			
Grade	**2006**	**2008**	**2010**
Middle School Youth	18.60%	18.70%	19.90%
High School Youth	19.90%	21.20%	21.50%

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?"

Why is the Issue of Asthma Important to Children's Health?

Asthma rates increased in Maryland between 2006 and 2010 among middle school and high school youth in all racial and ethnic groups and in 2010 affected approximately 1 in 5 Maryland youth. Black youth consistently report higher rates than other racial and ethnic groups. In 2010, 24.9% of Black 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 Blacks 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 Asthma Control Plan* is available at http://fha.dhmh.maryland.gov/mch/Documents/Asthma_Action_Agenda.pdf.

Endnotes

[i] For Maryland data, racial groupings were determined by the race of the mother.

[ii] Maryland jurisdictional maps with birth and infant mortality data by jurisdiction are available at http://eh.dhmh.md.gov/infantmortality/index.html and information on Maryland's Plan for Reducing Infant Mortality can be found at: http://dhmh.maryland.gov/babiesbornhealthy/pdf/Plan_Reducing_Infant_Mortality_MD_Dec2011.pdf

[iii] For Maryland data, racial groupings were determined by the race of the mother.

[iv] As pregnancies between ages 10 and 14 occur at a much lower rate than in age groups 15-19, there is greater variability between reporting years in the 10-14 year age group.

[v] National Immunization Survey (NIS) of children ages 19-35 months using random digit dialing methods.

[vi] For 2010 data, the 95% confidence interval was ±6.8% for Maryland, compared with ±1.2% for the national data. Therefore, Maryland data may not reflect immunization coverage as accurately as the national data.

[vii] These data refer to 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. Out-of-State hospitalizations for Maryland residents are not included in these data.

[viii] The unintentional injury category excludes those injuries due to medical procedure and therapeutic drug adverse events.

[ix] Rates are not calculated for counts less than 5 because of unstable statistical estimates. Caution should be used when interpreting small numbers.

[x] Insured rates represent the percentage of people who have health insurance for four (4) months or longer during the year.

[xi] Maryland Health Care Coalition (MHCC), Health Insurance Coverage in Maryland Through 2007. P. 5.

[xii] Paired-year measures (i.e., 2003-2555, 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 is paired and averaged to double the accuracy of the statistics.

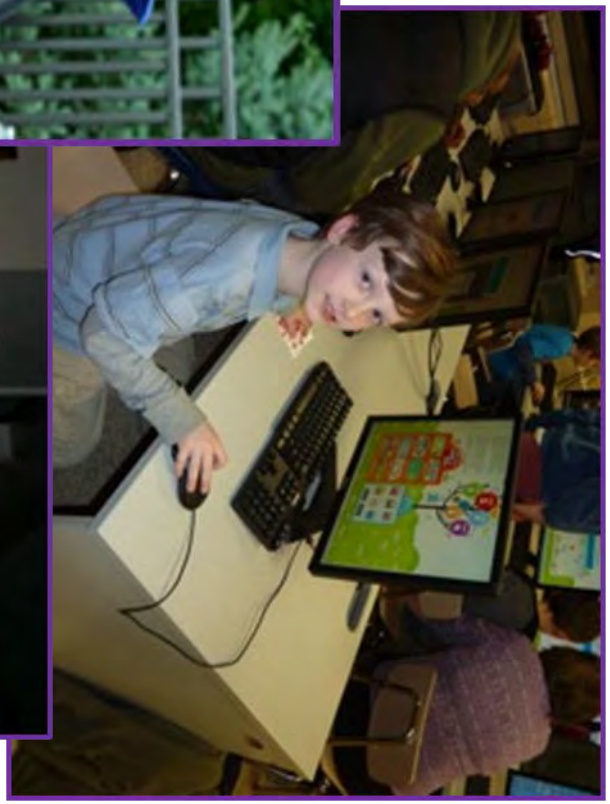
[xiii] Overweight and obesity are defined as medical conditions in which excessive body fat accumulation may lead to increased health problems. The most widely accepted method used to screen for overweight and obesity is the body mass index (BMI), which is a measure of a person's weight in relation to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

[xiv] The Maryland Youth Risk Behavior Survey (YRBS) is part of the Youth Risk Behavior Surveillance System (YRBSS) developed in 1990 by the US 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 heath-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 9–12. The YRBS data are presented by combined grade levels, 9-12. 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.

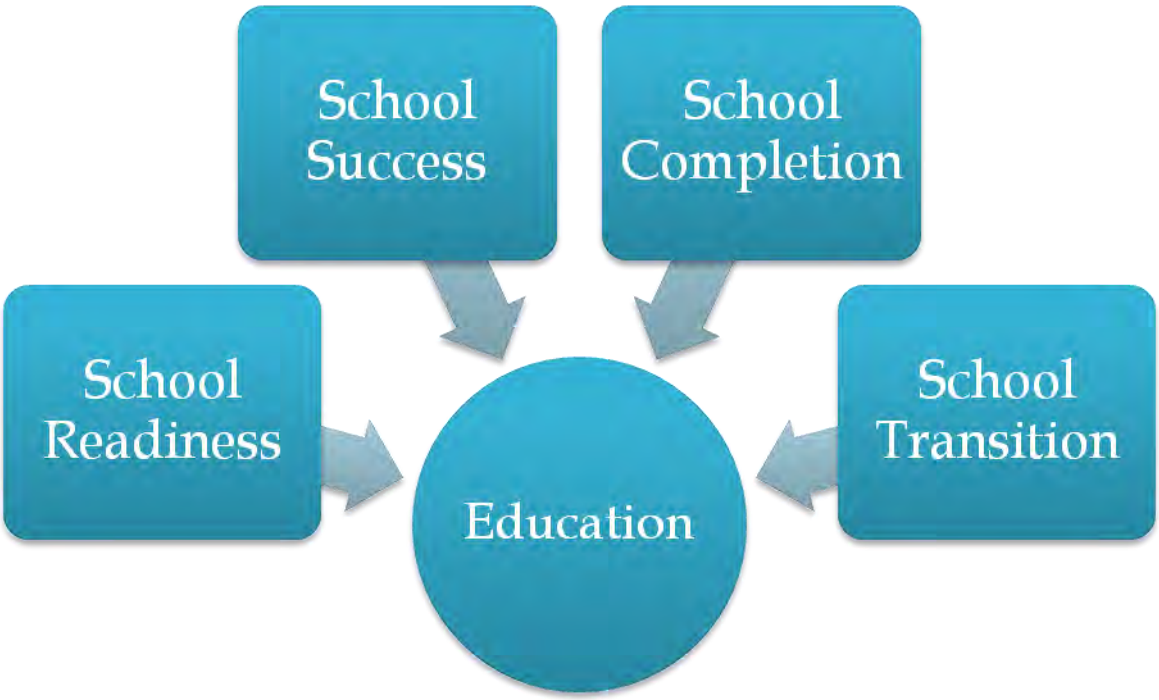
[xv] These data are from a biennial survey of randomly sampled Maryland public middle and high school students. Prevalence is based on child self-report of asthma diagnosis by a clinician and may represent an underestimate of actual asthma prevalence due to lack of access to healthcare or to lack of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

Transition | Completion | Success | Readiness

EDUCATION

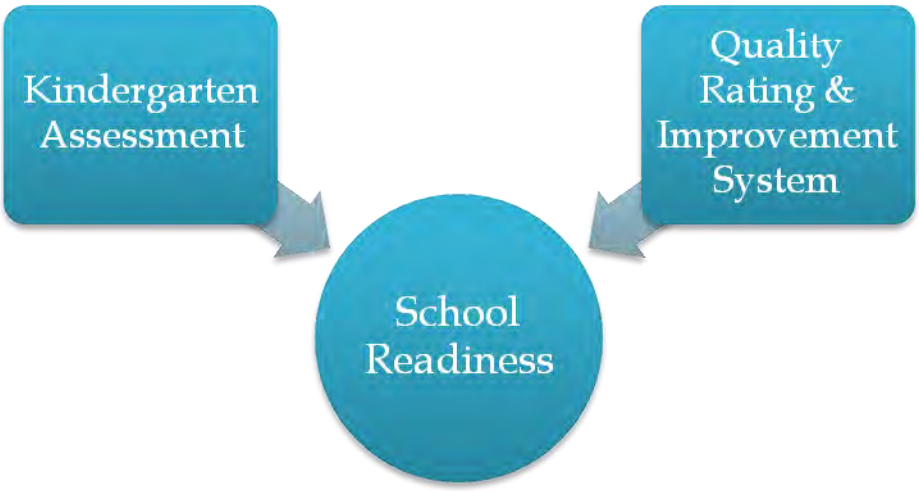


Education


School Success
School Completion
School Readiness
School Transition
Education

Readiness
Success
Completion
Transition
EDUCATION

Result 3: School Readiness



Indicators:

Kindergarten Assessment

The Maryland Model for School Readiness (MMSR) Framework and Standards defines the early learning standards in the Kindergarten Assessment and indicates what children should know and are able to do before they start formal education.

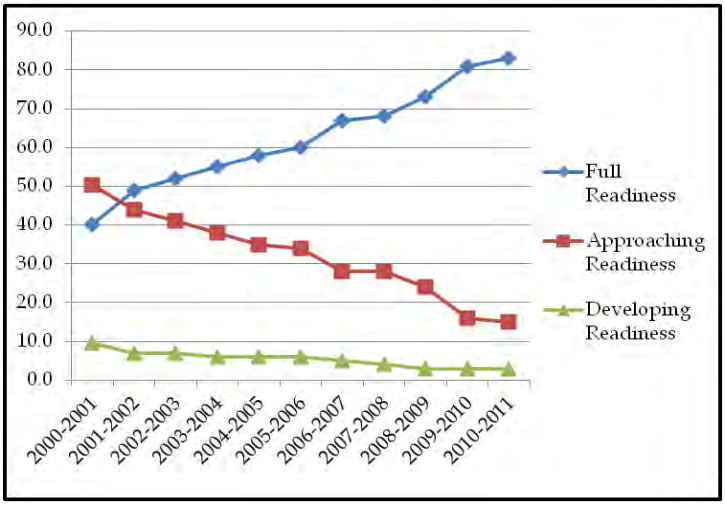
	Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Composite	↑	**0.8%**	**1.0%**	**1.0%**
Social & Personal	↑	**0.8%**	**1.0%**	**1.0%**
Language & Literacy	↑	**1.4%**	**1.1%**	**1.0%**
Mathematical Thinking	↑	**1.2%**	**1.1%**	**1.0%**
Scientific Thinking	↑	**1.7%**	**0.0%**	**0.0%**
Social Studies	↑	**0.4%**	**1.1%**	**1.0%**
The Arts	↑	**0.5%**	**0.0%**	**0.0%**
Physical Development	↑	**0.3%**	**-1.0%**	**-1.0%**

Quality Rating &Improvement System (QRIS)

Quality Rating and Improvement System (QRIS) is a systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs.

Kindergarten Assessment

Definition: The Maryland Content Standards and Maryland State Curriculum (SC) are included in the Maryland Model for School Readiness (MMSR) Framework and Standards which define early learning standards and indicators of what children should know and be able to do before they start formal education.[i]



Percent of Students, Grades 3-8, Scoring At or Above Proficient on the Maryland School Assessment, Academic Years 2004 - 2011								
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Reading	49.9%	51.6%	52.3%	52.9%	52.1%	54.2%	52.9%	53.8%
Math	46.0%	48.5%	50.7%	51.3%	51.6%	53.0%	53.1%	52.5%

Data Source: MSDE, Maryland State Report Card

Story Behind the Data: The annual MSDE Kindergarten Assessment - known as the assessment component of the MMSR - uses a customized version of the Work Sampling System® (WSS), a portfolio-based assessment system that helps kindergarten teachers document and evaluate children's skills, knowledge, behavior, and academic accomplishments across a variety of curricular areas. These areas are represented by seven domains. Each student is scored on his or her performance in each of the domains and then a composite score (overall readiness level) is computed from the student's assessment scores across all seven domains. 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.[ii]

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

- Social and Personal Development;
- Language and Literacy;
- Mathematical Thinking;
- Scientific Thinking;
- Social Studies;
- The Arts; and
- Physical Development and Health.

Kindergarten teachers use the WSS® with all children throughout the school year. For the annual MSDE report, *Children Entering School Ready to Learn*, kindergarten teachers provide information on students' skills for the first (fall) grading period. Teachers use portfolio-based assessments to document each student's 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 as well as the composite score of all domains. Assessment information is also analyzed for each of the seven domains and the composite score by the child's race/ethnicity, gender, prior early care, special education, English Language Learners (ELL), and enrollment in the free and reduced priced meals program (FARMs).

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.

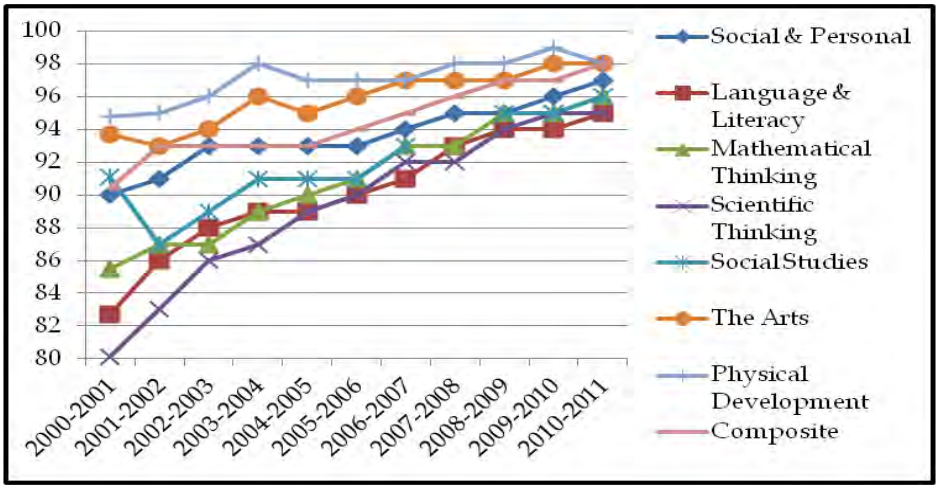
Each student's composite score is derived from the individual domain scores and represents the student's overall readiness level. The following outline shows the process by which domain and composite scores are determined:

- 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 are 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.

The following table shows Maryland's statewide readiness level data for the period FY 2002 – FY 2011:

	Social & Personal	Language & Literacy	Mathematical Thinking	Scientific Thinking	Social Studies	The Arts	Physical Development	Composite
2000-2001	90	83	86	80	91	94	95	90
2001-2002	91	86	87	83	87	93	95	93
2002-2003	93	88	87	86	89	94	96	93
2003-2004	93	89	89	87	91	96	98	93
2004-2005	93	89	90	89	91	95	97	93
2005-2006	93	90	91	90	91	96	97	94
2006-2007	94	91	93	92	93	97	97	95
2007-2008	95	93	93	92		97	98	96
2008-2009	95	94	95	94	95	97	98	97
2009-2010	96	94	95	95	95	98	99	97
2010-2011	97	95	96	95	96	98	98	98
Average Percent Change	0.8%	1.4%	1.2%	1.7%	0.4%	0.5%	0.3%	0.8%
Recent Year Percent Change	1.0%	1.1%	1.1%	0.0%	1.1%	0.0%	-1.0%	1.0%
Recent Year Unit Change	1.0%	1.0%	1.0%	0.0%	1.0%	0.0%	-1.0%	1.0%



Kindergarten Assessment

Research shows that children who have access to high quality early learning experiences are more likely to complete high school, graduate college, and become productive citizens. In addition, a Maryland study conducted by the Regional Economics Studies Institute (RESI) at Towson University shows that for every $1 spent on high quality early childhood education, society saves as much as $4 in remedial and corrective services. Ensuring that children are ready to enter school provides the best opportunity for guiding children toward success in school and in life. Kindergarteners who are ready to succeed when they begin school are less likely to need 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.

MMSR Kindergarten Assessment data are collected each year by the 24 local education agencies (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 free and reduced priced meals program).

MMSR Kindergarten Assessment data provide a snapshot of statewide and jurisdictional school readiness levels of entering kindergartners in the fall of each year. The school readiness information is designed for purposes of instructional accountability, *i.e.*, the data should inform practitioners and policymakers how to improve the learning opportunities for young children and begin the discourse for improving the quality of early childhood education. Generally, the information can be used to:

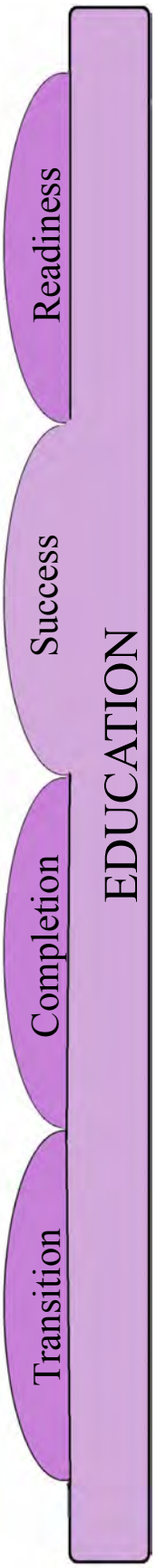
- Develop jurisdictional needs assessments regarding the skill levels of children entering kindergarten;
- Target federal, State, and local funds to address identified jurisdictional needs;
- Develop forums for partnership building; and
- Modify curricular and intervention programs and identify resources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

MMSR Kindergarten Assessment results for FY 2011 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 AY 2011-12 improved its overall school readiness skills by 2% compared to students who entered kindergarten in the 2010-11 school year.

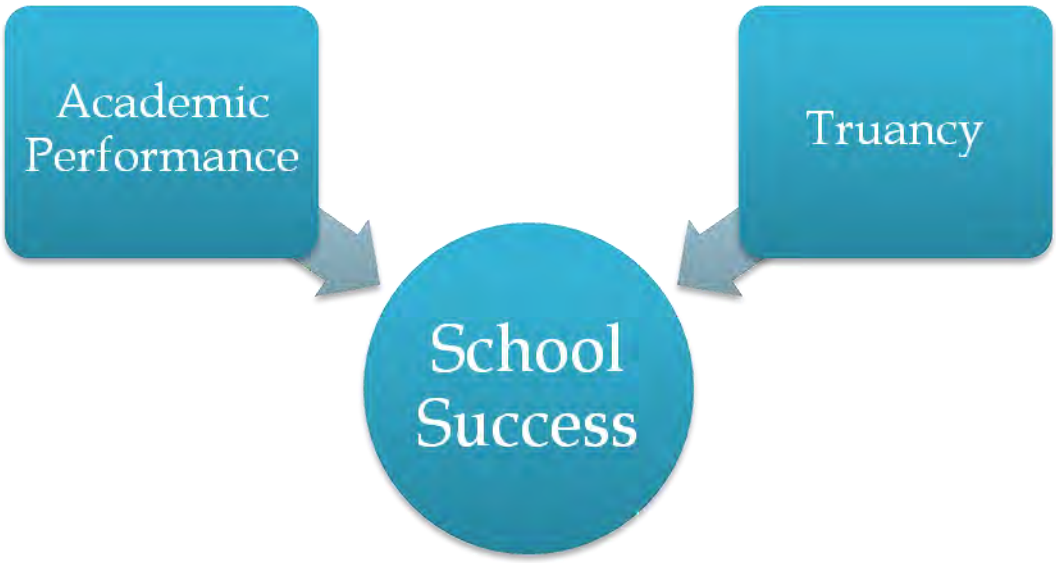
The percentage of incoming kindergarteners rated by their teachers as "fully ready" went up from 81% last year to 83% this year. The increase from the baseline year of 2001-2002 to this year is 34%.[iii]

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, 37% more children were rated "fully ready" compared to youngsters who entered kindergarten in 2001-2002. Thirty-seven percent more children were also rated "fully ready" in the domain of Mathematical Thinking compared to youngsters who entered kindergarten in 2001-2002.

The upward trend from AY 2001-2002 is evident for all subgroups. The improvement among low-income children and children with disabilities was significant, with an increase of 42% and 29%, respectively, in the composite score for those two groups. The increase for English Language Learners (ELL) from 2001-2002 is 37% for the composite score and 33% in the Language and Literacy score.



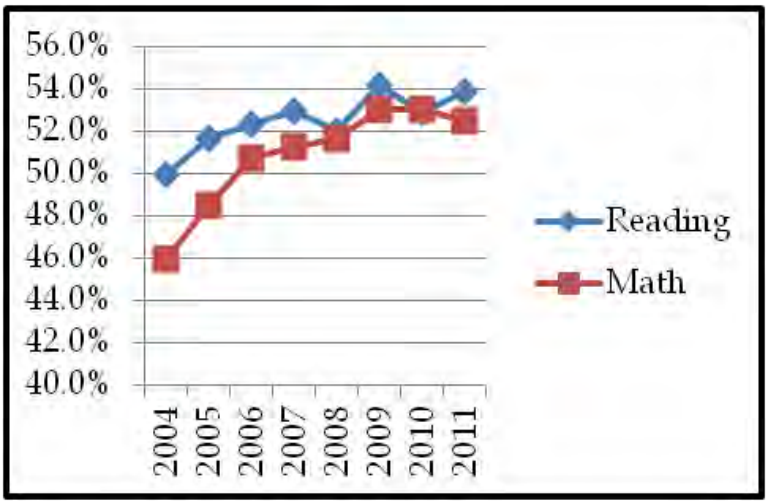
Result 4: School Success



Indicators:		Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Academic Performance	**Maryland School Assessment**	The average percent of public school students in grades 3 through 8 performing at or above proficient levels in reading and mathematics on the MSA.			
		↑	1.5%	0.3%	0.15%
	High School Assessment	The average 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.			
		↓	-0.2%	0.8%	0.67%
Truancy		Percent of public school students in all grades absent more than 20 days of the school year (excluding summer school).			
		↓	-1.4%	0.9%	0.1%

Academic Performance

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



Percent of Students, Grades 3-8, Scoring At or Above Proficient on the Maryland School Assessment, Academic Years 2004 - 2011								
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Reading	49.9%	51.6%	52.3%	52.9%	52.1%	54.2%	52.9%	53.8%
Math	46.0%	48.5%	50.7%	51.3%	51.6%	53.0%	53.1%	52.5%

Data Source: MSDE, Maryland State Report Card http://www.mdreportcard.org/.

Story Behind the Data: The MSA requires students in 3rd to 8th grades to demonstrate their knowledge of reading and math. The test produces a score that describes how well a student mastered the reading and math content specified in the Maryland Content Standards. Each child 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.

The MSA was established in 2002 to meet the requirements of the federal No Child Left Behind Act (NCLB). Students with severe cognitive disabilities who are pursuing an alternate course of study based on their Individualized Education Program (IEP) take the Alt-MSA, Maryland's alternate assessment.

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 for 100% of students to demonstrate proficiency (or higher) in reading and math.

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

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

Comparing the percentage of children scoring in the **Proficient** level from 2009-2011 across each grade level, it appears that there was an increase in 7th grade (3.8%), 3rd grade (1.8%), 4th grade (1.4%) and 8th grade (1.3%) in Reading, and there was an increase in 5th grade (1.5%) in Mathematics.

Similarly, comparing the percentage of children scoring in the **Advanced** level from 2009-2011 across each grade level, it appears that there were increases in 5th grade (2.5%) and 8th grade (1.1%) in Reading, and increases in 3rd grade (1.3%), 4th grade (3.1%), 6th grade (2.4%), 7th grade (2.0%), and 8th grade (2.9%) in Mathematics.

Percentage of Public School Students Scoring Basic, Proficient, or Advanced on the Maryland School Assessment- Academic Year 2009-2010, Maryland						
	Reading			Mathematics		
	Basic	Proficient	Advanced	Basic	Proficient	Advanced
3rd Grade	16.0	62.8	21.2	14.0	51.9	34.1
4th Grade	12.6	57.9	29.5	9.8	43.6	46.6
5th Grade	10.6	36.1	53.3	16.9	57.9	25.3
6th Grade	13.9	42.8	43.3	20.2	50.1	29.7
7th Grade	18.2	36.8	45.1	27.4	49.2	23.4
8th Grade	19.6	35.5	44.8	34.6	35.9	29.5

Percentage of Public School Students Scoring Basic, Proficient, or Advanced on the Maryland School Assessment- Academic Year 2010-2011, Maryland						
	Reading			Mathematics		
	Basic	Proficient	Advanced	Basic	Proficient	Advanced
3rd Grade	14.9	64.6	20.5	13.7	50.9	35.4
4th Grade	11.3	59.3	29.4	9.7	40.6	49.7
5th Grade	9.8	34.4	55.8	17.7	59.4	22.8
6th Grade	16.2	41.0	42.8	19.0	48.9	32.1
7th Grade	15.9	40.6	43.4	25.7	48.9	25.4
8th Grade	17.3	36.8	45.9	33.9	33.7	32.4

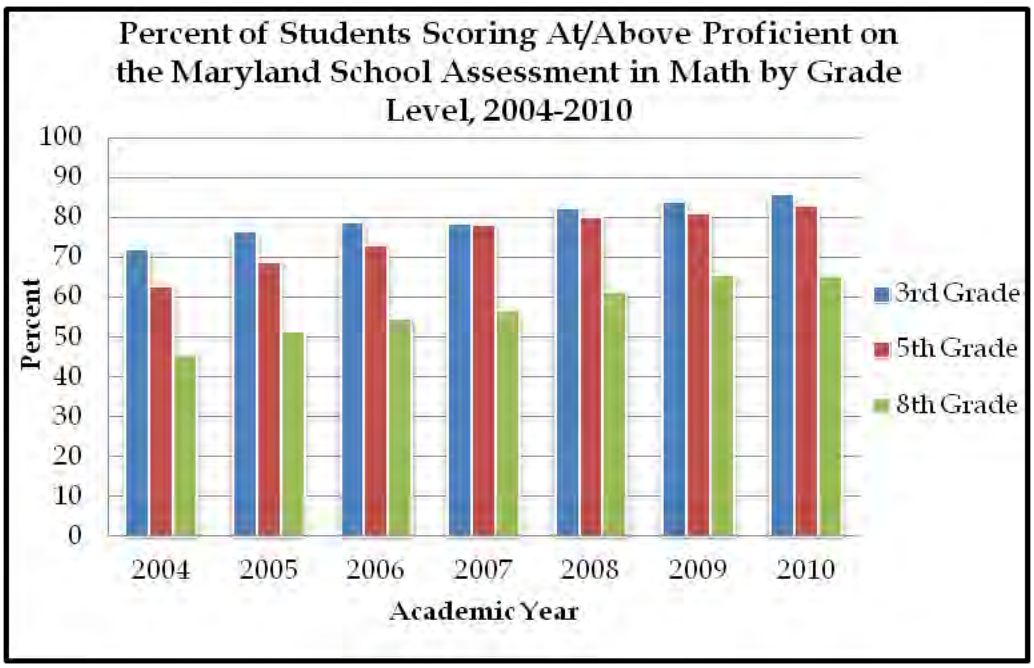
EDUCATION

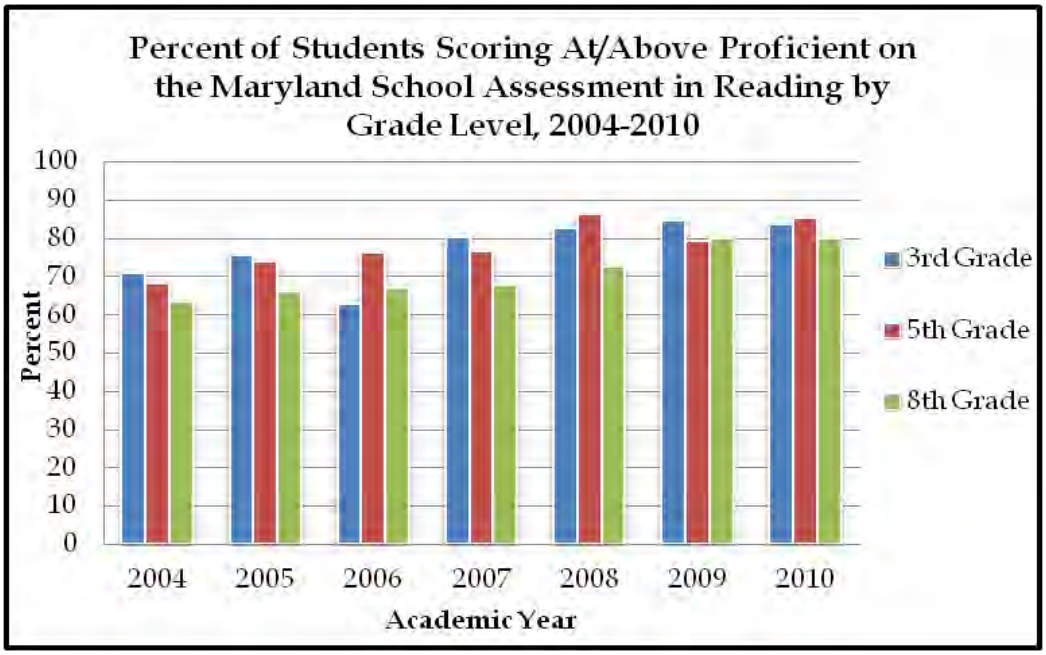
Readiness

Success

Completion

Transition





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

Percentage of Maryland High School Students Receiving a Passing Score in the Maryland High School Assessment				
	2008	**2009**	**2010**	**2011**
Algebra	84.4	85.1	83.6	83.6
Biology	82	82.6	80.9	81.3
English	82	83.5	80.2	81.8

Data Source: MSDE, Maryland State Report Card http://www.mdreportcard.org/.

HSA Story Behind the Data: The achievement of minimum academic standards affects graduation, adult achievement, future academic pursuits, and life skills.

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. In 2004, the State Board of Education ruled that, beginning with the class of 2009, public school students must pass the High School Assessments (HSA) to graduate.[iv]

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:

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

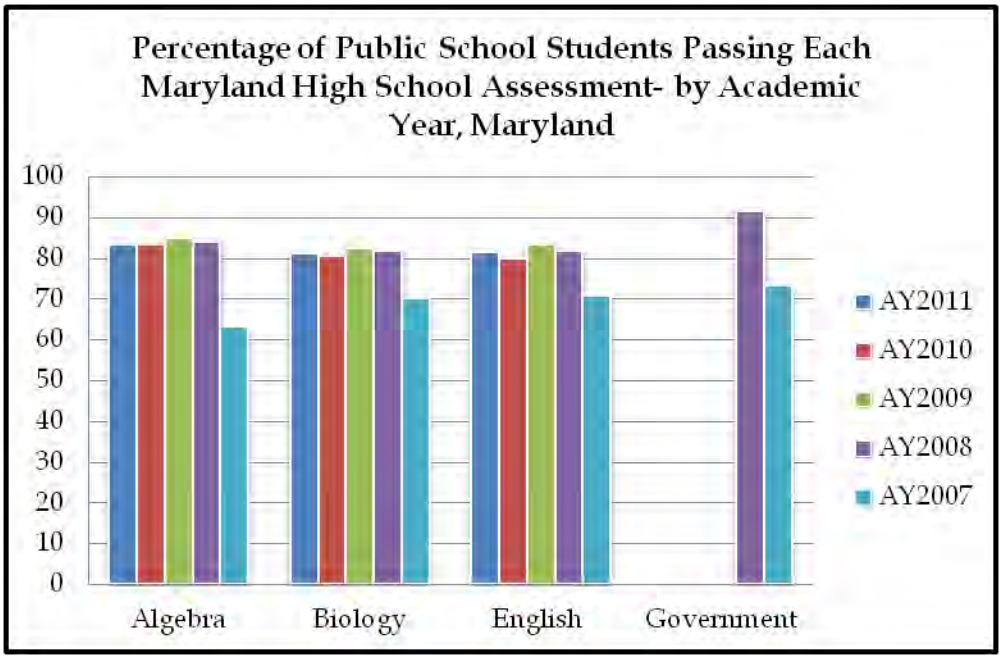
Each assessment test contains both selected and constructed response questions and covers about 60% of a course's content. Each HSA takes approximately three and one-half hours to complete. In 2011, the percentage of students passing in each subject area increased slightly from the 2010 percentage of students passing the HSAs. For students who do not pass the HSA, additional instruction is available through the local school systems 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. It should be noted that academic eligibility requirements must be met for this program.[v]

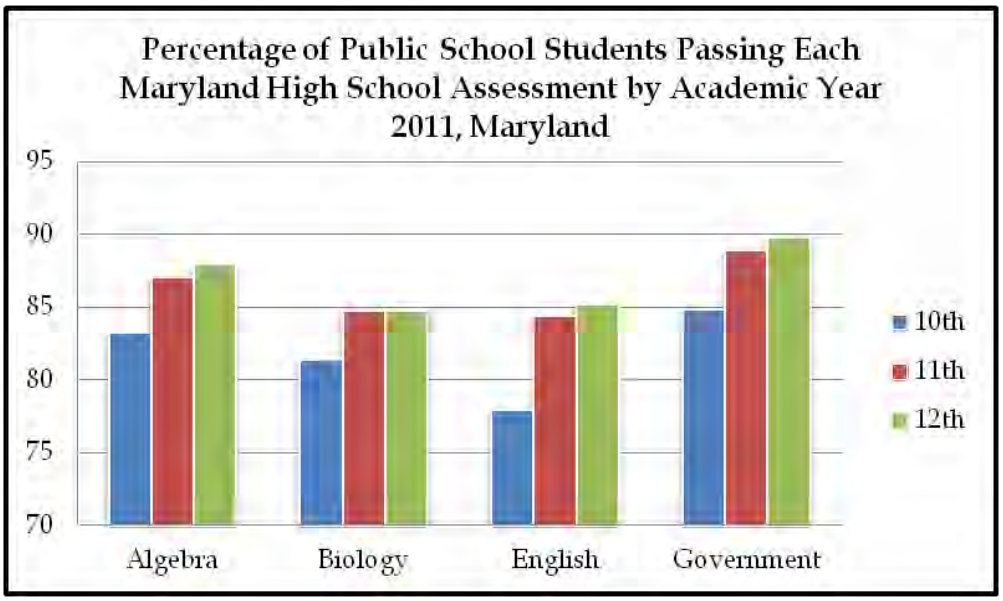
Percentage of Public School Students Passing Each Maryland High School Assessment- by Academic Year, Maryland					
Subject Area	**AY 2007**	**AY 2008**	**AY 2009**	**AY 2010**	**AY 2011**
Algebra	63.5	*84.4	85.1	83.6	83.6
Biology	70.3	*82	82.7	80.9	81.3
English	70.9	*82	83.5	80.2	81.8
Government	73.5	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 2010, Maryland				
Grade	**Algebra**	**Biology**	**English**	**Government**
10th	82.1	81.7	77.5	84.4
11th	87.5	84.5	83.3	89.1
12th	87.9	84.5	83.7	91.5

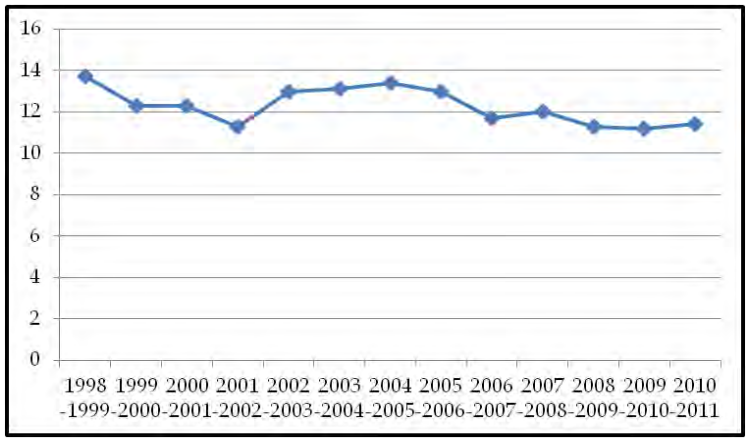
Percentage of Public School Students Passing Each Maryland High School Assessment- by Academic Year 2011 Maryland				
Grade	**Algebra**	**Biology**	**English**	**Government**
10th	83.2	81.4	77.9	84.8
11th	87.0	84.7	84.4	88.9
12th	87.9	84.7	85.2	89.8


Percentage of Public School Students Passing Each Maryland High School Assessment- by Academic Year, Maryland
100
90
80
70
60
50
40
30
20
10
0
Algebra
Biology
English
Government
AY2011
AY2010
AY2009
AY2008
AY2007


Percentage of Public School Students Passing Each Maryland High School Assessment by Academic Year 2011, Maryland
95
90
85
80
75
70
Algebra
Biology
English
Government
10th
11th
12th

Truancy

Definition: Percentage of students in all grades (public schools) absent more than 20 days of the school year (excluding summer school).[vi]



Percentage of Maryland Public School Students Absent More than 20 Days by Academic Year												
1998 -1999	**1999 -2000**	**2000 -2001**	**2001 -2002**	**2002 -2003**	**2003 -2004**	**2004 -2005**	**2005 -2006**	**2006 -2007**	**2007 -2008**	**2008 -2009**	**2009 -2010**	**2010 -2011**
13.7	12.3	12.3	11.3	13	13.1	13.4	13	11.7	12	11.3	11.2	11.4

Data Source: Maryland State Department of Education, 2011 Maryland Report Card, http://msp2011.msde.state.md.us/index.aspx.

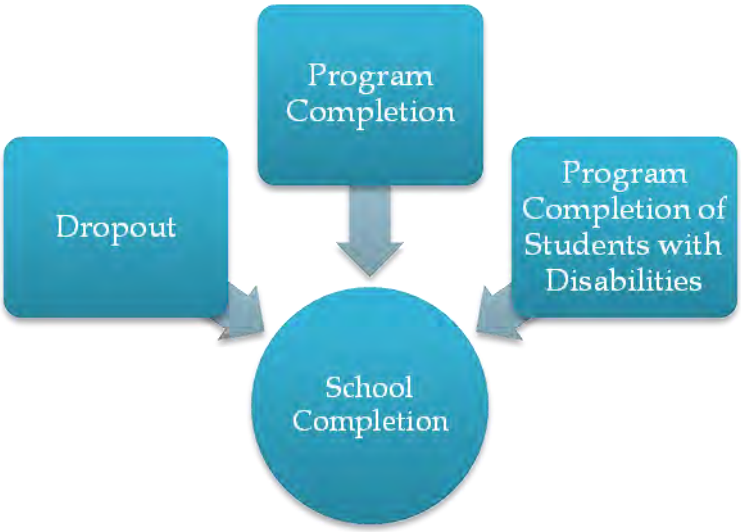
Story Behind the Data: Absenteeism and truancy represent a loss of learning opportunities and have negative long-term consequences for students and communities. High levels of school absence are associated with a higher risk of school failure, high school dropout, delinquent behavior, substance abuse,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

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 speaks 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.

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 2011, the percentage of students absent 20 or more days decreased from 13.7% to 11.3%.

The Maryland State Board of Education's family involvement policy, adopted in October 2001, 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 empowering parents to become involved in their children's education.

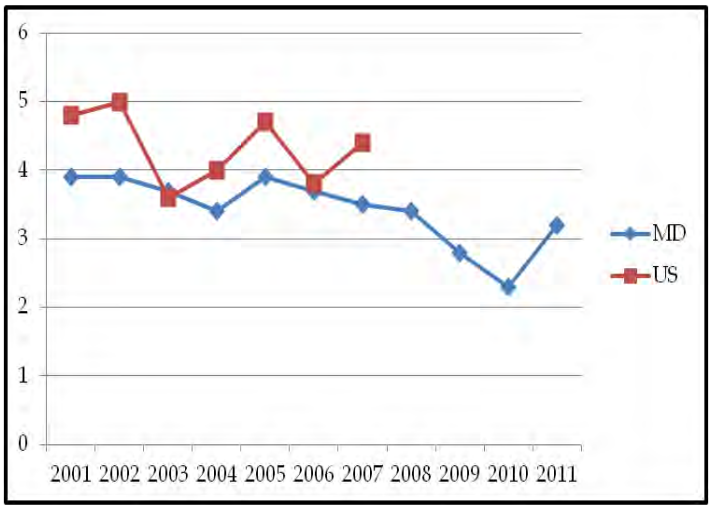
Result 5: School Completion



Indicators:		Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Dropout	The percent of public school students, grades 9-12, who withdrew from school before graduation or before completing a Maryland approved educational program during the academic year and are not known to have enrolled in another high school program.	↓	-0.8%	39.1%	0.9%
Program Completion	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.				
	University of MD	↑	1.3%	5.6%	3.1%
	Career & Technology	↓	-5.9%	-1.1%	-0.1%
	Both	↓	-0.6%	5.2%	0.5%
Program Completion of Students with Disabilities	Percent of children with disabilities who exit special education by graduating or completing school.				
	With Diploma	↑	3.7%	-1.5%	-0.6%
	With Certificate	↑	6.0%	1.2%	0.1%

Dropout

Definition: The percentage of public school students, grades 9-12, 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.[vii]



Percentage of Public High School Students, Grades 9-12, who Drop Out of School - by Academic year, Maryland and National

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
MD	3.9	3.9	3.7	3.4	3.9	3.7	3.5	3.4	2.8	2.3	3.2
US	4.8	5	3.6	4	4.7	3.8	4.4	*	*	*	*

*2008 - 2011 National Data is unavailable

Data Source: MSDE, Maryland State Report Card, www.mdreportcard.org

Story Behind the Data: Local school systems have data on the reasons why students drop out of school. These reasons often include expulsion, pregnancy, and parenthood. Additionally, the US Census Bureau collects two related measures: people ages 20-24 who have not completed high school and teenagers ages 16-19 who are not enrolled in school and are not high school graduates.

In 2010, Maryland ranked 27th in the nation for the percentage of teens, ages 16-19, 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 6% (The Annie E. Casey Foundation, Kids Count Data Center, http://www.kidscount.org/datacenter/). It is important to be cognizant of the different populations represented by these statistics. The previous data includes all teens ages 16-19 and those students originally enrolled in school.

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

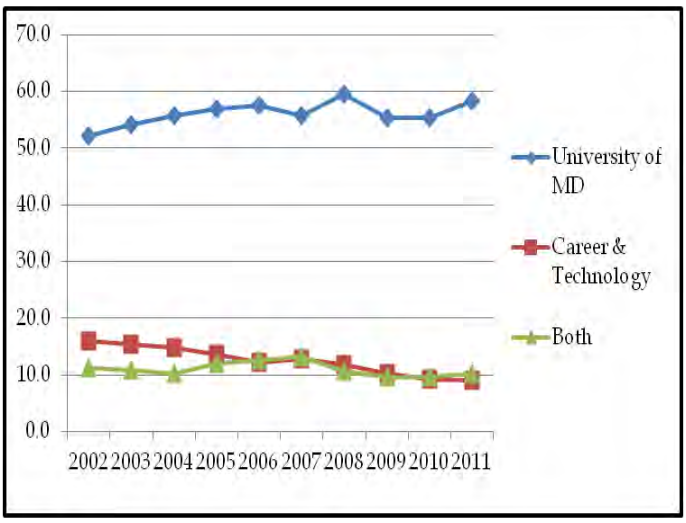
The smaller proportion of students who drop out during a specific school year, however, may be amenable to programs targeted at reentry into high school, especially when targeted at addressing the immediate causes of drop-out. School systems may have the most success in reenrolling these students as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

In 2011, the percentage of public high school students who dropped out of high school increased from 2.3% in 2010 to 3.2% in 2011. School dropouts in the last decade have decreased .8%.

Readiness
Success
Completion
Transition
EDUCATION

High School Program Completion

Definition: The percentage 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.



Percent of High School Graduates who Meet the Requirements to Enter the University of MD System, Complete a Career and Technology Program, or Both, by Academic Year										
	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
University of MD	52.2	54.1	55.7	57.0	57.6	55.7	59.5	55.3	55.3	58.4
Career & Technology	15.9	15.3	14.7	13.5	12.3	12.7	11.9	10.3	9.2	9.1
Both	11.3	10.8	10.3	12.0	12.5	13.2	10.7	9.6	9.7	10.2

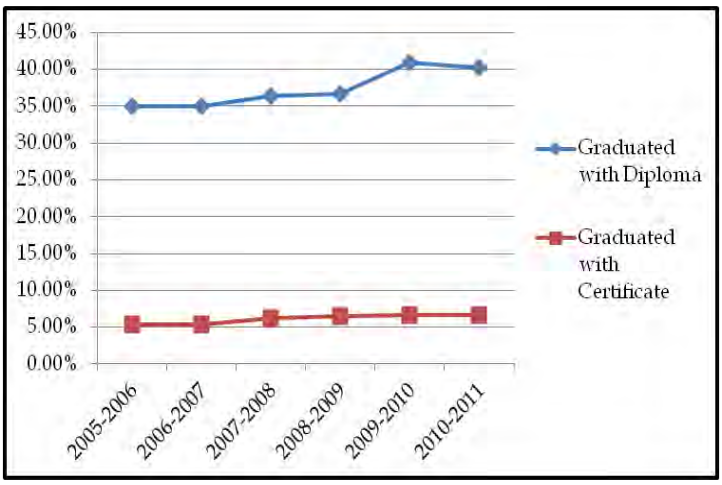
Data Source: MSDE, Maryland State Report Card, http://www.mdreportcard.org/downloadindex.aspx/

Story Behind the Data: The minimum required course work at the passing level might not be sufficient to predict success at the college level nor does this data predict academic/work pursuits chosen by students after graduation.[viii]

Between 2002 and 2011, the percentage of graduates who completed the requirements for both the University System of Maryland and the Career and Technology Education program has not significantly changed. In 2002, 11.3% of graduates completed both sets of requirements as compared to 10.2% in 2011. The percentage of students completing the University System of Maryland requirements increased to 58.4% but has remained relatively consistent since 2002. The Career and Technology Education program, however, fell to 9.1%; its lowest rate in over a decade.

Graduation/School Completion of Students with Disabilities

Definition: Percentage of children with disabilities who exit special education by graduating or completing school.[ix]



Maryland Students with Disabilities who Graduate with Diploma or Certificate						
	2005-2006	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
Graduated with Diploma	35.00%	35.00%	36.47%	36.68%	40.91%	40.30%
Graduated with Certificate	5.35%	5.35%	6.25%	6.48%	6.63%	6.71%

Data Source: MSDE; Graduation Completion Rate - Exit data: percentage of students with disabilities (reported by calendar year).

Story Behind the Data: High school dropout rates among children/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 is 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, Universal Design for Learning, 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).

Percentage of Students with Disabilities, Ages 14-21, Graduating/ Completing School (July 1st through June 30th, 2007-2011, Maryland and National/50 States Total Exit Data)					
	2007	**2008**	**2009**	**2010**	**2011**
National Diploma/ Certificate	32.67% / 9.57%	34.40% / 8.42%	60.69% / 15.09%	62.59% / 14.67%	Not Available
Maryland Diploma/ Certificate	35.00% / 5.35%	36.47% / 6.25%	36.68% / 6.48%	40.91% / 6.63%	40.30% / 6.71%

Data Sources: 2011 Maryland Data: Unpublished data provided by MSDE (State totals include students in non-jurisdictional agency placements). 2005-2010 National Data: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS) http://www.ideadata.org/PartBExiting.asp.

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 children/youth receive school and community-based wraparound supports and services, these students also compose the majority of children/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 more than 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 just over 28% of students with Emotional Disabilities completing school in 2011.

Disproportionate Identification of Minority Children/Youth

National data indicate that students from racial and ethnic minority groups are twice as likely to be identified as having an Intellectual Disability, Emotional Disability, or Specific Learning Disability than their White peers and 42 states cite disproportionate identification of minority students in these disability categories (OSEP, 2011). Congruently, Black students compose 37.9% of the student population in Maryland and Hispanic students compose 10% of Maryland's student body. In the special education subgroup, Black children/youth make up 42.2% and Hispanic children/youth account for 10.5% of students receiving special education and related services, respectively.

Graduation/School Completion of Students with Disabilities

A significant percentage of children/youth who are at risk for disproportionate identification and contact with special education share the following characteristics. They can be:

- from racial and ethnic minority groups;
- from families with low socioeconomic status that have experienced poverty;
- from non-English speaking family;
- from single parent headed households; or
- have a lack of supports/resources available to them in their community.

Current literature indicates that the over-identification of minority youth as disabled has distinct implications for:

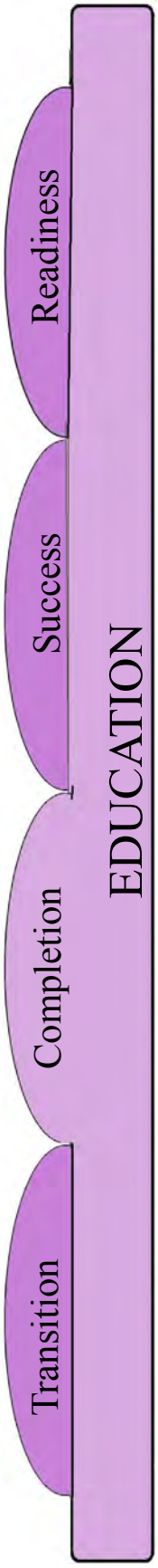
- impeding students' access to their least restrictive environment and their access to the most rigorous academic curriculum;
- negatively impacting achievement, attendance, discipline, educational placement, school climate, stigma, access to services, and graduation rates; and
- having global implications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

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 interventions. 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).

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 2011, when 40.30% 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 6.71% in 2011. 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 Role of the School Psychologist in the Identification of Emotional Disability*, the report of the Steering Committee on Students with Emotional Disabilities, the Autism Task Force Report).[x]



To promote achievement and improve overall outcomes for children, youth and their families, MSDE provides opportunities for school personnel to receive ongoing training, professional development, and technical assistance in employing primary prevention strategies including:

- The principles of Universal Design for Learning to guide curriculum development and instruction that is customized to accommodate diverse learners;
- Three-tiered logic models such as Response to Intervention (RtI) and Positive Behavioral Interventions and Supports (PBIS) for progress monitoring of achievement and behavior management;
- Continual development of new and innovative strategies to engage at-risk families and communities;
- Enhancing knowledge and delivery of strengths-based strategies for supporting academic, social, and vocational development; and
- Embracing the supports that emphasize the development of resilience factors in students.

MSDE and local school systems strive to provide a diverse array of school-based supports and services to accommodate at-risk students in general education and potentially divert them from enrollment in special education and related services. MSDE and other child-serving agencies have developed a variety of interagency initiatives to address the needs of at-risk children and youth in Maryland. These initiatives are primarily focused on preventing the over-representation of minorities in child-serving systems, and closing the achievement gap for diverse learners in Maryland schools, including:

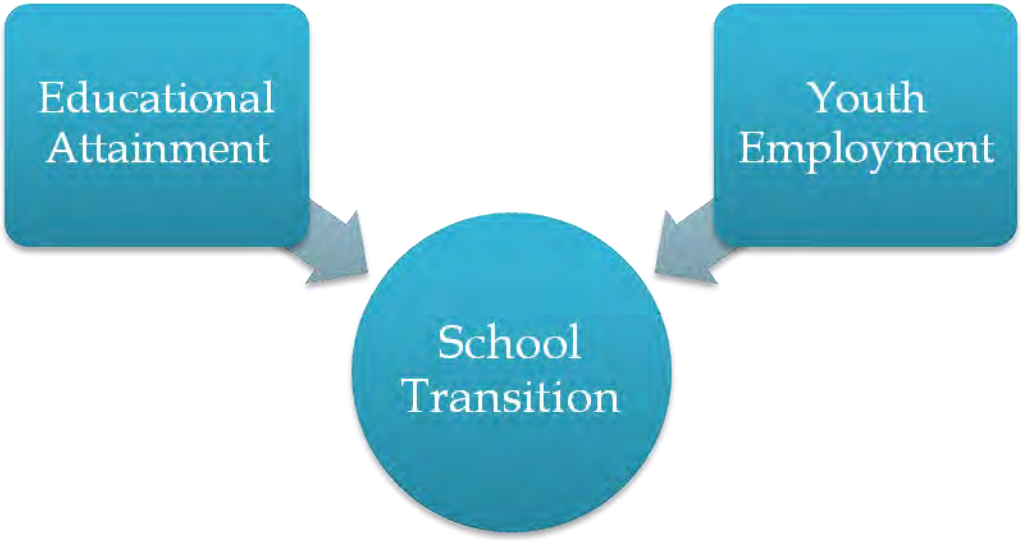
- *Healthy Families* - A collaborative initiative with DHMH, this evidence-based, nationally recognized home visiting program model is designed to work with overburdened families whose children are at-risk for child abuse and neglect and other adverse childhood experiences. It is the primary home visiting model designed to work with families who may have histories of trauma, intimate partner violence, mental health and/or substance abuse issues;

- Positive Behavioral Interventions and Supports (PBIS) - MSDE, in collaboration with Johns Hopkins University and Sheppard Pratt Health Systems, coordinates implementation of school-wide, universal PBIS 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 facilitating a shift from reactive, punitive practices to prevention and the promotion of positive 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.

    - Maryland is the recipient of a $14 million federal *Safe and Supportive Schools* grant, which will be utilized to provide PBIS to 60 persistently low-achieving schools.

- *Race to the Top* (RTTT) - On August 24, 2010, Maryland was awarded a $250 million federal RTTT grant. The RTTT program is aimed at boosting student achievement, reducing gaps in achievement among student subgroups, reforming struggling schools, and improving the teaching profession in the State. The longitudinal data collection and sharing agenda through RTTT will have a lasting impact on how child-serving agencies communicate and monitor child outcomes.

Result 6: School Transition

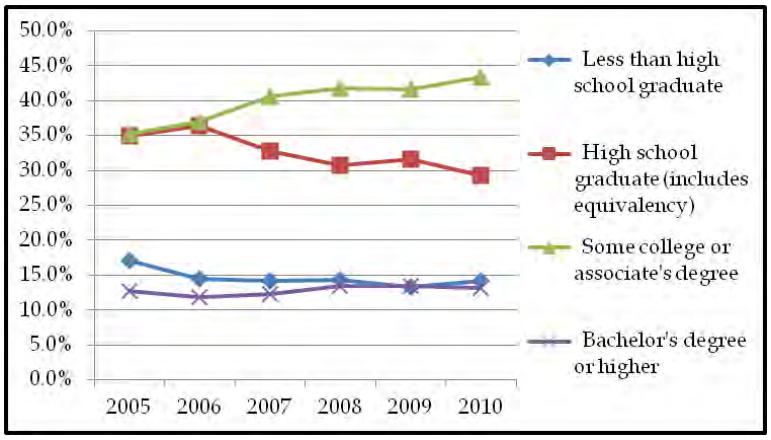


Indicators:

	Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Educational Attainment	The percent of young adults 18 to 24 years old who have attained a high school diploma, associate's degree, or higher degree by age groups, state and jurisdiction.			
Less than high school	↓	-3.3%	6.8%	0.90%
High school	↓	-3.3%	-7.3%	-2.30%
Some college or Associate's	↑	4.3%	4.1%	1.70%
Bachelor's	↑	0.9%	-2.2%	-0.30%
Youth Employment	Percentage of young adults who are employed by age groups 16-19 and 20-24 and jurisdiction.			
	↓	-2.2%	-2.0%	-1.2%

Educational Attainment

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



Educational Attainment of Young Adults Ages 18 - 24 in Maryland						
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
Less than high school graduate	17.1%	14.4%	14.2%	14.3%	13.3%	14.2%
High school graduate (includes equivalency)	35.0%	36.4%	32.8%	30.7%	31.6%	29.3%
Some college or associate's degree	35.2%	37.0%	40.6%	41.7%	41.6%	43.3%
Bachelor's degree or higher	12.7%	11.8%	12.3%	13.4%	13.5%	13.2%

Data Source: Maryland American Community Survey 2005 - 2010 Total Estimate

Story Behind the Data: Governor O'Malley has made great strides to reach the specific goals that are 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. The Governor aims to improve student achievement and school, college, and career readiness in Maryland by 25% by 2015.

Maximizing American Recovery and Reinvestment Act (ARRA) funding opportunities contribute to closing the achievement gaps, graduation rates, and ensuring students are successful competitors in the global economy. ARRA provides $589 million to prevent the reduction of funds from education and essential public services. Continually, the Governor is finding means to maximize ARRA funding opportunities within Maryland to enable students to become career and college ready. Through the RTTP grant, approximately $250 million was awarded to strengthen instruction within schools by adopting rigorous standards, retaining effective teachers and principals, and establishing clear measurements for student success and turning around low-performing schools.

Maryland is working continuously toward raising standards in education and adopting internationally benchmarked assessments to better prepare Maryland students for college and careers in the era of global competition. Collaboration is essential in discussing the interrelated challenges that students face to become successful from pre-kindergarten through graduate/professional school.

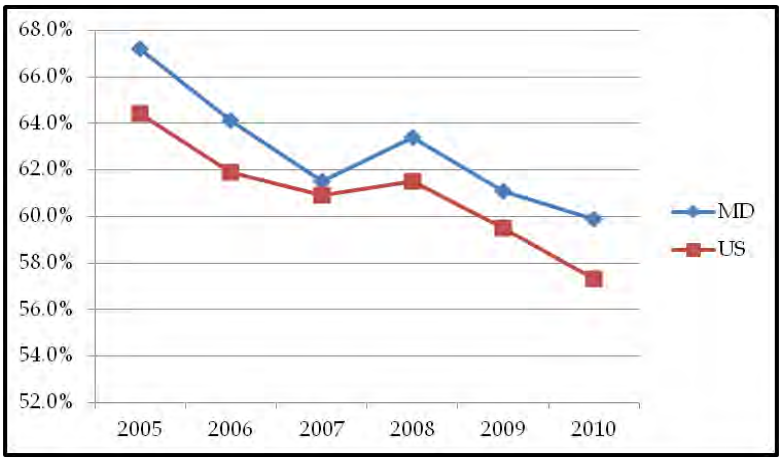
The College Success Task Force works to examine current Maryland policies and practices. Data collected from Maryland shows 2- and 4-year colleges have thousands of high school graduates who are placed into at least one developmental/remedial course in reading, English, or mathematics when they enter college the following year.[xi] The committee has aimed to help students enroll in college courses in high school prior to entering a post secondary education.

Students who do not display the necessary competencies to enter post-secondary courses may need to take remedial courses. Although remedial courses can delay the attainment of a degree, it also builds students' capacity and makes them more likely to complete their degree. The report of the Maryland P-20 College Success Task Force states: "2008 and 2010 performance accountability reports from Maryland community colleges indicate that students who enter remediation in college are not likely to leave remediation before they leave college (v.1, p. 5); but if students complete their remedial sequence, the rate at which they transfer to a 4-year program or complete an associate degree is comparable to, or even slightly higher than, those of students who did not need remediation—most recently, 84% versus 82.7%." In order for students to move into the workforce after college these issues must be addressed in a strategic manner.

Despite the needed changes within Maryland, it has the highest-ranked public school system for four years in a row, according to *Education Weekly*. Average rates of educational attainment are also above the national averages. According to MSDE, about 1 in 3 students from public high schools graduated with scholarship offers. Maryland's class of 2010 graduating seniors were offered $774 million in scholarship funding.

Youth Employment

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



16 - 24 year olds in Labor Force						
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
MD	67.2%	64.1%	61.5%	63.4%	61.1%	59.9%
US	64.4%	61.9%	60.9%	61.5%	59.5%	57.3%

Data Source: U.S. Census Bureau, American Community Survey (ACS) five-year estimates 2005-2010 Employment Status.

Story Behind the Data: The percentage of employed young adults in Maryland is 27.8% for ages 16-19 and 63.4% for ages 20-24; both are slightly higher than the national averages of 26.2% and 59.8%. Unemployment for young adults in Maryland is 29.3% for ages 16-19 and 15.6 for ages 20-24 as compared to the national unemployment percentages of 29.7 and 16.9.

Employment for 16 -24 year olds in the labor force is 59.9%, which is 2.6% higher than the national average at 57.3%. The labor force data includes all people classified in the civilian labor force plus members of the US Armed Forces (people on active duty with the US Army, Air Force, Navy, Marine Corps, or Coast Guard).[xii]

The O'Malley – Brown Administration is committed to creating opportunities for Marylanders in a time of economic difficulty. Increasing the number of Marylanders who receive skills and training by 20% by the end of 2012 is one of the administration's goals. In improving enrollment in occupational skills training the O'Malley – Brown administration is planning to expand outreach and seek additional federal and private sector funding. The appropriate funds will enable Maryland to expand the number of young adults who are seeking a post secondary education or training.

Providing Marylanders with adequate skills and training will increase the chances of getting a career or technical credential, industry certification, or college degree. Every working Marylander should have access to the equivalent of at least two years of training past high school leading to a career which is an initiative for the State. Plans to increase the number of high school students who graduate from Career and Technology Education (CTE) programs and attain industry certification, licensure, and early college credit will help those aspiring to further their education. Gaining a marketable skill can open up a variety of new opportunities.

Maryland intends to expand the number of persons with disabilities in post-secondary education and career technology training programs and the number obtaining a degree, certificate, or technical certification. The Maryland Rise program is one service available to help individuals with disabilities seeking to further their education. The program offers services for individuals with significant disabilities who are eligible to receive Division of Rehabilitation Services (DORS). DORS' mission is to present self-employment as a realistic and viable vocational option to individuals.[xiii] Throughout the program individuals may explore employment, develop a plan for a business, and receive funding and technical assistance.

To ensure Maryland's youth are ready for college and work, the State has adopted the Forum for Youth investment Ready by 21® action plan. Ready by 21® helps leaders build broader partnerships, set bigger goals, collect and use better data, and take bolder actions. In order to achieve these goals the Ready by 21® action plan includes State leaders, families, school, and community in order to improve children's outcomes. The Children's Cabinet has collaborated with numerous stakeholders to make a difference in the lives of Maryland's children and youth and to better prepare them for success in adulthood.[xiv]

New Perspectives in Children's Education

Quality Rating Improvement System (QRIS)

Definition: QRIS is a systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs. Maryland's QRIS, which will be called "**Maryland EXCELS**", will have five levels – 1 through 5 checkmarks – through which licensed child care centers and family child care providers can progress as they meet successive quality benchmarks.

Why is the QRIS Important to Children's Education?

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. By participating in QRIS, these programs embark on a path of continuous quality improvement. Over the past several years, a number of states have developed QRIS programs in an effort to enhance child care services and improve children's readiness to learn.

MSDE, in cooperation with the Johns Hopkins University Center for Technology in Education, launched **Maryland EXCELS** as a pilot in late 2011. At that time, a geographically diverse group of child care providers consisting of licensed child care centers and family child care providers began participating in a pilot version of the program. The purpose of the pilot is 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; and
- Administrative Policies and Procedures.

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 school-age child care 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; and
- Parents have easily accessible information about the quality of early care and education programs.

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 **Maryland EXCELS** program that will track participation rates, provider demographics, child populations served, performance issues such as compliance and license enforcement actions, staff qualifications, staff turnover, accreditation status, and geographical relationship to schools. This system, which is currently being implemented in various locations around Maryland, is scheduled for Statewide implementation by July 2013.

Alt-MSA

Definition: The Alternate Maryland School Assessment (Alt-MSA) tests the areas of math, reading, and science and is administered to students with disabilities in grades 3 through 8 and grade 10 when a student's IEP team finds that the Alt-MSA is the most appropriate assessment for the students' educational needs.

Percentage of Students with Disabilities Who Score At or Above Proficient on the Alternate-Maryland State Assessment

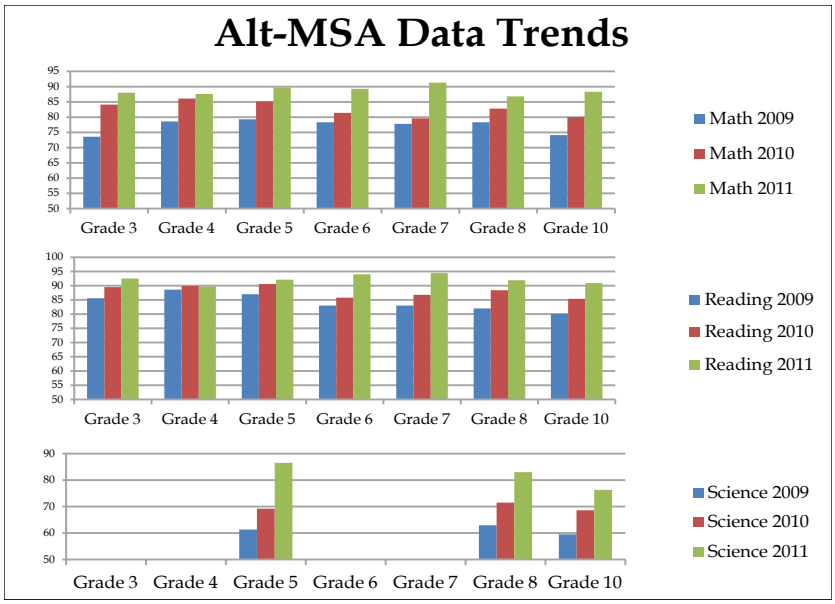
	2004	2005	2006	2007	2008	2009	2010	2011
Math	68.3%	67.7%	67.3%	81.4%	87.2%	76.9%	82.3%	88.7%
Reading	70.8%	69.6%	64.3%	81.4%	87.6%	83.7%	87.7%	92.2%
Science					69.3%	61.0%	69.6%	81.5%

Data Source: MSDE

Why is the Alt-MSA Important to Children's Education?

The Alt-MSA is the assessment used for students with the most significant cognitive disabilities if, through the IEP Team process, it has been determined that the student cannot participate in the Modified MSA (Mod-MSA), even with accommodations. The Alt-MSA combines instruction with assessment. The Alt-MSA assesses and reports student mastery of individually selected indicators and objectives from the reading and mathematics content standards or appropriate access skills for students in grades 3 through 8, grade 10, and in science content standards for students in grades 5, 8 and 10. The Alt-MSA is a portfolio assessment constructed of evidence that documents individual student mastery of the assessed reading, mathematics, and science objectives. The Statewide performance standards reflecting three levels of achievement; Basic, Proficient, and Advanced are reported for the Alt-MSA.

In 2009, 4,642 students with significant disabilities participated in Alt-MSA. The numbers decreased slightly to 4,616 in 2010, and 4,512 in 2011. Students participating in Alt-MSA have shown significant improvement in reading, mathematics, and science achievement from 2009 to 2011. The overall average increase in performance across all grades from 2009 to 2011 in the area of mathematics was 11.6 points. In reading, the overall average increase across all grades from 2009 to 2011 was 8.0 points. All grades in each content area made improvements.[xv]

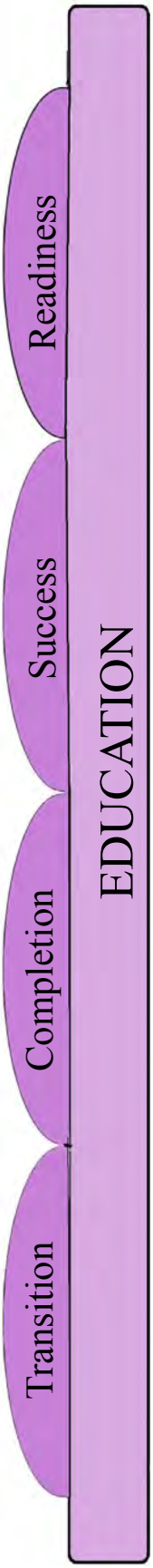


Bullying and Harassment

Definition: The number of incidents of bullying, harassment, or intimidation against students in the Maryland public schools that are reported to the Local School System.

Total Number of Bullying, Harassment, or Intimidation Incidents Reported				
	AY 2008	**AY 2009**	**AY 2010**	**AY 2011**
MD	1296	1706	3818	4678

Data Source: MSDE; "Bullying, Harassment, or Intimidation in Maryland Public Schools," March 31, 2012.



Story Behind the Data: The Safe Schools Reporting Act of 2005 (Education Article §7-424, Annotated Code) requires MSDE to report the incidences of harassment and intimidation that occur in Maryland public schools and are reported using the standard report form developed by MSDE that was modeled by law. Victims of bullying, their parents or relatives, or school staff may complete the report when an incident of bullying occurred. The reports gather information on the location of the incident, a description of the incident, information about the offender(s), the reasons for the harassment, whether there was physical or psychological injury, or whether the victim missed school time because of the incident. A follow-up investigation is also completed by school personnel to better understand the situation and to address any harm caused by the harassment.

The number of reports has been rising since the implementation of the Safe Schools legislation, with 4,678 reports filed in AY 2011, up 3,382 since AY 2008. This is most likely a result of an increasing awareness in schools about the report form as a reliable method for reporting harassment. The reports found that the victims and perpetrators of harassment were most frequently 12 year olds and that an overwhelming majority of incidents occurred on school property (84.9% in AY 2011) as opposed to on the bus, during a school sponsored event off premises, or on the way to/from school. Most of the reported incidents involved some kind of verbal name-calling or threats (61.2% in AY 2011) followed by harassment that involved physical aggression (42.4%).

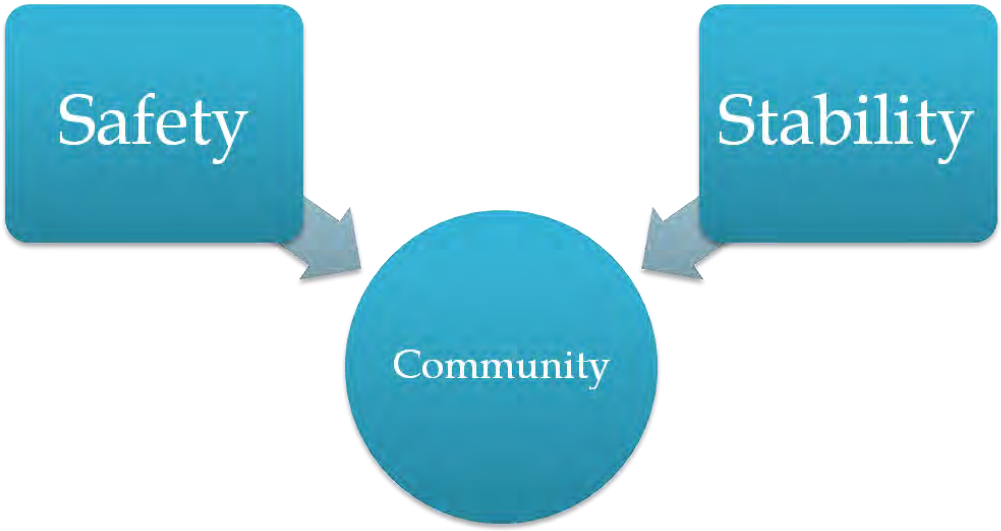
Reports of harassment and intimidation can give useful information to schools about the safety and behaviors of their students. As part of the investigation following a report of harassment, school personnel interview the victim or victim's representative to determine why the harassment took place. While many reports identify "Another Reason" or "Unknown" as the reason for bullying, the most frequently cited motive was that the perpetrator bullied "Just To Be Mean" (38.2%). Other alleged reasons for bullying are "To Impress Others" (16.3%), physical appearance (7%), race (2.1%), religion (2%), and disability (1.4%). Among the possible follow-up and corrective actions taken are: student conferences (72.6%), student warnings (48.5%), parent phone calls (48.4%), parent conferences (31.3%), and counseling offered (23.7%).

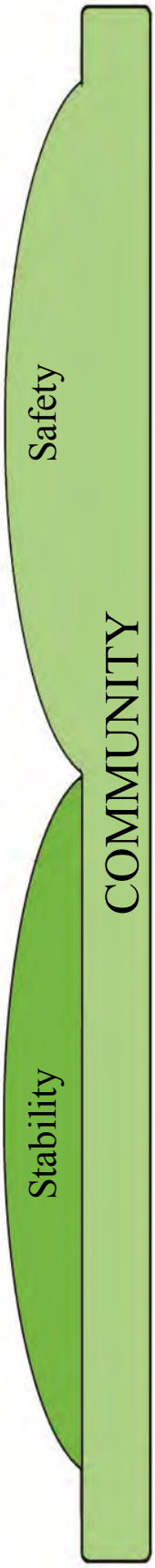
Endnotes

[i] National data on school readiness measurements that can be meaningfully compared to Maryland's Kindergarten Assessment process are not available.
[ii] MSDE conducts a reliability analysis of the data each year (of which the most recent one is posted online under the MMSR rubric at http://marylandpublicschools.org/MSDE/divisions/child_care/early_learning/. MSDE also conducts extensive professional development with all kindergarten teachers on the administration of the MMSR and the use of the assessment information for instruction in terms of the WSS domains of learning.
[iii] 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 prekindergarten or child care center. Caution must be taken when interpreting the information when relatively small numbers of children are involved.
[iv] 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.
[v] 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.
[vi] 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.
[vii] Dropping out is defined as leaving school without a high school diploma or equivalent credential such as a General Education Development (GED) certificate. This data includes students who drop out of summer, evening, and alternative high school programs.
[viii] Data regarding high school graduates' plans for further education, work, and the military is reported by MSDE (www.mdreportcard.org).
[ix] 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. The formula used for the Percentage of Students w/ Disabilities Graduating or Completing School is: (Diploma + Certificate + Aged Out)/(Diploma + Certificate + Aged Out + Dropped Out). Calculations completed by MSDE.
[x] More information can be obtained at www.marylandpublicschools.org.
[xi] Report of the Maryland P-20 College Task Force May 2010--- Final.
[xii] http://factfinder2.census.gov/help/en/american_factfinder_help.htm#glossary/glossary.htm.
[xiii] http://pdgrehab.com/services/rise-program.
[xiv] http://www.readyby21.org/what-ready-21.
[xv] Additional information regarding the Alt-MSA may be found on the School Improvement in Maryland website at http://www.mdk12.org, the MSDE website at http://www.marylandpublicschools.org, and the Maryland Report Card website at http://www.mdreportcard.org.

Safety
COMMUNITY
Stability

Community





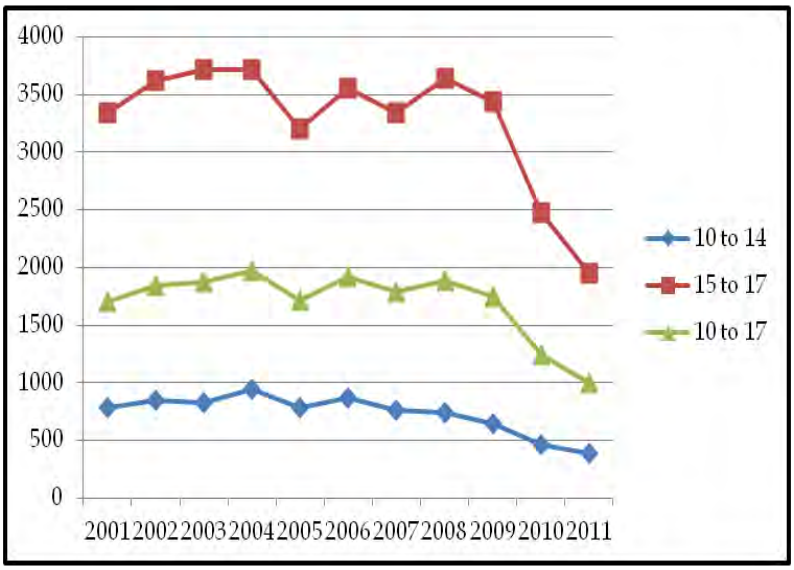
Result 7: Safety

Indicators:

		Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Juvenile Felony Offenses	The rate of intake referrals to the Maryland Department of Juvenile Services (DJS) for youth ages 10-17 for Felony offenses by Fiscal Year.				
	10 through 14	↓	-5.9%	-16.3%	-75 per 100,000
	15 through 17	↓	-4.4%	-21.3%	-528 per 100,000
	10 through 17	↓	-4.3%	-20.2%	-252 per 100,000
Recidivism	Juvenile and adult re-adjudicated/convicted recidivism rates for youths released from the DJS committed programs after 12, 24, and 36 Months.				
	12 Months	↑	1.3%	0.0%	0.0%
Maltreatment	Child Protective Service (CPS) investigations that 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.				
	Indicated	↓	-1.8%	6.5%	0.3 per 1,000
	Unsubstantiated	↓	-4.2%	-2.0%	-0.1 per 1,000

Juvenile Felony Offenses

Definition: The rate of intake referrals to the Maryland Department of Juvenile Services (DJS) for youth ages 10-17 for Felony offenses by Fiscal Year.



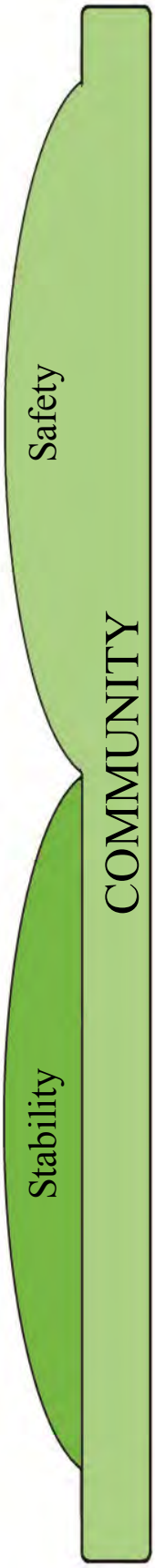
Rate of Referrals to DJS Per 100,000 Youth Ages 10-17, for Felony Offenses (Violent and Non-violent) by Fiscal Year, Maryland											
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
10 to 14	783	845	827	944	786	868	766	736	644	460	385
15 to 17	3345	3618	3712	3716	3204	3552	3344	3640	3439	2479	1951
10 to 17	1700	1841	1872	1968	1709	1917	1787	1886	1742	1248	996

Note: Violent and non-violent Felony offenses are counted once under each group per referral.
Data Source: DJS

Story behind the Data: The rate of referrals, per 100,000 youth ages 10-17, for felony offenses include both violent and non-violent charges.[i] For the purpose of differentiating violent offenses from non-violent ones, if a youth is referred for both within the same referral then it would be a count of two offenses for that referral. It is a rare situation to have multiple violent and/or non-violent felony offenses within the same referral. Data covers the fiscal year which spans from July 1 through June 30.

If a youth is age 14 or older, violent offenses are automatic referrals to the adult system for murder, rape and sex first degree charges and age 16 or older for robbery and aggravated assault. The rates reported above include any youth waived back from the adult system to the juvenile system, but do not include youth who were arrested and not sent back to the juvenile justice system.

Juvenile Felony Offenses



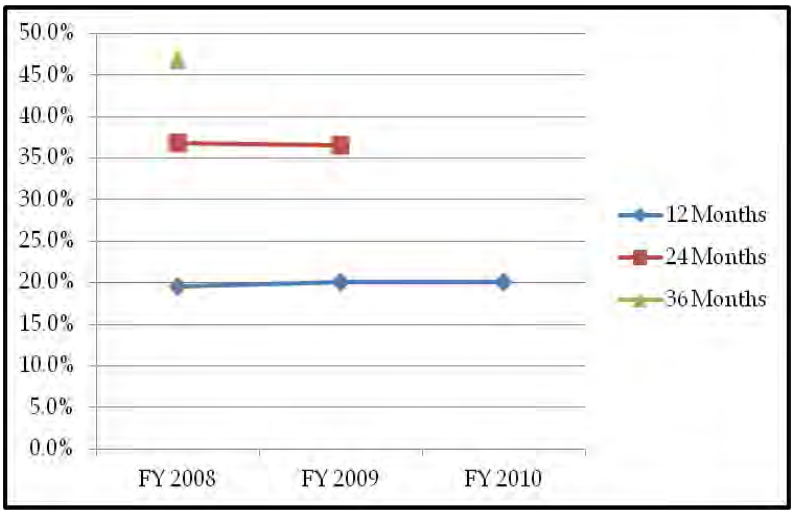
To calculate the rate for referrals per 100,000, there are two important variables. One is the juvenile felony referrals for children ages 10-17 and the other is the general population in that age group. Juvenile intake referrals for felony offenses for children ages 10-17 are obtained from the DJS automated data system, known as "ASSIST." All population data are obtained from the Office of State Planning. There are three sources for population estimates: 1. The past trend data from 2001 through 2009; 2. The actual 2010 census, and 3. The 2011[ii] population projections are given for every 5 years, *i.e.*, 2015, 2020… until 2040 for an interval of 5 years of age groups. The estimated percentage change was a .02% increase for children ages 10-17 in FY 2011.

The juvenile referral rate for felony offenses fluctuated from FY 2001 through 2006 for all age groups, declining in FY 2007. FY 2008 saw an increase for children ages 15-17. There has been a declining trend from FY 2009 for all children with FY 2011 showing the lowest rates of all reported fiscal years. Between 2001 and 2011, the referral rate for felony offenses dropped by 41% from 1,700 per 100,000 to 996 per 100,000 for ages 10-17. During this time, violent offense referrals dropped by 26% from 615 to 457 per 100,000. Non-violent felony offense referrals were reduced by half from 1073 in FY 2001 to 539 per 100,000. Overall referrals have been declining both nationwide and in Maryland.

Involvement in violent offenses increases the risk of injury or death and continued criminal activity into adulthood. Involvement in non-violent felony offenses 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 care and supervision by family. Poor school performance, including absence from school and falling behind in one or more grade levels, increases the likelihood of involvement in delinquent activity. Additionally, the number of youth adjudicated (those who are found responsible for the alleged offense) is an important correlate to juvenile referral rates.

Recidivism

Definition: Juvenile and adult re-adjudicated / convicted recidivism rates for youths released from the DJS committed programs after 12, 24, and 36 Months.

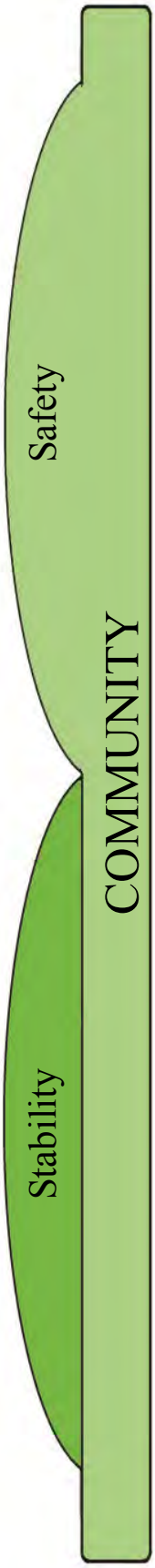


Re-adjudication/Conviction Recidivism Rates for Committed Program Releases 12, 24, and 36-Month Juvenile and/or Criminal Justice Recidivism Rates for FY 2008-2010 Releases, Tracked Through 2011			
	FY 2008	**FY 2009**	**FY 2010**
12 Months	19.6%	20.1%	20.1%
24 Months	36.8%	36.6%	NA
36 Months	46.8%	NA	NA

Data Source: DJS

Story Behind the Data: The juvenile justice community has not reached a consensus on how best to define recidivism with one measure. Therefore, consistent with other studies, this review focuses on several measures, including subsequent juvenile and/or criminal involvement of youths released from DJS's out of home commitment programs. The majority of youths released from these residential programs are close to 17 years of age. It is important to track these youth in the adult system and report their recidivism rates. DJS prepares the combined juvenile and/or criminal re-referral/arrest, re-adjudicated/conviction and re-committed/incarceration recidivism rates.[iii] A youth is counted once even if he or she has re-offended in both systems. The reporting of these three combined measures varies from state to state, with most states relying on their re-adjudicated/convicted recidivism rates. These data report the re-adjudicated/convicted recidivism rates.

Information from the juvenile and adult databases is retrieved, processed, and compiled for each of the selected released cohorts: the re-adjudication/conviction recidivism rates with 36 months follow-up for FY 2008 cohort releases; 24 months follow-up for FY 2009 cohort releases; and 12 months follow-up for FY 2010 cohort releases. When comparing FY 2009 and 2010 at 12-months, the re-adjudication and conviction rates remained the same. Similarly, the comparison of FY 2008 and 2009 at 24 months revealed little change.



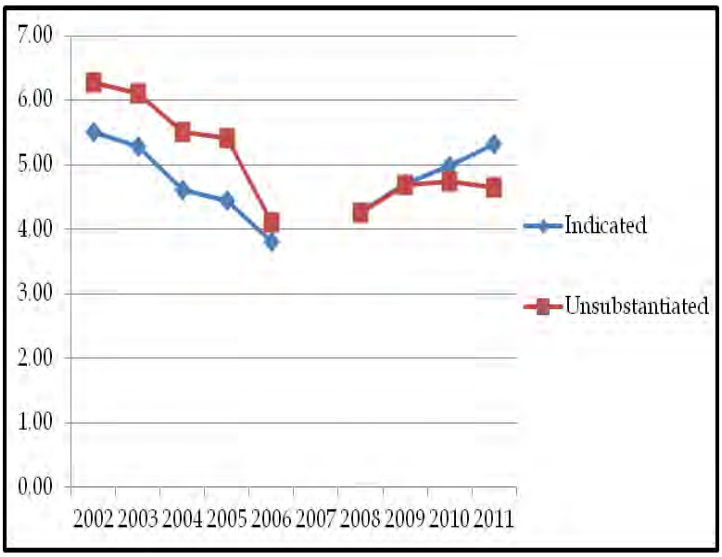
While the distinction between violent and non-violent crime is an important one in the legal system, a more important distinction in treating juvenile offenders is *their risk of re-offending* which may be high for a youth who committed a non-violent offense and low for a youth who committed a violent offense. This may be attributable to the sanctions provided for violent offenses which are more severe than those for non-violent felony offenses. Also, youth committing violent offenses are generally older and are transferred 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.

Acknowledging that recidivism is only one potential indicator of each program's impact on serious juvenile offenders, DJS' recidivism research and studies analyze recidivism rates and their implications for the juvenile justice system, its major programs, and youth in DJS custody. During the past fifteen years, DJS has greatly expanded and improved its recidivism research and calculated different measures for youths released from all committed programs each fiscal year.

Assessing the criminogenic factors and risk of re-offending, 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. Although recidivism rates are essential performance measurements, these data are also indicators of a program's effectiveness. Such indicators are impacted by aftercare and other community-based programs as well as numerous risk factors that are often beyond DJS control including the characteristics of each youth's community, local economic opportunities, and family problems. Unfortunately, these qualitative factors are not easily obtained and measured.

Maltreatment

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.

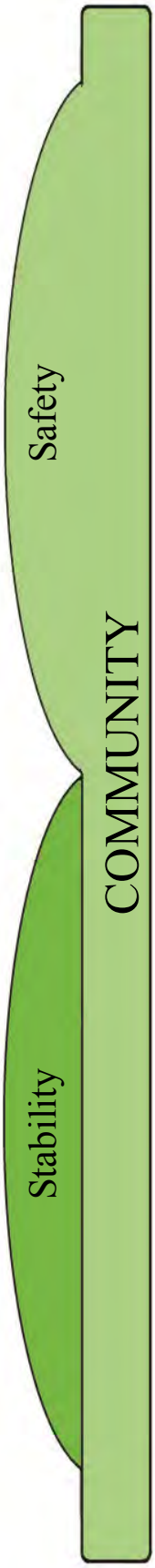


Rate of Indicated and Unsubstantiated Child Abuse and Neglect Findings Per 1,000 in the Population										
	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Indicated	5.51	5.29	4.60	4.44	3.80	*	4.28	4.71	4.99	5.32
Unsubstantiated	6.27	6.11	5.50	5.42	4.10	*	4.26	4.69	4.74	4.64

* Data unavailable due to CHESSIE conversion.

Story Behind the Data: This indicator measures the extent to which children experience abuse or neglect. Child abuse and neglect can result in mild to severe physical injuries, as well as death. Additional consequences to the child include possible attachment disorders, failure to thrive, mental health issues, developmental delays, educational challenges, and behavioral problems. Identifying families and children at risk for abuse or neglect, addressing these risk areas, and ensuring safety for children are essential in protecting children from harm.

The rate of indicated findings has been increasing since FY 2008. The rate of unsubstantiated findings, however, has remained fairly steady since FY 2009, following a slight increase from FY 2008. For both indicated and unsubstantiated findings, the rates of neglect have increased more than any other type of abuse/neglect in the past four fiscal years. Overall, indicated findings have increased while unsubstantiated findings have either declined or remained fairly constant.



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 more than 7.5% during 2010 (Maryland Labor Statistics: http://dllr.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. It is perhaps not surprising that the rates of indicated abuse and neglect have increased over the past few years of economic recession given that poverty and unemployment add significant stress on families, weakening parents' abilities to cope with other stressors.

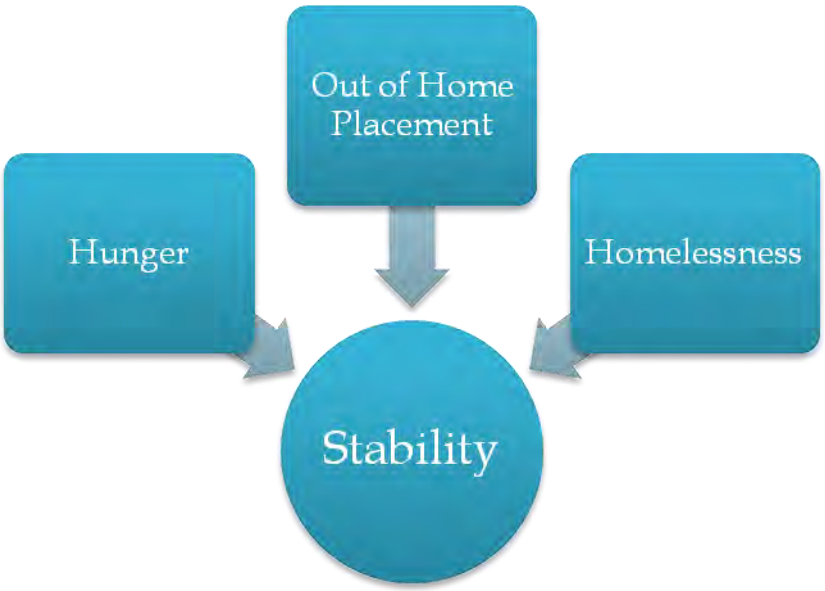
Accordingly, effective services must address these issues as well as the immediate safety risks to the family's children. Since July 2007, DHR has implemented its child welfare initiative, Place Matters, which is focused on the following goals:

- 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; and
- Managing with Data and Redirect Resources.

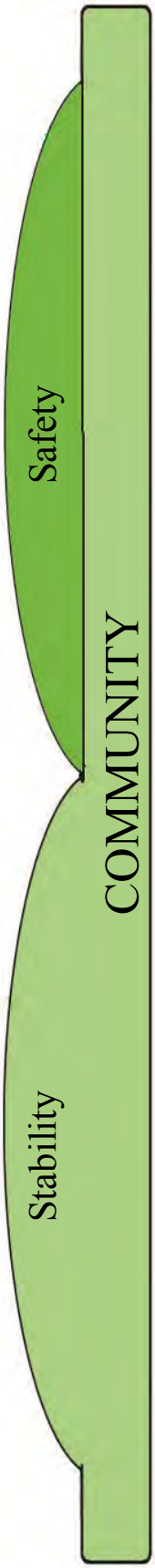
Each of these efforts is undertaken within the primary goal of maintaining safety for children.

As part of Place Matters, DHR has implemented a Family-Centered Practice model. Workers develop individualized service plans based on comprehensive assessments of the families' strengths and needs with goals of increasing families' capacities to protect their children. These efforts are designed to reduce risk factors which lead to abuse and neglect and increase safety for children. Family Involvement Meetings (FIM) 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. FIMs begin during an investigation when a child needs to be removed for his/her safety.

Result 8: Stability

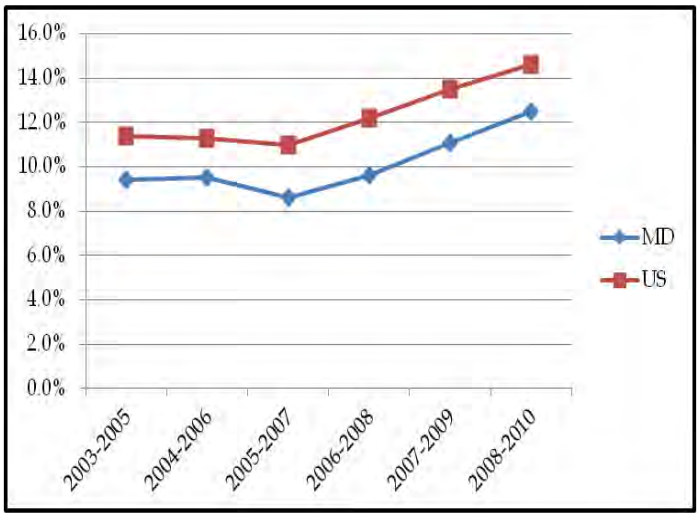


Indicators:	Trend	Average Percent Change	Recent Year Percent Change	Recent Year Unit Change
Hunger	The percentage of families who are food-insecure because of the lack of access, at times, to enough food for an active, healthy life for all household members; limited or uncertain availability of nutritionally adequate foods.			
	↑	6.3%	12.6%	1.4%
Out of Home Placement	The rate of entry into out of home placement is the number of children, per 1,000 children ages birth through 18, who enter placement during the fiscal year.			
	↓	-0.8%	-3.4%	-.4 per 1,000
Homelessness	The percentage of children enrolled in the public school system that lacks a fixed, regular, and adequate nighttime residence or who are awaiting foster-care placement.			
	↑	14.0%	5.2%	0.1%



Hunger

Definition: The percentage of families who are food insecure. The US Department of Agriculture (USDA) defines food insecurity as a measure of the 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.



Prevalence of Household-Level Food Insecurity (3-year Average)						
	2003-2005	**2004-2006**	**2005-2007**	**2006-2008**	**2007-2009**	**2008-2010**
MD	9.4%	9.5%	8.6%	9.6%	11.1%	12.5%
US	11.4%	11.3%	11.0%	12.2%	13.5%	14.6%

Data Source: Coleman-Jensen, Alisha, Mark Nord, Margaret Andrews, and Steven Carlson. *Household Food Security in the United States in 2010.* ERR-125, U.S. Dept. of Agriculture, Econ. Res. Serv. September 2011.[iv] Jurisdictional data is available from the Feeding America Map the Meal Gap: Child Food Insecurity 2011 Survey: http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx.[v]

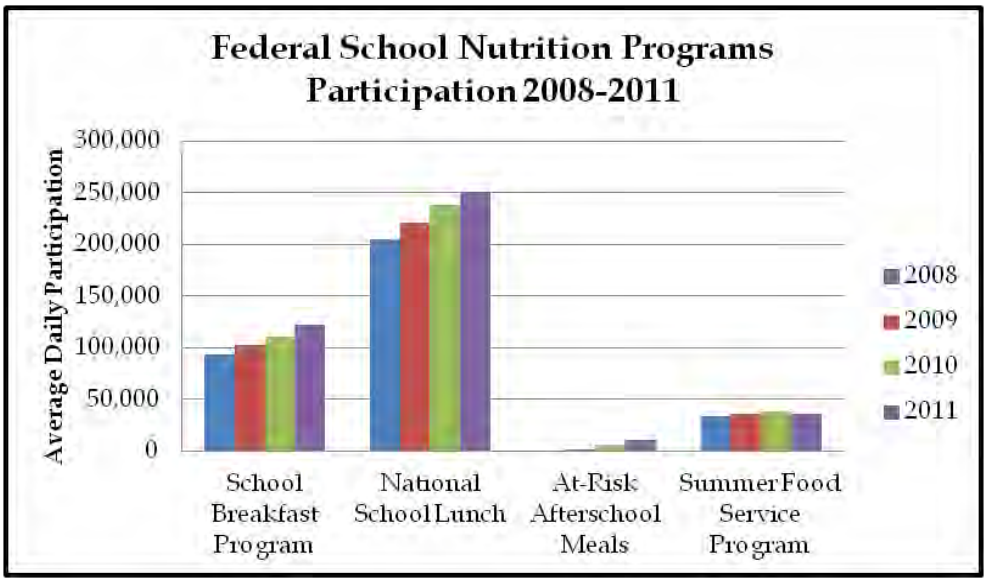
Story Behind the Data: Hunger affects the lives of children beyond not having access to enough food. Hunger affects the ability for children and youth to attend and achieve in schools and raises greater health concerns.

In Maryland, the face of hunger is not starvation, but rather lacking an adequate amount of and access to food. Although Maryland is one of the wealthiest states in the nation and home to seven counties with the top 25 median incomes in the United States, 12.5% of households in Maryland (1 in 8) face a constant struggle against hunger.

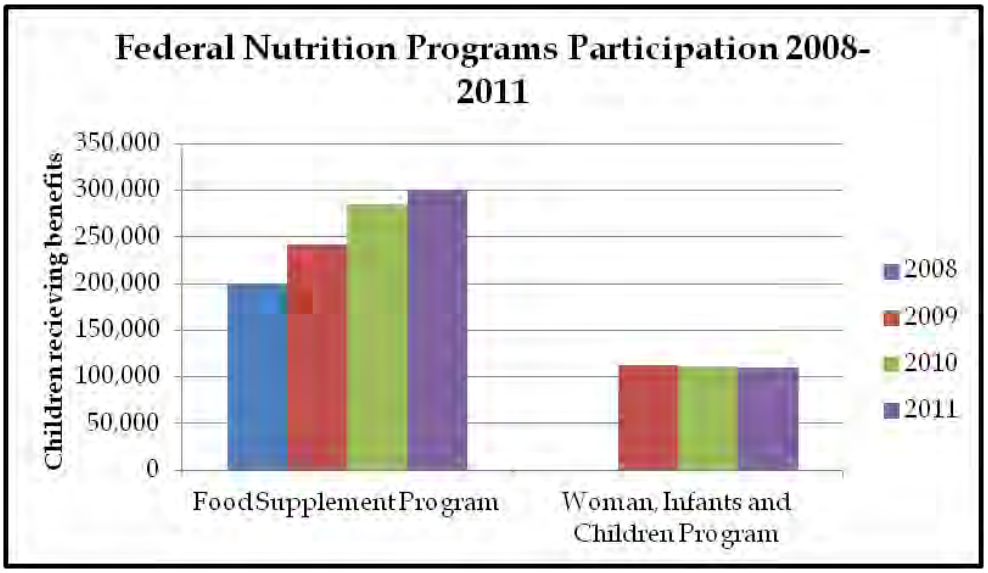
The participation rates of the federal nutrition programs (School Breakfast Program, National School Lunch Program, At-Risk Afterschool Meals Programs, and the Summer Food Service Program), Food Supplement Program (FSP), and the Women, Infants and Children (WIC) Program form the safety net protecting children and families from food insecurity.

In 2008, Governor O'Malley convened the Maryland Partnership to End Childhood Hunger. In partnership with Share Our Strength, and with the support of Maryland Hunger Solutions, the Partnership has led Maryland's initiative to end childhood hunger. This public-private partnership includes non-profit organizations, businesses and foundations, State and federal agencies, advocates, local leaders, and representatives from the faith community. The Partnership emphasizes the need to provide access to healthful food where children and their families live, work, and play.

The most effective way to reduce childhood hunger in Maryland is to improve the number of eligible families participating in already-established programs. The Partnership's goal is to close the gap between eligibility for the federal nutrition programs, FSP, and WIC and participation in those programs.



Data Source: Maryland State Department of Education



Data Source: Department of Human Resources, Department of Health and Mental Hygiene

The Partnership is increasing awareness and encouraging the use of the federal nutrition programs including the Summer Food Service Program (SFSP). This program provides free meals to children at critical times during the summer months when children need food.

Summer Food Service Program (SFSP) Average Daily Participation					
2009		2010		2011	
Total # of F/R Students	Average Daily Participation[vi]	Total # of F/R Students	Average Daily Participation	Total # of F/R Students	Average Daily Participation
294,122	35,870	326,871	38,220	343,569	35,807

Data Source: MSDE

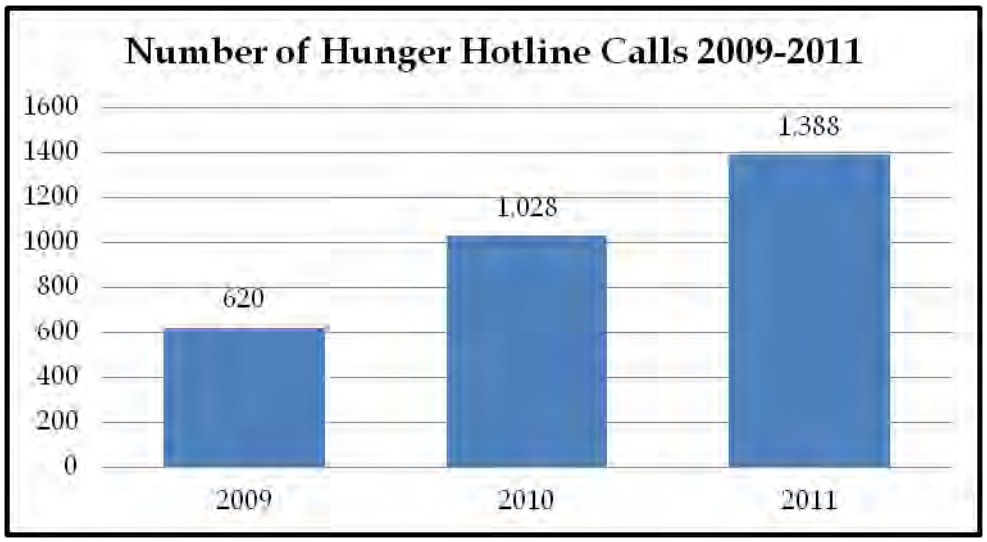
In 2011, only 10% of the students eligible for free and reduce-priced meals (FARM) participated in the SFSP. In 2011, Maryland experienced a decrease in the participation of the SFSP from 2010; an explanation for the decrease is the budget constraint causing schools not to operate summer school and summer programs, which in previous years were sites for children to receive a meal. There are other barriers to children accessing this program including eligibility and transportation.

In order to operate the SFSP, a site must be located near a school in which 50% or more of the students are eligible for FARM. In some counties the difference of program eligibility hinges on one FARM application. The Partnership provides outreach to families receiving FSP benefits that children can also receive FARM. Through this outreach the Partnership hopes to increase the number of eligible children receiving meals at school.

In rural, urban, and suburban communities throughout Maryland, there is limited access to transportation for children to travel where meals are served. In the summer of 2011, the Partnership piloted a mobile meals program in Baltimore City to address this issue. This model allowed the food providers to meet the children in centralized and easily accessible locations and deliver meals to children in areas of high need that had no existing program or site in place. The Partnership will continue the mobile meals program in the summer of 2012.

In June 2009, Maryland along with 13 states and the District of Columbia piloted the At-Risk Afterschool Meals Program, which became available to all states in 2010. This program provides a meal for children attending afterschool programs. In 2009, the Afterschool Meals Program served an average of 1,594 children daily at 51 sites; in 2010, the program served an average of 5,894 children daily at 257 sites; and in 2011, the program served an average of 10,580 children daily at 370 sites. For out-of-school time programs, the addition of a meal, through programs like the SFSP and the At-Risk Afterschool Meals Program, increases the enrollment and attendance of students while easing the programs' budgetary burden through the federal reimbursement.

Maryland has created innovative ways of providing outreach and access to food and nutrition programs. In collaboration with MSDE, the Partnership created the Hunger Hotline to provide information regarding open summer meals sites and additional resource information, including FSP and WIC. The Partnership has expanded the use of the hotline beyond the summer and now operates throughout the year.



Data Source: Governor's Office for Children

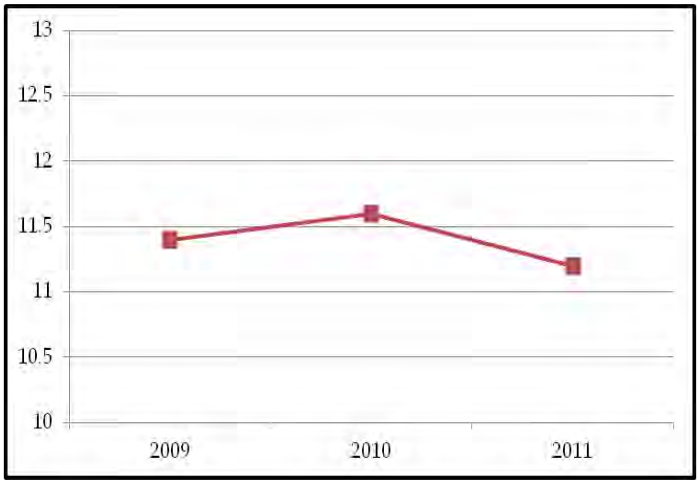
Safety

COMMUNITY

Stability

Out-of-Home Placement

Definition: The rate of entry into out-of-home placement is the number of children, per 1,000 children ages birth through 18, who enter placement during the fiscal year.[vii]



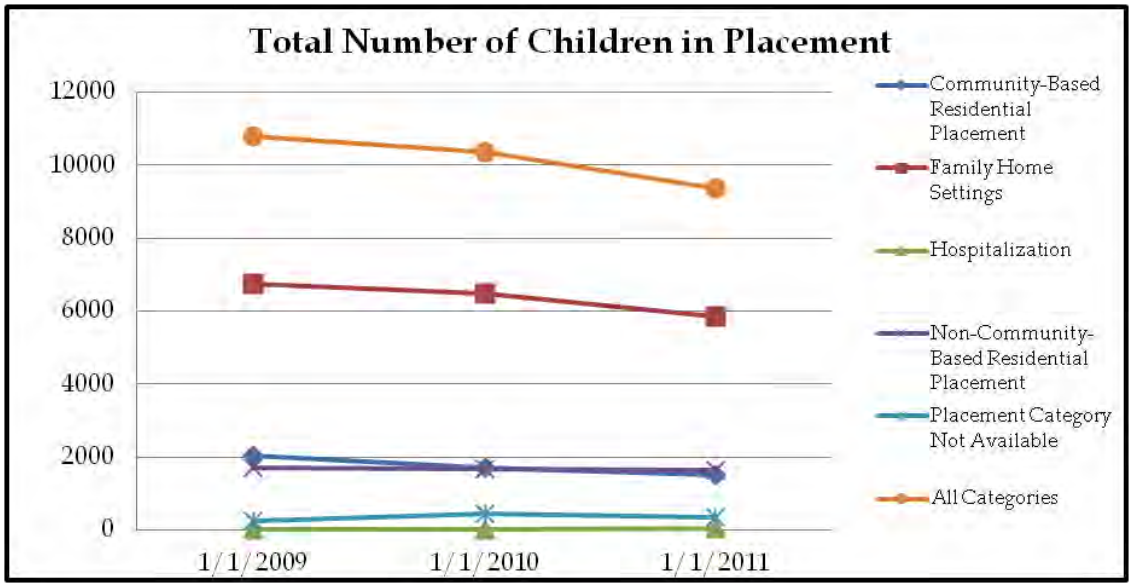
Rate of Entry (per 1,000 children birth through 18)						
State Fiscal Year	**2009**	**2010**	**2011**	**Three-Year Change**	**Recent Year Change**	**Average Change**
MD	11.4	11.6	11.2	-2%	-4%	-1%

Data Source: State of Maryland Out-of-Home Placement and Family Preservation Resource Plan, FY2011.

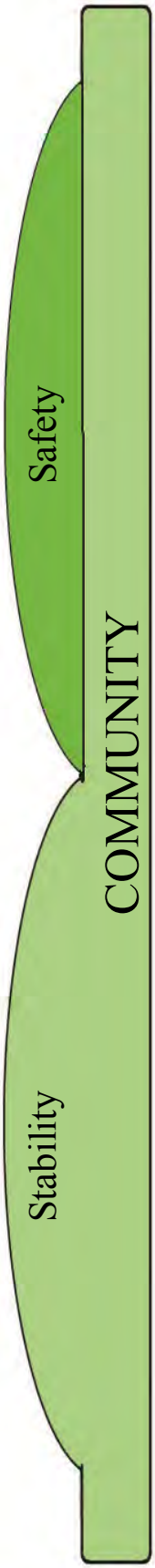
Story Behind the Data: Children in Maryland enter out-of-home care for a variety of reasons and under a number of different circumstances. Children may be placed in the care and custody of the State when they are determined to be a Child In Need of Assistance (CINA), a Child In Need of Supervision (CINS), or Delinquent. Children can also enter placement through a Voluntary Placement Agreement (VPA) in which a parent voluntarily places a child in the care of the State. This most often occurs when a child is unable to access funding for needed treatment through any avenue other than being in the care of the State.

In general, Maryland's goal is to reduce out-of-home placement and out-of-State placement, while emphasizing and implementing community-based and preventive strategies to serve children in their home and community environment. Although placement can be a protective factor for children whose behavior or environment puts them at-risk, there are consequences of placement that can also have a negative effect on children's outcomes. The consequences that sometimes occur are when children are moved between multiple placements, children's separation from their families or communities creates a wedge in those relationships, and children's needs are not identified early in their treatment. Placing children outside of their homes is costly to the State, with the most restrictive and non-community based placements accounting for the highest average cost per day, $469 for non-community based placements like residential treatment centers as opposed to $89 for family settings like foster care.

All Agencies All Categories Placement Trends				Percentage Change	
Category	**1/31/2009**	**1/31/2010**	**1/31/2011**	**(Y1-Y2)**	**(Y2-Y3)**
Community-Based Residential Placement	2035	1718	1514	-15.60%	-11.90%
Family Home Settings	6755	6490	5840	-3.90%	-10.00%
Hospitalization	29	31	43	6.90%	38.70%
Non-Community-Based Residential Placement	1704	1686	1640	-1.10%	-2.70%
Placement Category Not Available	251	435	336	73.30%	-22.80%
All Categories	10774	10360	9373	-3.80%	-9.50%



Maryland's rate of placing children in out-of-home care has decreased from 11.6 to 11.2 children per every 1,000 children in Maryland. Since FY 2009, Maryland's rate of placing children has decreased 1%. The most utilized type of placement is Family Home Settings, which served 62% of the children in placement in FY 2011, according to the total population counted during the one day census on January 31, 2011.[viii] Other types of placement are more restrictive in terms of encouraging children's interaction with the community environment: community-based residential placement, non-community-based residential placement, and hospitalization. Family home settings encompass kinship care (by a relative), foster care, adoptive care, and treatment foster care. This type of placement aims to immerse children as much as possible in their home and community environment so that their treatment can be linked to natural supports that will continue to support them after they have exited placement. This is another reason why Maryland seeks to reduce the number of children placed out-of-State, and has succeeded in doing so, decreasing out-of-State placement by an average of 16.45% since FY 2009. The total number of children residing in placement, based on the one-day census taken January 31st of each year, has been decreasing by an average of 6.65%, yearly, since FY 2009.

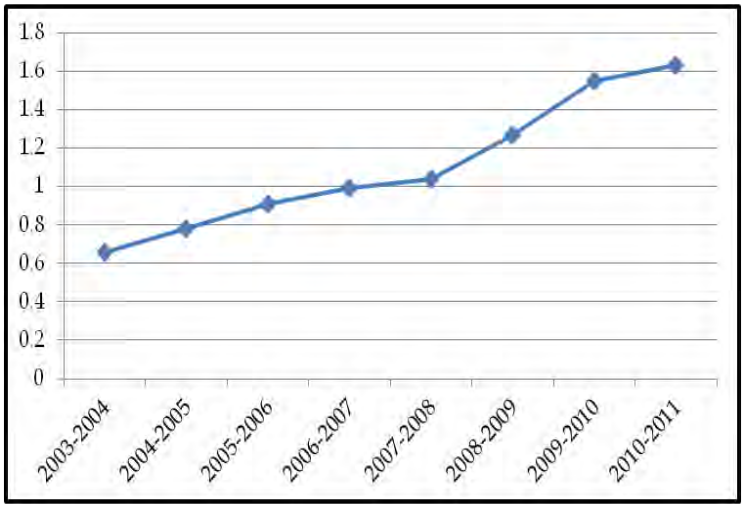


One of the ways that Maryland reduces out-of-home placement is by utilizing evidence-based practices and prevention programs for children who are at-risk and in need of a network of supportive services. The Children's Cabinet funds many of these programs through grants from the Interagency Fund to LMBs. These funds focus on strategies that are evidence-based to improve outcomes for children and divert them from placement include Functional Family Therapy, Multisystemic Therapy, and Trauma-Focused Cognitive-Behavioral Therapy. Maryland's Care Management Entities (CMEs) are another means to prevent placement of children by providing care coordination through a wraparound service delivery model. CMEs assume responsibility for the development and management of services to meet Plan of Care objectives for all life domains, with accountability for achieving outcomes. Each of these strategies is continually measured to determine how effectively they are improving children's outcomes, diverting them from placement or adjudication, and families' satisfaction with the services they are receiving.

Creating a child welfare system that identifies children's needs early and utilizes family and community resources to meet those needs requires a truly interagency, collaborative approach. One particular group, the Children's Cabinet's Advisory Council for Children, recommends ways for the State to reduce placement by utilizing best practices and increasing community-based interventions in place of institutional interventions. The State also partners with the Institute for Innovation and Implementation of the University of Maryland to collect outcomes and conduct fidelity monitoring for evidence-based practices prioritized by the Children's Cabinet and facilitate strategic planning among the Children's Cabinet Agencies.

Homelessness

Definition: The percentage of children enrolled in the public school system that lack a fixed, regular, and adequate nighttime residence or who are awaiting foster-care placement.



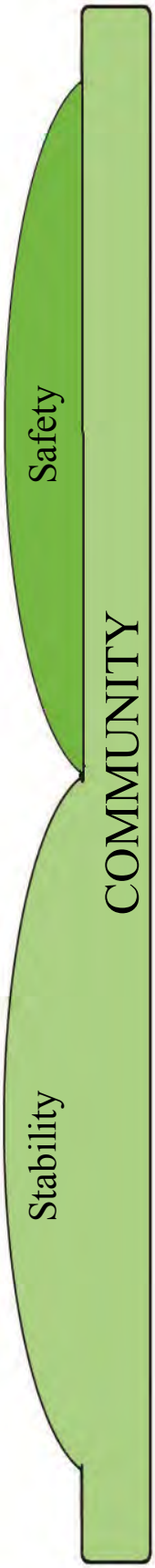
Percentage of Public School Children Who Are Homeless Out of Total Enrollment on September 30th of Each School Year								
	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
Percent homeless	0.66	0.78	0.91	0.99	1.04	1.27	1.55	1.63

Note: This is not a "point in time" count.
Data Source: MSDE

Story Behind the Data: 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 each LSS work with the Local Area Coordinator (LAC) to provide accurate counts to MSDE for accountability and 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 website at the following link: http://www.marylandpublicschools.org/MSDE/programs/esea/?WBCMODE=PresentationUnpublishe%25%25%25/.

The data reported for this indicator focus only on children enrolled in a Maryland public school at some point during the 2011 school year. Approximately 852, 211 children and youth were enrolled in a Maryland public school during 2011, 1.6% 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 1.63% in 2011.

DHR also tracks other demographics of shelter-users. Of all the homeless people served in shelters in FY 2009 as individual and family members (42% and 58% respectively), 26% were under age 18 and 38.7% of shelter-users were women. Additionally, 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 FY 2009, a total of 1,941,722 bed nights for emergency shelter, transitional housing and motel placements were reported.



In Maryland, as in most of the country, the data collected has limitations. The anecdotal responses received indicated that there were shelters that closed at the beginning of the fiscal year, which accounts for the decrease in the bed nights. This helps to explain why there was a decrease in bed nights (occupancy of one person, one night) during 2007 (1,857,026) and 2008 (1,547,434) when other variables like unemployment, lack of affordable housing, and foreclosures, demonstrated an increase in the homeless population needing shelter. By the end of the year, however, new shelters opened and by the end of the counting period there was a lower over-all count of bed nights. This phenomenon is verified by an increase in the number of shelter bed nights in FY2009 (1,941,722).

In addition to offering Title I services, MSDE distributes funds to LSSs 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, LSSs 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 he or she is homeless or until the end of the academic year in which he or she 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.

New Perspectives in Children's Communities

Crime

Definition: Violent crime rates are the number of incidents of violent crime per 1,000 persons. Violent crime includes murder, rape, robbery, and aggravated assault.[ix]

Rate of Violent Crime per 1,000 Persons						
	2005	**2006**	**2007**	**2008**	**2009**	**2010**
MD	7.1	6.8	6.4	6.3	5.9	5.6
US	4.7	4.7	4.7	4.6	4.3	4.0

Data Source: Maryland – Maryland Department of Planning Statistical Handbook, 2009; http://www.mdp.state.md.us/msdc/md_statistical_handbook09.pdf
National – FBI; http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/10tbl01.xls

Why is the Issue of Crime Important to Communities?

Crime does not only have a detrimental effect on the immediate victim of the crime; it also affects the community at large by creating an atmosphere of fear and alienation. Violent crime, in particular, is an indicator of safety in the community, because of the personal and confrontational nature of these types of crimes. In 2010, violent crimes accounted for 15% of the total Crime Index in Maryland.[x] Violent crime rates in Maryland continue to be higher than the national average by a margin of 1.6 crimes per 1,000 persons, although the rate in Maryland has been decreasing by an average of 4% yearly since CY 2005. In 2010, the violent crime rate in Maryland was 5% lower than the previous year's rate.

In Maryland, homicides involving children or mothers are reviewed by either the Child Fatality Review (CFR) or the Maternal Mortality Review (MMR). Deaths resulting from domestic violence are reviewed by the Domestic Violence Fatality Review (DVFR). These teams evaluate the "prevalence, risk factors and circumstances surrounding the death in order to make recommendations to prevent such deaths in the future."[xi] Their reviews have found that homicide was the second leading cause of death among children ages 1-17 and among women ages 18-24. Among the recommendations made by the group are for health care providers to assess for intimate partner violence (IPV) and for specialized involvement from criminal justice, law enforcement to address family violence and children exposed to violence.

Safety

COMMUNITY

Stability

Out-of-School Time Opportunities

Definition: Out-of-School Time (OST) opportunities are the activities provided for children and youth at all times when school is not in session. These activities serve school-age children and youth and provide safe places, encourage academic success, develop youth leadership, and nurture talents and interests so that young people can achieve in their own unique ways.

FY 2010-2011 State & Federally Funded Out of School Time Opportunities In Maryland	
Program Locations	**Youth Contracted to Serve**
364	**22,860**

Data Source: Maryland Out-of-School Time Network

Why Are Out of School Time Opportunities Important to Communities?

The hours between 3 p.m. and 6 p.m. and the summer months have long been recognized as a vulnerable time for children and youth.[xii] When young people are connected to OST programs, this time can also be hours of opportunity. A growing body of research indicates that youth participation in high quality OST programs can have a number of benefits including increased engagement in learning, improved school attendance, academics, and social skills.[xiii] OST programs also play an important role in addressing childhood hunger by offering snacks and meals after school and during the summer for children who may not get food at home. Unfortunately, nearly one-third of Maryland's school age young people spend more than 10 hours a week unsupervised.[xiv] Mapping the locations of local, State and federally-funded OST programs is important to identify gaps in access, areas for increased investment and targeted outreach to increase utilization of the federal At-Risk Afterschool Meals program.

The programs included in this data set receive grant funding to offer OST opportunities targeting specific populations including low-income or youth with specific risk factors. The funding streams included in the data survey are grants from the US Office of Juvenile Justice and Delinquency Prevention, US Department of Education--including the 21st Century Community Learning Centers as managed by MSDE, Maryland's Children's Cabinet Interagency Fund via LMBs, Maryland Office of Crime Control & Prevention and Baltimore City's local Out-of-School Time investment.

While licensed child-care program and parks and recreation programs that receive these funds are included in the data set, the totality of licensed school-age child-care programs and parks and recreation programs are not reflected in the current landscape. Programs that are funded solely by private means (foundations, corporate support or participant fees) are also not included. At the State level, a registry system for OST opportunities should be a long term goal to gain a complete understanding of the landscape of opportunities outside the school day.

In the 2012 Session, the Maryland Legislature passed SB524/HB886 which updates the original Maryland Afterschool Opportunity Fund (MASOF) legislation, renaming it to the Maryland Afterschool and Summer Opportunity Fund, moving the oversight to the Governor's Office for Children, reinstating the MASOF Advisory Board, and improving accountability, training and professional development for afterschool and summer programs. Though MASOF is currently unfunded, the renewed emphasis and focus on afterschool with the advisory board will help coordinate and improve current investments and build strategies for leveraging federal and private funds to support afterschool and summer learning opportunities.

Child Poverty

Definition: Children in poverty are part of households where the total income is equal to or below the federal poverty level.[xv]

Percentage of Children Whose Families' Incomes are Below the Poverty Level by Calendar Year, Three Year Averages													
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
MD	12.2	8.9	6.7	6.7	6.9	7.8	8.9	10.4	10.3	10.2	9.9	9.5	11.0
US	19.1	17.9	9.3	7.4	7.3	7.0	7.6	8.5	9.3	9.9	10.2	10.0	10.1

Data Source: 1998-2006 Current Population Survey (CPS) and 2007-2010 American Community Survey (ACS)-Percentage of related children under the age 18 in poverty

Why is the Issue of Poverty Important in Communities?

Maryland's rate of child poverty in 2010 (approximately 13%, or nearly 1 out of 8 children under 18) is far lower than the national average (over 21%, or just over 1 out of 5 children); it has, however, increased dramatically. The 2010 levels of child poverty are the highest seen in the last decade, which means than more children than ever in the last 10 years who are growing 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.

Rising unemployment has doubled from 3.4% in 2007 to 7.8% in 2010 in Maryland and has certainly impacted child poverty in the State. While there is a glimmer of hope for a reduction in child poverty as the unemployment rate decreases to 7.0% during 2011, and 6.9% through March 2012, enduring hope for a substantial and lasting reduction in child poverty is frustrated by economic inequality. A look at income and wealth in the United States indicates that the country has reached levels of disparity that have not been evidenced since the 1920s. Currently, the wealthiest 1% of Americans own 40% of the country's wealth, while 80% of Americans own 7%; moreover, the share of national income currently gained by the wealthiest 1% approaches 70%, which has not been repeated since the Great Depression (90% of Americans take home just over 10%).

The implications of high unemployment and income disparity are staggering for children - these factors combine to produce persistent poverty conditions for children. Poor health is not evenly distributed across populations, but is concentrated among the economically disadvantaged - the lower-income population generally gets sicker and dies earlier than the higher-income population. There is also growing evidence that living in a society with wide disparities in health, wealth, and education negatively impact all society's members, even the wealthy. The hope for the future of the State lies in its ability to care for and nurture the youngest of its members.

Endnotes

[i] This selection is based on the Maryland Sentencing Commission which utilizes the definition of "crime of violence" found in the Md. Code, Correctional Services Article, § 7-101(m) which states violent crime is a crime of violence as defined in § 14-101 of the Criminal law Article, or burglary in the 1st, end, or 3rd degree. Maryland Code, Criminal Law, § 14-401 lists violent offense as murder, manslaughter, except involuntary manslaughter, forcible rape, first degree sex, second degree sex with force or threat, robbery, use of a hand gun in the commission of a felony or other crime of violence, child abuse, car jacking, aggravated assault, and arson first degree.
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 second degree, destructive devices and conspiracy to commit any felony offense.

[ii] http://planning.maryland.gov/msdc/census.

1. "Table 2. Annual Estimates of the Resident Population by Sex and Age for Maryland: April 1, 2000 to July 1, 2009" for FY 2001 to 2009.
2. Actual 2010 is used from the site: http://planning.maryland.gov/msdc/census/cen2010/SF1/AgeProf/age_MDST.pdf; Census 2010, Summary File 1 AGE PROFILE 1: "AGE BY SEX FOR PERSONS IN HOUSEHOLDS AND PERSONS IN GROUP QUARTERS" State of MD.
3. FY 2011 projections were estimated from 'US Census Bureau's 2011 Population Estimates for Maryland's Jurisdictions, Table 1. Total Resident Population for Maryland's Jurisdictions, April 1, 2010 and July 1, 2011"

[iii] Re-referral/arrest refers to any subsequent contact a youth has either in the juvenile or adult system. Re-adjudication/conviction refers to any child or youth who has a judiciary hearing and is adjudicated delinquent or is arrested and has a criminal hearing in the adult system and is convicted or found guilty. Re-commitment/incarceration refers to any juvenile who is again committed to DJS custody for placement or is arrested, convicted, and incarcerated in the adult system.

[iv] The Economic Research Service, US Department of Agriculture, compiles and analyzes data for this indicator from an annual survey conducted by the US 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, 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.*, 2003-2555, 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 is paired and averaged to double the accuracy of the statistics.

[v] Annually, the Census Bureau conducts the Current Population Survey's (CPS) Annual Social and Economic Supplement to collect nationally-representative data assessing food insecurity among households and makes this data publicly available. *Map the Meal Gap: Child Food Insecurity 2011* aggregates this information from the CPS to the State level. With this State-level information, the relationship between children living in food insecure households and key indicators of food insecurity is assessed. The following indicators were used: unemployment rates, child poverty rates, family median income and percentage African American children and Hispanic children. These variables were selected because they are associated with food insecurity and are publicly available at the county, congressional district and state levels through CPS, Bureau of Labor Statistics, American Community Survey (ACS), and, in the case of congressional districts, ProximityOne. In addition, the model controls for state-specific and year-specific factors.
Based on the State-level relationships that exist between the variables described above and food insecurity, county and congressional district-level estimates of children in food insecure households were derived. The county-level results were aggregated to provide the State-level estimates. Estimates were also developed to sort food insecure children into categories based on household income: above and below 185% of the poverty line. This "income banding" of the food insecure child population was prepared using ACS data at the county and congressional district levels. Detailed information about the methodology can be found in a separate technical brief available on our website.

[vi] The average daily participation (ADP) is calculated by dividing the total number of meals by the number of operation days. For programs that served two meals per day, the meal with the highest total was used to determine the ADP.
County-level data was compiled by GOC based on data from MSDE. MSDE data was designated by individual sponsor; GOC used the location of sponsors to create county totals. The Maryland Food Bank sponsors sites in multiple counties, but is located in Baltimore County. As a result meals served by the Maryland Food Bank in other counties are counted in the Baltimore County total. The Maryland Food Bank served sites in eight counties (Anne Arundel, Baltimore City, Baltimore County, Caroline, Carroll, Dorchester, Somerset and Wicomico) in the summer of 2011.
[vii] Entry into placement can be considered any new enrollment in placement and also re-enrollment in either a different type of placement (like from a group home to foster care), a different jurisdiction (like a transfer from Somerset to Anne Arundel County), or a different placing agency (like DHR or DJS). Thus, the rate of entry counts placements and not children because a child can be placed in more than one category, jurisdiction, or agency in one year. This causes duplication of data and the result is that the numbers coming from the rate of entry will be higher than the number of children who are actually placed.
[viii] The one-day census is derived from a count of all children in placement on one day of the year. This is not the total number of children served in placement, or who were placed, during the course of the year. The number is meant to show how many children may be in placement at any given time. It is possible that the yearly trend of census totals could be the opposite of an increasing or decreasing trend of "total served," depending on children's average length of stay in placement. It must be noted that because some children are placed by more than one agency, there are actually fewer children in placement than the number of placements counted.
[ix] Incidences of crime include offenses that are established by police investigation. 3% of investigations result in an "unfounded" report, where the investigation discloses that no crime occurred. "Crime in Maryland, 2010 Uniform Crime Report." Maryland State Police. P. 13.
[x] *Ibid*.
[xi] "Maryland Fatality Reviews; Homicides among Women and Children." DHMH. P. 5.
[xii] Fight Crime: Invest in Kids. (2002).
[xiii] Durlak, J. A., Weissberg, R. P., & Pachan, M. (2010). A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. American Journal of Community Psychology, 45, 294-309.
[xiv] Afterschool Alliance. (2009). Maryland after 3p.m.
[xv] Information about the federal poverty thresholds and guidelines can be found at: http://aspe.hhs.gov/poverty/12poverty.shtml#thresholds

Appendix

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, CY2011
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 placements, FY10 to FY11
Rate of Change = {[(FY11 rate of placement) ÷ (FY10 rate of placement)] - 1} x 100
= {[10.9 ÷ 11.2] - 1} x 100
= -2.7% is the rate of change in the rate of placements from FY10 to FY11.

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.

Births to Adolescents

Birth Rate per 1,000 Women in Specified Age Group, 2010				
Region and Political Subdividion	**10-14 yrs**	**15-17 yrs**	**18-19 yrs**	**15-19 yrs**
Maryland	**0.4**	**13.5**	**47.5**	**27.2**
Northwest Area	**	**11.4**	**49.8**	**26.9**
Garrett	**	7.6	69.6	30.7
Allegany	**	19.0	41.1	31.8
Washington	**	12.4	76.9	36.0
Frederick	**	9.5	37.4	19.8
Baltimore Area	**0.5**	**14.9**	**47.8**	**28.4**
Baltimore City	1.8	37.7	68.7	53.3
Baltimore County	**	10.6	37.5	22.5
Anne Arundel	0.3	12.3	49.6	25.8
Carroll	**	5.2	34.7	15.5
Howard	**	2.9	28.2	10.1
Harford	**	7.6	34.7	16.9
National Capitol Area	**0.4**	**12.5**	**47.2**	**25.7**
Montgomery	0.3	7.8	39.2	17.4
Prince George's	0.5	17.7	52.1	33.1
Southern Area	**0.4**	**10.0**	**44.1**	**22.2**
Calvert	**	6.1	43.4	17.9
Charles	**	10.4	46.9	22.8
Saint Mary's	**	13.4	41.2	24.9
Eastern Shore Area	**0.5**	**15.3**	**47.3**	**30.4**
Cecil	**	14.2	63.1	32.1
Kent	**	**	20.9	15.5
Queen Anne's	**	8.0	32.4	16.4
Caroline	**	16.1	81.4	41.4
Talbot	**	7.2	47.8	20.4
Dorchester	**	16.0	117.0	55.1
Wicomico	**	22.4	36.7	30.9
Somerset	**	40.4	28.5	31.6
Worcester	**	8.7	64.2	26.6

**Rates based on fewer than five events in the numerator are not presented since such rates are likely to be unstable.

Infant Mortality

Region and Political Subdivision	Infant Mortality Rates per 1,000 in the Population					
	All	White		Black		
	Deaths	Total	Non-Hispanic	Total	Non-Hispanic	Hispanic*
Maryland	**6.7**	**4.1**	**4.2**	**11.8**	**12**	**4.1**
Northwest Area	5	4.4	4.4	12.4	12.9	***
Garrett	***	***	***	***	***	0
Allegany	6.8	7.1	7.2	***	***	***
Washington	6.2	4	4.2	25	26	***
Frederick	3.2	3	2.6	***	***	***
Baltimore Area	**7.2**	**3.8**	**4**	**13.7**	**13.6**	**4**
Baltimore City	11	3.6	4	14.7	14.8	***
Baltimore County	6.7	4.4	4.8	11.6	11.8	***
Anne Arundel	4.7	3.3	2.8	10.9	10.4	8.5
Carroll	5	4.6	4.8	***	***	***
Howard	6.8	3.5	4.3	19.4	19.7	***
Harford	5.5	3.7	3.9	11.2	***	***
National Capitol Area	**6.6**	**4.1**	**4.5**	**10**	**10.4**	**3.6**
Montgomery	4.3	3.3	3.1	7	7.2	3.7
Prince George's	9	5.8	10.2	11.1	11.5	3.5
Southern Area	**5.8**	**5.4**	**5.4**	**6.8**	**6.9**	***
Calvert	***	***	***	***	***	***
Charles	5.6	***	***	5.9	6.1	***
Saint Mary's	7.6	6.8	7.2	***	***	***
Eastern Shore Area	**6.9**	**4.5**	**3.8**	**15.1**	**15.3**	***
Cecil	5.9	***	***	***	***	***
Kent	***	***	***	***	***	***
Queen Anne's	10.3	***	***	***	***	***
Caroline	***	***	***	***	***	***
Talbot	***	***	***	***	***	***
Dorchester	***	***	***	***	***	***
Wicomico	5.6	***	***	***	***	***
Somerset	***	***	***	***	***	***
Worcester	16.7	15.3	***	***	***	***

*Includes all deaths to persons of Hispanic origin of any race.
***Rates based on fewer than five events in the numerator are not presented since such rates are likely to be unstable.

Data Source: MD DHMH, Vital Statistics Administration Annual Report 2010

Low Birth Weight

Percentage of Low Birth Weight[1] Infants by Race and Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2010					
Region and Political Subdivision	**All Births[2]**	**White non-Hispanic**	**Black non-Hispanic**	**Asian or Pacific Islander**	**Hispanic[3]**
Maryland	**8.8**	**6.9**	**12.1**	**8.9**	**7**
Northwest Area	**8.9**	**8.5**	**12.7**	**13.9**	**6.1**
Garrett	7.9	8	*	*	*
Allegany	10.3	10.8	*	*	*
Washington	9.1	8	19.3	*	6.5
Frederick	8.5	8	9.5	17.2	6.2
Baltimore Area	**9**	**6.8**	**12.8**	**8.9**	**6.8**
Baltimore City	11.7	7.3	14	9.2	6.5
Baltimore County	8.4	6.9	11.3	8.2	7
Anne Arundel	8.2	6.9	13.3	9.2	7.3
Carroll	5.8	5.7	*	11.9	*
Howard	7.7	5.9	10.6	9	7.8
Harford	7.6	7.1	10.4	11	*
National Capitol Area	**8.9**	**6.7**	**11.3**	**8.7**	**7.1**
Montgomery	7.7	6.9	9.6	8.6	6.7
Prince George's	10.2	6.1	11.9	9	7.6
Southern Area	**7.3**	**5.4**	**11.2**	**8.1**	**7.7**
Calvert	6	5.8	7.6	*	*
Charles	9.8	6.5	12.4	11.6	10.6
Saint Mary's	4.9	4.5	8.3	*	*
Eastern Shore Area	**8.3**	**7.3**	**11.9**	**6.6**	**7.5**
Cecil	7.8	7.6	10.4	*	*
Kent	10.8	10.3	*	*	*
Queen Anne's	10.5	8.4	27.9	*	14
Caroline	8.6	7	17.3	*	*
Talbot	6.7	6	12.5	*	*
Dorchester	11.3	8.3	15.3	*	13.5
Wicomico	8.2	6.7	10.4	*	9.5
Somerset	7.4	11.3	*	*	*
Worcester	5.3	3.4	10.7	*	*

1 Weighing 2,499 grams or less.

2 Includes races categorized as "other".

3 Includes all births to mothers of Hispanic origin of any race.

* Percentages based on <5 events in the numerator are not presented since such percentages based on small numbers are unstable.

Data Source: MD DHMH, Vital Statistics Administration Annual Report 2010

Kindergarten Assessment

Percentage of Kindergarten Students Who Are Fully, Approaching, or Developing Readiness for Kindergarten based on the Maryland Kindergarten Assessment			
	Full	**Approaching**	**Developing**
Allegany	90	8	2
Anne Arundel	86	12	1
Baltimore County	87	11	2
Calvert	87	11	2
Caroline	97	3	0
Carroll	95	4	1
Cecil	78	19	3
Charles	83	15	2
Dorchester	79	15	6
Frederick	88	10	2
Garrett	91	7	2
Harford	87	12	2
Howard	87	12	2
Kent	84	15	1
Montgomery	81	17	3
Prince George's	77	19	4
Queen Anne's	91	8	1
Saint Mary's	93	6	1
Somerset	93	5	2
Talbot	82	15	3
Washington	78	19	3
Wicomico	88	10	2
Worcester	89	9	2
Baltimore City	73	23	4
All Public Schools	83	15	3

Academic Performance

	ALGEBRA 2011				BIOLOGY 2011				ENGLISH 2011			
Jurisdiction	Advanced	Proficient	Basic	Total Passing	Advanced	Proficient	Basic	Total Passing	Advanced	Proficient	Basic	Total Passing
Allegany	23.5	60.9	15.7	84.4	13.5	69.1	17.3	82.6	27.2	50.4	22.4	77.6
Anne Arundel	38.8	51.6	9.6	90.4	18.5	68.3	13.2	86.8	31.1	55.8	13.1	86.9
Baltimore County	26.4	58.4	15.2	84.8	15.1	66.1	18.8	81.2	27.4	57.6	15.1	85.0
Calvert	41.6	54.7	3.7	96.3	36.2	61.5	2.3	97.7	44.1	50.7	5.2	94.8
Caroline	25.3	62.1	12.5	87.4	14.2	72.4	13.4	86.6	19.9	58.4	21.8	78.3
Carroll	35.0	58.3	6.7	93.3	32.1	57.1	10.8	89.2	34.0	55.1	10.9	89.1
Cecil	36.3	54.2	9.5	90.5	17.0	68.2	14.8	85.2	28.0	55.9	16.1	83.9
Charles	25.4	63.4	11.3	88.8	16.8	67.3	15.8	84.1	20.3	64.9	14.8	85.2
Dorchester	39.0	45.6	15.4	84.6	15.7	59.5	24.8	75.2	21.1	53.2	25.7	74.3
Frederick	37.7	53.4	8.9	91.1	26.9	63.4	9.7	90.3	35.8	51.8	12.4	87.6
Garrett	32.2	59.2	8.6	91.4	13.4	78.2	8.4	91.6	24.6	62.6	12.8	87.2
Harford	31.1	58.4	10.6	89.5	16.7	69.4	13.9	86.1	31.6	52.7	15.7	84.3
Howard	54.1	41.8	4.1	95.9	39.8	54.3	6.0	94.1	47.6	43.7	8.6	91.3
Kent	8.3	72.2	19.4	80.5	11.0	63.4	25.5	74.4	16.6	64.8	18.6	81.4
Montgomery	40.5	48.4	11.1	88.9	31.8	58.2	10.0	90.0	39.3	47.5	13.2	86.8
Prince George's	13.8	54.1	32.2	67.9	6.8	57.0	36.2	63.8	13.7	56.8	29.5	70.5
Queen Anne's	36.4	55.3	8.2	91.7	15.1	77.0	8.0	92.1	33.2	53.9	12.9	87.1
Saint Mary's	34.6	56.2	9.2	90.8	34.6	58.9	6.5	93.5	36.2	51.7	12.1	87.9
Somerset	20.2	58.9	20.9	79.1	6.5	64.9	28.6	71.4	17.0	58.8	24.2	75.8
Talbot	34.0	51.0	14.9	85.0	11.3	69.6	19.1	80.9	33.4	46.6	19.9	80.0
Washington	38.5	56.1	5.4	94.6	18.5	71.6	9.9	90.1	29.0	59.0	12.1	88.0
Wicomico	21.4	56.1	22.5	77.5	8.8	66.9	24.3	75.7	24.3	54.0	21.7	78.3
Worcester	42.6	50.4	7.0	93.0	24.6	63.2	12.2	87.8	33.8	50.4	15.8	84.2
Baltimore City	6.8	55.0	38.2	61.8	4.9	52.8	42.4	57.7	7.9	53.0	39.1	60.9
All Public Schools	30.0	53.6	16.4	83.6	19.8	61.5	18.7	81.3	28.4	53.4	18.3	81.8

Academic Performance

Percentage of Students' Scores on the Maryland State Assessment for Reading, Math, and Science Tests, AY 2011				
	% Scoring At or Above Proficient	% Advanced	% Proficient	% Basic
Allegany	80.9%	29.7%	51.2%	18.9%
Anne Arundel	85.4%	39.2%	46.3%	14.2%
Baltimore County	80.4%	31.4%	49.0%	19.6%
Calvert	90.3%	42.0%	48.3%	9.0%
Caroline	85.5%	33.7%	51.8%	14.5%
Carroll	88.4%	38.0%	50.4%	10.9%
Cecil	79.5%	26.4%	53.1%	20.3%
Charles	79.7%	28.8%	50.9%	20.1%
Dorchester	73.8%	23.7%	50.1%	26.0%
Frederick	87.2%	36.0%	51.2%	12.1%
Garrett	86.9%	31.1%	55.7%	13.1%
Harford	84.4%	33.6%	50.8%	15.6%
Howard	89.4%	46.5%	42.9%	10.0%
Kent	79.4%	25.3%	54.1%	20.1%
Montgomery	84.5%	39.6%	44.9%	15.4%
Prince George's	68.7%	18.5%	50.2%	30.8%
Queen Anne's	90.1%	40.1%	50.0%	8.9%
Saint Mary's	85.7%	37.2%	48.5%	14.3%
Somerset	83.6%	24.7%	58.9%	16.1%
Talbot	81.7%	29.8%	51.9%	18.3%
Washington	83.7%	34.2%	49.6%	16.3%
Wicomico	78.5%	27.6%	50.8%	21.1%
Worcester	91.0%	47.7%	43.2%	7.5%
Baltimore City	60.2%	13.2%	47.0%	39.5%
Total MD Public Schools	79.9%	31.8%	48.2%	20.1%

Truancy

Percentage of Maryland Public School Students Who Are Absent More than 20 Days of the School Year, AY 2011	
Allegany	11.8%
Anne Arundel	8.1%
Baltimore County	12.1%
Calvert	3.0%
Caroline	10.9%
Carroll	5.6%
Cecil	15.1%
Charles	8.6%
Dorchester	15.2%
Frederick	7.6%
Garrett	3.9%
Harford	8.0%
Howard	4.9%
Kent	12.0%
Montgomery	5.9%
Prince George's	15.4%
Queen Anne's	6.1%
Saint Mary's	10.2%
Somerset	11.4%
Talbot	8.9%
Washington	6.0%
Wicomico	10.7%
Worcester	10.7%
Baltimore City	25.0%
Total MD Public Schools	11.3%

Academic Performance

Percentage of Students with Disabilities Scores on the Alternate-Maryland State Assessment for Reading, Math, and Science Tests, AY 2011				
	% Scoring At or Above Proficient	% Advanced	% Proficient	% Basic
Allegany	78.9%	24.6%	54.4%	21.1%
Anne Arundel	93.1%	61.1%	32.1%	6.3%
Baltimore County	93.8%	65.4%	28.4%	5.0%
Calvert	92.3%	37.6%	54.7%	7.7%
Caroline	76.7%	36.7%	40.0%	23.3%
Carroll	88.8%	44.7%	44.2%	11.2%
Cecil	90.4%	53.6%	36.8%	9.6%
Charles	82.7%	44.9%	37.8%	17.3%
Dorchester	*	*	*	*
Frederick	91.3%	53.9%	37.4%	8.1%
Garrett	*	*	*	*
Harford	91.2%	48.0%	43.2%	8.4%
Howard	88.6%	53.8%	34.8%	10.7%
Kent	*	*	*	*
Montgomery	91.6%	57.7%	33.8%	7.9%
Prince George's	86.0%	46.0%	40.1%	13.7%
Queen Anne's	*	*	*	*
Saint Mary's	95.3%	53.2%	42.1%	3.7%
Somerset	*	*	*	*
Talbot	*	*	*	*
Washington	95.2%	68.6%	26.6%	3.8%
Wicomico	92.6%	59.7%	32.9%	7.4%
Worcester	*	*	*	*
Baltimore City	78.9%	41.1%	37.8%	21.1%
Total MD Public Schools	89.2%	53.3%	35.9%	10.6%

Dropout

Percentage of Public School Students Who Drop Out of School From Grade 9 through 12	
Allegany	<= 3.00
Anne Arundel	3.24
Baltimore County	3.57
Calvert	<= 3.00
Caroline	3.21
Carroll	<= 3.00
Cecil	3.13
Charles	<= 3.00
Dorchester	<= 3.00
Frederick	<= 3.00
Garrett	<= 3.00
Harford	<= 3.00
Howard	<= 3.00
Kent	<= 3.00
Montgomery	<= 3.00
Prince George's	5.82
Queen Anne's	<= 3.00
Saint Mary's	3.29
Somerset	4.23
Talbot	<= 3.00
Washington	<= 3.00
Wicomico	4.81
Worcester	<= 3.00
Baltimore City	4.19
Total MD Public Schools	3.18

High School Program Completion

Percent of Students who Completed the Course Requirements to Enter the University of MD System, a Career Technology Education Program, or Both			
	% Complete Credits to Enter University of MD System	% Completed CTE Program	% Completed Both
Allegany	54.3%	10.4%	9.1%
Anne Arundel	59.5%	9.6%	10.1%
Baltimore County	73.9%	6.0%	13.0%
Calvert	58.8%	23.2%	17.6%
Caroline	50.1%	23.1%	23.1%
Carroll	46.4%	17.8%	15.0%
Cecil	46.4%	14.3%	15.6%
Charles	52.8%	11.1%	13.5%
Dorchester	49.3%	31.3%	5.9%
Frederick	72.7%	10.9%	9.9%
Garrett	35.9%	41.2%	21.5%
Harford	52.3%	13.8%	14.5%
Howard	64.1%	7.2%	9.2%
Kent	*	*	*
Montgomery	71.5%	*	*
Prince George's	27.9%	*	*
Queen Anne's	55.5%	9.7%	30.6%
Saint Mary's	48.9%	35.6%	14.6%
Somerset	50.3%	35.6%	0.0%
Talbot	39.4%	26.3%	24.6%
Washington	58.3%	30.2%	10.4%
Wicomico	47.8%	14.4%	11.9%
Worcester	66.9%	*	26.3%
Baltimore City	67.5%	*	18.8%
Total MD Public Schools	57.7%	8.3%	9.7%

Juvenile Felony Offenses

Violent Crime in Maryland per 1,000 Persons, 2005-2009										
	2005		2006		2007		2008		2009	
	Number of Crimes	Rate Per 1000 Persons	Number of Crimes	Rate Per 1000 Persons	Number of Crimes	Rate Per 1000 Persons	Number of Crimes	Rate Per 1000 Persons	Number of Crimes	Rate Per 1000 Persons
MARYLAND *	**39369**	**7.1**	**38110**	**6.8**	**36062**	**6.4**	**35394**	**6.3**	**33626**	**5.9**
Baltimore Region	**21986**	**8.4**	**21575**	**8.2**	**20560**	**7.8**	**19938**	**7.6**	**19204**	**7.3**
Anne Arundel County	3167	6.2	3167	6.2	3068	6	2931	5.7	2920	5.6
Baltimore County	5650	7.2	5713	7.3	5381	6.8	4931	6.3	4555	5.8
Carroll County	400	2.4	374	2.2	359	2.1	360	2.1	393	2.3
Harford County	845	3.6	826	3.4	933	3.9	879	3.6	884	3.6
Howard County	615	2.3	624	2.3	590	2.2	705	2.5	751	2.7
Baltimore City	11309	17.7	10871	17	10229	16	10132	15.9	9701	15.2
Suburban Washington Region	**12429**	**6.2**	**11537**	**5.8**	**10529**	**5.3**	**10424**	**5.2**	**9576**	**4.7**
Frederick County	736	3.4	752	3.4	807	3.6	793	3.5	793	3.5
Montgomery County	2196	2.4	2304	2.5	2207	2.3	2231	2.3	2162	2.2
Prince George's County	9497	11.3	8481	10.1	7515	9	7400	8.9	6621	7.9
Southern Maryland Region	**1350**	**4.2**	**1306**	**4**	**1452**	**4.4**	**1465**	**4.4**	**1280**	**3.8**
Calvert County	231	2.7	257	2.9	279	3.2	367	4.1	271	3
Charles County	759	5.5	729	5.2	846	6	794	5.6	701	4.9
St. Mary's County	360	4.9	320	4.9	327	4.7	304	3.6	308	3.9
Western Maryland Region	**843**	**3.5**	**913**	**3.7**	**832**	**3.4**	**753**	**3**	**786**	**3.2**
Allegany County	260	3.6	282	3.9	262	3.6	240	3.3	323	4.5
Garrett County	62	2.1	63	2.1	64	2.2	71	2.4	68	2.3
Washington County	521	3.7	568	4	506	3.5	442	3	395	2.7
Upper Eastern Shore Region	**913**	**4**	**959**	**4.1**	**1025**	**4.4**	**1095**	**4.6**	**1161**	**4.9**
Caroline County	155	4.9	149	4.6	123	3.7	123	3.7	126	3.8
Cecil County	474	4.9	490	5	568	5.7	540	5.4	746	7.4
Kent County	89	4.5	76	3.8	80	4	113	5.6	86	4.2
Queen Anne's County	72	1.6	128	2.8	142	3	161	3.4	117	2.4
Talbot County	123	3.4	116	3.2	112	3.1	158	4.4	86	2.4
Lower Eastern Shore Region	**1644**	**8.4**	**1587**	**8**	**1382**	**6.9**	**1525**	**7.6**	**1482**	**7.4**
Dorchester County	174	5.6	181	5.8	160	5	187	5.8	183	5.7
Somerset County	124	3.7	127	3.2	122	3.3	94	3	102	3
Wicomico County	423	4.7	348	3.8	290	3.1	234	2.5	271	2.9
Worchester County	923	18.9	931	19	810	16.5	1010	20.5	926	18.9

Hunger

Summer Food Service Program Average Daily Participation										
		2009			2010			2011		
Jurisdiction	Population (2010 Census)	Total Student Enrollment	Total # of F/R Students	Average Daily Participation	Total Student Enrollment	Total # of F/R Students	Average Daily Participation	Total Student Enrollment	Total # F/R Students	Average Daily Participation
Maryland	5,773,552	849,319	294,122	35,870	850,252	326,871	38,220	853,696	343,569	35,807
Allegany	75,087	9,210	4,478	316	9,143	4,573	309	9,007	4,657	321
Anne Arundel	537,656	73,493	16,689	657	74,628	19,335	1,050	75,351	21,097	1,270
Baltimore City	620,961	83,539	60,480	15,075	83,676	69,862	15,951	84,605	70,962	16,066
Baltimore County	805,029	103,676	37,816	3,674	103,825	40,806	4,966	104,309	44,108	3,732
Calvert	88,737	17,095	2,678	97	16,627	3,192	81	16,421	3,592	111
Caroline	33,066	5,751	2,802	50	5,701	2,989	69	5,673	3,030	132
Carroll	167,134	28,979	3,569	*	28,306	4,077	*	27,903	4,351	*
Cecil	101,108	16,483	5,120	228	16,189	5,709	299	15,923	6,108	65
Charles	146,551	26,877	6,716	526	26,839	7,240	723	26,908	7,686	335
Dorchester	32,618	4,668	2,470	247	4,713	2,689	296	4,720	2,829	265
Frederick	233,385	40,170	7,419	225	40,121	8,465	310	40,281	9,213	485
Garrett	30,097	4,556	1,965	88	4,444	2,155	92	4,349	2,074	60
Harford	244,826	38,610	8,798	530	38,639	9,920	610	38,395	10,516	545
Howard	287,085	50,025	6,440	*	50,758	7,374	*	51,079	8,201	30
Kent	20,197	2,218	920	136	2,182	988	159	2,199	1,083	127
Montgomery	971,777	139,458	37,777	4,104	141,888	41,514	3,287	144,217	44,290	3,164
Prince George's	863,420	129,865	60,719	7,720	127,309	67,382	7,773	126,723	69,020	6,901
Queen Anne's	47,798	7,871	1,324	103	7,853	1,627	90	7,831	1,777	92
St. Mary's	105,151	16,790	4,203	118	17,139	4,544	120	17,349	5,039	123
Somerset	26,470	2,917	1,698	347	2,891	1,853	380	2,911	1,918	281
Talbot	37,782	4,467	1,409	83	4,552	1,541	37	4,509	1,591	*
Washington	147,430	21,269	8,771	547	21,338	9,113	658	21,633	9,781	873
Wicomico	98,733	14,555	7,430	587	14,555	7,134	510	14,341	7,667	454
Worcester	51,454	6,777	2,429	409	6,776	2,677	449	6,821	2,813	373

*Program not in operation

Out of Home Placement

Out-of-Home Placement - Rate of Entry into Placement						
Jurisdiction	**FY2009**	**FY2010**	**FY2011**	**Two Year Change**	**One Year Change**	**Average Change**
Allegany	18	13.9	14.4	-25%	3%	-13%
Anne Arundel	5.5	5.5	4.9	-12%	-12%	-6%
Baltimore	9.2	10.3	9.7	5%	-6%	2%
Calvert	6.8	9	9.4	28%	4%	14%
Caroline	14	12.7	14.2	1%	11%	0%
Carroll	4.6	5.3	6.2	26%	15%	14%
Cecil	11.1	13	13.4	17%	3%	9%
Charles	7.3	8.1	7.7	5%	-5%	2%
Dorchester	17.4	19.5	16.3	-7%	-20%	-4%
Frederick	6.7	8.4	7.6	12%	-11%	5%
Garrett	17.8	22	15.5	-15%	-42%	-11%
Harford	9	8.1	8.2	-10%	1%	-5%
Howard	3.2	2.9	2.9	-10%	0%	-5%
Kent	18.3	11.3	9.9	-85%	-14%	-38%
Montgomery	6.4	5.6	5.2	-23%	-8%	-11%
Prince George's	5.3	5.9	5.7	7%	-4%	3%
Queen Anne's	9.2	8.5	6.6	-39%	-29%	-19%
Somerset	11.9	17.1	15.4	23%	-11%	10%
St. Mary's	8.9	8.2	11.7	24%	30%	11%
Talbot	10.9	9.8	11.5	5%	15%	2%
Washington	13	13.1	13.8	6%	5%	3%
Wicomico	11.5	10.6	10.9	-6%	3%	-3%
Worcester	13.8	14.8	12.8	-8%	-16%	-4%
Baltimore City	43.5	44.7	43.1	-1%	-4%	-1%
MD Average	11.4	11.6	11.2	-2%	-4%	-1%

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