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December 1, 2021

The Honorable Larry Hogan
Governor
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Vanessa E. Atterbeary
Chair, House Ways and Means Committee
House Office Building, Room 131
6 Bladen Street
Annapolis, MD 21401

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Senator Mary Washington
Co-Chair, Joint Committee on Children, Youth and Families
102 James Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Delegate Ariana B. Kelly
Co-Chair, Joint Committee on Children, Youth and Families
425 House Office Building
6 Bladen Street
Annapolis, MD 21401

Dear Governor Hogan, Madam Chair Atterbeary, Madam Chair Kelley, Madam Chair Washington, and Madam Chair Kelly:

RE: Human Services Article § 8-507(c); Chapters 79(2) and 80(2) of 2012 (Senate Bill 566/House Bill 699)

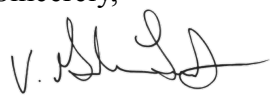
In accordance with the Home Visiting Accountability Act of 2012 (SB566/HB699) and Human Services Article §8-506 and 8-507 of the Annotated Code of Maryland, the Governor's Office of Crime Prevention, Youth, and Victim Services together with and on behalf of the Children's Cabinet is required to submit a report every two years on State-funded home visiting programs.

This report is the latest summary of Maryland's efforts to improve outcomes for young children through home visiting programs that support maternal, child, and family health. It describes the results of standardized reporting from sites across program models and

funding sources, and compares data from the baseline collection completed for FY 2015 through FY 2021. This data will be used to inform future decisions regarding home visiting investments and will allow stakeholders to look at home visiting in Maryland through a single lens.

Should you have any questions relating to the information provided in this report, please feel free to contact me at 410-697-9338.

Sincerely,



V. Glenn Fueston, Jr.
Executive Director
Governor's Office of Crime Prevention, Youth, and Victim Services

cc: Sarah Albert, Department of Legislative Services (5 copies)

Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland

Human Services Article § 8-507(c); Chapters 79(2) and 80(2) of 2012 (Senate Bill 566/House Bill 699)

Larry Hogan
Governor

Boyd K. Rutherford
Lt. Governor

V. Glenn Fueston, Jr.
Executive Director
Governor's Office of Crime Prevention, Youth, and Victim Services

Submitted on behalf of the Maryland Children's Cabinet
by the Governor's Office of Crime Prevention, Youth, and Victim Services

Contact: Cameron Edsall
410-697-9382 | Cameron.Edsall2@Maryland.gov

December 1, 2021
MSAR #12663

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Maryland's Children's Cabinet

The Children's Cabinet coordinates the child and family-focused service delivery system by emphasizing prevention, early intervention, and community-based services for all children and families.[1] The Children's Cabinet includes the Secretaries from the Departments of Budget and Management, Disabilities, Health, Human Services, and Juvenile Services; and the State Superintendent of Schools for the Maryland State Department of Education and the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services (*as illustrated below*).

V. Glenn Fueston, Jr., Chair
Executive Director
Governor's Office of Crime Prevention, Youth, and Victim Services

Sam J. Abed
Secretary, Department of Juvenile Services

Carol A. Beatty
Secretary, Department of Disabilities

David R. Brinkley
Secretary, Department of Budget and Management

Lourdes R. Padilla
Secretary, Department of Human Services

Dennis R. Schrader
Secretary, Maryland Department of Health

Mohammed Choudhury
State Superintendent of Schools, Department of Education

[1] Governor's Office of Crime Prevention, Youth, and Victim Services. *Maryland's Children's Cabinet*.

Acknowledgements

The Children's Cabinet gratefully acknowledges the hard work and dedication of the Maryland Department of Health's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program staff whose contributions with respect to data collection and analysis and preparation of the report were invaluable.

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Background: Maryland's Home Visiting Accountability Act of 2012

In March 2010, the Affordable Care Act established the MIECHV program which provided federal funds for evidence-based home visiting programs in each state and the U.S. territories based on the number of children living below poverty level. The major provisions of the MIECHV program require states to: 1) provide at least 75% of funding to home visiting programs that were evidence-based; 2) direct up to 25% of funding for "promising practice" approaches that had an evaluation component to determine effectiveness; and 3) complete a statewide needs assessment to inform decision making in the allocation of funds to the most vulnerable communities.

With the influx of MIECHV funds to Maryland in the form of both the initial formula funding (based on number of children below poverty level) and subsequent competitive awards, there was great interest to align State funding policy with federal policy. With assistance from the Pew Charitable Trusts Home Visiting Campaign, Maryland aligned State funding policy for home visiting programs with the federal MIECHV guidelines through the Home Visiting Accountability Act of 2012.

Maryland's Home Visiting Accountability Act of 2012 included new requirements for State-funded home visiting programs:

1. At least 75% of programs funded with State funding need to be evidence-based. Up to 25% of State-funded programs can be Promising Practice programs, defined as programs that have an evaluation component with a systematic method of establishing progress toward program goals and objectives, but, unlike evidence-based programs, have not undergone rigorous randomized control trial evaluation.
2. State-funded home visiting programs must submit regular reports that identify the number and demographic characteristics of women and children served and outcomes achieved.

In accordance with the Home Visiting Accountability Act of 2012 and §§ 8-506 and 8-507 of the Human Services Article, the Governor's Office for Children, together with and on behalf of the Children's Cabinet, reviewed current practices of home visiting programs in Maryland.[2] This review recommended the development of a "standardized reporting mechanism for the purpose of collecting information about and monitoring the effectiveness of State-funded home visiting programs." Beginning in FY 2015, recipients of State funding for home visiting programs

[2] Maryland General Assembly. (2012). *Chapters 79(2) and 80(2) of 2012 (Senate Bill 566/House Bill 699), Home Visiting Accountability Act of 2012*.

were required to report to the Governor's Office for Children on the standardized reporting measures adopted by the Children's Cabinet. In addition, § 8-507(c) of the Human Services Article required the Governor's Office for Children and agencies of the Children's Cabinet to report every two years, beginning with FY 2015, on the implementation and outcomes of State-funded home visiting programs.[3]

Although the MIECHV funds were separated from the Affordable Care Act in 2015, the benchmarks and rigorous data collection remained and became embedded as the foundation for this report. The standardized reporting measures adopted by the Children's Cabinet to evaluate home visiting were grouped in the following five domains:

- Child Health
- Maternal Mental Health
- Typical Child Development
- Children's Special Needs
- Family Relationships

A full breakdown of the standardized measures associated with each of the five domains can be found in Table 5 on page 29 of this Report.

Introduction: FY 2021 Statewide Home Visiting Data Collection Survey

This *FY 2021 Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland* (Report) represents the fourth summary of Maryland's efforts to improve outcomes for vulnerable populations through home visiting programs that support maternal, child, and family health. It describes the results of standardized reporting from sites across program models and funding sources, and compares data from the new baseline collection completed for FY 2019, the prior data collection period for FY 2017, and the original data collection from FY 2015 when applicable.

Background on Home Visiting

Home visiting is a term used to describe a voluntary support strategy in the early childhood system of care that addresses maternal, child, and family health and achievement outcomes and helps parents create healthy, positive environments for their baby and family. Home visiting programs pair new and expectant parents with trained professionals to provide parenting information, resources, and support during pregnancy and throughout the child's first two to five years. Home visiting programs have been available in all 24 Maryland jurisdictions

[3] Ibid.

historically, but an increase in closures and programs no longer offering home visiting services has reduced that number to 23 as of FY 2021.

Evidence-based home visiting models have undergone rigorous evaluation and have been shown to improve maternal and child outcomes by connecting families to essential community services; improving maternal health; strengthening parent-child relationships; promoting healthy development of children's cognitive, physical, and social emotional growth; and reducing the risk factors for child abuse and neglect.[4, 5]

Evidence-based home visiting programs are designed to ensure:

- Babies are born healthy and have opportunities to grow up healthy;
- Family bonds are strong and supportive;
- Family members are connected to essential community resources for health and self-sufficiency; and,
- Children enter school ready to learn.

Maryland's Home Visiting Program Models

In Maryland, five prevailing evidence-based home visiting program models are in operation for maternal and child home visiting:

- **Early Head Start (EHS)** focuses on low-income pregnant individuals and families with children from birth to three years of age. Low income is defined as being at or below the Federal Poverty Level or eligible for Part C services under the Individuals with Disabilities Education Act.
- **Healthy Families America (HFA)** focuses on parents facing challenges such as single parenthood, low income, childhood history of abuse, substance use, mental health issues, and/or domestic violence. Families are enrolled during the pregnancy or within the first three months after a child's birth. Once enrolled, services are available until the child enters kindergarten.
- **Home Instruction Program for Preschool Youngsters (HIPPY)** promotes school readiness by supporting parents with instruction provided in the home. The model targets parents who lack confidence in their ability to prepare their children for school. It offers weekly activities for 30 weeks of the year, and serves children ages three to five years old.

[4] Ammerman, R. T., Putnam, F. W., Altaye, M., Teeters, A. R., Stevens, J., & Van Ginkel, J. B. (2013). Treatment of depressed mothers in home visiting: Impact on psychological distress and social functioning. *Child abuse & neglect*,*37*(8), 544-554.

[5] Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., ... & Holmberg, J. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics*, *114*(6), 1550-1559.

- **Nurse-Family Partnership (NFP)** is designed for first-time, low-income mothers and their children. The program reinforces maternal behaviors that encourage positive parent-child relationships and maternal, child, and family accomplishments. Visits begin early in the mother's pregnancy and conclude when the child turns two years old.
- **Parents as Teachers (PAT)** programs provide parents with child development knowledge and parenting support. This model provides one-on-one home visits, group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits using a structured curriculum. Local sites decide on the intensity of home visits, ranging from weekly to monthly and the duration during which home visitation is offered. This model may serve families at any point from pregnancy to when the child enters kindergarten.

Although these are the prevailing models in Maryland, other evidence-based programs are in operation in the State, albeit on a much smaller scale. These programs are largely supported through federal, local, and philanthropic funding sources. The following two evidence-based models are offered by a home visiting program in Baltimore City:

- **Family Connects** is a universal nurse home visiting program available to all families with newborns residing within a defined service area. The program aims to support families' efforts to enhance maternal and child health and well-being and reduce rates of child abuse and neglect. It consists of one to three nurse home visits, typically when the infant is two to 12 weeks old, and follow-up contacts with families and community agencies to confirm families' successful linkages with community resources. During the initial home visit, a nurse conducts a physical health assessment of the mother and newborn, screens families for potential risk factors associated with mother's and infant's health and well-being, and may offer direct assistance (such as guidance on infant feeding and sleeping). If a family has a significant risk or need, the nurse connects the family to community resources. Program staff collaborate with the local department of social services and other local agencies that serve families with children aged birth to five years.[6] Although it is flagged as an evidence-based home visiting program, it is primarily a care coordination resource into programs like home visiting or other needed services.
- **Attachment Bio-Behavioral Catch-up** is a training program for caregivers of infants and young children six to 24 months old, including high-risk birth parents and caregivers of young children in foster care, kinship care (such as a grandparent raising a grandchild), and adoptive care. Parent coaches conduct 10 weekly home visits. The program is designed to help caregivers provide nurturance even when children do not appear to need it, mutually responsive interactions in which caregivers follow children's lead, and

[6] https://homvee.acf.hhs.gov/Model/1/Durham-Connects-Family-Connects/59/1

non-frightening care. Parent coaches provide immediate feedback on the caregivers' interaction with the child to help the caregivers attend to the target behaviors.[7]

In Maryland, there are other home visiting programs in operation that do not have the evidence base as determined by rigorous randomized control trials to determine their effectiveness in meeting targeted outcomes. These programs, referred to as "promising practices," are often funded by local government and provide home visiting services to locally-defined and identified at-risk populations. In FY 2021, seven "promising practices" in operation were identified in five jurisdictions.[8] These programs include:

- **Healthy Start** (Anne Arundel County) is a nurse home visiting program providing case management, home visiting, outreach, and other services that help to prevent injuries and deaths to high-risk pregnant individuals and children up to two years old. These services are provided by community health nurses and social workers.[9]
- **HOPE Program** (Baltimore City) is an interconception care program for mothers who have suffered a fetal or infant loss within the last two years. The HOPE Program has adapted the Healthy Families America program model to provide home visiting services to this high risk population to provide emotional support/coping, preventive care, and birth spacing counseling.
- **Healthy Start** (Baltimore City) is a federally-funded initiative to reduce the rate of infant mortality and improve perinatal outcomes in areas with high annual rates of infant mortality in one or more subpopulations. Home visiting services are provided until the child turns two years old.[10]
- **Prenatal Enrichment Program** (Baltimore County) is a nurse home visiting program that provides services to high risk postpartum individuals. Individuals placed at high risk receive visits until their child turns one year old.
- **Maternal-Child Health Program** (Charles County) is a nurse home visiting program that provides services to pregnant and postpartum individuals.
- **High Risk Infants Program** (Prince George's County) provides short term nursing assessment, support, and education to high risk individuals and infants at the time of delivery and in the early months of life via a combination of touch points during the hospital stay and through phone calls and home visits. It is important to note that the High Risk Infants Program ended at the start of FY 2022.
- **Early Care Program** (Worcester County) is a home visiting program for pregnant individuals and infants younger than one year old with high risk needs including

[7] https://homvee.acf.hhs.gov/effectiveness/Attachment%20and%20Biobehavioral%20Catch-Up%20(ABC)%20-Infant/In%20Brief

[8] It is important to note that these "promising practices" do not necessarily meet the HRSA definition of promising practice (i.e., receiving on-going evaluation for evidence of effectiveness).

[9] Anne Arundel County Department of Health. Healthy Start for Pregnant Women, Infants, and Toddlers.

[10] Baltimore Healthy Start, Inc. (2016). *Home Visiting Programs*.

domestic violence, lack of housing or transportation, present or past alcohol or drug use in the family, a teenage or first-time parent, or concerns with depression in the mother. Services provided include educational support and linkages to community resources based on the individual needs of the mother.[11]

Methodology

This Report is the fourth Statewide data collection on the standardized measures for prenatal and postnatal individuals and children served by home visiting programs in Maryland and includes data for FY 2021. Although the Maryland Home Visiting Accountability Act only requires home visiting programs that receive State General Funds to report, all known evidence-based and promising practice home visiting programs regardless of funding source were asked to submit data. Aggregate site-level data were collected for the service period of July 1, 2020 through June 30, 2021 for this report.

An inventory of home visiting programs across Maryland collected in FY 2021 was updated to determine which programs were providing home visiting services during that time. The inventory was created by collecting program lists previously compiled by the Maryland Department of Health, Maryland State Department of Education, Governor's Office of Crime Prevention, Youth, and Victim Services (successor agency to the Governor's Office for Children), Maryland Family Network, and Johns Hopkins School of Public Health. Each home visiting program was contacted by email and/or telephone to verify that the program was still in operation and still providing home visiting services, as well as to confirm the program model and curriculum. The final updated inventory indicated that 54 evidence-based and seven promising practice programs were operational during FY 2021.

The data survey developed in FY 2021 was updated to:

- Utilize more gender-inclusive language
- Add a short, qualitative response section to capture local, contextual information on home visiting programs (per the FY 2019 report recommendation)

The survey was created as a web-based data collection platform and was sent to all known home visiting programs that operated during FY 2021. The survey was launched on July 6, 2021, and sites had until September 13, 2021 to input their data. The Maryland Department of Health administered the survey and provided technical assistance to sites as needed during the data collection process.

[11] https://www.worcesterhealth.org/services/90-general/latest-news/news-section/112-womens-health-article

COVID-19 and Home Visiting

For the FY 2021 reporting year, Maryland home visiting was reshaped as a result of the ongoing COVID-19 pandemic. Programs had to rapidly switch to virtual and telephonic visits, adjust how they were delivering assessments and tools, overcome technology gaps, and cope with a new, more solitary reality as many began to work from home. As a result of the challenges COVID-19 presented, many home visiting programs stopped offering home visiting services. Fourteen EHS programs no longer offer home visiting options as a result. Other programs have closed as well since the FY 2019 report, though not specific to COVID-19, which has resulted in a significant loss of home visiting capacity throughout the State. Other programs that have closed include:

- Baltimore City's Bon Secours EHS and HFA programs;
- Worcester County's HIPPY program; and,
- Talbot County's PAT program.

In total, seven jurisdictions have lost home visiting programs: Anne Arundel (1 EHS), Baltimore City (7 EHS; 1 HFA), Calvert (1 EHS), Caroline (2 EHS), Cecil (1 EHS), Dorchester (1 EHS), Talbot (1 EHS; 1 PAT), and Worcester (1 HIPPY), accounting for 14 EHS, 1 HFA, 1 PAT, and 1 HIPPY program. This represents a loss of 17 programs/services (23%) throughout the State.

Overview of Reporting Programs

A total of 55 out of 61 programs submitted data which represents a return rate of approximately 90%, the same rate as in FY 2019. Of the 55 sites that submitted data, 67.3% (n = 37) received State funding in FY 2021. The remaining sites received some combination of federal, local, and/or philanthropic funding in FY 2021. Twenty-three jurisdictions in the State were represented in the data collection, with at least one home visiting program responding to the data survey. Table 1 provides a snapshot of all the programs that reported FY 2021 data compared to FY 2019, FY 2017, and FY 2015. Appendix A provides details on programs that submitted survey data for FY 2021. Appendix B provides details on all known home visiting programs in Maryland that were asked to submit data.

Table 1. Reporting Program Sites

Measure	FY 2021 Home Visiting Program Sites Reporting	FY 2019 Home Visiting Program Sites Reporting	FY 2017 Home Visiting Program Sites Reporting	FY 2015 Home Visiting Program Sites Reporting
Number of program sites reporting	45***	66**	58	46
Jurisdictions represented	23	24	24	23

Number of women served	3,768	4,357	4,602	0****
Number of "other" primary caregivers served*	71	181	109	0****
Number of children served	3,431	4,108	3,947	0****

*Other primary caregivers include fathers, grandparents, aunts, uncles, cousins, siblings, and foster/adoptive parents.
**Sixty-six sites represented 70 programs - some sites had more than one program per site.
***Forty-five sites represented 55 programs - some sites had more than one program per site.
****Data unavailable due to calculation or collection error.

Table 2 details the number of identified program sites that offered each type of evidence-based and promising practice home visiting model in Maryland. Home visiting programs serving multiple jurisdictions were asked to complete separate surveys for each jurisdiction served. However, in FY 2019, a number of sites submitted surveys containing multiple programs which resulted in the representation of more programs than sites, as a single site can house multiple programs.[12] In addition to providing information on the total number of programs by model, the table provides the number of programs reported for the FY 2021 Home Visiting Standardized Measures survey, and compared to the data collected in FY 2019, FY 2017 and FY 2015. See Appendix A for further details on programs serving multiple jurisdictions.

Table 2. Data-Reporting Sites by Program Model

Program Model	FY 2021 Number of Known Programs	FY 2021 Number of Programs Reporting	FY 2019 Number of Known Programs	FY 2019 Number of Programs Reporting	FY 2015 Number of Known Programs	FY 2017 Number of Programs Reporting	FY 2015 Number of Known Programs	FY 2015 Number of Programs Reporting
Early Head Start (EHS)	14	10	26	19	27	11	25	8
Healthy Families America (HFA)	24	24	26	25	28	28	27	25
Home Instruction for Parents of Preschool Youngsters (HIPPY)	2	2	3	2	3	3	4	2
Nurse Family Partnership (NFP)	1	1	1	1	1	1	1	1
Parents as Teachers (PAT)	14	13	15	15	14	13	13	9
Other*	6	5	8	8	10	2	0	**1

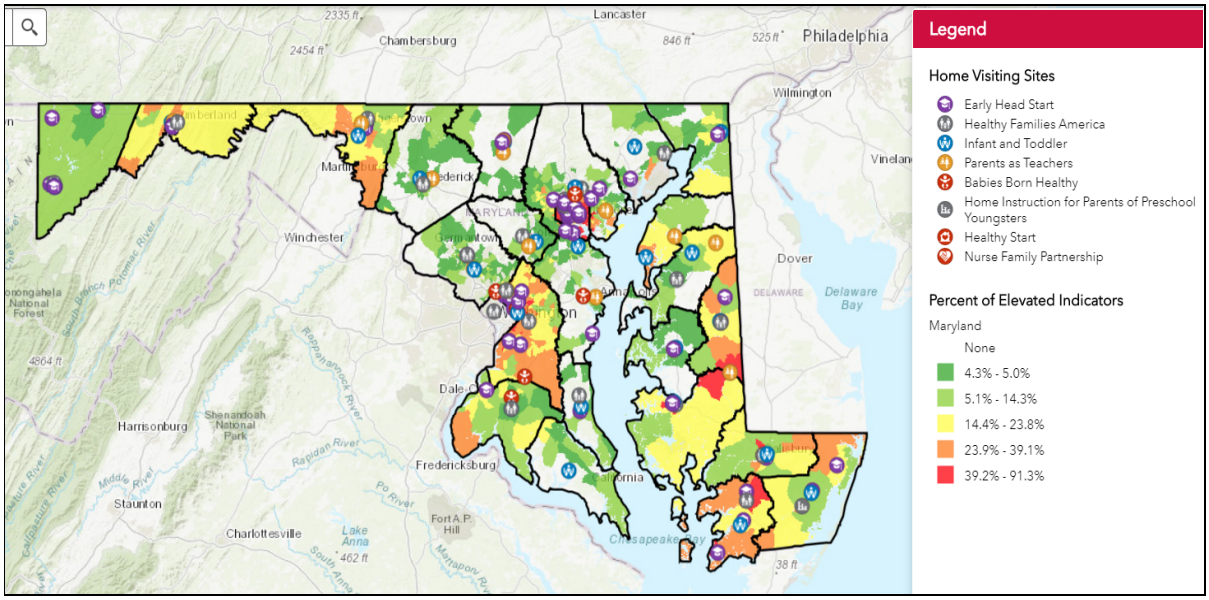
[12] For the purpose of reporting on program models, the phrasing of "Programs Reporting" will be used. For the rest of the Report, the basis of measurement remains at the site level as the sites contain the programs, hold the funding, house the staff, etc.

TOTAL	61	55	79	70	83	58	70	46
% Reporting	90.2%		88.6%		69.9%		65.7%	

*Other pertains to both evidence-based and promising practice programs that operate in individual localities.
**One program in FY 2015 reported data but did not identify the program or jurisdiction.

Figure 1 below represents locations of all evidence-based home visiting programs in the State, and a visual representation of the at-risk areas across the State. The map was developed as the result of a comprehensive needs assessment conducted in 2010, which was part of the initial implementation of federal MIECHV grants in the State and updated in 2019. For many metrics, the smallest geographic unit of measurement was census tract. Additional detail for home visiting and at-risk areas can be found here: https://maps.health.maryland.gov/phpa/mch/indicators/.

Figure 1: Map of All Maryland Home Visiting Sites



Ongoing assessment of community needs and strengths is crucial to develop a useful and well considered strategic plan. For example, home visiting programs across the State had to respond rapidly to the COVID-19 pandemic. This required programs to quickly develop or expand their ability to telework and conduct home visits virtually, respond to family needs and supports that had been exacerbated by the pandemic, and figure out ways in which to continue engagement with families and partners on a regular basis. Analysis of available secondary data allows the MIECHV home visiting team to better target home visiting services in the State to improve the health of mothers, infants, and children. This map and data are shared Statewide and used by other agencies and potential funders to identify at-risk areas in need of additional support.

Funding for Reporting Programs

Maryland's home visiting programs are supported by federal, State, local, and philanthropic funding. During FY 2021, nine of the 55 home visiting sites (16%) reported that they received State-only funding, and 60% indicated that they received a combination of funding from federal, State, local, and/or philanthropic sources.

According to the survey, State general funds are the main revenue source for home visiting programs supported by several different State agencies, including the Departments of Education and Human Services, the Children's Cabinet Interagency Fund (administered by the Governor's Office of Crime Prevention, Youth, and Victim Services), and local health departments. A total of 39 of the 55 sites indicated that they received funds from at least one of these sources in FY

2021. In total, these four sources invested $12.8 million in home visiting services for Maryland families, an increase of $800,000 from $11.7 million from FY 2019.

The federal government also provides funding for Maryland home visiting programs. The MIECHV program is funded through the Health Resources and Services Administration (HRSA). In FY 2021, MIECHV funding supported 15 sites in 10 jurisdictions. Federal MIECHV dollars add approximately $7.5 million each year for home visiting services and workforce support.

The federal offices of the Administration for Children and Families and the Office of Head Start provide partial or full funding for Early Head Start (EHS) home visiting programs. Twelve sites that responded to the survey indicated that they received direct federal funds through this office. Additionally, Promoting Safe and Stable Families grants administered through the federal Department of Health and Human Services supported four home visiting programs in Maryland. Other federal sources of funding included Community Based Child Abuse Prevention (CBCAP) grants and Title V Block Grants. Twelve sites (21.8%) reported that they received only federal funding in FY 2021, compared to 22 sites (40%) that received a portion of federal funding in combination with other sources. Overall, 60% of sites operate with braided funding from various combinations of federal, State, local, philanthropic, and university sources.

Local government and philanthropic funding also support a number of home visiting programs in Maryland. Six sites (10.9%) reported that they received more than 50% of funding from local government or philanthropic sources in FY 2021 (see Figures 2 and 3).

Figure 2: Home Visiting Funding by Source

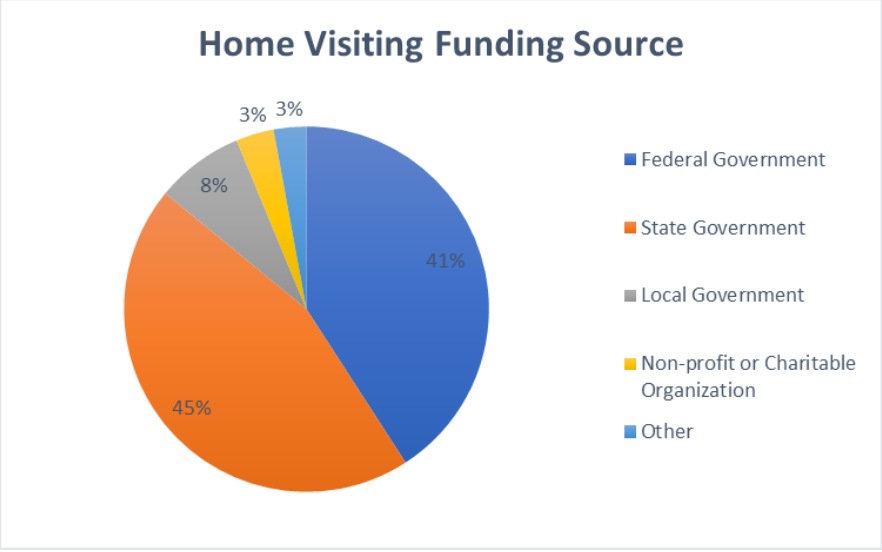
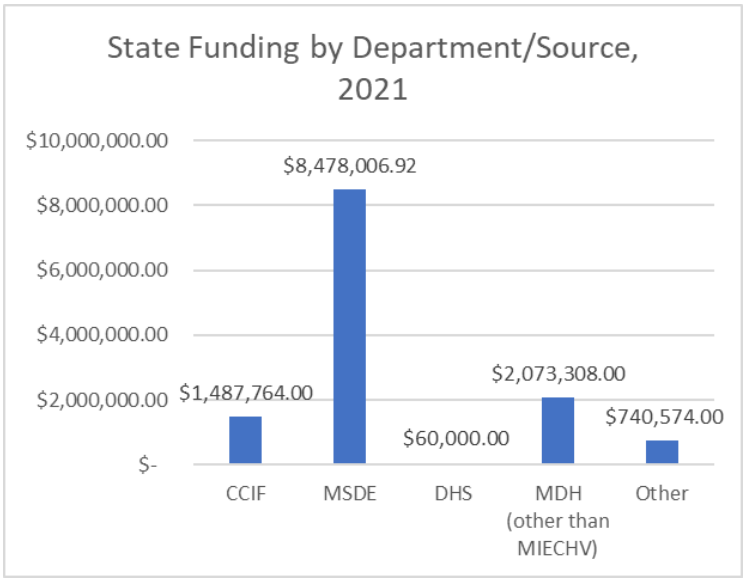


Figure 3: State Funding by Department/Source



Note: CCIF is the Children's Cabinet Interagency Fund

Maryland's Home Visiting Workforce

In FY 2021, and similar to the data collection processes in FY 2015, FY 2017, and FY 2019, the survey inquired about the number of full time equivalency home visitors employed (excluding administrative support roles such as managers, supervisors, and data entry/administrative assistants), and educational attainment. Gender identification, race and ethnicity, and the age range of home visitors continue to be collected to understand more about the home visiting workforce (see Figure 5 and Figure 6).

In FY 2021, 55 sites reported that they employed approximately 230 full time equivalent home visitors to serve enrolled families which is about four more compared to FY 2019 (226.18). The breakdown of home visitors' educational attainment is illustrated in Figure 4.

Figure 4: Education Level of Maryland Home Visiting Staff

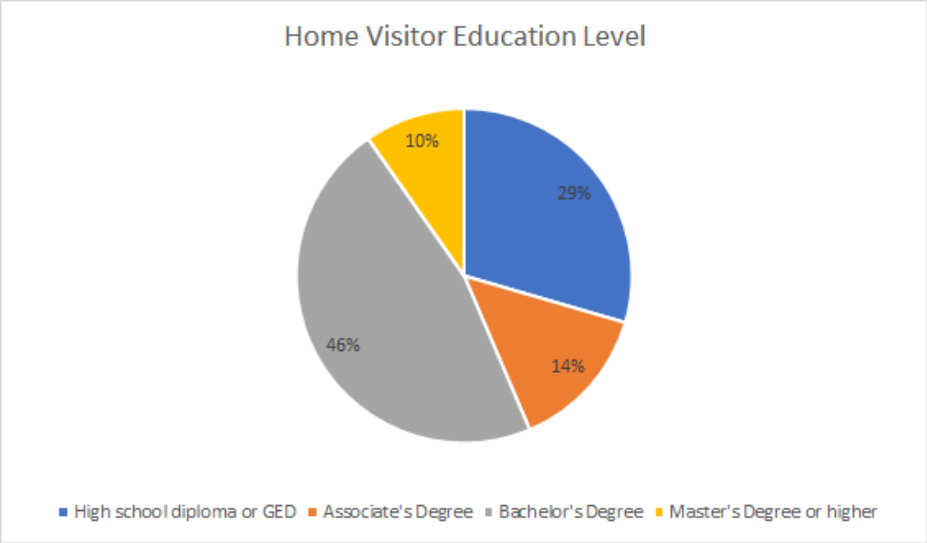


Figure 5. Home Visitor Gender Identification

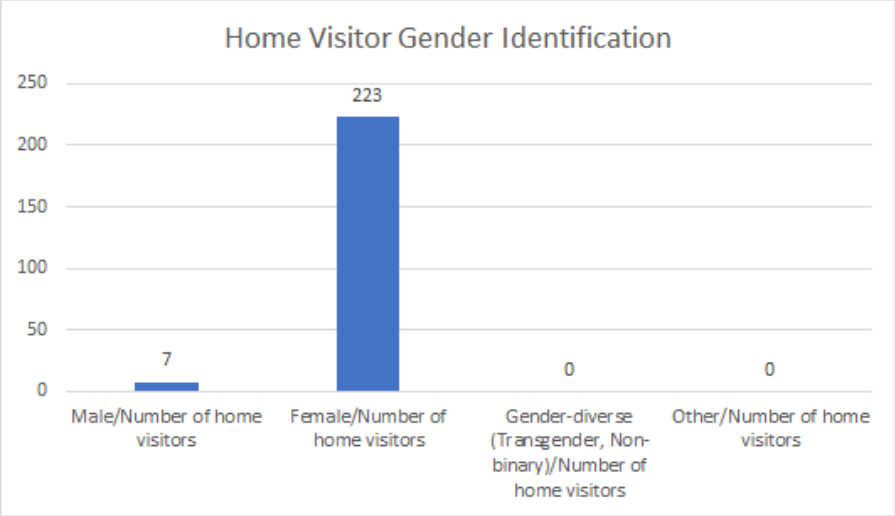
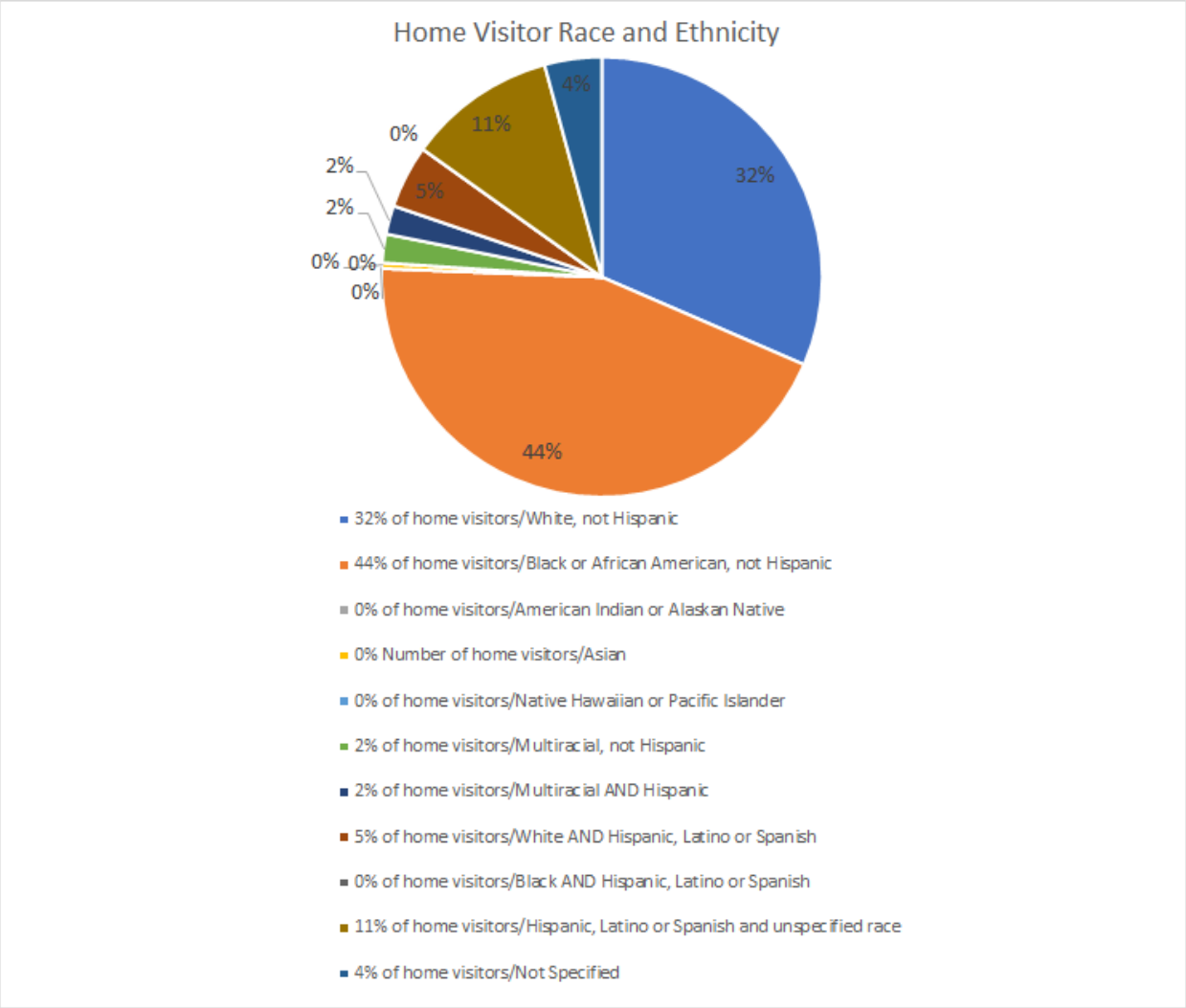


Figure 6: Home Visitor Racial/Ethnic Identification



Professional Development and Training

In addition to their formal education, home visitors receive extensive training specific to the program model and curriculum employed at their respective sites, and supplemental training throughout the year on topics ranging from child development to cultural competency.

Home Visitor Training Certificate Program: Using MIECHV program funds, the Maryland Department of Health, in collaboration with the University of Maryland, Baltimore County (UMBC) developed a Home Visitor Training Certificate Program ("Training Certificate Program") in 2015. The Training Certificate Program provides additional comprehensive training to home visitors on challenging issues such as mental health, substance use, and intimate partner violence that are often addressed during home visits. Though initially available to MIECHV-funded home visitors only, UMBC's Training Certificate Program is now open to all interested home visiting professionals. To date, 229 home visitors and supervisors have

completed the training. To receive a certification of completion, home visitors must successfully complete all seven modules, as required by UMBC staff. Training satisfaction and home visitor demographics can be found in Tables 3 and 4 below.

Table 3. Mean Confidence and Training Satisfaction Ratings from Fall 2020 and Spring 2021 Cohorts

Module	Confidence Pre-Test	Confidence Post-Test	Post-Training Satisfaction
Communication	4.4 (0.9)	5.1 (0.6)	5.5 (0.9)
Healthy Relationships	4.5 (0.9)	5.0 (0.6)	5.3 (0.8)
Parenting	4.5 (0.7)	5.2 (0.6)	5.4 (0.8)
Mental Health	4.4 (1.0)	5.0 (0.6)	5.6 (0.6)
Substance Use	4.7 (0.9)	5.1 (0.6)	5.5 (0.7)
Cultural Sensitivity	4.8 (0.9)	5.3 (0.6)	5.5 (0.6)

Note: Survey questions for each module utilize a likert scale of 1-6; higher numbers denoting a greater level of satisfaction/understanding/overall training experience.

Table 4. Demographic Data for Fall 2020 and Spring 2021 Cohorts (N = 42)

Variable		Percent (n)
Role (Trainees could select more than one option)	Home Visitor/Family Service Worker (FSW)	76% (32)
	Supervisor	2% (1)
	Family Assessment Worker	2% (1)
	Program Manager/Project Director	7% (3)
	Other	12% (5)
Program model (Trainees could select more than one option)	Healthy Families America	64% (27)
	Early Head Start	2% (1)
	Parents as Teachers	14% (6)
	Nurse Family Partnership	2% (1)
	Other	17% (7)
Gender	Female	98% (41)
	Male	2% (1)
Race/ Ethnicity (Trainees could select more than one option)	Black/African American	41% (17)
	White	48% (20)
	Asian/South Asian	2% (1)
	Native American/Alaskan Native	2% (1)
	Latino[a]	26% (11)
	Other	10% (4)
Highest educational level	High School/GED	21% (9)
	Some College	55% (23)
	College graduate	24% (11)
	Graduate degree	17% (7)
Mean age in years (range: 19-59)		37.9 (11.4)
Experience	Mean years as a home visitor (range = <1 yr. – 29 yrs).	3.5 (6.7)
	Median home visiting caseload size (range = 0 - 65)	15.3 (14.9)
	Mean number of home visitors supervised (range = 1 - 6)	3.0 (2.2)

Note: The values presented reflect all available data. Current cohort data unavailable.

Substance Exposed Newborn (SEN) Training: In 2019, the Maryland Department of Health, in partnership with the Department of Human Services and UMBC, developed a two-day training program for home visitors, supervisors, and other community health professionals to equip them with tools and education related to substance abuse for women, both pregnant and postpartum. The training and pilot were funded by the Maryland Department of Health and the rollout of the training to professionals was conducted by the Department of Human Services. Workforce training included home visitors, community health workers, and Infants and Toddlers staff, all of whom work with families in the home. This cross-disciplinary training was the first of its kind in Maryland and was well-received. Six regional SEN trainings were implemented in FY 2019, with a total of 247 trainees who completed both the prerequisite online training modules and the one-day in-person training.

Using participant feedback from the September 2018 pilot training, the Maryland Department of Health and UMBC made several revisions to the online and in-person components of the SEN training, to include: compressing video files to reduce lag and buffering issues; reorganizing the order of training materials; filming an additional video interview of a mother in recovery; and adding additional training topics such as working with fathers and infant care strategies, with supplemental handouts and activities provided. Further, multidisciplinary seating charts were created and enforced to promote inter-agency collaboration during table discussions and activities at each training. Having various disciplines represented at each table not only allowed participants to learn more about the roles, responsibilities, and eligibility criteria of different programs in the area, but facilitated the opportunity for participants to connect with each other to discuss possible collaborations.

In FY 2021, the SEN training continued after being redeveloped as a completely virtual training due to the COVID-19 pandemic. There was one pilot cohort consisting of individuals involved in the Maryland Department of Health's Babies Born Healthy program, and two other cohorts from a variety of programs for a total of 46 individuals.

The SEN curriculum has been posted to UMBC's training center website and mobile application. The content on the curriculum page mirrors information provided in the SEN training to serve as a resource and refresher for trainees and the families they serve. The website also features full length video interviews from all of the experts featured in the training which allows trainees to view footage that was not included in either the online or in-person training. UMBC's home visiting training center website may be accessed here: https://homevisitingtraining.umbc.edu/.

Statewide Collaboration to Support Workforce

Home Visiting Consortium: The mission of the Maryland Home Visiting Consortium (HVC) is to ensure coordination and collaboration between public and private partners in the planning,

implementation, and sustainability of evidence-based and promising practice home visiting programs in Maryland.

The vision of the HVC is to ensure that all vulnerable Maryland families with young children have access to high-quality, well-coordinated home visiting services that are family-centered and results driven.

The HVC is composed of representatives spanning multidisciplinary fields including home visiting, education, health care, research and evaluation, and public health and is designed to support the home visiting workforce. Representatives are responsible for sharing HVC information with their agency/organization and informing the HVC with input and perspectives from their representative group.

History of the Home Visiting Consortium

In 2000, the Maryland General Assembly's Joint Commission on Children, Youth, and Families commissioned a summer study group to review the status of State-funded home visiting programs and to develop strategies for coordination and sustainability. At this time, the study group reviewed existing State-funded home visiting programs which included Healthy Families; Healthy Start; Even Start; Maryland Office for Children, Youth, and Families; Family Support Centers; HIPPY; Baltimore City Maternal and Infant Program; and Responsible Choices. The study group made four recommendations including: 1) creation of a home visiting oversight committee, 2) develop a consolidated and unified grant process to fund home visiting, 3) coordinate data collection, monitoring and evaluation, and 4) develop a single point of entry. The HVC became the oversight committee for home visiting programs in Maryland.

The structure and function of the HVC remained the same until 2007. With the transfer of some home visiting programs from the former Governor's Office for Children, Youth, and Families to the Maryland State Department of Education in 2005, and the subsequent loss of the Home Visiting Coordinator position in 2007, the HVC was then contracted out to the Maryland Family Network beginning in 2008. Between 2008 and 2010, the Maryland Family Network facilitated quarterly meetings of the HVC which focused on establishing best practice standards across home visiting models. Beginning in 2010, with attendance waning at quarterly meetings, the HVC focused its efforts on the planning and coordination of the Annual Home Visitors Conference.

With the award of MIECHV funding to the State, the HVC reconvened in the fall of 2015, with the Maryland State Department of Education and the Maryland Department of Health as co-facilitators, with the purpose of coordinating home visiting efforts across funding streams and agencies. Stakeholders from State and local government, universities, non-profits,

physicians groups, and program providers meet quarterly to develop an action plan for home visiting in the State.

In 2017, the HVC decided to draft an action plan to help guide its work. Throughout several workgroup sessions over the next year, the HVC came up with two main goals on which to focus: coordination and collaboration, and sustainability. In 2018, the HVC realized that a major piece was missing from this draft -- equity in home visiting -- and asked the Maryland Department of Health's Office of Minority Health and Health Disparities to draft a third goal for the action plan focused on equity. The HVC has been reviewing this draft to ensure that it contains reasonable and realistic goals while also reflecting the overall mission to improve maternal and child health for families across the State.

MIECHV Peer Sharing Mini-Series

In the spring of FY 2021, the Maryland MIECHV hosted a peer sharing mini-series with its 15 funded sites. This consisted of three sessions - two of which were led and facilitated by grantee program staff at MIECHV funded sites. The Maryland MIECHV solicited survey feedback from funded sites on what topics on which they wanted to focus. The top three topics were selfcare, engaging families virtually, and equity. One grantee staff led and facilitated the session on selfcare, and a panel of three grantee staff led the session and panel on engaging families virtually. The third equity session was led by Dr. Robin Butler from North Central University and titled *Historical Implications & Health Disparities Among Material Child Health.*

These sessions gave staff the chance to present their own expertise, engage in peer learning, and build rapport and community with each other. Particularly in the midst of COVID-19 restrictions, it was imperative that programs maintain connection with one another to maintain morale and reduce isolation. A total of 63 people attended the three sessions and were well received by MIECHV grantees.

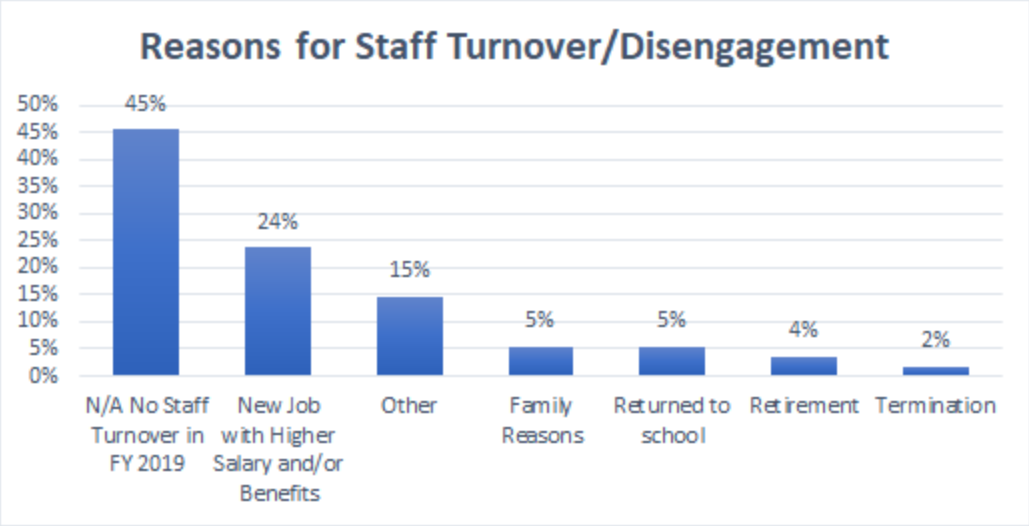
Staff Retention

Tracking and analyzing staff retention is an important aspect of home visiting program management. A family's investment and tenure in a home visiting program is largely determined by the trusting relationship they are able to establish with their home visitor. Research has shown that staff retention can have a significant impact on family engagement which, in turn, directly affects family outcomes.[13] Additionally, staff turnover leads to lower caseloads and fewer families served, due to the requirement to maintain certain caseload sizes in order to maintain fidelity to the program model, particularly among the evidence-based models.

[13] Maternal and Child Health Bureau. (2015). *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Issue Brief on Family Enrollment and Engagement*.

The FY 2021 survey collected data on staff retention to obtain more information on workforce development and retention issues within home visiting programs. Thirty of the 55 sites (54.5%) indicated that they experienced staff turnover in FY 2021, the same percentage as FY 2019. A total of 50 staff turned over, representing 22% of the overall home visiting workforce. Thirteen (43%) of these programs indicated that the most prevalent reason for staff turnover centered on home visitors obtaining other employment opportunities that offered higher salaries and/or better benefits. The second most common reason for staff turnover fell under "other" (27%) which included home visitors not feeling comfortable with virtual visits, increased stressors at home due to COVID-19, and family related issues due to COVID-19. Other reasons for turnover included: termination, staff retirement, family reasons, and returning to school (see Figure 7).

Figure 7: Reasons for Staff Turnover/Disengagement

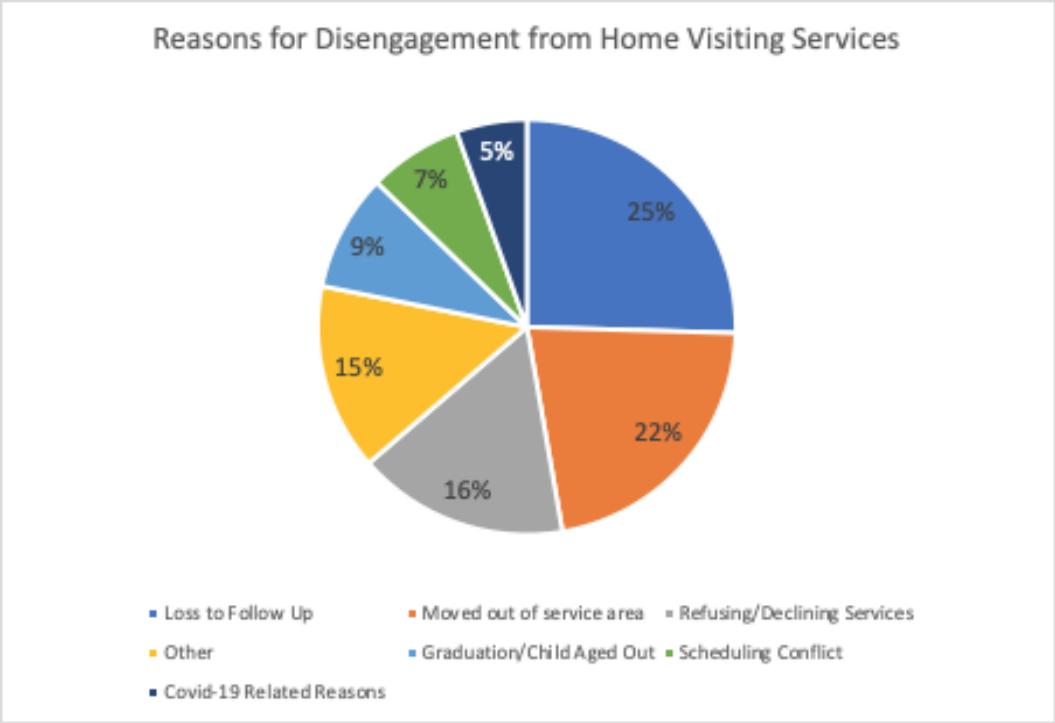


*Other includes: staff moving, transitioning to a new program, laid off, health issues, and undisclosed reasons.

Program Retention

The 55 programs that reported data in FY 2021 were funded to serve 3,994 women. A total of 3,768 women and 71 other caregivers including 40 fathers, 19 grandmothers, nine foster/adoptive parents, one aunt, one grandfather, and one sibling received at least one home visit during the time period; whereas, 1,122 women disenrolled from services which represents a seven person decrease from FY 2019. The primary drivers of disengagement that sites reported included being unable to contact or locate families (25%), and families moving out of the service area (22%). Other reasons behind disengagement included COVID-19 related stressors, difficulty with virtual visiting, the target child aging out of the program, becoming pregnant and leaving the program, and people graduating/successfully completing the program.

Figure 8: Reasons for Disengagement from Home Visiting Service



Demographics of Women Served

In FY 2021, 3,768 women were served by the 55 programs throughout Maryland, which represents a 13.5% decrease in women served when compared with FY 2019 (4,357 women served by 55 sites). The demographics of the women served in FY 2021 slightly differed from the findings in FY 2019. Women served were predominantly 20-29 years old (47%), compared to 51% in FY 2019; and Black, not of Hispanic, Latino, or Spanish (HLS) origin (48%), compared to 43% in FY 2019. In total, during FY 2021, the service population for Maryland home visiting programs was 77% minority races/ethnicities, an increase from the 57% minority service representation in FY 2019, and 70% in FY 2017. Twenty-eight percent of women served were White, not of HLS origin, 8% were White and of HLS origin, and 5% were HLS of an unspecified race. Figures 9 and 10 illustrate the demographics of women served during FY 2021.

Figure 9: Maternal Age of Home Visiting Participant

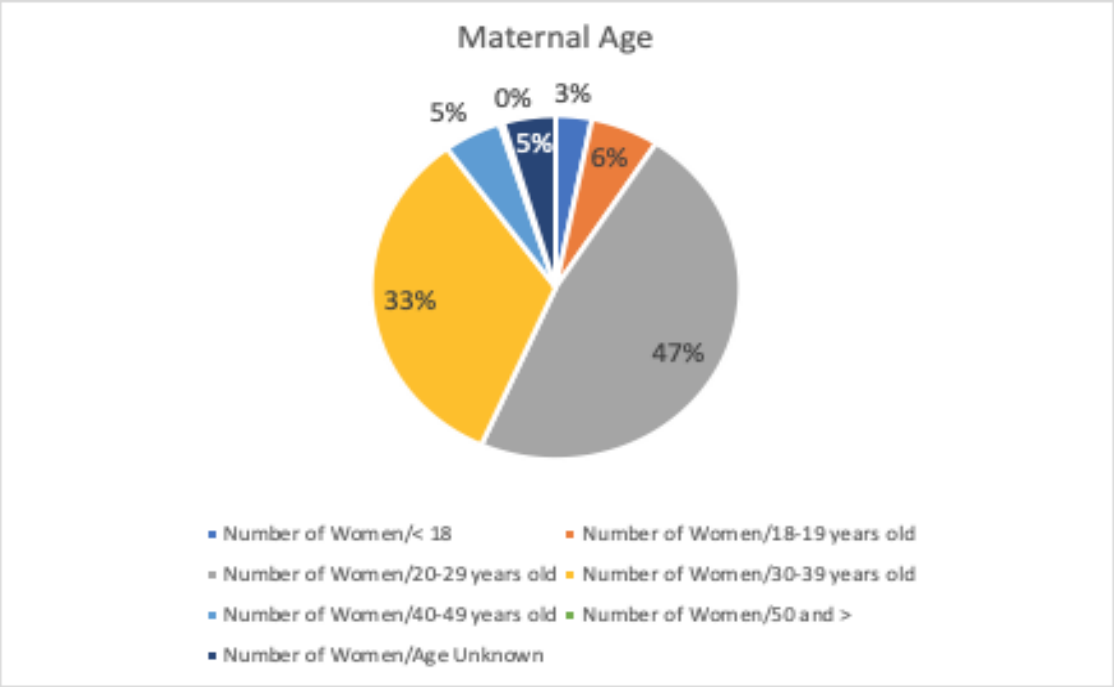
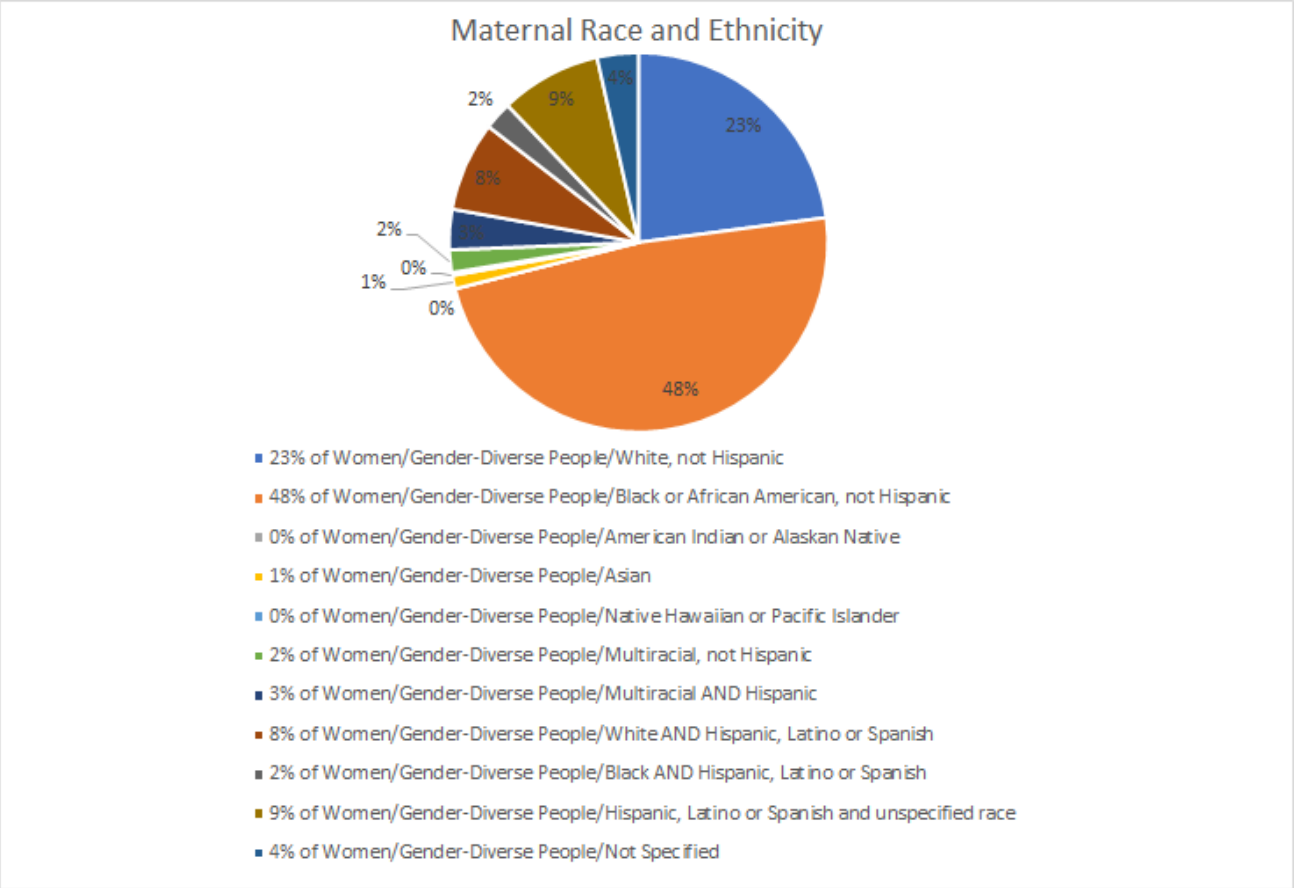


Figure 10: Maternal Race and Ethnicity



Demographics of Children Served

In FY 2021, 3,431 children were served by the 55 programs throughout Maryland, compared to 4,108 from the 61 programs in FY 2019. The majority of children served (35%) were between the ages of 13 and 35 months. The children's service population was 77% minority races/ethnicities, compared to 79% in FY 2019. Forty-two percent of children were Black and not of HLS origin. The next largest racial and ethnic categories of children served were White and not of HLS origin (23%), White and of HLS origin (9%), and Hispanic and not specified (8%). Figures 11 and 12 illustrate the demographics of children served during FY 2021.

Figure 11: Child Age

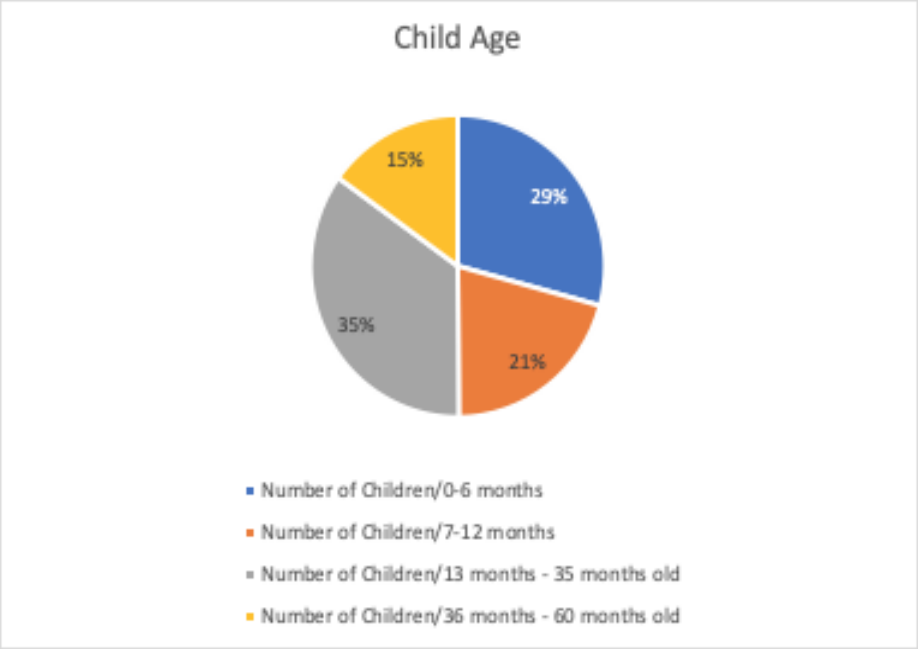
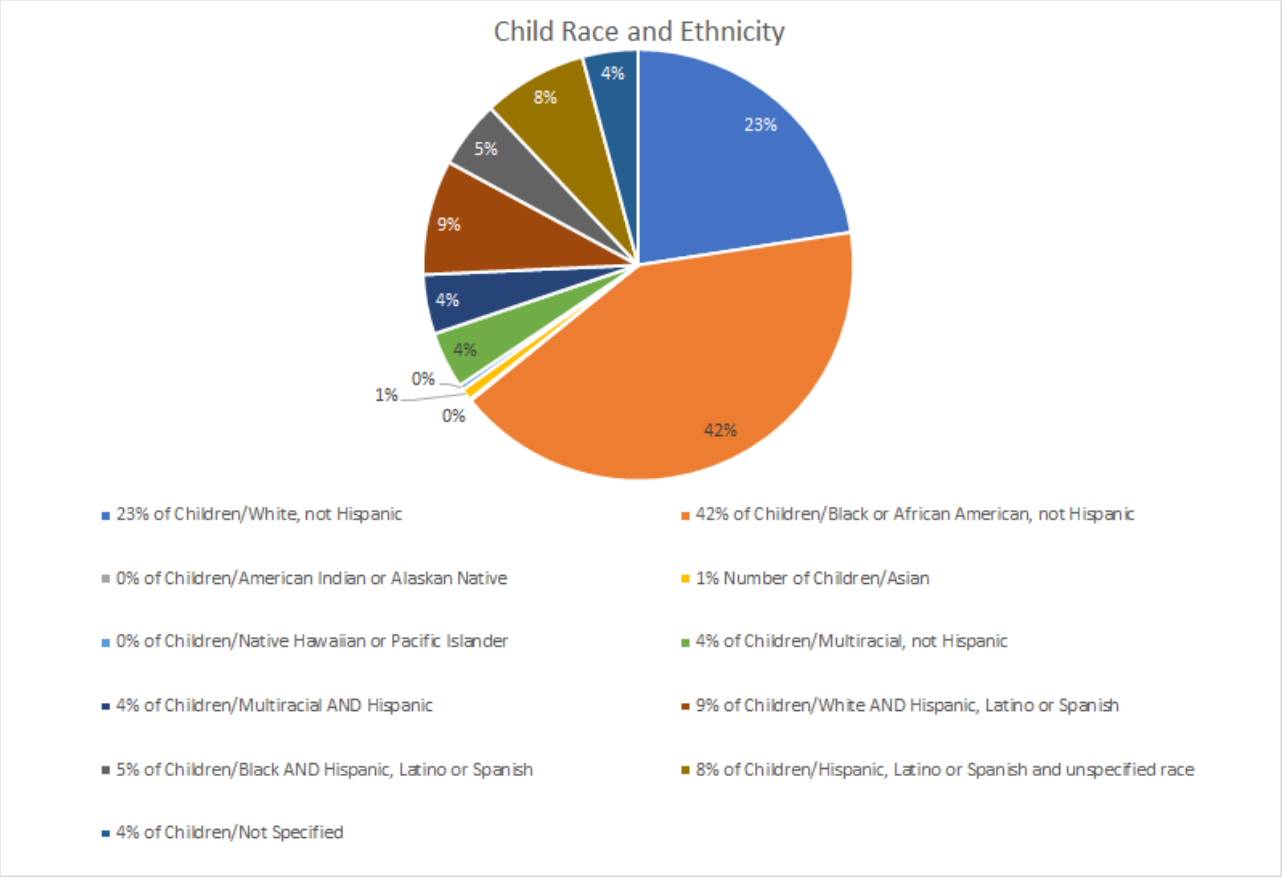


Figure 12: Child Race and Ethnicity



Maryland's Home Visiting Standardized Measures

Following the passage of the Maryland Home Visiting Accountability Act of 2012, the former Governor's Office for Children was tasked to convene a workgroup to develop specific strategies to track and report home visiting outcomes on a Statewide scale. The workgroup consisted of representatives from the State's child serving agencies, home visiting programs, and advocates. Technical assistance was provided to the former Governor's Office for Children by staff from the Pew Foundation's Home Visiting Campaign, which had successfully assisted other states with similar projects.

In March 2014, the Children's Cabinet approved the measures that the workgroup identified as the standardized domains and correlating data points for all home visiting programs across the State, regardless of the program model or funding agency. Table 5 details each domain and related data measure(s). These domains were implemented in the data collection survey in FY 2015, and continued to be measured in FY 2021. Data on each domain can be found beginning on page 32.

Table 5. Maryland's Standardized Home Visiting Measures

Domain	Standardized Measures[14]
1. Child Health	▪ % of enrolled children receiving well-child visits per American Academy of Pediatrics recommendations.
2. Maternal Mental Health	▪ % of enrolled mothers screened for mental health; ▪ % of enrolled mothers referred to mental health services; ▪ % of referred mothers who have received supplemental mental health services; and ▪ % of enrolled mothers who score over the clinical cut-point for parenting stress according to the Parenting Stress Index or other appropriate tool.
3. Typical Child Development	▪ % of enrolled children whose development is scored as "typical" according to a developmental screening tool; and ▪ % of enrolled children scored as "typical" according to the Ages and Stages Questionnaires-Social Emotional.
4. Children's Special Needs	▪ % of enrolled children referred to Part C/Early Intervention and Part B services for special needs.
5. Relationships	▪ % of mothers with an increase in positive parenting behavior and improved parent-child relationship; ▪ % of mothers who were screened for intimate partner violence; ▪ % of mothers who screened positive for intimate partner violence; and ▪ % of mothers who completed safety plans within 24 hours of screening.

[14] Approved by Maryland's Children's Cabinet in March 2014.

Baseline Comparison

For this Report, FY 2021 data were used as the new baseline for data comparisons, and will be used for future reports as well.[15]

Table 6. Domain 2 - Maternal Mental Health: Initiation of Services After a Positive Depression Screening				
Measure	**FY 2021**	**FY 2019**	**FY 2017**	**FY 2015**
Percent of women with a positive maternal depression screen who received a referral for treatment	98%	82%	73%	72%
Percent of women initiating treatment services after a positive maternal depression screen	60%	77%	68%	61%

What the data tell us: Data indicated that sites continue to refer women to appropriate treatment resources when a positive maternal depression screen occurs, but fewer parents in FY 2021 initiated services from that referral. It is important to note that it is difficult to engage women that score positively as they are less likely to voluntarily engage in services, and an increase in initiating treatment/services may reflect the positive training effects of the UMBC Home Visitor Training or site specific trainings, guidance, and policies. This increase is a successful marker of the progress that programs in Maryland are making in addressing mental health needs.

Opportunity for improvement: Federal data reporting requirements and best practice standards of evidence-based program models set an 85% benchmark to meet or exceed a given measure. Assuring sites Statewide are trained in screening, referring, and appropriately supporting the mother to follow through with recommendations is a critical next step in engagement to ensure a higher rate of both screening and follow-up.

Table 7. Domain 5 - Relationships: Improvement in Parent-Child Relationships/Parenting Behavior				
Measure	**FY 2021**	**FY 2019**	**FY 2017**	**FY 2015**
Percent of women showing improvement in parent-child relationships/parenting behavior	70%	75%	71%	40%

[15] It is important to note that the data from FY 2015 captured some erroneous calculations that resulted in errors when compared with other data for analysis. Because of this, only data that were accurately captured were used in this report for comparison purposes.

What the data tell us: Data indicated a plateau and slight decrease in the percentage of women who showed improvement in parent-child relationships/parenting behavior from baseline to follow-up. Improvements could be related to an increased emphasis on the use of evidence-based parenting curricula in programs and/or an increase in the use of validated screening tools. Improvement measurements in this domain could be adopted into program models that do not require assessments of parent-child interaction to enhance program and family outcomes. Research demonstrates that positive parenting behavior and bonding is essential for a healthy relationship and increases a child's ability to attach and adapt.

Opportunity for improvement: In FY 2015, 12 of the 46 sites (26.1%) reported only 79 improvements in parent-child interactions out of 536 assessments (14.7%), which greatly suppressed the percent of overall improvement. In FY 2017, 11 of those 12 sites (one did not submit a survey) reported 193 improvements in parent-child interactions out of 355 assessments (54.4%), which dramatically improved the overall percentage of screenings that demonstrated improvements in parent-child interactions. This positive trend continued into FY 2019 (75%), making small strides forward. However, in FY 2021, the improvement percentage dropped by 5 percentage points. This may be due to having fewer programs to sample due to program closures and service stoppages. Additional questions on the survey that provide context to the data will allow for conclusions to be drawn and provide a clearer sense as to the impact of home visiting on the well-being of both caregivers and children. This elucidated that programs had difficulty screening for parent-child interactions virtually as this often requires direct observation on how they interact. Some families did not have video access and could not complete the screening, and for those that did, screening was harder to facilitate.

Table 8. Domain 5 - Relationships: Safety Plan After a Positive Intimate Partner Violence Screen

Measure	FY 2021	FY 2019	FY 2017	FY 2015
Percentage of women with a safety plan 24 hours after a positive intimate partner violence screen	52%	50%	44%	38%

What the data tell us: Data from FY 2021 indicated small, continuing improvements in addressing positive intimate partner violence screenings by implementing safety plans. Intimate partner violence is a sensitive and challenging issue that many home visiting programs struggle to address. Since FY 2015, there have been efforts to more adequately train home visitors to address intimate partner violence. Training in Mental Health First Aid, the use of annual Futures Without Violence curriculum trainings, as well as the Training Certificate Program[16] are examples of such efforts.

[16] National Home Visiting Resource Center. *Helping Home Visitors Address Sensitive Topics with Families: An Overview of Three Professional Developmental Initiatives.*

Opportunity for improvement: Continuing to provide training opportunities for home visitors as well as provide supervisor support to home visitors to address these very difficult and sensitive issues can make a marked improvement in the ability to be comfortable in difficult conversations. Other stakeholders including the local Departments of Social Services and school systems can assist in training home visitors to meet the needs of vulnerable families by developing safety plans. Other home visiting stakeholders such as the Maryland Department of Health, the Maryland State Department of Education, the Governor's Office of Crime Prevention, Youth, and Victim Services, local health departments, universities, and non-profit partners could also present opportunities to assist home visitors become more acclimated to sensitive screenings and conversations. Having family members present during these hard conversations caused participants to be uncomfortable in completing the screening, which led to incomplete or no screenings. It was more difficult to facilitate conversations on this topic virtually. Additional questions on the survey that provide context to the data will provide greater insight on what is happening that may impact the safety plan development.

Domain 1: Child Health—Well-Child Visits

Well-child visits include a thorough physical exam and evaluation of the child's progress toward developmental milestones. These visits provide opportunities for health education and communication between the parents and the primary care provider. Attending regular well-child visits allows parents to address concerns about the child's health and an opportunity for the child to receive preventative care such as immunizations. Well-child visits are key in helping health care providers form reliable and trustworthy relationships with families they serve.[17]

Thirty-eight of the 55 programs that reported (69.1%) indicated that they collect well-child visit information from parents. At the end of FY 2021, 2,965 children were eligible for a well-child screening. Of those children, 1,917 (64.7%) completed the most recent well-child visit recommended by the American Academy of Pediatrics *Bright Future*™ schedule,[18] demonstrating that they are up-to-date on age-appropriate immunizations, education, and developmental assessments from a healthcare provider (see Figure 13). This is a significant decrease from FY 2019 where 87% of children completed their most recent well-child visit. It could be that the closure of programs/stoppage of services and COVID-19 pandemic both contributed to this decrease. As you will read in the qualitative section, a number of families were scared to leave their homes due to fear of COVID-19 -- which resulted in missing well-child appointments, immunizations, and other forms of routine care.

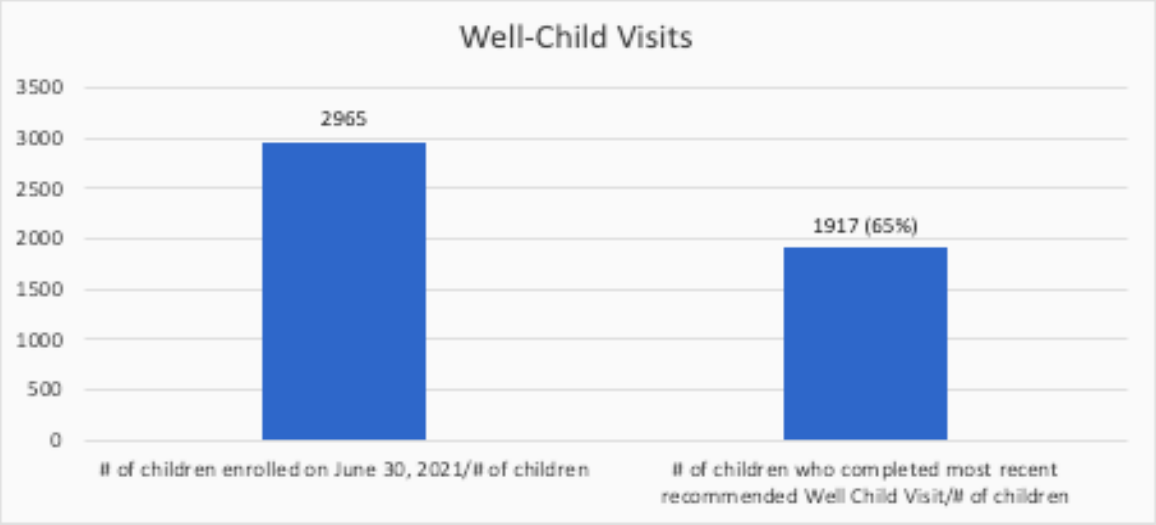
[17] American Academy of Pediatrics. (2019). *AAP Schedule of Well-Child Care Visits*.
[18] American Academy of Pediatrics. *Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)*.

Target population: All children enrolled in home visiting as of June 30, 2021.

Measure: Percent of enrolled children who completed the most recently recommended well-child visit per the American Academy of Pediatrics schedule.

Calculation: # of enrolled children who completed last recommended well-child visit / Total # of enrolled children

Figure 13: Children Up-to-Date on Well Child Visits



Domain 2: Maternal Mental Health—Depression

When mothers are unable to take care of themselves, they cannot properly care for their children. Depression is prevalent in the home visiting population and can have a profoundly negative impact on parenting, maternal life course, and child development.[19]

Target population: All women enrolled in a home visitation program.

Measure: Percent of women who were screened for maternal depression.

Calculation: # of women screened for depression / Total # of women eligible for screening per program's protocol

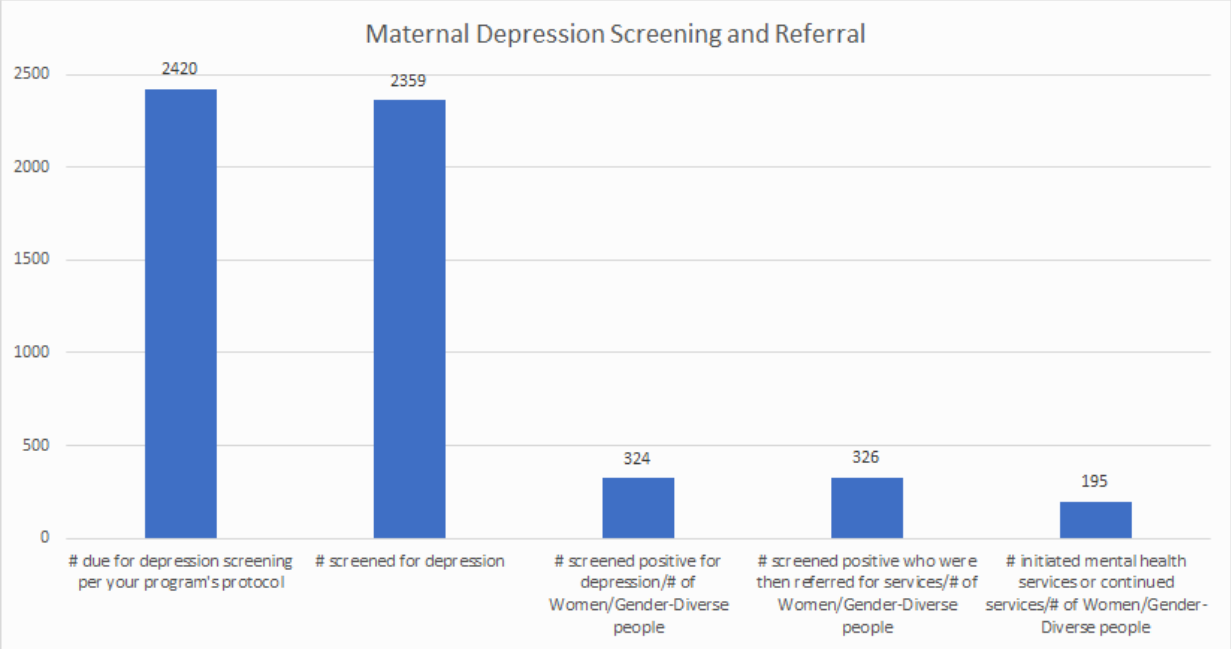
Forty-five of the 55 programs (81.8%) conducted depression screenings of enrolled women. In FY 2021, 2,420 women were due for a depression screening per the home visiting program's screening protocols. Of the women due for a screening, 2,359 (97.5%) received a depression

[19] Ammerman, R. T., Putnam, F. W., Bosse, N. R., Teeters, A. R., & Van Ginkel, J. B. (2010). *Maternal depression in home visitation: A systematic review. Aggression and Violent Behavior*, *15*(3), 191-200.

screening -- an increase from 89% in FY 2019. Of those 2,359 women screened, 363 (15.4%) screened positive for depressive symptomatology warranting further assessment from a healthcare provider. Of the women who screened positive for depression, 326 (89.8%) were referred for further assessment and treatment, with 60% of those women initiating or continuing mental health treatment (see Figure 14). In a couple of programs, a few women were referred more than once for treatment. This again is a significant decrease in initiation or continuing mental health treatment from FY 2019 (77%). The survey does not currently collect data on reasons why a woman was or was not referred, but is a suggestion for further data collection efforts.

Programs use a variety of validated tools to screen for maternal depression. On average, home visiting programs screen women four times for depression during the course of services. A full list of the tools utilized by reporting programs can be found in Appendix C.

Figure 14: Number of Women Screened & Referred for Possible Maternal Depression



Domain 2: Maternal Mental Health—Substance Use

Many substances, including nicotine, alcohol, cocaine, and methamphetamine cross the placenta and impact the developing fetus.[20] Opiates can cross the placental wall as well, though

[20] Behnke, M., Smith, V. C., Levy, S., Ammerman, S. D., Gonzalez, P. K., Ryan, S. A., ... & Watterberg, K. L. (2013). Prenatal substance abuse: short-and long-term effects on the exposed fetus. *Pediatrics*, *131*(3), e1009-e1024.

less efficiently than stimulants and alcohol. Use of these substances during pregnancy can be associated with maternal, fetal, and infant morbidity and mortality.[21]

Target Population: All women enrolled in a home visitation program.

Measure: Percent of women who were screened for substance use.

Calculation: $\frac{\text{\# of women screened for substance use}}{\text{Total \# of women eligible for screening per program's protocol}}$

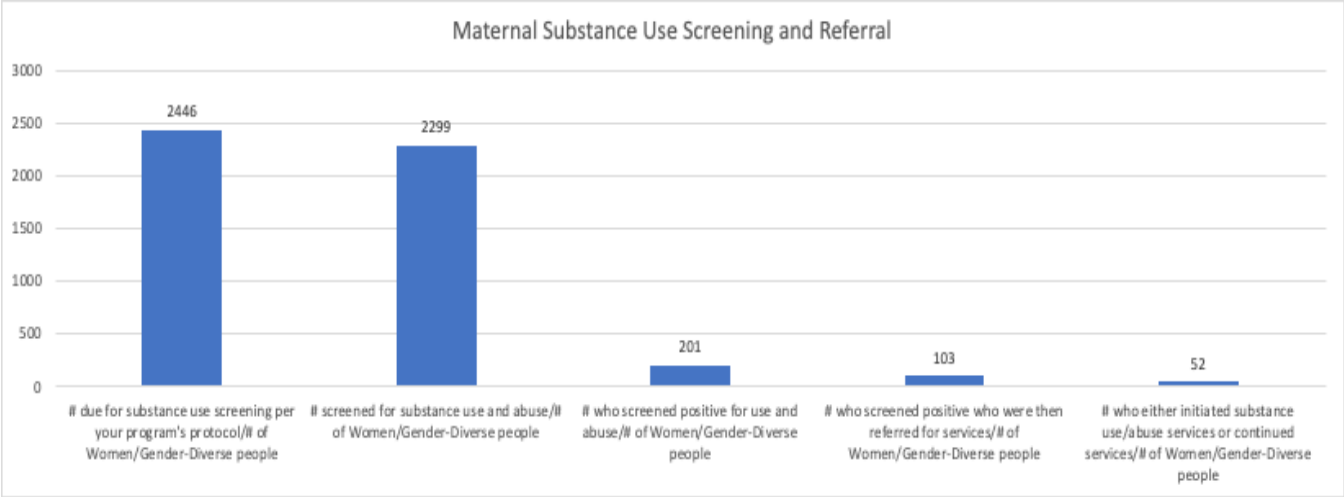
Only 32 of the 55 programs reporting data conduct routine substance use screenings for enrolled women. In FY 2021, 2,446 women were due for a substance use screening per the home visiting program's screening protocols. Of those women, 2,299 (93.9%) of enrolled women were screened for substance use, an increase from 88% in FY 2019. Of the 2,299 women screened, 201 (8.7%) screened positive for substance use warranting further assessment and evaluation -- a decrease from 11% in FY 2019. Of the 201 women screening positive, 103 (51.2%) were referred for treatment services, another increase from 48% in FY 2019. Fifty two women either initiated or continued treatment for substance use, an increase of 22 mothers from FY 2019 (30). As with maternal depression, the survey does not currently collect data on reasons why a woman was or was not referred, but is a suggestion for further data collection efforts.

Programs use a variety of validated tools to screen women for substance use. On average, home visiting programs that do screen for substance use screen women four times during the course of services. A full list of the tools utilized can be found in Appendix D.

The majority of substance use data from FY 2021 shows positive growth from FY 2019: sites reported improvements in conducting screenings (58% up from 42%); percentage of women screened (94% up from 88%); percentage referred to treatment after a positive screen (51% up from 48%); and the number of women initiating/continuing treatment (52 up from 30). While this is good news, especially considering the challenges COVID-19 presented in FY 2021, there still remain opportunities for improvement in increasing the number of sites screening for substance use, referring to treatment, and providing follow-up to those referred to treatment.

Figure 15: Screening and Referral for Maternal Substance Use

[21] The American College of Obstetricians and Gynecologists. (2017). Committee Opinion: Smoking Cessation During Pregnancy: Interim Update.



Domain 2: Maternal Mental Health—Parenting Stress

Clinically high parenting stress arises from a parent's perception of the overwhelming demands of being a parent. Feelings of high parenting stress are associated with heavy workload, low social support, negative life events, and a perception that the child is difficult. The presence of clinically high parenting stress is closely linked with poor parent-child bonding and interaction, difficulty in family functioning, and child abuse and neglect.[22]

Target population: All enrolled mothers.

Measure: Percent of enrolled mothers who score over the clinical cut-point for parenting stress according to the Parenting Stress Index or another appropriate tool.

Calculation: $\frac{\text{\# of women who presented with clinically high parenting stress}}{\text{Total \# of women eligible for the screening per the program's protocols}}$

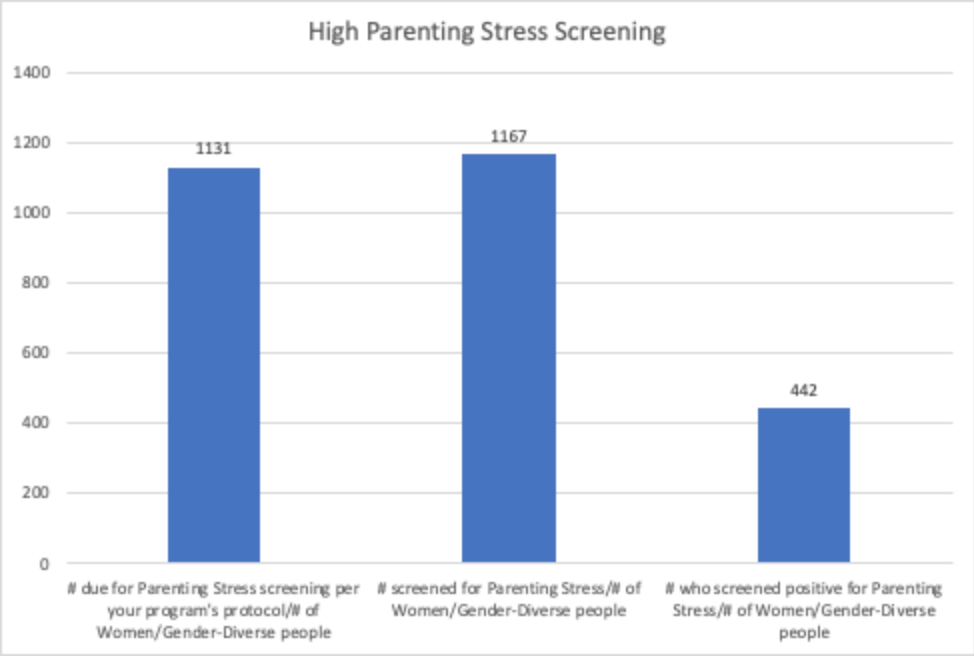
Thirty of the 55 programs (54.5%) reported that they screen enrolled women for high parenting stress. In FY 2021, 1,131 women were eligible for high parenting stress screening per the home visiting program's screening protocols. A total of 1,167 women were screened of which 442 (37.9%) were positive for high parenting stress (see Figure 16). Some programs screened enrolled mothers more than is typically required.

Programs use a variety of tools to screen for high parenting stress. On average, home visiting programs are screening women four times for parenting stress during the course of services. A full list of the tools utilized can be found in Appendix E. Data on whether women who screen

[22] Östberg, M., & Hagekull, B. (2000). A structural modeling approach to the understanding of parenting stress. *Journal of Clinical Child Psychology*, *29*(4), 615-625.

positive for parenting stress are referred to services is not currently collected and can be considered for future data collection.

Figure 16: Number of Women Screened for High Parenting Stress



Domain 3: Typical Child Development—Developmental Screenings

Measurement of childhood development toward expected milestones is essential to support children's health. Early identification of developmental delays, along with subsequent referral, can improve children's developmental outcomes.[23]

Target population: Enrolled children.

Measure: Percent of enrolled children who were screened with a developmental screening tool.

Calculation: $\frac{\text{\# of children screened for typical development}}{\text{Total \# of children}}$

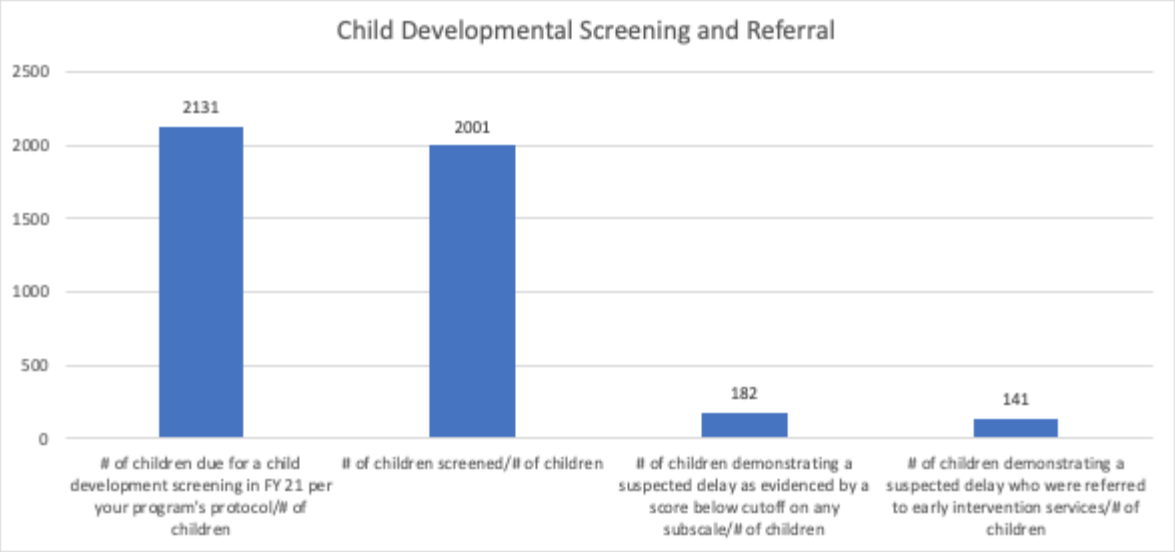
Fifty-one of the 55 programs (92.7%) reported that they screen children for typical development using a developmental screening tool. In FY 2021, 2,131 children were due for a developmental screening per the program's home visiting screening protocols. Of those children, 2,001 (93.9%)

[23] Hix-Small, H., Marks, K., Squires, J., & Nickel, R. (2007). Impact of implementing developmental screening at 12 and 24 months in a pediatric practice. *Pediatrics*, *120*(2), 381-389.

received screening. Of the children screened, 182 (9.1%) were suspected of having a developmental delay in at least one domain. One hundred forty-one children (77.5%) were referred for further assessment and evaluation.

Programs use a variety of validated tools to screen children for typical development. On average, home visiting programs screen children six times for typical development during the course of services. A full list of tools used to screen for typical development can be found in Appendix F.

Figure 17: Number of Children Screened and Referred for Developmental Delay



The emotional well-being of children is essential for future success in social and academic settings. Children with social emotional delays are often less resilient than children who are developing typically and may experience behavioral problems in response to normal stressors.[24]

Target population: Enrolled children who are six months of age and older.

Measure: Percent of enrolled children who were screened with the Ages and Stages Questionnaires - Social Emotional.

Calculation: $\frac{\text{\# of children screened for social emotional development}}{\text{Total \# of children eligible for screening}}$

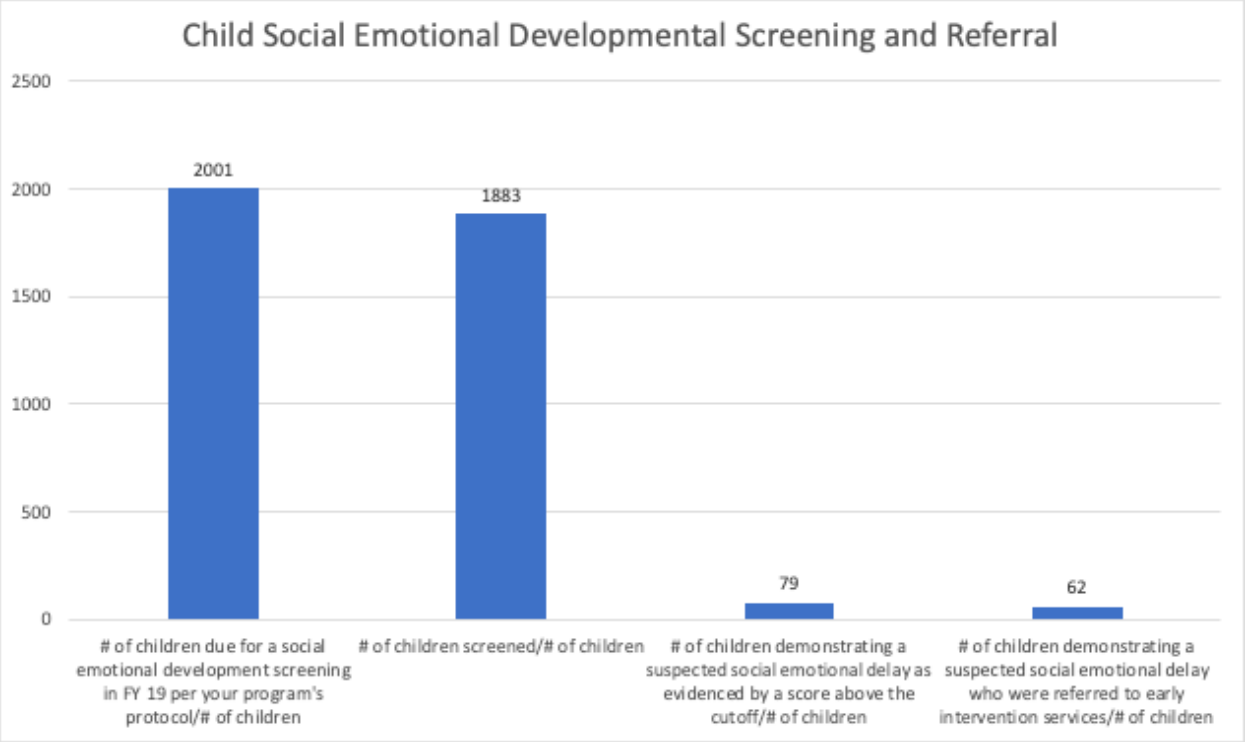
Fifty of the 55 programs (90.9%) reported that they screen children for social emotional development. In FY 2021, 1,883 children out of 2,001 eligible children (94.1%) received a screening for social emotional development. Of the 1,883 children screened, 79 (4.2%) were suspected of having a social emotional developmental delay of which 62 (78.5%) were referred

[24] American Academy of Pediatrics. (2019). *Mental Health Initiatives: Social and Emotional Problems*.

for further assessment and evaluation.

Programs use a variety of validated tools to screen children for typical social emotional development. On average, home visiting programs screen children for social emotional development three times during the course of services. A full list of tools used to screen for typical development can be found in Appendix G.

Figure 18: Number of Children Screened for Typical Social Emotional Development



Domain 4: Children's Special Needs

The Federal Individuals with Disabilities Education Act (IDEA) ensures the provision of early intervention services under Part C to children diagnosed with developmental delays birth through age three, and their families. Children who received services under Part C of IDEA can continue receiving supportive services under Part B from age 3-21.[25] Early intervention can minimize delays and strengthen children's cognitive, physical, and behavioral development, thereby reducing the incidence of future problems.[26]

[25] © 2021 Maryland Learning Links. *Maryland Learning Links*.
[26] Center on the Developing Child at Harvard University. (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*.

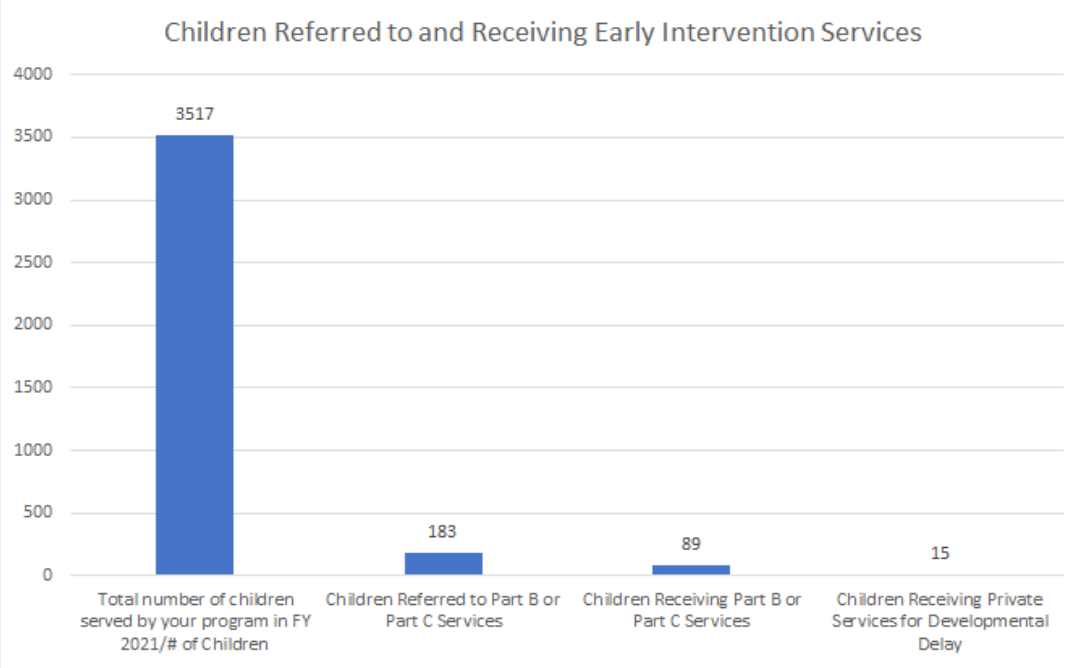
Target population: Enrolled children who were referred for services due to identified developmental delays.

Measure: Percent of enrolled children referred to Federal Individuals with Disabilities Act Part C and Part B services.

Calculation: $\frac{\text{\# of children receiving IDEA Part C and/or Part B services}}{\text{Total \# of enrolled children referred to IDEA Part C and/or Part B services}}$

During FY 2021, 183 children were referred to Part B or Part C early intervention services. Of those 183 children, 89 (48.6%) received early intervention services, a large decrease from FY 2019 (79%). Another 15 children received private early intervention services not associated with IDEA. Those children that received services for developmental delays (104) represented only 3% of all children served by home visiting programs in FY 2021, down from 7% from FY 2019 (see Figure 19).

Figure 19: Children Referred to Part B or Part C Early Intervention Services



Domain 5: Family Relationships—Parent-Child

Early parent-child relationships have enduring impacts on childhood growth and development. This first relationship can positively or negatively influence a child's emotional well-being, coping skills, problem solving skills, and the capacity for building healthy relationships in the

future.[27,28] Evidence-based home visiting programs can support parents in developing trusting, positive, and reliable relationships with their children.

Target population: Enrolled mothers.

Measure: Percent of mothers with an increase in positive parenting behaviors and improved parent-child relationship.

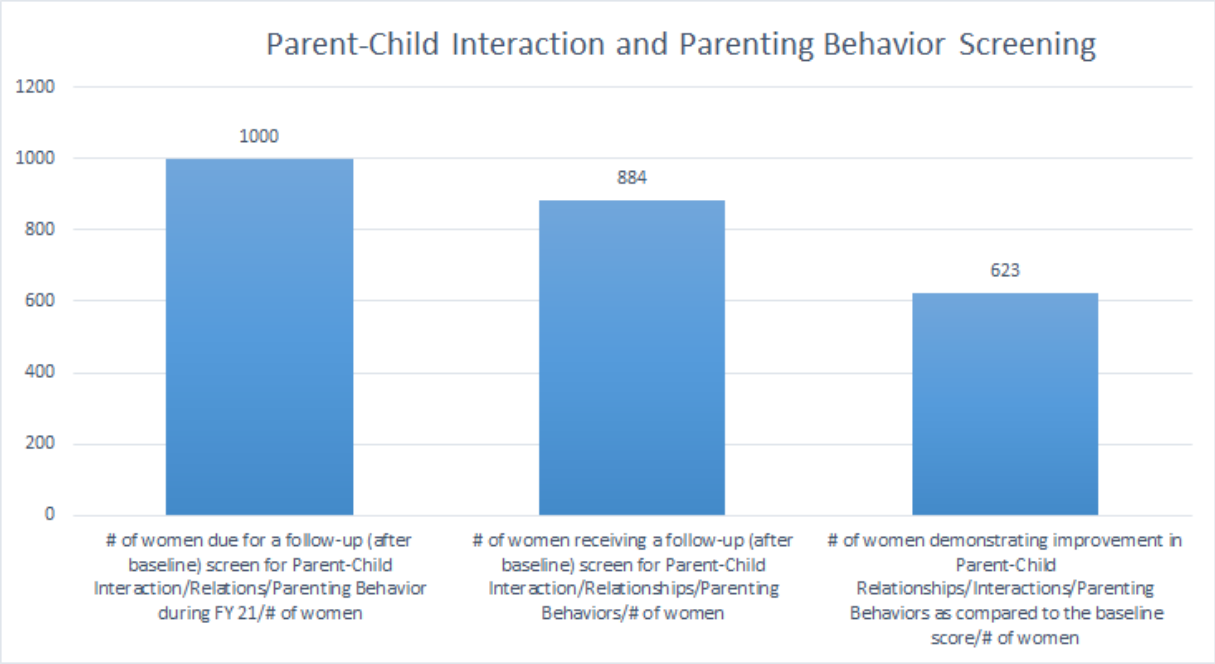
Calculation: $\frac{\text{\# of mothers who improved in parenting behaviors/P-C relationships}}{\text{Total \# of mothers who were screened at baseline and follow-up}}$

Forty-two of the 55 programs (76.4%) reported that they conduct screenings related to parent-child relationships/parenting behaviors. In FY 2021, 884 enrolled women received a follow-up screening on parent-child relationships/parenting behavior. Of those 884 women with both a baseline and a follow-up screening, 623 (70.4%) showed improvements in positive parent-child relationships/parenting behaviors (see Figure 20).

Programs use a variety of tools to screen women for parent-child relationships/parenting behaviors. On average, the 42 home visiting programs that regularly screened women for parent-child relationships/parenting behaviors conducted this screening 3.7 times during the course of services. A full list of tools used to screen for parent-child relationships/parenting behavior can be found in Appendix H.

Figure 20: Parent-Child Relationship/Parenting Behavior Improvement

[27] Dawson, G., & Ashman, S. B. (2000). On the origins of a vulnerability to depression: The influence of the early social environment on the development of psychobiological systems related to risk for affective disorder. *Effects of Early Adversity on Neurobehavioral Development*, *31*, 245-279.
[28] Lerner, R. M., Rothbaum, F., Boulos, S., & Castellino, D. R. (2002). Developmental systems perspective on parenting. *Handbook of parenting*, *2*, 315-344.



Domain 5: Family Relationships—Intimate Partner Violence

Intimate Partner Violence (IPV) is a pattern of coercive behavior characterized by control of one person by someone who is intimately associated (e.g., a family member, husband/wife, boyfriend/girlfriend). Abuse can be physical, sexual, psychological, verbal, and/or economic. In the United States, approximately one in four women report being a victim of IPV.[29] For mothers, exposure to IPV is associated with mental health and parenting problems, while children experience a variety of social and emotional difficulties.[30]

Target population: Enrolled women.

Measures: Percent of women who were screened for IPV; percent of women who screened positive; and percent of positive screens who completed safety plans within 24 hours of the screening.

Calculation: $\frac{\text{\# of women screened for IPV}}{\text{Total \# of women eligible for screening per the program's protocol}}$

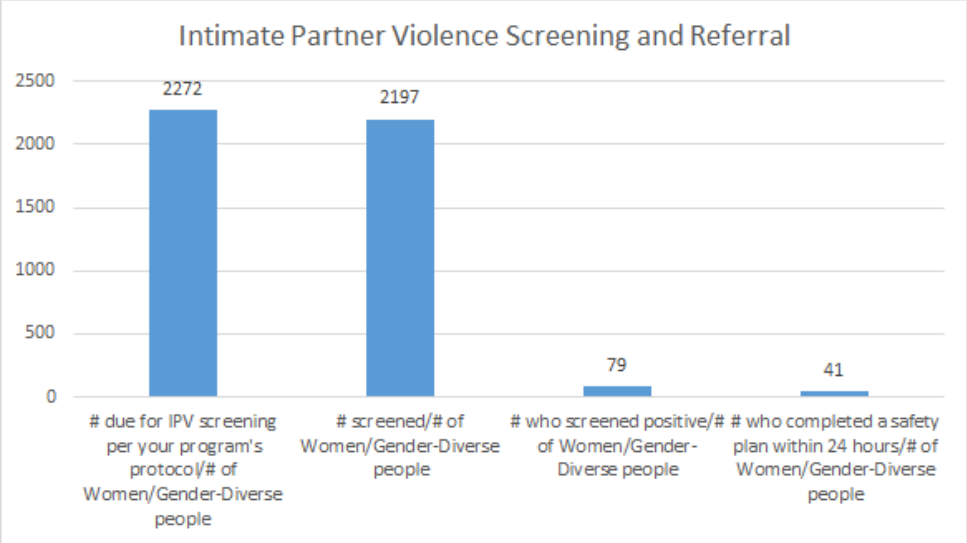
Thirty-two out of the 55 programs (58.2%) reported that they screened women for IPV. In FY 2021, 2,272 women were eligible for a screening per the home visiting program's protocols. Of those women, 2,197 (96.7%) were screened of which 79 (3.6%) screened positive. Forty-one

[29] *Maryland Network Against Domestic Violence*.
[30] Holmes, M. R. (2013). Aggressive behavior of children exposed to intimate partner violence: An examination of maternal mental health, maternal warmth and child maltreatment. *Child abuse & neglect*, *37*(8), 520-530.

women (51.9%) completed a safety plan within 24 hours of the screening (see Figure 21), which represents an increase of 3% from FY 2019.

Programs use a variety of tools to screen women for IPV. On average, home visiting programs screen women for IPV twice during the course of services. A full list of tools used to screen for IPV can be found in Appendix I.

Figure 21: Screening of Women for Intimate Partner Violence (IPV)



Reporting on Children's Cabinet Priorities

In addition to the standardized reporting measures approved by the Children's Cabinet, the FY 2021 data collection survey also included questions specific to the Children's Cabinet's family economic self-sufficiency priorities. As a result, additional data were collected on the following:

- Number of women aged 24 and under who are neither employed full-time or in school;
- Number of women aged 18-24 who have not graduated high school or obtained a GED; and,
- Number of enrolled families impacted by incarceration.

All data relate to women/families enrolled in home visiting services as of June 30, 2021.

Priority 1: Women/Gender-Diverse People Under Age 24 Not Working or in School

Education and employment are two leading indicators of overall well-being. In Maryland, about 92,000 youth aged 16-24 are neither working nor in school.[31] Youth who are disconnected from

[31] Maryland's Children's Cabinet. (2017). *Maryland Children's Cabinet Three-Year Plan: Vision for Cross-Agency Collaboration to Benefit Maryland's Children, Youth and Families*.

work and educational opportunities are more likely to live in poverty, more likely to rely on social services, less likely to contribute to local tax revenue, less likely to exhibit other signs of mental and physical well-being, and more likely to be disengaged from their communities.

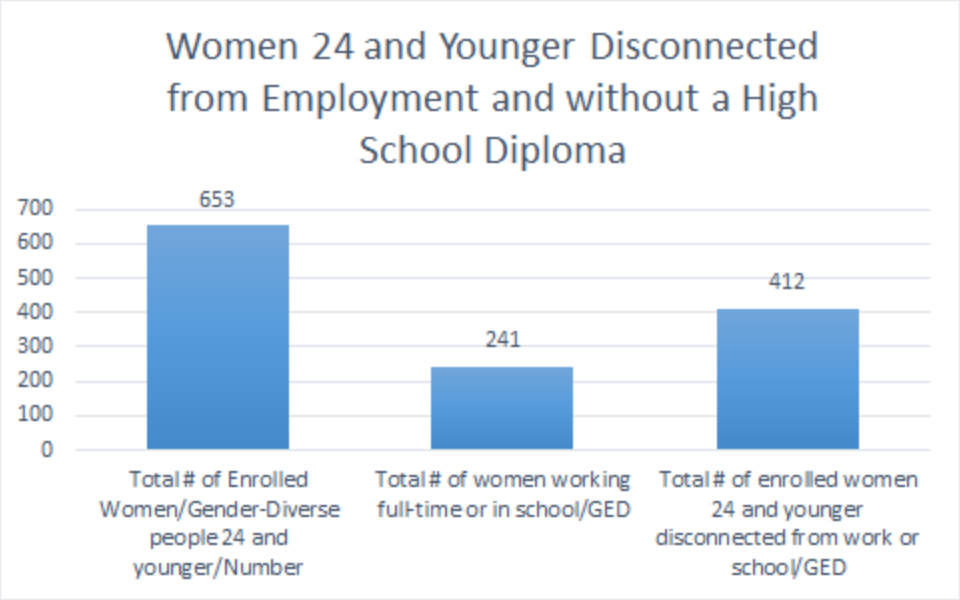
Target population: Enrolled women under the age of 24.

Measures: Percent of women under the age of 24 who are neither working full-time nor in school.

Calculation: $\frac{\text{\# of enrolled women < age 24 who neither work full-time nor are in school}}{\text{Total \# of enrolled women under age 24 as of June 30, 2021}}$

Forty-three of the 55 programs (78.2%) reported that they track this type of data on women under the age of 24. The sites reported a total of 653 enrolled women under the age of 24 as of June 30, 2021, a decrease from 931 and 44 sites in FY 2019. Of those 653 women, 412 (63.1%) were disconnected from work and school opportunities in FY 2021 (see Figure 22), an increase from FY 2019, when that percentage was 54. Though the overall number of enrolled women under the age of 24 decreased, the increase in those disengaged from both work and school is of some concern and could be a result of the pandemic.

Figure 22: Number of Women/Gender-Diverse People Age 24 and Younger Not Working or in School



Priority 2: Women Aged 18-24 Not Graduated/Not Obtained General Equivalency Diploma (GED)

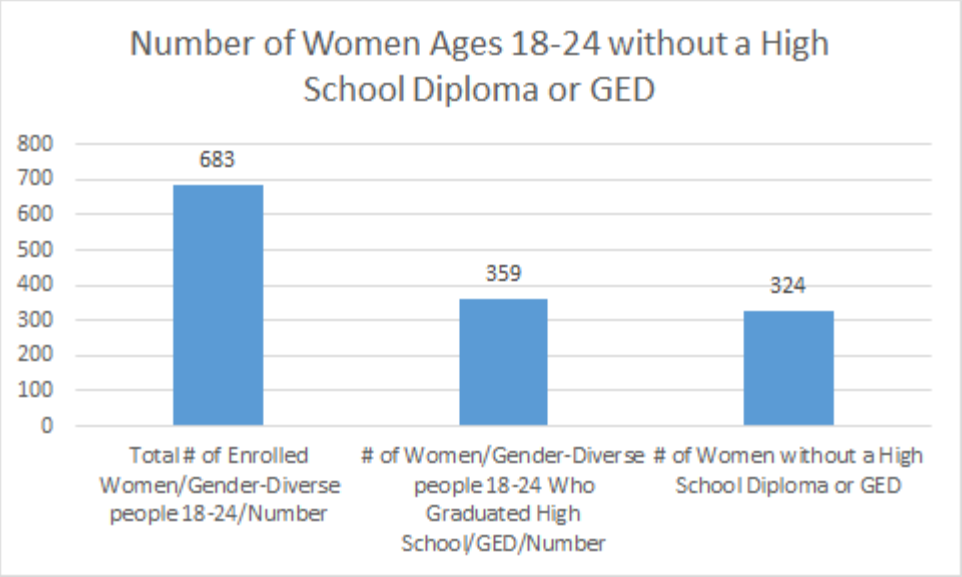
Target population: Enrolled women aged 18-24.

Measures: Percent of women 18-24 who have not graduated or obtained a GED.

Calculation: $\frac{\text{\# of enrolled women 18-24 who have not graduated or obtained a GED}}{\text{Total \# of enrolled women 18-24 as of June 30, 2021}}$

Forty-three of the 55 programs (78.2%) reported that they track this type of data on enrolled women aged 18-24. The 43 programs reported a total of 683 enrolled women aged 18-24 as of June 30, 2021. Of those 683 women, 324 (47.4%) had not graduated nor obtained a GED which represents an increase since FY 2019, when that percentage was 42 (see Figure 23).

Figure 23: Number of Women Ages 18-24/Gender-Diverse People with and without a High School Diploma or GED



Priority 3: Families Impacted by Incarceration

Children of incarcerated parents are more likely to become homeless or enter foster care.

Target population: Enrolled families.

Measures: Percent of enrolled families impacted by incarceration.

Calculation: $\frac{\text{\# of enrolled families impacted by incarceration}}{\text{Total \# of enrolled families as of June 30, 2021}}$

Twenty-nine of the 55 programs (52.7%) reported that they track this type of data on enrolled families, which represents an increase from the 27 sites that reported this information in FY 2019. The 29 sites reported a total of 1,765 families enrolled in home visiting services as of June 30, 2021, an increase from 1,447 in FY 2019. Of those 1,765 families, 149 (8.4%) were impacted by the incarceration of a family member (see Figure 24). This percentage is similar to FY 2019, when 9% of families were impacted by incarceration.

Figure 24: Number of Families Impacted by Incarceration

Home Visiting Program Perspectives

For the current reporting year, the survey contained a qualitative response section located at the end of the quantitative survey questions. These questions were implemented per the qualitative survey recommendation from the FY 2019 Report, with the intention to capture a better, more contextual understanding of the home visiting-related data that programs submit.

Six questions were included in the qualitative survey touching on COVID-19; program operations; equity; challenges families face and what could best assist them; and what programs have done to best meet the needs of the families they serve. The original qualitative questions developed were reviewed by six other individuals representing the programmatic and geographic diversity of the State. These individuals represent HFA, HIPPY, EHS, PAT, and a Promising Practice across Baltimore City, and Allegany, Baltimore, Caroline, Calvert, and Prince George's Counties. Feedback was gathered in order to make sure the questions were meaningful, clear, and relevant to the realities of home visiting. As each home visiting program represented works with unique populations, their input and guidance was invaluable.

Qualitative Section Methodology

General Thematic Analysis: As mentioned, six open-ended questions were added to the survey for this Report per the FY 2019 recommendation of including a qualitative survey component to capture greater context within home visiting services. The questions were written to

characterize home visiting program managers' perspectives on the impact of COVID-19, their families' biggest challenges, and their programs' practices.

Survey responses were downloaded into Microsoft Excel for qualitative analysis. Two analysts reviewed the responses to each question independently, and then developed a list of preliminary codes. Using this information, they collectively drafted a preliminary codebook for each question, to include a unique set of codes for each. The analysts then systematically applied codes to the data, and collectively revised codes as necessary. It is important to note that a single response could be assigned multiple codes.

The analysts collectively coded the first 10 responses to each question to reach an agreement on the meaning of each code, and to finalize the codebook. Following this, each analyst coded responses independently, with the exception of jointly coding responses to every fifth question to ensure intercoder reliability and prevent coder drift. Interpretation of responses was reasonably narrow, meaning that if a response was unclear, analysts did not assume any underlying meaning.

Data were analyzed by calculating the frequency with which each code was applied (Table 9). For the purposes of this Report, "codes" are also referred to as "themes." Table 9 provides code counts and frequencies (out of a total of 55 completed surveys). Tables 10-15 include example responses for each code. Examples are verbatim. To promote transparency and reproducibility, analysts created an audit trail of research memos, codes, and themes.

Qualitative Survey Response Themes

Table 9. Themes and Responses to Six Open-Ended Questions in HV Program Survey

Theme	# of Responses (out of 55)	% of Responses
Question 67: In what ways has COVID-19 impacted your program? *Note: this can include operations, staff, fiscal/funding, case capacity, etc.		
Remote Services	40	73%
Staff/HR Problems	29	53%
Outreach, Referral, & Enrollment	20	36%
Specific Technology Problems	9	16%
Funding Issues	8	15%
Positive Impacts	7	13%
Social Determinants of Health (SDOH)	3	5%
Question 68: In what ways has COVID-19 affected families enrolled in your program?		
SDOH	31	56%

Mental Health	21	38%
Tech Problems	12	22%
COVID-Illness Related	8	15%
Virtual Visit Problems	7	13%
Positive Effects	6	11%
Delayed Healthcare	5	9%
Enrollment	4	7%
Crisis/Survival/Emergency	3	5%
Question 69: What activities is your program engaging in to ensure equity in the following domains: *Note: Here equity is defined as ensuring that services are being provided to communities most in need/marginalized and that services are reflective of the communities they serve.		
Outreach	34	62%
Community and Stakeholder Engagement	33	60%
Staff Characteristics and Activities	21	38%
Services Tailored to the Family(ies)	20	36%
Prioritize Most Marginalized Families	12	22%
Direct Aid	8	15%
Question 70: What are the biggest overall challenges families enrolled in your program face?		
SDOH	42	76%
SDOH: Financial Stress	18	33%
Mental Health	26	47%
Virtual Services	6	11%
Services for Immigrants	4	7%
Covid-Illness Related	2	1%
Question 71: What activities or best practices has your program engaged in to help support families in these challenges?		
Referrals, Resources, and Care Coordination	40	73%
SDOH	27	49%
Direct Aid	25	45%
Social Opportunities	11	20%
Services for Immigrants	4	7%
Question 72: In your view, what could be done to strengthen the communities you serve?		
SDOH	26	47%
SDOH: Transportation	13	24%
Referrals, Resources, & Care Coordination	14	25%

Mental Health Services	12	22%
HV Program Funding	8	15%
Services for Immigrants	6	11%
Improved Technology Infrastructure	6	11%
Community Events	4	7%
Other	1	2%

The following data tables are broken down by survey question. Each table includes the frequency that each theme appeared among responses for that question and quotations from respondents related to that theme.

Question 67: In what ways has COVID-19 impacted your program? *Note: this can include operations, staff, fiscal/funding, case capacity, etc.

Table 10. Effect of COVID-19 on Programs

Theme	% of Responses	Exemplary Responses
Remote Services	73%	"Our staff worked remotely from March 2020 to July 2020 and again from November 2020 to March 2021." "In-person services suspended March 2020-April 2021; visits made by phone and supplemented by contactless drop-offs of materials and donations."
Staff/HR Problems	53%	"Due to the impact of COVID-19 the program experienced employment terminations which negatively impacted our ability to deliver pre COVID standard of services." "It has had a profound effect on our ability to recruit staff members." "The number of HV staff has not increased nor has the amount of funding thereby creating additional stress on the home visitors and administrative staff." "Staff working through personal COVID challenges with own children, child's school/daycare issues. Program funds for staff off on FMLA (extra dollars in the budget). Some staff cut hours back to be able to care for own family. It was more challenging to enroll families virtually. Staff required additional support during telework. Some staff suffered isolation, pandemic fatigue." "Staff being required to work at testing sites, vaccination clinics and contact tracing while balancing caseloads."

Outreach, Referral, & Enrollment	36%	"There was a decline in the number of referrals received for HV services in the first 6 months after the pandemic started." "Increase in referrals, especially after January 1, 2021. Home visitors operating at or near case load capacity for the entire year." "Outreach and enrollment, engaging newly enrolled families and keeping them engaged in services, have all been increasingly more challenging as the pandemic has continued."
Specific Technology Problems	16%	"Visits are shorter in length since families have limited minutes on their phones. Only one family has the technology and internet access necessary for video visits." "Challenges with moving from hard copy to digital files."
Funding Issues	15%	"Decreased funding." "Funding for the program remained level despite having to utilize a larger portion of the budget for PPE and other materials for families and staff." "The PAT Home Visiting program budget was affected by COVID-19, as there was not nearly as much mileage to be paid as services switched to virtual." "We had surplus at the end of FY21." [because of inability to fill positions]
Positive Impacts	13%	"Our funding actually increased for this year due to CARES and ARP funds." "We HAVE been able to serve a more diverse population that we were unable to serve before due to the flexibility of virtual and Activity drop offs. We have also seen an increase in engagement as well."
SDOH	5%	"Staff and families felt isolated and disconnected from one another." "Clients facing increased food/income/housing crises."

The most common theme (73%) mentioned by participants in response to the impact of COVID-19 on their program was the transition to remote services, as most programs transitioned to online or otherwise remote delivery of home visiting from the beginning of the pandemic in March 2020 until sometime in late spring or summer 2021 (with many continuing to offer virtual-only home visits). The second most common theme (53%) related to personnel and/or Human Resources (HR) problems, demonstrating the impact that the transition to remote services had on home visiting staff. A range of personnel issues were reported in the responses, including employment terminations, challenges recruiting new staff, reallocation of staff to COVID-19-related duties, and staff's own personal problems, among others.

Another notable theme that emerged in about a third of the responses was related to outreach, referral, and enrollment of families. Like staff and HR problems, this included a range of challenges for programs, including both increases and decreases in referrals and trouble managing these changes in either direction because of either overwhelming or insufficient caseloads.

Some final themes that were mentioned less frequently among respondents but still merit discussion were technology challenges, funding problems, and impact on the social determinants of health (SDOH). Thirteen percent of programs also noted positive impacts on their programs due to the pandemic, including increased funding and engagement; this merits discussion on how to maintain these gains as the pandemic becomes more manageable.

Question 68: In what ways has COVID-19 affected families enrolled in your program?

Table 11. Effect of COVID-19 on Families

Theme	% of Responses	Exemplary Responses
SDOH	56%	"One of the major impact on our families has been food insecurity; as parents lost their jobs and unemployment benefits were delayed. Most families participated in events in which food was distributed and shared with them." "Our families had faced unemployment." "Families were in need of emergency supplies more often. This included food, formula, diapers and other necessary goods. A couple of our families became homeless despite the various moratoriums on evictions."
Mental Health	38%	"Families report increased bouts of depression, lack of sufficient food supply, fatigue and anxiety." "domestic violence" "Many participants expressed feelings of increased stress and anxiety as well as loneliness and desolation."
Tech Problems	22%	"Some families were not able to participate 100% at the beginning of the pandemic due to not having access [to] internet and computers"
COVID-Illness Related	15%	"Numerous families contracted the disease and some family members of participants have succumbed to the disease."
Virtual Visit Problems	13%	"The referrals and the number of families enrolling in the program decreased. Some families disengaged when doing virtual visits."

Positive Effects	11%	“Most of our families have reported that they are financially in a better place due to increased unemployment, increased food stamps, and P-EBT. While many programs reported that their families were experiencing food insecurity, we did not find that with our families. There were so many extra food resources available in our community during COVID that our families reported they had access to more than they could use.”
Delayed Healthcare	9%	“Many families don't feel safe visiting their health providers and have canceled appointments for immunizations and well-child visits.”
Enrollment	7%	“Enrollment decreased by about 40%.”
Crisis/Survival/Emergency	5%	“Many are in survival mode- taking it one day at a time.”

The most significant ways that families were impacted by COVID-19 were with needs surrounding social determinants of health. This included issues such as increased food insecurity and supply shortages, housing instability and homelessness despite a moratorium on evictions, issues in accessing safety net programs, job loss, and economic instability. These issues were coupled with other compounding problems including mental health challenges such as increased depression and anxiety; domestic violence; issues with technology and virtual home visits; having family members die of COVID-19; delaying healthcare including vaccinations and well-child visits; and experiencing crisis situations. COVID-19 has exacerbated existing struggles families face, and has presented new challenges as well with virtual visiting and an emphasized use of technology that families may or may not have adequate access to. Further, the move to virtual visits led some to disengage from their program as they prefer in-home visits. A number of programs also reported that enrollments were down in FY 2021, with one program reporting that enrollment had decreased by about 40%.

There were reported positive outcomes, however. One program reported that families were able to access unemployment and enhanced benefits and were better off than they were prior. In addition, their community had many extra food resources available and families reported that they had more than they could use. So while most programs and jurisdictions faced compounding challenges, it is the case that a minority of programs and jurisdictions experienced positive outcomes.

Question 69: What activities is your program engaging in to ensure equity in the following domains: *Note: Here equity is defined as ensuring that services are being provided to communities most in need/marginalized and that services are reflective of the communities they serve.

a) Operations *(Program operations equity include family voice and are reflective of communities they serve)

b) Service Delivery *(Services delivered are culturally competent and trauma-informed)
c) Outreach *(Families outreached are those who could benefit most from home-visiting services, and from communities with the largest concentration of need)

Table 12. Activities to Ensure Equity in Operations, Service Delivery, and Outreach

Theme	% of Responses	Exemplary Responses
Outreach	62%	"The Healthy Families program ensures that all participants in the community are outreached equitably and systematically." "Each family was able to receive outreach based on their voiced needs as home visitors conducted weekly home visits." "We engage and partner with organizations like WIC whose goals are focused on those with the greatest need. Additionally our enrollment efforts also are focused on reaching those communities where the high level of need exists."
Community and Stakeholder Engagement	60%	"Family surveys are conducted annual allowing families a chance to voice level of satisfaction with services received and offer feedback about the program. Families are invited and encouraged to participate on the sites Advisory Board which meets quarterly." "Families from each county community have a voice through the program Head Start Policy Council." "We offer monthly groups based on the wants and needs of our enrolled families. We survey our families to learn about their specific ideas so we can better serve them."
Staff Characteristics and Activities	38%	"All staff have received ACEs (Adverse Childhood Experiences) training." "Our service staff is representative of the community, including Black, Latina, and white staff members. Diversity is valued in hiring, with an emphasis on the value of lived experience." "Staff are largely hired from the areas we serve. Staff are reflective of the population we serve." "Staff have taken classes for trauma informed care, undoing racism and Mental health first aid"
Services Tailored to the Family(ies)	36%	"Services and materials are provided in Spanish and English, as well as other relevant languages whenever possible. Materials are chosen that reflect the cultural and racial makeup of our service population. Accommodations in service provision is made for participants with limited literacy, learning differences, and/or intellectual disabilities."

Prioritize Most Marginalized Families	22%	"We use a community needs-assessment as the guide for determining our target population for enrollment" "The focus of the BBH/Healthy Start program is primarily on pregnant and postpartum women affected by substance use disorder, mental health diagnosis, and high risk Non-Hispanic and Hispanic women referred to BBH/Healthy Start in the census tracts experiencing the highest infant mortality disparities and adverse outcomes."
Direct Aid	15%	"We provided daily meals to interested families along with weekend food boxes." "Diaper and local produce distribution continued during this time (arrangements were made for families who could not drive to get them)" "We provided lap tops to families in need."

Programs try to address equity in multiple and overlapping ways. As seen in Table 12, Outreach and Community and Stakeholder Engagement are the dominant ways in which programs seek to advance equity, with each theme evident in 62% and 60% of respondents, respectively. As seen in the second exemplary quote, programs are often concentrating their services to areas in their communities that have been identified as having need in addition to engaging with other providers in the community so they may be responsive to a variety of needs a family may have. Families are also often surveyed by programs to gauge whether the services are meeting their needs, and in the case of EHS families, are offered the opportunity to participate in a Parent Advisory Council so that they may have more direct input into the program.

Thirty-eight percent of programs referenced staff in relation to equity. This involved initiatives such as staff training on Adverse Childhood Experiences (ACEs) and trauma-informed care; the Undoing Racism workshop offered by the People's Institute for Survival and Beyond; valuing diversity in hiring; prioritizing lived experience when hiring staff; and making sure that staff were reflective of the community they served, and hired from the community. A similar proportion of programs (36%) responded that they tailor services to families in a number of ways: by utilizing individualized service plans; utilizing culturally competent materials and materials that are translated into multiple languages; making accommodations for clients with disabilities; utilizing survey feedback; and having bi/multilingual staff.

To ensure that services are equitably distributed, 22% of programs responded that they take steps to prioritize services to the most marginalized families in the communities they serve. Programs achieve this by conducting and utilizing community needs assessments to know where and to whom services are most needed; by utilizing zip code-level data to identify where to target services; by assessing family risk factors; and by utilizing a prenatal risk assessment or

vulnerability index in order to prioritize services. Fifteen percent of programs provided direct aid to families to ensure equity in a tangible way. Programs directly provided food boxes via door-to-door delivery on a monthly or weekly basis; provided baby supplies (diapers, wipes, formula); purchased laptops and tech devices so that families without means or access were able to take part in services; operated in-house donation services; and provided learning kits for the home.

In summary, many programs in FY 2021 have utilized numerous avenues to ensure their services are as equitable as possible. This has included involving family voice in their operations and programming; utilizing assessments and analytics to identify where home visiting would be most equitably accessed; working with partners to ensure that needs can be addressed; ensuring that staff are reflective of the community and have appropriate training; and have assumed a direct response to equitable resource distribution by providing supplies directly to families facing food insecurity and crucial supply shortages. Many home visiting programs have engaged in multi-faceted ways, using a mix of programmatic, policy, capacity, and direct tools to best ensure equity in their services amidst an unprecedented time.

Question 70: What are the biggest overall challenges families enrolled in your program face?

Table 13. Biggest Overall Challenges Faced by Families

Theme	% of Responses	Exemplary Responses

SDOH	76%	“Access to affordable health care.” “Prenatal care access is many times difficult to access as clinics may be at capacity and services are expensive. Prenatal care access is sometimes conditioned to the stage of pregnancy.” “Affordable Housing.” “Transportation.” “Limited support network.” “Financial stability is a challenge. Securing employment that pays well, is flexible to families with young children and allows for professional/career growth is difficult to obtain. Affordable child care is also an issue that may exacerbate employment success.” “Our families typically have a lack of resources, such as housing, employment, transportation, health care, and child care. Furthermore, our families tend to have a history of adverse childhood events (ACE's) or childhood trauma, contributing to mental health and physical challenges in their adulthood.” “Increasing substance use.” “Increasing mental health issues.” “Increasing community violence, including gun violence.”
SDOH: Financial Stress	33%	“Currently the biggest challenges seem to be financial. The program is serving many families who are worried about eviction and homelessness after months of being behind on their rent or the inability to pay their rent. The other financial challenges stem from lack of childcare due to the reduction of childcare facilities from the pandemic and the surge in childcare prices in order for families to return to work.” “Severe financial problems/at or below poverty level.” “The biggest challenge relates to financial barriers. This hinders families from working on being the best parent.”
Mental Health	47%	“Many, many have trauma histories and/or grew up in households with toxic stress levels and they have not received effective mental health treatment.” “Parent anxiety about enrolling children in a home visiting program during a global pandemic.” “Adverse Childhood Experiences of the primary adult in the home” “pre-COVID challenges are now compounded with the effects of the pandemic, making maintaining mental health more challenging than ever for the enrolled PAT families.”

Virtual Services	11%	"One of the biggest challenges faced by Healthy Families Calvert County families in FY 2021 was adjusting to the new way of conducting home visiting – virtually and/or telephonically. Some families experience "Zoom fatigue" - being overwhelmed due to multiple hours in front of electronic devices. Additionally, families grappled with having enough bandwidth to meet with home visitors on virtual platforms." "technology issues or lack of technology" "Not having proper equipment and internet during the pandemic"
Services for Immigrants	7%	"Language barriers" "Access to mental health providers that speak home language." "Legal status" "Access to affordable prenatal care for undocumented pregnant women who do not qualify for medical assistance."
COVID-Illness Related	1%	"Covid-19 illness and deaths"

As with responses to questions about how COVID-19 affected families, the dominant theme that arose among responses to this question was related to the SDOH. Programs reported that their families struggled with housing, transportation, employment, childcare, healthcare, food security, community violence, and more. Many of these problems are related to low-income and/or income instability, which the analysts presented as a sub-theme (SDOH: Financial Stress) because about a third of programs specifically mentioned that their families have financial challenges. These findings are not surprising given that home visiting programs intend to serve low-income, vulnerable, and marginalized families. However, the broad range of challenges that families face underscores the need for home visiting programs to have strong linkage and referral practices to other high-quality social service providers alongside the curricula they deliver.

Another common theme that emerged as one of the largest overall challenges for families among about half of respondents was mental health. Caregivers were described as having trauma histories, and some struggle with anxiety, depression, and toxic stress without having access to care. Several respondents specifically mentioned high levels of Adverse Childhood Experiences (ACEs), which research has shown is linked to elevated risk of numerous chronic conditions. These responses suggest that linkage to mental health care for parents and children should be a priority of home visiting programs, particularly in the context of a growing body of literature on the importance of early relational health.

Question 71: What activities or best practices has your program engaged in to help support families in these challenges?

Table 14. Best Practices to Support Families During COVID-19

Theme	% of Responses	Exemplary Responses
Referrals, Resources, and Care Coordination	73%	"We have worked with our local Adult Education Program to develop a 2G Center for Strengthening Families. This center is a one stop shop where parents can access GED/ABE services, obtain job skills, complete work readiness activities, do job skills assessments to earn national credentials, etc." "Collaborate with local DSS to assist families with completing SNAP, WIC, and referrals to local food pantries." "We refer families to Meds Trans and Mobility Manager through HRDC for transportation. For child care, we refer families to DSS for child care vouchers and Apples for Children website to find licensed child care providers." "Linkages to Baltimore Crisis Response, Attempted Calls to Baltimore Housing, Successful Calls to Local Shelters, Attempted and Successful Call/Referrals to Early Head Start, Successful Calls to Mayor's Office of Employment and Development."

SDOH	49%	“Access to affordable health care: We have connected families to prenatal care access at Mary's Center and other community clinics that offer a sliding scale fee so services can be paid based off the participant's income and capacity. “Prenatal Care access: We do out best to connect the family with prenatal care services within the Mary's Center. However, we do our best to connect the family with other community clinics if Mary's Center has no capacity at the time the service is needed.” “Affordable housing: We search in different websites and share the referral. However, there are instances in which the participant cannot provide the required documentation in the application due to legal status. Therefore, we encourage families to inquire within the social circle as this is something we have noticed that has worked in the past. Yet, the housing comfort may be impacted.” “Transportation: We work on education families to use public transportation when available or if possible, we have provided free rides to participants when there is an important appointment (prenatal care or doctor visit) if program budget allows.” “We assist families with how to connect to community resources, help with resume writing, filling out employment applications and interview practicing.” “In addition, our agency also provides services beyond EHS & HS to help families try and obtain self sufficiency through job training, GED courses, life skills, etc.”
Direct Aid	45%	“Chromebooks and hotspots” “monthly give away of food and diapers.” “We utilized emergency funding to support families with diapers, formula, and other basic care needs” “Currently the program has a housing grant which allows us to give participants $500 a month if they meet their expected number of home visits a month. We have found that this has not only increased engagement but has support families in maintaining housing and providing food for their family.” “We have assisted families by paying child care enrollment fees and weekly child care costs….We have helped pay fees for school/skill advancement opportunities.”

Social Opportunities	20%	"Our family support center also has a center-based program and the home visit families can join in on the socialization activities and special events." "Family events, designed to engage families in literacy and social/emotional learning, were held in the spring" "Monthly Parent Support Group Meetings" "For families who struggled with isolation and limited support they were given information and/or referred to virtual support groups. These groups allowed parents to have social network that included other moms who may be having a similar experience"
Services for Immigrants	7%	"Bilingual Parent Educator" "We also work with the Local Community College to provide ESL to Families who request it"

The most common theme that emerged regarding best practices that programs engaged in to support their families' challenges was related to referrals, resources, and care coordination. This is not surprising as these practices are an integral part of most home visiting models. Among the nearly three quarters of responses that mentioned these practices, a frequent topic was referral or collaboration with other local social services, such as adult education, job training, childcare, housing organizations, and formal and informal medical services. Because of these referrals, many of these responses were also coded as addressing the SDOH—the second most common theme that emerged. However, these themes were distinct because some programs provided services in-house, while others only coordinated care for health-related issues.

Nearly half of the programs described engaging in direct aid to their families, meaning the provision of in-kind goods like food, diapers, formula, and technology items. In some cases, programs even paid for or provided money for rent, childcare fees, and adult education. Given the volume of programs engaging in these services, more research is needed to evaluate the importance of direct aid as a part of home visiting programs.

Question 72: In your view, what could be done to strengthen the communities you serve?

Table 15. Ways to Strengthen Communities Served

Theme	% of Responses	Exemplary Responses

SDOH	47%	"Free health care access to prenatal participants or at least prenatal care services." "More affordable child care access." "We need more family friendly structures in place in the community such as affordable, safe housing, access to affordable child care and employers who pay a living wage." "provide more comprehensive programming, more job training programs, provide a pathway to citizenship, offer affordable housing and affordable childcare options, provide more early childhood education programs, more family literacy programs, more case management services, and more opportunities for peer support" "Hold landlords responsible for safe and secure and affordable housing"
SDOH: Transportation	24%	"Our community needs a much better public transportation system. The current system does not serve all areas of the county and does not have accessible pick up/drop off locations for all of our families. The system also is typically only available weekdays and not weekends and evenings." "Provide better public transportation, extending bus routes to all areas of the county and reducing rates." "provide affordable transportation options (city buses, fleet of mini-vans to transport women and children to medical appointments)"
Referrals, Resources, & Care Coordination	25%	"Charles County needs better connection between services - many providers are overtasked and underpaid, and not able to efficiently coordinate services." "Partnerships with community agencies, private and public, and coordination among macro level leaders and policy makers is an opportunity to strengthen our communities."
Mental Health Services	22%	"Our community is also plagued with tremendous trauma. Investing in prevention programs can help break the cycle of trauma and abuse and connect families with the help and support they need." "Reduced stigma surrounding mental health and those impacted by substance [use]."
HV Program Funding	15%	"More money to pay staff (less turn-overs) and so families can keep consistency in their life through staff." "Additional funding for grant programs – increasing home visitor salaries to prevent to attrition and increased funding to meet the needs of the families enrolled – would strengthen this program."

Services for Immigrants	11%	“More Equity: If undocumented families had the same opportunities to access health care services, jobs and education, there will be less poverty.” “More Ethiopian/bilingual staff” “Empathy towards immigrants”
Improved Technology Infrastructure	11%	“The Advocates believe that offering families devices and providing internet access would be beneficial to the community, so that more members of the community could engage in virtual services.” “The next thing would be related to technology and have it easier for Families to connect to reliable AND affordable internet in the area. Many children during lockdown struggled because the HotSpots given to Rural Families, did not work very well.”
Community Events	7%	“More free art and cultural community events.”
Other	2%	“Multiple focus groups have been completed with families on varying topics. When offered to attend more focus groups families have asked "what has been completed with the last information given?" One way that the community could be strengthen is transparency as it relates to research, focus group, and studies.”

Respondents identified a number of areas that would, in their view, benefit the communities they work with. Responses were wide ranging, covering areas such as SDOH, resources and care coordination, mental health services, technology infrastructure, and transparency in research done in their communities. The most common area respondents referenced was SDOH, with about half of respondents addressing issues such as healthcare access, affordable and safe housing, employment and wages, and child care. Transportation was referenced so often within the SDOH theme that a separate code was created to appropriately account for its frequency -- SDOH: Transportation. Programs reported that extending transportation lines more extensively into counties, more affordable transportation, and more service times on nights and weekends would be helpful for their communities.

Programs stated the need for strengthening and creating additional partners and referral systems to better address family needs, and that more work could be done with leaders and policy on a macro level. This was a common theme emerging among 25% of respondents, and can intersect with many of the other areas mentioned (SDOH, Mental Health, Services for Immigrants, etc). Mental Health Services was referred to by 22% of respondents and many emphasized specific service needs for families around trauma and investing in prevention services, abuse, reducing stigma, and substance use.

An interesting observation within the “HV Program Funding” theme was the emphasis on staff wages. As demonstrated in Table 15, staff wages are seen as tools to reduce turnover and create

consistency with families. With regular and consistent staffing, respondents suggest that programs would be better at serving the needs of families.

Eleven percent of programs stated that better meeting the needs of immigrant families was important. Specifically, respondents mentioned more Ethiopian/bilingual staff; more empathy towards immigrants; and equitable access to healthcare, jobs, and education opportunities.

Improved Technology Infrastructure appeared at the same frequency (11%) as Services for Immigrants and included specific recommendations such as providing devices and internet access, noting that consistent and affordable internet access would be helpful to children in the community.

Observations Among Urban, Suburban, and Rural Jurisdictions

Across all jurisdictions programs reported similar challenges: program and operations practices were affected by COVID-19 in similar ways, and many identified and shared solutions to common barriers families faced in their communities. For example, all geographic areas reported implementing virtual home visiting services, facing challenges with turnover and staffing, experiencing lower enrollments, engaging in equity work, and providing direct aid to families.

Yet while there are many similarities across jurisdictions, there are a number of nuanced differences observed among them. For example, for question 72, only rural jurisdictions and one suburban jurisdiction referenced transportation as something that could help strengthen the communities they serve. Rural and suburban counties were also the only geographies to emphasize Services for Immigrants in question 72. In question 68, the Positive Effects code and Crisis/Survival/Emergency code were exclusive to rural Counties. More specifically, Allegany County was the only jurisdiction in which both of these codes were identified. Two programs discussed families being in survival mode, and all four programs reporting from Allegany County said that families had experienced positive effects. All four programs are in the same zip code and located in the same city, but span the western, central, and eastern parts of that city. The western- and eastern-most programs reported their families having positive experiences, while the two central programs reported having families experiencing crises and increased feelings of isolation in addition to positive effects. Local level differences can exist anywhere and are a common phenomena within zip codes and cities, though it is interesting that this time they can be seen so starkly in a rural city.

Progress to Date: FY 2019 Recommendations

In the table below are the recommendations made in FY 2019 and the progress to date.

Table 16. Progress on FY 2019 Recommendations

Recommendations from FY 2019 Data on Standardized Home Visiting Measures	Progress on FY 2019 Recommendations
<u>Recommendation 1: Increase Educational and Employment Opportunities for Mothers Aged 18-24</u> Of the 44 sites that reported on educational and employment attainment, 54% of the women enrolled in their programs were disconnected from employment and school opportunities -- a 2% increase from FY 2017. Of those 828 women aged 18-24, 57% had graduated or obtained a GED. Although this represents an increase from FY 2017, many young women served by home visiting programs do not have a high school diploma. Research has well established that poverty and limited maternal educational attainment have negative effects on childhood outcomes including behavior, IQ, allostatic load, and physical health. Childhood, birth outcomes, in addition to maternal health indicators, are also known to be affected by maternal unemployment. Additionally, limited educational attainment which is associated with increased probability of low birth weight, decreased gestational age weight, poorer maternal health, low-income, social disadvantage, and higher rates of maternal mortality. Adverse outcomes, using preterm birth as an example, is a particularly salient experience for Black mothers who are the majority of women served by home visiting programs in Maryland. Considering the research in conjunction with the data for Maryland, it is imperative that employment/income and education opportunities and services are accessible to young mothers.	As of FY 2021, 63% of the women aged 18-24 enrolled in their programs were disconnected from employment and school opportunities. This is a large increase from 54% in FY 2019. It may be due to the fewer number of programs reporting indicating the possibility that programs with more engaged young parents were the ones who did not submit a survey which means that the percentage could be lower. In FY 2021, there were 677 fewer women aged 18-24 that were accounted for which could have impacted the sample to skew high. Additionally, 52.5% had graduated or obtained a GED. This is a decrease from 57% in FY 2019, which again, may be due to the more limited data due to program closures. Because both measures trended in a negative direction, it is possible that FY 2021 had a greater adverse impact on that demographic. As of this Report, there is no indication of a concerted effort or campaign to address educational or employment opportunities for mothers aged 18-24. This recommendation will remain.

Recommendation 2: Taking Action on Home Visitor Retention In FY 2019, similar to FY 2017, the primary cause (54.5%) of home visitor turnover was finding employment elsewhere with either higher pay or benefits. For FY 2019, a little over a quarter of all home visiting staff exited their positions primarily for that reason, in addition to burnout, feeling unfit for the position, personal circumstances such as health complications or moves, retirements, and terminations. Turnover has effects on families as well by negatively affecting rates of retention and contributing to continued familial issues. While staff turnover and retention, particularly in human/social services, can be a complex and ecological phenomena that encompass a wide array of causes/strategies, for this specific labor market, as illustrated by recent data collection, increasing pay for home visiting staff should be considered. To this end, it is important to note that there is work being done between MIECHV and its funded sites to introduce non-monetary strategies to increase retention. These strategies include reviewing retention and recruitment information from HRSA and conducting an upcoming webinar for sites so that they can receive the information in an efficient manner and implement the strategies provided as they see fit, and developing and introducing the SEN training so home visitors feel more secure addressing issues arising from substance use. As mentioned previously, the two-day SEN training developed by UMBC in conjunction with MIECHV has reached a total of 247 staff across the State, including not only home visitors but community health workers, supervisors, and other staff who work with infants and toddlers. This training has provided more tools and education that staff can keep in their toolbelt to address substance use with mothers and families that are both prenatal and postpartum (https://homevisitingtraining.umbc.edu/curriculum/substance-exposed-newborns). Programs with vacancies must assign an increased workload to limited staff which increases caseloads of remaining staff and restricts recruiting and retention efforts. With higher work demands concentrated over long periods of time, the probability of turnover increases and the cycle continues. Absent meaningful intervention in areas identified by home visitors that contribute to turnover, in this case, compensation and benefits, there will likely be very little change in	In FY 2021, the primary cause (54.5%) of home visitor turnover was finding employment elsewhere with either higher pay or benefits. This percentage remains unchanged from FY 2019. In addition, in FY 2021, a total of 50 staff turned over, representing 22% of the overall home visiting workforce. Reasons staff left included personal circumstances such as health complications or needing to become a primary caregiver for family who became sick, retirements, terminations, and COVID-19 related illness and fear. Turnover has effects on families as well by negatively affecting rates of retention and contributing to continued familial issues. While staff turnover and retention, particularly in human/social services, can be a complex and ecological phenomena that encompass a wide array of causes/strategies, for this specific labor market, as illustrated by recent data collection, increasing pay for home visiting staff should be considered as budgets allow. Programs with vacancies must assign an increased workload to limited staff which increases caseloads of remaining staff and restricts recruiting and retention efforts. With higher work demands concentrated over long periods of time, the probability of turnover increases and the cycle continues. Absent meaningful intervention in areas identified by home visitors that contribute to turnover -- in this case, compensation and benefits -- there will likely be very little change in retention or turnover rates with home visiting staff. As such, this recommendation will remain for FY 2021.

retention or turnover rates with home visiting staff.	
<u>Recommendation 3: Investigate Feasibility of Statewide Centralized Data System</u> The Maxwell system, while continuing to be increasingly useful for MIECHV and the sites MIECHV funds, has a number of limitations. Maxwell is currently limited to MIECHV-funded sites implementing the Healthy Families America (HFA) evidence-based curriculum, which has resulted in Maxwell being curated specifically to meet the needs of HFA only. Out of the 70 programs reporting in FY 2019, 25 (35.7%) were HFA programs. There are only 14 MIECHV HFA sites that currently utilize Maxwell to its full capabilities. This means that only 20% of home visiting sites Statewide have access to a centralized data system. The possibility remains that Maxwell is utilized by all Maryland home visiting programs and could be curated to serve not only HFA programs, but Parents as Teachers curriculum, HIPPY programs, Early Head Start, Family Spirit, and other evidence-based and promising-practice home visiting models. This would require mapping out and coding their standards into the current system. This process could be facilitated with relative ease as Maxwell developers have ongoing CQI and implementation-feedback with MIECHV and provider sites. Centralization provides an opportunity for increased efficiency, transparency, and data accountability and could aid in data collection efforts for future reports and research**.** Establishing a centralized data system also allows for data to be shared across sectors and programs to highlight best practices, uncover the strengths and weaknesses of the Maryland home visiting system and increase collaboration between institutional entities. A centralized data system further lends itself to the alignment of family health indicators among all home visiting programs.	To date, MIECHV sites remain the only home visiting programs that have access to the Maxwell data system. Talks of a centralized system remain, but there has been no tangible progress on this recommendation.

Recommendation 4: Inclusion of Family-Centered Qualitative Data This Report captures crucial data on home visiting programs and the individuals served throughout Maryland. Although the data encompass a large swatch of important public health-related indicators and display "how" home visiting is working, the "why" behind the data is missing. This hole in the data could be filled with a mixed-methods approach, adding a supplemental qualitative survey accompanying the report survey for sites to report on the conditions and barriers that families, staff, and programs face in order to further contextualize the quantitative data reported, and deliver a holistic representation of the home visiting landscape of Maryland. Additionally, any nuanced differences among jurisdictional needs or operations can be missed without clarifying information. Utilizing open-ended questions, there remains the possibility of a site reporting something important to front-line processes or operations that is outside of the scope of this Report. Adding context to data is crucial to developing a deep understanding of what the data represent. The more that can be gathered, the better understanding one can have of the home visiting landscape of Maryland.	This FY 2019 recommendation was adopted in FY 2021 and six qualitative questions were added to the survey to address the contexts that surround home visiting. This has resulted in the FY 2021 survey being more of a mixed-methods approach, and the information that programs have provided on themselves and their families has resulted in more nuanced and rich responses. These qualitative questions proved especially useful in capturing the many creative ways in which the home visiting programs supported their families during the COVID-19 pandemic.

Recommendations from FY 2021 Data on Standardized Home Visiting Measures

Recommendation 1: Increase Educational and Employment Opportunities for Mothers Aged 18-24

This recommendation originated from the FY 2019 report and will remain a recommendation for this Report. Of the 43 programs that reported on educational and employment attainment, 63% of the 653 women aged 18-24 enrolled in their programs were disconnected from employment and school opportunities -- an increase from 54% in FY 2019. Of those 653 women, 241 (36.9%) had graduated or obtained a GED, demonstrating a significant decrease from 57% in FY 2019. Research has well established that poverty and limited maternal educational attainment have negative effects on childhood outcomes including behavioral health, physical

health, and cognitive development.[32] Childhood, birth outcomes, and maternal health indicators are also known to be affected by maternal unemployment.

Additionally, limited educational attainment is associated with increased probability of low birth weight, decreased gestational age weight, neonatal and postnatal death, maternal mortality, and preterm birth.[33] [34] [35] Adverse outcomes, for example preterm birth, are more likely for Black mothers, who are the majority of women served by home visiting programs in Maryland. Considering the research in conjunction with the data for Maryland, it is imperative that employment/income and education opportunities and services are accessible to young mothers.

Recommendation 2: Take Action on Home Visitor Retention

In FY 2021, the primary cause (54.5%) of home visitor turnover was finding employment elsewhere with either higher pay or benefits. This percentage remains unchanged from FY 2019, and remains the primary cause of turn over since FY 2017. In addition, in FY 2021, a total of 50 staff turned over, representing 22% of the overall home visiting workforce. Other reasons staff left were due to personal circumstances such as health complications or needing to become a primary caregiver for family who became sick, retirements, terminations, and COVID-19 related illness and fear. Turnover has effects on families as well by negatively affecting rates of retention. While staff turnover and retention, particularly in human/social services, can be a complex and ecological phenomena that encompass a wide array of causes/strategies, for this specific labor market, as illustrated by recent data collection, increasing pay for home visiting staff should be considered.

Programs with vacancies must assign an increased workload to limited staff which increases caseloads of remaining staff and restricts recruiting and retention efforts. With higher work demands concentrated over long periods of time, the probability of turnover increases and the cycle continues. Absent meaningful intervention in areas identified by home visitors that contribute to turnover, in this case, compensation and benefits, there will likely be very little change in retention or turnover rates with home visiting staff. It seems that non-monetary strategies have not meaningfully affected the retention of home visitors. In lieu of this, it would

[32] Jackson, M., Kiernan, K., & McLanahan, S. (2017). Maternal Education, Changing Family Circumstances, and Children's Skill Development in the United States and UK. *The Annals of the American Academy of Political and Social Science*, *674*(1), 59–84. https://doi.org/10.1177/0002716217729471.

[33] Luo, Z. C., Wilkins, R., & Kramer, M. S. (2006). Effect of neighbourhood income and maternal education on birth outcomes: a population-based study. *Cmaj*, *174*(10), 1415-1420.

[34] Karlsen, S., Say, L., Souza, JP. *et al.* The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health. *BMC Public Health* 11, 606 (2011). https://doi.org/10.1186/1471-2458-11-606

[35] Din-Dzietham, R., & Hertz-Picciotto, I. (1998). Infant mortality differences between whites and African Americans: the effect of maternal education. *American journal of public health*, *88*(4), 651–656. https://doi.org/10.2105/ajph.88.4.651.

be advantageous for home visiting programs, and funders to find ways of increasing home visitor compensation, and find ways to increase support for other causes of turnover.

Recommendation 3: Improve Comprehensive Systems of Care

In FY 2021, programs overwhelmingly indicated that SDOH and mental health were significant challenges to families, especially during the COVID-19 pandemic. SDOH can be defined as: "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[36] Many families faced food insecurity, housing instability and homelessness, baby supply shortages, transportation barriers, healthcare access barriers, lack of childcare, unemployment and economic instability/poverty, increases in depression, IPV, anxiety, feelings of isolation, and crisis situations. SDOH inequities can result in elevated mortality, as an antecedent to chronic disease, and fall upon the most marginalized families.[37] [38] [39]

As a result of this, the labor of coordinating care fell into home visitors who had to work in dual roles -- both in their capacity providing parental education, fostering parent-child attachment and positive child development, and taking on case management roles for their families. Home visitors typically do some amount of coordinating services, though are not trained or expected to manage the needs of families through multiple crises.

A low barrier comprehensive system to coordinate multiple systems of care could provide families with a single point of contact for multiple resources, and take the burden of case management off of home visitors so that they can fully invest in their piece of the care system. There is also evidence that centralized coordination can lead to lower costs of care over time.[40]

The coordination of care would require a tight infrastructure and well facilitated partnerships among home visiting programs, social service agencies, safety net programs, healthcare entities, and others that cater to the specific needs of families. Examples of such a system exist in Baltimore City and Baltimore County. Baltimore City has Healthcare Access Maryland (HCAM), which operates as the centralized intake for the city for home visiting, healthcare, housing, and

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[36] Centers for Disease Control and Prevention. (2021, March 10). *About Social Determinants of Health (SDOH)*. Social Determinants of Health: Know What Affects Health. Retrieved 10 25, 2021, from https://www.cdc.gov/socialdeterminants/about.html.

[37] Kim D. The associations between US state and local social spending, income inequality, and individual all-cause and cause-specific mortality: The National Longitudinal Mortality Study. Prev Med. 2016 Mar;84:62-8. doi: 10.1016/j.ypmed.2015.11.013. Epub 2015 Nov 25. PMID: 26607868; PMCID: PMC5766344.

[38] Clark, M. L., & Utz, S. W. (2014). Social determinants of type 2 diabetes and health in the United States. *World journal of diabetes*, *5*(3), 296–304. https://doi.org/10.4239/wjd.v5.i3.296.

[39] Quiñones, J., & Hammad, Z. (2020). Social Determinants of Health and Chronic Kidney Disease. *Cureus*, *12*(9), e10266. https://doi.org/10.7759/cureus.10266.

[40] Rodriguez, S. R., & Pirlot, S. (2021). Return on Investment of a Centralized Telephonic Case Management Program in a Commercial Population. *Nursing Economics*, *39*(1), 39-42.

food access. Many partner organizations and service providers have worked to build and continually improve upon the coordination system with HCAM, and amongst each other to provide as comprehensive coordination of services/care as possible. The more newly-developed Maternal and Child Health intake system in Baltimore County utilizes a vulnerability matrix to triage clients to different programs within the Baltimore County Health Department. This allows for streamlined processes, taking the burden of managing multiple needs of clients off of home visitors, and placing it into the hands of institutions which have more resources and capacity to respond to client needs quickly.

Recommendation 4: Increase IPV Screenings, Referrals, and Supports

In FY 2021, only 58% of programs reported that they screened participants for IPV. And of those who received a positive screening, only 52% developed a safety plan within 48 hours. While these numbers are slight improvements from FY 2019, the risk of missing instances of IPV and providing support is high and the consequences could be disastrous for families, maternal health and morbidity,[41] and child developmental outcomes.[42]

Domestic and IPV were specifically mentioned by programs in qualitative responses as occurring more or being exacerbated by the COVID-19 pandemic, which reflects national and global trends.[43] [44] In order to adequately provide support and identify when and where IPV is occurring, it is imperative that programs adopt screening protocols for caregivers and develop systems that can rapidly respond by assisting with safety plans, resource and shelter identification, transportation, and other needs that may arise. Quick and comprehensive responses could prevent negative outcomes associated with IPV for parents and children, create stability, and save their lives.

Conclusion

The data in this summary Report on Maryland Home Visiting Standardized Measures identifies the impact of home visiting on the well-being of families served. In FY 2021, 3,768 women and 3,431 children were served through one of seven evidence-based home visiting models and three promising practices. The data reveal that Maryland home visiting has continued to

[41] Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during pregnancy: maternal and neonatal outcomes. *Journal of women's health*, *24*(1), 100-106.
[42] Wathen, C. N., & Macmillan, H. L. (2013). Children's exposure to intimate partner violence: Impacts and interventions. *Paediatrics & child health*, *18*(8), 419–422.
[43] Rossi FS, Shankar M, Buckholdt K, Bailey Y, Israni ST, Iverson KM. Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19. J Gen Intern Med. 2020 Sep;35(9):2728-2731. doi: 10.1007/s11606-020-05990-0. Epub 2020 Jun 30. PMID: 32607932; PMCID: PMC7325833.
[44] Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American journal of emergency medicine*, *38*(12), 2753-2755.

positively affect families and children, and that programs worked diligently to continue providing services for families during the COVID-19 pandemic. Of those sites that complete child and social emotional developmental screenings, 94% of children have been screened for typical development, and 94% have been screened for social emotional development, maintaining the percentage completed from FY 2019. In addition, 78% of children with positive screenings for social emotional needs were referred for services, which is an increase from 71% in FY 2019. Seventy percent of children were screened for Part B and Part C services, compared to 71% in FY 2019, and 49% of those screened received early intervention services, compared to 79% in FY 2019. In addition, the number of children who attended their most recent well-child visit decreased from 87% in FY 2019 to 65% in FY 2021.

The data related to maternal health and family relationships indicate that the extent of focus on the primary caregiver varies among the different home visiting models. Eighty-one percent of reporting sites screen for maternal depression; 58% screen for IPV and 52% complete a safety plan within 24 hours; 58% screen for substance use; and 54% screen for parenting stress. Each of these indicators has improved from FY 2019.

While there are observed improvements, the qualitative survey section reveals numerous challenges faced by programs and families. Due to COVID-19 and the subsequent restrictions on in-person visits, programs had to rapidly adapt their services to a virtual world. They met the challenge of the moment, but still faced a number of challenges including difficulty in adjusting to virtual visits, lower enrollments, difficulty in outreach, concerns about model fidelity, staff turnover due to COVID-19 and feeling isolated, and home visitors had to adapt to serving in additional capacities than they had (i.e., case management for families). Families experienced a myriad of issues surrounding social determinants of health, mental health, technology and virtual visits, COVID-19 related illness and family deaths, crisis/emergency situations, and some immigrant families faced additional barriers due to their legal status and language barriers.

Home visiting programs adopted their programs to try and best meet the exacerbated and emergent needs of families. The majority of programs worked to strengthen and expand their referral network to better meet the needs of families, more quickly and comprehensively. Some programs also began providing direct aid in the form of emergency supplies, food/produce delivery, and some providing transportation to families to appointments. A few programs also linked immigrant clients to ESL classes and brought on bilingual staff to best meet their families needs.

During FY 2021, COVID-19 forced programs across Maryland to drastically change how they approached their work. It also created compounding inequalities for families enrolled in programs. Home visiting programs in Maryland stepped-up, often beyond their capacity to try and meet the emerging needs of families. Working together, programs and families were able to

usher themselves through an unprecedented and tumultuous year.

APPENDICES

Appendix A: *FY 2019 Maryland Home Visiting Sites Reporting Data*

Appendix B: *All Maryland Home Visiting Sites FY 2019*

Appendix C: *Maternal Depression Screening Tools*

Appendix D: *Maternal Substance Use Screening Tools*

Appendix E: *Parenting Stress Screening Tools*

Appendix F: *Child Development Screening Tools*

Appendix G: *Social Emotional Development Screening Tools*

Appendix H: *FY 2019 Home Visiting Data Survey Results*

Appendix I: *Intimate Partner Violence Screening Tools*

Appendix J: *Progress to Date FY 2015 Recommendations*

Appendix A: FY 2021 Maryland Home Visiting Sites Reporting Data

Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	PAT
YMCA Cumberland	PAT
Allegany County HRDC, Inc	EHS
Healthy Families Allegany County, Allegany County Health Department	HFA
Anne Arundel County	
Annapolis Family Support Center (FSC)	PAT
Anne Arundel Healthy Start	PP
The Y of Central Maryland	EHS
Baltimore City	
Family Tree	HFA, ABC, FC, PATH
Baltimore City Health Department Maternal and Infant Care Program	NFP
DRU/Mondawmin Healthy Families (DRUM)	HFA
Park Heights Renaissance	HIPPY
Sinai Hospital of Baltimore Inc. M. Peter Moser Community Initiatives	HFA
Baltimore County	
Healthy Families Baltimore County, Abilities Network	HFA
Young Parent Support Center	PAT
YMCA Highland Village Head Start Center	EHS (2 sites)
Calvert County	
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA, PAT
Caroline County	
Federalsburg Judy Hoyer Center (FSC)	PAT
Healthy Families Mid-Shore, Caroline County Health Department	HFA
Carroll County	
Family Support Center (FSC)	PAT
Judy Center Partnership Parents as Teachers Program	PAT
Associated Catholic Charities	EHS
Cecil County	
N/A	N/A
Charles County	
Healthy Families Charles County Center for Children	HFA
Southern MD Tri-County Community Action Committee	PAT
Dorchester County	
Healthy Families Dorchester, Dorchester County Health Department	HFA
Family Partnership (FSC)	PAT
Healthy Families Frederick County, Mental Health Association of Frederick	HFA
Garrett County	
Garrett County Early Head Start [CAC]	EHS
Garrett County Health Department	HFA
Harford County	
Healthy Families Harford County, Harford County Health Department	HFA
Howard County	
Department of Community Resources and Services	HFA
Kent County	

Healthy Families Mid-Shore, Kent County Health Department	HFA
County Commissioners of Kent County	PAT
Montgomery County	
Family Services, Inc.	EHS
Family Discovery Center (FSC)	PAT
Healthy Families Montgomery, Sheppard Pratt	HFA
CentroNia	EHS
Prince George's County	
Healthy Families Prince George's County, Child Care Resource Center	HFA
Mary's Center	HFA
Adelphi/Langley Park Family Support Center (FSC)	PAT
Lourie Center	EHS
Queen Anne's County	
Family Support of QA's County (FSC)	PAT
Healthy Families Mid-Shore, Queen Anne's County Health Department	HFA
Somerset County	
Healthy Families Lower Shore	HFA
St. Mary's County	
Healthy Families Southern Maryland, Center for Children	HFA
Talbot County	
Healthy Families Mid-Shore, Talbot County Health Department	HFA
Talbot County Judy Center	PAT
Washington County	
Healthy Families Washington County, Washington County Health Department	HFA
Head Start of Washington County	EHS
Washington County Family Support Center (FSC)	PAT
Wicomico County	
Healthy Families Wicomico County, Wicomico County Health Department	HFA
Shore Up! Early Head Start Center	EHS
Worcester County	
Healthy Families Lower Shore	HFA
Promising Practice	
Anne Arundel County- Anne Arundel County Health Department	Healthy Start, Babies Born Healthy (PP)
Baltimore City - Roberta's House	HOPE - for mothers with an infant loss (PP)
Baltimore City - Healthy Start	Healthy Start (PP)
Baltimore County - Baltimore County Health Department	Perinatal Enrichment Program (PP)
Charles County Health Department	Maternal-Child Health Program (PP)
Worcester County - Worcester County Health Department	Early Care (PP)

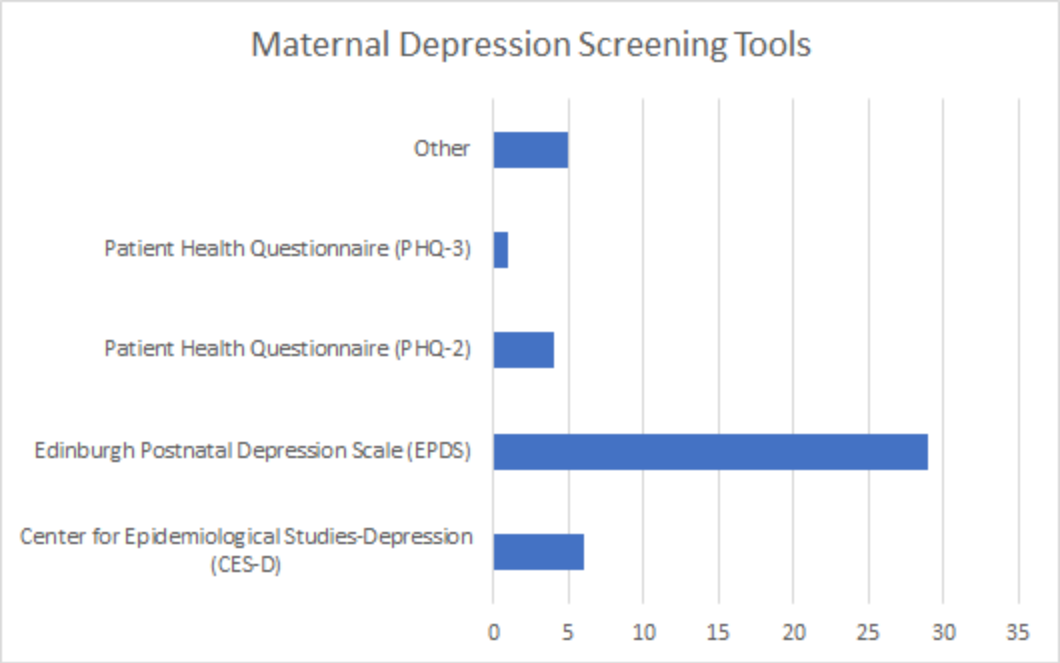
Appendix B: All Maryland Home Visiting Sites FY 2019

Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	PAT
YMCA Cumberland	PAT
Healthy Families Allegany County, Allegany County Health Department	HFA
HRDC Seymore Street Head Start Center	EHS
Anne Arundel County	
Annapolis Family Support Center (FSC)	PAT
YMCA of Central Maryland	EHS
Anne Arundel Healthy Start	PP
Baltimore City	
Family Tree	HFA
	Attachment and Biobehavioral Catch-up: ABC
	MD Family Connects (MDFC)
	Parent Assistance in The Home (PATH)
Baltimore City Health Department Maternal and Infant Care Program	NFP
DRU/Mondawmin Healthy Families (DRUM)	HFA
Park Heights Renaissance	HIPPY
Sinai Hospital of Baltimore Inc. M. Peter Moser Community Initiatives	HFA
Baltimore County	
Baltimore County Health Department	PP
Healthy Families Baltimore County, Abilities Network	HFA
YMCA Highland Village Head Start Center	EHS (2 Sites)
Young Parent Support Center	PAT
Calvert County	
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA, PAT
Caroline County	
Federalsburg Judy Hoyer Center (FSC)	PAT
Healthy Families Mid-Shore, Caroline County Health Department	HFA
Carroll County	
Catholic Charities Head Start and Early Head Start of Carroll County	EHS
Family Support Center (FSC)	PAT
Judy Center Partnership Parents as Teachers Program	PAT
Cecil County	
N/A	N/A
Charles County	
Healthy Families Southern Maryland, Center for Children	HFA
Southern MD Tri-County Community Action Committee	PAT
Healthy Families Charles County, Charles County Health Department	PP
Dorchester County	
Healthy Families Dorchester County, Dorchester County Health Department	HFA
Frederick County	
Family Partnership (FSC)	PAT
Healthy Families Frederick County, Mental Health Association of Frederick	HFA

Garret County	
Garrett County Early Head Start (CAC)	EHS (2 sites)
Healthy Families Garrett County, Garrett County Health Department	HFA
Harford County	
Catholic Charities Early Head Start	EHS
Healthy Families Harford County, Harford County Health Department	HFA
Howard County	
Howard County Office of Children's Services	PAT
Kent County	
Healthy Families Mid-Shore, Kent County Health Department	HFA
Kent County Family Center (FSC)	PAT
Montgomery County	
Centro Nia	EHS
Discovery Station Early Head Start, Family Services, Inc.	EHS
Family Discovery Center (FSC)	PAT
Healthy Families Montgomery, Family Services, Inc.	HFA
Prince George's County	
Adelphi/Langley Park Family Support Center (FSC)	PAT
Healthy Families Prince George's County, Child Care Resource Center	HFA
Mary's Center	HFA
Reginald Lourie Center	EHS
Queen Anne's County	
Family Support of QA's County (FSC)	PAT
Healthy Families Mid-Shore, Queen Anne's County Health Department	HFA
Somerset County	
Early Head Start Center	EHS
St. Mary's County	
Healthy Families Southern Maryland, Center for Children	HFA
Talbot County	
Healthy Families Mid-Shore, Talbot County Health Department	HFA
Talbot County Judy Center	PAT
Washington County	
Head Start of Washington County	EHS
Healthy Families Washington County, Washington County Health Department	HFA
Washington County Family Support Center (FSC)	PAT
Wicomico County	
Healthy Families Wicomico County, Wicomico County Health Department	HFA
Salisbury 1 and Early Head Start Center	EHS
Worcester County	
Healthy Families Lower Shore	HFA
Promising Practices	
Anne Arundel County- Anne Arundel County Health Department	Healthy Start (PP)
Baltimore City – Roberta's House	HOPE- for mothers with an infant loss (PP)
Baltimore City - Healthy Start	Baltimore Healthy Start (PP)
Baltimore County - Baltimore County Health Department	Prenatal Enrichment Program (PP)
Charles County - Charles County Health Department	Maternal-Child Health Program (PP)
Prince George's County-Prince George's County Health Department	High Risk Infant Program (PP)
Worcester County - Worcester County Health Department	Early Care (PP)

Appendix C: Maternal Depression Screening Tools

All Respondents



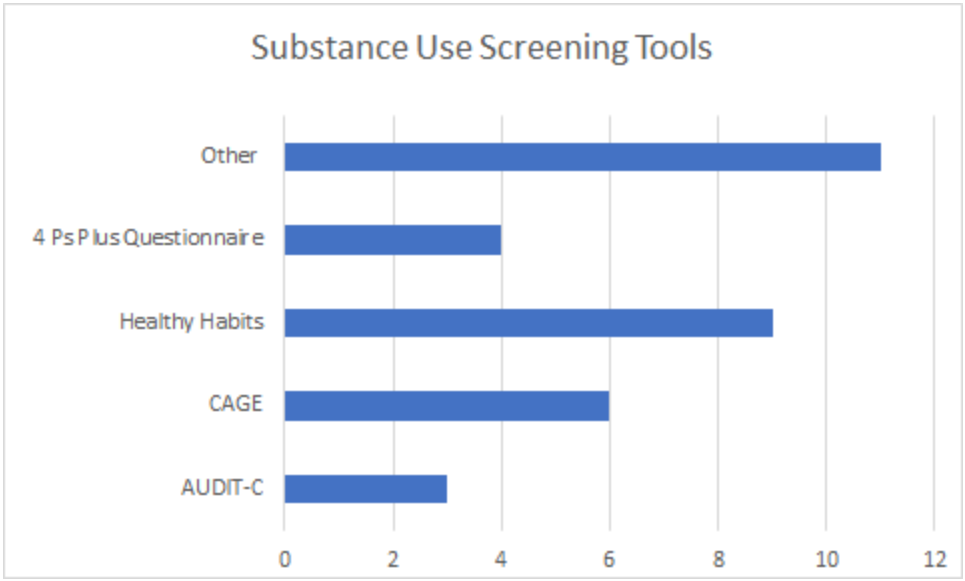
	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0%
Total:	55	100%

*Other tools used include: Life Skills Progression, PHQ-9, Devereux Adult Resiliency Scale, Strengths and Needs Assessment, Zung, and PAT based screening.

In FY 2021, sites were asked to indicate how many depression screens a typical parent would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicated that, on average, a parent is screened approximately four times, with a range of zero (for those that do not screen) to 12 times during the course of services. Screening for maternal depression did not occur if not required by the program model, sites need training on a screening tool, or screenings are handled by an outside agency.

Appendix D: Maternal Substance Use Screening Tools

All Respondents



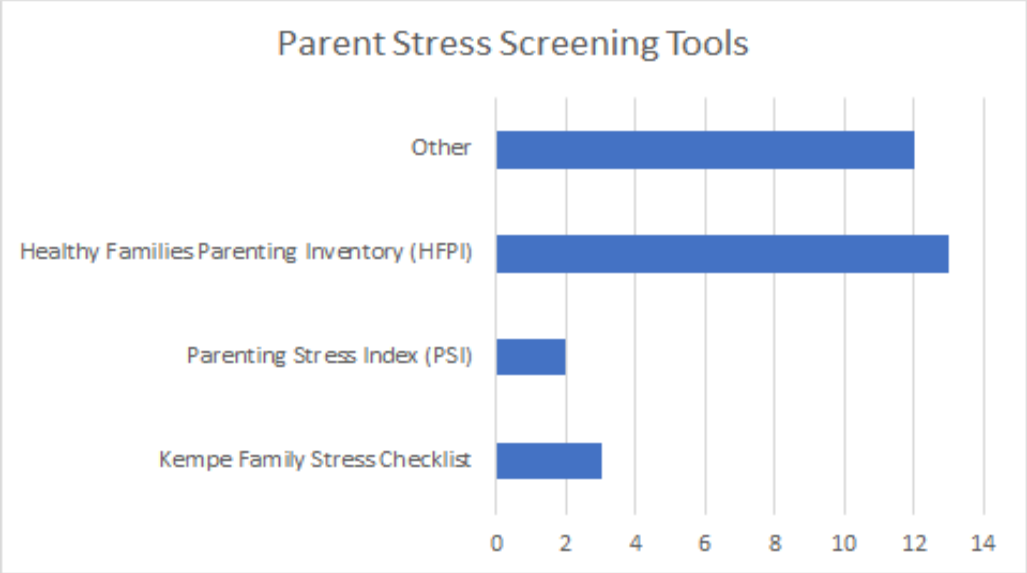
	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0%
Total:	55	100%

*Other tools used include: Life Skills Progression, Strengths and Needs Assessment, SBIRT, TICS, and in-house screening.

In FY 2021, sites were asked to indicate how many substance use screens a typical parent would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a parent is screened two times, with a range of zero (for those that do not screen) to 12 times during the course of services. Reasons for not screening for substance use included that it is not required by the program model.

Appendix E: Parenting Stress Screening Tools

All Respondents



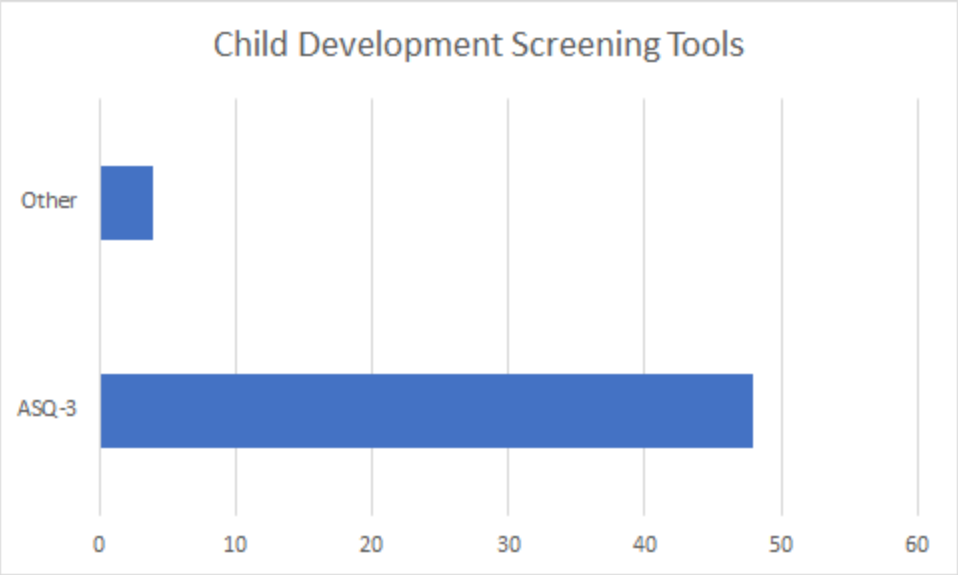
	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0
Total:	66	100%

*Other tools used include: Life Skills Progression, Parental Stress Scale, Adult-Adolescent Parenting Inventory, and Duke University Designed Screening Tool.

In FY 2021, sites were asked to indicate how many parenting stress screens a typical parent would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a parent is screened two times, with a range of zero (for those that do not screen) to 12 times during the course of services. Reasons for not screening for parenting stress included the following: it is not required by the program model, sites have not found a screening tool, and/or sites need training on a screening tool.

Appendix F: Child Development Screening Tools

All Respondents



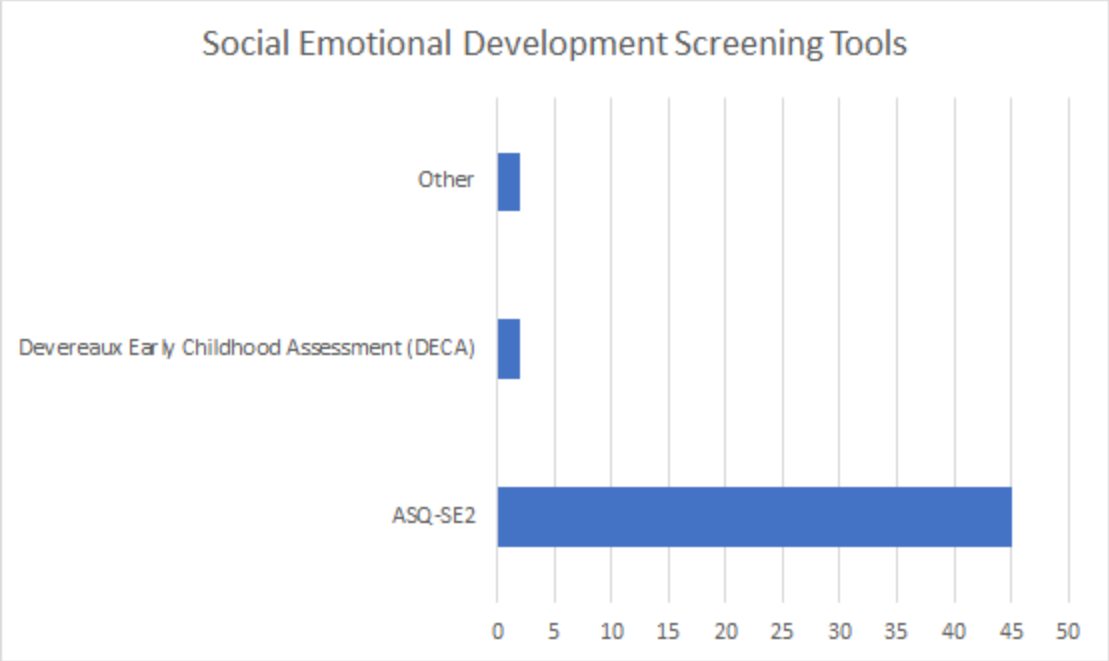
	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0%
Total:	55	100%

*Other tools used include: Brigance Developmental Screener III and Infant Inventory.

In FY 2021, sites were asked to indicate how many child development screens a typical child would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a child is screened approximately six times with a range of zero (for those that do not screen) to 12 times during the course of services. Screening for child development did not occur if it was not required by the program model.

Appendix G: Social Emotional Development Screening Tools

All Respondents



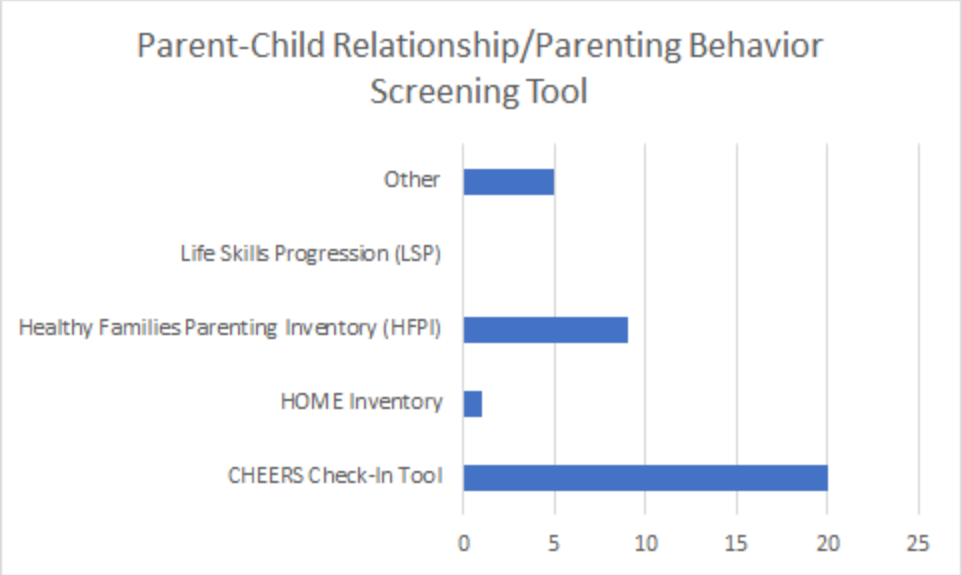
	Responses	Percene
Total Responded to this question:	55	100%
Total who skipped this question:	0	0%
Total:	55	100%

*Other includes Brigance Screening

In FY 2021, sites were asked to indicate how many social emotional development screens a typical child would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a child is screened approximately four times with a range of zero (for those that do not screen) to nine times during the course of services. Screening for social emotional development did not occur if it was not required by the program model.

Appendix H: Parent-Child Relationships/Parenting Behavior Screening Tools

All Respondents



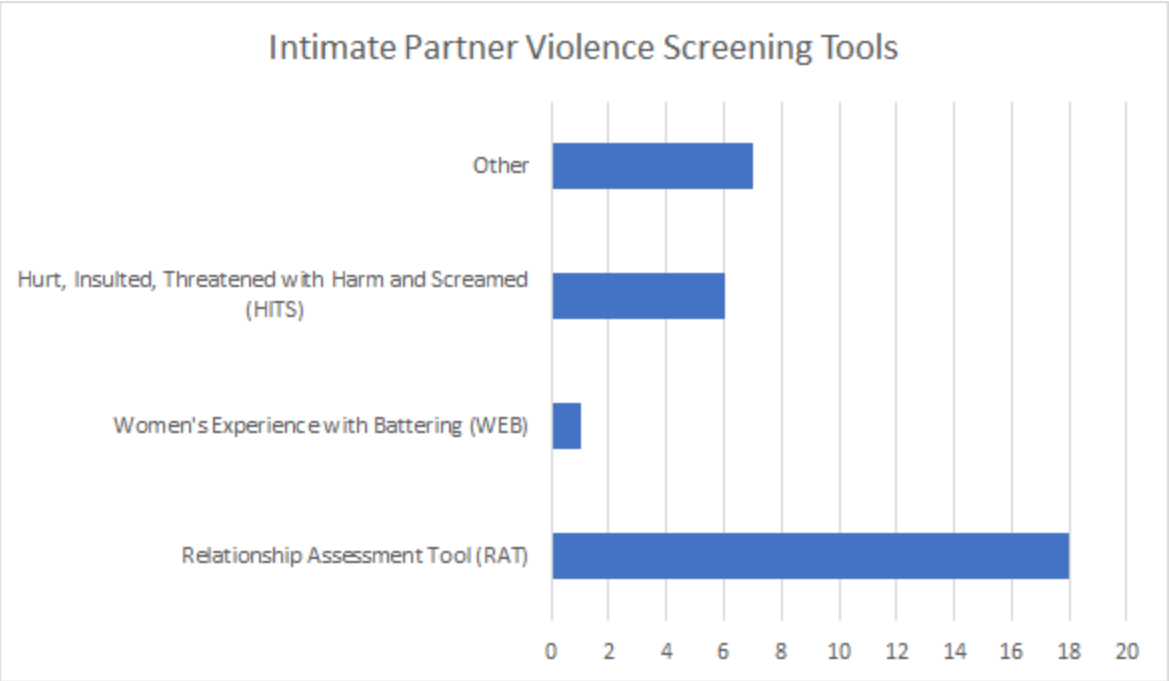
	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0%
Total:	55	100%

** Other includes: DANCE,, AAPI, Duke University Tool, Assessing Interactions

In FY 2021, sites were asked to indicate how many parenting behavior screens a typical parent would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a parent is approximately four times with a range of zero (for those that do not screen) to 10 times during the course of services. Screening for parenting behavior did not occur if it was not required by the program model, and if no screenings occurred during FY 2021.

Appendix I: Intimate Partner Violence Screening Tools

All Respondents



	Responses	Percent
Total Responded to this question:	55	100%
Total who skipped this question:	0	0
Total:	55	100%

*Other tools used include: Life Skills Progression, General Questionnaire, Clinical IPV Assessment, Relationship Assessment, and Domestic Violence Survey.

In FY 2021, sites were again asked to indicate how many intimate partner violence screens a typical parent would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a parent is screened two times with a range of zero (for those that do not screen) to seven times during the course of services. Screening for IPV did not occur if it was not required by the program model and if sites were not trained on a screening tool.