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

Human Services Article § 8-507(c)

December 2023

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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; the State Superintendent of Schools for the Maryland State Department of Education, and the Executive Director of the Governor's Office for Crime Prevention and Policy (*as illustrated below*).

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[1] Governor's Office for Crime Prevention and Policy. *Children's Cabinet*.

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Background: Maryland's Home Visiting Accountability Act of 2012

In March 2010, the Affordable Care Act established the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, which provided federal funds for evidence-based home visiting (EBHV) 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.

The Governor's Office for Children (presently known as Office for Crime Prevention and Policy), 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 fiscal year (FY) 2015, recipients of State funding for home visiting programs were required to report to the Governor's

[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*.

Office of Crime Office for Crime Prevention and Policy on the standardized reporting measures adopted by the Children's Cabinet. However, following the 2023 Maryland Legislative Session, recipients are now required to report to the Maryland Department of Health (MDH). This report is required to be submitted every two years, in accordance with § 8-507(c) of the Human Services Article.[3]

Although the MIECHV funds were separated from the Affordable Care Act in 2015, the benchmarks and 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

Introduction: FY 2023 Statewide Home Visiting Data Collection

This report represents the fifth 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 FY 2023 and previous fiscal years 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 are available in all of Maryland's 24 jurisdictions.

Evidence-based home visiting (EBHV) 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;

[3] Ibid.

promoting healthy development of children's cognitive, physical, and social-emotional growth; and reducing the risk factors for child abuse and neglect.[4, 5]

EBHV 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.

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 assess 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.

Maryland's Home Visiting Program Models

There are seven EBHV programs and four promising practices programs in Maryland. The EBHV programs are:

- **Attachment Bio-Behavioral Catch-up (ABC)** is a training program for caregivers of infants and young children 6 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 the child's lead, and non-frightening care. Parent coaches provide immediate feedback on the caregivers' interaction with the child to help the caregivers attend to the target behaviors.[6]
- **Early Head Start (EHS)** focuses on low-income pregnant individuals and families with children from birth to three years old. 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.
- **Family Connects (FC)** is a universal nurse home visiting program available to all families with newborns residing within a defined service area. The program aims to support

[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.
[6] Attachment and Biobehavioral Catch-Up (ABC) -Infant.
https://homvee.acf.hhs.gov/effectiveness/Attachment%20and%20Biobehavioral%20Catch-Up%20%28ABC%29%20-Infant/In%20Brief

families' efforts to enhance maternal and child health and well-being while reducing rates of child abuse and neglect. The program consists of one to three nurse home visits, typically when the infant is 2 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 the 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.[7] Although it is identified as an EBHV program, it is primarily a care coordination resource and may refer clients to more intensive home visiting programs.

- **Healthy Families America (HFA)** is dedicated to supporting parents facing challenges such as single parenthood, low income, history of childhood 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 3 to 5 years old.
- **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 2 years old.
- **Parents as Teachers (PAT)** programs provide parents with child development knowledge and parenting support. This model incorporates 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 visiting is offered. This model may serve families at any point from pregnancy to when the child enters kindergarten.

The promising practice models include:

- **Early Care Program** (Worcester County) is a home visiting program for pregnant individuals and infants younger than one year old with high-risk challenges including

[7] Family Connects. https://homvee.acf.hhs.gov/effectiveness/Family%20Connects/In%20Brief

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.[8]

- **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 2 years old. These services are provided by community health nurses and social workers.[9]
- **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 2 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 1 year old.

Statewide Home Visiting Support

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, MDH, 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, 233 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.

[8] Worcester County Health Department Women's Health https://www.worcesterhealth.org/index.php?option=com_content&view=article&id=112&Itemid=117#:~:text=The%20Early%20Care%20program%20is,to%206%20months%20of%20age.

[9] Anne Arundel County Department of Health Healthy Moms and Healthy Babies. https://aahealth.org/healthy-start/

[10] Baltimore Healthy Start, Inc. Home Visiting Programs. *https://baltimorehealthystart.org/home-visiting/*

Substance Exposed Newborn (SEN) Training: In 2019, MDH, 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 both pregnant and postpartum women. The training and pilot were funded by MDH, while the Department of Human Services oversaw the rollout of the training to professionals. Workforce training included home visitors, community health workers, and Infants and Toddlers Program 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. In 2019, six regional SEN trainings were implemented. To date, 352 trainees have completed the training, with 59 completing the training in FY 2023.

The SEN curriculum is 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 with experts featured in the training, providing trainees with access to additional content 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 - Home Visiting Consortium (HVC)

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 that time, the study group reviewed existing State-funded home visiting programs which included Healthy Families, Healthy Start, Even Start, the Governor's Office of Crime Control and Prevention Home Visiting Program, 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) development of a consolidated and unified grant process to fund home visiting, 3) coordinated data collection, monitoring and evaluation and 4) development of a single point of entry. The HVC became the oversight committee for home visiting programs in Maryland.

With the award of MIECHV funding to the state, the HVC reconvened in the fall of 2015, with MSDE and MDH as co-facilitators, with the purpose of coordinating home visiting efforts across funding streams and agencies. Partners from state and local governments, universities, non-profits, physicians' groups, and program providers meet quarterly to develop an action plan for home visiting in the state.

Mission: 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.

Vision: 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. It 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.

Methodology

This report is the fifth 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 2023. 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, 2022 through June 30, 2023 for this report.

In FY 2023, an inventory of home visiting programs across Maryland was updated to identify which programs were providing home visiting services during that time. The inventory was created by collecting program lists previously compiled by MDH; Maryland State Department of Education (MSDE); the Governor's Office for Crime Prevention and Policy; Maryland Family Network; and Johns Hopkins Bloomberg School of Public Health. Each home visiting program was contacted by email and/or phone call to verify its continued operation, and to confirm they were still offering home visiting services, and the program model being used.

The FY 2023 survey consisted of 86 questions and was updated to include questions about interest in new EBHV models, as well as caregiver sexual orientation and gender identity. It also included five open-ended questions designed to characterize home visiting program managers' perspectives on their families' biggest challenges, their programs' practices, and family strengths. The web-based survey was sent to all known home visiting programs operating during FY 2023, and ran from August 4 through September 8, 2023. MDH administered the survey and provided technical assistance to sites as needed during the data collection process.

Results: Overview of Reporting Programs

Data were submitted by 41 out of 61 programs, resulting in a return rate of 67%. Twenty-three jurisdictions in the state were represented in the data collection. Home visiting programs serving multiple jurisdictions were asked to complete separate surveys for each jurisdiction served. Table 1 provides an overview of all the programs that reported data in FY 2023 compared to previous fiscal years.

Table 1. Reporting Program Sites

Measure	FY 2023 Home Visiting Program Sites Reporting	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	41	45***	66**	58	46
Jurisdictions Represented	23	23	24	24	23
Number of Women Served	3,143	3,768	4,357	4,602	0****
Number of "Other" Primary Caregivers Served*	-	71	181	109	0****
Number of Children Served	3,053	3,431	4,108	3,947	0****

* Other primary caregivers include fathers, grandparents, aunts, uncles, cousins, siblings, and foster/adoptive parents.
** Sixty-six (66) sites represented 70 programs - some sites had more than one program per site.
*** Forty-five (45) sites represented 55 programs - some sites had more than one program per site.
**** Data unavailable due to calculation or collection error of previous reporting agency.
- In FY 2023, data were not collected for the number of "Other" primary caregivers served.

Table 2 details the number of identified program sites that offered each type of home visiting model in Maryland. In the FY 2023 survey, programs were asked about their interest in implementing EBHV models other than their current ones. Two of the 41 programs expressed an interest in doing so, and had considered the ABC, Family Connects, and Maternal Early Childhood Sustained Home-Visiting Program (MECSH) models. MECSH, a nurse-driven EBHV, provides home visiting services that are designed to enhance maternal and child outcomes, and is not currently being implemented in Maryland.[11]

[11] Implementing Maternal Early Childhood Sustained Home-Visiting Program (MESCH). https://homvee.acf.hhs.gov/implementation/Maternal%20Early%20Childhood%20Sustained%20Home-Visiting%20Program%20%28MECSH%29/Model%20Overview

Table 2. Data-Reporting Sites by Program Model					
Program Model	**FY 2023 Number of Programs Reporting**	**FY 2021 Number of Programs Reporting**	**FY 2019 Number of Programs Reporting**	**FY 2017 Number of Programs Reporting**	**FY 2015 Number of Programs Reporting**
Early Head Start (EHS)	6	10	19	11	8
Family Connects	2	-	-	-	-
Healthy Families America (HFA)	22	24	25	28	25
Home Instruction for Parents of Preschool Youngsters (HIPPY)	1	2	2	3	2
Nurse Family Partnership (NFP)	2	1	1	1	1
Parents as Teachers (PAT)	6	13	15	13	9
Other*	2	5	8	2	1**
TOTAL #	41	55	70	58	46

- Family Connects did not report data during these years.
* 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

Maryland home visiting was reshaped as a result of the COVID-19 pandemic. Programs had to rapidly switch to virtual and telephonic visits, adjust how they were delivering assessments and tools, and overcome technology gaps. As a result of the challenges COVID-19 presented, many programs that offered home visiting services stopped offering home visiting services in order to meet community demand for alternative child care. Since the FY 2021 report, other programs have closed, though not as a direct result of COVID-19, which has led to a significant loss of home visiting capacity throughout the state. Appendix A provides details on programs that submitted survey data for FY 2023. Appendix B provides details on all known home visiting programs in Maryland that were asked to submit data.

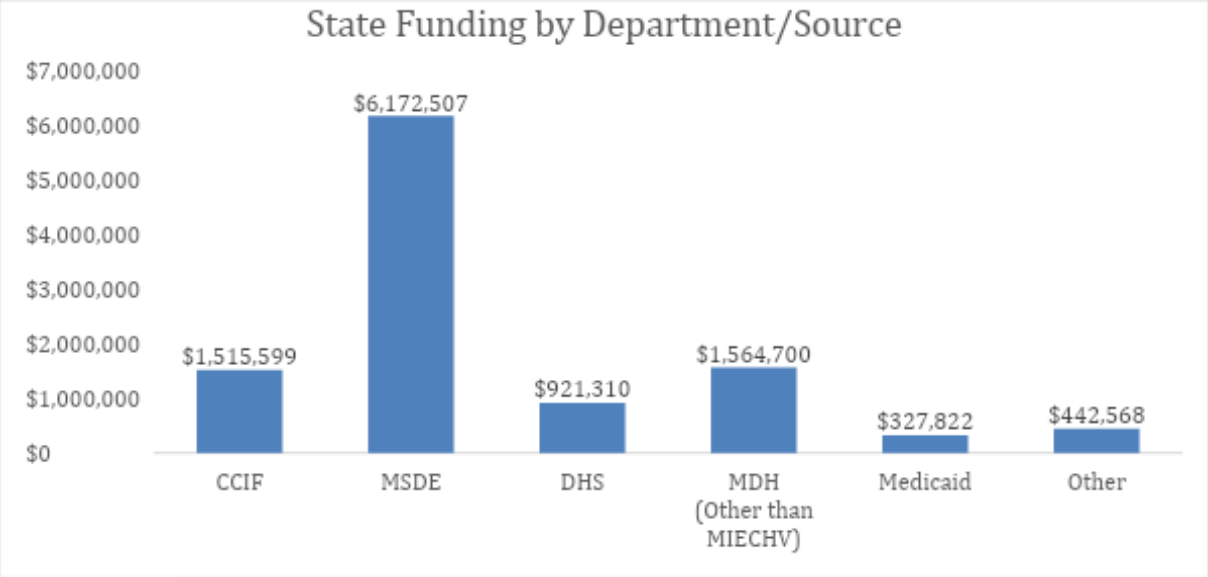
Funding for Reporting Programs

Maryland's home visiting programs are supported by state, federal, local, and philanthropic funding. In FY 2023, 31 of the 41 (76%) programs received state funding, and seven of the 41 (17%) reported that they only received state funding.

State general and special funds serve as key funding sources for home visiting programs and are provided by several different State agencies, including MSDE, Department of Human Services (DHS), the Children's Cabinet Interagency Fund (CCIF) (administered by the Governor's Office for Crime Prevention and Policy and MDH). A total of 39 of the 41 sites indicated that they received funds from at least one of these sources in FY 2023. In total, these four sources invested over $10 million in home visiting services for Maryland families (see Figure 1).

In 2018, Medicaid reimbursement for home visiting services was piloted in Maryland with two home visiting sites. The Home Visiting Services Pilot Program was expanded in 2022 to a statewide benefit through a State Plan Amendment under the 1115 HealthChoice Waiver Renewal. Reimbursement is permissible through two EBHV models, Healthy Families America and Nurse Family Partnership. Three sites received a total of $327,822 in support through Medicaid reimbursement (see Figure 1). Many sites began or continued the enrollment process during this fiscal year, and it is expected that Medicaid revenue will grow in future years.

Figure 1. State Funding by Department/Source, FY 2023



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 2023, federal MIECHV funding supported 16 sites in 10 jurisdictions. Federal MIECHV funding added approximately $7.5 million each year for home visiting services and workforce support.

The federal offices of the Administration for Children and Families (ACF) and the Office of Head Start (OHS) provide partial or full funding for Early Head Start (EHS) home visiting programs. Six sites indicated that they received direct federal funds through ACF. Additionally, Promoting Safe and Stable Families grants administered through the federal Department of Health and Human

Services (DHHS) supported three home visiting programs in Maryland. Other federal sources of funding included Community Based Child Abuse Prevention (CBCAP) grants and the HRSA Title V Block Grants. In FY 2023, seven sites (17%) reported that they received only federal funding, compared to 27 sites (66%) that received a portion of federal funding in combination with other sources.

Local government and philanthropic funding also support a number of home visiting programs in Maryland. Six sites (15%) reported that they received more than 50% of funding from local government or philanthropic sources in FY 2023.

Home Visiting Workforce

In FY 2023, and similar to the data collection processes in FYs 2015—2021, the survey inquired about the number of full-time equivalency (FTE) home visitors employed (excluding administrative support roles such as managers, supervisors, and data entry/administrative assistants), and educational attainment. Forty-one sites reported that they employed approximately 199 FTE home visitors to serve enrolled families. Home visitors are educated staff who have varying titles, including: family support worker, family support specialist, nurse, home visitor, in-home interventionist, and parent educator. Gender, age, race and ethnicity, and educational attainment of home visitors continue to be collected to understand more about the home visiting workforce (see Table 3). Ninety percent of the home visitors are female, 28% are between 30-39 years old, 14% are Hispanic or Latino, 41% are Black or African American, and 34% have a bachelor's degree.

Table 3. Home Visitor Demographics, FY 2023

Variable	Frequency	Percent
Gender		
Female	179	90%
Male	8	4%
Transgender man	0	0%
Transgender woman	0	0%

Genderqueer/Gender non-confirming/Non-binary	0	0%
Other	0	0%
Did not report	12	6%
Age Groups		
Younger than 20	0	0%
20-29	25	13%
30-39	56	28%
40-49	43	22%
50-59	38	19%
60 and older	14	7%
Did not report	23	11%
Ethnicity		
Hispanic/Latino	28	14%
Non-Hispanic/Latino	133	67%
Did not report	38	19%
Race		
American Indian or Alaska Native	0	0%
Asian	0	0%
Black or African American	81	41%
Native Hawaiian or other Pacific Islander	6	3%
White	62	31%
Multiracial	8	4%
Not specified	9	5%
Did not report	33	16%
Educational Attainment		
Less than High School/GED	0	0%
High School Diploma/GED	56	28%
Associate's Degree	31	16%
Bachelor's Degree	67	34%
Master's Degree or Higher	15	7%
Did not report	30	15%

Note: Due to rounding, the sum of percentages may not always equal 100.

Home Visiting Participants

Primary Caregivers Served

Home visiting participants include primary caregivers and children. In this survey, the primary caregiver (caregiver) refers to the person enrolled as the primary participant in the home visiting program. This may be the mother, father, grandparents, guardian, or other person who has primary responsibility for the child enrolled in the program. The programs were funded to serve 4,077 caregivers, and 3,289 caregivers received at least one home visit during the time period.

Approximately 32% of the caregivers served were 20-29 years old, 31% were 30-39 years old, and 5% were under 18 years old. Approximately 21% of caregivers were of Hispanic or Latino descent, and most (46%) caregivers were Black or African American. Approximately 32% were White and 7% identified as multiracial. Approximately 96% of the caregivers served were female, and 3% were male. The sites did not report serving any gender-diverse caregivers. In addition, only two sites tracked the sexual orientation of their caregivers, and one site reported serving two caregivers who were lesbian or gay. Table 4 illustrates the demographics of caregivers served during FY 2023.

Programs reported that 1,049 participants disengaged from services. The primary drivers of disengagement reported included work scheduling conflicts, relocation out of the service area, and inability to contact or locate families. Other reasons for disengagement included loss of interest in the program, change in family's needs (e.g. custody, full-time childcare needs), and participants graduating/successfully completing the program. The definition of program completion varies by model, incorporating factors such as the child reaching the program's age limit, entering school, and graduating. Approximately 367 families completed a home visiting program.

Table 4. Primary Caregiver Demographics, FY 2023		
Variable	**Frequency**	**Percent**
Gender		
Female	3,142	96%
Male	108	3%
Transgender man	0	0%
Transgender woman	0	0%
Genderqueer/Gender non-confirming/Non-binary	0	0%
Other	39	1%
Age Groups		
Younger than 18	173	5%
18-19	106	3%
20-29	1,055	32%
30-39	1,010	31%
40-49	134	4%
50 and older	8	0%
Unknown	730	22%
Did not report	73	2%
Ethnicity		
Hispanic/Latino	691	21%
Non-Hispanic/Latino	2,540	77%
Did not report	58	2%
Race		
American Indian or Alaska Native	29	1%
Asian	85	3%
Black or African American	1,514	46%
Native Hawaiian or other Pacific Islander	56	2%
White	1,041	32%
Multiracial	222	7%
Not Specified	206	6%
Did not report	136	4%
Educational Attainment		
Less than High School/GED	491	15%
High School Diploma/GED	1,105	34%
Associate's Degree	175	5%
Bachelor's Degree	301	9%
Master's Degree or Higher	181	6%
Did not report	1,036	31%

Note: Due to rounding, the sum of percentages may not always equal 100.

Children Served

In FY 2023, 3,053 children were served by the 41 programs throughout Maryland. Most (35%) of the children served were between the ages of 0 and 6 months, about 25% were of Hispanic or Latino descent, and most were Black or African American (44%). Table 5 illustrates the demographics of children served during FY 2023.

Table 5. Demographics of Children Served, FY 2023

Variable	Frequency	Percent
Age Groups		
0-6 mos	1,070	35%
7-12 mos	539	18%
13-35 mos	965	31%
36-60 mos	479	16%
Ethnicity		
Hispanic/Latino	688	23%
Non-Hispanic/Latino	2,014	66%
Did not report	351	11%
Race		
American Indian or Alaska Native	12	<1%
Asian	72	2%
Black or African American	1,252	41%
Native Hawaiian or other Pacific Islander	4	<1%
White	917	30%
Multiracial	393	13%
Not Specified	225	7%
Did not report	178	6%

Note: Due to rounding, the sum of percentages may not always equal 100.

Maryland's Home Visiting Standardized Measures

Following the passage of the Maryland Home Visiting Accountability Act of 2012, the Governor's Office for Crime Prevention and Policy 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 Governor's Office for Crime Prevention and Policy by staff from the Pew Charitable Trusts' 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 6 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 2023.

Table 6. Maryland's Standardized Home Visiting Measures

Domain	Standardized Measures[12]
Child Health	▪ % of enrolled children receiving well-child visits per American Academy of Pediatrics recommendations
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 ▪ % of enrolled mothers who score over the clinical cut-point for parenting stress according to the Parenting Stress Index or other appropriate tool
Typical Child Development	▪ % of enrolled children whose development is scored as "typical" according to a developmental screening tool ▪ % of enrolled children scored as "typical" according to the Ages and Stages Questionnaires-Social Emotional
Children's Special Needs	▪ % of enrolled children referred to Part C/Early Intervention and Part B services for special needs
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 ▪ % of mothers who completed safety plans within 24 hours of screening

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

Child Health—Well-Child Visits

Well-child visits include a thorough physical exam and evaluation of the child's progress toward developmental milestones. Attending regular well-child visits allows parents to address concerns about the child's health and provides an opportunity for the child to receive preventative care such as immunizations. Well-child visits are key to helping health care providers form reliable and trustworthy relationships with the families they serve.[13]

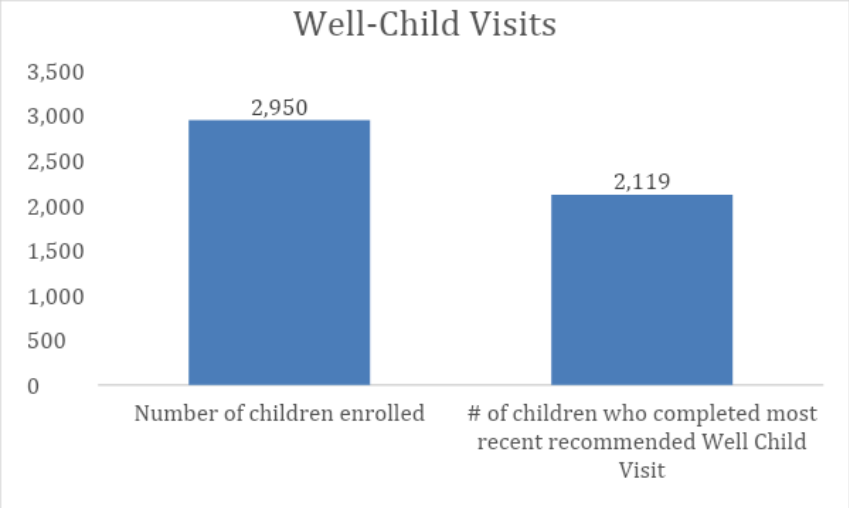
Thirty-eight of the 41 programs (93%) reported that they collect well-child visit information from parents. At the end of FY 2023, 2,950 children were eligible for a well-child screening. Of those children, 2,119 (72%) completed their most recent well-child visit, aligning with the recommendations outlined by the American Academy of Pediatrics *Bright Future*™ schedule.[14] This indicates that they had an opportunity to receive up-to-date and age-appropriate immunizations, education, and developmental assessments from a healthcare provider (see Figure 2). This is an increase from FY 2021, where 65% of children completed their most recent well-child visit. It is possible that the return to service after the COVID-19 pandemic contributed to this increase.

Focus population:	All children enrolled in home visiting as of June 30, 2023
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

[13] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits (2023). https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

[14] American Academy of Pediatrics. Preventive Care/Periodicity Schedule. https://www.aap.org/periodicityschedule.

Figure 2: Children Up-to-Date on Well-Child Visits, FY 2023



Maternal Mental Health—Depression

Parental depression is prevalent in the home visiting population and can have a profoundly negative impact on parenting, child development, and home visiting engagement.[15]

Focus population: All women enrolled in a home visiting program

Measure: Percent of women who were screened for maternal depression

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

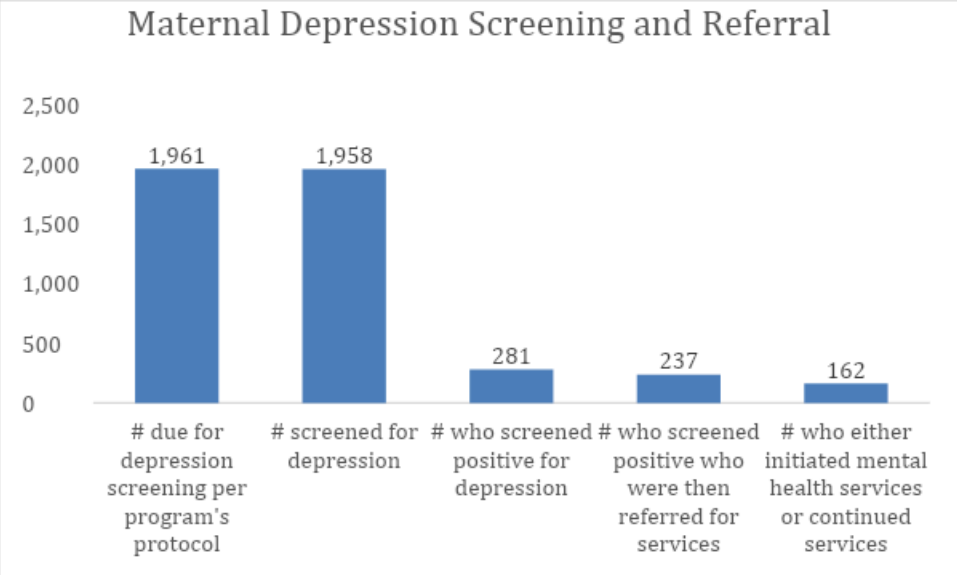
Thirty-two (32) of the 41 programs (78%) conducted depression screenings of enrolled women. In FY 2023, 1,961 women were due for a depression screening per the home visiting program's screening protocols. Of the women due for a screening, almost all (1,958) received a depression screening (99%) — an increase from 97% in FY 2021. Of those 1,958 women screened, 281 (14%) screened positive for depressive symptomatology warranting further assessment from a healthcare provider. Of the women who screened positive for depression, 237 (84%) were referred for further assessment and treatment, with 68% of those women initiating or continuing mental health treatment (see Figure 3). 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. Nine of the programs do not screen for maternal depression, and the most prevalent reason is that the program model does not require it.

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

[15] Ward, E. A., Tandon, S.D. & Ammerman, R. T. (2022). Parent and child mental health and home visiting.

list of the tools utilized by reporting programs can be found in Appendix C.

Figure 3: Number of Women Screened and Referred for Possible Maternal Depression, FY 2023



Maternal Mental Health—Substance Use

Many substances, including nicotine, alcohol, cocaine, and methamphetamine, cross the placenta and can impact the developing fetus.[16] Opiates can cross the placental wall as well, though less efficiently than stimulants and alcohol. Use of these substances during pregnancy can be associated with maternal, fetal, and infant morbidity and mortality.[17]

Focus Population: All women enrolled in a home visiting program

Measure: Percent of women who were screened for substance use

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

Twenty-seven (27) of the 41 (66%) programs conduct routine substance use screenings for enrolled women. In FY 2023, 1,952 women were due for a substance use screening per the home visiting programs' screening protocols. Of those women, 1,773 (91%) were screened for substance use, a decrease from 94% in FY 2021. Among the 1,773 women screened, 97 (5%) screened positive for substance use, warranting further assessment and evaluation, and a decrease from 9% in FY 2021. Of the 97 women screening positive, 48 (49%) were referred for

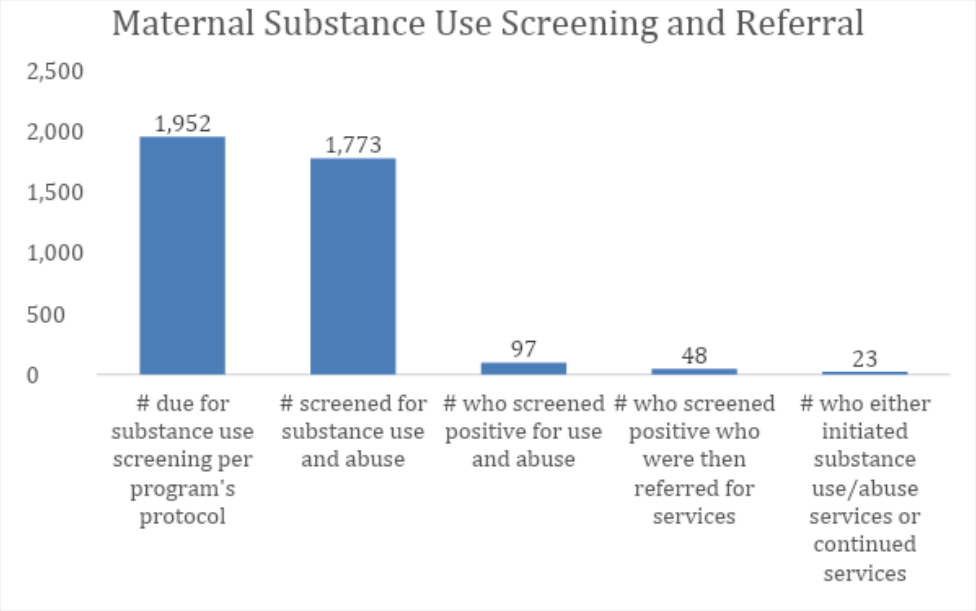
[16] Behnke, M., Smith, V. C., Levy, S., Ammerman, S. D., Gonzalez, P. K., Ryan, S. A., ... & Watterberg, K. L. (2013). Prenatal substance abuse: short-and long-term effects on the exposed fetus. *Pediatrics*, *131*(3), e1009-e1024.

[17] The American College of Obstetricians and Gynecologists. (2020). Committee Opinion: Tobacco and Nicotine Cessation During Pregnancy

treatment services, a decrease from 51% in FY 2021. Twenty-three (48%) women either initiated or continued treatment for substance use. Similar to 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. Fourteen (34%) of the programs do not screen for maternal substance use, with the most prevalent reason being that the model does not require it.

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 five times during the course of services. A full list of the tools utilized can be found in Appendix C.

Figure 4: Screening and Referral for Maternal Substance Use, FY 2023



Maternal Mental Health—Parenting Stress

Clinically, high parenting stress arises from a parent's perception of the overwhelming demands of being a parent. High parenting stress is often 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.[18]

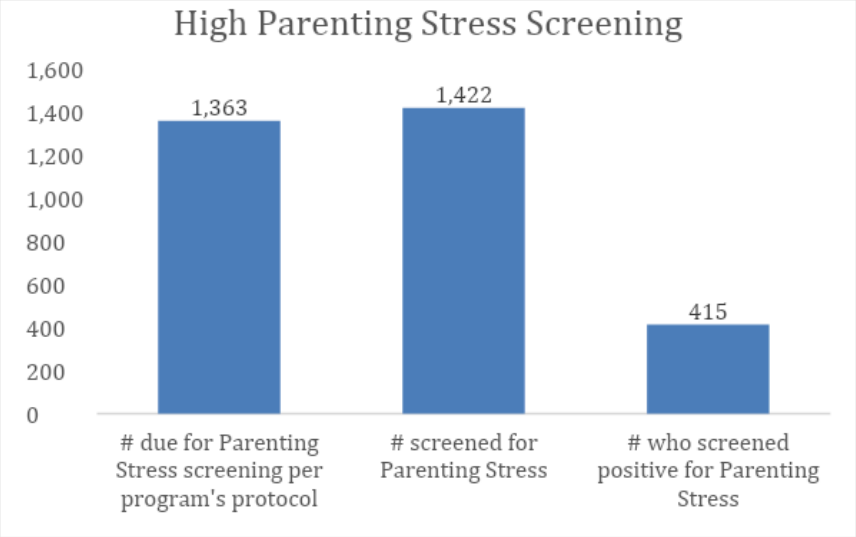
[18] Östberg, M., & Hagekull, B. (2000). A structural modeling approach to the understanding of parenting stress. *Journal of Clinical Child Psychology*, *29*(4), 615-625.

Focus 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:	# of women who presented with clinically high parenting stress Total # of women eligible for the screening per the program's protocols

Twenty (20) of the 41 programs (49%) reported that they screen enrolled women for high parenting stress. In FY 2023, of the 1,442 women screened, 415 (29%) screened positive for high parenting stress (see Figure 5). Twenty-one programs do not screen for parenting stress, and the most common reason is because it is not required by the program model.

Programs use a variety of tools to screen for high parenting stress. On average, home visiting programs are screening women six times for parenting stress during the course of services. A full list of the tools utilized can be found in Appendix C. Data on whether women who screen positive for parenting stress are referred to services is not currently collected, and can be considered for future data collection.

Figure 5: Number of Women Screened for High Parenting Stress, FY 2023



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.[19]

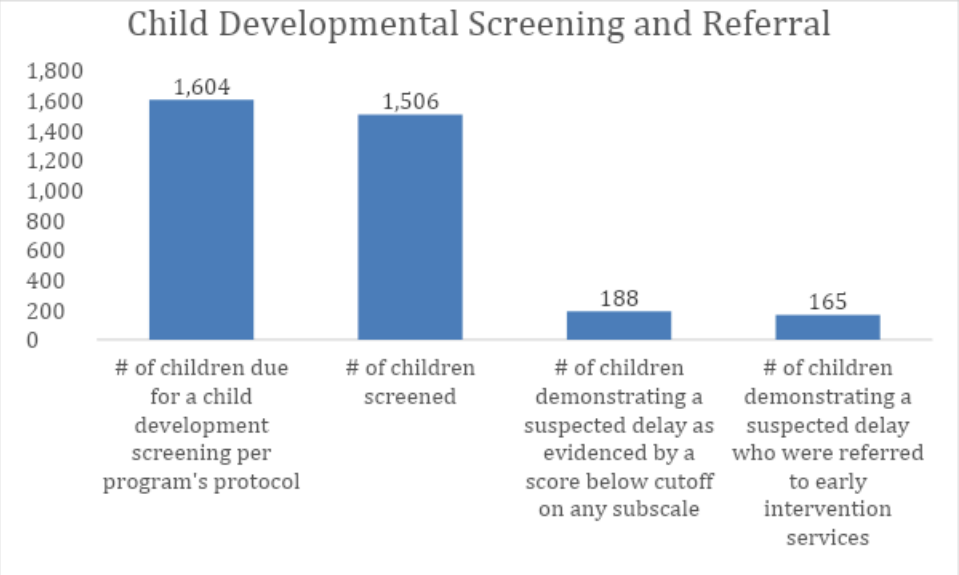
Focus population:	Enrolled children
Measure:	Percent of enrolled children who were screened with a developmental screening tool
Calculation:	# of children screened for typical development / Total # of children

Thirty-nine (39) of the 41 programs (95%) reported that they screen children for typical development using a developmental screening tool. In FY 2023, 1,604 children were due for a developmental screening per the home visiting programs' protocols. Among them, 1,506 (94%) children underwent screening, and 188 (12%) were suspected of having a developmental delay in at least one domain. One hundred sixty-five children (88%) were referred for further assessment and evaluation. Eight children were identified but not referred due to parental non-consent, and nine children were not referred as they were already receiving early intervention services. Two programs did not screen for typical development because the model does not require the screening and the visit was conducted virtually.

On average, home visiting programs screen children seven times for typical development during the course of services.

[19] 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.

Figure 6: Number of Children Screened and Referred for Developmental Delay, FY 2023



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.[20]

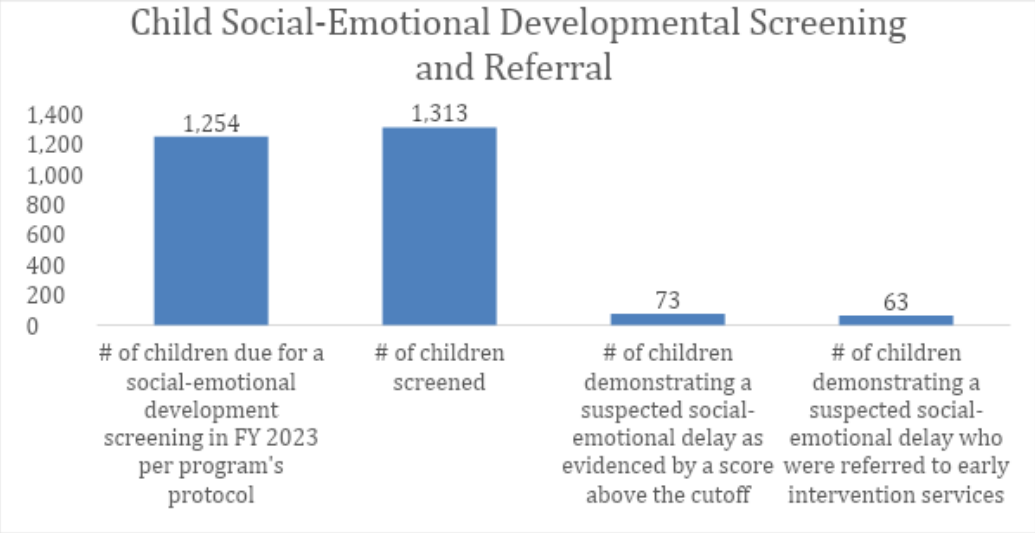
Focus population:	Enrolled children who are six months of age and older
Measure:	Percent of enrolled children who were screened with the Ages and Stages Questionnaires - Social Emotional
Calculation:	# of children screened for social-emotional development / Total # of children eligible for screening

Thirty-six (36) of the 41 programs (65%) reported that they screen children for social-emotional development. In FY 2023, of the 1,313 children screened for social-emotional development, 73 (6%) were suspected of having a social-emotional delay, and 63 (86%) were referred for further assessment and evaluation. Nine children were identified but not referred because their parents would not consent to the referral, and eight children were identified but not referred because they were already receiving early intervention services.

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 five times during the course of services. A full list of tools used to screen for typical development can be found in Appendix C.

Figure 7: Number of Children Screened for Typical Social-Emotional Development, FY 2023

[20] American Academy of Pediatrics. (2019). Mental Health Initiatives. https://www.aap.org/en/patient-care/mental-health-initiatives/



Children's Special Needs

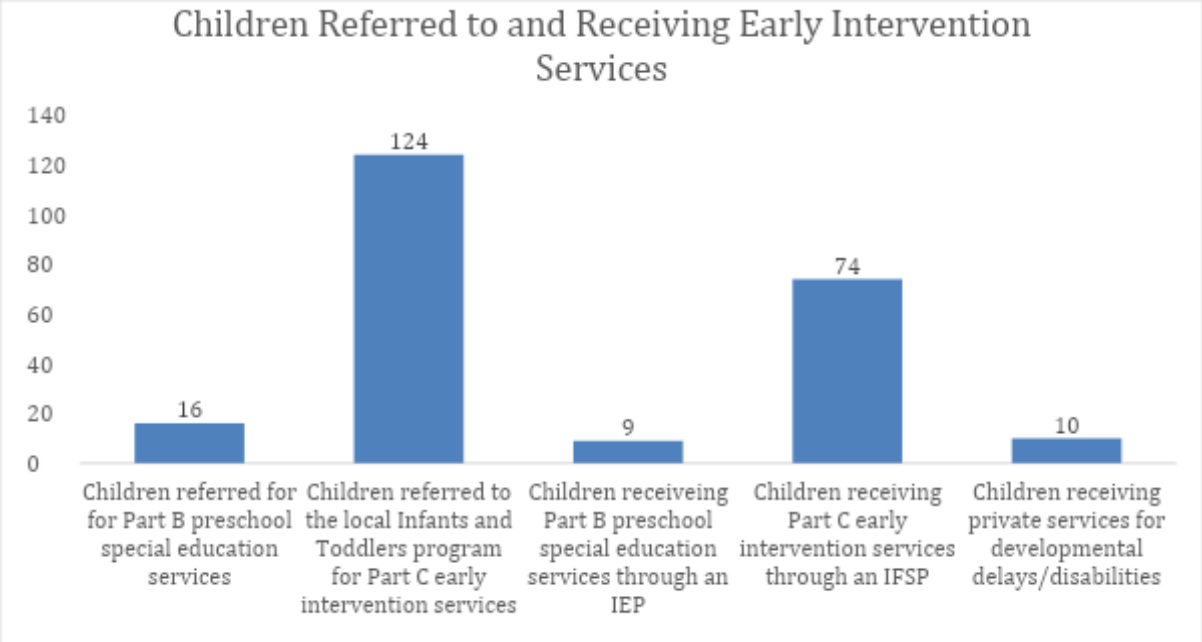
The Federal Individuals with Disabilities Education Act (IDEA) ensures the provision of early intervention services under Part C to children diagnosed with developmental delays from birth through age three, and their families. An Individualized Family Service Plan (IFSP) that identifies the intervention services and supports needed, is developed in partnership with families to support the needs of the child. Children who received services under Part C of IDEA can continue receiving supportive services under Part B from age 3-21 through the Individualized Education Program (IEP) in public schools.[21] Early intervention can minimize delays and strengthen children's cognitive, physical, and behavioral development, thereby reducing the incidence of future problems.[22]

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:	# of children receiving IDEA Part C and/or Part B services # of enrolled children referred to IDEA Part C and/or Part B services

[21] Early Intervention and Special Education Services. (no date). https://marylandpublicschools.org/programs/Pages/Special-Education/index.aspx
[22] Center on the Developing Child at Harvard University. (2010). The foundations of lifelong health are built in early childhood.https://developingchild.harvard.edu/resources/the-foundations-of-lifelong-health-are-built-in-early-childhood/

During FY 2023, 140 children were referred to Part B or Part C early intervention services. Of those 140 children, 83 (59%) received early intervention services, an increase from FY 2021 (49%). Another 10 children received private early intervention services not associated with IDEA. Those children who received services for developmental delays (93) represented 3% of all children served by home visiting programs in FY 2023 (see Figure 8).

Figure 8: Children Referred to Part B or Part C Early Intervention Services, FY 2023



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.[23,24] Evidence-based home visiting programs can support parents in developing trusting, positive, and reliable relationships with their children.

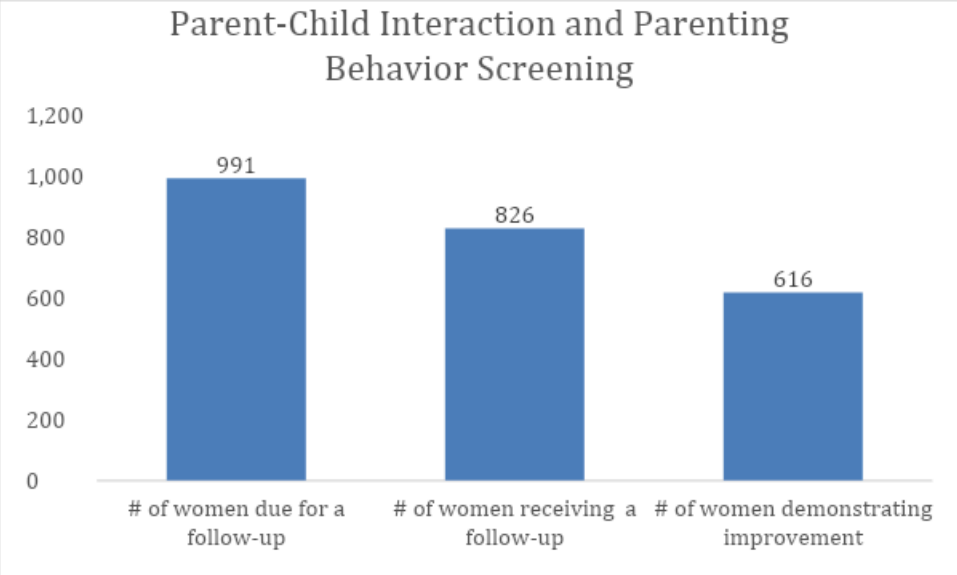
Focus population:	Enrolled mothers
Measure:	Percent of mothers with an increase in positive parenting behaviors and improved parent-child relationship
Calculation:	# of mothers who improved in parenting behaviors/Parent-child (P-C) relationships Total # of mothers who were screened at baseline and follow-up

Thirty-five (35) of the 41 programs (85%) reported that they conduct screenings related to parent-child relationships/parenting behaviors. In FY 2023, 991 women were due for a follow-up screen for parent-child relationships/parenting behavior, and 826 enrolled women received a follow-up screening. Of those 826 women with both a baseline and a follow-up screening, 616 (75%) showed improvements in positive parent-child relationships/parenting behaviors (see Figure 9).

Programs use a variety of tools to screen women for parent-child relationships/parenting behaviors. On average, the 35 home visiting programs that regularly screened women for parent-child relationships/parenting behaviors conducted this screening six 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 C.

[23] 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.
[24] Lerner, R. M., Rothbaum, F., Boulos, S., & Castellino, D. R. (2002). Developmental systems perspective on parenting. *Handbook of parenting*, *2*, 315-344.

Figure 9: Parent-Child Relationship/Parenting Behavior Improvement, FY 2023



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.[25] For mothers, exposure to IPV is associated with mental health and parenting problems, while children experience a variety of social and emotional difficulties.[26]

Focus 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[27] within 24 hours of the screening

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

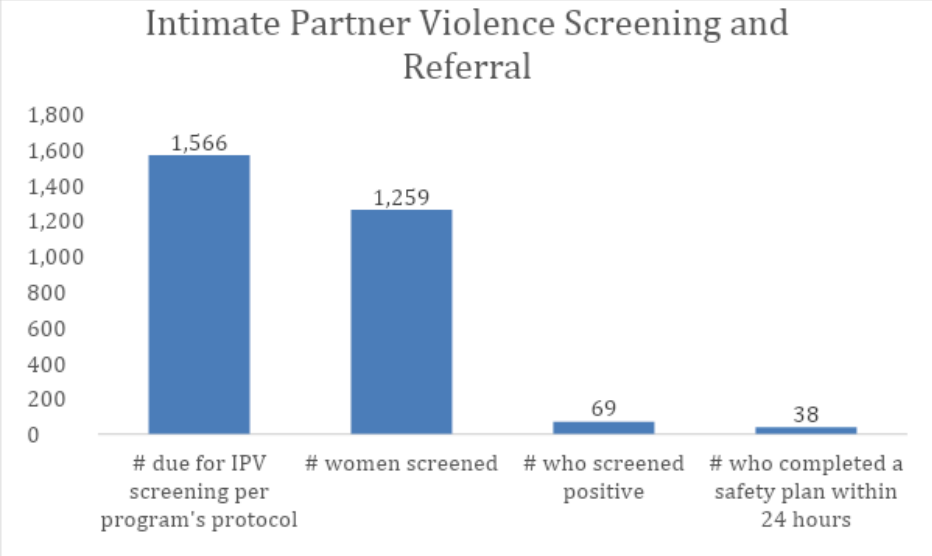
Twenty-eight (28) out of the 41 programs (68%) reported that they screened women for IPV. In FY 2023, 1,566 women were eligible for a screening per the home visiting programs' protocols. Of those women, 1,259 (80%) were screened, and 69 (5.5%) screened positive. Thirty-eight (38) women (55%) completed a safety plan within 24 hours of the screening (see Figure 10), which

[25] Maryland Network Against Domestic Violence. https://www.mnadv.org/
[26] 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.
[27] A safety plan is a personalized and practical plan for reducing the risk of being hurt.

represents an increase of 3% from FY 2021. The most common reason for not screening for IPV was that the model does not require the screening.

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

Figure 10: Screening of Women for Intimate Partner Violence (IPV), FY 2023



Qualitative Survey Response Themes

In addition to the quantitative questions, the survey included five open-ended questions to contextualize the challenges and opportunities of EBHV programs. Each of the 41 programs provided responses, and verbatim responses are italicized below.

What are the most impactful forces influencing your program? *Note: This may include repercussions of COVID-19.

Home visiting programs reported being influenced by a mixture of economic and social factors. The most frequent survey responses were related to programmatic budgets and fell into two categories. There were concerns related to funding changes from MSDE and the instability of future funding. Additionally, budgets were stretched due to the rising costs of goods and services due to inflation and higher staffing costs. Some programs lost staff who sought positions with higher pay and more flexibility. Other programs retained staff as a result of higher salaries and other incentives, but at the expense of reduced funding for other line items.

Within communities, the lack of transportation, housing instability, and increasing rates of violence are impacting families' ability to travel to and participate in services, creating additional stressors for families and staff. Programs that also provide child care services have been impacted by the continuing child care crisis, which has forced some staff to provide child care coverage rather than home visiting services. Additionally, many parents cited a greater need for child care than home visiting services. Finally, programs also reported lingering challenges due to the COVID-19 pandemic, including staff burnout and rocky transitions from virtual to in-person or hybrid services. These issues are highlighted by some of the respondents below:

"Additionally, the repercussions of COVID-19 still impact how we deliver services, who can participate, and where services are rendered."

"The number of Prenatal Risk Assessments received by the [health department] went down during the pandemic and may finally be making a comeback, but this has impacted our ability to enroll families prenatally."

"In addition, staff are feeling burned out due to the post-traumatic impact of COVID without significant time or resources to manage these effects. Business, deadlines, and program requirements had to continue as usual without any meaningful coping mechanisms and skills acquired to address any secondary impacts of the pandemic."

What activities is your program engaging in to ensure equity in home visiting?

Programs reported analogous efforts to ensure equity in home visiting. Their practices include: 1) staff training, 2) seeking community and participant feedback through regular satisfaction surveys and advisory boards, 3) offering flexibility in service delivery— including hours, modality, and location, with some programs meeting in community locations, like libraries. Furthermore, programs connect families to other services, like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); hiring staff from the community, including former clients; and providing translation and interpretation services. These issues are highlighted by some of the respondents below:
These issues are highlighted by some of the respondents below:

"Our Team Commitment acknowledges differences in experiences and power, and encourages respect, seeking understanding, affirming others' feelings, and embracing discomfort, learning, and growth. While that is a guiding document for staff interactions, there is an expectation that those principles translate to client relationships as well."

"Key informant interviews with representatives from diverse populations, and having those with lived experience participate in non-clinical portion of weekly case conferences and participation in our Leadership Advisory Board."

"We began using the Language Line and portable translation earbuds to work with families when we do not have a home visitor that speaks their primary language."

What are the biggest overall challenges faced by families enrolled in your program?

The programs reported that the biggest challenges faced by families include lack of reliable transportation, finances, access to quality health care, child care, and safe, affordable housing. These challenges are all related to social determinants of health (SDOH). Other concerns are substance use, mental health, food insecurity, limited social support, neighborhood crime, and access to services. The underlying issues of individual and structural racism, as well as implicit bias, contribute to the challenges experienced by the families. 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. These issues are highlighted by some of the respondents below:

"Without reliable transportation or affordable housing, many of our families leave our county – and our program – for better choices in neighboring counties."

"Finances- whether this is tied to food insecurity, housing, transportation, communication resources, medical needs, etc., it all stems from lack of financial resources."

"Clients feel like their doctors do not take their issues and concerns seriously, missed opportunities both inside and outside of the hospital and clinics for quality care and follow up."

What activities or best practices has your program engaged in to help support families in the challenges mentioned above?

Programs are *"Meeting families where they are."* The most common themes that emerged regarding programmatic activities were related to referrals and resources, which are integral parts of most home visiting models. The programs reported that they have provided transportation, purchased baby supplies, provided training on life skills and advocacy, and referred families to community services and resources. Programs are also being intentional about their staffing which includes nurses and dedicated staff who assist families with meeting employment and educational goals, or create resources for home visitors to share with families.

These issues are highlighted by some of the respondents below:

"Also, we have invited representatives from community partners to conduct professional development with our team so that we can educate staff on what community resources are available."

"We are currently exploring sources to fund ($1,000) our nurse to become a Certified Breastfeeding Specialist. Our nurse developed a breastfeeding support kit to distribute to clients."

"We offer various locations for socializations to accommodate families and open availability for home visits."

In your view, what are the greatest strengths of the families enrolled in your program?

The resilience of the families was mentioned most frequently. Despite the trauma and daily stress experienced, families are able to see the positive and overcome the challenges. This quote captures the sentiment of their responses:

"The greatest strengths of our enrolled families are their tenacity, perseverance, resiliency, and positive attitude."

The programs also described their families as having strong family attachments, resourceful, motivated, engaged, curious, courageous, and hardworking. The programs acknowledged that parents love their children and want the best for them, and have a desire to thrive in their parenting roles. This is evident by their active engagement in home visiting, and willingness to strengthen their parenting skills. Their engagement also helps to build social capital and interconnectedness. This issue is highlighted by the respondent below:

"Additionally, there has been a growing sense of community among our families. Families have been connecting with each other during the program's monthly parent groups and showing each other support and sharing resources they have accessed which the program may have not known about. This spirit of unity has forged friendships among numerous families in the program and created an inviting environment for all of the participants of the program."

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

The programs reported that communities could be strengthened by improvements in systems that support families, transportation, housing, healthcare, and education. Other areas for improvement are reduction in neighborhood crime, provision of affordable child care,

participation in needs assessments, and increased community resources such as grocery stores and legal services for immigrants seeking citizenship.

Families could be better supported by increased funding to support the expansion of home visiting services, broadening home visiting eligibility criteria, and increasing home visitor pay. Additional activities for supporting families include increased investment in early intervention programs, funding to support basic needs such as food and diapers, and streamlined access to services. These issues are highlighted by some of the respondents below:

"Create a designated position just for community management and referral assistance."

"Having a counselor on staff to see families in the home."

"In Maryland, a universal intake or referral system for home-based services would help to connect agencies and families."

Transportation was cited earlier as a major challenge for families. It was referenced multiple times as a solution for supporting family self-sufficiency and maintaining their health, especially for families who have to rely on public transportation but live outside city limits.

"If the rules surrounding [medical assistance] (MA) Transportation could be altered to allow transportation to any appointments to government agencies (WIC, DSS, MVA) or if MA Transportation (sic) in rural counties could enter into a MOU with Lyft or Uber to provide transportation to these other appointments and if women need to take baby to her appt (Mental Health intake appt, postpartum appt)"

The need for more affordable and safe housing was reported multiple times. Programs also reported the need for changes to policy on housing access and accountability.

"Additional subsidized and affordable housing would be life-changing for many of our families."

"Hold landlords and property owners accountable for the safety, cleanliness, rodents and pests, etc. in the living spaces they ask renters to live in and pay for!"

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.

"We would need to make a systemic change by developing policies and legislations at a government level that are more equitable and sustainable."

"We will have a successful community when the impact of the policies promotes self-sufficiency and stability."

In summary, it was recognized that, *"We need to continue working together to strengthen our communities and provide a better future for the next generations."*

Recommendations from FY 2023 Data on Standardized Home Visiting Measures

Recommendation 1: Strongly recommend the voluntary adoption of screenings where not required by the program.

In order to implement models with fidelity, EBHV programs are required to deploy various screening tools. However, there is inconsistency in which screenings are required, despite the fact that the programs prioritize similar families with similar risk factors. Given the positivity rates in screening for maternal depression (14%), substance use (5%) and intimate partner violence (6%), it is recommended that programs adopt screening tools voluntarily in order to identify and refer clients facing mental and behavioral health challenges or those that might be in danger. Due to the significant data collection and reporting burden facing home visiting programs, it will be difficult to adopt all screening tools. Nonetheless, programs are encouraged to utilize data-driven decision-making processes to prioritize the integration of additional screening tools.

Recommendation 2: Develop a statewide home visitor retention assessment and strategy. Home visitor attrition has been a feature of this report since its inception and has been exacerbated by social and economic shifts during the COVID-19 pandemic, and most recently increases in cost of living. In previous iterations this report recommended increasing home visitor wages and exploring career growth opportunities. While many programs have adopted these recommendations, and home visitors and programs have likely benefited, a statewide assessment and strategy would be more likely to result in staff retention and growth on a larger scale. This assessment and strategy could include recommended salaries, the potential for certification, and the adoption of best practices from other states, among other activities.

Recommendation 3: Strengthen the statewide coordination of home visiting oversight. There are a number of state and local agencies that implement home visiting programs, each with their own priorities, funding, application processes, reporting requirements, and referral systems. In order to ensure that the needs of the most vulnerable Maryland families are being met, it is critical that these agencies are leveraging their resources, rather than duplicating them. As the number of home visiting programs has continued to decrease, a combined effort

to prioritize this issue and support the establishment of new programs will mitigate further loss, and as a result, prevent negative health, social, and economic outcomes for families. Moreover, survey responses indicated systemic, structural challenges that cannot be addressed by one community alone. Strengthening statewide coordination is likely to result in more efficient and effective use of limited resources, sharing of lessons learned, reduced administrative burden for the programs, and a clearer picture of needs related to home visiting programs across the state.

Conclusion

The data in this summary report on Maryland Home Visiting Standardized Measures provide a trend line from which Maryland can assess home visiting's effect on the well-being of families served. In FY 2023, 3,143 caregivers and 3,053 children were served through one of seven EBHV models and three promising practices. The data reveal that Maryland home visiting has continued to positively affect families and children. Notably, of the sites that completed child and social emotional developmental screenings, 94% of children have been screened for typical development, and 100% have been screened for social emotional development. Seventy-two percent of children attended their most recent child well visit.

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. Seventy-eight (78) percent of reporting sites screen for maternal depression; 68% screen for intimate partner violence and 55% completed a safety plan within 24 hours; 66% screen for substance use; and 49% screen for parenting stress.

While there are observed improvements, the qualitative survey section reveals numerous challenges faced by programs and families. Families experienced a myriad of issues surrounding social determinants of health, mental health, and some immigrant families faced additional barriers due to their legal status and language barriers. Home visiting programs have adapted their programs to try and 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.

APPENDICES

Appendix A: FY 2023 Maryland Home Visiting Sites Reporting Data

Allegany County	
Program	**Model**
Allegany County HRDC, Inc.	EHS
Healthy Families Allegany County, Allegany County Health Department	HFA
Anne Arundel County	
N/A	
Baltimore City	
Family Tree	HFA, FC
Baltimore City Health Department Maternal and Infant Care Program	NFP
DRU/Mondawmin Healthy Families (DRUM)	HFA
Sinai Hospital of Baltimore Inc.	HFA
Baltimore Healthy Start, Inc.	Healthy Start
Harry and Jeanette Weinberg	EHS
Baltimore County	
Healthy Families Baltimore County, Abilities Network	HFA
The Y in Central Maryland Baltimore	EHS
Calvert County	
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA, PAT
Caroline County	
Healthy Families Mid-Shore, Caroline County Health Department	HFA
Carroll County	
Carroll County Family Center	PAT
Carroll County Public Schools	PAT
Associated Catholic Charities	EHS
Cecil County	
Cecil County Health Department	HFA
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
Frederick County	
Healthy Families Frederick County, Mental Health Association of Frederick	HFA
Family Connects Frederick County	FC
Garrett County	
Garrett County Community Action Committee, Inc.	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
Montgomery County	
Healthy Families Montgomery, Sheppard Pratt	HFA
Prince George's County	

Healthy Families Prince George's County, Child Care Resource Center	HFA
Mary's Center	HFA
Queen Anne's County	
Family Support of QA's County (FSC)	PAT
Healthy Families Mid-Shore	HFA
Somerset County	
Healthy Families Lower Shore	HFA
St. Mary's County	
St. Mary's County Health Department	NFP
Talbot County	
Healthy Families Mid-Shore, Talbot County Health Department	HFA
Washington County	
Healthy Families Washington County, Washington County Health Department	HFA
Head Start of Washington County	EHS
Wicomico County	
Healthy Families Wicomico County, Wicomico County Health Department	HFA
Worcester County	
Healthy Families Lower Shore	HFA

Key

ABC - Attachment Bio-Behavioral Catch-up
EHS - Early Head Start
FC - Family Connects
HFA - Healthy Families America
HIPPY - Home Instruction Program for Preschool Youngsters
NFP - Nurse-Family Partnership
PAT - Parents as Teachers

Appendix B: 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, PAT
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
Baltimore City - Roberta's House	HOPE - for mothers with an infant loss
Baltimore City - Healthy Start	Healthy Start
Baltimore County - Baltimore County Health Department	Perinatal Enrichment Program
Charles County Health Department	Maternal-Child Health Program
Worcester County - Worcester County Health Department	Early Care

Appendix C: Screening Tools Used by Programs, FY 2023

Maternal Depression Screening Tools
Center for Epidemiological Studies-Depression (CES-D)
Edinburgh Postnatal Depression Scale (EPDS)
Patient Health Questionnaire (PHQ-2)
Patient Health Questionnaire (PHQ-3)
Zung Self-Rating Depression Scale (SDS)
Patient Health Questionnaire (PHQ-9)

Maternal Substance Use Screening Tools
Alcohol Use Disorders Identification Test- Concise (Audit-C)
Cut, Annoyed, Guilty, and Eye (CAGE)
Healthy Habits
The 4Ps Plus© Questionnaire
Program created Substance Use Tool
Baltimore Healthy Start Checklist
CAGE-AID
NFP Screening Tool
Nursing Assessment Questionnaire

Parenting Stress Screening Tool
Healthy Families Parenting Inventory
General Anxiety Disorder -7 (GAD-7)
Family Resource and Opportunities for Growth (FROG) Scale
Baltimore Healthy Start Checklist
Life Skills Progression™ (LSP™)
NFP Screening Tool

Child Development Screening Tools
Ages & Stages (ASQ-3™)

Social Emotional Development Screening Tool
ASQ-2™
Devereux Early Childhood Assessment (DECA)

Parent-Child Relationships/Parenting Behavior Screening Tools
CHEERS Check-In (CCI) Tool
Life Skills Progression (LSP)
Healthy Families Parenting Inventory
Behavioral and Emotional Rating Scale (BERS)
Partners in Parenting Education (PIPE)
Dyadic Assessment of the Naturalistic Caregiver-Child Experience (DANCE)
Duke Fidelity Tool

Intimate Partner Violence Screening Tools
Relationship Assessment Tool
Hurt, Insulted, Threatened with Harm and Screamed (HITS)
Clinical Intimate Partner Violence
Baltimore Healthy Start Checklist
Strengths and Needs Assessment| Family Success Roadmap
Slapped, Threatened, and Throw (*STaT*)