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

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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 programs in each state and the U.S. territories based on the number of children living below poverty level. The major provisions of the Maternal, Infant and Early Childhood Home Visiting program required 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 Maternal, Infant and Early Childhood Home Visiting funds to Maryland in the form of both the initial formula funding (based on number of children below poverty level) and later 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 guidelines of the Maternal, Infant and Early Childhood Home Visiting program.

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 the Human Services Article §8-506 and 8-507 of the Annotated Code of Maryland, 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. 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 were required to report to the Governor's Office for Children on the standardized reporting measures adopted by the Children's Cabinet. This report is required to be submitted every two years beginning with FY 2015. Although the Maternal, Infant and Early Childhood Home Visiting 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 20 of this report.

Introduction: FY 2017 Statewide Home Visiting Data Collection Survey

This report represents the second 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 baseline collection completed for FY 2015.

Home visiting is a term used to describe a strategy in the early childhood system of care that addresses maternal, child, and family health and achievement outcomes. Home visiting programs are available in all 24 Maryland jurisdictions.

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. 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.[1, 2]

State Goals for Home Visiting

Evidence-based home visiting is a voluntary family support strategy that helps parents create healthy, positive environments for their baby and family. Evidence-based home visiting programs are designed to ensure:

- babies are born healthy and have opportunities to grow up healthy;

[1] 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.

[2] 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.

- 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** targets low-income pregnant women 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** targets parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, 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** 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.
- **Nurse-Family Partnership** 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** 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. In Baltimore City, home visiting services are offered through three other evidence-based home visiting models:

- **Maryland Family Connects** (Durham 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 age birth to five years.[3]

- **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 non-frightening care. Parent coaches provide immediate feedback on the caregivers' interaction with the child to help the caregivers attend to the target behaviors.[4]

- **Exchange Parent Aide Model** is a program of the National Exchange Club. Exchange Parent Aides are trained, professionally supervised individuals (volunteer or paid) who provide supportive and educational weekly in-home services to families with children at risk of child abuse and neglect.[5]

Additionally, there are other home visiting programs in operation in jurisdictions in the State 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 2017, seven "promising practices" in seven jurisdictions were identified. These programs include:

- Anne Arundel County's **Healthy Start** 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 women and children up to two years old. These services are provided by community health nurses and social workers.[6]

- Baltimore City's **HOPE Program** 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

[3] https://homvee.acf.hhs.gov/Model/1/Durham-Connects-Family-Connects/59/1
[4] https://homvee.acf.hhs.gov/Model/1/Attachment-and-Biobehavioral-Catch-Up--ABC--Intervention/51/1
[5] https://centers.preventchildabuse.com/content/exchange-parent-aide-program-overview
[6] https://aahealth.org/programs/children-services/babies/healthy-start

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.

- Baltimore City's **Healthy Start** 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.[7]

- Baltimore County Health Department's **Prenatal Enrichment Program** is a nurse home visiting program that provides services to high risk postpartum women. High risk mothers receive visits until their child turns one year old.

- Charles County's **Maternal-Child Health Program** is a nurse home visiting program that provides services to pregnant and postpartum women.

- Prince George's County's **High Risk Infants Program** provides short term nursing assessment, support, and education to high risk mothers 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.

- Worcester County's **Early Care Program** is a home visiting program for pregnant women and infants younger than one-year-old with high risk needs including 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]

Methodology

This report is the follow-up to the baseline data collected in FY 2015 on the standardized measures for prenatal and postnatal women and children served by home visiting programs in Maryland. 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, 2016 through June 30, 2017 for this report.

An inventory of home visiting programs across Maryland collected in FY 2015 was updated to determine which programs were providing home visiting services during FY 2017. The inventory was created by collecting program lists previously compiled by the Maryland Department of Health, Maryland State Department of Education, Governor's Office for Children, Maryland Family Network and the Johns Hopkins Home Visiting Evaluation Team. Each program was contacted [via email and/or phone call] to

[7] https://baltimorehealthystart.org/home-visiting/
[8] http://www.worcesterhealth.org/treatment-menu/early-care-services-menu

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 76 evidence-based and seven promising practice programs were operational during FY 2017.

The data survey developed in FY 2015 was updated to improve ease of use, include feedback obtained from the baseline collection, and gather data on the Governor's priorities. The survey was launched using a web-based data collection platform and was sent to all home visiting programs that operated during FY 2017. The survey was launched on August 14, 2017 and sites had until September 15, 2017 to input their data. A webinar was offered by the Maryland Department of Health prior to the launch of the survey and technical assistance was provided to sites as needed during the collection process.

Overview of Reporting Programs

A total of 58 out of 83 sites submitted data, representing a return rate of 70%, compared to a return rate of 66% in FY 2015. Of the 58 sites reporting, 78% (42) received State funding in FY 2017. The other 16 sites received some combination of federal, local, and/or philanthropic funding in FY 2017. All 24 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 2017 data compared to baseline FY 2015 data. Appendix A provides details on programs submitting survey data for FY 2017. Appendix B provides details on all known home visiting programs in Maryland who were asked to submit data.

Table 1: Reporting Program Sites

Measure	FY 2017 Home Visiting Program Sites Reporting	FY 2015 Home Visiting Program Sites Reporting
Number of program sites reporting	58	46
Jurisdictions represented	24	23
Number of women served	4,602	3,535
Number of "other" Primary Care Givers served*	109	157
Number of children served	3,947	3,493

*Other Primary Care Givers includes fathers, grandparents, aunts, uncles, cousins, siblings and foster/adoptive parents

Table 2 details the number of identified program sites that offer each type of evidence-based and promising practice home visiting model available in Maryland jurisdictions. Home visiting programs serving multiple jurisdictions were asked to complete separate surveys for each jurisdiction served. Therefore, the number of program sites is greater than the actual number of programs. For example: Healthy Families Mid-Shore (program) provides home visiting services in Kent, Queen Anne's, Talbot, and Caroline Counties (four sites). In addition to providing information on the total number of programs

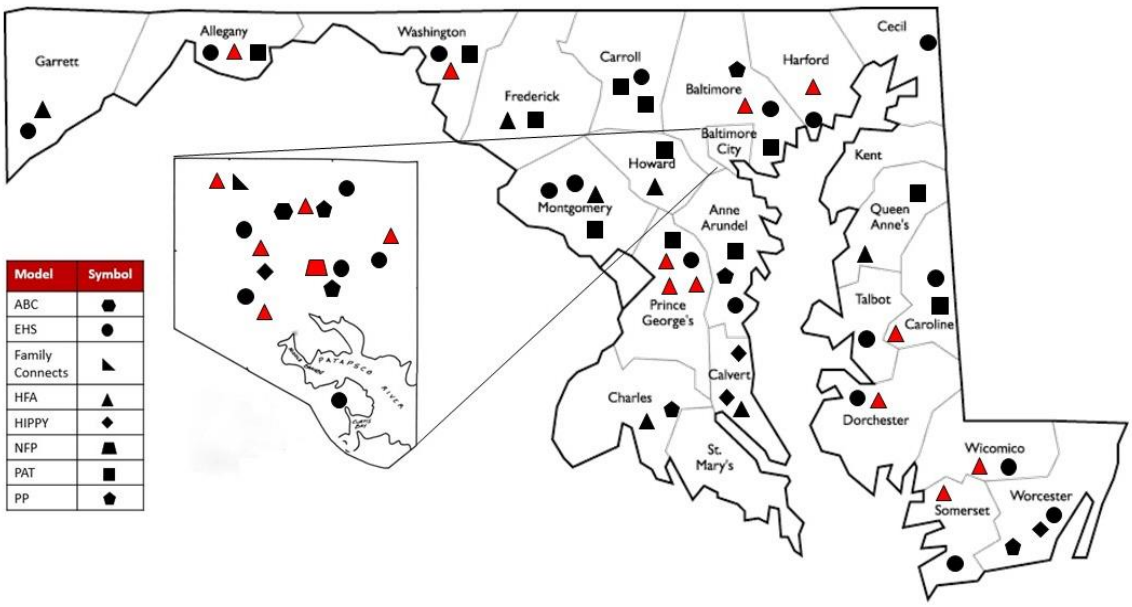
by model, the table indicates the number of each program type that reported data for the FY 2017 Home Visiting Standardized Measures survey as compared to the baseline collection completed in FY 2015. See Appendix A for further details on programs serving multiple jurisdictions.

Table 2: Data-Reporting Sites by Program Model

Program Model	FY 2017 Number of Known Program Sites	FY 2017 Number Reporting	FY 2015 Number of Known Program Sites	FY 2015 Number Reporting
Early Head Start (EHS)	27	11	25	8
Healthy Families America (HFA)	28	28	27	25
Home Instruction for Parents of Preschool Youngsters (HIPPY)	3	3	4	2
Nurse Family Partnership (NFP)	1	1	1	1
Parents as Teachers (PAT)	14	13	13	9
Other*	10	2	0	**1
TOTAL #	83	58	70	46
% Reporting	70%		66%	

*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: Map of All Maryland Home Visiting Sites



Red indicates MIECHV site

Funding for Reporting Programs

Maryland's home visiting programs are supported by federal, State, local, and philanthropic funding. During FY 2017, only 10 home visiting sites (17%) of the 58 reporting received State-only funding, while 42 received State funding in combination with other sources. Eighty-five percent of reporting sites indicated that they received a combination of funding from federal, State, local, and/or philanthropic sources in FY 2017.

State General Funds, according to the survey, were provided for home visiting services from several different State agencies including the Departments of Education, Human Services, Health (excluding federal Maternal, Infant and Early Childhood Home Visiting funds), and the Children's Cabinet Interagency Fund. A total of 36 of the 58 reporting sites indicated receiving funds from at least one of these sources in FY 2017. In total, these four sources invested eight million dollars in home visiting services for Maryland families.

The federal government also provides funding for Maryland home visiting programs. The Maternal, Infant and Early Childhood Home Visiting program is funded through the Health Services Resource Administration. In FY 2017, Maternal, Infant and Early Childhood Home Visiting funding supported 18 sites in 10 jurisdictions. The Administration for Children and Families, Office of Head Start provides partial or full funding for Early Head Start programs. Twelve sites responding to the survey indicated that they received funds through this office. Additionally, Promoting Safe and Stable Families grants administered through the Department of Health and Human Services supported two home visiting programs in Maryland. Other federal sources of funding for Maryland home visiting programs included Community Based Child Abuse Prevention (CBCAP) grants and the Department of Housing and Urban Development's Community Development Block Grants (CDBG). Eight sites (14%) reported receiving only federal funding in FY 2017, with another 29 sites (50%) indicating receiving some portion of federal funding in combination with other sources.

Local government and philanthropic funding also support a number of home visiting programs in Maryland. Eight sites (14%) reported receiving more than 50% of their funding from local government or philanthropic sources in FY 2017 (See Figure 2 and Figure 3).

Figure 2: Home Visiting Funding by Source

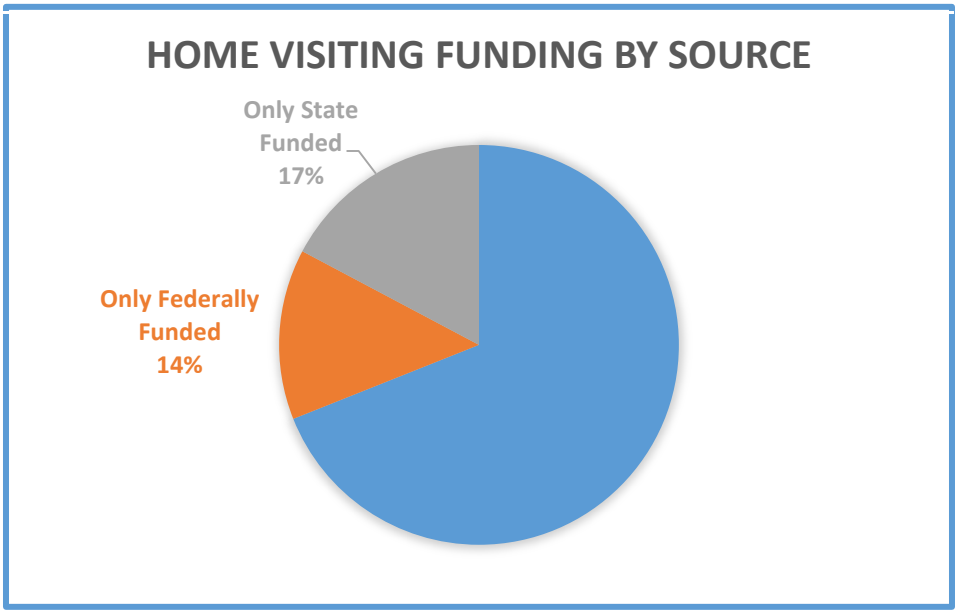
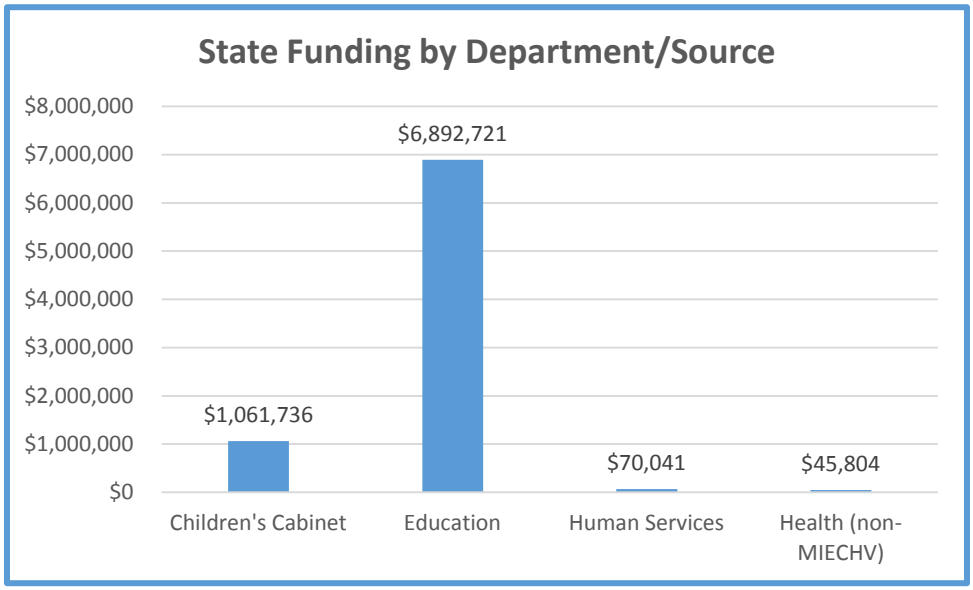


Figure 3: State Funding by Department/Source

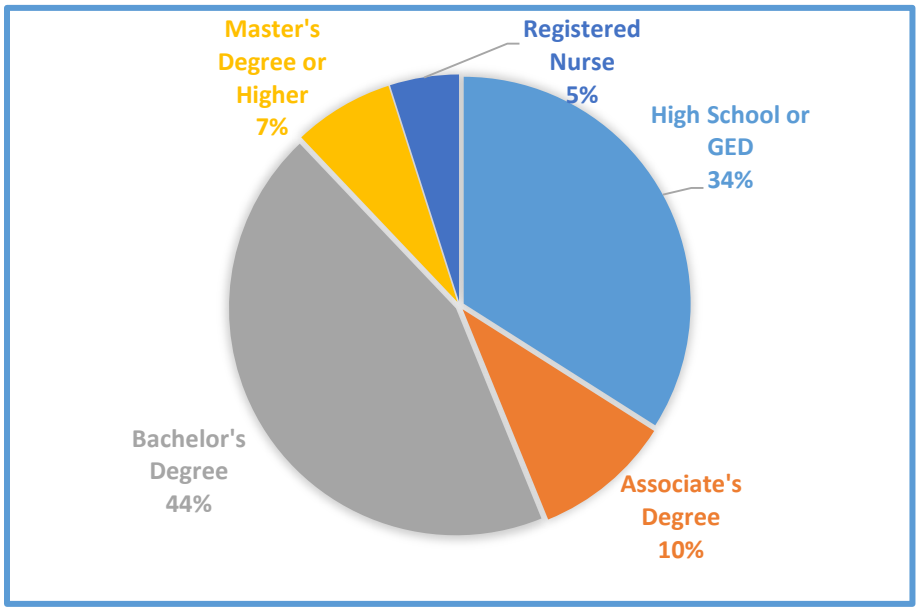


Maryland's Home Visiting Workforce

With the FY 2015 baseline data collection, a picture began to develop of the home visiting workforce in Maryland. Again in FY 2017, the data collection 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), educational attainment of home visiting staff, and the most common reasons for home visitor turnover.

In FY 2017, 58 programs reported employing 207.8 full time equivalent home visitors to serve enrolled families. The breakdown of home visitors' educational attainment is illustrated in Figure 4.

Figure 4: Home Visitor Education Level



In addition to their formal education, home visitors receive extensive training specific to the program model and curriculum as well as supplemental training throughout the year and their employment on topics ranging from child development to cultural competency. Additionally, with the use of federal Maternal, Infant and Early Childhood Home Visiting Program funds, the Maryland Department of Health in collaboration with the University of Maryland, Baltimore County has developed a Home Visitor Training Certificate Program ("Training Certificate Program"). The Training Certificate Program provides additional training to home visitors on challenging issues such as mental health, substance abuse, and intimate partner violence that are often addressed during home visits. To date, 50 home visitors funded by the Maternal, Infant and Early Childhood Home Visiting grant have completed the Training Certificate Program. Training satisfaction and home visitor demographics can be found below:

Table 3: Mean confidence and training satisfaction ratings from fall 2016 and spring 2017 Training Certificate Program cohorts

Module	Confidence Pre-test	Confidence Post-test	Post-training satisfaction
Communication	4.5 (1.0)	4.9 (0.6)	5.5 (1.0)
Healthy Relationships	4.7 (0.8)	5.0 (0.6)	5.2 (1.0)
Parenting	4.9 (0.7)	5.2 (0.5)	5.5 (0.6)
Mental Health	4.7 (0.8)	5.1 (0.6)	5.7 (0.5)
Substance Use	4.9 (0.9)	5.1 (0.7)	5.6 (0.5)
Culture	5.1 (0.8)	5.3 (0.5)	5.5 (0.6)

Table 4: Demographic data for fall 2016 and spring 2017 Training Certificate Program cohorts

Variable		Percent (n)
Role (Trainees could select more than one option)	Home Visitor/Family Service Worker (FSW)	69% (43)
	Administrator	2% (1)
	Supervisor	21% (13)
	Family Assessment Worker	15% (9)
	Program Manager/Project Director	8% (5)
Program model (Trainees could select more than one option)	Healthy Families America	92% (57)
	Early Head Start	7% (4)
	Nurse Family Partnership	3% (2)
	Parents as Teachers	3% (2)
	Home Instruction for Parents of Preschool Youngsters	3% (2)
Gender	Female	94% (58)
	Male	5% (3)
Race/ Ethnicity (Trainees could select more than one option)	Black/African American	48% (26)
	White	37% (20)
	Asian/South Asian	2% (1)
	Native American/American Indian/Alaska Native	2% (1)
	Other (Biracial, Latino[a])	13% (7)
	Latino[a]	16% (10)
	Prefer not to answer	13% (8)
Highest educational level	Some High School	2% (1)
	High School/GED	5% (3)
	Some College	21% (13)
	College Graduate	46% (28)
	Graduate Degree	26% (16)
Mean age in years (range: 24-63)		40 (11.5)
Experience	Mean years as a home visitor (range = <1 yr. – 29 yrs.)	6.3 (3.1)
	Median home visiting caseload size (range = 0 - 11)	4.0
	Mean number of home visitors supervised (range = 3 - 11)	5.7 (2.9)

Note: values presented here reflect all available data. Caseload data only reflect spring 2017, as this question was not asked in fall 2016.

Tracking and analyzing staff retention is an important aspect of home visiting program management. A family's investment and tenure in the 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[9]. Additionally, staff turnover leads to lower caseloads, i.e. less families served, due to the restrictions of caseload size for new staff by the evidence based program models.

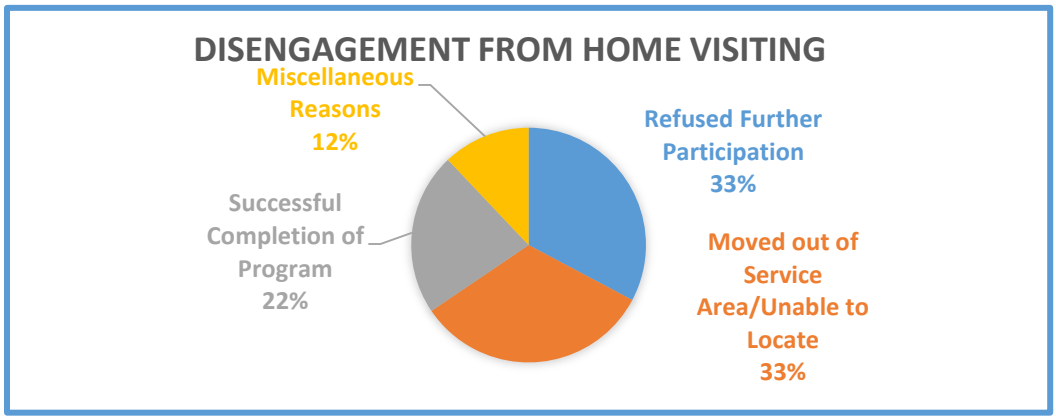
[9]https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/tafiles/enrollmentandengagement.pdf

Data on staff retention were also collected through the Statewide survey to obtain more information on workforce development and retention issues within home visiting programs. Thirty-one out of the 58 (53%) reporting sites indicated that during FY 2017 they experienced staff turnover. Fifty-five percent of these programs indicated that the prevalent reason for staff turnover centered on home visitors finding other employment opportunities that offered higher salaries and/or better benefits. The second most common reason for staff turnover for reporting programs in FY 2017 was family/personal reasons (19%). Other reasons included: new opportunities with better hours or closer to home, return to school, staff burnout, retirement, and personnel issues.

Of the Maryland home visiting sites reporting data in FY 2017, the 58 sites were funded to serve between 3,466 and 3,721 women. A total of 4,602 women received at least one home visit during the time period while 1,502 women disengaged from services. Thirty-eight of the 58 sites reporting data indicated that the top two reasons for disengagement in FY 2017 were 1) refusing further participation and 2) moving out of the service area/unable to locate. An additional seven sites reported miscellaneous reasons for disengagement ranging from needing more intensive services to conflicts with school/work schedules.

On a more positive note, 13 sites indicated that the primary reason that families disengaged was due to the successful completion of the home visiting program (graduation).

Figure 5: Reasons for Disengagement from Home Visiting Services



Demographics of Women Served

Data collected indicate that 4,602 women were served by the 58 reporting home visiting sites throughout Maryland in FY 2017 as compared to 3,535 by the 46 reporting programs in FY 2015. Women served in FY 2017, similar to the findings in FY 2015, were predominately 20-29 years old (48%) and Black, not of Hispanic, Latino, or Spanish (HLS) origin (48%). In total, during FY 2017 the service population for Maryland home visiting programs was 70% minority races/ethnicities. Twenty-two percent of women served were White, not of Hispanic, Latino, or Spanish origin, 11% were White and of HLS origin, and 6% were HLS of unspecified race. Figures 6 and 7 illustrate the demographics of women served during FY 2017.

Figure 6: Maternal Age

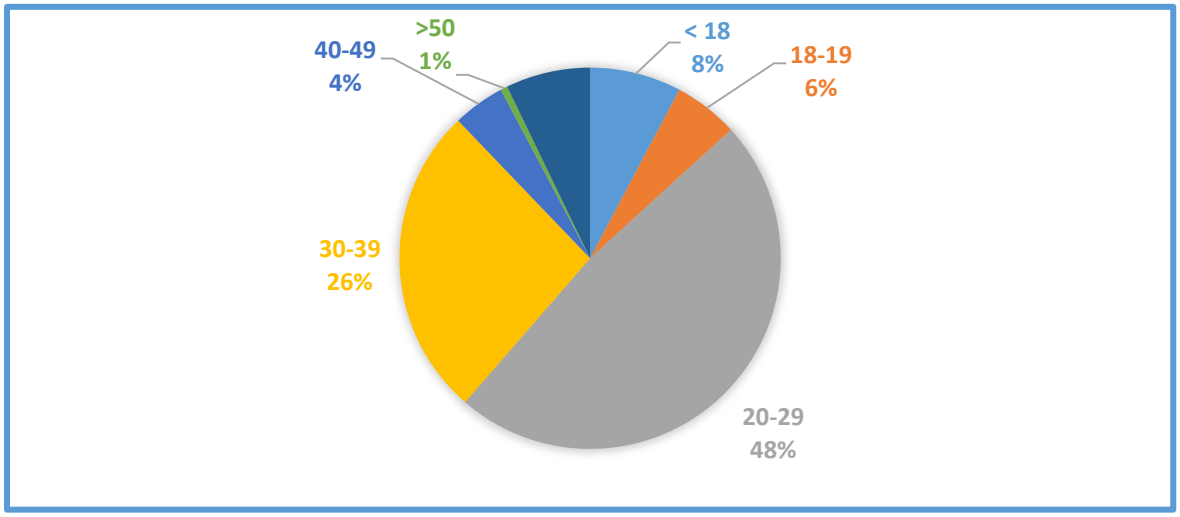
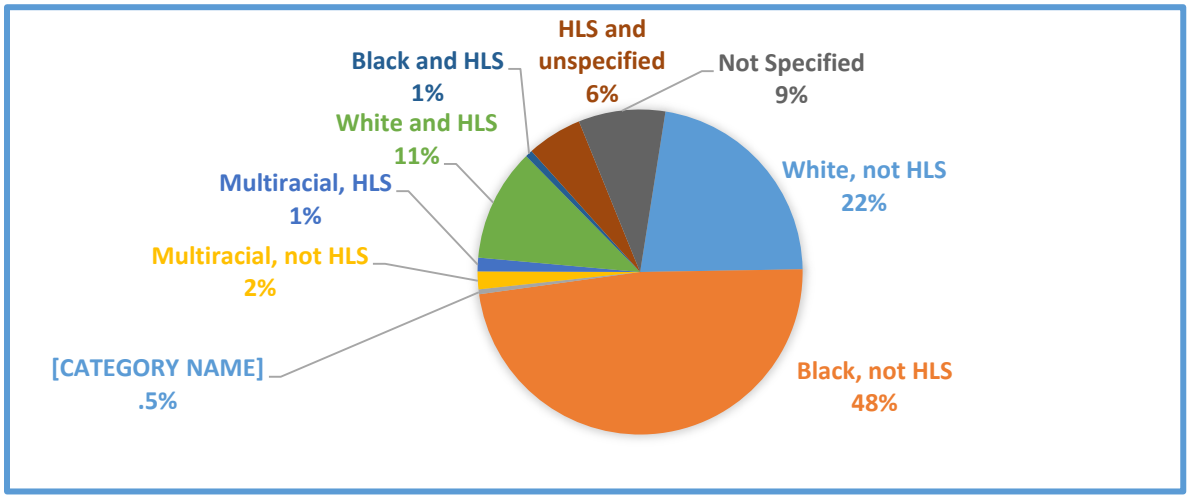


Figure 7: Maternal Race and Ethnicity



*HLS pertains to Hispanic, Latino or Spanish

Demographics of Children Served

Data collected indicate that 3,947 children were served by the 58 reporting home visiting sites throughout Maryland in FY 2017 as compared to 3,493 from the 46 reporting programs in FY 2015. The majority of children served (42%) were between the ages of 13 and 35 months. Similar to the women served in FY 2017, the children's service population was 87% minority races/ethnicities. Fifty-two percent of children were Black and not of Hispanic, Latino, or Spanish (HLS) origin. The next largest racial and ethnic categories of children served were White and of HLS origin (17%), Multiracial not of Hispanic, Latino, or Spanish origin (8%) and White, not of HLS origin (8%). Figures 8 and 9 illustrate the demographics of children served during FY 2017.

Figure 8: Child Age

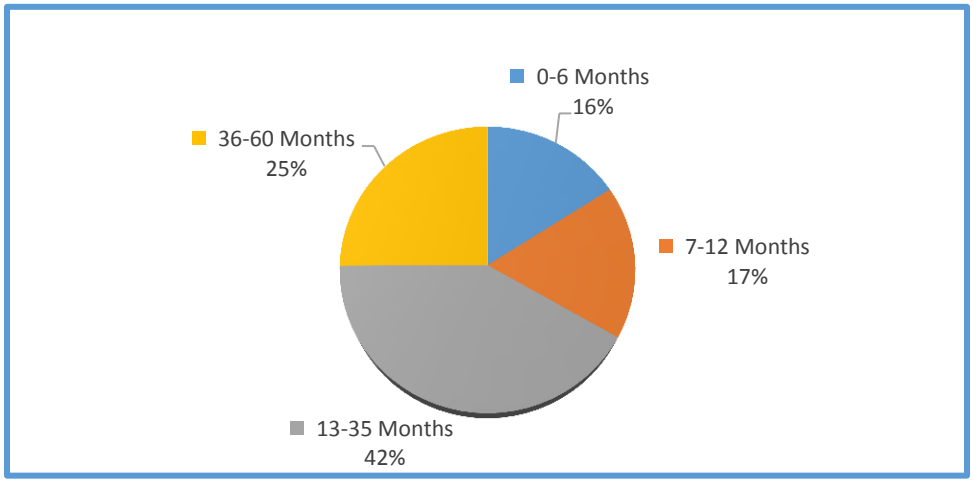
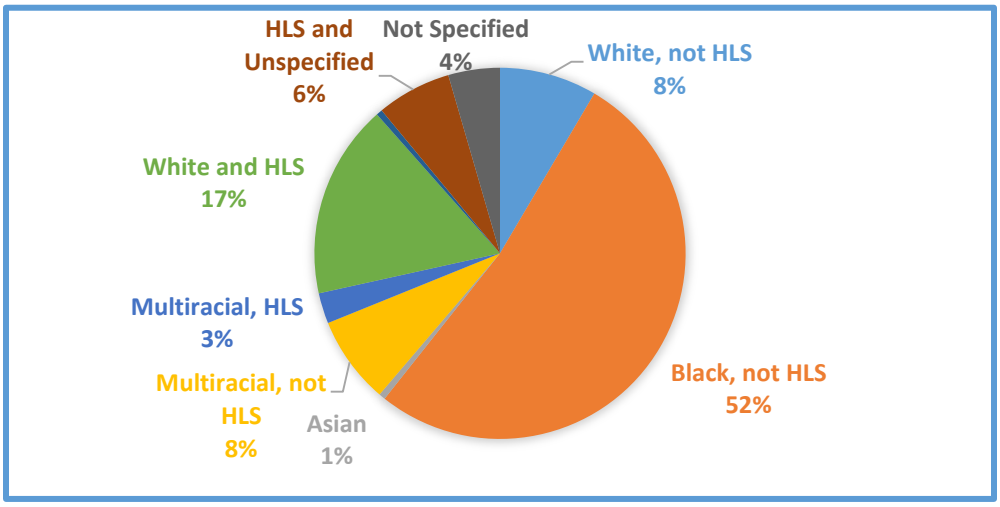


Figure 9: Child Race and Ethnicity



*HLS pertains to Hispanic, Latino or Spanish

Maryland's Home Visiting Standardized Measures

Following the passage of the Maryland Home Visiting Accountability Act of 2012, The Governor's Office for Children was tasked with convening a workgroup to develop specific strategies for tracking and reporting 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 Children by staff from the Pew Foundation's Home Visiting Campaign who had successfully assisted other states with similar projects.

In March of 2014, the Children's Cabinet approved the measures 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 measures.

Table 5: Maryland's Standardized Home Visiting Measures

Domain	Standardized Measures[10]
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.

Baseline Comparison

In reviewing data from FY 2015 for the baseline comparison with FY 2017, it was discovered that some of the analysis of the FY 2015 data included erroneous calculations. For data pertaining to the number of women or children who were screened within the five domains, the denominator used to determine the percentage screened mistakenly used all women or children served in FY 2015. The denominator for these calculations, as used for the FY 2017 data, should have been the number of women or children who were eligible for such screenings during that particular fiscal year. Depending on the home visiting programs' protocols for screening, not all women/children may be eligible for a particular screening during the time period used for the previous report. For example: a home visiting program may only screen an enrolled mother for maternal depression 4-6 weeks after giving birth. She may have received that screening after birth and is now two years into her enrollment in the home visiting program. Per the screening protocols, the woman is not eligible for/in need of screening and should not be included in the calculation.

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

In an attempt to account for the erroneous calculations, raw data for FY 2015 were retrieved and re-analyzed. However, some questionable data that were submitted by sites could not be reasonably validated. For this reason, there are some standardized measures that are not comparable between FY 2015 and FY 2017 -- specifically screening rates.

In future years, FY 2017 data will be used as the baseline data to determine trends in the standardized measures now that the calculations have been corrected. However, in consideration of the calculation errors with the FY 2015 data, a few measures could be compared and are summarized below.

Table 6: Initiation of Services after a Positive Depression Screening

Measure	FY 2015	FY 2017
Percent of women with a positive maternal depression screen who receive a referral for treatment	72%	73%
Percent of women initiating treatment services after a positive maternal depression screen	61%	68%

What the data tells us:
Data from FY 2015 and FY 2017 indicate that the reporting sites are continuing to refer women to appropriate treatment resources when a positive maternal depression screen occurs, but more women are initiating services from that referral. It is important to note that it is difficult to engage women that score positively, and an increase in initiating treatment/services is a successful marker of the strides Maryland is making in mental health.

Opportunity for improvement:
Federal data reporting requirements as well as the 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 and referral and how to appropriately support the woman to follow through with recommendations are a critical next step in engagement of the mother, thereby assuring a higher rate of both screening and follow up.

Table 7: Improvement in Parent-Child Relationships/Parenting Behavior

Measure	FY 2015	FY 2017
Percent of women showing improvement in parent-child relationships/parenting behavior	40%	71%

What the data tells us:
Data from FY 2015 and FY 2017 indicate progress in the percentage of women who show 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

the increase in the use of validated screening tools. 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:
Although the specific reasons why there has been such a marked improvement in parenting behaviors between FY 2015 and FY 2017 are unknown it does provide an opportunity for improvement in future data collection efforts. 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 home visiting has on the well-being of both caregivers and children.

Table 8: Safety Plan after a Positive Intimate Partner Violence Screen

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

What the data tells us:
Data from FY 2015 and FY 2017 indicate that reporting sites are making improvements in addressing positive intimate partner violence screenings by implementing safety plans. Intimate partner violence is a sensitive and challenging issue many home visiting programs struggle to address. Since FY 2015, efforts have been initiated 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[11] are examples of such efforts for improvement.

Opportunity for improvement:
Continuing to provide training opportunities for home visitors as well as provide supervisor support [for supervision of home visitors] to address these very difficult and sensitive issues can make a marked improvement in the ability to be comfortable in difficult conversations. Engaging other State stakeholders including the Departments of Social Services and Education can assist in training home visitors to meet the needs of vulnerable families by developing safety plans. Additional questions on the survey that provide context to the data will allow for further understanding as to what is happening that may impact the safety plan development.

Domain 1: Child Health—Well-Child Visits

Well-child visits include a complete physical and evaluation of the child's progress toward developmental milestones. These visits provide opportunities for health education and communication between the parent and the pediatrician. Attending regular well-child visits allows parents to raise concerns about the child's health and also to receive preventative care such as immunizations. Well-

[11] https://www.nhvrc.org/product/sensitive-topics/

child visits are key in helping health care providers form reliable and trustworthy relationships with families they serve.[12]

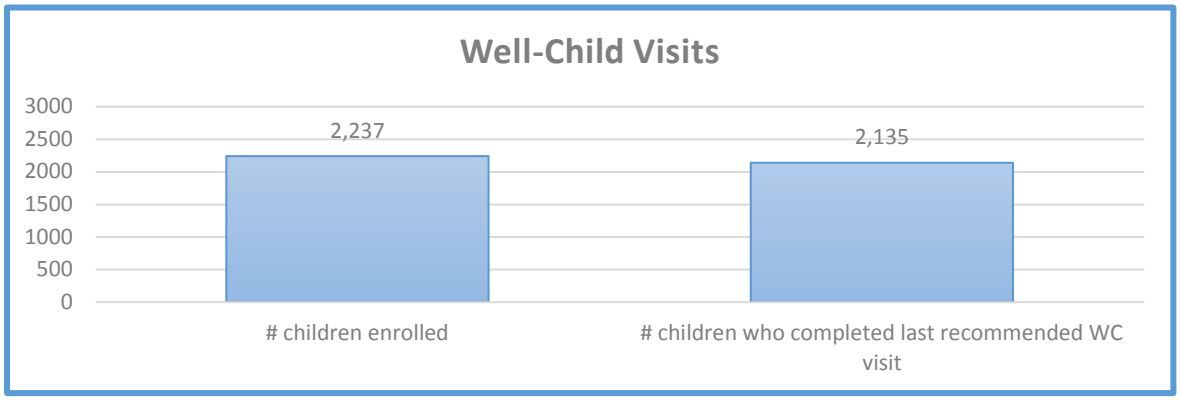
Target population: All children enrolled in home visiting as of June 30, 2017.

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

Calculation: $\frac{\text{\# of enrolled children who completed last recommended well-child visit}}{\text{Total \# of enrolled children}}$

Forty-three of the 58 reporting sites indicate that they collect well-child visit information from parents. At the end of FY 2017, 2,237 children were enrolled in the 43 home visiting sites reporting data. Of those 2,237 children, 2,135 (95%) completed the most recent well-child visit recommended by the American Academy of Pediatrics *Bright Future™* schedule[13], demonstrating that they are up-to-date on age-appropriate immunizations, education, and developmental assessments from a healthcare provider (see Figure 10).

Figure 10: 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 population served through home visiting and can have a profoundly negative impact on parenting, maternal life course, and child development.[14]

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

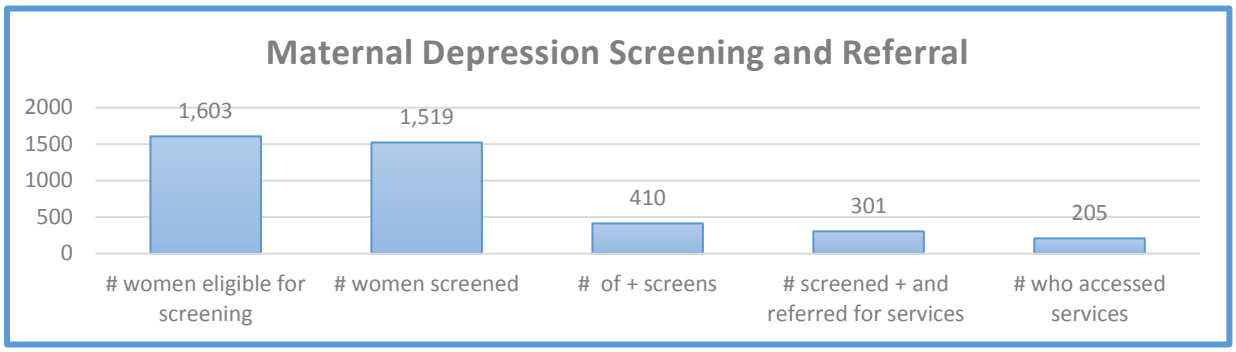
Measure: Percent of women who were screened for maternal depression.

[12] www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
[13] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
[14] 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.

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

Forty-two of the 58 sites reporting data conduct depression screenings of enrolled women. In FY 2017, 1,603 women were due for a depression screening per the home visiting program's screening protocols. Of the 1,603 women due for a screening, 1,519 (95%) received a depression screening. Of those 1,519 women screened, 410 (27%) screened positive for depressive symptomology warranting further assessment from a healthcare provider. Of the women who screened positive for depression, 301 (73%) were referred for further assessment and treatment, with 68% of those women initiating or continuing mental health treatment (see Figure 11). The survey does not currently collect data on reasons why a woman was or was not referred, but can be 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 three 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 11: Number of Women Screened & Referred for Pos. Maternal Depression Screening



Domain 2: Maternal Mental Health—Substance Use

Many substances, including cigarettes, alcohol, and opiates, cross the placenta and impact the developing fetus.[15] Use of these substances during pregnancy is associated with maternal, fetal, and infant morbidity and mortality.[16]

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

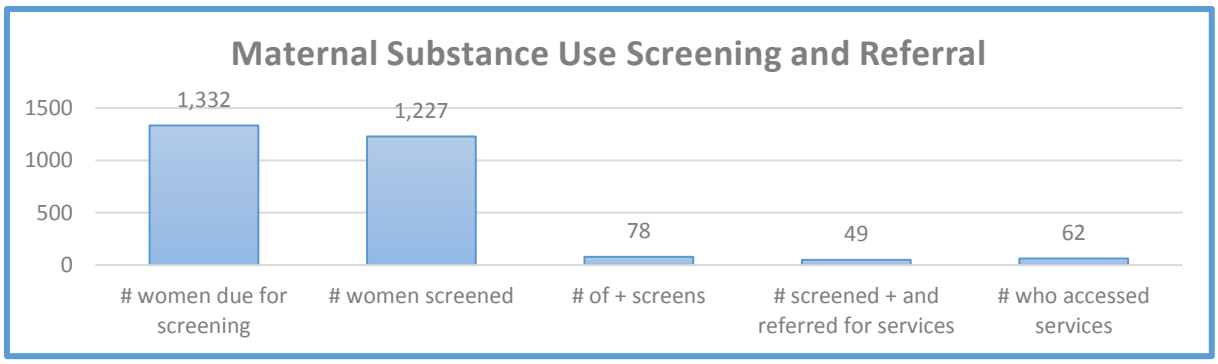
Measure: Percent of women who were screened for substance use.

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

[15] 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.
[16] The American College of Obstetricians and Gynecologists. (2010). Committee Opinion: Smoking Cessation During Pregnancy.

Only 50% (29) of the 58 sites reporting data conduct routine substance use screenings for enrolled women. In FY 2017, 1,332 women were due for a substance use screening per the home visiting programs' screening protocols. Of those 1,332 women, 1,227 (92%) of enrolled women were screened for substance use. Of the 1,227 women screened, 78 (6%) screened positive for substance use warranting further assessment and evaluation. Of the 78 women screening positive, 49 (63%) were referred for treatment services. Sixty-two women either initiated or continued treatment for substance use. This number is an indication that 13 women who screened positive were already receiving treatment for substance use (see Figure 12). Like the data above, the survey does not currently collect data on reasons why a woman was or was not referred, but can be 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 screen women twice for substance use during the course of services. A full list of the tools utilized can be found in Appendix D.

Figure 12: Screening and Referral for Maternal Substance Use



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.[17]

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:

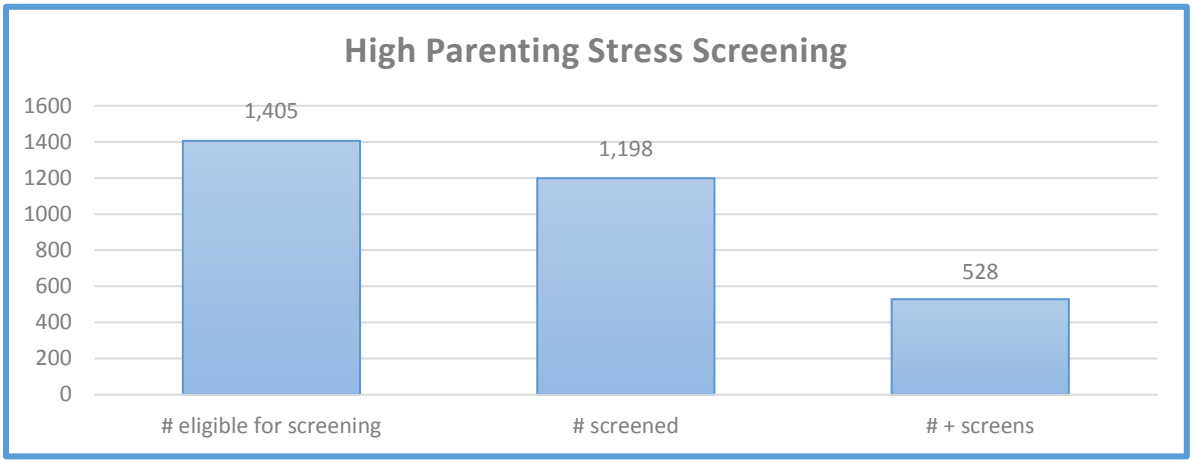
$$\frac{\text{\# of women who presented with clinically high parenting stress}}{\text{Total \# of women eligible for the screening per the program's protocols}}$$

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

Twenty-eight of the 58 sites reporting data screen enrolled women for high parenting stress. In FY 2017, 1,405 women were eligible for high parenting stress screening per the home visiting programs' screening protocols. Of those 1,405 women, 1,198 (85%) women were screened and 528 (44%) women were positive for high parenting stress (see Figure 13).

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

Figure 13: 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.[18]

Target population: Enrolled children.

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

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

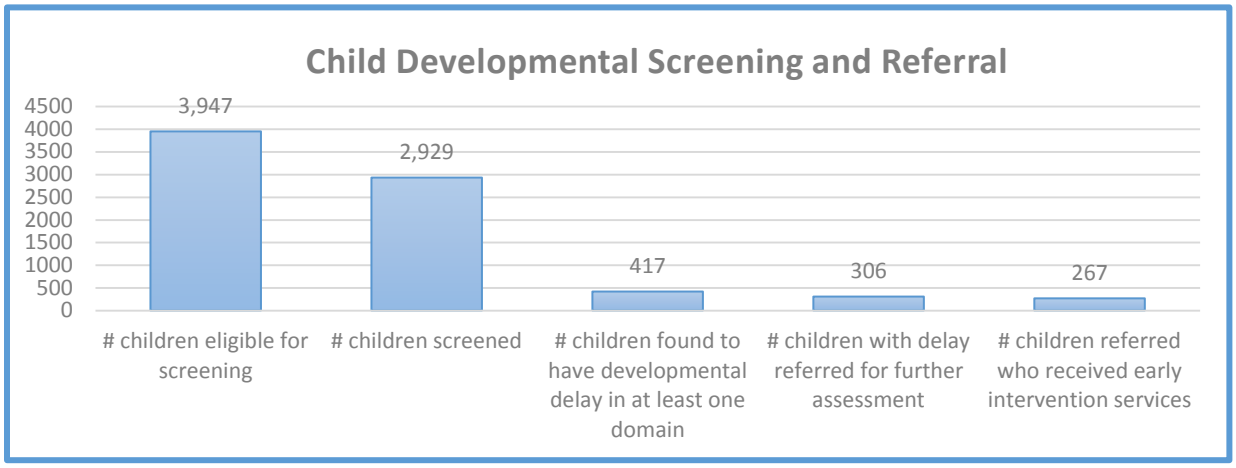
Fifty-six of the 58 sites providing data screen children for typical development using a developmental screening tool. In FY 2017, 2,929 children out of 3,947 children (74%) were screened per the home visiting programs' protocols. Of the 2,929 children screened, 417 (14%) were suspected of having a developmental delay in at least one domain. Three hundred six children (73%) were referred for further

[18] 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.

assessment and evaluation. Eighty-seven percent of the children referred are receiving early intervention services (see Figure 14).

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 14: Number of Children Screened and Referred for Developmental Delay



Domain 3: Typical Child Development—Social Emotional

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.[19]

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:

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

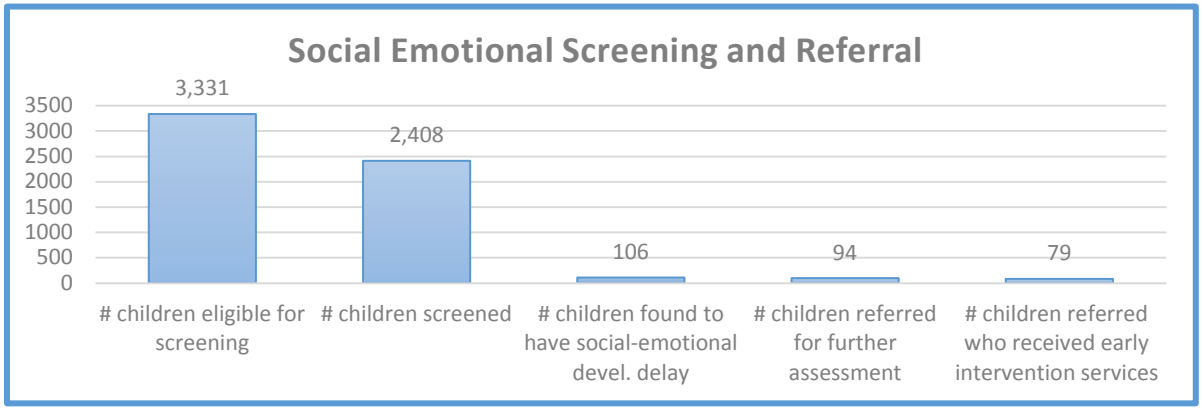
Fifty-three of the 58 sites reporting data screen children for social emotional development. In FY 2017, 2,408 children (72%), out of 3,331 eligible children, received a screening for social emotional development. Of the 2,408 children screened, 106 (4%) children were suspected of having a social emotional developmental delay. Ninety-four (89%) were referred for further assessment and evaluation.

A total of 79 (84%) children received early intervention services following the referral (see Figure 15).

[19] American Academy of Pediatrics: Social and Emotional Problems. Accessed 11/16/15 from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/social-and-emotional-problems.aspx

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 15: 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.[20] Early intervention can minimize delays and strengthen children's cognitive, physical, and behavioral development, thereby reducing the incidence of future problems.[21]

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:

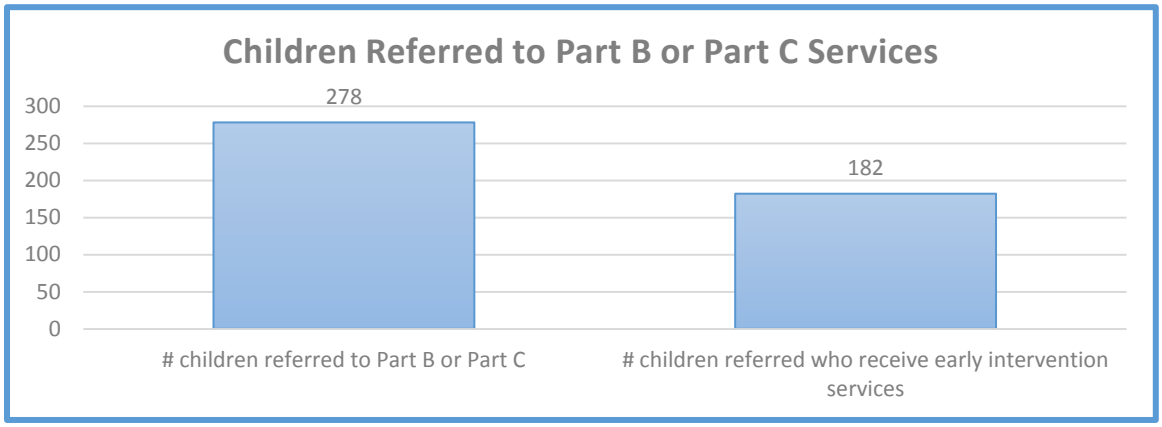
$$\frac{\text{\# of children receiving IDEA Part C and/or Part B services}}{\text{\# of enrolled children referred to IDEA Part C and/or Part B services}}$$

During FY 2017, 278 children were referred to Part B or Part C early intervention services. Of those 278 children, 182 (65%) received early intervention services. Another 22 children received private early intervention services not associated with IDEA. Those children receiving services for developmental delays (204) represented only 5% of all children served by home visiting programs in FY 2017 (see Figure 16).

[20] Maryland Learning Links. (no date). Accessed 06.11.15 from http://marylandlearninglinks.org/361448

[21] Center on the Developing Child at Harvard University. (2010). The foundations of lifelong health are built in early childhood. http://developingchild.harvard.edu/library/reports_and_working _papers/foundations-of-lifelong-health/

Figure 16: 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.[22,23] Evidence-based home visiting programs can support parents in developing trusting, positive, and reliable relationships with their children.

Target population: Enrolled mothers.

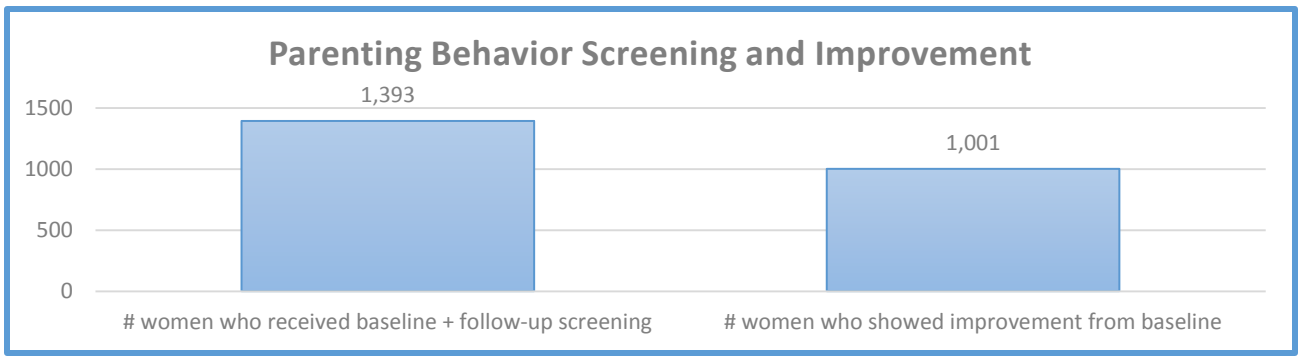
Measure: Percent of mothers with an increase in positive parenting behaviors and improved parent-child relationship.

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-seven of the 58 reporting sites conduct screenings related to parent-child relationships/ parenting behaviors. In FY 2017, 1,393 enrolled women received a follow-up screening on parent-child relationships/parenting behavior. Of those 1,393 women with both a baseline and a follow-up screening, 1,001 (72%) women showed improvements in positive parent-child relationships/parenting behaviors (see Figure 17). Programs use a variety of tools to screen women for parent-child relationships/parenting behaviors. On average, home visiting programs screen women for parent-child relationships/ parenting behaviors three 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 17: Parent-Child Relationship/Parenting Behavior Improvement

[22] 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.
[23] 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 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 intimate partner violence.[24] For mothers, exposure to intimate partner violence is associated with mental health and parenting problems, while children experience a variety of social and emotional difficulties.[25]

Target population: Enrolled women.

Measures: Percent of women who were screened for Intimate Partner Violence; Percent of women who screened positive; Percent of positive screens who completed safety plans within 24 hours of the screening.

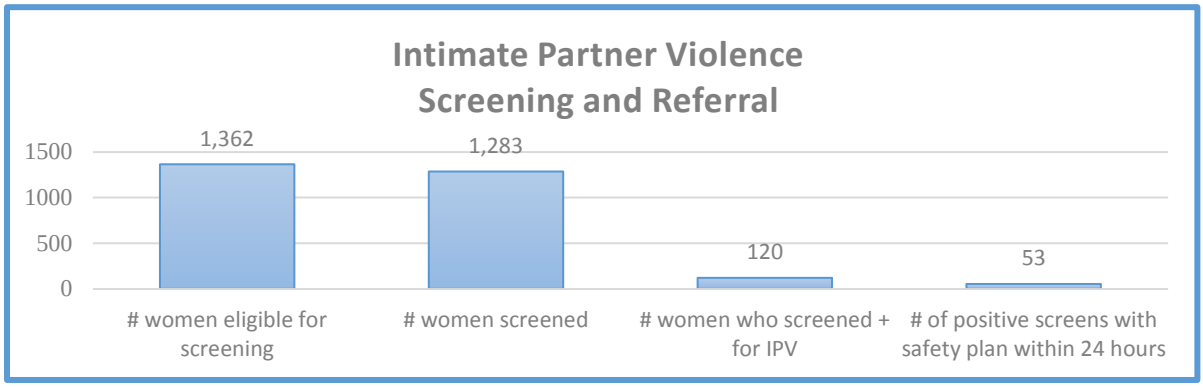
Calculation:

$$\frac{\text{\# of women screened for Intimate Partner Violence}}{\text{Total \# of women eligible for screening per the program's protocol}}$$

Thirty-four out of the 58 reporting sites conducted screening of women for intimate partner violence. In FY 2017, 1,362 women were eligible for a screening per the home visiting programs' protocols. Of those 1,362 women, 1,283 (94%) were screened with 120 (9%) women screening positive. Fifty-three women (44%) completed a safety plan within 24 hours of the screening (see Figure 18). Programs use a variety of tools to screen women for intimate partner violence. On average, home visiting programs screen women for Intimate Partner Violence twice during the course of services. A full list of tools used to screen for Intimate Partner Violence can be found in Appendix I.

[24] Maryland Network Against Domestic Violence, www.mnadv.org
[25] 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.

Figure 18: Screening of Women for Intimate Partner Violence (IPV)



Reporting on the Governor's Priorities

In addition to the standardized reporting measures approved by the Children's Cabinet, the FY 2017 data collection survey also included questions specific to the Governor's family economic self-sufficiency priorities. Additional data was collected on:

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

All data relates to women/families enrolled in home visiting services as of June 30, 2017.

Priority 1: Women 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 age 16-24 are neither working nor in school.[26] Youth who are disconnected from 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 wellbeing, 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:

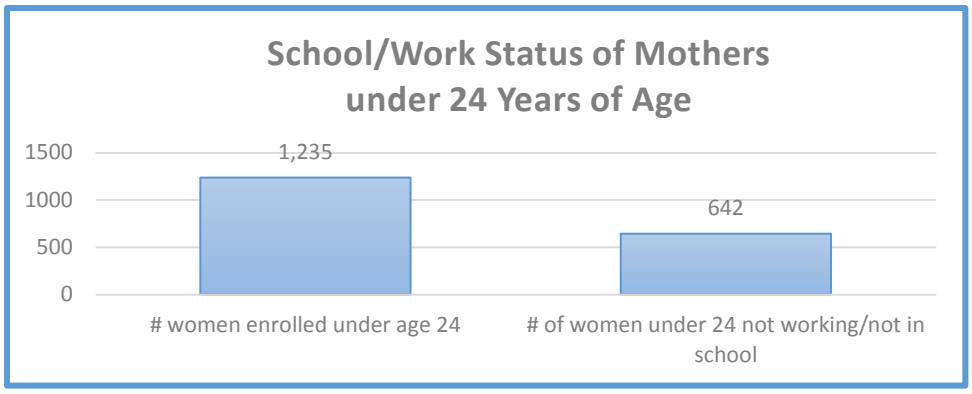
$$\frac{\text{\# of enrolled women < age 24 who neither work full-time nor are in school}}{\text{Total \# of enrolled women under age 24 as of June 30, 2017}}$$

Forty-four of the 58 reporting sites track this type of data on women under the age of 24. The 44 sites report a total of 1,235 enrolled women under the age of 24 as of June 30, 2017. Of those 1,235 women,

[26] Maryland Children's Cabinet Three-Year Plan, March 10, 2017.

642 (52%) were disconnected from work and school opportunities in FY 2017 (See Figure 19).

Figure 19: Number of Women Not Working or in School



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

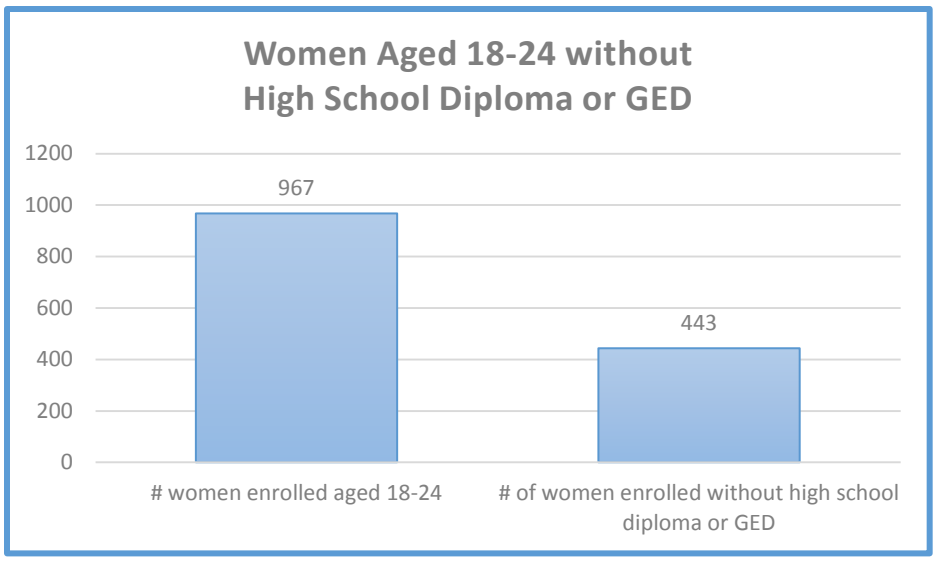
Target population: Enrolled women age 18-24.

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

Calculation: $\frac{\text{\# of enrolled women 18-24 who have not graduated or obtained a GED}}{\text{Total \# of enrolled women 18-24 as of June 30, 2017}}$

Forty-three of the 58 reporting sites track this type of data on enrolled women age 18-24. The 43 sites reported a total of 967 enrolled women age 18-24 as of June 30, 2017. Of those 967 women age 18-24, 443 (46%) had not graduated or obtained a General Equivalency Diploma (See Figure 20).

Figure 20: Number of Women without High School Diploma or GED



Priority 3: Families Impacted by Incarceration

While Maryland has seen decreased incarceration from 2011 to 2016, overall rates of incarceration are still concerning.[27] As the number of incarcerated adults increases, so does the number of impacted children and families. Average family income decreases by more than 22% during a parent's incarceration, and the parent's earning power drops following release.[28] 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:

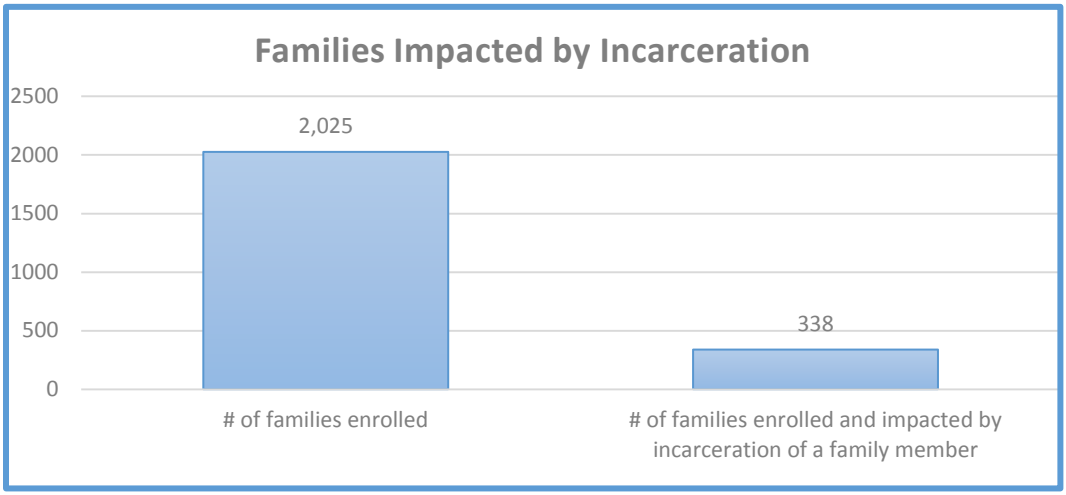
$$\frac{\text{\# of enrolled families impacted by incarceration}}{\text{Total \# of enrolled families as of June 30, 2017}}$$

Thirty-three of the 58 reporting sites track this type of data on enrolled families. The 33 sites reported a total of 2,025 families enrolled in home visiting services as of June 30, 2017. Of those 2,025 families, 338 (17%) were impacted by the incarceration of a family member (See Figure 21on the next page).

[27] Source: Maryland Department of Public Safety and Correctional Services

[28] Johnson, Rucker. "Ever Increasing Levels of Parental Incarceration and the Consequences for Children." Do Prisons Make us Safer? The Benefits and Costs of the Prison Boom. 2008.

Figure 21: Number of Families Impacted by Incarceration



Progress to Date: FY 2015 Recommendations

In the table below are the recommendations made in FY 2015 and the progress to date.

Recommendations from FY 2015 Data on Standardized Home Visiting Measures	Progress to Date
Data Reporting Of the 83 programs surveyed, 58 sites submitted data. Of those 58, 42 reported receiving State funding. Prior to this reporting mechanism, no centralized list of home visiting programs supported with State general funds was available. Therefore, the total number of State-funded home visiting programs was not known. To ensure that all State-funded home visiting programs are reporting on the standardized measures, each State agency that funds home visiting with State funds should provide detailed information about the mandated reporting requirements for all programs and include the standardized reporting requirements in future award notices and contractual agreements. Further, each State agency should provide a list of home visiting program sites and contact information to the Governor's Office for Children annually to ensure accuracy of contact information and site locations. For the best picture of what is happening Statewide, a possible modification to this collection could be that all programs that operate within Maryland	This data collection effort saw a 4% increase in response (12 more sites) from the last reporting period. An updated list of all known home visiting programs in the State is maintained.

Recommendations from FY 2015 Data on Standardized Home Visiting Measures	Progress to Date
must complete the survey biannually. This would ensure the broadest and most clear view of the reach of home visiting services.	
Recognition and Promotion of Home Visiting as a Two-Generation Approach Two-Generation strategies work to reduce the transmission of trauma and socioeconomic disadvantage from parents to their children. This is done by strengthening the social determinants of health for both generations concurrently. To enhance this two-generation focus, early childhood interventions, such as home visiting, could be accompanied by caregiver-focused practices to build health and well-being, family economic self-sufficiency, and positive social networks.[29,30] From FY15 data collected, it appears that sites vary widely in the focus on the two-generation approach. Program sites may see substantial gains in maternal and child health outcomes if they provide formal supports for primary caregivers as well young children.[31] State agencies that fund maternal and child home visiting should consider whether adopting a two-generation approach will help to support the goals and objectives that the agency has for the home visiting program. The agencies should then develop a work plan with a timeline for assisting programs to integrate a two-generation focus into the existing home visiting program.	With the Governor's two-generation initiative, there is increased interest in home visiting programs that incorporate this approach into program services. Further training in the past two years around two-generational issues (maternal depression, substance abuse, intimate partner violence) has assisted in supporting and promoting this approach among home visiting programs Through federal Maternal, Infant and Early Childhood Home Visiting funding, a home visitor seven day training certificate has been developed. The training certificate program is currently training home visitors and supervisors Statewide. This training is an integral part of work force development to provide advanced skills in dealing with difficult topics and develop best practices in communication and family engagement.
Participation of the Home Visiting Consortium The Maryland Home Visiting Consortium is comprised of public and private stakeholders representing education, health care, home visiting, and other related groups interested in early childhood services. Using data from this Report and other relevant sources, the Consortium should continue to explore a training, technical assistance, and continuous quality	The Home Visiting Consortium meets quarterly and continues to explore a training, technical assistance, and continuous quality improvement agenda to focus on Statewide program improvements that ensure the provision of the highest quality of service to women and children. The Consortium is completing an action agenda that will focus the group's work moving forward

[29] Smith, T., & Coffey, R. (2012) Two-Generation Strategies for Expanding the Middle Class.
[30] Shonkoff, J. P., & Fisher, P. A. (2013). Rethinking evidence-based practice and two-generation programs to create the future of early childhood policy. *Development and psychopathology*, *25*(4pt2), 1635-1653.
[31] Shonkoff et al., 2013.

Recommendations from FY 2015 Data on Standardized Home Visiting Measures	Progress to Date
improvement agenda to focus on Statewide program improvement to ensure the provision of the highest quality of service to enrolled women and children.	and, with the assistance of multiple State agency partners, ensure braiding of resources, initiatives and information.
Addressing Maternal Health Issues Health and school readiness outcomes for infants and young children enrolled in home visiting are heavily dependent on the ability of the primary caregiver to provide a supportive, responsive, and positive environment for children to grow.[32] Women enrolled in home visiting may have experienced significant trauma during their own early childhood years that is now impairing their own parenting capacity.[33] Prior trauma may be a contributing factor to current mental health problems, substance use, and intimate partner violence.[34] Of the programs that currently provide any screening for maternal health issues, screening protocols span a continuum from multiple screening intervals annually to screening at the discretion of the home visitor. There are a number of programs that currently conduct no screening for maternal health issues, as this has not been an area of focus for the home visiting program model utilized. State-funded home visiting programs could consider the feasibility of implementing universal screening, referral, and support protocols for mental health, substance use, and intimate partner violence. Universal screening involves screening 100% of maternal clients at pre-determined intervals, as defined by the program. A commitment to staff training and the identification of available referral and support resources is also essential to supporting mothers	To date, there is no mandate for universal screening for maternal depression, substance use, or intimate partner violence within State-funded home visiting programs. However home visiting programs are trained through their evidence-based models as well as the Training Certificate Program on screening protocols and referral resources that are most effective for optimal participation and acceptance.

[32] Ammerman, R. T., Shenk, C. E., Teeters, A. R., Noll, J. G., Putnam, F. W., & Van Ginkel, J. B. (2012). Impact of depression and childhood trauma in mothers receiving home visitation. *Journal of child and family studies*, *21*(4), 612-625.
[33] Ammerman et al., 2012
[34] Grossman, J., & Hollis, B. (1995). Two-generation Interventions: An Employment and Training Perspective. *Two generation programs for families in poverty: A new intervention strategy*, *9*, 229.

Recommendations from FY 2015 Data on Standardized Home Visiting Measures	Progress to Date
with a positive screen through treatment and recovery.	
Support for Communication and Collaboration between Home Visiting and Health Care Documenting the adherence of enrolled children to the American Academy of Pediatrics *Bright Futures™* well-child visit schedule is an important initial step in supporting children's health. An effort to enhance children's health may involve forging relationships between health care and home visiting to fully integrate the health and safety resources between all of the key supports for enrolled families. At a very basic level, home visitors could help families to prepare for the scheduled well-child visit and then debrief on any follow-up actions necessary from the health care visit. For example, are there any changes in the home environment that the parents need to consider based on the child's developing mobility? Are there nutritional changes that the family should integrate based on the child's changing metabolic needs?	There are potential synergies between healthcare and home visiting, as both stakeholders play a role in improving and stabilizing maternal and child health. This is currently being explored in Maryland in several ways. A better understanding of how to optimize communication and collaboration between healthcare and home visiting is being explored at the local and State level with the Medicaid 1115 Health Choice Home Visiting Pilot Waiver, which funds home visiting services. This is Maryland's first attempt at using Medicaid dollars to fund non-medical home visiting services to support maternal and child health. In addition, research is currently underway by the University of Maryland that explores reinforcement of relationships between pediatricians and home visitors.
Research into the Home Visiting Workforce The survey process could expand to include additional questions on the home visiting workforce to better understand the strengths and challenges of recruiting, training, supporting, and retaining high-quality staff to support maternal and child health in Maryland	The Home Visiting Consortium and Maternal, Infant and Early Childhood Home Visiting Team are working on collecting baseline data and addressing Continuous Quality Improvement issues in workforce retention. Further discussion around these findings could help identify critical questions for future home visiting surveys. See 2017 recommendations as well.
Systematic Review of the Standardized Measures A periodic review of the adopted home visiting standardized measures could be built in to the data collection process to ensure that Maryland is collecting the most relevant data to support the progress of maternal and child health for Maryland families. The Pew Center for the States has been engaged in helping the states implement performance measures and has recently published a report that can provide further guidance—*Using Data to Measure Performance: A new framework for assessing the*	For this year's data collection and analysis, the data survey was reviewed and modifications were made to ensure collection of the strongest data on measures that tell the story of home visiting's effectiveness and reach in serving vulnerable populations.

Recommendations from FY 2015 Data on Standardized Home Visiting Measures	Progress to Date
effectiveness of home visiting.[35]	

Recommendations from FY 2017 Data on Standardized Home Visiting Measures

1. Use of an Integrated Management Information System for Data Reporting

One of the biggest challenges to collecting and reporting Statewide home visiting measures is the lack of an integrated management information system. Each program model maintains its own database of data points that are required by its model and/or its funders. The use of many different systems can make data collection for the survey arduous on program personnel. If the database in use does not collect the information required by the data survey, programs are left to track this information by their own means, whether by use of an electronic tracking system such as an Excel spreadsheet or by hand. This then raises the concern of data quality and reliability.

The Maryland Maternal, Infant and Early Childhood Home Visiting program has invested significant time and monetary resources into developing a management information system to assist its grantees (18 sites in 10 jurisdictions) to collect federally-required data. The system has also been structured to collect the information required by the two program models currently funded and has the ability to be "built out" to include specific data required by other funders. The Maxwell system has the capability of importing data from other data systems and data formats and thus provides an opportunity for home visiting programs Statewide to collect data for this biannual report in a thoughtful and methodical way. With additional financial support to the current system, modifications and upgrades can be made that will allow home visiting programs, through Business Associate Agreements, to input data while maintaining the confidentiality of families. Another option, using the same Business Associate Agreement example, would allow home visiting programs to input non-identifiable data into the Maxwell system for the purpose of the biannual Statewide data collection survey.

Next Steps

The Governor's Office for Children and the Departments of Health and Education will meet to discuss the impact of moving forward with utilizing Maxwell to collect home visiting data Statewide. The discussion will include funding implications, effort by programs and ease of use of the system, as well as a cost benefit analysis and the long term impact of using this data system. After these meetings occur, the three agencies should make a proposal to the Children's Cabinet on the:

a. Feasibility of using the Maxwell data system to collect broader data (other than Maternal, Infant and Early Childhood Home Visiting program data);
b. Cost and impact to program sites for this use; and,
c. Benefit of using one central data system for home visiting data.

[35] http://www.pewtrusts.org/~/media/assets/2015/10/hv_datainitiativereport.pdf?la=en

2. Home Visitor Professional Development: Addressing Sensitive and Challenging Issues

Health and school readiness outcomes for infants and young children enrolled in home visiting programs are heavily dependent on the ability of the primary caregiver to provide a supportive, responsive, and positive environment for children to grow.[36] Women enrolled in home visiting programs may have experienced significant trauma during their own early childhood years that is now impairing their parenting capacity.[37] Prior trauma may be a contributing factor to current mental health problems, substance use, and intimate partner violence.[38]

These sensitive topics can be a challenge for home visitors to address. Home visitors and their programs need continued support and professional development to adequately address these issues and utilize motivational interviewing to effect change in the families served. This is currently being done through the Training Certificate Program, but there is also a need to address and support the collateral concerns that arise because of these issues, such as substance exposed newborns.

Next Steps

The home visitor is often the first contact a family may have with a trained professional that can provide support with addressing sensitive and challenging issues many of our families face. Assuring that these front line staff have adequate training, especially on sensitive topics and emerging issues of concern, is an integral part of their ability to effectively support the families in Maryland.

a. The Training Certificate Program has already been developed to provide continued training and education for home visitors and has been piloted successfully with research conducted through a randomized control trial to determine effectiveness. It is recommended that this training, delivered through a University setting, and providing a consistent message across topics, be used Statewide.
    i. The Home Visiting Consortium will organize a panel of stakeholders including home visitors, supervisors, partners from the Governor's Office for Children and the Departments of Health and Education, as well as University and Statewide trainers to address the impact and costs of expanding the training to home visitors and supervisors Statewide. This panel will make recommendations for delivery of the training Statewide and the costs and impact to jurisdictions.
b. The ability to add sensitive topics on emerging issues when they arise is a must in the changing landscape of Maryland. The panel noted in this recommendation also needs to develop a strategic plan for how to:
    i. Develop consistent messaging to address current trends, such as the opioid
    ii. crisis and substance exposed newborns, to support the home visiting workforce; and,

[36] Ammerman, R. T., Shenk, C. E., Teeters, A. R., Noll, J. G., Putnam, F. W., & Van Ginkel, J. B. (2012). Impact of depression and childhood trauma in mothers receiving home visitation. *Journal of child and family studies*, *21*(4), 612-625.
[37] Ammerman et al., 2012
[38] Grossman, J., & Hollis, B. (1995). Two-generation Interventions: An Employment and Training Perspective. *Two generation programs for families in poverty: A new intervention strategy*, *9*, 229.

iii. Provide a venue for home visitors to share training needs.

c. These recommendations will be brought to the Consortium for review and then presented to the Children's Cabinet for approval.

3. Research into Home Visiting Workforce Retention

During FY 2017, over half of the 58 reporting sites indicated incidents of staff turnover with 54% of those sites reporting insufficient compensation/benefits as the primary reason for staff attrition.

Next Steps

a. The Home Visiting Consortium will examine national research on home visitor retention, best practices, and the impact of home visitor compensation on retention to identify recommendations for Maryland.
b. The Home Visiting Consortium will bring together home visiting program stakeholders to identify the least burdensome/most effective approach to collecting the most relevant information about retention from each program.

4. Revised Data Collection Processes

The Children's Cabinet should consider revised data collection mechanisms to ensure all programs, regardless of funding source, that operate in Maryland complete the survey biannually. Additionally, State contracts or grants should require State-funded programs to respond to the data collection survey as required. This would ensure the broadest and clearest view of the reach of home visiting services and the impact these programs have on Maryland's most vulnerable families.

Next Steps

a. The Governor's Office for Children and the Departments of Health and Education will meet to consider should consider revised data collection mechanisms to ensure all programs, regardless of funding source, that operate in Maryland complete the survey biannually to provide data for future reports on the Implementation and Outcomes of State-Funded Home Visiting Programs.

Conclusion

The data in this second summary report on Maryland Home Visiting Standardized Measures provides a trend line from which Maryland can begin to assess home visiting's effect on the well-being of families served. In FY 2017, 4,602 women and 3,947children were served through one of five evidence-based home visiting models and two promising practices. The data reveal that Maryland home visiting has a strong emphasis on children's health and development. Ninety-four percent of enrolled children at sites that track child well visits are up-to-date. Of those sites that complete child and social emotional developmental screenings, 74 percent of children have been screened for typical development, and 72 percent have been screened for social emotional development. Seventy-three percent of children with a suspected developmental delay and 89 percent of children with a suspected social emotional delay are being referred to early intervention services. Children receiving on-going early intervention services for

developmental delays represent only 5 percent of all children served in FY 2017.

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. Although 72 percent of reporting sites screen for maternal depression, only 58 percent screen for intimate partner violence; only 50 percent screen for substance use; and only 48 percent screen for parenting stress. Each of these maternal mental health and family relationship issues has great potential to significantly impact the trajectory of childhood growth and development. Results of the data survey indicate service gaps among the home visiting models in fully supporting maternal health and family relationships.

The two-generation implications of home visiting specific to caregiver-focused practices to build health and well-being and family economic self-sufficiency are vast. Maryland believes that supporting two-generation approaches that focus on creating opportunities for and addressing the needs of vulnerable families is a unique opportunity to advance child and family well-being. Research shows the impact of a parent's education level and economic stability on the overall health and well-being of their children. Similarly, a child's education and healthy development has a positive impact on the parent. Home visiting provides a family-centered approach to child well-being wherever possible. In addition, there is an opportunity through home visiting programs that use a two-generation approach, to support families in attaining greater economic stability by supporting the educational attainment and employment goals of the families served.

The passage of the Maryland Home Visiting Accountability Act of 2012 was an important first step in Maryland's commitment to helping children and families during critical developmental periods and preparing children for success in school. Home visiting can continue to contribute considerably to the State's early childhood system of care. This report should be used to guide Maryland stakeholders in developing strategies that fully articulate the current and potential impacts of home visiting on maternal and child health outcomes in the State.

APPENDICES

Appendix A: *FY 2017 Maryland Home Visiting Sites Reporting Data*

Appendix B: *All Maryland Home Visiting Sites FY 2017*

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 2017 Home Visiting Data Survey Results*

Appendix I: *Intimate Partner Violence Screening Tools*

Appendix J: *Infographic- FY 2017 Home Visiting Data Survey Results*

Appendix A: FY 2017 Maryland Home Visiting Sites Reporting Data

Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	PAT
Healthy Families Allegany County, Allegany County Health Department	HFA
HRDC Seymore Street Head Start Center	EHS
Anne Arundel County	
Anne Arundel Early Head Start (FSC) (CAA)	EHS
Baltimore City	
Bon Secours	HFA
Family Tree	HFA
Baltimore City Health Department Early Head Start Center (FSC)	EHS
*Baltimore City Health Department Maternal and Infant Care Program *Program ended 6/30/17	NFP HFA
Baltimore City Healthy Start, Inc. Healthy Families America	HFA
DRU/Mondawmin Healthy Families (DRUM)	HFA
Family & Children's Services Early Head Start (FSC)	EHS
Our House Early Head Start, Housing Authority Baltimore City (HABC)	EHS
Park Heights Renaissance	HIPPY
Sinai Hospital of Baltimore Inc. M. Peter Moser Community Initiatives	HFA
Roberta's House	PP- HOPE Inter-conception Program
Southeast Baltimore Early Head Start Center (SEEHS)	EHS
Waverly Early Head Start Center of Goodwill (FSC)	EHS
Baltimore County	
Healthy Families Baltimore County, Abilities Network	HFA
Young Parent Support Center	PAT
Calvert County	
Calvert County Head Start	EHS
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA
Caroline County	
Caroline County Family Support Center (FSC)	EHS
Federalsburg Judy Hoyer Center (FSC)	PAT
Greensboro Judy Hoyer/Early Head Start Center	EHS (2 sites)
Healthy Families Mid-Shore, Caroline County Health Department	HFA
Carroll County	
Family Support Center (FSC)	PAT
Judy Center Partnership Parents as Teachers Program	PAT
Cecil County	
Family Education Center	EHS
Charles County	
Charles County Health Department	PP-Maternal-Child Health Program
Healthy Families Southern Maryland, Center for Children	HFA
Dorchester County	
Early Head Start Center, Shore Up!	EHS
Healthy Families Dorchester, Dorchester County Health Department	HFA
Frederick County	
Family Partnership (FSC)	PAT
Healthy Families Frederick County, Mental Health Association of Frederick	HFA
Garrett County	
Healthy Families Garrett County, Garrett County Health Department	HFA

Harford County	
Healthy Families Harford County, Harford County Health Department	HFA
Howard County	
Healthy Families Howard County, Howard County General Hospital Wellness Center	HFA
Kent County	
Healthy Families Mid-Shore, Kent County Health Department	HFA
Kent County Family Center (FSC)	PAT
Montgomery County	
Discovery Station Early Head Start, Family Services, Inc.	EHS
Family Discovery Center (FSC)	PAT
Healthy Families Montgomery, Family Services, Inc.	HFA
Prince Georges County	
Adelphi/Langley Park Family Support Center (FSC)	PAT
Bright Beginnings	HFA
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, Queen Anne's County Health Department	HFA
Somerset County	
Healthy Families Lower Shore, Eastern Shore Psychological Services	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 Family Support Center (FSC)	EHS
Washington County	
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
Worcester County	
Head Start, Shore Up! Stockton Head Start	EHS
Healthy Families Lower Shore, Eastern Shore Psychological Services	HFA
Judy Center Partnership Snow Hill Elementary School	HIPPY

Appendix B: All Maryland Home Visiting Sites FY 2017

Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	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
Anne Arundel Early Head Start (FSC) (CAA)	EHS
Baltimore City	
Bon Secours (FSC)	HFA
Bon Secours (FSC)	EHS
Family Tree	HFA
	Attachment and Biobehavioral Catch-up: ABC
	MD Family Connects (MDFC)
	Parent Assistance in The Home (PATH)
Baltimore City Health Department Early Head Start Center (FSC)	EHS
*Baltimore City Health Department Maternal and Infant Care Program *Program ended 6/30/17	NFP HFA
Baltimore City Healthy Start, Inc. Healthy Families America	HFA
DRU/Mondawmin Healthy Families (DRUM)	HFA
Family & Children's Services Early Head Start (FSC)	EHS
Harry and Jeanette Weinberg Early Childhood Learning Center (FSC)	EHS
Our House Early Head Start, Housing Authority Baltimore City (HABC)	EHS
Park Heights Renaissance	HIPPY
Sinai Hospital of Baltimore Inc. M. Peter Moser Community Initiatives	HFA
Southeast Baltimore Early Head Start Center (SEEHS)	EHS
Waverly Early Head Start Center of Goodwill (FSC)	EHS
Baltimore County	
Baltimore County Health Department	PP, PAT
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 Head Start	EHS
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA
Caroline County	
Caroline County Family Support Center (FSC)	EHS
Federalsburg Judy Hoyer Center (FSC)	PAT
Greensboro Judy Hoyer/Early Head Start Center	EHS (2 sites)
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	
Family Education Center	EHS
Charles County	
Healthy Families Southern Maryland, Center for Children	HFA
Dorchester County	
Early Head Start Center, Shore Up!	EHS
Healthy Families Dorchester County, Dorchester County Health Department	HFA

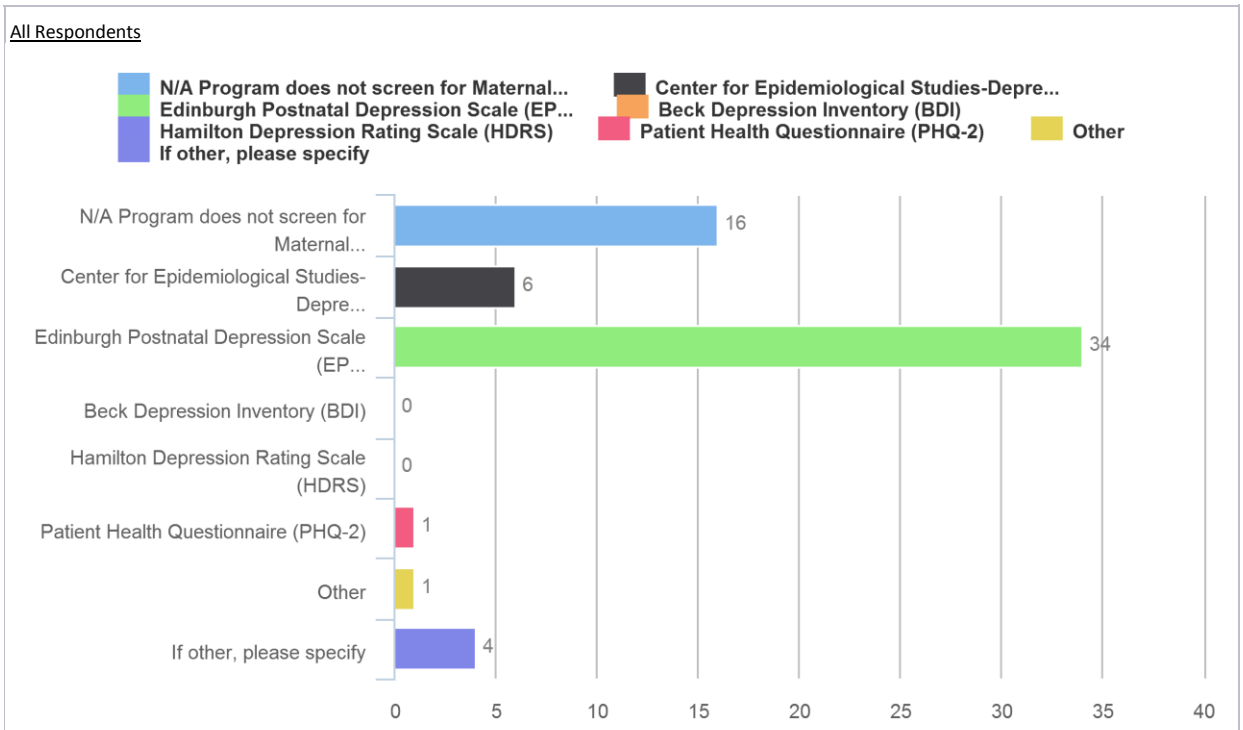
Frederick County	
Family Partnership (FSC)	PAT
Healthy Families Frederick County, Mental Health Association of Frederick	HFA
Garret County	
Garrett County Early Head Start (CAC)	EHS (2 sites)
Healthy Families Garrett County, Garrett County Health Department	HFA
Harford County	
Catholic Charities Early Head Start	EHS
Healthy Families Harford County, Harford County Health Department	HFA
Howard County	
Healthy Families Howard County, HC General Hospital Wellness Center	HFA
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
Bright Beginnings	HFA
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	
Somerset County	
Early Head Start Center	EHS
Healthy Families Lower Shore, Eastern Shore Psychological Services	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 Family Support Center (FSC)	EHS and 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	
Eden Head Start (FSC)	EHS
Healthy Families Wicomico County, Wicomico County Health Department	HFA
Salisbury 1 and Early Head Start Center	EHS
Worcester County	
Early Head Start, Shore Up! Snow Hill Head Start	EHS
Head Start, Shore Up! Stockton Head Start	EHS
Healthy Families Lower Shore, Eastern Shore Psychological Services	HFA
Judy Center Partnership Snow Hill Elementary School	HIPPY
Promising Practices	
Anne Arundel County- Anne Arundel County Health Department	Healthy Start
Baltimore City – Roberta's House	HOPE- for mothers with an infant loss
Baltimore City	Baltimore Healthy Start
Baltimore County - Baltimore County Health Department	Prenatal Enrichment Program

Charles County - Charles County Health Department	Maternal-Child Health Program
Prince George's County-Prince George's County Health Department	High Risk Infant Program
Worcester County - Worcester County Health Department	Early Care

Appendix C: Maternal Depression Screening Tools

Maternal Depression Screening Tools

Summary of Maternal Depression Screening Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

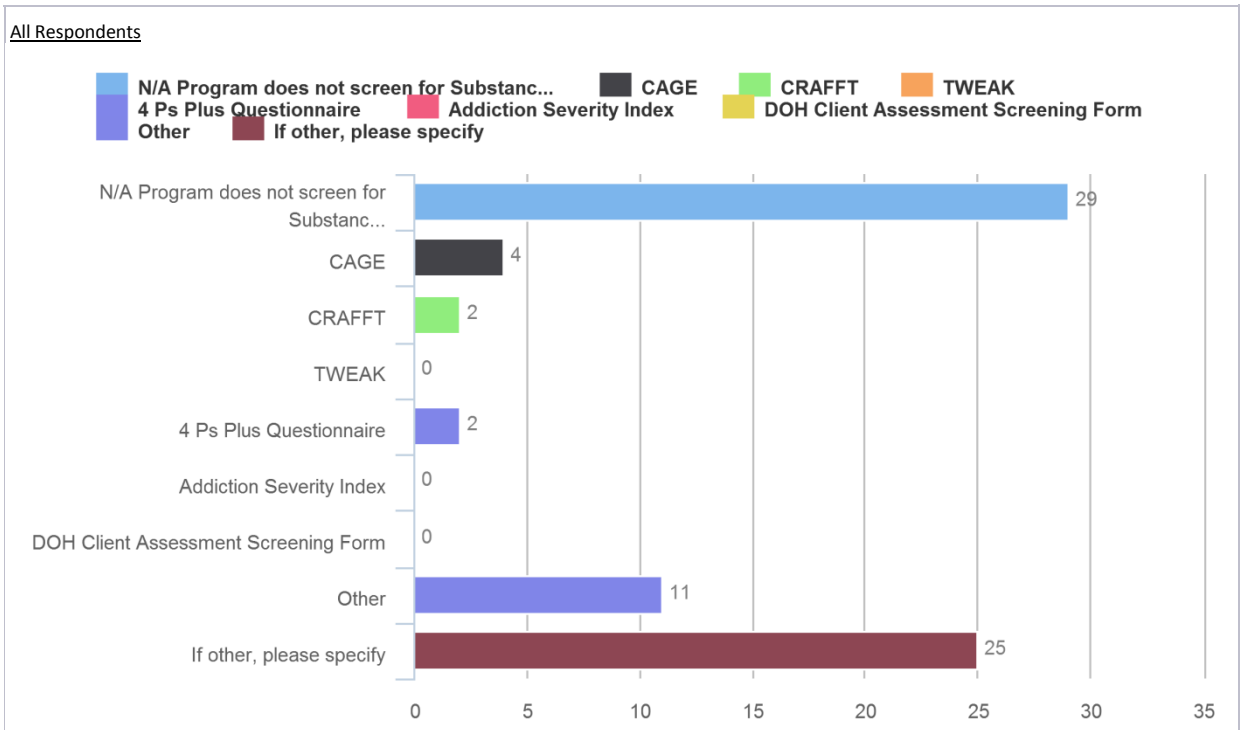
*Other tools used include: Life Skills Progression and Adverse Childhood Experiences Questionnaire

In FY 2017 sites were asked to indicate how many depression screens a typical woman would receive during the full course of services according to the home visiting program's screening protocols, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a woman is screened three times, with a range of 0 (for those that do not screen) to nine times during the course of services. Reasons for not screening for maternal depression included that it is not required by the program model, that screening is done by a contracted provider (mental health consultant), and/or that screening is only done if observation warrants it.

Appendix D: Maternal Substance Use Screening Tools

Maternal Substance Use Screening Tools

Summary of Substance Use Screening Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

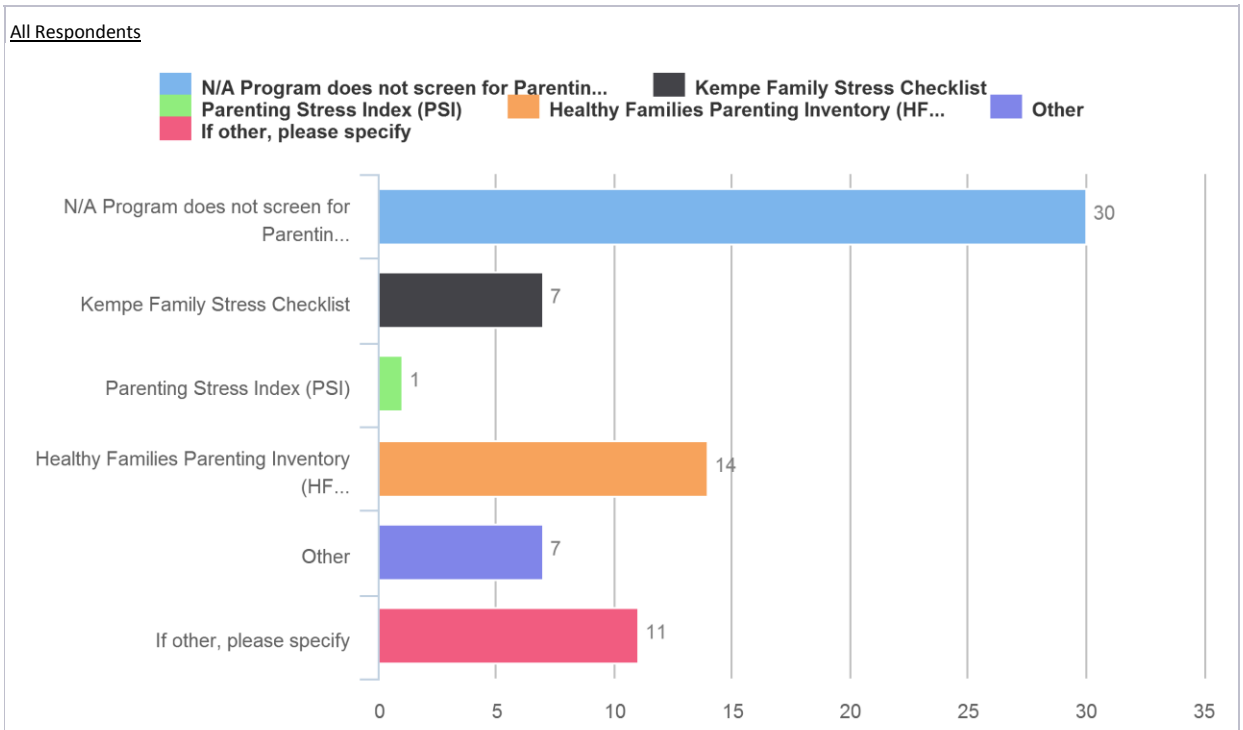
*Other tools used include: Life Skills Progression, Health Habits, Healthy Families Parenting Inventory, and PROMIS Adult Health Form

In FY 2017 sites were asked to indicate how many substance use screens a typical woman would receive during the full course of services according to the home visiting program's screening protocols, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a woman is screened twice, with a range of 0 (for those that do not screen) to 21 times during the course of services. Reasons for not screening for substance use included that it is not required by the program model and that sites need training on a screening tool.

Appendix E: Parenting Stress Screening Tools

Parenting Stress Screening Tools

Summary of Parenting Stress Screening Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

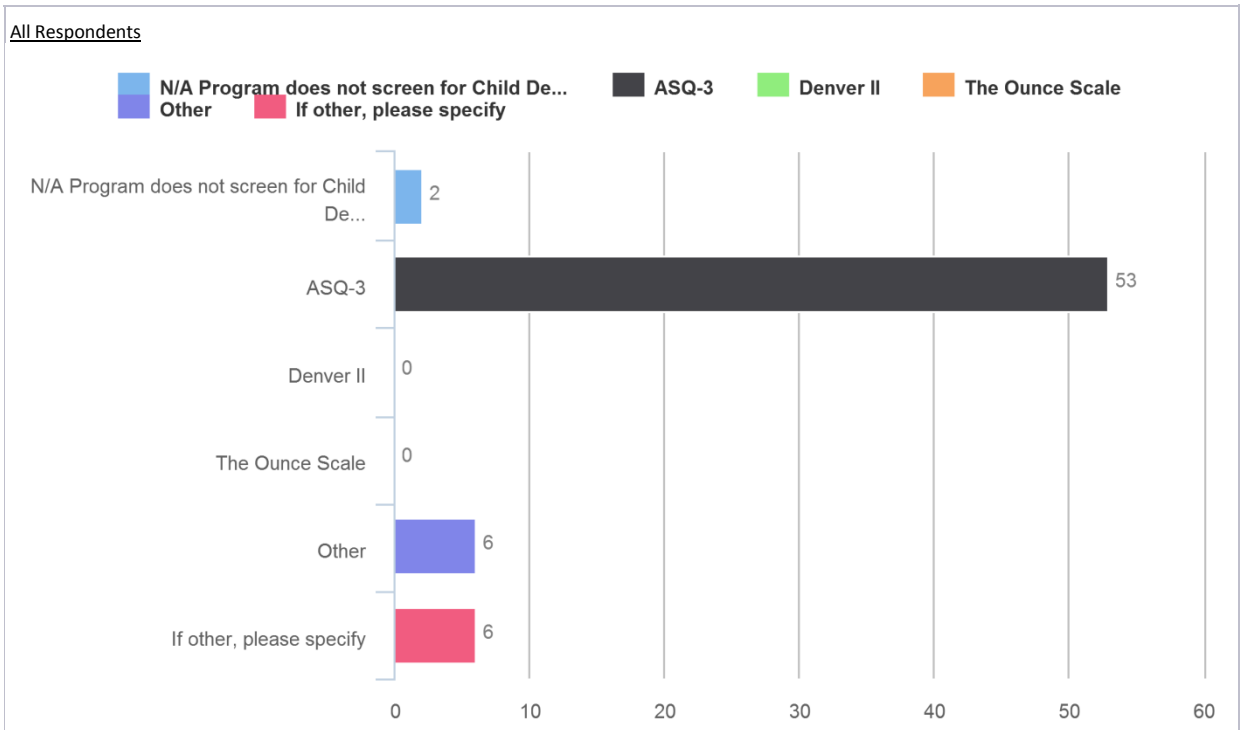
*Other tools used include: Life Skills Progression, GAD 7, Strengths and Needs Assessment, Family Centered Assessment and Home

In FY 2017 sites were asked to indicate how many parenting stress screens a typical woman would receive during the full course of services according to the home visiting program's screening protocols, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a woman is screened twice, with a range of 0 (for those that do not screen) to 11 times during the course of services. Reasons for not screening for parenting stress included that it is not required by the program model, that sites have not found a screening tool, and/or that sites need training on a screening tool.

Appendix F: Child Development Screening Tools

Child Development Screening Tools

Summary of Child Development Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

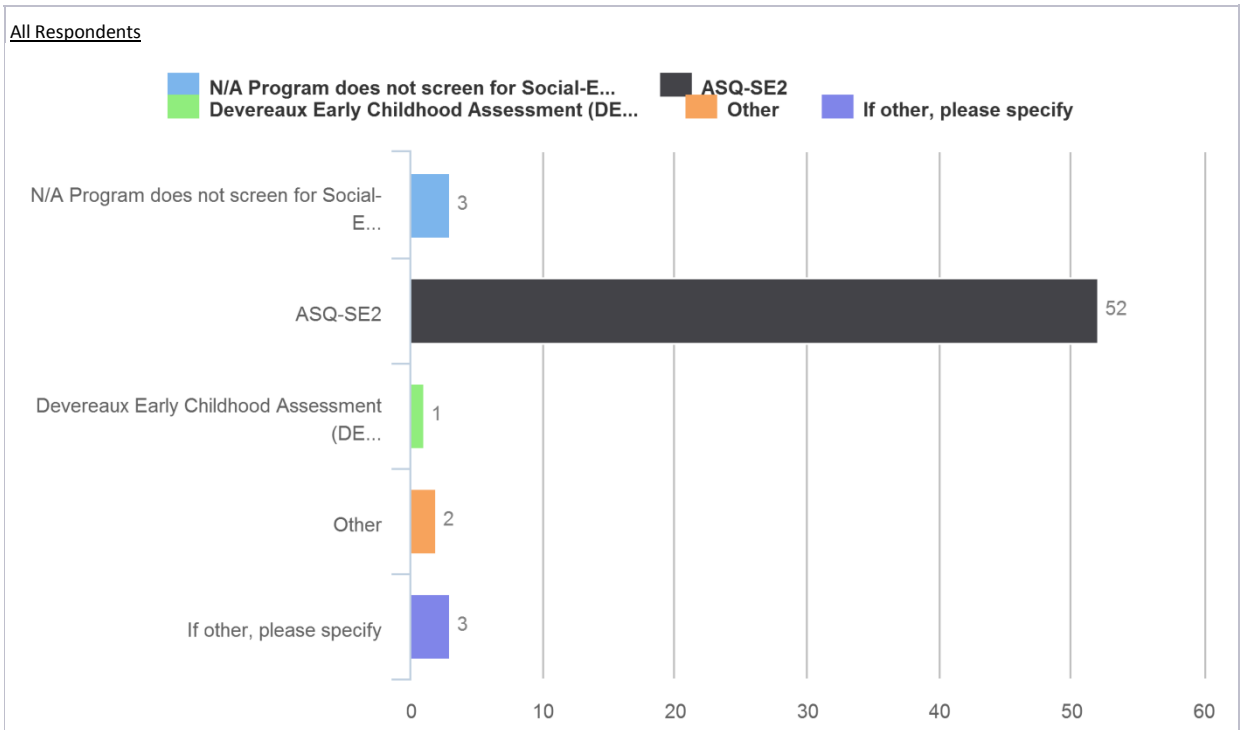
*Other tools used include: Brigance Developmental Screener III and Teacher Assessment

In FY 2017 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, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a child is screened six times, with a range of 0 (for those that do not screen) to 21 times during the course of services. Reasons for not screening for child development included that it is not required by the program model and that sites need training on a screening tool.

Appendix G: Social Emotional Development Screening Tools

Social Emotional Screening Tools

Summary of Social Emotional Screening Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

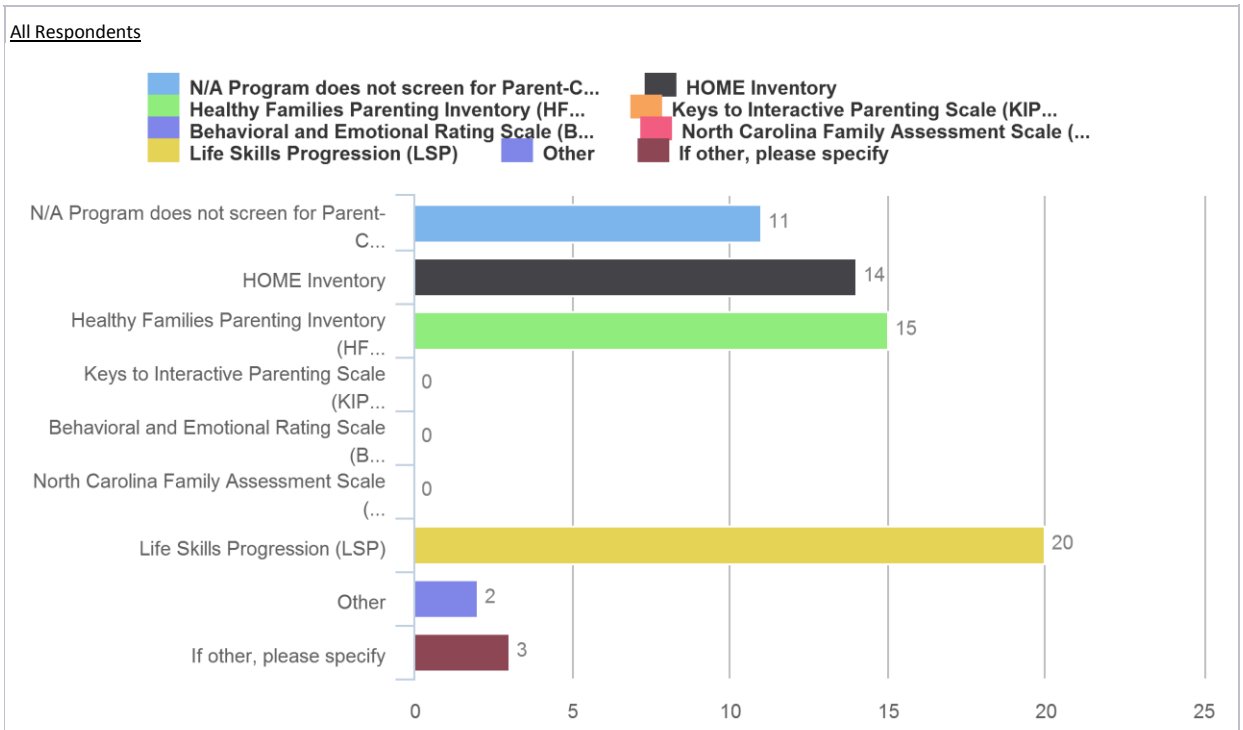
*Other tools used include: Brigance Developmental Screener III and Teacher Assessment

In FY 2017 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, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a child is screened three times with a range of 0 (for those that do not screen) to 10 times during the course of services. Reasons for not screening for social emotional development included that it is not required by the program model and that sites need training on a screening tool.

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

Parent-Child Relationships/Parenting Behavior Screening Tools

Summary of Parent-Child Relationships/Parenting Behavior Screening Tools



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

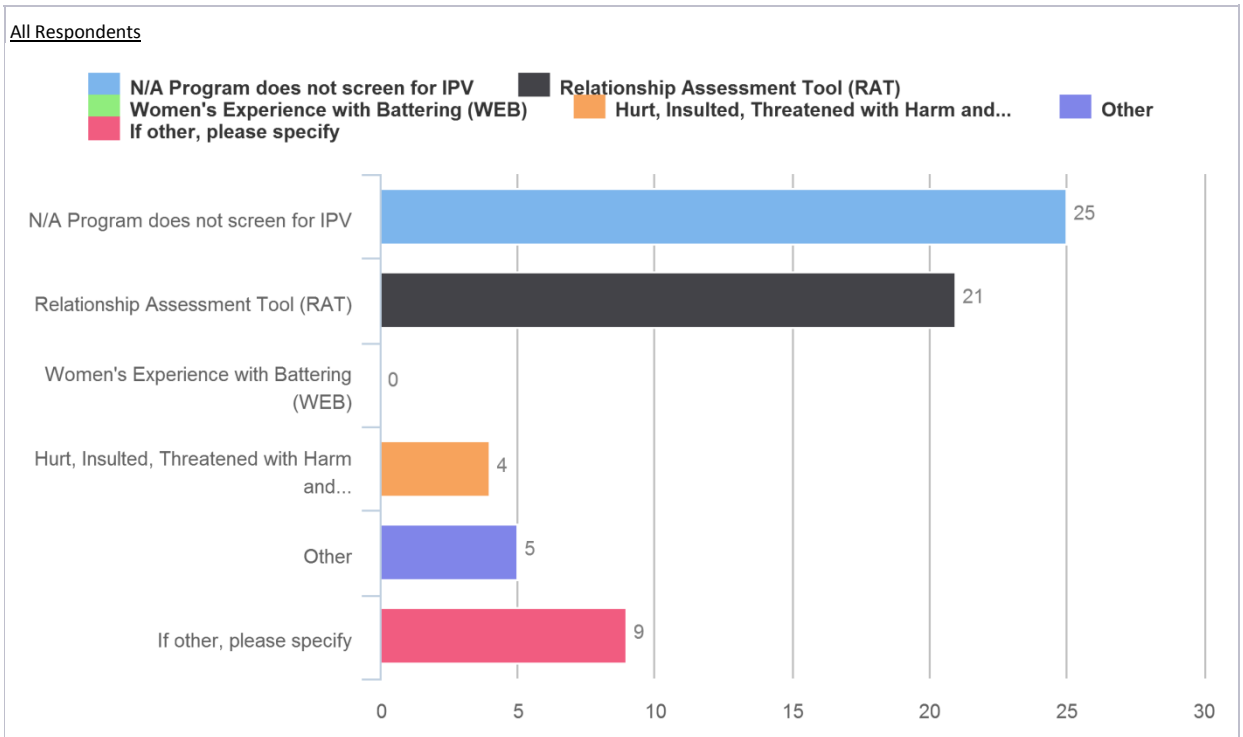
*Other tools used include: Kempe Family Checklist, DANCE and CHEERS

In FY 2017 sites were asked to indicate how many parenting behavior screens a typical woman would receive during the full course of services according to the home visiting program's screening protocols, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a woman is screened three times with a range of 0 (for those that do not screen) to 11 times during the course of services. Reasons for not screening for parenting behaviors included that it is not required by the program model, that sites need training on a screening tool, and/or that there has been a recent change in screening tool.

Appendix I: Intimate Partner Violence Screening Tools

Intimate Partner Violence Screening Tools

Summary of Intimate Partner Violence Screening Tools used by reporting sites



	Responses	Percentage
Total Responded to this question:	58	100%
Total who skipped this question:	0	0%
Total:	58	100%

*Other tools used include: Life Skills Progression, Parents as Teachers, Clinical IPV Assessment, Adult General Health, Colorado BRFSS Relationship Assessment, Abusive Behavior Inventory and DOVE

In FY 2017 sites were asked to indicate how many intimate partner violence screens a typical woman would receive during the full course of services according to the home visiting program's screening protocols, rather than the intervals of screening as asked in FY 2015. Reporting sites indicate that on average a woman is screened two times with a range of 0 (for those that do not screen) to eight times during the course of services. Reasons for not screening for parenting behaviors included that it is not required by the program model or funding source, that sites need training on a screening tool, and that sites screen only as needed.

Appendix J: FY 2017 Home Visiting Data Survey Results

FY 2017 Maryland Home Visiting Data Survey Results

58 Home Visiting Sites Reporting

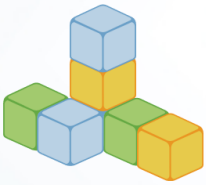
Representing all 24 of Maryland's Jurisdictions

4,602 Women/Families Served

3,947 Children 0-5 Served

Child Health Measures

95% of children up-to-date with most recent well-child visit



74% of children screened for child development, 72% for social emotional development

14% of children suspected of developmental delay, 4% suspected of social emotional delay

5% of all children served receive IDEA Part B or C services

Maternal Health Measures

73% of women screened for maternal depression

92% of women screened for substance use

85% of women screened for high parenting stress

Family Relationship Measures

72% of women have improved parent-child relationships

94% of women screened for intimate partner violence

Babies born healthy, family bonds strong and supportive, families are connected to essential community resources and children enter school ready to learn