March 30, 2020

Partners in Community Outreach Report of Home Visitation Program Staff Compensation Review and Recommendations

Partners in Community Outreach

Education Begins at Home

By: Stone Strategies and Thrive Collaborative

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thrive COLLABORATIVE LLC

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Introduction

Project Background

Stone Strategies and Thrive Collaborative were contracted by West Virginia's early childhood advocacy organization, Partners in Community Outreach (PiCO), to explore the compensation rates for Home Visitation Programs (HVP) staff within the state and in neighboring states and to issue a report of recommendations. The outstanding question for PiCO was: What can we do to best support West Virginia's Office of Home Visitation Programs and provider agencies in increasing compensation for home visitation staff?

The overall project had two components: interviews with West Virginia's five (5) border states and compensation research on local county boards of education in West Virginia's seven (7) Home Visiting Program Continuous Quality Improvement (CQI) regions.

Overview of Previous Compensation Study

Partners in Community Outreach completed a companion study on the compensation rates within West Virginia's Home Visitation programs in 2018. That report was developed based on responses to a questionnaire sent out to Program Leaders and Agency Administrators. The study provided information on salaries, payment structures (hourly, by visit, salary, etc.), benefits, and other key considerations. That study offers the context and baseline data necessary to make the recommendations at the end of this report.

Border State Review

Review Methodologies

Question Development: Interview questions were designed to be used in telephone interviews with contacts from the border states of Kentucky, Ohio, Pennsylvania, Maryland, and Virginia. Contacts were sought for their knowledge of their state's Home Visitation Programs (HVP) and overall state structure

as well as HVP staffing and compensation levels in the border counties of their state nearest West Virginia. The information is to be used to inform PiCO on how best to support West Virginia's Home Visitation Programs to retain quality home visitation staff.

Identifying State Contacts: The interviewer contacted Michele Baranaskas, Coordinator, Partners in Community Outreach (PiCO), who provided a list of state contacts. Jackie Newson, West Virginia's Director of West Virginia Home Visitation Programs in the Office of Maternal, Child, and Family Health, also provided a current email listing of all the state partners in West Virginia's federally designated region.

The interviewer also spoke by phone, emailed, and texted with Lisa King, Sr. Public Health Analyst/Women's Health Specialist, Division of Home Visiting and Early Childhood Systems Maternal and Child Health Bureau, HRSA. The Health Resources and Services Administration (HRSA) is an agency of the U.S. Department of Health and Human Services located in North Bethesda, Maryland. HRSA oversees the funds to states to provide home visitation services. Lisa was helpful in providing names of contacts in Ohio and Pennsylvania and talking with the interviewer about the federal and state structure of home visitation programming. All five (5) states were contacted.

Interview Process: The interview process began on January 9, 2020 and closed on February 14, 2020. Two comprehensive telephone interviews were completed within this period. A total of five people representing two states' home visitation programming structure participated. Interviews lasted between 35 and 65 minutes. All participants appeared interested and engaged and seemed to speak with professional candor.

Border State Review Findings

- Across five border states, and the United States Health Resources and Services Administration (HRSA) 22 people were contacted. Two states identified knowledgeable staff and completed an interview.
- In the five states bordering WV, 67 counties are within an hour's drive of the WV border
- Two of the five states, KY and OH, were unable to identify persons knowledgeable of or responsible for overseeing a statewide system of home visitation programs.
- One state, Virginia, was unable to gather the necessary information and people to participate in an interview within the given timeframe.
- Persons spoken with in the three states unable to be interviewed indicated they knew only about the program and program host site pay scale for the program for which they worked.
- Both of the two states interviewed acknowledged that salaries varied widely depending on the program host site and whether positions fit into education, pay and benefits schedules regulated by government, union oversite or independent non-profit organizations.

- WV is the only state that holds quarterly HVP meetings, offers face-two-face Continuous Quality Improvement support onsite to programs. Maryland and Pennsylvania come ~~the~~ closest to WV's current level of support to home visitation programs. MD offers 2.0 level certificate training beyond the training required of the evidence-based program model. PA has 3 consultants that monitor program compliance and report needed training to the state office of home visitation programs. A state conference is held every other year in partnership with other early care and education agencies. Seven (7) orientation webinars are made available.
- Maryland and Pennsylvania acknowledge a challenge in meeting the expectations of state and federal officials to serve more families and to support the staff and programmatic needs of home visitation programs, especially wage levels for home visitation staff.
- Three states, MD, VA and PA, do not keep or track salary data on home visitation staff. PA has a data program that attempts to collect this information and acknowledges concerns about the accuracy and consistency of the data begin entered by programs.
- Maryland has been asked, as a result of their latest report to the governor, to examine compensation to home visiting staff in their state. Maryland's Governor's Report is included as Appendix B in this report. It was recommended in the interview with MD, that we pay special attention to the workforce segment of their report.

West Virginia County Board of Education Compensation Review by HVP Region

Review Methodologies

Data Sourcing: To gather the necessary information on West Virginia educator salaries for this portion of the report, we referenced the *Professional Salary Schedule by County 2019-2020* and the *Service Salary Schedule by County 2019-2020.* (Both documents are included in the appendix of this report.)

The salary scale for West Virginia educators is complex and varies by county, position, education level, qualifications, and years of service. Because of that, there are myriad ways of interpreting the salary data.

However, for the purposes of this report, we looked at four different salary categories:

1) High School Diploma or GED: For this classification, we have gathered data on the position "Aide II," which is included under Pay Grade B within the WV School Service Personnel Salary Schedule.

2) High School Diploma +: An attempt was made to determine a position requiring an associate degree for comparison. However, there are no equivalent positions that "require" an associate degree as their entry level education. Instead, we selected "Aide IV," which is included under Pay Grade D within the WV School Service Personnel Salary Schedule. Aide IV refers to an aide who, in addition to the required training and High School Diploma/GED, has completed 18 hours of State-Board approved college credit or has completed 15 hours of State Board-approved college and has successfully completed an in-service training program equivalent of three hours of college credit. While not a perfect equivalent, it should serve as a point of reference for the starting salary of someone in between a high school diploma and a bachelor's degree.

3) Bachelor's Degree: For this classification, we have selected "A.B." within the WV Professional/Teaching Salary Schedule. According to state code, this distinction refers to a teacher with "a bachelor's degree, from an accredited institution of higher education, which has been issued to, or for which the requirements for such have been met by, a person who qualifies for or holds a professional certificate or its equivalent."

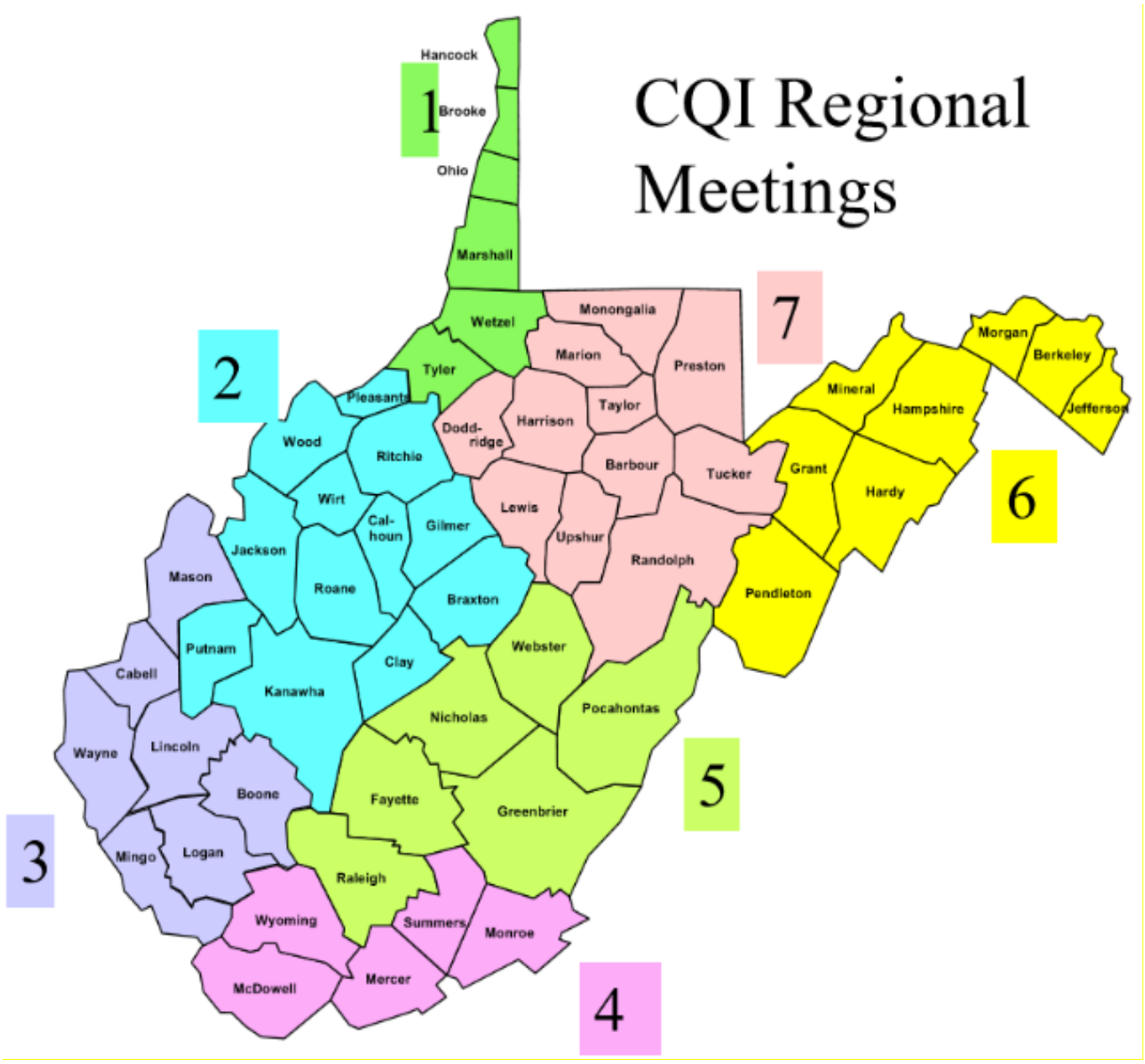
4) Master's Degree: For this classification, we have selected "M.A." within the WV Professional/Teaching Salary Schedule. According to state code, this distinction refers to a teacher with "a master's degree, earned in an institution of higher education approved to do graduate work, which has been issued to, or the requirements for such have been met by, a person who qualifies for or holds a professional certificate or its equivalent."

For all these positions, we considered entry level salaries only (i.e. zero years of service). As noted above (and provided in the appendix), salaries increase yearly based on years of service.

The majority of teachers and service personnel are on 200-day contracts. While the length of their day can vary slightly by county and contract, the most common is eight (8) hours. Therefore, for the purposes of this report, we have calculated the hourly rate for all education employees at 1,600 hours (200 days x 8 hours/day = 1,600 hours).

Home Visiting Program Regions: While West Virginia is a very county-centric state, it is also very regionalized. When considering salary trends and the ability of individuals to travel for employment, it seemed most beneficial to calculate and reflect on salary trends by region for the purposes of this report.

Seeing as Partners in Community Outreach and the West Virginia Home Visitation Program already recognize seven (7) regions for CQI purposes, the salary data is broken by these seven regions.


CQI Regional Meetings
1
2
3
4
5
6
7
Hancock
Brooke
Ohio
Marshall
Wetzel
Tyler
Pleasants
Wood
Ritchie
Wirt
Cal-houn
Gilmer
Jackson
Mason
Roane
Braxton
Putnam
Cabell
Kanawha
Clay
Wayne
Lincoln
Boone
Mingo
Logan
Raleigh
Wyoming
McDowell
Mercer
Summers
Monroe
Fayette
Greenbrier
Nicholas
Webster
Pocahontas
Monongalia
Marion
Preston
Dodd-ridge
Harrison
Taylor
Barbour
Tucker
Lewis
Upshur
Randolph
Pendleton
Grant
Hardy
Mineral
Hampshire
Morgan
Berkeley
Jefferson

Compensation Review Findings

Salary by Region:

CQI Region	Counties	HS Diploma/GED (Aide II—0 years)	HS Diploma + (Aide IV—0 years)	Bachelor's degree (A.B. Teacher—0 years)	Master's Degree (M.A. Teacher—0 years)
Region 1	Brooke, Hancock, Marshall, Ohio, Tyler, Wetzel	$22,425.00 $14.01/hour	$23,386.67 $14.61/hour	$38,984.17 $24.33/hour	$41,865.50 $26.16/hour
Region 2	Braxton, Calhoun, Clay, Gilmer, Jackson, Kanawha, Pleasants, Putnam, Ritchie, Roane, Wirt, Wood	$21,971.25 $13.73/hour	$22,583.58 $14.11/hour	$37,932.33 23.70/hour	$40,737.67 $25.46/hour
Region 3	Boone, Cabell, Lincoln, Logan Mason, Mingo, Wayne	$22,031.43 $13.76/hour	$22.984.29 $14.36/hour	$38,260.43 $23.91/hour	$41,083.29 $25.67/hour
Region 4	McDowell, Mercer, Monroe, Summers, Wyoming	$21,456.00 $13.41/hour	$22,406.00 $14.00/hour	$37,581.00 $23.48/hour	$40,393.00 $25.24/hour
Region 5	Fayette, Greenbrier, Nicolas, Pocahontas, Raleigh, Webster	$21,505.00 $13.44/hour	$22,488.33 $14.05/hour	$37,606.67 $23.50/hour	$40,418.67 $25.26/hour
Region 6	Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, Pendleton	$21,253.13 $13.28/hour	$22,211.88 $13.88/hour	$37,718.63 $25.57/hour	$40,547.50 $25.34/hour
Region 7	Barbour, Doddridge, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, Upshur	$21,621.36 $13.51/hour	$22,288.14 $13.93/hour	$37,871.64 $23.66/hour	$40,701.91 $25.43/hour

It is important to underscore that these are the average salary and hourly rates for these starting positions in each region. The individual county salaries vary because of different levels of supplemental funding on top of the state minimum. While a detailed breakdown within each region is provided in the appendix, most county salaries do not vary drastically from the minimum provided. However, there are a few outliers who have significantly higher salaries than their regional partners. Those counties are Berkeley, Kanawha, Mercer, Monongalia, Putnam, and Raleigh. Home visitation provider agencies within Regions 2, 3, 5, 6, and 7 should review Appendix D to understand how these higher-paying counties impact the averages of their region.

Benefits within the West Virginia Education System:

Health Insurance: West Virginia teachers and school service personnel and their immediate family members qualify to be enrolled in a health insurance plan through the Public Employee Insurance Agency (PEIA).

PEIA offers several different plans that vary in pricing. The employee's deductible and out-of-pocket limit also vary by salary. Each plan offers various coverage options and includes preventative services, medical home program, prescription drug program, routine prenatal care, and well child exams.

The state also offers optional additional benefits at a cost, including life insurance, dental and optical benefits, flexible spending accounts, and disability insurance.

Personal Leave: All full-time employees are entitled to at least one and a half (1.5) days of personal leave for each employment month. Unused leave accumulates indefinitely and is transferable within the state. (Similarly, a .5 employee accumulates leave at a .5 rate.)

Employees may use up to four (4) days annually without "regard to the cause for the absence." In the event the employee does not use all four days within a school year, the employee may accumulate up to a maximum of five (5) days. These personal days may not be used on consecutive workdays unless authorized or approved by the employee's principal or immediate supervisor, as appropriate.

All other days are to be used for the purposes of sick leave for the employee or an immediate family member. A note from a physician may be required for an absence exceeding two consecutive days.

Retirement: West Virginia teachers and school service personnel are covered by the State Teachers' Retirement System (TRS). TRS currently has approximately 41,594 members and 36,394 retirees receiving annuity benefits. A current employee contributes 6% of his or her gross monthly salary into TRS. The employer contributes an additional 7.5% or 15% of the employee's gross monthly salary, depending on the employee's hiring date.

Other benefits: In addition to these benefits, West Virginia educators are eligible for further bonuses for missing less than four (4) days of school per year ($500) and a county bonus for accrued leave upon retirement.

Conclusions

After reviewing the salaries provided in the section above, of this report in comparison with the Home Visitation Program salaries provided in the 2019 Partners in Community Outreach Compensation Study and conducting interviews with West Virginia's border states, it is clear that:

- Home Visitation Programs are at a severe disadvantage statewide, and in West Virginia's surrounding national regions, when competing for and retaining a high-quality workforce.
- In every region of the state, the average hourly rate of pay in the school system is higher than the average rate of pay for the same or similarly educated home visitor. The difference in pay is most dramatic as education increases. Individuals within the school system with a bachelor's or master's degree are paid significantly more (in many cases double) per hour than the comparable home visitor.
- While the average salaries of High School Diploma and High School Diploma+ individuals within the school system are not outpacing their Home Visitation counterparts on the surface, it is important to highlight that a school system employee is working 1,600 hours per year (200 days x 8 hours/day) to the roughly 2,000 hours per year for home visitors (50 weeks x 5 days x 8 hours/day). When calculating the hourly rate, Home Visitors are again at a disadvantage.
- Low pay and the resulting workforce turnover and shortages are a national problem. This is not a unique struggle to West Virginia and, in many ways, West Virginia is at an advantage in combatting the problem.
- West Virginia has a superior state-level infrastructure to any of the surrounding states interviewed. The WV Home Visitation Program has consistent and familiar leadership, has a relationship with all of the programs, and provides ongoing training and evaluation. This is unique to West Virginia. This ongoing investment from the state provides a level of support to the local programs and the individual home visitors that other states do not enjoy. The state should be commended for this ongoing support.

However, since the underpaid workforce issue is a national problem, it requires a multistate approach to solve, even with the commendable support provided within West Virginia. Families' need for support is only increasing due to growing economic, health, and cultural crises. In the initial phase of implementing home visitation programs nationwide, a priority was given to providing services to the most families possible. This was the correct first step. The next phase of home visitation programs will require a shift in decision making and prioritization. In order to continue to provide high quality services, policy makers

must refocus on investing in families with young children and the workforce that serves them. No one state can do this alone—it will require multiple states working together to make it happen.

Recommendations

Programmatic Recommendations:

Given the significant pay discrepancy across all regions, we are not providing individual regional recommendations for West Virginia. The recommendations remain the same for all home visitation regions in West Virginia. For Home Visitation Programs everywhere to compete for the most qualified workforce:

- Pay and benefits should be increased to be competitive with similarly qualified positions within their regional school systems

This study indicates that this is not an option for individual programs to implement on their own. Increasing pay and benefits for home visitation staff will require systemic support and change, which is addressed in the next section.

However, there are efforts that programs and employers can make that will improve recruitment, retention, and morale while working with others to increase pay and benefits.

- Provide other incentives and benefits where possible. These can include:
    - flexible work schedules,
    - options to telework,
    - paid leave, and
    - other benefits that attract and support a skilled workforce.

The public education system attracts many employees not only because of the pay, but because of the benefits, schedule, and stability. While not always easy, home visitation programs can act to improve their work processes and support structures to attract and retain employees prior to implementing the desperately needed pay increases.

Systemic Recommendations:

- West Virginia should work with the other states making up HRSA Regions 3 and 4 to enter into a systemic and regional effort to support and cultivate its home visitation human infrastructure.
- This effort should be a multifaceted approach that includes:
    - a multistate compensation study,
    - research into home visitation workforce trends,

- leadership and stakeholder roundtables, and
- recommendations to policy makers at all levels that increase investments in the Home Visitation system to one that delivers equitable pay, benefits, and support to workers while providing all families that are interested with home visitation services.

Appendix

a. Report of Interview Results

b. Maryland Governor's Report

c. WV Professional and Service Personnel Salary Schedules

d. Detailed Salary Averages by County

Report of Interview Results
West Virginia State Border County Contacts' Interview Responses
February 14, 2020
Interviewer: Leslie Stone, Stone Strategies, LLC

Project Background: Stone Strategies and Thrive Collaborative were contracted by West Virginia's early childhood advocacy organization, Partners in Community Outreach (PiCO) to explore the compensation rates for Home Visitation Programs (HVP) staff within the state and in West Virginia's neighboring states and to issue a report of recommendations. The outstanding question for PiCO was: What can we do to best support WV's Office of Home Programs and provider agencies in increasing compensation for home visitation staff?

The overall project had two components; salary and compensation research in local county boards of education in West Virginia's six (6) HVP regions and interviews with West Virginia's five (5) border counties. This report focuses on the interview process and raw response data.

Interview Purpose: Questions were designed to be used in telephone interviews with contacts from the border states of Kentucky, Ohio, Pennsylvania, Maryland and Virginia. Contacts were sought for their knowledge of their state's Home Visitation Programs (HVP) and overall state structure as well as HVP staffing and compensation levels in the border counties of their state nearest West Virginia. The information is to be used to inform PiCO how best to support West Virginia's Home Visitation Programs to retain quality home visitation staff.

Protocol: Interview questions and a list of counties bordering West Virginia were sent in advance to West Virginia's five border states. Compensation information was sought from the counties that are 'two deep' on the map. The choice of these counties was based on the assumption that it is reasonable to assume that home visitation staff might travel into a neighboring state for work (up to 1 hour from home), if wages and other compensation are greater.

Identifying State Contacts: The interviewer contacted Michele Baranaskas, Coordinator, Partners in Community Outreach (PiCO), A Program of TEAM for West Virginia Children who provided a list of state contacts. Jackie Newson, West Virginia's Director of West Virginia Home Visitation Programs in the Office of Maternal, Child and Family Health, a Division of Public Health in West Virginia's Department of Health and Human Resources also provided a current email listing of all the state partners in West Virginia's federally designated regions.

This interviewer also spoke by phone, emailed and texted with Lisa King, Sr. Public Health Analyst/Women's Health Specialist, Division of Home Visiting and Early Childhood Systems Maternal and Child Health Bureau, HRSA The Health Resources and Services Administration (HRSA) is an agency of the U.S. Department of Health and Human Services located in North Bethesda, Maryland. HRSA oversees the funds to states to provide home visitation services. Lisa was helpful in providing names of contacts in Ohio and Pennsylvania and talking with the

interviewer about the federal and state structure of home visitation programming. All five (5) states were contacted.

Interview Process: The interview process began on January 9, 2020 and closed on February 14, 2020. Two comprehensive telephone interviews were completed within this period. A total of five people representing two states' home visitation programming structure participated. Interviews lasted between 35 and 65 minutes. All participants appeared interested, engaged and seemed to speak with professional candor.

Efforts to Identify Appropriate Contacts:

Ohio: No person was ever reached, within the timeframe of this project, that had a state-level and border county understanding of home visitation programming in the state. The following contacts were made:

- Ohio Department of Education 614-466-3543
  - Elizabeth Lococo 614-644-8755
  - HVTraining@odh.ohio.gov
- Help Me Grow
  - Toni 216-236-0805
- Southern and Southeastern Regional Referral Agencies
  - Amy 740-289-3824
  - 740-732-1775

Helpful conversations were had with Amy and Toni. They offered insight and phone numbers for contacts they thought would be more appropriate to this project. The message they both shared was that all agencies that deliver home visitation programming set their own pay and benefits. Neither of them knew what pay and benefits were offered. Both were involved in referring families to needed services.

Information was sought for the Ohio counties of:

• Lawrence • Gallia • Meigs • Athens • Washington • Monroe • Belmont • Jefferson • Columbiana • Scioto	• Jackson • Vinton • Hocking • Morgan • Noble • Guernsey • Harrison • Carroll • Mahoning

Kentucky:

No person was ever reached, within the timeframe of this project, that had a state-level and border county understanding of home visitation programming in the state. The following contacts were made:

- Kentucky Department of Education 502-564-3756
- First Steps, Department for Public Health - (502) 564-3756, Option 1
- Karen McCracken, Parent Consultant, University of Kentucky
  Kentucky Early Intervention System

  275 E. Main St., HS2W-C

  Frankfort, KY 40621

  502-564-3756 ext. 4397

- Point of Entry Offices (covering targeted counties)
  - Clorissa McConnel 606-929-9155
  - Donna Dyer – ddyer@mtcomp.org
- June Wideman, Eastern Kentucky Childcare Coalition - junewideman@ekcc.org
- Kathy Hogg, Woodford County Board of Education, Early Childhood Director 859-879-4600

Information was sought for the Kentucky counties of:

- Pike
- Martin
- Lawrence
- Boyd
- Carter
- Elliott
- Johnson
- Floyd

Phone conversations were had with Kathy Hogg and Karen McCracken. Both expressed challenges in locating the appropriate persons within Kentucky to address our questions and had no personal or professional knowledge to approach the questions themselves.

Virginia:

No person was ever reached, within the timeframe of this project, that had a state-level and border county understanding of home visitation programming in the state. The following contacts were made:

- Andelicia Neville – 804-318-8655
- Ashley - 804-318-8655
- Families Forward
    - Michelle Powell – mpowell@familiesforwardva.org
- Jacque Hale 804-514-0444
- Laurel Aparicio, Early Impact Virginia – laparicio@earlyimpact.va.org

Information was sought for the Virginia counties of:

• Buchanan • Tazewell • Bland • Giles • Craig • Alleghany • Bath • Highland • Rockingham • Shenandoah • Fredrick • Clarke • Loudon	• Russell • Smyth • Wythe • Pulaski • Montgomery • Roanoke • Botetourt • Rockbridge • Augusta • Greene • Page • Warren • Fauquier

Personal email contact was made between Mary LaCasse of Maryland and Laurel Aparicio, Director, Early Impact Virginia on February 11th. Laurel responded via electronic mail on February 13th stating that no such data is collected in Virginia and that they were willing to make an effort to collect the data. The end date, in order to complete the review within the project timeframe, did not allow enough time for data collection and interviewing.

Questions:

Q1. What is your name and position related to home visitation in your state?

Maryland: Mary LaCasse, Chief, Early Childhood and Family Support Maternal, Infant, & Early Childhood Home Visiting Program; Donna Mullen, Program Coordinator- MIECHV and Maggy Gerghty, Policy Analyst

Pennsylvania: Andrew Dietz, Family Support Program Manager (responsible for all PA home visiting excluding child welfare, human services and education) and Jim Powell, MEICHV Program Monitor

Q2. What is the structure of your state's Home Visitation Programming? Is it managed at the state level? Do individual agencies direct their work independently? Other?

Maryland: MIECHV funds are coordinated and dispersed at the state level. We created a certificate training program that allows HVP staff to earn a certificate at no cost and receive 2.0 level training beyond the training required of the evidence-based program model. The training is 7 days long. Since we cannot increase pay, we offer this certificate learning program. Some topics include substance use, motivational interviewing, etc. it allows people to increase their skills and network across providers, programs and geographic regions of the state.

Pennsylvania: Our office offers competitive grants with federal and state program requirements for 5 evidence-based models; PAT, Nurse Family Partnership (NFP), Family Check Up, Safe Care Augmented and Health Families America. Our most prevalent models are PAT and NFP. We offer a state conference every other year and 7 orientation webinars, 3 Family Support Consultants to assist with compliance and to recommend training needs back to our office. There is also an annual Early Childhood Summit that is offered to all but is put on and primarily attended by Early Head Start.

Q3. What revenue sources fund home visitation programming in your state? Please do not include Early Head Start when you consider Home Visitation.

Maryland: MD uses a braided/blended funding model that is made up of state, federal, private, philanthropic, Department of Education and Governor's Office funds.

Pennsylvania: We have MEICHV monies, and two state line items, one for evidence-based home visiting program models and one for Nurse Family Partnership. Where appropriate, we use federal Child Abuse Prevention funds for some fatherhood programming in homes and family centers and Safe and Stable Families funds.

Q4. What program models are used to guide the delivery of home visitation services in the counties of your state that we are discussing?

Maryland: Nurse-Family Partnership, Healthy Families America, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY) Family Connects (offers care coordination only)

- Garrett - HFA
- Allegany - NFP

- Washington - HFA

Pennsylvania:

- Beaver – Family Check Up (small pilot just started)
- Allegheny – NFP, PAT, HFA, and Family Check Up
- Washington – PAT, NFP
- Westmoreland - PAT
- Greene – PAT and NFP (5 families) – all home visitors in Greene are county employees with county pay scale
- Fayette - NFP
- Somerset– PAT, NFP
- Bedford– PAT, NFP (lost United Way funding and have been back-filled with state funds)
- Fulton - PAT
- Franklin – NFP

Q5. How and when was the information you plan to share about Home Visitation compensation collected? Please do not include Early Head Start when you consider Home Visitation.

Maryland: MD has a 25% annual turnover rate in Home Visitation staff due to low pay. All program models within sites set their own pay scales. We have not made an effort to collect data on salaries outside of what MIECHV requires us to collect. In response to our 2 Year Report to the Governor, we have been asked to look at HVP compensation. We are not sure how to go about this because of the complexity. ***The Governor's report is provided as a separate document.***

Pennsylvania: We have not attempted to collect compensation data. It is too complex and uneven because of varying program models, program sites and geographic disparities. There is only a limited amount of federal funding available and we cannot adequately increase pay and reach equitable pay while trying to balance federal and state requests to serve more families. Legislators want to see more families served.

Q6. In the counties bordering WV, what is the average hourly rate paid to home visitation staff according to their highest level of education? Please do not include Early Head Start when you consider Home Visitation. If salaried, please provide hourly calculation.

- **High school or GED**
- **Associate degree**
- **Bachelor's degree**
- **Master's degree**

Maryland: We do not know the answer to this. This is too different across models and sites and cannot easily be answered. Some positions are considered 'pinned positions' they are not contractual but, merit employees. Merit employees receive health, pension, etc. We try to get as many merit slots as we can. Merit positions are created through legislation and sometimes individual counties are able to find ways to create more merit positions.

Things are complicated by the site requirements and geographic area. For example, if a program is housed in the Public Health Department all employees are classified as state employees with various classifications based on education, experience and the specific job itself. The YMCA may pay home visitors $10/hour. There is a big challenge with nurses in NFP. In MD, nurses are unionized and as such cannot do home visits outside of their regular workday, even if it is best for the family. For example, because their official end of the workday is 5pm, nurses cannot do a home visit at 6pm.
Pennsylvania: These are estimates only; based on gut instinct and experiences through program monitoring. We ask grantees to identify salaries with benefits carved out, but it is apparent that the reports are often calculated and/or reported incorrectly. Rural counties pay less. Medical models pay more. Some counties pay more by giving county funds to family centers that offer PAT. A rough guess of ranges appears below.

- High school or GED - $20-$24,000
- Associate degree - $27-$32,000
- Bachelor's degree - $35-$65,000 (BSN/RN only at the high end)
- Master's degree – Nurses (Family Check Up and NFP) $50-$65,000

Q7. What benefits are offered home visitation staff in addition to an hourly rate of pay? Please do not include Early Head Start when you consider Home Visitation.

- **Health and/or dental insurance?**
- **Paid annual and/or sick leave?**
- **Retirement contributions?**

Maryland: We do not know the answer to this because of the variety of types of positions, sites and classifications of employees.

Pennsylvania: It is very difficult, if not impossible to tell. Most programs offer health and dental insurance as well as paid annual and sick leave. Retirement contributions may not be offered or may be offered without a match by the employer. We are not uniformly privy to this information. It depends on the site and the classification of the employee. Allegheny County Family Centers, that offer PAT, have state funds. Other counties with Family Centers (that provide PAT) do not have state monies. All counties have independent decisions over pay, benefits and programming as long as state and federal program requirements are met. We do know that many programs offer informal benefits such as undocumented flextime and time or days off for stress without a formal policy statement as to these benefits. Many programs try to support employees in respectful ways that recognize the level of stress in the home visiting job. PA faces a

common challenge of recruitment, retention, pay and continued engagement of home visiting staff. The job is high stress with often low or lower pay.

Q8. Have you and your colleagues looked at compensation for Home Visitation within the last five (5) years?

Maryland: No. The response to the last Governor's Report asks us to do this. We haven't yet done it.

Pennsylvania: No. We have been hesitant to do so. It is difficult with 5 program models. We lose a lot of nurses to hospitals with sign-on bonuses. It is hard to maintain a balance between serving more families and trying to reach pay equity. MEICHV funds are fixed. We have thought about looking at or setting salary minimums, but this offers specific challenges as well. We see the struggles in increasing minimum wage. If minimum wage levels were increased, this would impact the number of families that we are able to serve with available funds. We do have a unified data system across programs and we ask for salary information in the model. The system is 2 years old and we are not yet able to run reports on this data. For years there was a cost/child or cost/family/program that was used. This has stopped because the issue is too complex and can cause discomfort, challenges and a negative competition between models. Programs are not comparable because there are nuances and the ratio is an overly simplistic view of the issues. These comparisons can cause underfunding and a loss of appropriate services to families. Family needs should dictate the type of services and the program model or models best suited to the individual family.

Q9. Have you seen changes in salaries for Home Visitation providers in over the last 5 years? How? If there was an increase, how was it achieved?

Maryland: No! This is very difficult. Early childhood positions that are not paid for by the state seem to average about $10/hour, example YWCA or other non-profit. We were just at a national HVP conference and the report there is that there are wide salary disparities across HVPs with little latitude for changes within each state. I will send you the MD Governor's Report. You may want to highlight the workforce piece of that report.

Pennsylvania: No, except in the years of state budget expansions which we have seen over the last 3 years.

2017-18 - $5M
2018-19 - $4.5M (specifically to address the opioid crisis)
2019-20 - $5M
2020-21 - $1M proposed (to cover an HVP deficit)

NFP funding has been in the state budget since 1990. Family Center funding has been in the state budget since 1991 (family centers deliver PAT in PA).

We believe that the investment of state funds has remained intact and modest increases have been seen because:

- Only modest increases were sought
- Strong advocacy, across programs, is involved and watchful. There is an active coalition, representing all home visiting models, that focuses on preventing a loss of funds and/or advocating for modest increases to meet demonstrated need.

Maryland

GOVERNOR'S OFFICE FOR CHILDREN

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

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

Larry Hogan
Governor

Boyd K. Rutherford
Lt. Governor

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

Submitted on behalf of the Maryland Children's Cabinet
by the Governor's Office for Children

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December 1, 2019
MSAR #9107

Table of Contents

Maryland's Children's Cabinet

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

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

Sam J. Abed
Secretary, Department of Juvenile Services

Carol A. Beatty
Secretary, Department of Disabilities

David R. Brinkley
Secretary, Department of Budget and Management

Lourdes R. Padilla
Secretary, Department of Human Services

Robert M. Neall
Secretary, Department of Health

Karen B. Salmon
State Superintendent of Schools

[1] Governor's Office for Children. *Children's Cabinet*.

Acknowledgements

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

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Background: Maryland's Home Visiting Accountability Act of 2012

In March 2010, the Affordable Care Act established the 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 MIECHV program require states to: 1) provide at least 75% of funding to home visiting programs that were evidence-based; 2) direct up to 25% of funding for "promising practice" approaches that had an evaluation component to determine effectiveness; and 3) complete a statewide needs assessment to inform decision making in the allocation of funds to the most vulnerable communities.

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

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

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

In accordance with the Home Visiting Accountability Act of 2012 and 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.[2] This review recommended the development of a "standardized reporting mechanism for the purpose of collecting information about and monitoring the effectiveness of State-funded home visiting programs." Beginning in FY 2015, recipients of State

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

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, in accordance with § 8-507(c) of the Human Services Article.[3]

Although the MIECHV funds were separated from the Affordable Care Act in 2015, the benchmarks and 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 26 of this report.

Introduction: FY 2019 Statewide Home Visiting Data Collection Survey

This Report represents the third summary of Maryland's efforts to improve outcomes for vulnerable populations through home visiting programs that support maternal, child, and family health. It describes the results of standardized reporting from sites across program models and funding sources, and compares data from the new baseline collection completed for FY 2017 and the original data collection from FY 2015 when applicable.

Background on Home Visiting

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

[3] Ibid.

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

Evidence-based home visiting 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;
- 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.

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

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

- **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. These home visiting services offered in Baltimore City employ three other evidence-based home visiting models:

- **Family Connects** is a universal nurse home visiting program available to all families with newborns residing within a defined service area. The program aims to support families' efforts to enhance maternal and child health and well-being and reduce rates of child abuse and neglect. It consists of one to three nurse home visits, typically when the infant is two to 12 weeks old, and follow-up contacts with families and community agencies to confirm families' successful linkages with community resources. During the initial home visit, a nurse conducts a physical health assessment of the mother and newborn, screens families for potential risk factors associated with mother's and infant's health and well-being, and may offer direct assistance (such as guidance on infant feeding and sleeping). If a family has a significant risk or need, the nurse connects the family to community resources. Program staff collaborate with the local department of social services and other local agencies that serve families with children aged birth to five years.[6] Although it is flagged as an evidence-based home visiting program, it is primarily a care coordination into programs like home visiting or other needed services.
- **Attachment Bio-Behavioral Catch-up** is a training program for caregivers of infants and young children six to 24 months old, including high-risk birth parents and caregivers of young children in foster care, kinship care (such as a grandparent raising a grandchild), and adoptive care. Parent coaches conduct 10 weekly home visits. The program is designed to help caregivers provide nurturance even when children do not appear to need it, mutually responsive interactions in which caregivers follow children's lead, and non-frightening care. Parent coaches provide immediate feedback on the caregivers' interaction with the child to help the caregivers attend to the target behaviors.[7]
- **Exchange Parent Aide Model** is a program of the National Exchange Club. Exchange Parent Aides are trained, professionally supervised individuals (volunteer or paid) who

[6] https://homvee.acf.hhs.gov/Model/1/Durham-Connects-Family-Connects/59/1
[7] https://homvee.acf.hhs.gov/Model/1/Attachment-and-Biobehavioral-Catch-Up--ABC--Intervention/51/1

provide supportive and educational weekly in-home services to families with children at-risk of child abuse and neglect.[8]

In Maryland, there are other home visiting programs in operation that do not have the evidence base as determined by rigorous randomized control trials to determine their effectiveness in meeting targeted outcomes. These programs, referred to as "promising practices," are often funded by local government and provide home visiting services to locally-defined and identified at-risk populations. In FY 2019, seven "promising practices" in operation in seven jurisdictions were identified. These programs include:

- **Healthy Start** (Anne Arundel County) is a nurse home visiting program providing case management, home visiting, outreach, and other services that help to prevent injuries and deaths to high-risk pregnant women and children up to two years old. These services are provided by community health nurses and social workers.[9]
- **HOPE Program** (Baltimore City) is an interconception care program for mothers who have suffered a fetal or infant loss within the last two years. The HOPE Program has adapted the Healthy Families America program model to provide home visiting services to this high risk population to provide emotional support/coping, preventive care, and birth spacing counseling.
- **Healthy Start** (Baltimore City) is a federally-funded initiative to reduce the rate of infant mortality and improve perinatal outcomes in areas with high annual rates of infant mortality in one or more subpopulations. Home visiting services are provided until the child turns two years old.[10]
- **Prenatal Enrichment Program** 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.
- **Maternal-Child Health Program** (Charles County) is a nurse home visiting program that provides services to pregnant and postpartum women.
- **High Risk Infants Program** (Prince George's County) 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.
- **Early Care Program** (Worcester County) 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

[8] The National Exchange Club (NEC). (2013). *Child Abuse Prevention Services provided by Exchange: The National Exchange Club (America's Service Club)*

[9] *https://aahealth.org/healthy-start/*

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

provided include educational support and linkages to community resources based on the individual needs of the mother.[11]

Methodology

This Report is the third Statewide data collection on the standardized measures for prenatal and postnatal women and children served by home visiting programs in Maryland and includes data for FY 2019. 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, 2018 through June 30, 2019 for this Report.

An inventory of home visiting programs across Maryland collected in FY 2019 was updated to determine which programs were providing home visiting services during that time. The inventory was created by collecting program lists previously compiled by the Department of Health, Maryland State Department of Education, Governor's Office for Children, Maryland Family Network, and Johns Hopkins School of Public Health. Each home visiting program was contacted (via email and/or phone call) to verify that the program was still in operation and still providing home visiting services, as well as to confirm the program model and curriculum. The final updated inventory indicated that 72 evidence-based and six promising practice programs were operational during FY 2019.

The data survey developed in FY 2019 was updated to:

- Improve ease of use;
- Include feedback obtained from the FY 2017 data collection; and
- Gather data on certain Children's Cabinet priorities.

The survey was created as a web-based data collection platform and was sent to all known home visiting programs that operated during FY 2019. The survey was launched on July 22, 2019, and sites had until October 4, 2019 to input their data. The Department of Health administered the survey and provided technical assistance to sites as needed during the data collection process.

[11] http://www.worcesterhealth.org/treatment-menu/early-care-services-menu

Overview of Reporting Programs

A total of 66 out of 78 sites submitted data which represents 70 programs with a return rate of 85%, compared to a return rate of 70% in FY 2017. Of the 66 sites that submitted data, 68% (n = 45) received State funding in FY 2019. The remaining sites received some combination of federal, local, and/or philanthropic funding in FY 2019. 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 2019 data compared to FY 2017 and FY 2015. Appendix A provides details on programs that submitted survey data for FY 2019. Appendix B provides details on all known home visiting programs in Maryland that were asked to submit data.

Table 1. Reporting Program Sites

Measure	FY 2019 Home Visiting Program Sites Reporting	FY 2017 Home Visiting Program Sites Reporting	FY 2015 Home Visiting Program Sites Reporting
Number of program sites reporting	66**	58	46
Jurisdictions represented	24	24	23
Number of women served	4,357	4,602	***0
Number of "other" Primary Caregivers served*	181	109	***0
Number of children served	4,108	3,947	***0

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

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

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

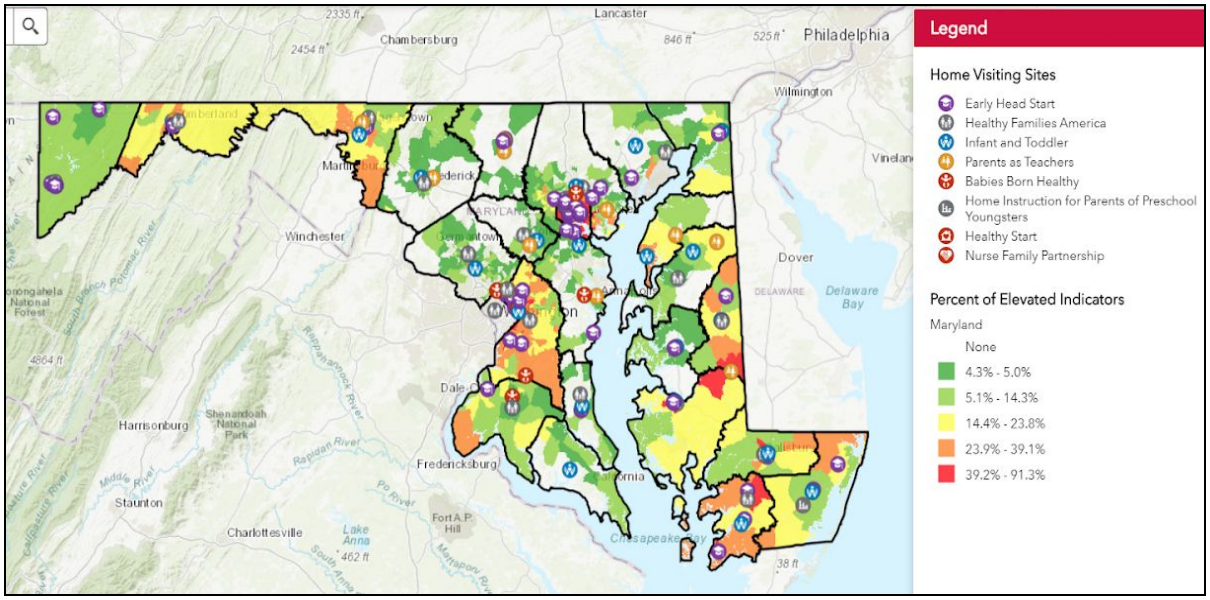
Table 2. Data-Reporting Sites by Program Model						
Program Model	**FY 2019 Number of Known Programs**	**FY 2019 Number Programs Reporting**	**FY 2015 Number of Known Programs**	**FY 2017 Number Programs Reporting**	**FY 2015 Number of Known Programs**	**FY 2015 Number Programs Reporting**
Early Head Start (EHS)	26	19	27	11	25	8
Healthy Families America (HFA)	26	25	28	28	27	25
Home Instruction for Parents of Preschool Youngsters (HIPPY)	3	2	3	3	4	2
Nurse Family Partnership (NFP)	1	1	1	1	1	1
Parents as Teachers (PAT)	15	15	14	13	13	9
Other*	8	8	10	2	0	**1
TOTAL #	78	70	83	58	70	46
% Reporting	90%		70%		65%	

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

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

Ongoing assessment of community needs and strengths is crucial to develop a useful and well considered strategic plan. Analysis of available secondary data allows the MIECHV home visiting team to better target home visiting services in the State to improve the health of mothers, infants, and children. This map and data is shared Statewide and used by other agencies and potential funders to identify at-risk areas in need of additional support.

Figure 1: Map of All Maryland Home Visiting Sites



Funding for Reporting Programs

Maryland's home visiting programs are supported by federal, State, local, and philanthropic funding. During FY 2019, 11 of the 66 home visiting sites (16%) reported that they received State-only funding, and 58% indicated that they received a combination of funding from federal, State, local, and/or philanthropic sources.

According to the survey, State general funds are the revenue source for home visiting programs supported by several different State agencies, including the Departments of Education and Human Services, the Children's Cabinet Fund (administered by the Governor's Office for Children, a division within the Governor's Office of Crime Control and Prevention), and local health departments. A total of 44 of the 66 sites indicated that they received funds from at least one of these sources in FY 2019. In total, these four sources invested $11.7 million in home visiting services for Maryland families.

The federal government also provides funding for Maryland home visiting programs. The MIECHV program is funded through the Health Resources and Services Administration (HRSA). In FY 2019, MIECHV funding supported 15 sites in 10 jurisdictions. Federal MIECHV dollars add approximately $7.5 million each year for home visiting services and workforce support.

The federal offices of the Administration for Children and Families, and the Office of Head Start provide partial or full funding for Early Head Start home visiting programs. Fifteen sites that responded to the survey indicated that they received direct federal funds through this office. Additionally, Promoting Safe and Stable Families grants administered through the federal

Department of Health and Human Services supported four home visiting programs in Maryland. Other federal sources of funding included Community Based Child Abuse Prevention (CBCAP) grants and Title V Block Grants. Fifteen sites (22.7%) reported that they received only federal funding in FY 2019, compared to 31 sites (47%) that received a portion of federal funding in combination with other sources. Overall, 57% of sites operate with braided funding from various combinations of federal, state, local, philanthropic, and university sources.

Local government and philanthropic funding also support a number of home visiting programs in Maryland. Six sites (9%) reported that they received more than 50% of funding from local government or philanthropic sources in FY 2019 (see Figure 2 and Figure 3).

Figure 2: Home Visiting Funding by Source

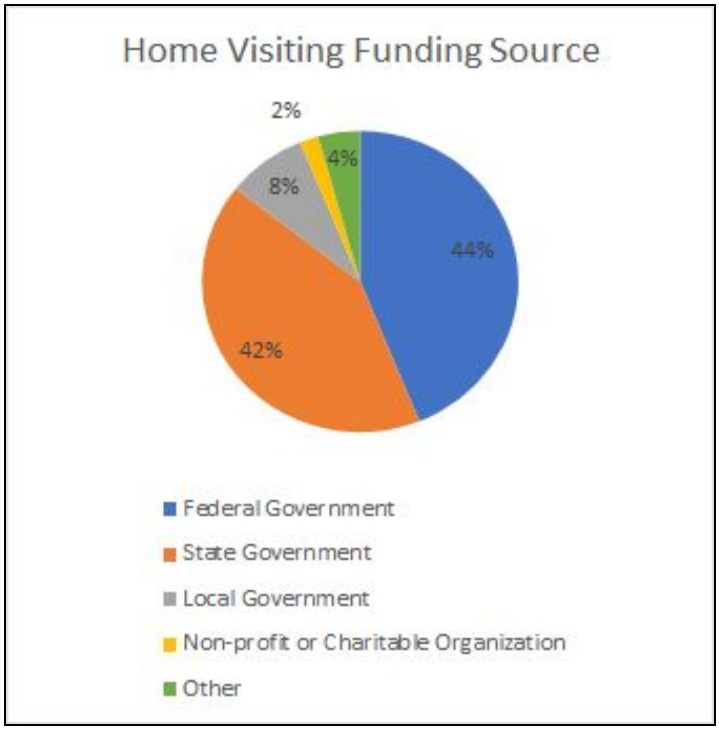
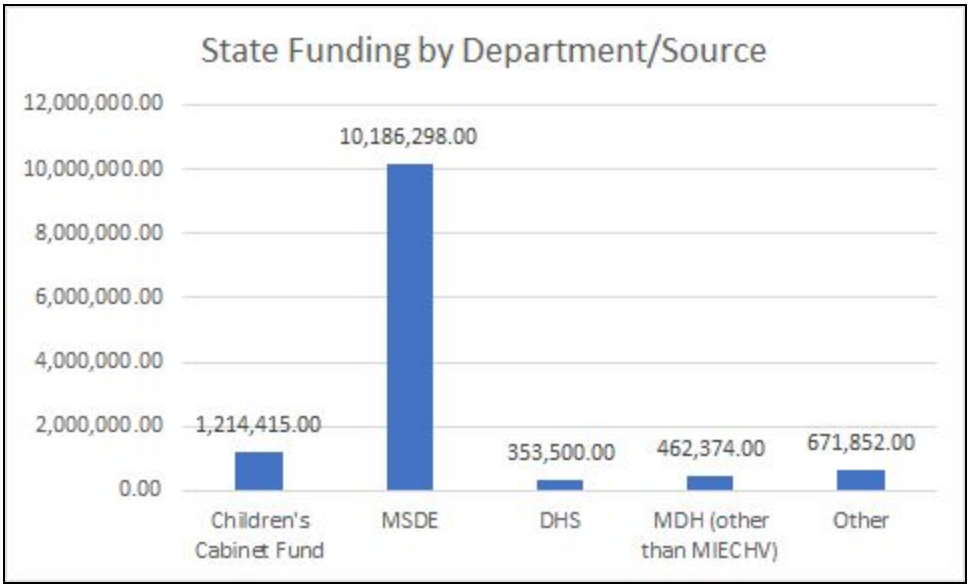


Figure 3: State Funding by Department/Source



Maryland's Home Visiting Workforce

In FY 2019, and similar to the data collection process in FY 2015 and FY 2017, the survey inquired about the number of full time equivalency home visitors employed (excluding administrative support roles such as managers, supervisors, and data entry/administrative assistants), educational attainment, and other common reasons for home visitor turnover. Gender identification, race, and the age range of home visitors were also added to the FY 2019 data collection survey to capture a more complete picture of the workforce (see Figure 5 and Figure 6).

In FY 2019, 66 sites reported that they employed approximately 226.18 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

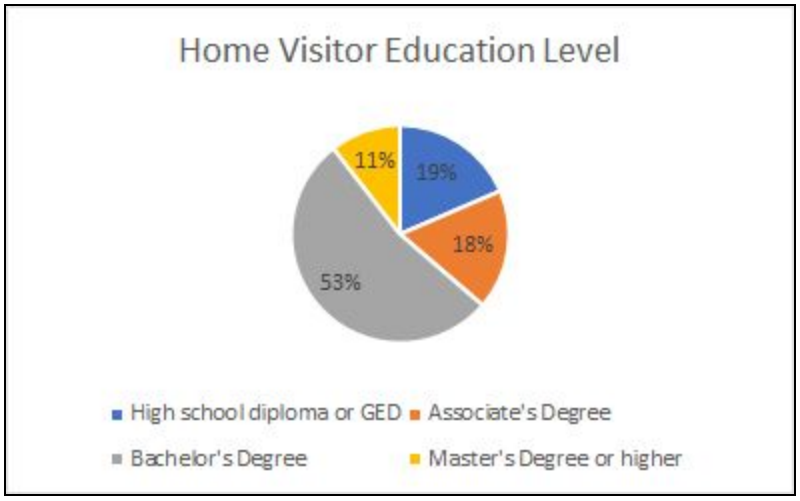


Figure 5. Home Visitor Gender Identification

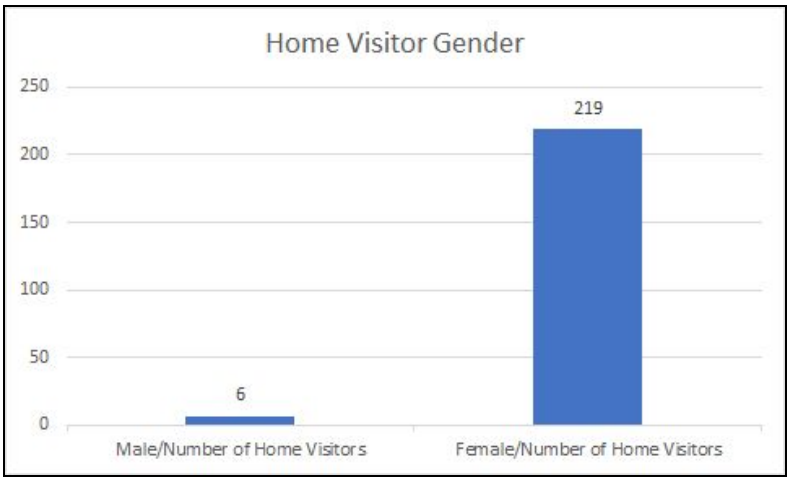
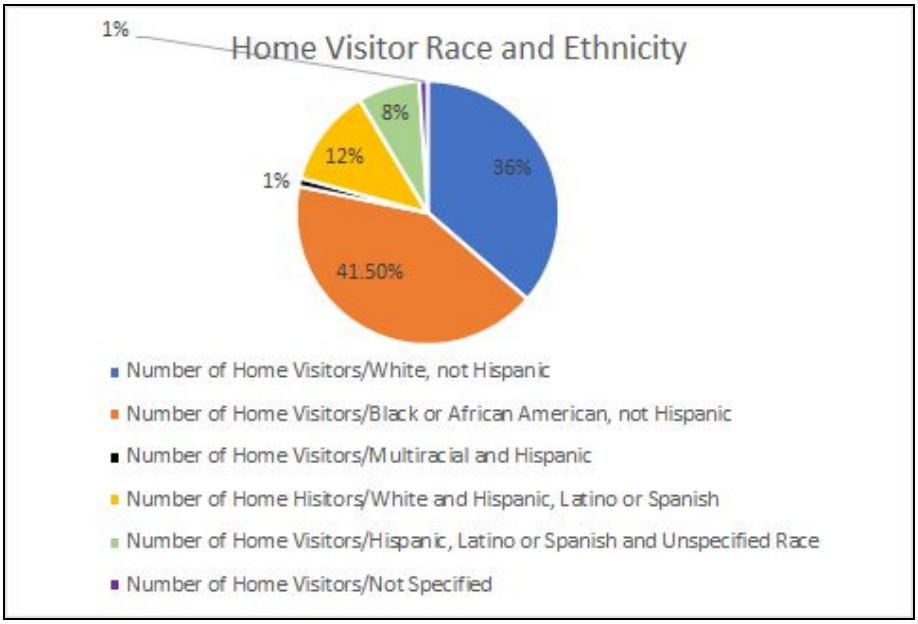


Figure 6: Home Visitor Racial/Ethnic Identification



Professional Development and Training

In addition to their formal education, home visitors receive extensive training specific to the program model and curriculum employed at their respective sites, and supplemental training throughout the year on topics ranging from child development to cultural competency. Additionally, using MIECHV program funds, the Maryland Department of Health (MDH), in collaboration with the University of Maryland, Baltimore County (UMBC) developed a Home Visitor Training Certificate Program ("Training Certificate Program"). The Training Certificate Program provides additional comprehensive training to home visitors on challenging issues such as mental health, substance abuse, and intimate partner violence that are often addressed during home visits. Though initially available to MIECHV-funded home visitors only, UMBC's Training Certificate Program is now open to all interested home visiting professionals. To date, 150 home visitors have completed the training. To receive a certification of completion, visitors must successfully complete all seven modules, as required by UMBC staff. Training satisfaction and home visitor demographics can be found below:

Table 3. Mean Confidence and Training Satisfaction Ratings from Fall 2018 and Spring 2019 Cohorts

Module	Confidence Pre-Test	Confidence Post-Test	Post-Training Satisfaction
Communication	4.2 (0.7)	4.5 (0.6)	5.6 (0.9)
Healthy Relationships	4.6 (0.9)	5.0 (0.7)	5.6 (0.7)
Parenting	4.5 (0.7)	5.1 (0.6)	5.5 (0.6)
Mental Health	4.4 (1.0)	5.1 (0.6)	5.5 (0.7)
Substance Use	4.7 (0.9)	5.2 (0.6)	5.6 (0.7)
Culture	4.9 (0.9)	5.3 (0.6)	5.5 (0.6)

Table 4. Demographic Data for Fall 2018 and Spring 2019 Cohorts (N = 45)		
Variable		**Percent (n)**
Role (Trainees could select more than one option)	Home Visitor/Family Service Worker (FSW)	67% (30)
	Administrator	18% (8)
	Supervisor	2% (1)
	Family Assessment Worker	4% (2)
	Program Manager/Project Director	9% (4)
Program model (Trainees could select more than one option)	Healthy Families America	71% (32)
	Early Head Start	19% (8)
	Other	11% (5)
Gender	Female	98% (46)
	Male	2% (1)
Race/ Ethnicity (Trainees could select more than one option)	Black/African American	49% (22)
	White	33% (15)
	Asian/South Asian	2% (1)
	Native American/American Indian/Alaska Native	2% (1)
	Other (Biracial, Latino[a])	13% (7)
	Latino[a]	29% (13)
Highest educational level	Trade School	2 (1)
	High School/GED	6% (3)
	Some College	9% (4)
	College Graduate	59% (27)
	Graduate Degree	24% (11)
Mean age in years (range: 24-63)		37.5 (10.7)
Experience	Mean years as a home visitor (range = <1 yr. – 29 yrs.)	3.1 (1.6)
	Median home visiting caseload size (range = 0 - 11)	10.0
	Mean number of home visitors supervised (range = 3 - 11)	3.8 (1.6)

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

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

trainees who completed both the prerequisite online training modules, and the one-day in-person training.

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

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

Statewide Collaboration to Support Workforce

The mission of the Maryland Home Visiting Consortium (HVC) is to ensure coordination and collaboration between public and private partners in the planning, implementation, and sustainability of evidence-based and promising practice home visiting programs in Maryland.

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

The HVC was resurrected in 2015 to address current challenges to home visiting in Maryland, to include:

- Timely dissemination of information throughout all evidence-based home visiting programs across Maryland.
- Duplication of resources/efforts (examples: evaluation efforts, trainings, services to families).
- Sharing of best practices.
- Challenges in coordination and collaboration among home visiting models.

- Inconsistent data to measure collective impact.
- Identification and coordination of training.
- Maximizing funding opportunities.
- Big picture understanding of home visiting needs across the State.

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

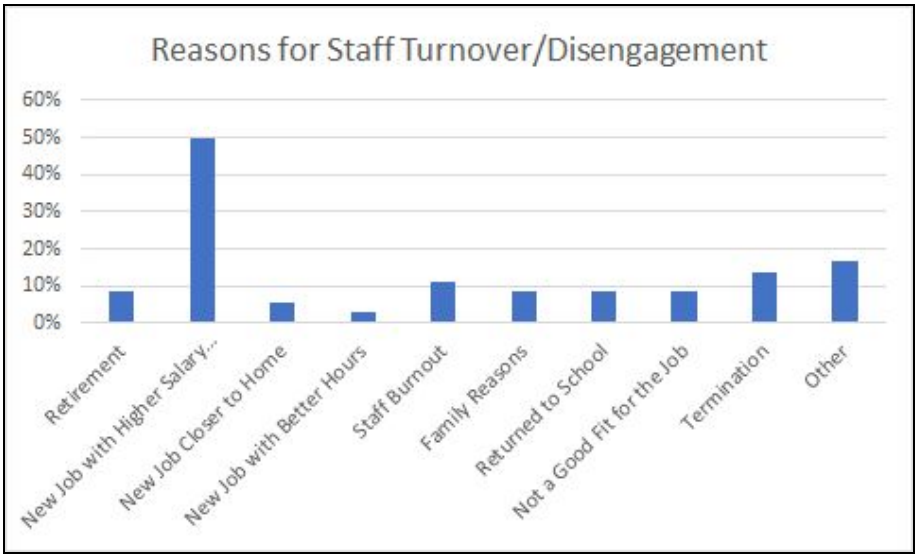
Staff Retention

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 affect family outcomes.[13] Additionally, staff turnover leads to lower caseloads and fewer families served, due to the requirement to maintain certain caseload sizes in order to maintain fidelity to the evidence-based program model.

The FY 2019 survey collected data on staff retention to obtain more information on workforce development and retention issues within home visiting programs. Thirty-six of the 66 sites (54.5%) indicated that they experienced staff turnover in FY 2019, an increase of 1.5% from FY 2017. A total of 61 staff turned over, representing 27% of the overall home visiting workforce. Fifty 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 fell under "other" (17%) which included home visitors moving, health complications, a lay off, moving to a different program, and taking a new job opportunity for undefined reasons. Other reasons included: termination, staff burnout, retirement, family reasons, returning to school, not feeling fit for the job, and new opportunities with better hours or closer to home (Figure 7).

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

Figure 7: Reasons for Staff Turnover/Disengagement



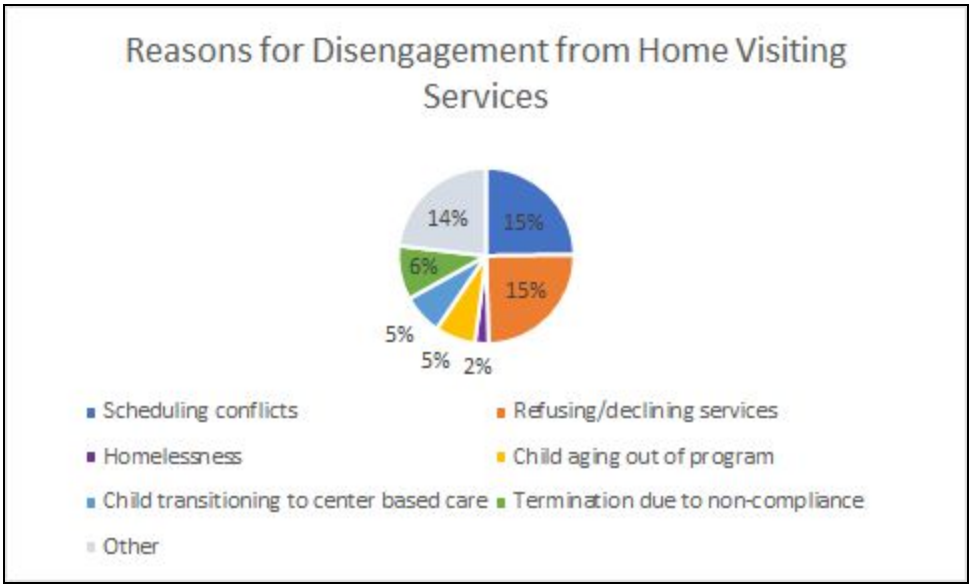
*Other includes: staff moving, transitioning to a new program, laid off, health issues, and undisclosed reasons.

Program Retention

The 66 sites that reported data in FY 2019 were funded to serve 3,619 women. A total of 4,357 women and 181 other caregivers including 161 fathers, 32 grandmothers, 21 foster/adoptive parents, eight aunts, three grandfathers, and one cousin received at least one home visit during the time period; whereas, 1,229 women disengaged from services, an 18% decrease from FY 2017. The primary drivers of disengagement that sites reported included families moving (18%), being unable to contact or locate families (18%), scheduling conflicts (15%) of which three were due to clients getting new jobs, and refusal/declining services (15%). Among those who refused/declined services, three directly cited not wanting to work with a new home visitor as the reason for declining services - an effect of staff turnover on client services. Other reasons behind disengagement included the target child aging out of the program, children transitioning to center-based care, and homelessness.

In addition, five sites indicated that the primary reason that families disengagement was due to the successful completion of the home visiting program (graduation) with a total of 1,222 women who completed home visiting programs.

Figure 8: Reasons for Disengagement from Home Visiting Service



Demographics of Women Served

In FY 2019, 4,357 women were served by the 66 sites throughout Maryland, which represents a 5% decrease in women served when compared with FY 2017 (4,602 women served by 58 sites). The demographics of the women served in FY 2019 were similar to the findings in FY 2017. Women served were predominantly 20-29 years old (44.8%), compared to 48% in FY 2017; and Black, not of Hispanic, Latino, or Spanish (HLS) origin (43%), compared to 48% in FY 2017. In total, during FY 2019, the service population for Maryland home visiting programs was 57% minority races/ethnicities, a decrease from the 70% minority service representation in FY 2017. Twenty-one percent of women served were White, not of HLS origin, 16% were White and of HLS origin, and 4% were HLS of an unspecified race. Figures 9 and 10 illustrate the demographics of women served during FY 2019.

Figure 9: Maternal Age

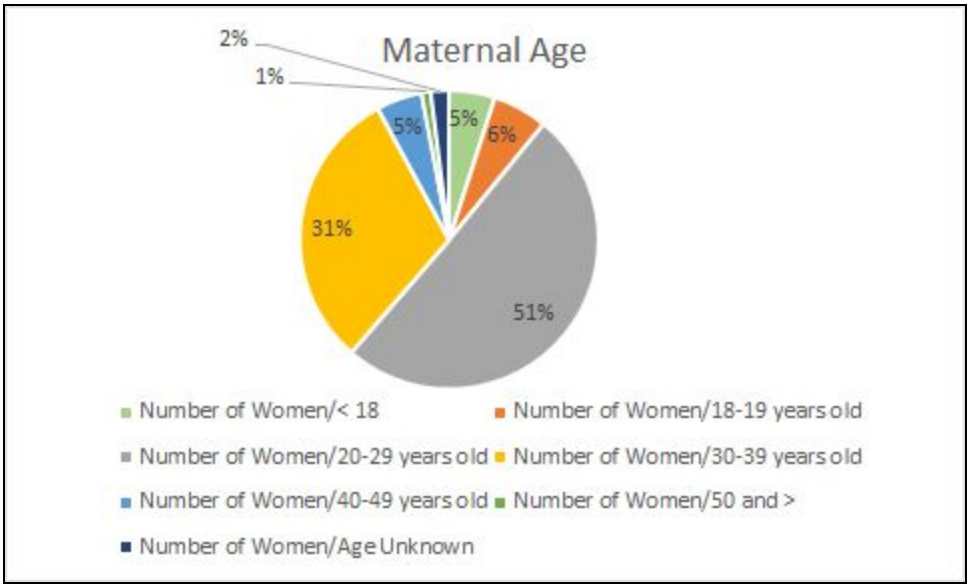
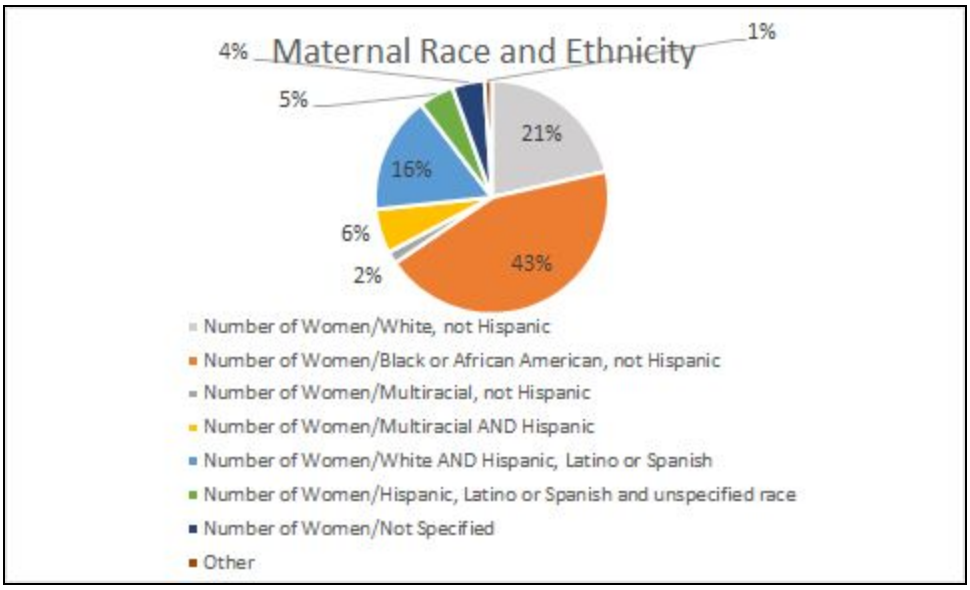


Figure 10: Maternal Race and Ethnicity



Demographics of Children Served

In FY 2019, 4,108 children were served by the 66 sites throughout Maryland, compared to 3,947 from the 58 sites in FY 2017. The majority of children served (39%) were between the ages of 13 and 35 months. The children's service population was 55% minority races/ethnicities, compared to 87% in FY 2017. Thirty-nine percent of children were Black and not of HLS origin. The next largest racial and ethnic categories of children served were White and of HLS origin

(23%), White and not of HLS origin (20%), and Multiracial and not of HLS origin (6%). Figures 11 and 12 illustrate the demographics of children served during FY 2019.

Figure 11: Child Age

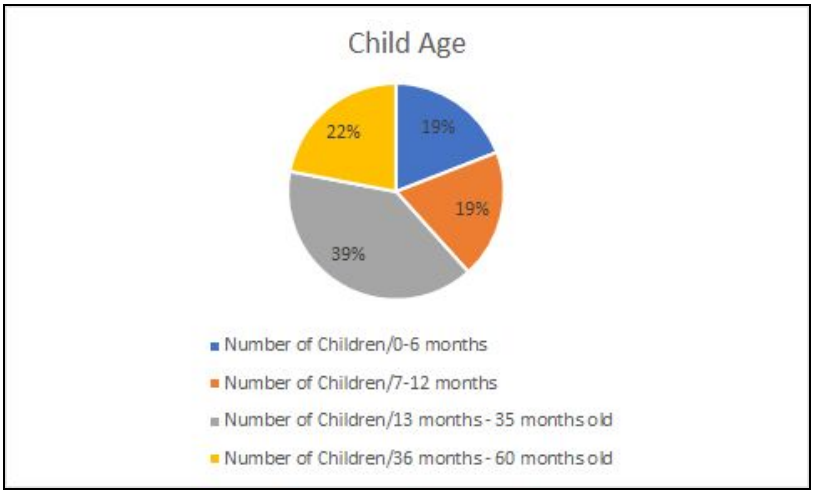
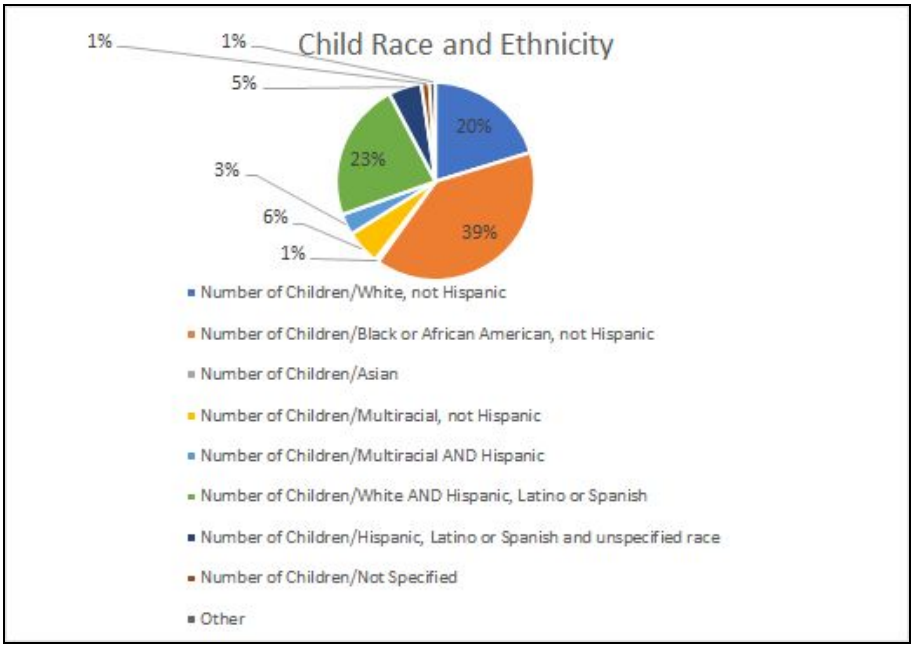


Figure 12: Child Race and Ethnicity



*Other includes: American Indian and Alaskan Native, Native Hawaiian or Pacific Islander, Black AND 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 to convene a workgroup to develop specific strategies to track and report home visiting outcomes on a statewide scale. The workgroup consisted of representatives from the State's child serving agencies, home visiting programs, and advocates. Technical assistance was provided to the Governor's Office for Children by staff from the Pew Foundation's Home Visiting Campaign, which had successfully assisted other states with similar projects.

In March 2014, the Children's Cabinet approved the measures that the workgroup identified as the standardized domains and correlating data points for all home visiting programs across the State, regardless of the program model or funding agency. Table 5 details each domain and related data measure(s).

Table 5. Maryland's Standardized Home Visiting Measures

Domain	Standardized Measures[14]
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.

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

Baseline Comparison

For this Report, FY 2017 data were used as the new baseline for data comparisons, and will be used for future reports as well.[15] Although some data were used from FY 2015 for comparison purposes, FY 2017 data were predominantly used as the baseline for this Report.

Table 6. Initiation of Services After a Positive Depression Screening			
Measure	**FY 2019**	**FY 2017**	**FY 2015**
Percent of women with a positive maternal depression screen who receive a referral for treatment	82%	73%	72%
Percent of women initiating treatment services after a positive maternal depression screen	77%	68%	61%

What the data tells us: Data from FY 2019 and FY 2017/FY 2015 indicated that sites continue to refer women to appropriate treatment resources when a positive maternal depression screen occurs, and more women initiated services from that referral. It is important to note that it is difficult to engage women that score positively as they are less likely to voluntarily engage in services, and an increase in initiating treatment/services may reflect the positive training effects of the UMBC Home Visitor Training or site specific trainings, guidance, and policies. This increase is a successful marker of the progress that programs in Maryland are making in addressing mental health needs.

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

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

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

What the data tells us: Data from FY 2019 and FY 2017/FY 2015 indicated progress in the percentage of women who showed improvement in parent-child relationships/parenting behavior from baseline to follow-up. Improvements could be related to an increased emphasis on the use of evidence-based parenting curricula in programs and/or an increase in the use of validated screening tools. Research demonstrates that positive parenting behavior and bonding is essential for a healthy relationship and increases a child's ability to attach and adapt.

Opportunity for improvement: In FY 2015, 12 of the 46 sites (26%) reported only 79 improvements in parent-child interactions out of 536 assessments (14.7%), which greatly suppressed the percent of overall improvement. In FY 2017, 11 of those 12 sites (one did not submit a survey) reported 193 improvements in parent-child interactions out of 355 assessments (54%), which dramatically improved the overall percentage of screenings that displayed improvements in parent-child interactions. Given this continued increase, and the improvements in parent-child interactions in FY 2019 (75%), it appears that the programs are maintaining their positive screenings, and making small strides forward. Additional questions on the survey that provide context to the data will allow for conclusions to be drawn and provide a clearer sense as to the impact of home visiting on the well-being of both caregivers and children.

Table 8. Safety Plan After a Positive Intimate Partner Violence Screen

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

What the data tells us: Data from FY 2019 indicated further improvements in addressing positive intimate partner violence screening by implementing safety plans. Intimate partner violence is a sensitive and challenging issue that many home visiting programs struggle to address. Since FY 2015, there have been efforts to more adequately train home visitors to address intimate partner violence. Training in Mental Health First Aid, the use of annual Futures Without Violence curriculum trainings, as well as the Training Certificate Program[16] are examples of such efforts.

Opportunity for improvement: Continuing to provide training opportunities for home visitors as well as provide supervisor support to home visitors to address these very difficult and sensitive issues can make a marked improvement in the ability to be comfortable in difficult conversations. Other stakeholders including the local Departments of Social Services and school systems can assist in training home visitors to meet the needs of vulnerable families by developing safety plans. Additional questions on the survey that provide context to the data

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

will allow for further understanding as to what is happening that may impact the safety plan development.

Domain 1: Child Health—Well-Child Visits

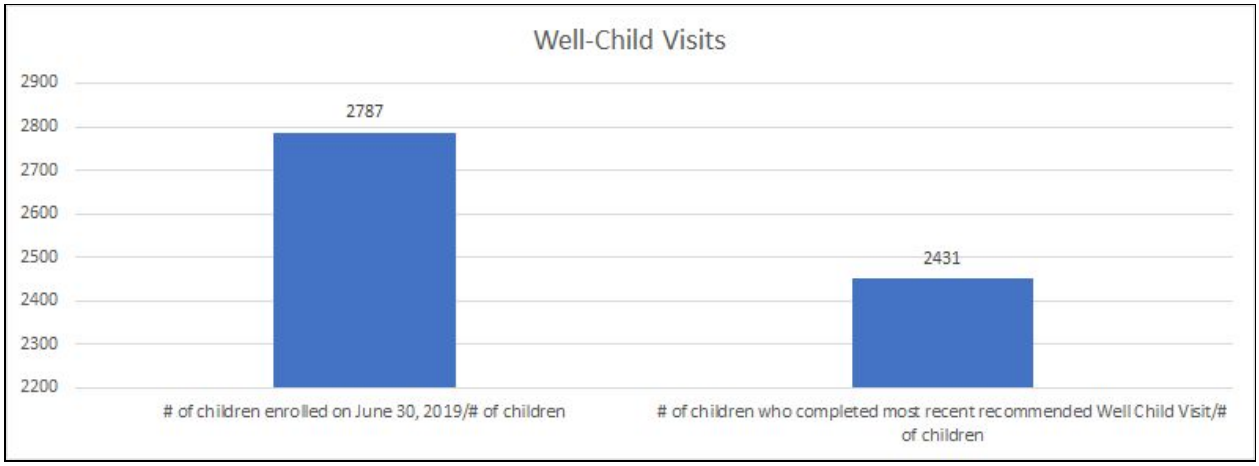
Well-child visits include a thorough physical and evaluation of the child's progress toward developmental milestones. These visits provide opportunities for health education and communication between the parents and the primary care provider. Attending regular well-child visits allows parents to address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

Sixty of the 66 sites that reported, indicated that they collect well-child visit information from parents. At the end of FY 2019, 2,787 children were enrolled in the 66 sites. Of those 2,787 children, 2,431 (87%) completed the most recent well-child visit recommended by the American Academy of Pediatrics *Bright Future™* schedule,[18] demonstrating that they are up-to-date on age-appropriate immunizations, education, and developmental assessments from a healthcare provider (see Figure 13).

Target population:	All children enrolled in home visiting as of June 30, 2019.
Measure:	Percent of enrolled children who completed the most recently recommended well-child visit per the American Academy of Pediatrics schedule.
Calculation:	# of enrolled children who completed last recommended well-child visit Total # of enrolled children

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

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



Domain 2: Maternal Mental Health—Depression

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

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

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

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

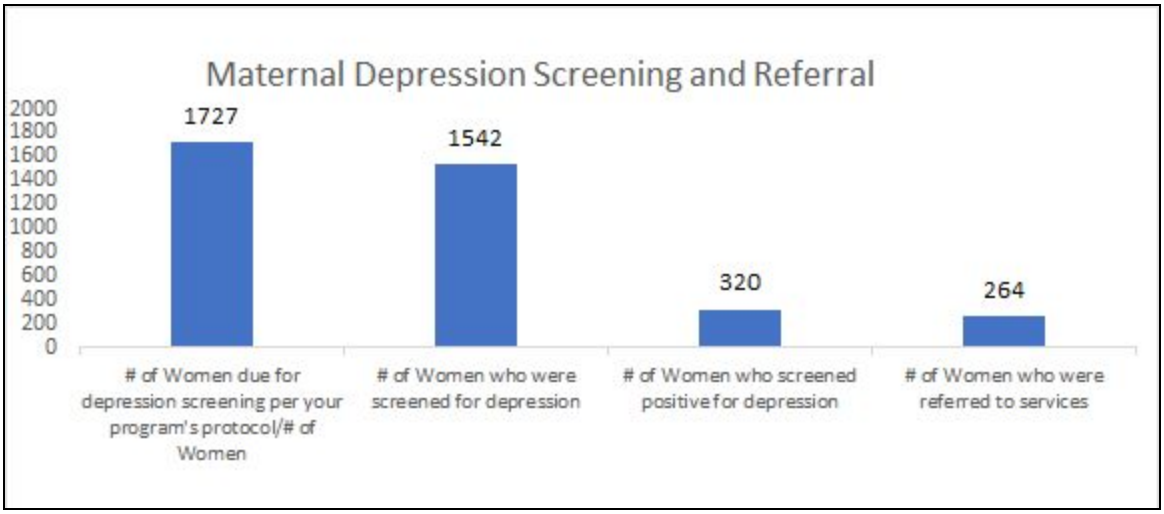
Forty-five of the 66 sites conducted depression screenings of enrolled women. In FY 2019, 1,727 women were due for a depression screening per the home visiting program's screening protocols. Of the 1,727 women due for a screening, 1,542 (89%) received a depression screening. Of those 1,542 women screened, 320 (21%) screened positive for depressive symptomatology warranting further assessment from a healthcare provider. Of the women who screened positive for depression, 264 (83%) were referred for further assessment and treatment, with 77% of those women initiating or continuing mental health treatment (see Figure 14). The survey does not currently collect data on reasons why a woman was or was not referred, but is a suggestion for further data collection efforts.

Programs use a variety of validated tools to screen for maternal depression. On average, home visiting programs screen women four times for depression during the course of services. A full

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

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

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



Domain 2: Maternal Mental Health—Substance Use

Many substances, including cigarettes, alcohol, opiates, cocaine, and methamphetamine cross the placenta and impact the developing fetus.[20] Use of these substances during pregnancy is associated with maternal, fetal, and infant morbidity and mortality.[21]

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

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

Calculation: # of women screened for substance use
Total # of women eligible for screening per program's protocol

Only 42% (28) of the 66 sites reporting data conduct routine substance use screenings for enrolled women. In FY 2019, 1,515 women were due for a substance use screening per the home visiting programs' screening protocols. Of those 1,515 women, 1,337 (88%) of enrolled women were screened for substance use. Of the 1,337 women screened, 158 (11%) screened positive for substance use warranting further assessment and evaluation. Of the 158 women screening positive, 76 (48%) were referred for treatment services. Thirty women either initiated or continued treatment for substance use. As with maternal depression, the survey does not

[20] Behnke, M., Smith, V. C., Levy, S., Ammerman, S. D., Gonzalez, P. K., Ryan, S. A., ... & Watterberg, K. L. (2013). Prenatal substance abuse: short-and long-term effects on the exposed fetus. *Pediatrics*, *131*(3), e1009-e1024.
[21] The American College of Obstetricians and Gynecologists. (2017). Committee Opinion: Smoking Cessation During Pregnancy: Interim Update.

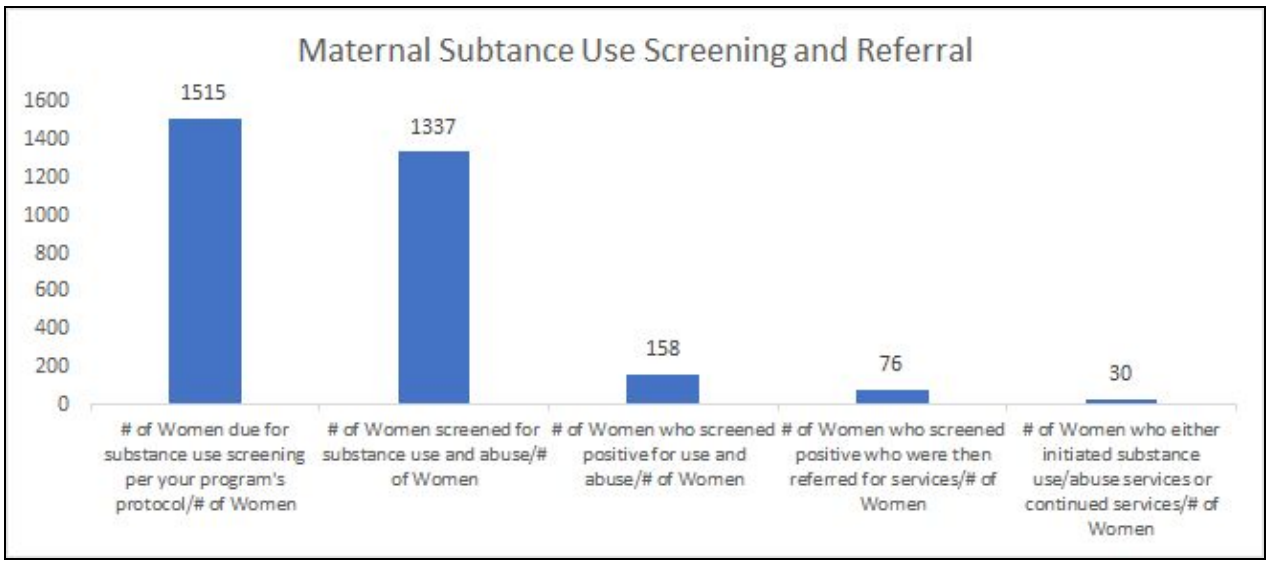
currently collect data on reasons why a woman was or was not referred, but is a suggestion for further data collection efforts.

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

The majority of substance use data from FY 2019 shows decreases from FY 2017: sites reported conducting screenings (42% down from 50%); percentage of women screened (88% down from 92%); percentage referred to treatment after a positive screen (48% down from 68%); and the number of women initiating/continuing treatment (30% down from 62%). Only the percentage of positive screens increased from 6% to 11%. Screenings and the associated decreases may be for a number of reasons, to include: problems with sites' program models providing a tool that does not screen well for their clients; issues administering the screening tools; confounding data due to the additional sites that have reported in FY 2019; clients fearful of disclosing substance use; and the potential consequences for their family (i.e., child welfare involvement). Interestingly, the percentage of positive screenings increased by 5%, which may indicate an increased burden of substance use in the home visiting population.

To address the issue of sites having difficulties with the screening tools they are provided, and programs not screening for substance use, the MIECHV team elicited feedback from its participant sites. As a result of this collaboration, MIECHV now requires all participating sites to use a validated substance use screening tool in their program. Ideally this will begin to assist sites in gathering more robust data on maternal substance use.

Figure 15: 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.[22]

Target population: All enrolled mothers.

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

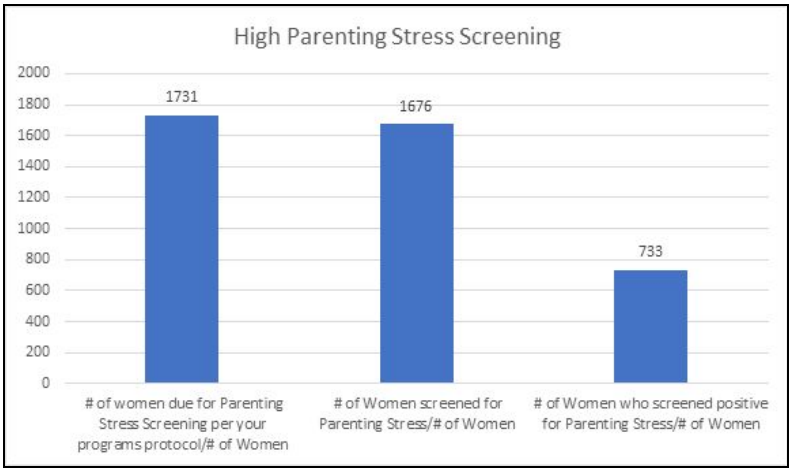
Calculation: $\frac{\text{\# of women who presented with clinically high parenting stress}}{\text{Total \# of women eligible for the screening per the program's protocols}}$

Thirty of the 66 sites reported that they screen enrolled women for high parenting stress. In FY 2019, 1,731 women were eligible for high parenting stress screening per the home visiting programs' screening protocols. Of those 1,731 women, 1,676 (97%) were screened of which 773 (46%) were positive for high parenting stress (see Figure 16).

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

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

Figure 16: Number of Women Screened for High Parenting Stress



Domain 3: Typical Child Development—Developmental Screenings

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

Target population: Enrolled children.

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

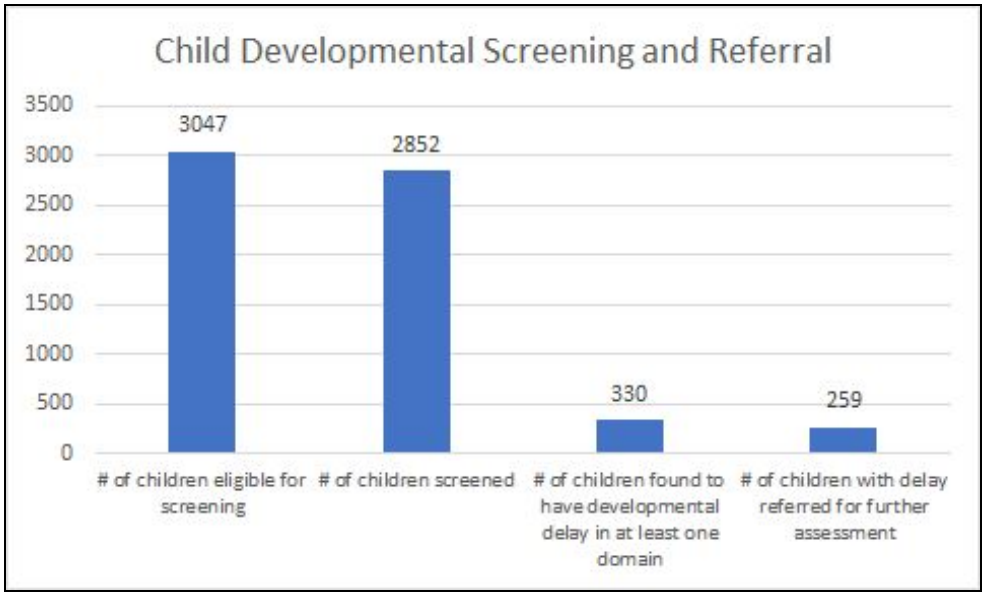
Calculation: $\frac{\text{\# of children screened for typical development}}{\text{Total \# of children}}$

Sixty-three of the 66 sites reported that they screen children for typical development using a developmental screening tool. In FY 2019, 2,852 children out of 3,047 (94%) were screened per the home visiting programs' protocols. Of the 2,852 children screened, 330 (12%) were suspected of having a developmental delay in at least one domain. Two hundred fifty-nine children (78%) were referred for further assessment and evaluation.

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

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

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



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

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

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

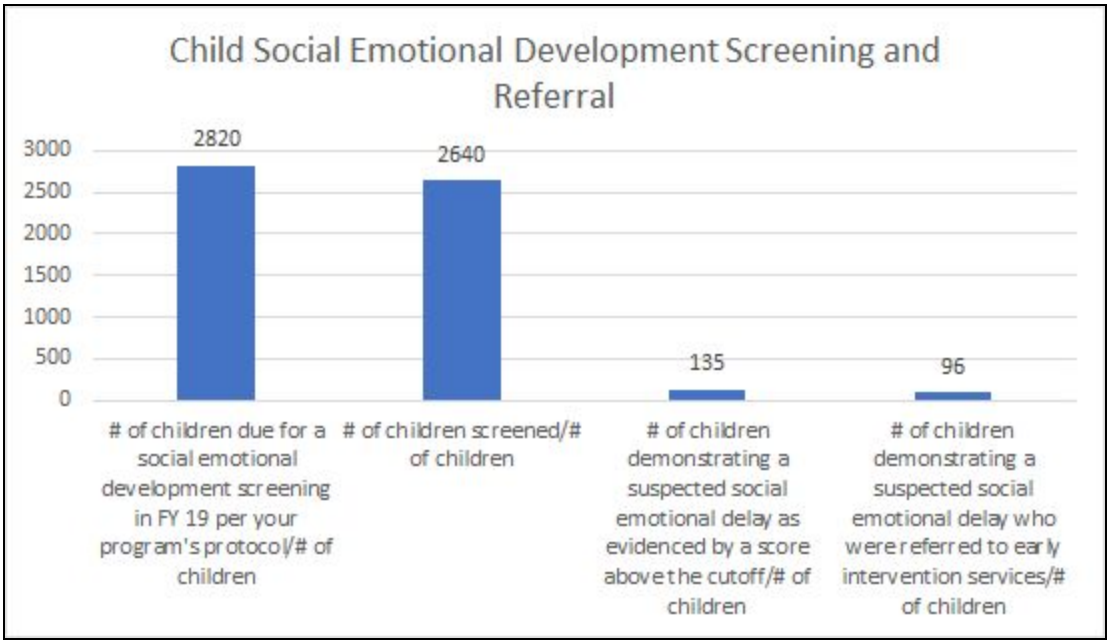
Calculation: # of children screened for social emotional development / Total # of children eligible for screening

Sixy-two of the 66 sites reported that they screen children for social emotional development. In FY 2019, 2,640 children (94%) out of 2,820 eligible children received a screening for social emotional development. This represents a 16% increase from data collected in FY 2017. Of the 2,640 children screened, 135 (5%) were suspected of having a social emotional developmental delay of which 96 (71%) were referred for further assessment and evaluation.

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

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

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



Domain 4: Children's Special Needs

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

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.

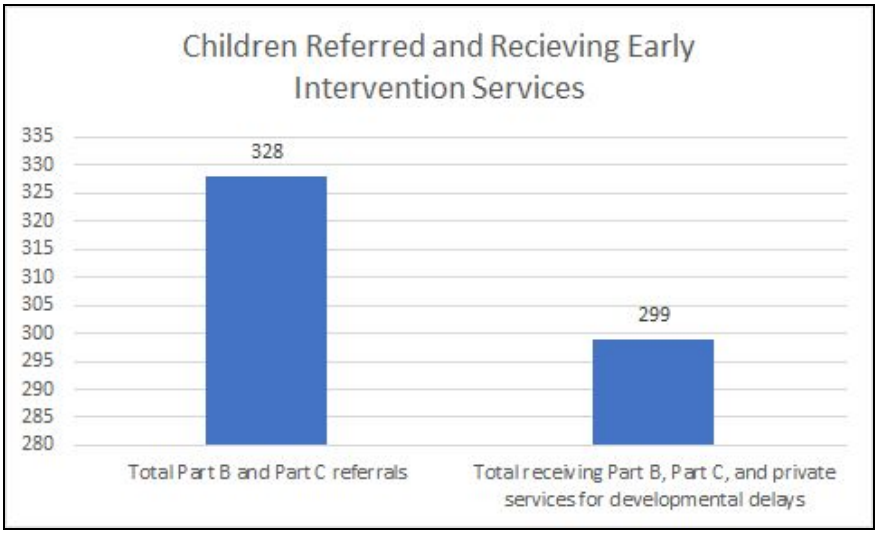
Calculation: $\frac{\text{\# of children receiving IDEA Part C and/or Part B services}}{\text{\# of enrolled children referred to IDEA Part C and/or Part B services}}$

During FY 2019, 328 children were referred to Part B or Part C early intervention services. Of those 328 children, 262 (79%) received early intervention services, an increase from FY 2017 (65%). Another 37 children received private early intervention services not associated with

[25] Maryland Learning Links. (no date). Accessed 06.11.15 from https://marylandlearninglinks.org/
[26] 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/

IDEA. Those children that received services for developmental delays (299) represented only 7% of all children served by home visiting programs in FY 2019, though that figure is up 2% from FY 2017 (see Figure 19).

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



Domain 5: Family Relationships—Parent-Child

Early parent-child relationships have enduring impacts on childhood growth and development. This first relationship can positively or negatively influence a child's emotional well-being, coping skills, problem solving skills, and the capacity for building healthy relationships in the future.[27,28] Evidence-based home visiting programs can support parents in developing trusting, positive, and reliable relationships with their children.

Target population: Enrolled mothers.

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

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

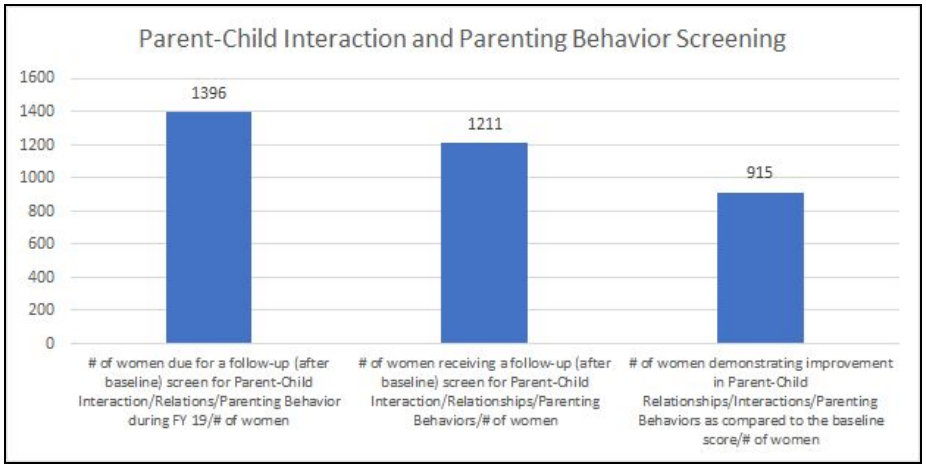
Forty-nine of the 66 sites reported that they conduct screenings related to parent-child relationships/parenting behaviors. In FY 2019, 1,211 enrolled women received a follow-up

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

screening on parent-child relationships/parenting behavior. Of those 1,211 women with both a baseline and a follow-up screening, 915 (75%) showed improvements in positive parent-child relationships/parenting behaviors which represents an increase of 3% from FY 2017 (see Figure 20).

Programs use a variety of tools to screen women for parent-child relationships/parenting behaviors. On average, the 49 home visiting programs that regularly screened women for parent-child relationships/parenting behaviors conducted this screening five times during the course of services. A full list of tools used to screen for parent-child relationships/parenting behavior can be found in Appendix H.

Figure 20: Parent-Child Relationship/Parenting Behavior Improvement



Domain 5: Family Relationships—Intimate Partner Violence

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

Target population: Enrolled women.

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

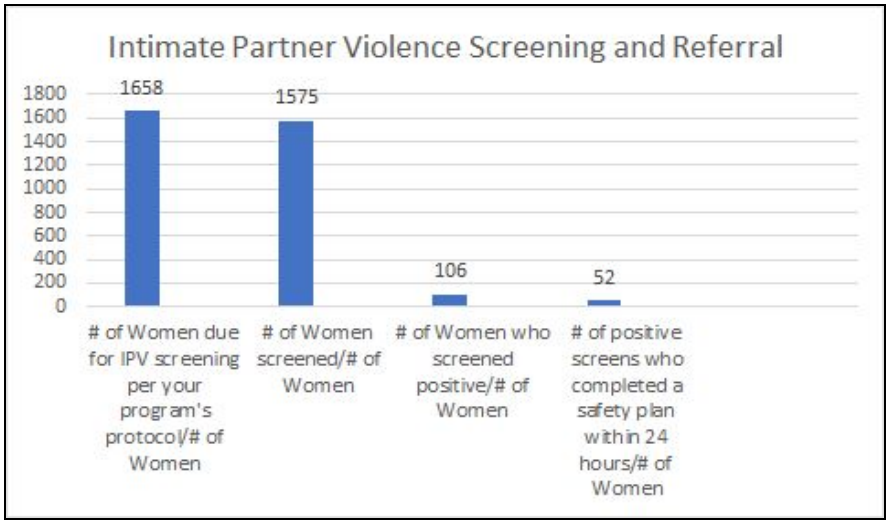
Measures: Percent of women who were screened for IPV; percent of women who screened positive; and percent of positive screens who completed safety plans within 24 hours of the screening.

Calculation: # of women screened for IPV
Total # of women eligible for screening per the program's protocol

Thirty-four out of the 66 sites reported that they screened women for IPV. In FY 2019, 1,658 women were eligible for a screening per the home visiting programs' protocols. Of those 1,658 women, 1,575 (95%) were screened of which 106 (7%) screened positive. Fifty-two women (49%) completed a safety plan within 24 hours of the screening (see Figure 21), which represents an increase of 5% from FY 2017.

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

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



Reporting on Children's Cabinet Priorities

In addition to the standardized reporting measures approved by the Children's Cabinet, the FY 2019 data collection survey also included questions specific to the Children's Cabinet's family economic self-sufficiency priorities. As a result, additional data were collected on the following:

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

All data relate to women/families enrolled in home visiting services as of June 30, 2019.

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.[31] 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 well-being, and more likely to be disengaged from their communities.

Target population: Enrolled women under the age of 24.

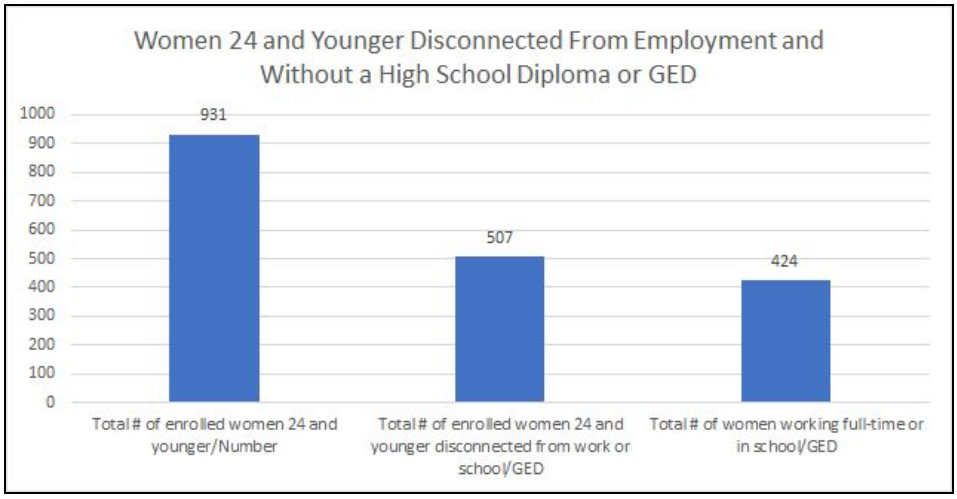
Measures: Percent of women under the age of 24 who are neither working full-time nor in school.

Calculation: # of enrolled women < age 24 who neither work full-time nor are in school
Total # of enrolled women under age 24 as of June 30, 2019

Forty-four of the 66 sites reported that they track this type of data on women under the age of 24. The 44 sites reported a total of 931 enrolled women under the age of 24 as of June 30, 2019, a decrease from 1,235 in FY 2017. Of those 931 women, 507 (54%) were disconnected from work and school opportunities in FY 2019, an increase of 2% from FY 2017 (see Figure 22).

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

Figure 22: Number of Women Not Working or in School



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

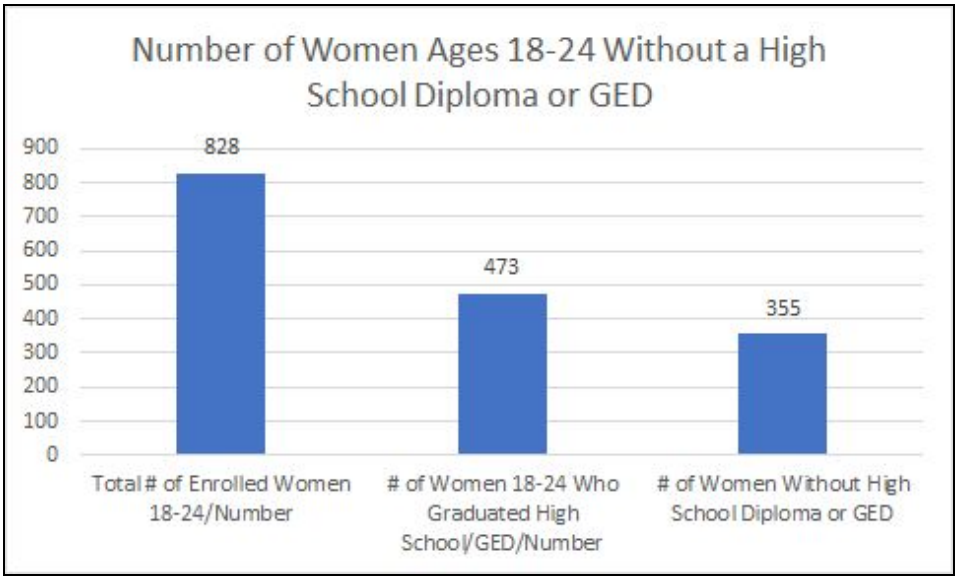
Target population: Enrolled women age 18-24.

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

Calculation: $\frac{\text{\# of enrolled women 18-24 who have not graduated or obtained a GED}}{\text{Total \# of enrolled women 18-24 as of June 30, 2019}}$

Forty-four of the 66 sites reported that they track this type of data on enrolled women age 18-24. The 44 sites reported a total of 828 enrolled women age 18-24 as of June 30, 2019. Of those 828 women, 355 (42%) had not graduated or obtained a GED which represents an increase (4%) in those who graduated or obtained a GED (see Figure 23).

Figure 23: Number of Women without High School Diploma or GED



Priority 3: Families Impacted by Incarceration

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

Target population: Enrolled families.

Measures: Percent of enrolled families impacted by incarceration.

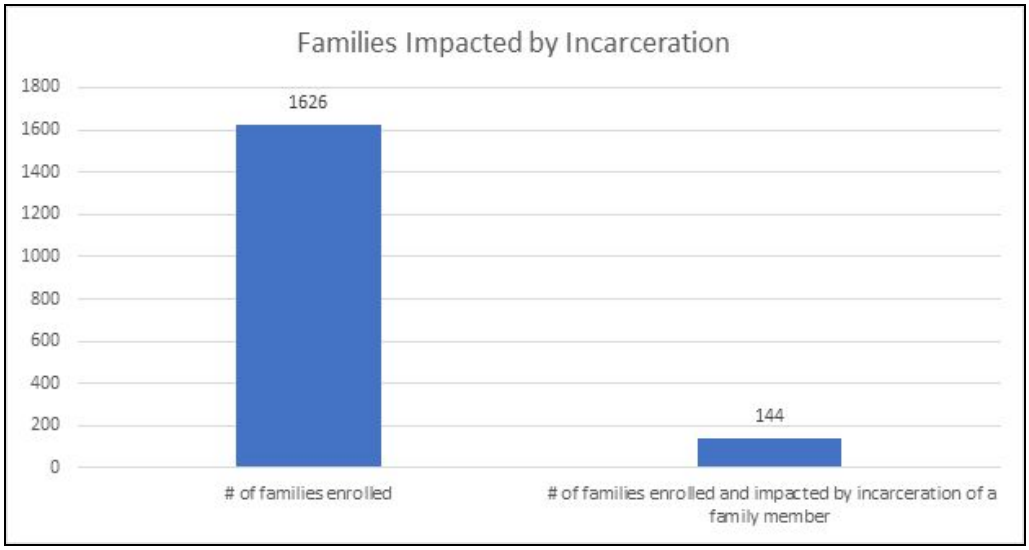
Calculation: $\frac{\text{\# of enrolled families impacted by incarceration}}{\text{Total \# of enrolled families as of June 30, 2019}}$

Twenty-seven of the 66 sites reported that they track this type of data on enrolled families which represents a decrease from the 33 sites that reported this information in FY 2017. The 27 sites reported a total of 1,447 families enrolled in home visiting services as of June 30, 2019, which represents a decrease from 2,025 in FY 2017. Of those 1,447 families, 130 (9%) were impacted by the incarceration of a family member (see Figure 24). This is a noticeable drop as there were 338 families (17%) in FY 2017 who were impacted by the incarceration of a family member. The reductions in those affected by incarceration in the FY 2019 survey data may be due to the fewer number of responding sites who track these data -- which would represent fewer families enrolled and even fewer families impacted by incarceration. Maryland has also made progress on reducing its prison population down to 18,509 inmates as of November 2019 [32] - and has taken steps towards reducing the probability that an individual may be jailed

[32] Maryland Department of Public Safety and Correctional Services, FY 2020 Monthly Reporting, Total Average Daily Population, November 2019

through programs like Safe Streets, Law Enforcement Assisted Diversion (LEAD), and others that may have contributed to this reduction.

Figure 24: Number of Families Impacted by Incarceration



Progress to Date: FY 2017 Recommendations

In the table below are the recommendations made in FY 2017 and the progress to date.

Recommendations from FY 2017 Data on Standardized Home Visiting Measures	Progress on FY 2017 Recommendations
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 MIECHV program has invested significant time and monetary resources into developing a management information system to assist its grantees (16 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.	Maryland MIECHV transitioned to the new data system, Maxwell, in October 2018. This affected all data including data collection and infrastructure. In previous years the 16 Maryland MIECHV local implementing agencies (LIAs) had different means of data storage and collection. Variations existed between forms used to collect data, and systems like ETO, PIMS and Insight were used to store the data. Each year when the annual report was due, extracting, cleaning and analyzing the data from each unique collection system was a taxing endeavor averaging an approximate 80 plus working hours. Maxwell is intuitive and improves programmatic oversight at all levels. Prompts keep home visitors on schedule for their families, so the days of hand tracking curriculum and timelines are a thing of the past. Validated tools automatically calculate when assessments are completed. Missing data can be monitored more effectively and granular analysis can uncover which construct questions are missing for a particular family. Prior to Maxwell, data managers could only see if entire assessments were missing not a specific construct question. Going forward, the annual MIECHV data report will be computed in far less time due to built-in reports to pull the information for federal reporting. To date, 34 reports have been built for data quality, missing forms, and reporting and accreditation needs of funders.
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	The UMBC Home Visitor Training Certificate is the most potent tool provided to home visiting staff in order to address adverse conditions and experiences of the mothers and families they work with. The training certificate program continues to see increasing numbers of home visiting staff participants from jurisdictions

to provide a supportive, responsive, and positive environment for children to grow. Women enrolled in home visiting programs may have experienced significant trauma during their own early childhood years that is now impairing their parenting capacity. Prior trauma may be a contributing factor to current mental health problems, substance use, and intimate partner violence. 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 UMBC's Home Visitor 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.	around the State. In addition, the staff who participate in the training report feeling more confident in their skills and abilities to broach tough subjects with families across the board -- mental health and substance use in particular. Complementary to the Home Visiting Training Certificate, MDH, in partnership with UMBC, developed a two-day SEN training program for home visitors, supervisors, and other community health professionals to equip them with the tools and education related to substance abuse for women, both pregnant and postpartum. The training and pilot were funded by MDH; and the rollout of the training to professionals will be conducted by the Department of Human Services. Workforce training included home visitors, community health workers, and infants and toddlers staff, all of whom work with families in the home. This cross-disciplinary training was the first of its kind in Maryland and was well-received. Six regional SEN trainings were implemented in 2019 with a total of 247 trainees that completed both the prerequisite online training modules and the one-day in-person training.
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.	Data continued to be collected in FY 2019 from sites with regard to staff turnover and the primary reasons for staff exiting positions. Staff turnover increased by 1.5% which accounts for 27% of the total home visiting workforce. Half of those home visitors who exited programs indicated that the lack of increased compensation or benefits was the primary reason for leaving. The data remain fairly consistent with FY 2017 data. Considering the reported data, the retention of home visiting staff remains a concern. The HVC will meet and research methods and strategies to retain staff.
Revised Data Collection Processes The Children's Cabinet should consider revised data collection mechanisms to ensure all programs, regardless of funding source, 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 its impact these programs have on Maryland's most vulnerable families. One solution after working with State partners at MSDE is to add the required data survey into all conditions of award so that	Data collection continues to improve. In FY 2019, eight additional programs reported data for a total of 70 out of 76 programs. For this reporting period, the time in which programs had to respond was extended due to low initial return rates. This extra time was beneficial as more programs were responsive, and MIECHV staff had more time to conduct outreach. Going forward, in order to ensure a greater response rate, MSDE has agreed to include required reporting of data for this report in its contracts, as recommended in the FY 2017 report.

continued funding is tied to accurate completion of this survey.	

Recommendations from FY 2019 Data on Standardized Home Visiting Measures

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

Of the 44 sites that reported on educational and employment attainment, 54% of the women enrolled in their programs were disconnected from employment and school opportunities -- a 2% increase from FY 2017. Of those 828 women age 18-24, 57% had graduated or obtained a GED. Although this represents an increase from FY 2017, many young women served by home visiting programs do not have a high school diploma. Research has well established that poverty and limited maternal educational attainment have negative effects on childhood outcomes including behavior, IQ, allostatic load, and physical health. Childhood, birth outcomes, in addition to maternal health indicators are also known to be affected by maternal unemployment.

Additionally, limited educational attainment which includes increased probability of low birth weight, decreased gestational age weight, poorer maternal health, low-income, social disadvantage, and higher rates of maternal mortality. Adverse outcomes, using preterm birth as an example, is a particularly salient experience for Black mothers who are the majority of women served by home visiting programs in Maryland. Considering the research in conjunction with the data for Maryland, it is imperative that employment/income and education opportunities and services are accessible to young mothers.

Next Steps

- Meet with representatives from GOC, MDH, MSDE, Department of Labor, home visiting programs, families, and community stakeholders (i.e., universities, workforce development programs, local businesses and municipal governments) to identify barriers to education and employment for the young mothers that home visiting programs serve, and determine how the partnership can effectively increase opportunities for education and employment.
- With the information gathered from that meeting, develop a draft plan outlining possible steps to be taken from the identification of employment or educational need to becoming either enrolled in a GED program, in school, employed, or a mix, and what the role that each partner may play in linking home visiting participants to the continuum of existing services.

- Present the plan to stakeholders for feedback, then present a final plan to the Children's Cabinet for support to implement the strategies.

Recommendation 2: Taking Action on Home Visitor Retention

In FY 2019, similar to FY 2017, the primary cause (54.5%) of home visitor turnover was finding employment elsewhere with either higher pay or benefits. For FY 2019, a little over a quarter of all home visiting staff exited their positions primarily for that reason, in addition to burnout, feeling unfit for the position, personal circumstances such as health complications or moves, retirements, and terminations. Turnover has effects on families as well by negatively affecting rates of retention and contributing to continued familial issues. While staff turnover and retention, particularly in human/social services, can be a complex and ecological phenomena that encompass a wide array of causes/strategies, for this specific labor market, as illustrated by recent data collection, increasing pay for home visiting staff should be considered.

To this end, it is important to note that there is work being done between MIECHV and its funded sites to introduce non-monetary strategies to increase retention. These strategies include reviewing retention and recruitment information from HRSA and conducting an upcoming webinar for sites so that they can receive the information in an efficient manner and implement the strategies provided as they see fit, and developing and introducing the SEN training so home visitors feel more secure addressing issues arising from substance use. As mentioned previously, the two-day SEN training developed by UMBC in conjunction with MIECHV has reached a total of 247 staff across the State, including not only home visitors but community health workers, supervisors, and other staff who work with infants and toddlers. This training has provided more tools and education that staff can keep in their toolbelt to address substance use with mothers and families that are both prenatal and postpartum (https://homevisitingtraining.umbc.edu/curriculum/substance-exposed-newborns).

Programs with vacancies must assign an increased workload to limited staff which increases caseloads of remaining staff and restricts recruiting and retention efforts. With higher work demands concentrated over long periods of time, the probability of turnover increases and the cycle continues. Absent meaningful intervention in areas identified by home visitors that contribute to turnover, in this case, compensation and benefits, there will likely be very little change in retention or turnover rates with home visiting staff.

Next Steps

- Conduct research on comparable pay for home visitors and similar positions across the United States to determine where Maryland pay rates rank among other states and similar positions.

Recommendation 3: Investigate Feasibility of Statewide Centralized Data System

The Maxwell system, while continuing to be increasingly useful for MIECHV and the sites MIECHV funds, has a number of limitations. Maxwell is currently limited to MIECHV-funded sites implementing the Healthy Families America (HFA) evidence-based curriculum, which has resulted in Maxwell being curated specifically to meet the needs of HFA only. Out of the 70 programs reporting in FY 2019, 25 (36%) were HFA programs. There are only 14 MIECHV HFA sites that currently utilize Maxwell to its full capabilities. This means that only 21% of home visiting sites Statewide have access to a centralized data system.

The possibility remains that Maxwell is utilized by all Maryland home visiting programs and could be curated to serve not only HFA programs, but Parents as Teachers curriculum, HIPPY programs, Early Head Start, Family Spirit, and other evidence-based and promising-practice home visiting models. This would require mapping out and coding their standards into the current system. This process could be facilitated with relative ease as Maxwell developers have ongoing CQI and implementation-feedback with MIECHV and provider sites. Centralization provides an opportunity for increased efficiency, transparency, and data accountability and could aid in data collection efforts for future reports and research**.** Establishing a centralized data system also allows for data to be shared across sectors and programs to highlight best practices, uncover the strengths and weaknesses of the Maryland home visiting system and increase collaboration between institutional entities. A centralized data system further lends itself to the alignment of family health indicators among all home visiting programs.

Next Steps

- Create a feasibility investigation team to conduct a feasibility study to include State funding agencies (MIECHV, MSDE, Children's Cabinet), and implementing home visiting agencies.
    - The investigation team will conduct research on potential costs required to develop and implement Maxwell as a Statewide data system using existing funding resources, the infrastructure required to facilitate implementation on both the State and local level, the unique needs of each program, and how the different data collection and reporting requirements would need to be represented in such a system.

- The team will present findings to state and implementing agencies for further review and development.

Recommendation 4: Inclusion of Family-Centered Qualitative Data

This Report captures crucial data on home visiting programs and the individuals served throughout Maryland. Although the data encompass a large swatch of important public health-related indicators and display "how" home visiting is working, the "why" behind the data is missing.

This hole in the data could be filled with a mixed-methods approach, adding a supplemental qualitative survey accompanying the Report survey for sites to report on the conditions and barriers that families, staff, and programs face in order to further contextualize the quantitative data reported, and deliver a holistic representation of the home visiting landscape of Maryland. Additionally, any nuanced differences among jurisdictional needs or operations can be missed without clarifying information. Utilizing open-ended questions, there remains the possibility of a site reporting something important to front-line processes or operations that is outside of the scope of this Report. Adding context to data is crucial to developing a deep understanding what the data represent. The more that can be gathered, the better understanding one can have of the home visiting landscape of Maryland.

Next Steps

- Together with home visiting funders, sites and those they serve, develop a brief qualitative survey containing three to five open-ended questions that can adequately capture important contextual information to further inform the Report survey data.
- After a draft is complete, pilot the survey with 22 sites (one-third of reporting sites in FY 2019). Responses will be considered in the context of the Report Survey data these programs had reported on previously to gauge whether the information provided on the qualitative survey can successfully contextualize its data.
- If successful, send the qualitative survey with the quantitative Report Survey to home visiting sites in 2021 to be filled out voluntarily.

Recommendation 5: Encourage Screenings for Parent Well-being

The insignificant decrease in the number of sites that are conducting screenings for parental well being from FY 2017 represent an opportunity to improve service to families. Without information on the physical and mental health of caretakers, practitioners will not know what are caretaker needs and meaningful intervention will remain elusive. 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.

- Partnering with the largest State agencies that support home visiting, develop a series of webinars on screening tools and referral sources for programs. Since the resources are often free or very low cost, this information sharing should increase awareness as well as use to support families served.

Conclusion

The data in this summary Report on Maryland Home Visiting Standardized Measures provide a trend line from which Maryland can assess home visiting's effect on the well-being of families served. In FY 2019, 4,357 women and 4,108 children were served through one of seven evidence-based home visiting models and four promising practices. The data reveal that Maryland home visiting has continued to positively affect families and children. Of those sites that complete child and social emotional developmental screenings, 94 percent of children have been screened for typical development, and 94 percent have been screened for social emotional development, representing a significant increase from FY 2017. Seventy-one percent of children were screened for Part B and Part C services, an increase from 65% in FY 2017, and of those screened 79% received early intervention services. On the other end, children having attended their most recent child well visit decreased from 94% to 87%. In addition, 71% of children with positive screenings for social emotional needs are referred, which is a decrease from 89% in FY 2017. This is likely due to a number of the children screening positive for social emotional needs already receiving early intervention so no referral was needed, a number of families not providing consent to referral, or not having early intervention services available to refer to.

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. 66 percent of reporting sites screen for maternal depression, only 51 percent screen for intimate partner violence and 49 percent completed a safety plan within 24 hours; only 42 percent screen for substance use; and only 45 percent screen for parenting stress. Each of these indicators is decreased from FY 2017, with the exception of completing a safety plan within 24 hours after a positive IPV screen, which was an increase of 5%. The decrease is likely due to statistical conditions as more sites are reporting data in FY 2019 and the raw number of sites reporting that they conduct screenings are relatively the same (There are 3 fewer sites reporting conducting maternal depression screens, 1 fewer conducting substance use screenings, and 2 additional sites conduction parenting stress screens). This however is also concerning as one would expect to see more sites conducting screenings related to caretaker wellbeing with an increased response rate. Further, although there was a 5% increase in completing a safety plan with a mother

within 24 hours after a positive IPV screening, the overall completion rate is still low at 49%. This means that 51% of mothers who screened positive for experiencing IPV were not assisted with a plan and remain in volatile situations with no guidance on how to proceed when they need assistance the most.

At the beginning of FY 2020, Maryland had a carceral population of 70,555. Those under carceral supervision include not only those in prison or jailed, but those actively under probationary supervision, parole, and involuntarily committed to an institution.[33] In FY 2019, the average length of stay for Maryland's 18,614 sentenced inmates was 2.49 years, or 29.86 months. Maryland's length of stay has increased over time, similar to other justice reinvestment states, as reforms lowered the number of nonviolent short sentences served in the state prison system, increasing the overall ratio of violent to nonviolent inmates.[34] In addition, approximately 90,000 children in Maryland have a family member involved in some form of carceral supervision on a given day. The effects of a family member being involved in the criminal justice system include family instability, adverse economic outcomes, poverty, and poorer academic outcomes for children.[35] In FY 2019, 27 out of 66 sites report screening for whether or not families are affected by incarceration - a decrease from 33 sites in FY 2017. In total 1,447 individuals were served by the 27 sites, which again represents a decrease from the 2,025 served by 33 sites in FY 2017, resulting in 578 fewer screens. One hundred and thirty screens were positive, equating to 9 percent of families screened being affected by incarceration, which is a significant decrease from 17 percent in FY 2017. There are a number of possible explanations for these results. There were 6 fewer sites in FY 2019 reporting on families affected by incarceration. It may be for this reason that fewer screenings were conducted and because fewer screenings were conducted there were less families identified as being affected by incarceration. This would mean that the indicator "9 percent of families being affected by incarceration" is artificially low and that the population of families affected by incarceration remains unidentified due to the limited application of the question among sites.

However, there are certain interventions addressing criminal justice in Maryland that could have the benefit of positively impacting families affected by incarceration. These include expansion of the Safe Streets program — a community-based and led street violence intervention program in Baltimore City, the institution of Law Enforcement Assisted Diversion (LEAD) in Baltimore City and Bel Air in Harford County, and the passage of the Justice Reinvestment Act of 2016 which has placed a greater emphasis on treatment as opposed to incarceration — diverting low level drug offenders to treatment, and eliminating mandatory minimum sentences for non-violent drug offences among other provisions[36]. A culmination of

[33] Maryland Department of Public Safety and Correctional Services, FY 2019 Annual Reporting
[34] Maryland Department of Public Safety and Correctional Services, FY 2019 Annual Reporting
[35] Governor's Office for Children. *Children and Families Affected by Incarceration*.
[36] Georgetown Law. (2017). *The Justice Reinvestment Act: An Opportunity for Change and Progress in Maryland*.

criminal justice related policy and programming on the federal, state, and local levels have resulted in continued decreases in the prison population overall. These represent marked progress in improving the carceral conditions affecting families and continued work on incarceration and criminal justice involvement will translate to positive effects on families served by home visiting programs.

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 as an integral piece of a system of care for ensuring positive maternal and child health outcomes in Maryland.

Pritzker Children's Initiative

Maryland received a prenatal-to-age-three state grant. The vision of this grant is that all expectant families and those with very young children in Maryland thrive. The mission of the workgroup is to establish, enhance and expand high-quality programs and services for all expectant families and those with young children across Maryland. The plan is to increase awareness of the critical importance of equity and early life experiences in achieving lifelong health, learning, and well-being. The goal of the Pritzker prenatal-to-three planning grant is to establish a coalition of diverse stakeholders; develop an action plan and implementation strategy to increase high-quality services to pregnant women and children from birth to three in Maryland, particularly those at or below 200% of the Federal Poverty Guideline. Maryland is also part of the National Governors Association policy Academy (funded through Pritzker) and is working to develop a prenatal-to-three system that coordinates and aligns programs; structures funding streams to avoid duplication and gaps in services; and achieves greater efficiencies.

APPENDICES

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

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

Appendix C: *Maternal Depression Screening Tools*

Appendix D: *Maternal Substance Use Screening Tools*

Appendix E: *Parenting Stress Screening Tools*

Appendix F: *Child Development Screening Tools*

Appendix G: *Social Emotional Development Screening Tools*

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

Appendix I: *Intimate Partner Violence Screening Tools*

Appendix J: *Progress to Date FY 2015 Recommendations*

Appendix A: FY 2019 Maryland Home Visiting Sites Reporting Data

Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	PAT
YMCA Cumberland	PAT
Healthy Families Allegany County, Allegany County Health Department	HFA
Anne Arundel County	
Annapolis Family Support Center (FSC)	PAT
Anne Arundel Early Head Start (FSC) (CAA)	EHS
Baltimore City	
Bon Secours	HFA
Bon Secours	EHS
Family Tree	HFA, ABC, FC, PATH
Baltimore City Health Department Early Head Start Center (FSC)	EHS
Baltimore City Health Department Maternal and Infant Care Program	NFP
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
Southeast Baltimore Early Head Start Center (SEEHS)	EHS
Waverly Early Head Start Center of Goodwill (FSC)	EHS
United Way Family Center	N/A
St. Vincent De Paul Early Head Start	EHS
Baltimore County	
Healthy Families Baltimore County, Abilities Network	HFA
Young Parent Support Center	PAT
YMCA Highland Village Head Start Center	EHS (2 sites)
Calvert County	
Calvert County Public Schools	HIPPY
Healthy Families Calvert County, Calvert County Public Schools	HFA, PAT
Caroline County	
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	
Healthy Families Charles County Center for Children	HFA
Dorchester County	
Healthy Families Dorchester, Dorchester County Health Department	HFA
Early Head Start Center, Shore Up!	EHS
Frederick County	
Family Partnership (FSC)	PAT

Healthy Families Frederick County, Mental Health Association of Frederick	HFA
Garrett County	
Garrett County Early Head Start [CAC]	EHS
Garrett County Health Department	HFA
Harford County	
Healthy Families Harford County, Harford County Health Department	HFA
Howard County	
Harford County Health Department	HFA
Healthy Families Howard County, Howard County General Hospital Wellness Center	HFA
Kent County	
Healthy Families Mid-Shore, Kent County Health Department	HFA
Montgomery County	
Discovery Station Early Head Start, Family Services, Inc.	EHS
Family Discovery Center (FSC)	PAT
Healthy Families Montgomery, Family Services, Inc.	HFA
Lourie Center	EHS
Prince Georges County	
Healthy Families Prince George's County, Child Care Resource Center	HFA
Mary's Center	HFA
Adelphi/Langley Park Family Support Center (FSC)	PAT
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
Head Start of Washington County	EHS
Washington County Family Support Center (FSC)	PAT
Wicomico County	
Healthy Families Wicomico County, Wicomico County Health Department	HFA
Worcester County	
Healthy Families Lower Shore, Eastern Shore Psychological Services	HFA
Promising Practice	
Anne Arundel County- Anne Arundel County Health Department	Healthy Start, Babies Born Healthy (PP)
Allegany County - The Family Junction	Incredible Years (PP)
Baltimore City - Roberta's House	HOPE - for mothers with an infant loss
Charles County Health Department	Maternal-Child Health Program (PP)

Appendix B: All Maryland Home Visiting Sites FY 2019

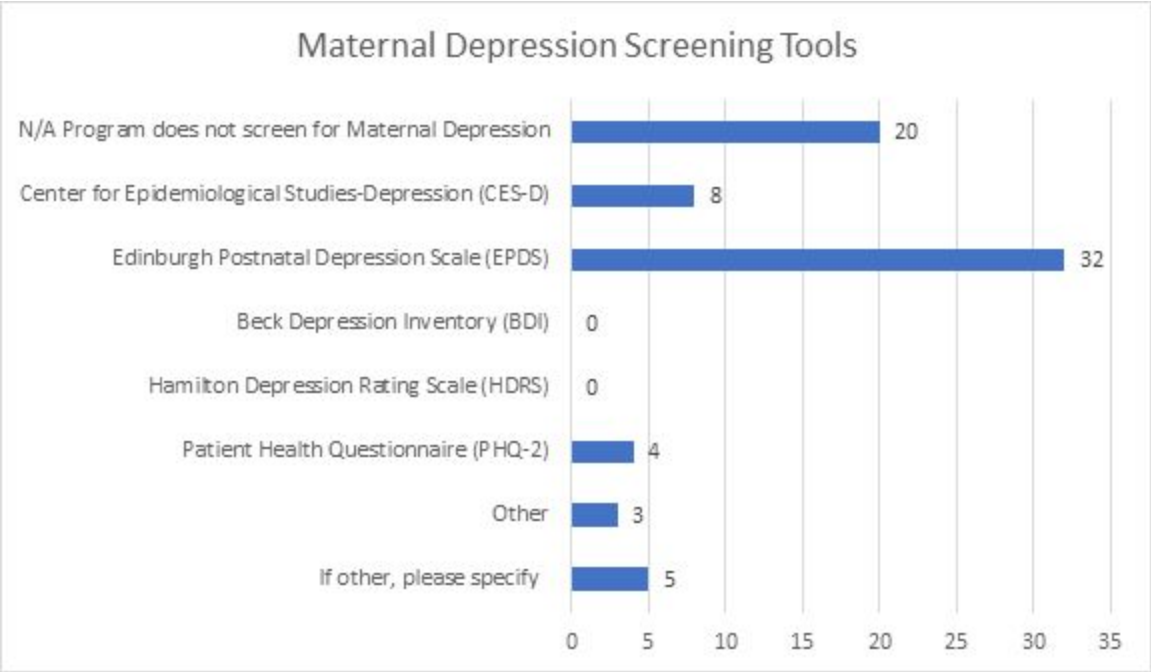
Allegany County	
Program	**Model**
Cumberland Family Support Center (FSC)	PAT
YMCA Cumberland	PAT
Healthy Families Allegany County, Allegany County Health Department	HFA
HRDC Seymore Street Head Start Center	EHS
Anne Arundel County	
Annapolis Family Support Center (FSC)	PAT
Anne Arundel Early Head Start (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	NFP
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
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, PAT
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
Healthy Families Charles County, Charles County Health Department	PP
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	HFA
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 (PP)
Allegany County - The Family Junction	Incredible Years (PP)
Baltimore City – Roberta's House	HOPE- for mothers with an infant loss (PP)
Baltimore City	Baltimore Healthy Start (PP)
Baltimore County - Baltimore County Health Department	Prenatal Enrichment Program (PP)
Charles County - Charles County Health Department	Maternal-Child Health Program (PP)
Prince George's County-Prince George's County Health Department	High Risk Infant Program (PP)
Worcester County - Worcester County Health Department	Early Care (PP)

Appendix C: Maternal Depression Screening Tools

All Respondents



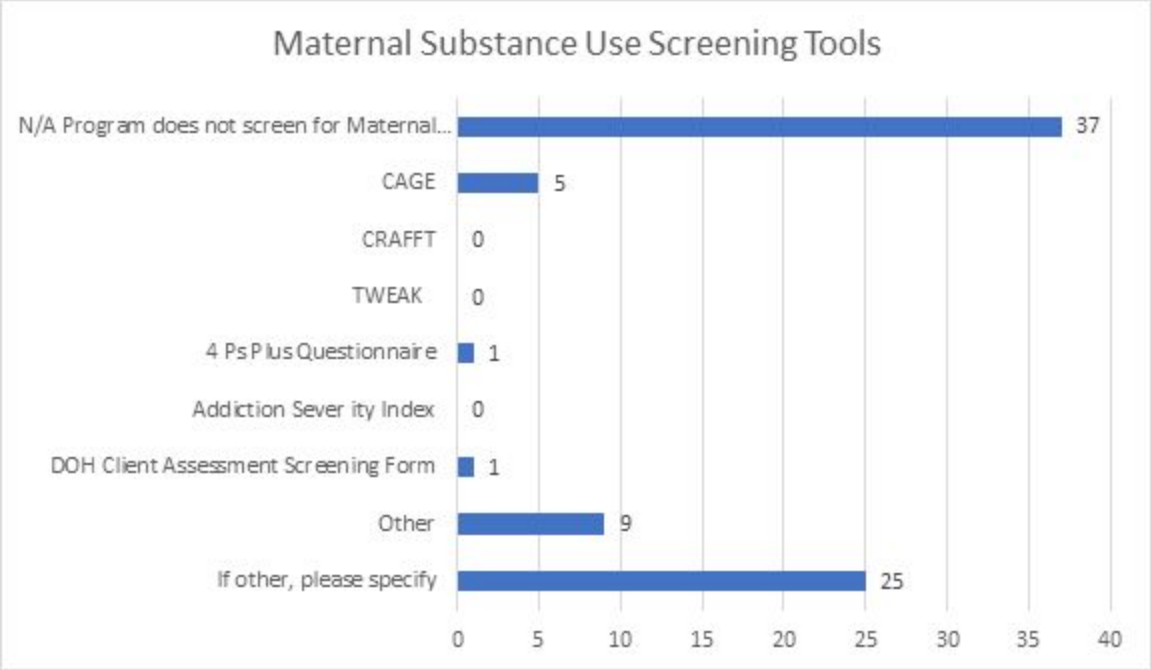
	Responses	Percentage
Total Responded to this question:	66	100%
Total who skipped this question:	0	0%
Total:	66	100%

*Other tools used include: Life Skills Progression and Adverse Childhood Experiences Questionnaire; PHQ-9

In FY 2019 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. Reporting sites indicate that on average a woman is screened four times, with a range of 0 (for those that do not screen) to ten times during the course of services. Reasons for not screening for maternal depression use included that it is not required by the program model, sites need training on a screening tool, or have not found an appropriate screening tool.

Appendix D: Maternal Substance Use Screening Tools

All Respondents



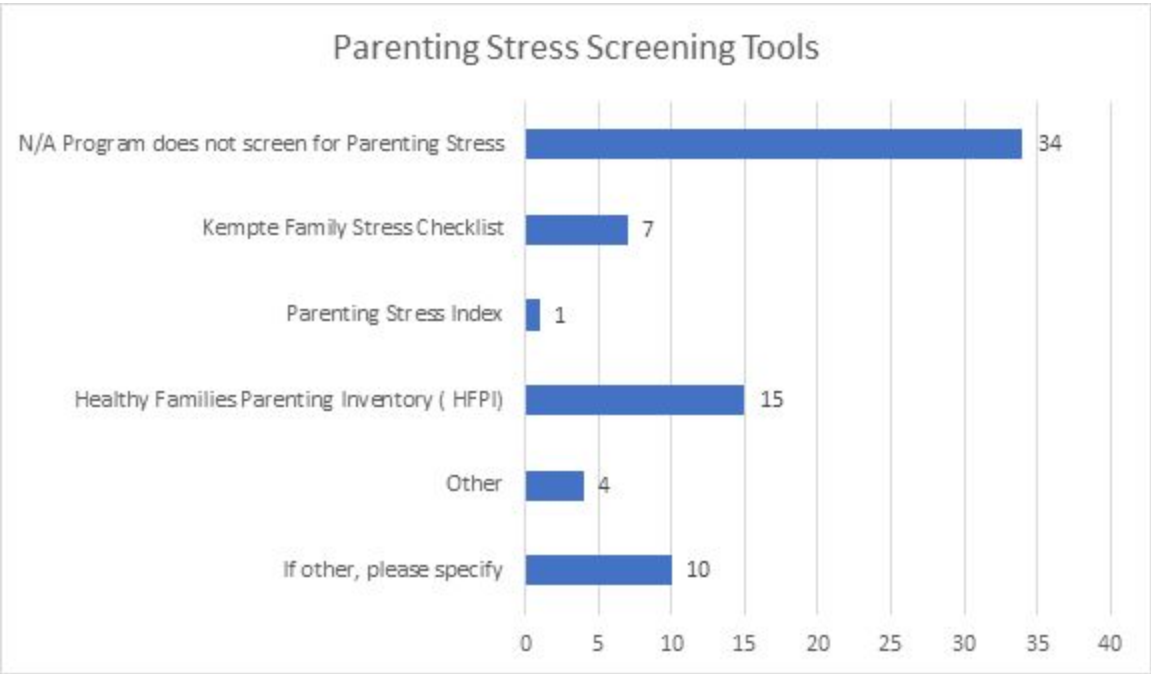
	Responses	Percentage
Total Responded to this question:	66	100%
Total who skipped this question:	0	0%
Total:	66	100%

*Other tools used include: Life Skills Progression, Health Habits, Healthy Families Parenting Inventory, PROMIS Adult Health Form, AUDIT-C, Strengths and Needs Assessment, Psychosocial Assessment, General Intake Screening, TICS, 4 P's.

In FY 2019 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. Reporting sites indicate that on average a woman is screened four 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 substance use included that it is not required by the program model, sites need training on a screening tool, families referred already have substance use history, and screenings are done by the referral source.

Appendix E: Parenting Stress Screening Tools

All Respondents



	Responses	Percentage
Total Responded to this question:	65	98.48%
Total who skipped this question:	1	1.52%
Total:	66	100%

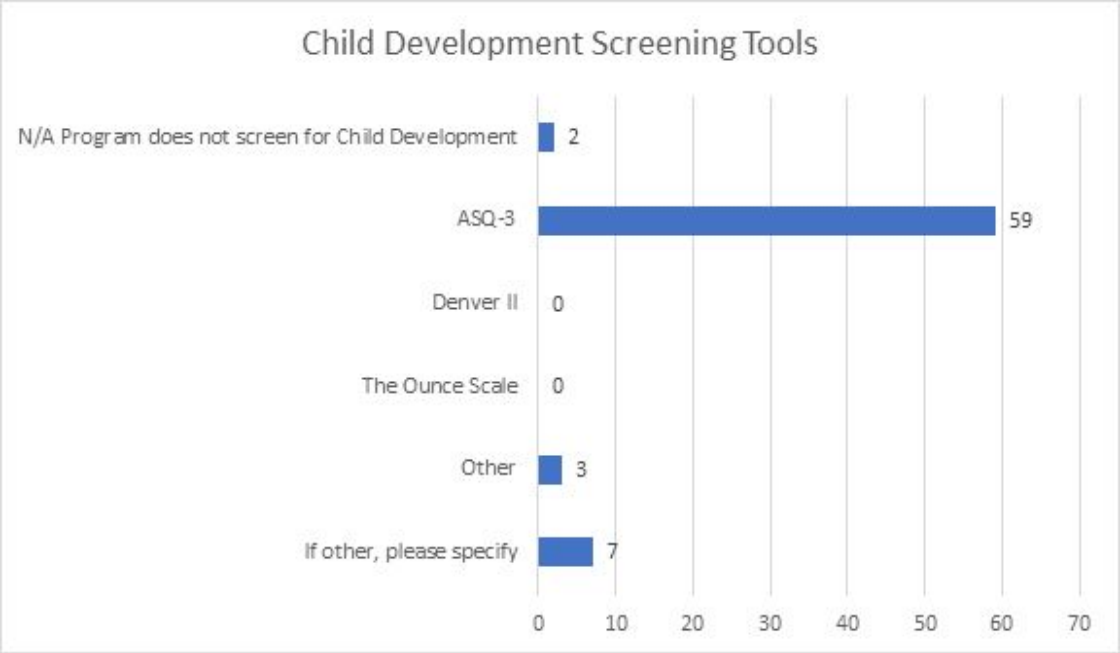
*Other tools used include: Life Skills Progression, GAD 7, Strengths and Needs Assessment, Family Centered Assessment and Home

In FY 2019 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. Reporting sites indicate that on average a woman is screened four times, with a range of 0 (for those that do not screen) to 7 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 B

Appendix F: Child Development Screening Tools

All Respondents

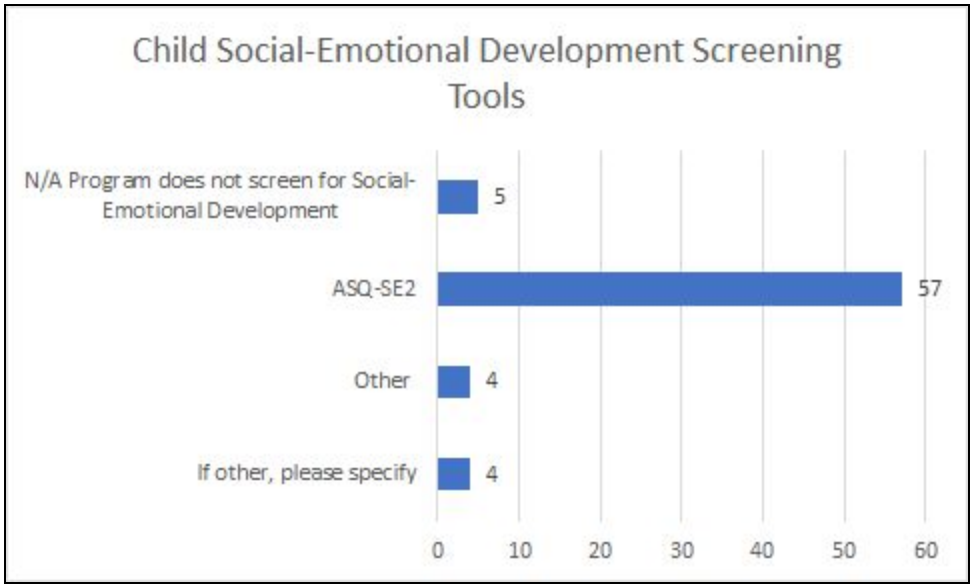


	Responses	Percentage
Total Responded to this question:	66	100%
Total who skipped this question:	0	0%
Total:	66	100%

*Other tools used include: Brigance Developmental Screener III; Teacher Assessment; PAT Growth & Development

In FY 2019 sites were asked to indicate how many child development screens a typical child would receive during the full course of services according to the home visiting program's screening protocols. Reporting sites indicate that on average a child is screened six times. Data was not collected on the frequency of screening. Reasons for not screening for child development included that it is not required by the program model.

Appendix G: Social Emotional Development Screening Tools



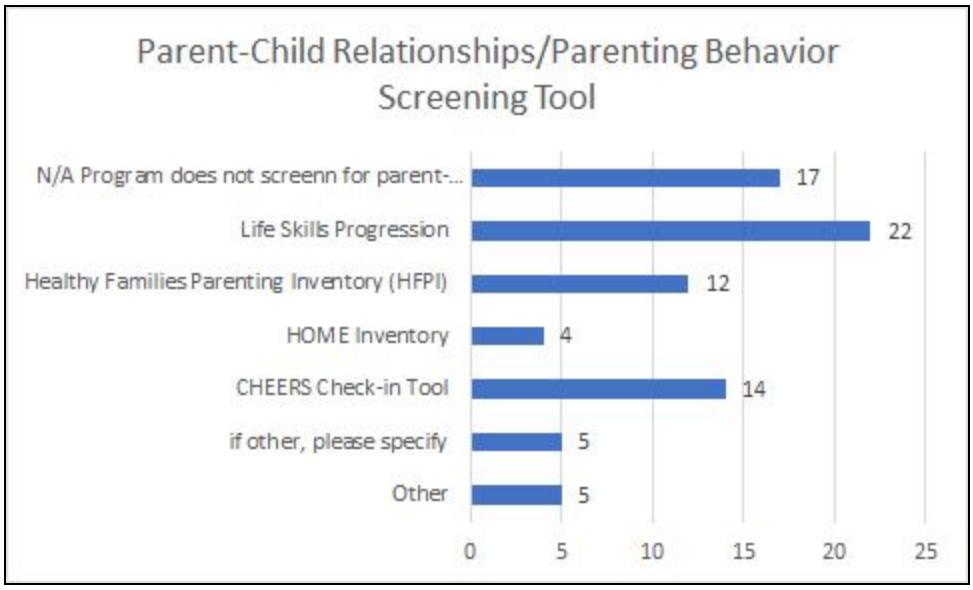
*Other includes Teacher Questionnaire, Brigance Screening, ECBI, Parents as Teachers Screening

All Respondents

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

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



* Note - total is greater than 66 as sites with multiple programs may use more than one tool.
** Other includes: DANCE, Parent Child Socialization, NCAST, Parent Questionnaire, HOVRS.

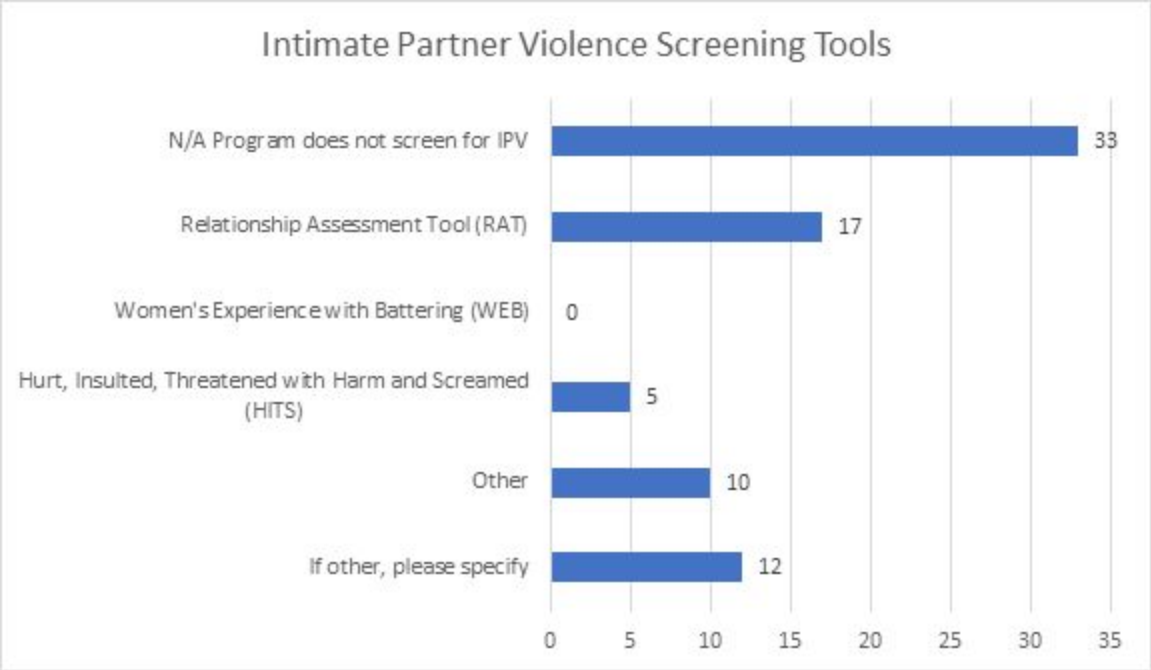
All Respondents

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

In FY 2019 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. Reporting sites indicate that on average a woman is screened five times. There was no data captured on the specific frequency in which sites screen for Parenting Behavior. Reasons sites do not screen for parenting behaviors is that it is not required by the program model.

Appendix I: Intimate Partner Violence Screening Tools

All Respondents



	Responses	Percentage
Total Responded to this question:	65	98.48%
Total who skipped this question:	1	1.52%
Total:	5668	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 2019 sites were again 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. Reporting sites indicate that on average a woman is screened two times with a range of 0 (for those that do not screen) to seven times during the course of services. The reported reason for not screening for IPV is that it is not required by the program model.

Appendix J : Progress to Date - FY 52015 Recommendations

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 must complete the survey biannually. This would ensure the broadest and most clear view of the reach of home visiting services.	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. Now that a second round of data has been collected, this recommendation still remains: modification to this legislation is recommended so that all programs that operate within Maryland must complete the survey biannually. This would ensure the broadest and clearest 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.[37],[38] From FY 2015 data collected, it appears that sites vary widely in the focus on the two-generation approach. Program sites may see substantial gains in maternal	With the State's two-generation initiative, it is evident that more home visiting programs are beginning to incorporate this approach into program services. Further training in the past two years around two-generational issues (maternal depression, substance abuse, IPV) has assisted in supporting and promoting this approach among home visiting programs Through federal MIECHV 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 workforce development to provide advanced skills in dealing with difficult topics and

[37] Smith, T., & Coffey, R. (2012) Two-Generation Strategies for Expanding the Middle Class.
[38] 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.

and child health outcomes if they provide formal supports for primary caregivers as well young children.[39] 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.	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 improvement agenda to focus on Statewide program improvement to ensure the provision of the highest quality of service to enrolled women and children.	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 ensures 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 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.[40] Women enrolled in home visiting may have experienced significant trauma during their own early childhood years that is now impairing their own parenting capacity.[41] Prior trauma may be a contributing factor to current mental health problems, substance use, and intimate partner violence.[42] 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	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.

[39] Shonkoff et al., 2013.
[40] 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.
[41] Ammerman et al., 2012.
[42] 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.

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 predetermined 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 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 MIECHV 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	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

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 effectiveness of home visiting.*[43]	that tell the story of home visiting's effectiveness and reach in serving vulnerable populations.

[43] The PEW Charitable Trusts. (2015). *Using Data to Measure Performance: A New Framework for Assessing the Effectiveness of Home Visiting*.

Appendix C

WV Professional and Service Personnel Salary Schedules

Professional Salary Schedule by County 2019-2020: https://wvde.us/wp-content/uploads/2019/08/Professional-Salary-Schedules-by-County-20.pdf

Service Salary Schedule by County 2019-2020: https://wvde.us/wp-content/uploads/2019/08/Service-Salary-Schedules-by-County-20.pdf

Appendix D

Detailed Salary Averages By Region

Region 1	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Hancock	$38,863.00	$41,527.00	$21,830.00	$22,880.00
Brooke	$39,341.00	$42,194.00	$22,720.00	$23,680.00
Ohio	$39,015.00	$41,827.00	$22,650.00	$23,600.00
Marshall	$39,668.00	$42,720.00	$22,220.00	$23,030.00
Wetzel	$38,468.00	$41,423.00	$21,640.00	$22,640.00
Tyler	$38,550.00	$41,502.00	$23,490.00	$24,490.00
AVERAGE	**$38,984.17**	**$41,865.50**	**$22,425.00**	**$23,386.67**

Region 2	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Pleasants	$39,507.00	$42,036.00	$26,665.00	$23,613.00
Wood	$38,575.00	$41,387.00	$22,460.00	$23,410.00
Ritchie	$37,515.00	$40,327.00	$21,200.00	$22,150.00
Wirt	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Jackson	$39,025.00	$41,827.00	$22,900.00	$23,850.00
Roane	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Calhoun	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Gilmer	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Putnam	$40,442.00	$43,281.00	$24,110.00	$24,940.00
Kanawha	$39,234.00	$42,232.00	$22,120.00	$23,140.00
Clay	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Braxton	$36,815.00	$39,627.00	$20,700.00	$21,650.00
AVERAGE	**$37,932.33**	**$40,737.67**	**$21,971.25**	**$22,583.58**

Region 5	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Raleigh	$39,265.00	$42,077.00	$23,350.00	$24,500.00
Fayette	$38,615.00	$41,427.00	$22,500.00	$23,450.00
Greenbrier	$37,315.00	$40,127.00	$21,080.00	$22,030.00
Nicolas	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Webster	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Pocahontas	$36,815.00	$39,627.00	$20,700.00	$21,650.00
AVERAGE	**$37,606.67**	**$40,418.67**	**$21,505.00**	**$22,488.33**

Region 6	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Pendleton	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Grant	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Hardy	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Mineral	$37,490.00	$40,302.00	$21,375.00	$22,325.00
Hampshire	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Morgan	$38,971.00	$41,840.00	$21,970.00	$22,930.00
Berkeley	$39,628.00	$42,518.00	$22,440.00	$23,450.00
Jefferson	$38,400.00	$41,212.00	$21,440.00	$22,390.00
AVERAGE	**$37,718.63**	**$40,547.50**	**$21,253.13**	**$22,211.88**

Appendix D

Region 3	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Mason	$38,540.00	$41,552.00	$22,425.00	$23,375.00
Cabell	$39,168.00	$42,040.00	$22,770.00	$23,740.00
Wayne	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Lincoln	$37,565.00	$40,177.00	$21,150.00	$22,100.00
Mingo	$37,815.00	$40,827.00	$22,400.00	$23,350.00
Logan	$38,815.00	$41,627.00	$22,075.00	$23,025.00
Boone	$39,105.00	$41,733.00	$22,700.00	$23,650.00
AVERAGE	**$38,260.43**	**$41,083.29**	**$22,031.43**	**$22,984.29**

Region 4	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
McDowell	$38,465.00	$41,277.00	$22,350.00	$23,300.00
Wyoming	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Mercer	$38,995.00	$41,807.00	$22,830.00	$23,780.00
Summers	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Monroe	$36,815.00	$39,627.00	$20,700.00	$21,650.00
AVERAGE	**$37,581.00**	**$40,393.00**	**$21,456.00**	**$22,406.00**

Region 7	AB (Bachelor's Degree)	MA (Master's Degree)	Aide II (HS Diploma/GED)	Aide IV (HS Diploma/GED+)
Monongalia	$41,540.00	$44,352.00	$25,225.00	$23,590.00
Preston	$36,815.00	$39,627.00	$20,700.00	$23,700.00
Marion	$36,855.00	$39,627.00	$21,110.00	$21,650.00
Taylor	$37,065.00	$39,877.00	$20,950.00	$21,650.00
Doddridge	$40,083.00	$43,176.00	$22,550.00	$22,700.00
Harrison	$39,105.00	$41,877.00	$22,750.00	$21,650.00
Barbour	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Tucker	$36,815.00	$39,627.00	$20,700.00	$22,579.55
Lewis	$37,865.00	$40,677.00	$21,750.00	$22,700.00
Upshur	$36,815.00	$39,627.00	$20,700.00	$21,650.00
Randolph	$36,815.00	$39,627.00	$20,700.00	$21,650.00
AVERAGE	**$37,871.64**	**$40,701.91**	**$21,621.36**	**$22,288.14**