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

A report to the Governor, Senate Finance Committee, House Ways and Means Committee, and the Joint Committee on Children, Youth, and Families

Submitted by the Governor's Office for Children and the Children's Cabinet

DECEMBER 1, 2015

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Introduction

This report provides the first glimpse at how Maryland supports maternal, child, and family health through home visiting programs. It describes the results of standardized reporting from sites across program models and funding sources.

Home visiting is a term used to describe a two-generation 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 Maryland jurisdictions.

Home visiting programs pair new and expectant parents with trained professionals to provide parenting information, resources, and support during pregnancy and throughout the child's first two to five years. Evidence-based home visiting models have undergone rigorous evaluation and have been shown to improve maternal and child outcomes by connecting families to essential community services, improving maternal health, strengthening parent-child relationships, promoting healthy development of children's cognitive, physical and social-emotional growth, and reducing the risk factors for child abuse and neglect.[1, 2]

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 and the agencies of the Children's Cabinet reviewed current practices of home visiting programs in Maryland. This review recommended the development of a "standardized reporting mechanism for the purpose of collecting information about and monitoring the effectiveness of State-funded home visiting programs." Beginning in FY15, recipients of State funding for home visiting programs were required to report to the Governor's Office for Children on the standardized reporting measures that were adopted by the Children's Cabinet. The standardized measures include data on well-child visits, maternal mental health screening and referral, maternal substance use screening and referral, parenting stress and parent-child relationships, childhood development, referral for children with developmental delay, and screening and safety planning for intimate partner violence.

State Goals for Home Visiting

Evidence-based home visiting is a voluntary family support strategy than helps parents create healthy, positive environments for their baby and family. Evidence-based home visiting 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.

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[1] Ammerman, R. T., Putnam, F. W., Altaye, M., Teeters, A. R., Stevens, J., & Van Ginkel, J. B. (2013). Treatment of depressed mothers in home visiting: Impact on psychological distress and social functioning. *Child abuse & neglect*,*37*(8), 544-554.
[2] Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., ... & Holmberg, J. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial.*Pediatrics*, *114*(6), 1550-1559.

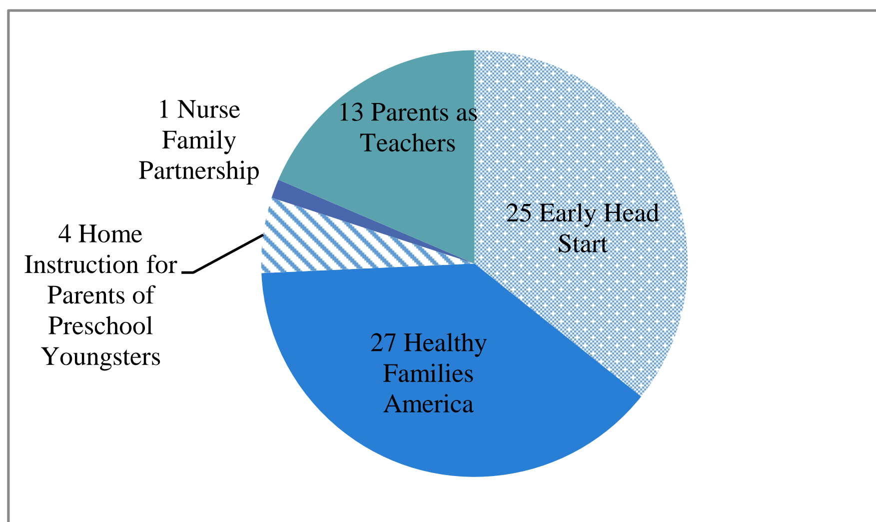
Maryland's Home Visiting Program Models

In Maryland, five prevailing evidence-based models of service delivery are in operation for maternal and child home visiting.

- **Early Head Start** targets low-income pregnant women and families with children 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.
- The **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.
- The **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 woman's pregnancy and conclude when the child turns two years old.
- **Parents as Teachers** programs provide parents with child development knowledge and parenting support. This model provides one-on-one home visits, group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits using a structured curriculum. Local sites decide on the intensity of home visits, ranging from weekly to monthly and the duration during which home visitation is offered. This model may serve families at any point from pregnancy to when the child enters kindergarten.

Figure 1 and Figure 4 display the number and distribution of sites by type of home visiting program model in Maryland.

Figure 1: Number of Maryland Home Visiting Sites by Evidence-Based Model



Maryland's Home Visiting Accountability Act of 2012

The 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 served and outcomes achieved.

At the direction of the Children's Cabinet, the Governor's Office for Children convened a workgroup that included representatives from multiple State agencies, home visiting experts, and stakeholders. The workgroup's functions included the development of specific strategies for tracking home visiting outcomes on a Statewide scale. Technical assistance was provided to the Office and workgroup through the Pew Foundation's Home Visiting Campaign.

In March of 2014, standardized reporting measures were adopted by the Children's Cabinet to evaluate home visiting. The standardized measures were grouped in the following five domains:

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

A full list of Maryland's home visiting standardized reporting measures can be found in Table 3.

Methodology

This report represents Maryland's first effort to collect baseline data on standardized measures for women[3] and children served by home visiting programs, regardless of the program's funding source or the home visiting model in use. Aggregate site-level data were collected for the service period of July 1, 2014 through June 30, 2015. An inventory of home visiting programs across Maryland was first created to determine which programs were providing home visiting services during FY15. The inventory was created by collecting program lists previously compiled by the Maryland Department of Health and Mental Hygiene, the Maryland Family Network, the Governor's Office for Children and the Johns Hopkins Home Visiting Research Network. Each program on the lists was contacted via email or phone call to verify that the program provided home visiting

[3] In this report, "women" indicates pregnant women and mothers.

services as the predominant method of service delivery and to confirm the program model and curriculum. The final updated inventory indicated that 70 evidence-based programs were operating in FY15.

A mid-year trial survey was conducted to identify and troubleshoot issues with the data collection effort, to educate home visiting providers about the standardized measures and survey process, and to provide technical assistance to program providers that are required to report.

The data collection tool for full FY15 data was available as an online survey from July 20, 2015 through September 14, 2015.The survey link and information regarding reporting requirements were sent out via email to representatives from the State agencies that fund home visiting, directors of all known home visiting sites, and staff for the 24 Local Management Boards. Prior to the launch of the online survey, four meetings were held throughout Maryland to provide technical assistance about the reporting requirements.

Reporting Programs, At-A-Glance

A total of 46 sites submitted data, representing a return rate of 66%. Of those 46 sites, 35 were found to be State-funded programs. The remaining 11 programs did not receive State funds for FY15. Table 1 provides a snapshot of all the programs that reported FY15 data.

Table 1. Reporting Programs, At-a-Glance

Measure	Reporting Home Visiting Programs
Number of programs reporting	46[4]
Jurisdictions represented	23
Number of women served	3,535
Number of “other” Primary Care Givers served[5]	157
Number of children served	3,493

[4] 35 of these programs receive State funding.
[5] “Other” primary caregivers include fathers, grandparents, aunts, and uncles.

Funding for Reporting Programs

Maryland's home visiting programs are supported by federal, State, local government and non-profit funding. The majority (60%) of sites reported receiving funding from a combination of these sources.

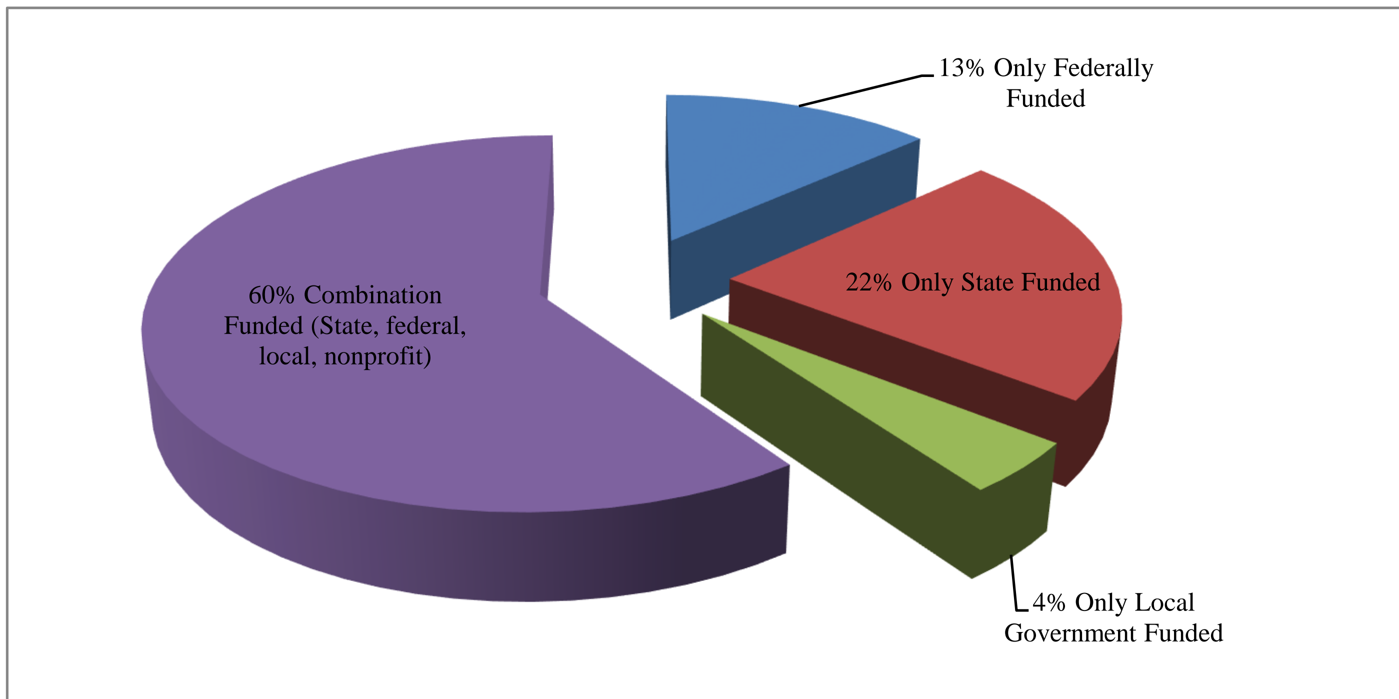
In FY15, State General Funds were provided for home visiting from several different State agencies: the Maryland State Department of Education, the Department of Human Resources, the Department of Health and Mental Hygiene, and the Children's Cabinet Interagency Fund. As reported through the survey, the Department of Human Resources provided funding to home visiting programs as a match for the federal *Promoting Safe and Stable Families* grant. The Department of Health and Mental Hygiene provided funding to support home visiting services through two grant programs: Babies Born Healthy and Child Health Systems Improvement. Twenty-two percent of the sites reported receiving funding only from the State.

The federal government also provides funding for home visiting programs. The Maternal, Infant and Early Childhood Home Visiting program is funded through the Health Services Resource Administration. The Office of Head Start that is housed within the Administration for Children and Families provides partial or full-funding for Early Head Start programs throughout Maryland, which can include home visiting. Thirteen percent of sites reported receiving only federal funds to operate the home visiting program in FY15.

Local government and non-profit funding also support a number of programs. Four percent of sites reported receiving only local government funds to operate the home visiting program in FY15.

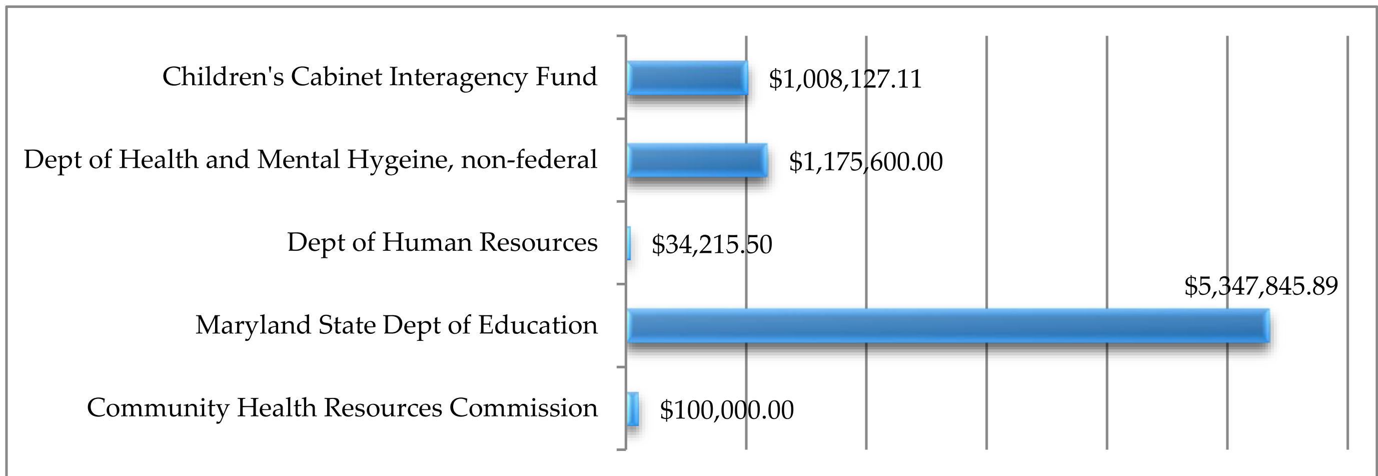
A breakdown of the funding sources for the reporting home visiting programs is represented in Figure 2.

Figure 2: Maryland Home Visiting Funding Sources for Reporting Sites



As reported in these data, the various State sources that funded home visiting in FY15 are detailed in Figure 3 below.

Figure 3: Reported Sources and Amounts of State Funds for Home Visiting, FY15



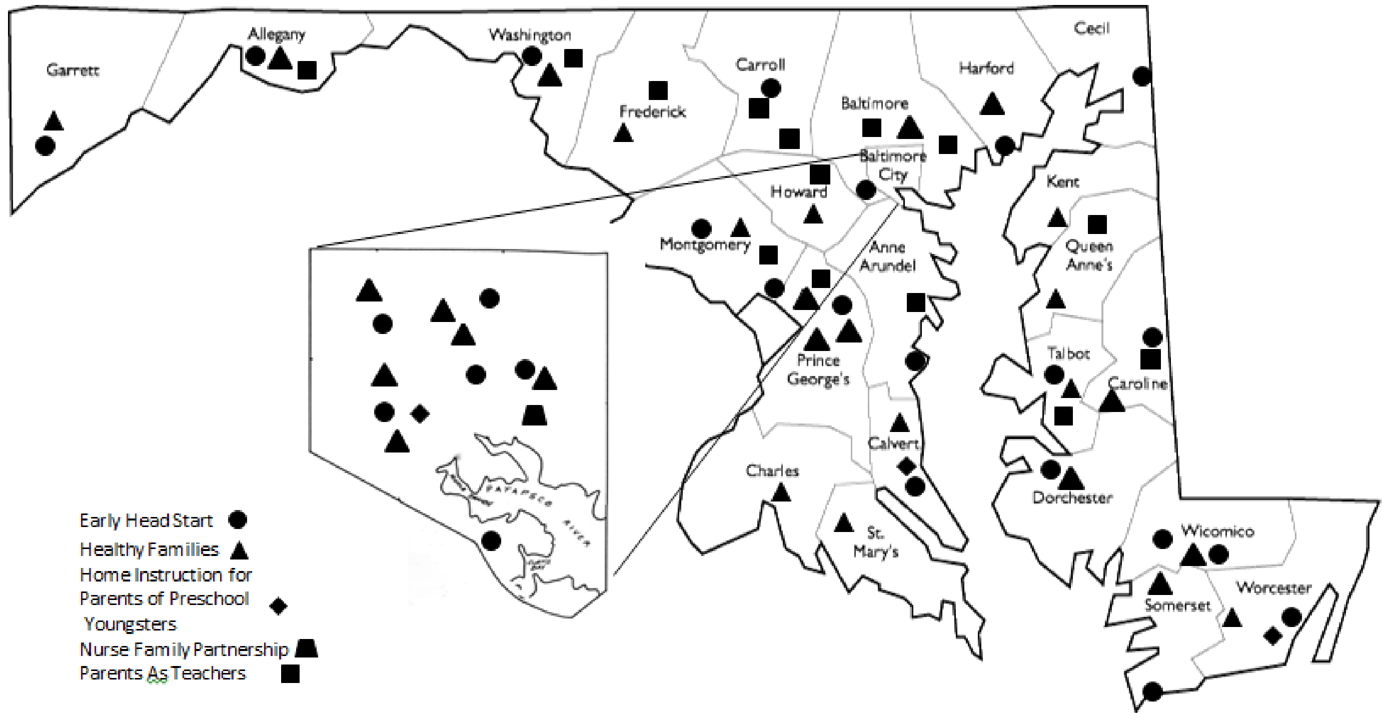
Who Reported?

Table 2 details the number of identified home visiting programs that offer each type of model available in Maryland. In addition to providing information on the total number of programs by model, the table indicates the number of each program type that reported data for the *FY15 Home Visiting Standardized Measures* survey. The *Combination-funded* row provides information on the reporting programs funded through all sources (State, federal, local, non-profit, other), while the *State-funded* row provides information on only those State-funded programs that reported data. Note that the only programs mandated to report data are those receiving State funding.

Table 2. Data-Reporting Sites by Program Model

	Early Head Start	Healthy Families	Home Instruction for Parents of Preschool Youngsters	Nurse Family Partner -ship	Parents As Teachers	Totals
Total known programs in MD	25	27	4	1	13	70
Combination-funded, reported	8	26	2	1	9	46
State-funded	5	20	1	1	8	35

Figure 4: FY15 Identified Home Visiting Sites



Home Visiting Workforce

Through the FY15 survey, a picture is developing of the home visiting workforce in Maryland. Site directors were asked about the numbers and educational attainment of staff members, and the most common reasons for staff attrition.

In FY15, the reported programs employed 222 home visitors to serve enrolled families. In addition to their formal education, home visitors received extensive training specific to the program model, curriculum, and supplemental training throughout the year on topics such as healthy boundaries and cultural competencies.

The common reasons indicated for staff attrition include low salaries, lack of health insurance or leave time, and promotion within the agency.

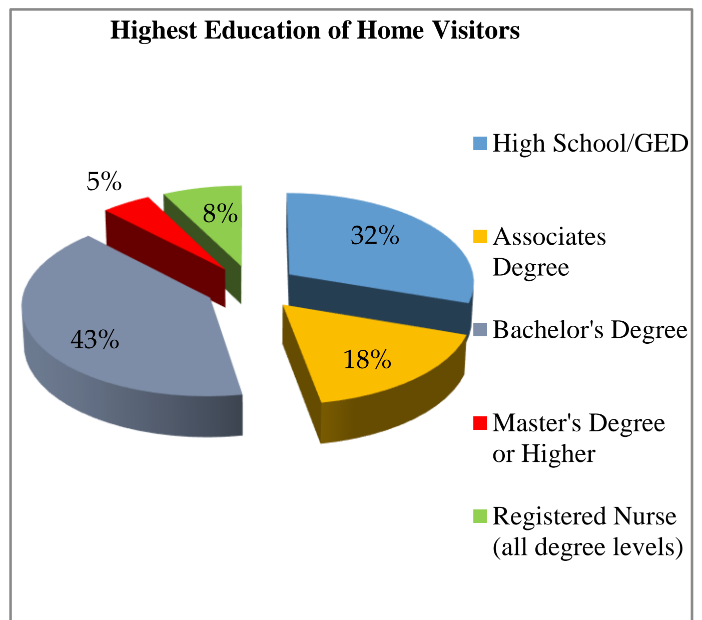


Figure 5

Demographics of Women Served

Data indicated that 3,535 women were served by home visiting programs throughout Maryland in FY15. They were predominately 24 years old or younger (45%) and Black, not of Hispanic, Latino or Spanish origin (46%). The age range of women served was between 15 years to 49 years of age. Twenty five percent of women served were White, not of Hispanic, Latino or Spanish origin , twelve percent were White and of Hispanic, Latino or Spanish origin and ten percent were Hispanic, Latino or Spanish of unspecified race . The following charts provide more detailed demographic information on women served during FY15.

Figure 6

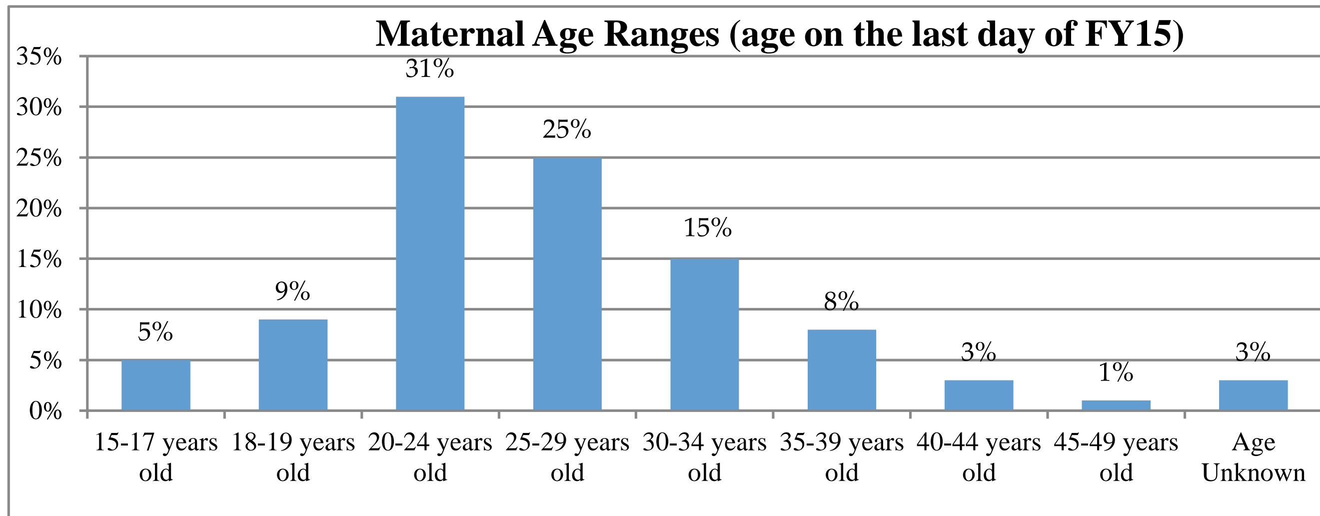
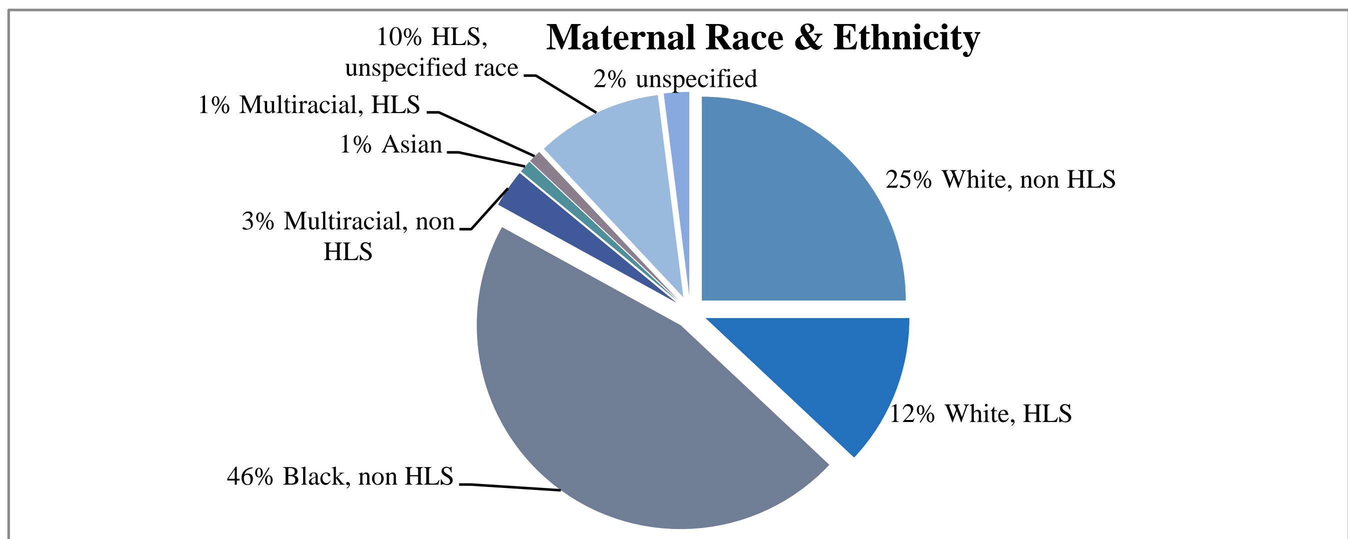


Figure 7



*HLS indicates Hispanic, Latino or Spanish

Demographics of Children Served

Data indicated that 3,493 children were served by home visiting programs in Maryland in FY15. The majority of children served (44%) were between 12 and 35 months old. Forty percent of children were Black and not of Hispanic, Latino or Spanish origin. The next largest racial and ethnic categories of children served were White, not of Hispanic, Latino or Spanish origin (24%), White and of Hispanic, Latino or Spanish origin (13%) and Hispanic, Latino or Spanish of unspecified race (10%). The following charts provide more detailed demographic information on children served during FY15.

Figure 8

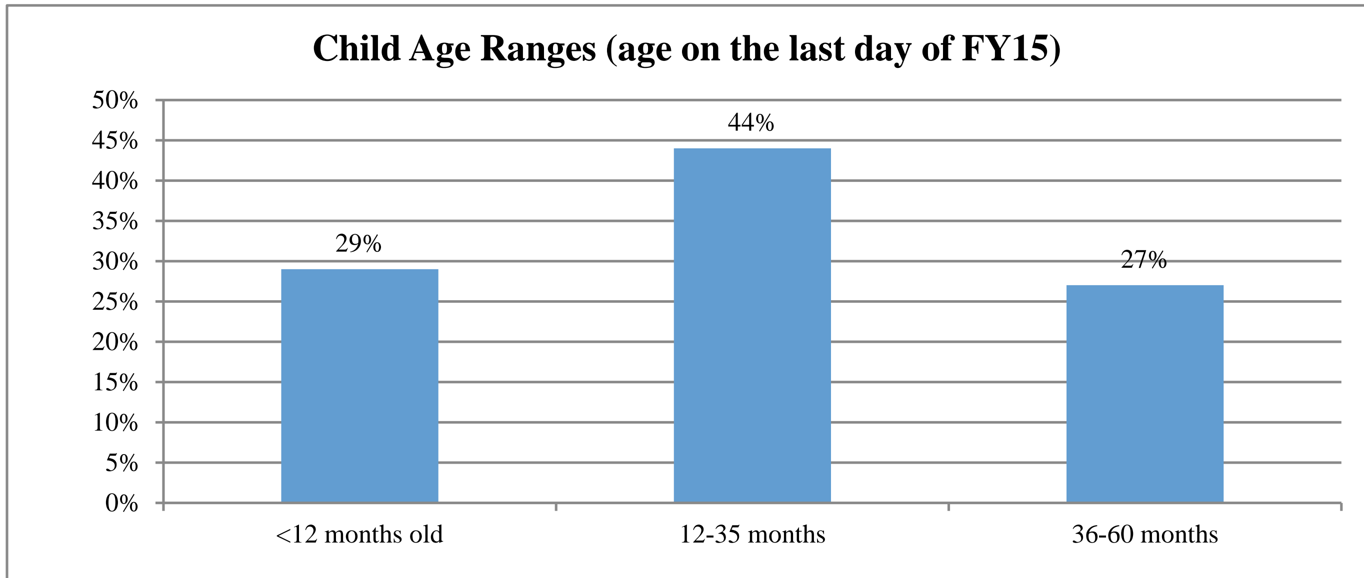
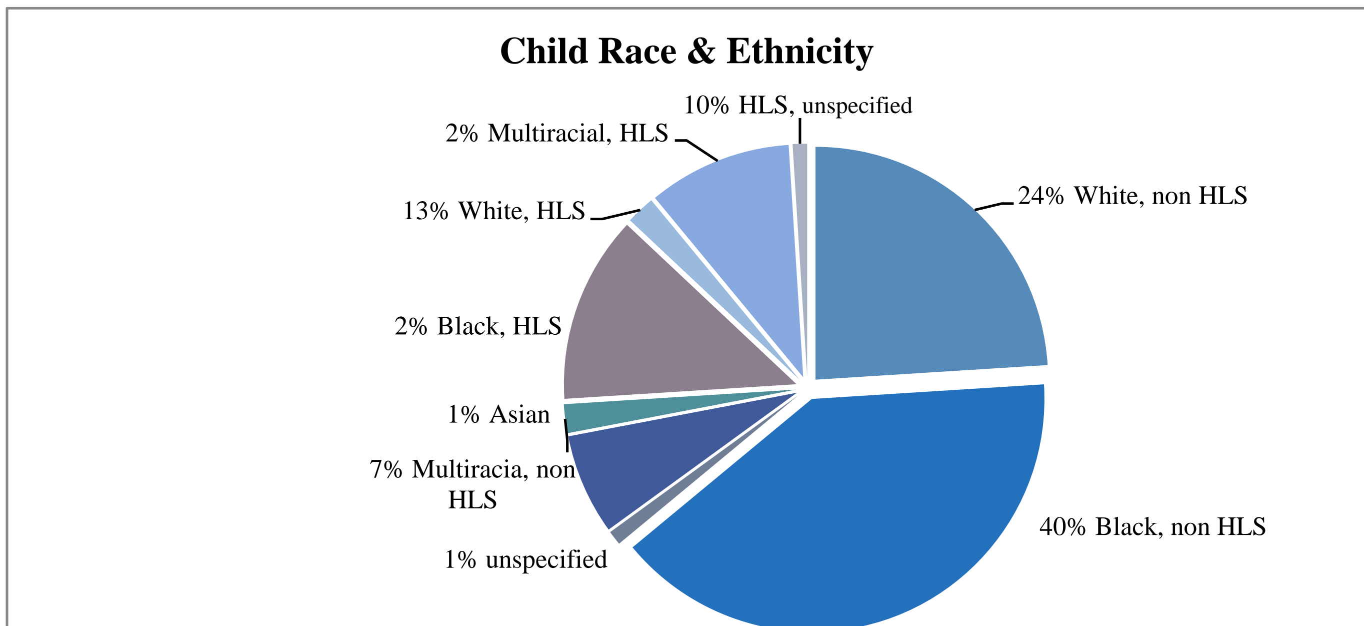


Figure 9



*HLS indicates Hispanic, Latino or Spanish

Maryland Home Visiting Standardized Measures

The Governor's Office for Children convened a workgroup that included representatives from multiple State agencies and home visiting experts and stakeholders. The Workgroup's functions included the development of specific strategies for tracking home visiting outcomes on a Statewide scale. Technical assistance was provided to the Governor's Office for Children by staff from the Pew Foundation's Home Visiting Campaign.

In March of 2014, the Children's Cabinet approved the measures below to begin collecting standardized data on home visiting programs regardless of the program model or funding agency.

Table 3. Maryland's Standardized Home Visiting Measures

Domain	Standardized Measures[6]
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 the Ages and Stages Questionnaires; % 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 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.

The following pages provide further detail about the baseline data collected on each standardized measure.

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

Domain 1: Child Health—Well-Child Visits

Well-child visits include a complete physical and evaluation of the child's progress toward developmental milestones. These visits also provide rich opportunities for health education and communication between the parent and the pediatrician. Attending regular well-child visits allows parents to raise concerns about the child's health. These visits are key in helping health care providers form reliable and trustworthy relationships with families they serve.[7]

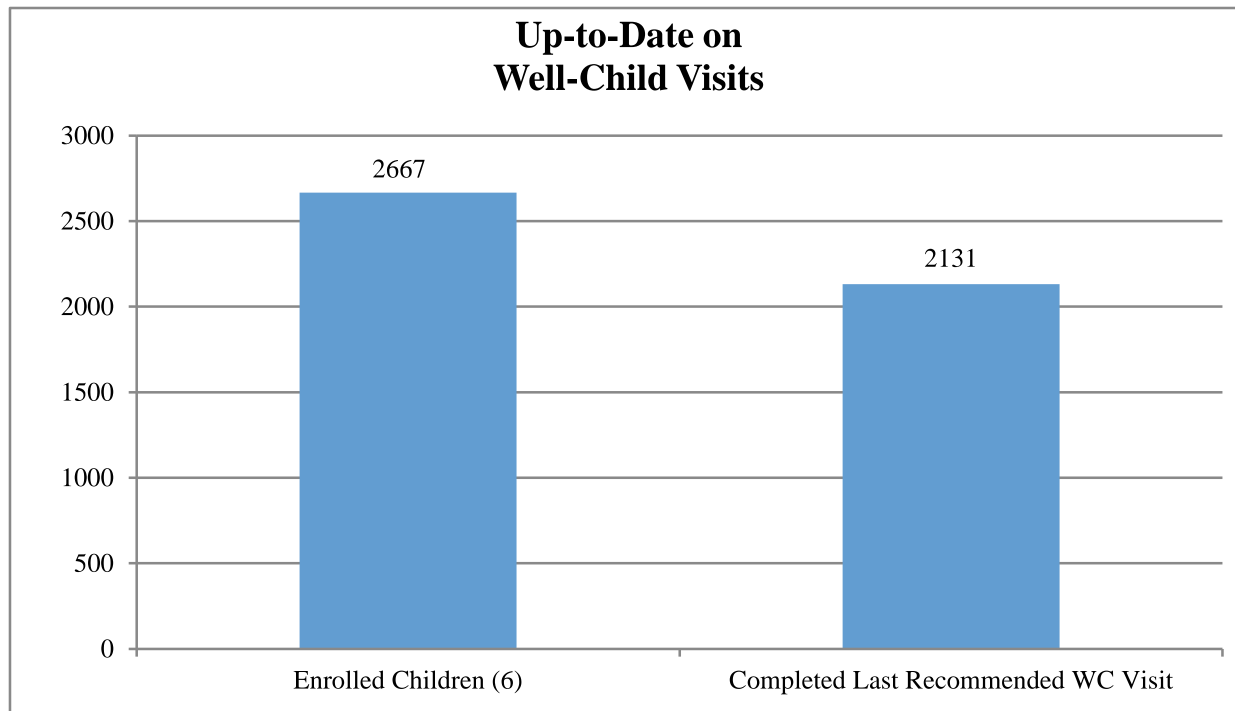
Target population: All children enrolled in home visiting.

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

Calculation:

$$\frac{\text{\# of enrolled children who completed last recommended well-child visit}}{\text{Enrolled children for whom data are collected}^{8}}$$

Forty of the 46 programs that reported data collected information from parents about well-child visits, representing 2,667children. Data shows that 80% completed the most recent well-child visit recommended by the American Academy of Pediatrics *Bright Future*™ schedule[9], indicating that they are up-to-date on age-appropriate immunizations, education, and developmental assessments from a healthcare provider.



[7] www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
[8] Six programs do not track this data point. The number of children enrolled in those programs were removed from this calculation, as data on well-child visit status for those children is unavailable. Five of the programs included in this calculation collect data on well-child visits associated with immunizations.
[9] https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

Domain 2: Maternal Mental Health- Depression

When mothers are unable to take care of themselves, they cannot properly care for their children. Depression is prevalent in the population served through home visiting, and can have a profoundly negative impact on parenting, maternal life course, and child development.[10]

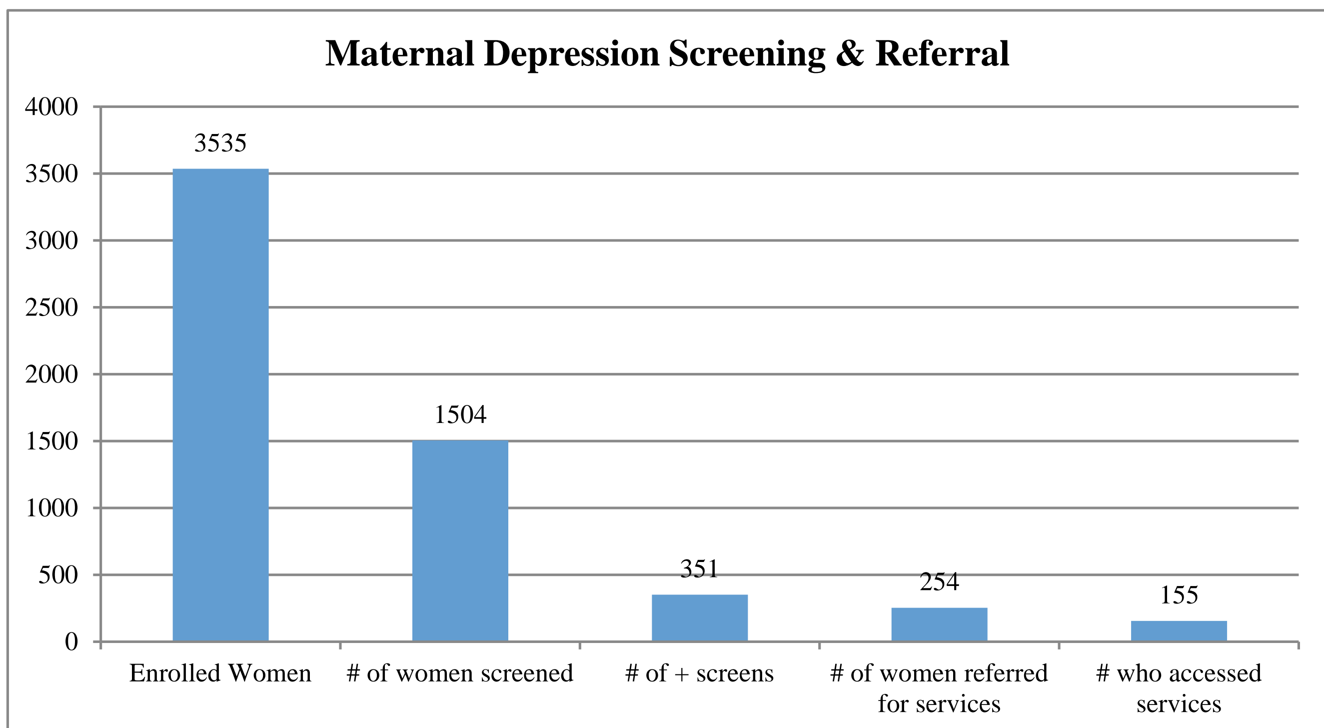
Target population: All women enrolled in a home visitation program.

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

Calculation:

$$\frac{\text{\# of women screened for depression}}{\text{Total \# of women enrolled in the home visiting program}}$$

Thirty five of the 46 programs that reported data conducted any depression screening. For FY15, 43% of women enrolled in home visiting were screened for depression. Of the women screened, 23% screened positive for depressive symptoms, warranting further assessment from a healthcare provider. Of the women who screened positive for depression, 72% were referred for further assessment and treatment. Programs use a variety of tools to screen for maternal depression. A full list of the tools utilized can be found in Appendix B.



[10] 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.

Domain 2: Maternal Mental Health—Substance Use

Many substances, including cigarettes, alcohol and opiates, cross the placenta and impact the developing fetus.[11] Use of these substances during pregnancy is associated with maternal, fetal, and infant morbidity and mortality.[12]

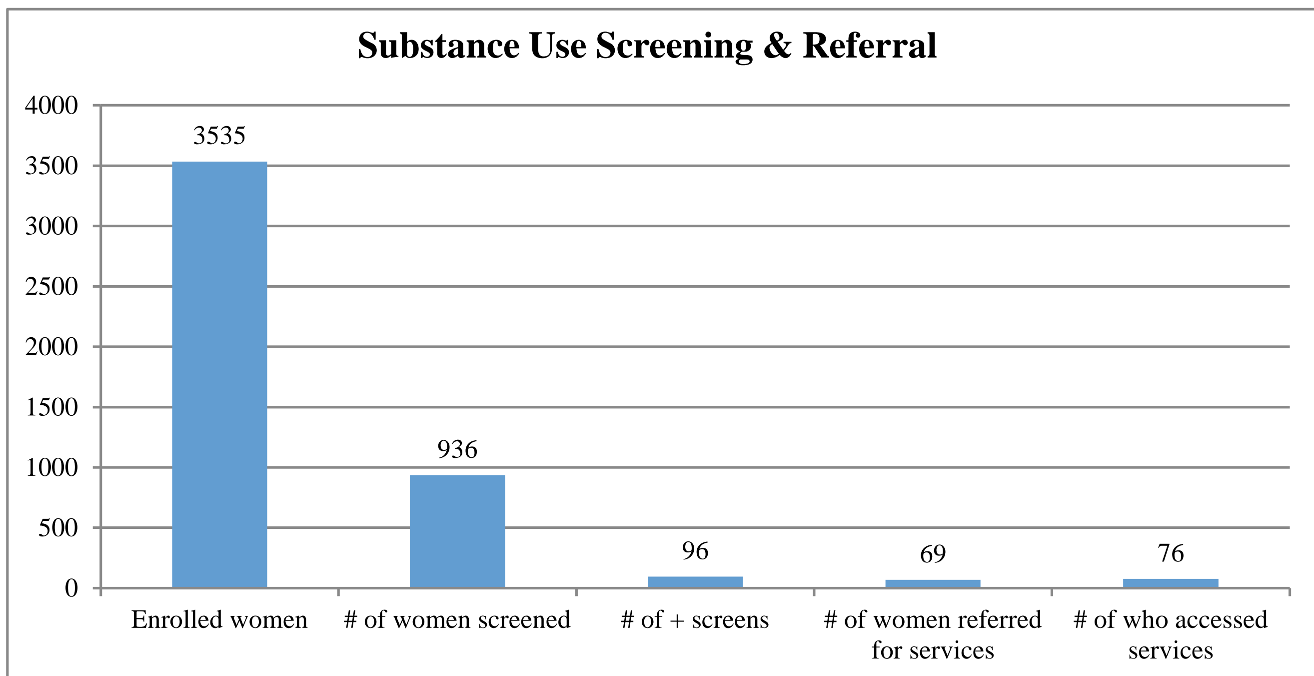
Target Population: All women enrolled in a home visitation program.

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

Calculation:

$$\frac{\text{\# of women screened for substance use}}{\text{Total \# of women enrolled in the home visiting program}}$$

Twenty-six of the 46 programs that reported data conducted any substance use screening. For FY15, 26% of enrolled women were screened for substance use. Ten percent of those women screened positive for substance use, warranting further assessment from a healthcare provider. Of the women who screened positive for substance use, 72% were referred for further assessment and treatment. Programs use a variety of tools to screen for maternal substance use. A full list of the tools utilized can be found in Appendix C.



[11] 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.

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

Domain 2: Maternal Mental Health- Clinically High 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.[13]

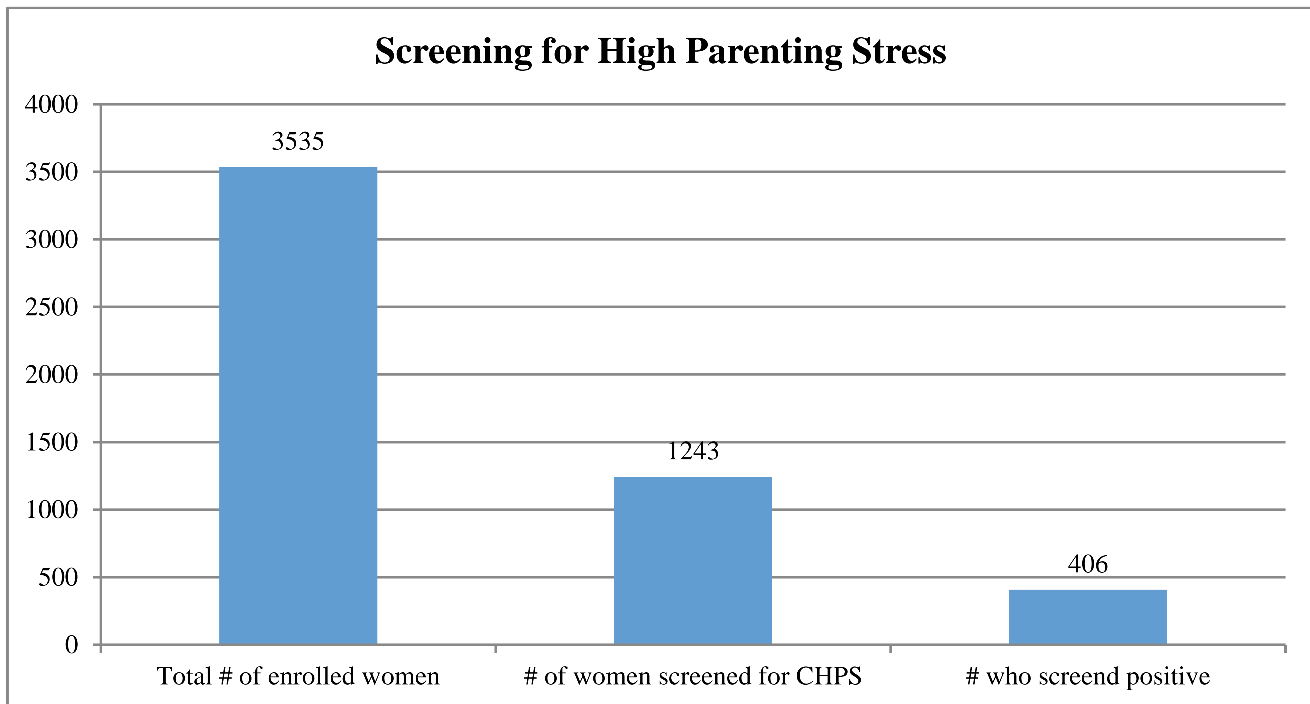
Target population: All enrolled mothers

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

Calculation:

$$\frac{\text{\# of women who presented with clinically high parenting stress}}{\text{Total \# of women enrolled in the home visiting program}}$$

Twenty-seven of the 46 programs that reported data conducted any screening for high parenting stress. For FY15, 35% of enrolled women were screened for high parenting stress. From those screenings, 33% of the women were screened positive for high parenting stress. Programs use a variety of tools to screen for high parenting stress. A full list of the tools utilized can be found in Appendix F.



[13] Östberg, M., & Hagekull, B. (2000). A structural modeling approach to the understanding of parenting stress. *Journal of clinical child psychology*, *29*(4), 615-625

Domain 3: Typical Child Development-Ages and Stages Questionnaires

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.[14]

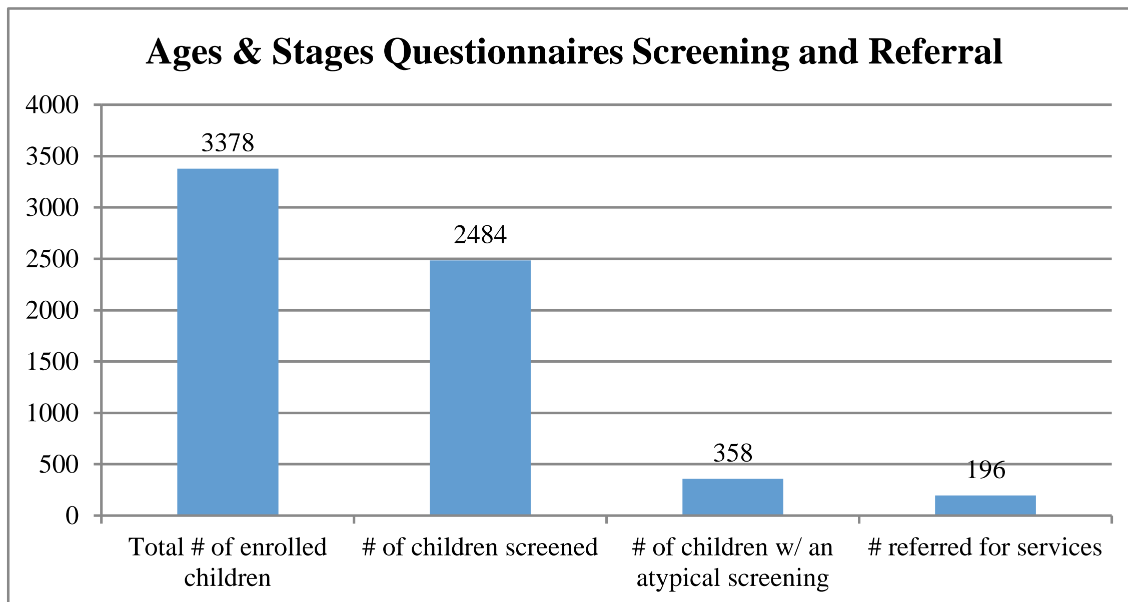
Target population: Enrolled children

Measure: Percent of enrolled children who were screened with the Ages and Stages Questionnaires

Calculation: $\frac{\text{\# of children screened via the Ages and Stages Questionnaires}}{\text{Total \# of children enrolled in the home visiting program}}$

Forty-five of the 46 programs that provided data screened children for developmental delays via the Ages and Stages Questionnaires. In FY15, 74% of enrolled children[15] were screened for development toward expected milestones via this tool.

Fourteen percent of children who were screened presented with atypical development. Fifty-five percent of these children were referred for supplemental services to address a developmental delay. Children may not be immediately referred for services for several reasons: the family may already be receiving services; the home visitor may provide supplemental activities to parents to improve developmental skills prior to making a referral; and, the family may refuse the referral.



[14] 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.
[15] The Ages and Stages Questionnaires can be used with children starting at 2 months of age, and includes the following subscales: communication, gross motor, fine motor, problem solving and personal-social skills.

Domain 3: Typical Child Development: Ages and Stages Questionnaires-Social Emotional

The emotional well-being of children is essential for future success in social and academic settings. Children with social-emotional delays are often less resilient than children who are developing typically and may experience behavioral problems in response to normal stressors.[16,17]

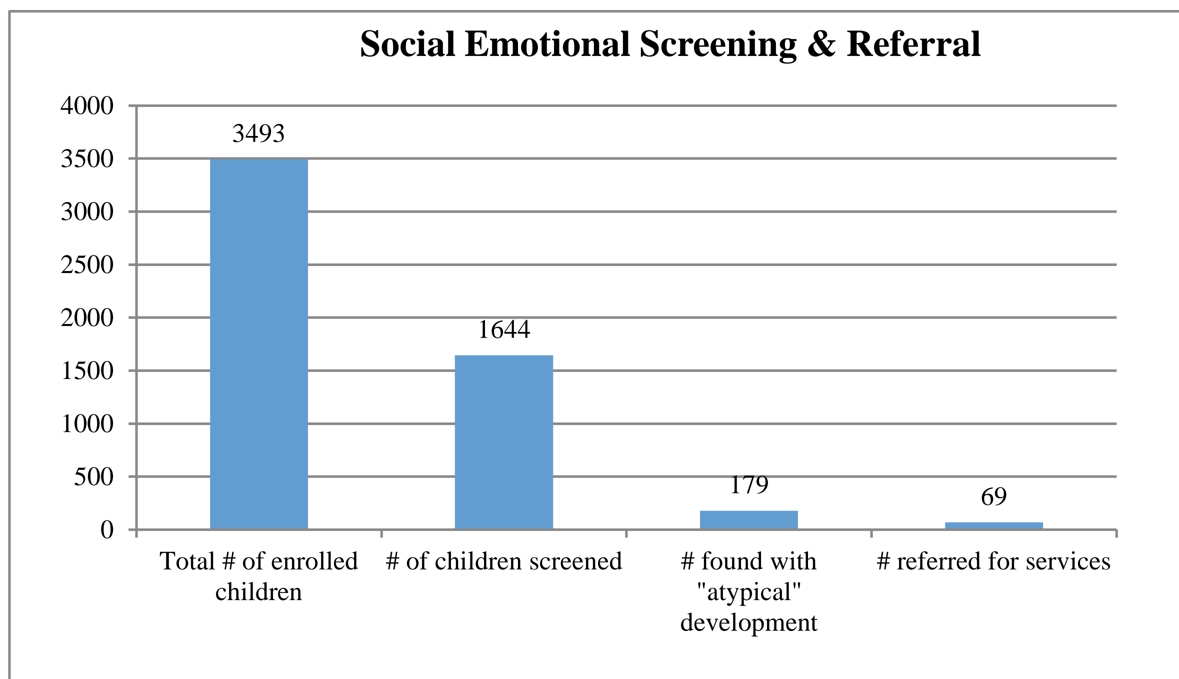
Target population: Enrolled children who are 6 months of age and older

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

Calculation:

$$\frac{\text{\# of children screened via the Ages and Stages Questionnaires –Social Emotional}}{\text{Total \# of children enrolled in the home visiting program}}$$

Forty-one of the 46 programs reporting data screened for social and emotional development via the Ages and Stages Questionnaire- Social Emotional. In FY15, 47% of enrolled children were screened for development toward expected milestones via this tool. Of the children who were screened, 11% presented with atypical social and emotional development. Thirty-nine percent of these children were referred for supplemental services.



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

[17] The Ages and Stages Questionnaires- Social Emotional can be used with children starting at 6 months of ages and include the following subscales: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people.

Domain 4: Children's Special Needs

The Federal Individuals with Disabilities Education Act (The Act) ensures the provision of early intervention services under Part C to children diagnosed with developmental delays, ages birth through three, and their families. Children who received services under Part C of the Act can continue receiving supportive services through age 21.[18] Early intervention can minimize delays and strengthen children's cognitive, physical and behavioral development, thereby reducing the incidence of future problems.[19]

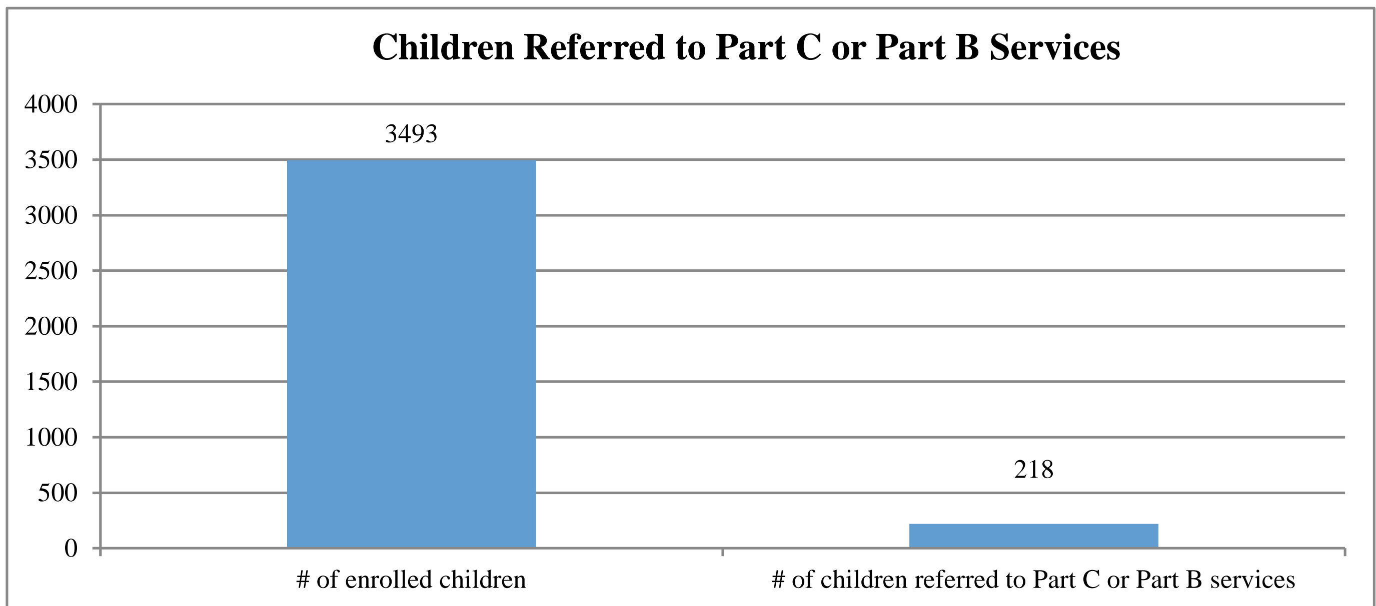
Target population: Enrolled children who were referred for services due to identified developmental disabilities

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

Calculation:

$$\frac{\text{\# of enrolled children referred to Federal Individuals with Disabilities Act Part C and/or Part B services}}{\text{Total \# of children enrolled in the home visiting program}}$$

For FY15, programs reported that 218 children were referred for Part C or Part B services to address developmental delays, representing 6% of children enrolled in home visiting.



[18] Maryland Learning Links. (no date). Accessed 06.11.15 from http://marylandlearninglinks.org/361448
[19] 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/

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.[20,21] Evidence-based home visiting programs can support parents in developing trusting, positive and reliable relationships with their children.

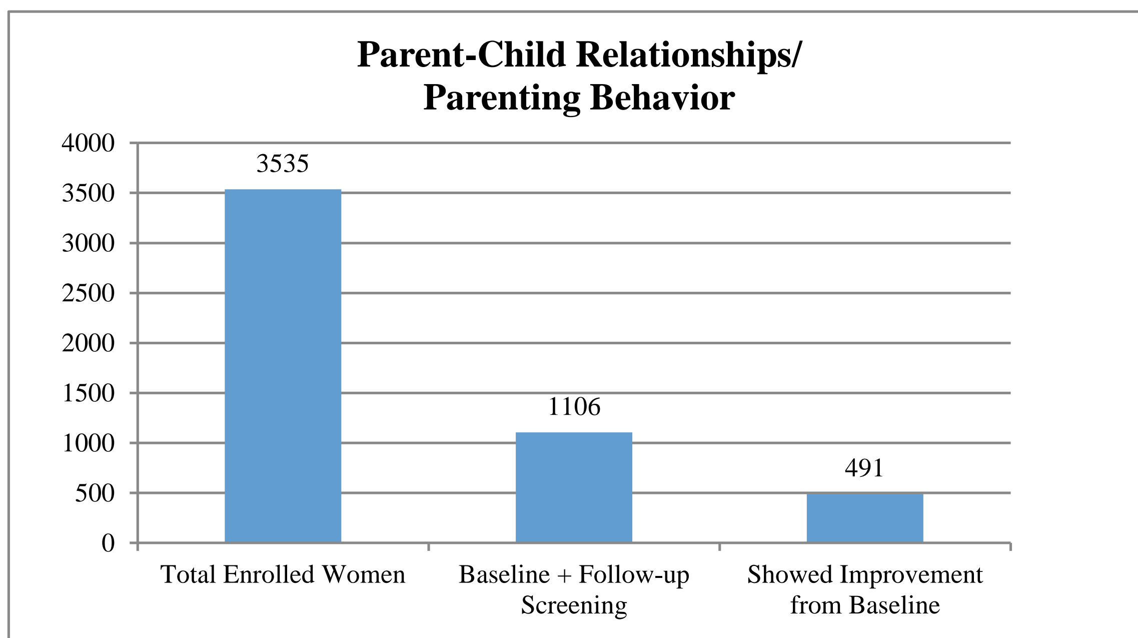
Target population: Enrolled mothers

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

Calculation:

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

Thirty-seven of the 46 sites reporting data conducted any screening related to parent-child relationships/parenting behaviors. In FY15, 31% of enrolled women received a follow-up screening on this measure. Of those women with both a baseline and a follow-up screening, 44% showed improvements in parent-child relationships/parenting behaviors. [22] Programs use a variety of tools to screen for high parenting stress. A full list of screening tools utilized can be found in Appendix E.



[20] 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.

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

[22] Data from several programs indicates that many women presented with healthy parenting behavior scores at baseline and remained at a healthy score at follow-up.

Domain 5: Family Relationships: Intimate Partner Violence

Intimate Partner Violence is a pattern of coercive behavior characterized by control of one person by someone who is intimately associated (*e.g.* a family member, husband/wife, boyfriend/girlfriend). Abuse can be physical, sexual, psychological, verbal and/or economic. In the U.S. approximately 1 in 4 women reported being victim to violence from a current or former partner.[23] For mothers, exposure to intimate partner violence is associated with mental health and parenting problems, while children experience a variety of social and emotional difficulties.[24]

Target population: Enrolled women

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

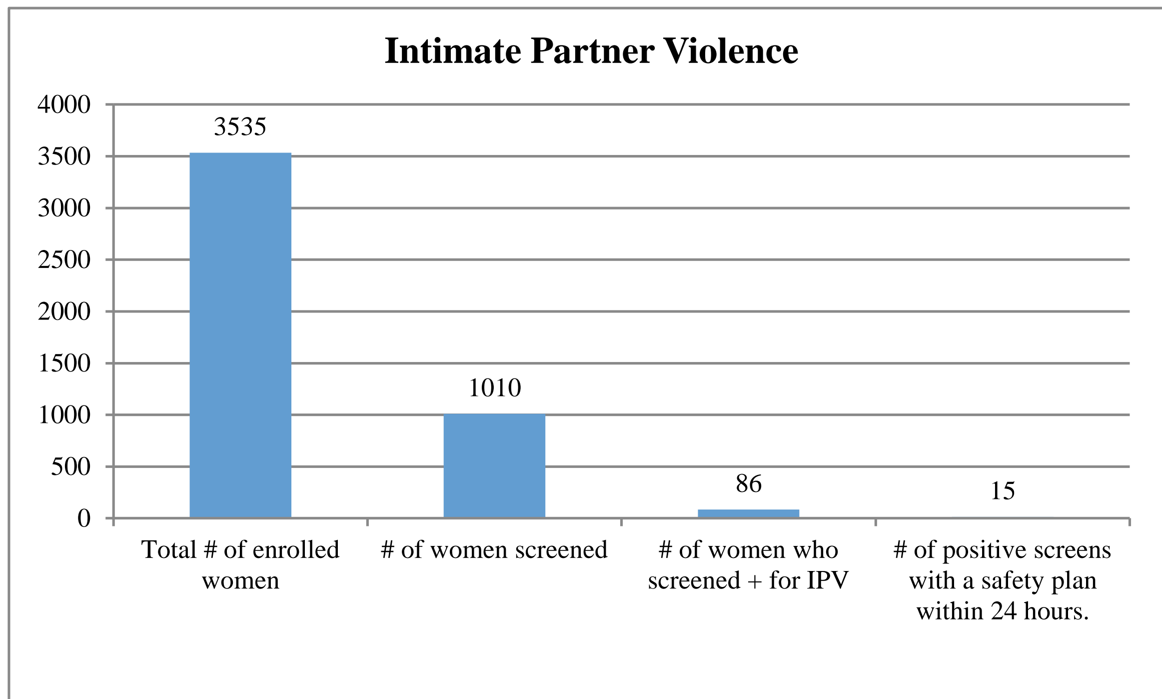
Calculation:

$$\frac{\text{\# of women screened for Intimate Partner Violence}}{\text{Total \# of women enrolled in the home visiting program}}$$

Twenty-three of the 46 sites that reported data conducted any screening for Intimate Partner Violence. In FY15, 29% of enrolled women were screened for Intimate Partner Violence. Of those women screened, nine percent screened positive. Thirty-eight percent of women created a safety plan within 24-hours of the positive screen. Programs use a variety of tools to screen for high parenting stress. A full list of screening tools utilized can be found in Appendix D.

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

[24] 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.



Recommendations from FY15 Data on Standardized Home Visiting Measures

1. Data Reporting

Of the 70 programs surveyed, 46 submitted data. Of those 46, 35 reported receiving State funding. Prior to this reporting effort, no centralized list of home visiting programs supported with State General Funds was available. Therefore, the total number of State-funded home visiting programs is 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 in advance of the required data collection.

2. 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.[25,26]

From FY15 data collected, it appears that sites vary widely in the focus on the two-generation approach. Program sites may see substantial gains in maternal and child health outcomes if they provide formal supports for primary caregivers as well young children.[27] State agencies that fund maternal and child home visiting

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[25] Smith, T., & Coffey, R. (2012) Two-Generation Strategies for Expanding the Middle Class.
[26] 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.
[27] Shonkoff et al., 2013.

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 workplan with a timeline for assisting programs to integrate a two-generation focus into the existing home visiting program.

3. 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.

4. 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.[28] Women enrolled in home visiting may have experienced significant trauma during their own early childhood years that is now impairing their own parenting capacity.[29] Prior trauma may be a contributing factor to current mental health problems, substance use, and intimate partner violence.[30]

Of the programs that currently provide any screening for maternal health issues, screening protocols span a continuum from multiple screening intervals annually to screening at the discretion of the home visitor. There are a number of programs that currently conduct no screening for maternal health issues, as this has not been an area of focus for the home visiting program model utilized.

State-funded home visiting programs could consider the feasibility of implementing universal screening, referral, and support protocols for mental health, substance use, and intimate partner violence. Universal screening involves screening 100% of maternal clients at pre-determined intervals, as defined by the program. A commitment to staff training and the identification of available referral and support resources is also essential to supporting mothers with a positive screen through treatment and recovery.

A subcommittee within the Home Visiting Consortium could research best practices and methods of integrating universal screenings in a sustainable manner.

5. 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?

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[28] 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.
[29] Ammerman et al., 2012
[30] 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.

There are potential synergies between healthcare and home visiting, as both stakeholders play a role in improving and stabilizing maternal and child health. A better understanding of how to optimize communication and collaboration between healthcare and home visiting could be explored at the local and State level through the Home Visiting Consortium and other healthcare collaborations.

6. Research into the Home Visiting Workforce

This survey gathered initial data on the workforce of home visiting programs. 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 could convene a workgroup to research workforce survey protocols and to identify critical questions for future home visiting surveys.

7. Systematic Review of the Standardized Measures

A periodic review of the adopted home visiting standardized measures could be built in to the data collection process to ensure that Maryland is collecting the most relevant data to support the progress of maternal and child health for Maryland families. The Pew Center for the States has been engaged in helping the states implement performance measures and has recently published a report that can provide further guidance—*Using Data to Measure Performance: A new framework for assessing the effectiveness of home visiting.*[31]

Conclusion

The data in this inaugural report on Maryland Home Visiting Standardized Measures provide a baseline from which Maryland can begin to view home visiting through a single lens. In FY15, 3,535 women and 3,493 children were served through one of five different home visiting models. The data reveal that Maryland home visiting has a solid focus on children. Eighty percent of those enrolled are up-to-date on well-child visits with a healthcare provider. Seventy-four percent of children have been screened for development toward expected milestones with the Ages and Stages Questionnaires, and, as delays are identified, appropriate referrals for early intervention services are taking place.

The data related to maternal health and family relationships indicate that the focus on the primary caregiver is not as uniform throughout Maryland home visiting programs. Less than half (43%) of women were screened for maternal depression. Maternal substance use and intimate partner violence were addressed with less than 30% of enrolled women. Each of these maternal health concerns has great potential to impact childhood growth and development. These data reveal gaps in service to support maternal health.

The passage of the Home Visiting Accountability Act of 2012 was an important step in Maryland's commitment to helping children and families during critical developmental periods and preparing children for success in school. Home visiting can contribute considerably to the continuum of the early childhood system of care. This report can help guide Maryland stakeholders in developing a more complete picture of the current and potential impacts of this family support strategy on maternal and child health.

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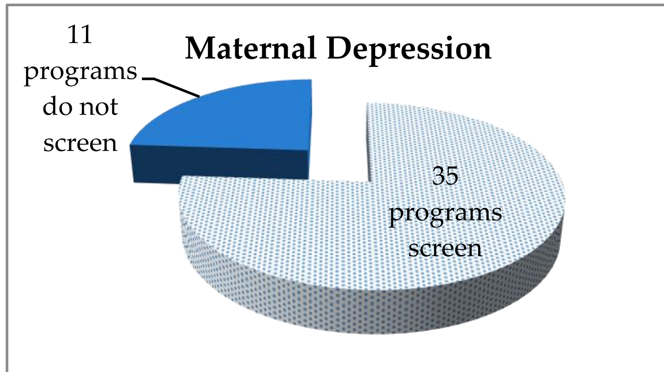
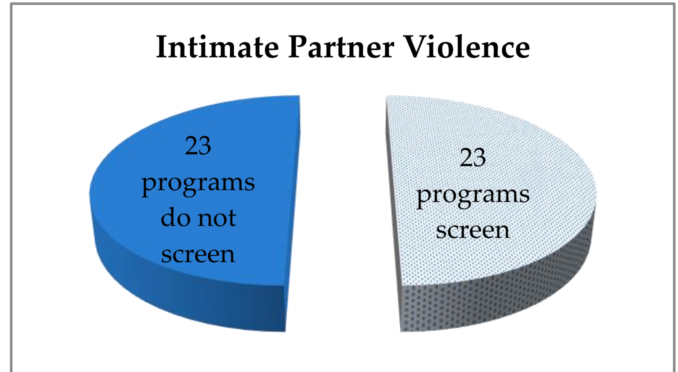
[31] http://www.pewtrusts.org/~/media/assets/2015/10/hv_datainitiativereport.pdf?la=en

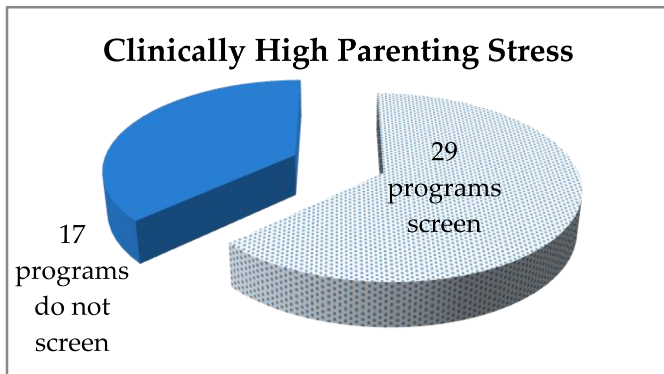
APPENDICES

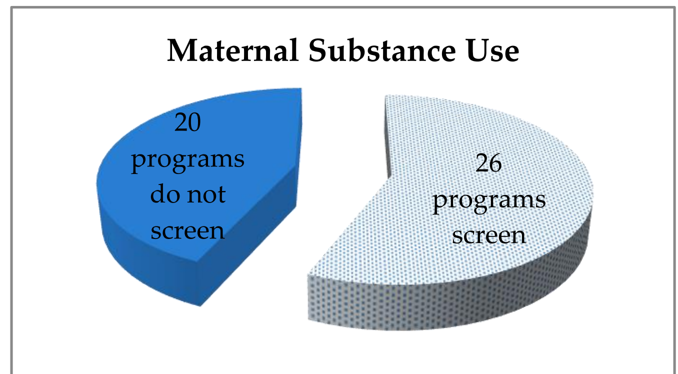
Appendix A: Programs that Screen for Maternal and Child Outcomes

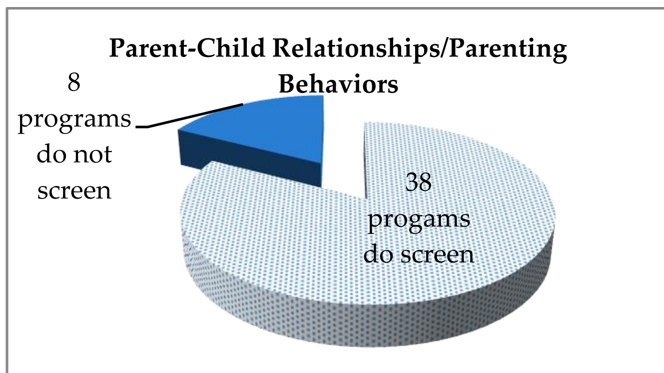
The following charts provide information about the number of home visiting programs that screen for each standardized measure.

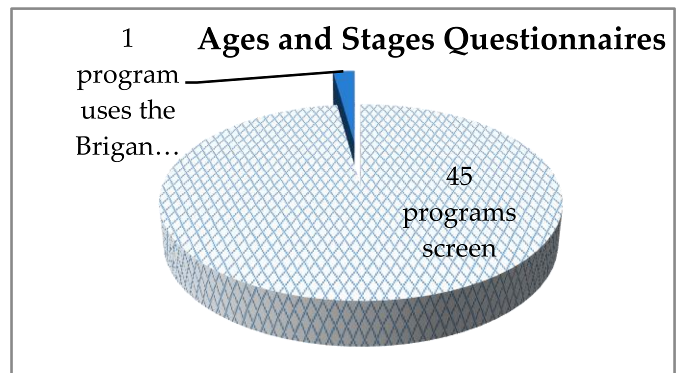


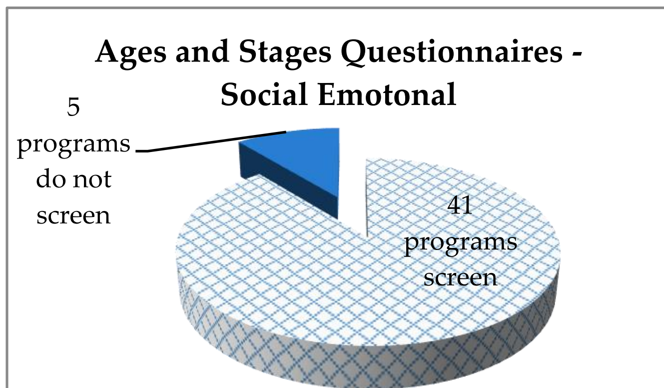












With the exception of the Ages and Stages Questionnaires screening, "program screening" is not universally conducted with all enrolled clients. Some programs screen 100% of clients at pre-determined intervals while others may only screen small numbers of clients that home visitors suspect to be impacted by certain issues.

Appendix B: Maternal Depression: Tools and Intervals

The following tables provide information about the tools and screening intervals used by home visiting staff during FY15 to screen for maternal depression.

Screening Tools Used	Percent of Sites That Use Tool[32]
Edinburgh Post-Natal Depression Score	74%
Center for Epidemiological Studies – Depression	22%
Healthy Families Parenting Inventory	8%
Other[33]	5%

Intervals Used	Percent of Sites That Screen on Interval[34]
Pre-natal[35]	25%
Pre-natal within 34-36 weeks	34%
At Enrollment (or within 30-90 days)[36]	42%
Post-partum[37]	14%
Post-partum within 2 weeks	5%
Post-partum within 4 weeks	28%
Post-partum within six weeks	14%
Post-partum within two months	17%
Post-partum within three months	20%
Post-partum within six months[38]	31%
Post-partum at 12 months	17%
Annual	60%
PRN/As needed[39]	22%

Sixty percent of programs that screen for maternal depression do so on an annual basis. Fifty-nine percent indicated that they screen prenatally. Forty-two percent of programs screen at enrollment, or within 90 days of enrollment. Sixty-one percent of programs screen at some postpartum point between birth and six weeks.

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[32] Percentages are counted on discrete instances of tool usage; some programs use more than one tool, so percentages may total more than 100

[33] Two sites use EPDS in conjunction with Life Skills Partnership

[34] Percentages are counted on discrete instances of interval usage; most sites screen at more than one interval, so percentages may total more than 100

[35] No timeframe mentioned

[36] Percentage could include both pre-natal and post-partum clients, depending on when enrollment takes place

[37] No timeframe mentioned

[38] Includes sites that indicate screening within 4-6 months post-partum

[39] Includes when either home visitor or parent suspects concerns

Appendix C: Maternal Substance Use Screening: Tools and Intervals

The following tables provide information about the tools and screening intervals used by home visiting staff during FY15 to screen for maternal substance use.

Screening Tools Used	Percent of Sites That Use Tool[40]
Health Habits	48%
Life Skills Progression	16%
CAGE	12%
4 Ps Patient Questionnaire	8%
Tobacco, Alcohol, and Drug Questionnaire[41]	8%
Intake Questionnaire[42]	8%

Intervals Used[43]	Percent of Sites That Screen on Interval[44]
Enrollment (or within 30-90 days)[45]	68%
Pre-natal (34-36 weeks)[46]	44%
Post-partum within six months[47]	28%
Post-partum at 12 months	8%
Annual	52%
PRN/as needed[48]	20%

[40] Percentages are counted on discrete instances of tool usage; some programs use more than one tool, so percentages may total more than 100

[41] Used with LSP and Intake Questionnaire

[42] Used with Tobacco, Alcohol, and Drugs Questionnaire and LSP

[43] Includes each instance of each interval used at all sites who reported

[44] Percentages are counted on discrete instances of interval usage; most sites screen at more than one interval, so percentages may total more than 100

[45] Includes sites that reported screening at "3rd or 4th home visit after enrollment." This percentage could include both pre-natal and post-partum clients.

[46] Two sites did not specify *when* they screened prenatally; they are included in this count

[47] Includes sites that screen at intervals before six months

[48] Includes when either home visitor or parent suspects concerns

Appendix D: Intimate Partner Violence Screening: Screening Tools and Intervals

The following tables provide information about the tools and screening intervals used by home visiting staff during FY15 to screen for intimate partner violence.

Tools Used	Percent of Sites That Use Tool[49]
Relationship Assessment Tool	52%
HITS – Hurt, Insulted, Threatened with Harm, and Screamed	30%
36 week Intimate Partner Violence Screening Tool	13%
LSP and Intake Questionnaire	8%
D.O.V.E.[50]	8%

Intervals Used	Percent of Sites That Screen on Interval[51]
Enrollment[52]	78%
Every Visit	13%
Pre-natal at 36 weeks	65%
Post-partum within two months	8%
Post-partum within three months	8%
Post-partum at six months	13%
Post-partum at 12 months	21%
Annual	60%
PRN/as needed[53]	21%

[49] Percentages are counted on discrete instances of tool usage; some programs use more than one tool, so percentages may total more than 100

[50] Sites that use D.O.V.E. pair with Relationship Assessment Tool

[51] Percentages are counted on discrete instances of interval usage; most sites screen at more than one interval, so percentages may total more than 100

[52] Includes one site that screens within 90 days of enrollment. Percentage could include both pre-natal and post-partum clients, depending on when enrollment takes place.

[53] Includes when either home visitor or parent suspects concerns

Appendix E: Parent-Child Relationships/Parenting Behaviors Screening: Tools and Intervals

The following tables provide information about the tools and screening intervals used by home visiting staff during FY15 to screen for strengths and challenges with parent-child relationships/parenting behaviors.

Tools Used	Percent of Sites That Use Tool[54]
Healthy Families Parenting Inventory	59%
Life Skills Progression	40%
HOME Inventory	10%
Parents As Teachers Pre-Post Survey	6%
Keys to Interactive Parenting Scale	6%

Intervals Used	Percent of Sites That Screen on Interval[55]
Enrollment (or within 30-90 days)[56]	43%
Post-partum at birth	9%
Post-partum at six months	83%
Post-partum at 12 months	16%
Post-partum at 18 months	29%
Annual	65%

[54] Percentages are counted on discrete instances of tool usage; some programs use more than one tool, so percentages may total more than 100

[55] Percentages are counted on discrete instances of interval usage; most sites screen at more than one interval, so percentages may total more than 100

[56] Includes sites that reported screening at "3rd or 4th home visit after enrollment." This percentage could include both pre-natal and post-partum clients.

Appendix F: Clinically High Parenting Stress Screening: Tools and Intervals

The following tables provide information about the tools and screening intervals used by home visiting staff during FY15 to screen for high parenting stress.

Tools Used	Percent of Sites That Use Tool[57]
Healthy Families Parenting Index	66%
Life Skills Progression	40%

Intervals Used	Percent of Sites That Screen on Interval[58]
Enrollment (or within 30-90 days)[59]	48%
Pre-natal[60]	11%
Post-partum within 30 days[61]	22%
Post-partum at six months	85%
Post-partum at 12 months	18%
Post-partum at 18 months	25%
Annual	66%

The most common interval for screening for clinically high parenting stress is at six months (85%). Many sites that screen at six months do so continuously, meaning that they screen on an annual basis. Sixty-six percent of sites reported that they screen annually.

[57] Percentages are counted on discrete instances of tool usage; some programs use more than one tool, so percentages may total more than 100

[58] Percentages are counted on discrete instances of interval usage; most sites screen at more than one interval, so percentages may total more than 100

[59] Percentage could include both pre-natal and post-partum clients, depending on when enrollment takes place

[60] No specific time-frame indicated

[61] Includes some sites that screen prior to 30 days

Appendix G: Data Graphic- FY15 Home Visiting Survey on Standardized Measures

FY15 Maryland Home Visiting Survey on Standardized Measures

Babies are born healthy.

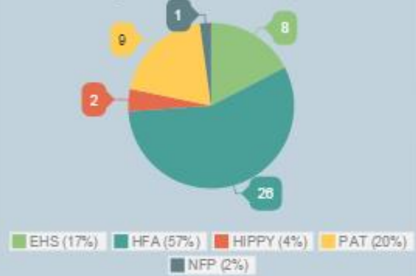
Family bonds are strong & supportive.

Families are connected to essential community resources.

Children enter school ready to learn.

3692 Maryland families served

46 HV Program Sites Responded



Child Health Measures

3493 Target Children Served

Children up-to-date on well-child visits: 80%.

Children screened for typical development via the ASQ-3: 74%

Children Identified with atypical development via ASQ-3: 14%

Children Referred for Part B or Part C services: 6%

Maternal Health Measures

Depressive Symptoms:
43% screened
23% screened +
72% of + screens referred for MH services

Substance Use/Abuse: 26% screened
10% screened +
72% of + screens referred for substance use services

Domestic Viiolence: 29% screened
9% screened +
38% created safety plans w/i 24 hours

Parent-Child Measures

High Parenting Stress: 35% of women were screened for clinically high parenting stress. 33% of those women screened positive.

Parent-Child Relationships: 44% of women with a follow-up screening showed improvements in parent-child relationships/parenting behaviors