2020 Maryland MIECHV Home Visiting Needs Assessment
Executive Summary

2020 Needs Assessment

New Priority Areas

Maryland identified "at-risk counties" using an independent method and indicators aligned with the HRSA guidance, which was vetted by stakeholders across the state. In total, 37 indicators of risk were considered to assess community needs. The indicators aligned with MIECHV domains, benchmarks, objectives, state priorities, and potential data sources for each compiled and examined indicator. This process ensured that indicators used to identify at-risk jurisdictions were internally defined by Maryland's stakeholders and therefore are reflective of priorities and goals specific to the state's home visiting programs.

The independent method identified 10 jurisdictions as being at-risk, including Baltimore City and Somerset, Washington, Talbot, Queen Anne's, St. Mary's, Dorchester, Garrett, Prince George's, and Worcester counties. This directly contrasts the 2010 MD-MIECHV needs assessment when only five of the jurisdictions above were identified as most at-risk and further identified Maryland's changing landscape and demographics. Conversely to the 2010 needs assessment, this assessment also compared each jurisdiction to itself. This revealed the diversity within each of Maryland's jurisdictions, even those that are not considered at-risk from the home visiting state map. This more in-depth look into each jurisdiction provided perspective and demonstrated pockets of need that would not otherwise be identified.

The needs assessment found that in most of the state, demand for home visiting services is greater than the current capacity of programs. Throughout the state, data collection is fragmented, including screenings administered to families and children. Furthermore, there is evidence that parents do not always know about the services. Home visiting programs serve an important role in connecting parents to vital community resources including substance use disorder treatment. However, of those who screen positive for substance use, only about half are referred to treatment, and only half of those referred get treatment. More could be done to help home visiting programs coordinate and collaborate with state and local agencies who serve these vulnerable populations.

The most common elevated indicator throughout the state was "Prenatal Care Began in the 3rd Trimester or not at all," with six jurisdictions having a z-score above 1 on this indicator. Table A below is a summary of data found in the 2020 needs assessment report in Appendix A, Tables 6 and 7 that show the jurisdictions with elevated indicators. These 10 jurisdictions have a higher concentration of at-risk indicators than the remaining 14 jurisdictions in the state.

Table A. Jurisdictions Identified as At-Risk 2020

Jurisdiction	# of elevated indicators	Identified in 2010*	Indicators of Risk Identified
Baltimore City	8	Yes	Poverty, Pregnancy Associated with Hypertension on Hospitalization Rate, Child Injury Emergency Department Visit Rate, Medicaid, Substance Use Treatment Rate, Protective Order, Crime, Dropout
Somerset County	7	Yes	Low Birth Weight, Prenatal Care Began in 3rd Trimester or None at all, Poverty, Pregnancy Associated with Hypertension Hospitalization Rate, Gestational Diabetes Hospitalization Rate, Very Preterm and Very Low Birth Weight, Dropout
Washington County	6	Yes	Low Birthweight, Prenatal Care Began in 3rd Trimester or None at all, Poverty, Maternal Tobacco Use, Very Preterm and Very Low Birth Weight, Protective Order, Kindergarten Readiness, Dropout
Talbot County	4	No	Low Birthweight, Prenatal Care Began in 3rd Trimester or None at all, Poverty, Maternal Tobacco Use, Very Preterm and Very Low Birth Weight.
Queen Anne's County	3	No	Low Birth Weight, Prenatal Care Began in 3rd Trimester or None at all, Very Preterm and Very Low Birthweight
St. Mary's County	3	No	Premature Birth, Low Birth Weight, Prenatal Care Began in 3rd Trimester or None at all
Dorchester County	2	Yes	Maternal Tobacco Use, Child Injury Emergency Department Visit Rate
Garrett County	2	No	Maternal educational attainment; Child Injury Emergency Department Visit Rate
Prince George's County	2	Yes	Kindergarten Readiness, Dropout
Worcester County	2	No	Prenatal Care Began in 3rd Trimester or None at all, Child Injury Emergency Department Visit Rate

* method for identifying jurisdictions at-risk changed and it is not possible to make direct comparisons

Findings

The MIECHV Needs Assessment Steering Committee provided many detailed recommendations to help focus the next steps in our work. These recommendations (listed below) will be used to gather input, determine regional preferences, and statewide trends. These next steps will drive the development of a five-year action agenda.

MD-MIECHV Needs Assessment Steering Committee Recommendations

Awareness of Home Visiting

- Lead a coordinated campaign with partners from various child-serving organizations about what is available to improve children's outcomes in their first 1,000 days.
- Develop specific infographics for stakeholders to help them understand what home visiting is and what it does.
- Partner with the MD Chapter of the AAP to increase awareness about home visiting within the medical community.
- Develop [with other state and local partners] a parent leader model that, using parents that have successfully completed a home visiting program, can educate other families on the importance of home visiting services.

Data and Standardized Measures

- Develop a statewide strategic mission/strategy for aligning benchmarks, streamlining reporting and quality initiative requirements, and coordinating funding mechanisms.
- Move towards one statewide Management Information System for all reporting requirements--centralized to accommodate different reporting if the state aligns measures.
- Develop statewide standards based on the quality of programs and differences in how quality is conceptualized based on program models and geographic location.

Coordinated Statewide Efforts

- Explore centralized intake and "one-stop-shop" options to facilitate better coordination and communication among providers at the local and state level, possibly using HCAM Baltimore as a model.
- Create a comprehensive statewide list of referral sources by the jurisdiction that home visitors and others in the field can access.
- Conduct a salary survey to see disparities among various models/jurisdictions and engage agencies in determining the feasibility of developing a coordinated salary scale across home visiting models.

Substance Use Supports

Collaborate with state agencies to determine how to expand wraparound services for women with substance use issues.	Increase substance use training access to programs for mothers, fathers, and children that home visiting programs can leverage.
Add an SBIRT (Screening, Brief Intervention, and Referral to Treatment) module to the UMBC HV Training Certificate program.	Provide training in a "warm handoff" for families to substance use referrals.
Use the Substance Exposed Newborn Training statewide as a regional training platform to reintroduce an opportunity to work as a team for treatment and referral.	Increase training for home visitors around substance use and intimate partner violence.

2010 Needs Assessment

The 2010 Home Visiting Needs Assessment looked at 15 indicators that put children and families at-risk: prematurity, low-birth-weight, late or no prenatal care, teen birth and infant mortality rates; poverty; crime; domestic violence; high-school drop-outs; low school readiness rates; substance abuse treatment; unemployment; WIC and Medicaid participation; and/or child maltreatment. The state was divided into 368 potential "communities" (including 55 neighborhoods in Baltimore City and census tracts in the rest of the state). Maryland then used a ZIP code/Community Statistical Area (CSA) analysis to identify risk (having at least one elevated indicator) in the 368 communities. Based on this analysis, the state's 24 jurisdictions/communities were divided into four Tiers. Tier one communities were deemed most at-risk because they were elevated on 10 or more of the 15 indicators described above. These 46 "hot spot" communities were located in six jurisdictions: Baltimore City and Dorchester, Washington, Prince George's, Wicomico, and Somerset counties. The State Home Visiting Team decided to initially begin local planning activities with the six most at-risk jurisdictions.

The Maryland Home Visiting Team used the following criteria for identifying the state's targeted at-risk communities for FY 2010:

· Ranking on the state's home visiting needs assessment. Priority consideration was given to the six areas ranked as "hot spots" on the needs assessment. These included (in order of weighted risk) Baltimore City, Dorchester County, Washington County, Wicomico County, Prince George's County, and Somerset County. With additional competitive funding, Maryland was able to fund the top 10 jurisdictions at-risk and added tier 2 communities to the existing six jurisdictions already funded, including Allegany, Baltimore, Caroline, and Harford counties.

· Current Capacity to reach families/children in need. Priority consideration was given to communities with evidence-based home visiting program slots for less than 10% of poor families (as measured by the U.S. Census– number of poor families with children under age 18). Consideration was also given to population size and the ability to support a new or expanded program.

· Community readiness to implement/expand a home visiting program. The state considered such factors as a willingness to align/realign existing home visiting programs; the existence of a well-developed local plan; review of community needs to determine the most appropriate home visiting model for implementation and willingness to leverage current home visiting resources to maximize the use of new funding.

Table B below provides a list of jurisdictions identified as at-risk in 2010 and in 2020 and demonstrates differences between 2010 and 2020.

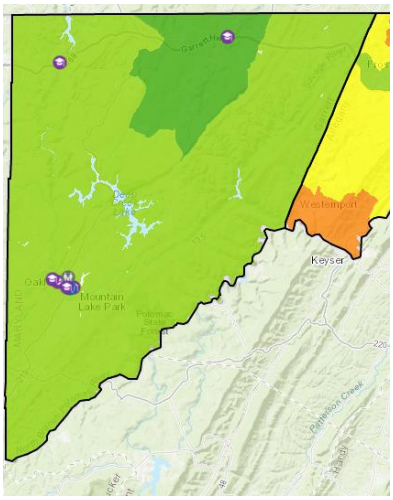
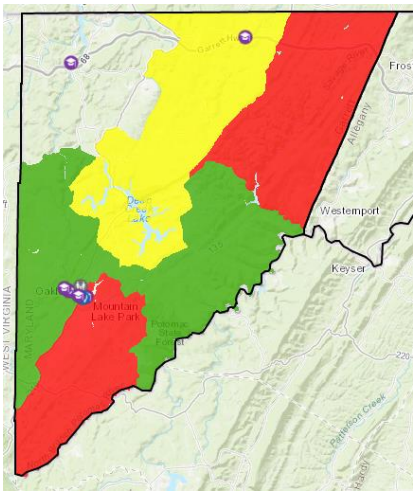
Table B. Jurisdictions Identified as At-Risk 2010-2020: Comparison

Jurisdiction Name	Identified at-risk 2010	Identified at-risk 2020
Allegany County	✓	
Baltimore City	✓	✓
Baltimore County	✓	
Caroline County	✓	
Dorchester County	✓	✓
Garrett County		✓
Harford County	✓	
Prince George's County	✓	✓
Queen Anne's County		✓
Somerset County	✓	✓
St. Mary's County		✓
Talbot County		✓
Washington County	✓	✓
Wicomico County	✓	
Worcester County		✓

Key	Jurisdiction Identified by Needs Assessment Year	Summary
	2010 and 2020	Five jurisdictions that were funded in the original needs assessment plan are still identified as at-risk in 2020 including Baltimore City, Dorchester, Prince George's, Somerset, and Washington Counties.
	2010	Five jurisdictions that were funded in the original needs assessment plan were not identified as at-risk in the 2020 needs assessment including Allegany, Baltimore, Caroline, Harford, and Wicomico Counties.
	2020	Five jurisdictions were identified in the 2020 needs assessment as areas with high concentrations of risk including Garrett, Queen Anne's, St. Mary's, Talbot, and Worcester Counties.

Funding
HRSA has yet to provide guidance concerning if/when MIECHV will be funding additional areas, altering funding to accommodate new areas, or reallocating funds from jurisdictions no longer weighted at-risk. Maryland is creating a plan for how this will be communicated once we are provided written HRSA guidance.

Direct comparisons of data from the 2010 needs assessment to this update in 2020 are not possible. Data in 2010 was calculated across the state, and the 2020 needs assessment, data were analyzed both at the state and individual jurisdictional differences. A good example of this is Garrett County, where on the state data map it appears to be no significant risk for families. However, when observing that same county compared to itself, there are disparate pockets of need.

STATE DATA: Garrett County	JURISDICTIONAL COMPARISON: Garrett County
	

Therefore, funding using this new needs assessment must take into consideration, HRSA guidance, stakeholder input, and jurisdictional data.

Next Steps
MD-MIECHV shared preliminary findings from this report with members of the steering committee once HRSA has approved the report. The full report will be disseminated after HRSA approves the needs assessment report (current estimated date by February 2021).

- The report will be uploaded to our web page, disseminated via newsletter and email blast, and shared widely with partners;
- A meeting will be scheduled with the Home Visiting Consortium members and the Early Childhood Advisory Council to present findings.
- Regional town halls will be hosted to gather input, determine regional preferences, and statewide trends.

Using the information gathered, Maryland will develop a five-year home visiting action agenda with the state, local, and university partners. When HRSA guidance is released, Maryland will have a plan for funding.