STATE OF DELAWARE

2020 MIECHV NEEDS ASSESSMENT

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Center for Family Health Research and Epidemiology

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I. INTRODUCTION

This document serves as the 2020 Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment for the State of Delaware. At the federal level, the MIECHV program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). The Delaware MIECHV program receives funding through the federal MIECHV program to implement evidence-based home visiting programs and promising approaches. By conducting a statewide needs assessment, the Delaware MIECHV program can identify target populations and select home visiting service delivery models that best meet state and local needs.[1] As Delaware and the nation celebrate 10 years of the MIECHV program, it is essential to note that the program has been instrumental in improving more "traditional" maternal, infant, and early childhood measures, such as safe sleep practices, developmental screening rates, and intimate partner violence screening while also recognizing that "newer" challenges exist, such as accessing services and maintaining clients' livelihoods during the ongoing COVID-19 crisis as well as addressing increased rates of opioid dependency among perinatal women.

The State of Delaware's 2020 MIECHV Needs Assessment was completed in a multifaceted manner, which included performing the following actions:

- Updating data and data sources used in the 2010 and 2015 MIECHV Needs Assessments;
- Conducting surveys of home visitors and field supervisors to gain insights on the carrying out of the state's evidence-based home visiting programs;
- Making use of data reports amassed through the MIECHV program, specifically annual performance measurement reports, ongoing continuous quality improvement (CQI) reports, and a recently-completed MIECHV innovation project on opioid dependency, substance misuse, and neonatal abstinence syndrome (NAS);
- Detailing existing substance use disorder treatment and counseling services offered within the State of Delaware; and
- Integrating data reports and documentation from focus groups, interviews, and surveys completed on other maternal, infant, and early childhood needs assessments, namely the Title V MCH Block Grant, Head Start, CAPTA, and PDG B-5.

Like HRSA, the State of Delaware recognizes this needs assessment as a critical and foundational resource for identifying at-risk communities, understanding the needs of families, and assessing services in their early childhood systems. This needs assessment update helped reveal population trends, determine areas of increasing or decreasing risk, and identify potential resources to support families in need.

The results of this needs assessment update will also inform strategic decision-making by the Delaware MIECHV program and its stakeholders and identify opportunities for collaboration to strengthen and expand services for at-risk families. In addition, it is anticipated that this needs assessment update will be used by evidence based home visiting partners within the state as well as other maternal, infant, and early childhood programs such as Title V, Head Start, CAPTA, and PDG B-5.

[1] In Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

II. IDENTIFYING COMMUNITIES WITH CONCENTRATIONS OF RISK

The State of Delaware has identified all three of its counties – Kent County, New Castle County, and Sussex County – as counties that have communities with concentrations of risk. However, given the relatively small size of the state, the Delaware MIECHV program will be focusing on specific geographic regions in each of these counties for its programmatic efforts. Therefore, the state has chosen to adopt an independent method for identifying communities at risk, recognizing that it will report all three of its counties as being at higher risk for this needs assessment.

A. Methodology of Independent Method

Choosing a Basic Geographic Unit for Analysis

A meticulous study was performed on what geographic unit would be used to help define the communities at higher risk for adverse outcomes. The county level has some merit as a geographic unit since many agencies report data at this level. County data, however, has its limitations given that Delaware has only three counties and one of these three counties (New Castle) is home to more than half of the state population. Given these facts, it was determined that county level analysis would be too crude. Conversely, Delaware has 196 census tracts that could be aggregated in varying ways to generate larger geographic units for evaluation. Nevertheless, agencies rarely report data at the census tract level rendering this geographic unit to be too minute to conduct analysis. Keeping the benefits and drawbacks of both county and census tract levels in mind, it was decided that zip codes would serve as a geographic unit to balance both accessibility and granularity of data. According to the 2010 census, Delaware has 67 populated zip codes and several agencies report data at this level.

Aggregating Zip Codes into "Zones"

Zip codes may vary considerably in population and sizeable demographic differences may exist from one location within a zip code to another. To help mitigate these weaknesses, Delaware's zip codes were aggregated into 18 "zones" with estimated populations ranging from 23,266 to 93,267. Table 1 on the following page presents each of the zones, the zip codes that comprise the zone, the general location of the zone, and the total population of the zone.

The zip codes were loosely assigned to each zone by sharing similar rates of the following demographic indicators:

- *High School Completion*. Defined as the percentage of the population age 25 and over without a high school degree.
- *Poverty Level*. Defined as the percentage of the population below the 100% Federal Poverty Level.
- *Unemployment Rate*. Defined as the percentage of the population age 16 and over in the labor force who are unemployed.

Table 1. Zip Codes, Location, and Population by Zone.

Zone	Zip Codes	Location	Total Population
Zone 1	19703, 19809	Northeast Wilmington	29,932
Zone 2	19803, 19810	North Wilmington	47,829
Zone 3	19801, 19802, 19806	East Wilmington	51,897
Zone 4	19804, 19805	Central Wilmington	57,077
Zone 5	19808	West Wilmington	40,726
Zone 6	19707, 19710, 19732, 19736, 19807, 19735	Northwest Wilmington	23,266
Zone 7	19706, 19720, 19733	Southeast Wilmington	63,428
Zone 8	19711, 19717	North Newark	56,407
Zone 9	19713, 19716	Central Newark	31,699
Zone 10	19702	South Newark	54,668
Zone 11	19701, 19709, 19730, 19731, 19734, 19736	Middletown, Townsend	93,267
Zone 12	19904, 19938, 19955, 19977	Smyrna, West Dover	69,923
Zone 13	19901, 19902	East Dover	37,579
Zone 14	19934, 19943, 19953, 19962, 19964, 19979	Camden, Felton	43,593
Zone 15	19941, 19946, 19950, 19952, 19954, 19960, 19963	Milford, Harrington	55,000
Zone 16	19931, 19951, 19958, 19968, 19971	Lewes	51,796
Zone 17	19933, 19940, 19947, 19956, 19973	Georgetown, Seaford	76,042
Zone 18	19930, 19939, 19944, 19945, 19966, 19967, 19970, 19975	East Sussex	62,859

Source: U.S. Census Bureau, 2013-2017 American Community Survey.

In addition to sharing similar demographic characteristics, the zones were designed to surround and not divide regional population centers in Delaware. For example, zone 16 largely comprises the zip codes in and around the Lewes area. The major exceptions to this plan include:

- *Dover*. The city has one large zip code by population (19901) in one half of the city and several smaller ones in the other half of the city and environs. To keep population sizes consistent, the region surrounding the city was split into two zones (12 and 13).
- *Newark*. The city has three zip codes, each of which has a sizeable population. Like Dover, the region was split into multiple zones (8, 9 and 10) in order to maintain consistent population sizes.
- *Wilmington*. The city has several zip codes and the region has considerable socioeconomic diversity. Consequently, zip codes were allocated to zones with particular emphasis on the three demographic indicators above as well as population size.

The median household income reported in the 2013-2017 American Community Survey for each of the zip codes was taken, and through regression analysis, was assessed as being a fairly robust variable to explain the three demographic indicators above. To ascertain the weighted average median income of each zone, a calculation involving both the population proportion of each zip code within each zone and median income was performed. Table 2 on the following page lists the total number of households in the zone and the weighted median income for each zone.

B. Indicators Used to Determine At-Risk Zones

Relatively recent zip code level data was available for the following indicators, were ultimately used to determine the at-risk zones:

- *Adults Reporting Transportation Barriers*
- *Adults with No Dental Visit in Past Year*
- *Adults who Binge Drink*
- *Adults who Smoke*
- *Adults who Witnessed Violence*
- *Age-Adjusted Mortality Rate*
- *Chronic Conditions (3 Sub-Indicators)*
  - *Adults with Diabetes*
  - *Adults with High Blood Pressure*
  - *Adult Obesity*
- *Educational Attainment (Less Than High School Graduate)*
- *Health Insurance (No Coverage)*
- *Limited Access to Health Care*
  - *Adults Delaying/Not Seeking Care*
  - *Adults with No Usual Source of Care*
- *Limited English Proficiency*
- *Low Birth Weight*
- *Poverty (Below 100% FPL)*
- *Unemployment*

Of these indicators, two indicators (Adults Reporting Transportation Barriers and Adults who Witnessed Violence) were drawn from the 2015 Delaware Household Survey; one indicator (Age-Adjusted Mortality Rate) was derived from CDC Vital Statistics data from 2015-2017; one indicator (Low Birth Weight) was sourced from the Uniform Data System, 2018; five indicators (Educational Attainment, Health Insurance, Limited English Proficiency, Poverty, and Unemployment) were extracted from the 2013-2017 American Community Survey data; and the remaining eight indicators made use of data from the 2017 Behavioral Risk Factor Surveillance System (BRFSS);. The results by zone for each of the indicators are presented in Tables 3A and 3B.

Table 2. Total Households and Weighted Median Household Income by Zone.

Zone	Total Households	Weighted Median Household Income
Delaware	352,357	$62,470
Zone 1	11,880	$62,109
Zone 2	18,244	$93,209
Zone 3	21,378	$42,320
Zone 4	21,988	$45,801
Zone 5	15,398	$70,601
Zone 6	8,974	$123,683
Zone 7	22,206	$59,468
Zone 8	19,087	$73,136
Zone 9	11,965	$54,273
Zone 10	19,350	$74,668
Zone 11	31,358	$92,697
Zone 12	24,550	$21,469
Zone 13	13,688	$47,874
Zone 14	16,009	$63,090
Zone 15	20,195	$53,868
Zone 16	22,917	$67,677
Zone 17	26,834	$50,922
Zone 18	26,336	$58,836

Source: U.S. Census Bureau, 2013-2017 American Community Survey.

C. Determining At-Risk Communities from the Indicator Results

For each of the indicators listed on the previous page, the five zones with the most adverse (or unfavorable) results were highlighted in bold font in Tables 3A and 3B. For example, for *Low Birth Weight*, the data reported in zones 3, 7, 10, 12, and 13 were put in bold as these five zones had the highest low birth weight rates. Note that the three Chronic Condition sub-indicators and two Limited Access to Health Care sub-indicators were each given one-third of the weight and one-half of the weight, respectively, of separate indicators. Finally, as indicators highly linked to MIECHV benchmarks, five indicators (Adults Who Smoke, Educational Attainment, Health Insurance, Low Birth Weight, and Poverty) were given two times the weight of one indicator.

Table 3A. Indicator Results for Delaware and Zones 1-9.

Indicator	State	Zone 1	Zone 2	Zone 3	Zone 4	Zone 5	Zone 6	Zone 7	Zone 8	Zone 9
Adults w/Transportation Barriers	**8.7%**	5.6%	5.6%	**16.4%**	3.1%	3.1%	3.5%	8.2%	**9.2%**	**9.2%**
Adults w/No Dental Visit in Past Year	**34.8%**	36.9%	37.4%	35.1%	36.8%	37.6%	37.2%	**37.7%**	**37.8%**	**37.8%**
Adults who Binge Drink	**15.4%**	**16.6%**	11.6%	15.4%	**19.9%**	14.0%	11.7%	**16.3%**	**19.6%**	15.8%
Adults who Smoke	**16.5%**	13.1%	11.3%	16.5%	17.3%	13.8%	12.2%	**18.5%**	16.4%	15.6%
Adults who Witnessed Violence	**24.6%**	17.7%	17.7%	**34.9%**	23.5%	23.5%	6.4%	**30.6%**	14.1%	14.1%
Age-Adjusted Mortality Rate	**709.5**	700.1	698.6	**766.6**	685.0	679.5	680.0	714.7	685.8	681.5
Chronic Conditions										
Adults with Diabetes	**13.0%**	9.3%	12.7%	13.1%	8.2%	14.2%	**14.8%**	13.9%	8.6%	**15.3%**
Adults with High Blood Pressure	**35.5%**	33.5%	36.6%	**39.8%**	26.2%	37.5%	**40.6%**	33.9%	24.2%	36.8%
Adult Obesity	**31.7%**	26.0%	22.3%	**35.4%**	29.9%	24.6%	25.1%	**35.2%**	27.6%	28.0%
Educational Attainment	**10.7%**	7.4%	3.7%	**13.9%**	**16.8%**	7.5%	2.7%	12.2%	4.8%	9.6%
Health Insurance (No Coverage)	**6.7%**	6.6%	3.5%	5.3%	**9.4%**	6.4%	2.3%	**8.1%**	4.2%	5.5%
Limited Access to Health Care										
Adults Delaying/Not Seeking Care	**13.9%**	10.0%	10.2%	14.9%	**17.4%**	12.1%	9.4%	**18.5%**	**16.2%**	11.6%
Adults with No Usual Source of Care	**20.2%**	15.4%	15.0%	19.7%	**26.7%**	18.7%	12.4%	21.8%	**26.3%**	19.2%
Limited English Proficiency	**2.4%**	2.2%	1.5%	1.5%	**4.7%**	2.7%	0.8%	2.6%	2.2%	**4.6%**
Low Birth Weight	**8.3%**	8.5%	7.4%	**10.9%**	8.6%	7.5%	7.3%	**9.5%**	7.6%	8.2%
Poverty	**12.1%**	11.1%	4.0%	**26.4%**	**20.1%**	10.1%	2.9%	12.9%	**16.3%**	11.0%
Unemployment	**6.4%**	**8.4%**	4.8%	**9.0%**	**9.2%**	5.0%	3.0%	**7.0%**	4.9%	6.2%

Table 3B. Indicator Results for Delaware and Zones 10-18.

Indicator	State	Zone 10	Zone 11	Zone 12	Zone 13	Zone 14	Zone 15	Zone 16	Zone 17	Zone 18
Adults w/Transportation Barriers	**8.7%**	**11.9%**	2.1%	3.1%	**14.9%**	6.8%	8.3%	6.9%	8.9%	2.9%
Adults w/No Dental Visit in Past Year	**34.8%**	**37.9%**	**37.7%**	28.7%	27.8%	27.7%	31.2%	33.2%	33.8%	33.3%
Adults who Binge Drink	**15.4%**	**20.4%**	13.9%	14.7%	15.0%	14.1%	16.0%	11.4%	15.8%	12.4%
Adults who Smoke	**16.5%**	17.3%	17.6%	**18.0%**	**18.2%**	16.9%	**17.8%**	15.0%	**18.9%**	15.7%
Adults who Witnessed Violence	**24.6%**	27.5%	12.6%	**30.1%**	**28.6%**	25.9%	19.7%	22.5%	**29.6%**	19.9%
Age-Adjusted Mortality Rate	**709.5**	670.9	707.9	**740.1**	**720.0**	**745.2**	**732.1**	719.7	708.3	708.2
Chronic Conditions										
Adults with Diabetes	**13.0%**	8.5%	**19.4%**	12.9%	12.1%	14.1%	10.8%	**16.4%**	12.5%	**15.6%**
Adults with High Blood Pressure	**35.5%**	26.8%	**44.9%**	35.2%	32.5%	36.9%	33.4%	**43.7%**	34.6%	**41.5%**
Adult Obesity	**31.7%**	27.0%	33.2%	**37.5%**	**38.9%**	**36.5%**	34.8%	31.5%	35.0%	31.8%
Educational Attainment	**10.7%**	9.8%	5.7%	**13.8%**	13.0%	11.7%	**14.8%**	6.1%	**18.4%**	12.3%
Health Insurance (No Coverage)	**6.7%**	7.6%	4.8%	**8.9%**	6.7%	7.1%	6.9%	5.8%	**8.8%**	**8.1%**
Limited Access to Health Care										
Adults Delaying/Not Seeking Care	**13.9%**	16.0%	13.7%	13.2%	**16.1%**	12.2%	12.9%	10.2%	**16.3%**	11.0%
Adults with No Usual Source of Care	**20.2%**	**28.1%**	18.6%	19.2%	**24.4%**	16.9%	19.0%	13.5%	**23.9%**	15.3%
Limited English Proficiency	**2.4%**	**3.9%**	0.9%	2.5%	**3.2%**	1.3%	1.8%	0.5%	**5.0%**	1.5%
Low Birth Weight	**8.3%**	**8.9%**	8.5%	**8.8%**	**8.7%**	8.1%	7.9%	7.1%	7.5%	7.1%
Poverty	**12.1%**	9.5%	5.3%	11.8%	**16.2%**	9.4%	15.5%	7.1%	**15.2%**	10.6%
Unemployment	**6.4%**	6.1%	6.1%	6.8%	**7.4%**	5.8%	6.4%	5.5%	6.5%	6.2%

D. Results

Table 4 displays the zones by the sum of risk indicators. The six zones with the highest sum are designated as the at-risk zones and are given in light grey highlight. Note that a sizable drop-off in the sum of indicators occurs between these top six zones and the remaining twelve zones. For each at-risk zone, general comments are also given based on the indicators listed within the top five (e.g., *Unemployment* as "Low SES", *Adult Obesity* as "Poor Health").

Table 4. Zones Identified as At-Risk.

Zone	Location	Sum of Indicators	General Comments
13	East Dover	11.3	Poor Health, Low SES
17	Georgetown, Seaford	11.0	Poor Health, Low SES
7	Southeast Wilmington	10.8	Low SES
12	Smyrna, West Dover	10.3	Poor Health
4	Central Wilmington	10.0	Poor Health, Low SES
3	East Wilmington	9.7	Poor Health, Low SES
10	South Newark	5.5	
8	North Newark	5.0	
15	Milford, Harrington	5.0	
18	East Sussex	2.7	
9	Central Newark	2.3	
1	Northeast Wilmington	2.0	
11	Middletown, Townsend	1.7	
14	Camden, Felton	1.3	
6	Northwest Wilmington	0.7	
16	Lewes	0.7	
2	North Wilmington	0.0	
5	West Wilmington	0.0	

Note that three at-risk zones (zones 3, 4, and 7) are within New Castle County and the other three zones (zones 12, 13, and 17) are within Kent and Sussex counties. This may suggest that public health and social service programs need to deliver services equitably across the state, especially given the differences in socioeconomic challenges within the state. Notably, poor access to care and geographic barriers impact southern Delaware more than northern Delaware while racial disparities and urban poverty adversely affect northern Delaware more than southern Delaware.

E. Limitations

This analysis features several limitations. The use of zip codes presents some challenges given the diversity of demographic indicators present within many of these geographic units. In addition, this assessment makes use of health and socio-demographic indicators that may not be as relevant to maternal and child health outcomes. This limitation reduces the integrity of this assessment in the maternal and child health setting; however, many of these measures – such as adult obesity and age-adjusted mortality rate – may serve as proxies for community health based on the tenets of the life course framework. Finally, with the exception of Low Birth Weight, this analysis suggests that all indicators are of equal weight in defining "at-risk" communities.

III. QUALITY AND CAPACITY OF EXISTING PROGRAMS

Table 5 summarizes the characteristics of home visiting services in each of the at-risk counties in Delaware (this is the same table given in the required Needs Assessment Data Summary Excel workbook). Note that all three of Delaware's counties are designated as at-risk counties for MIECHV services per the results detailed in the prior section. The estimated number of families served by a home visiting program makes use of data provided by both the MIECHV-supported and non-MIECHV supported programs and by reported zip code of residence. As evidenced by this table, the estimated number of families served by a home visiting program is markedly less than the estimate of need across all counties; however, the gap in estimated coverage ranges from 41.3 percent in Kent County to 15.3 percent in Sussex County.

Table 5. Home Visiting Characteristics of At-Risk Counties, State of Delaware.

	Kent	New Castle	Sussex
The county is served, in whole or in part, by at least one home visiting program	Yes	Yes	Yes
The county is served, in whole or in part, by at least one home visiting program that implements evidence-based home visiting service delivery models eligible for implementation by MIECHV	Yes	Yes	Yes
The county is served, in whole or in part, by home visiting programs funded by MIECHV	Yes	Yes	Yes
Estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year	309	589	317
Estimate of need in the county (from HRSA)	748	2,890	2,076
Estimate of coverage (families served/need)	41.3%	20.4%	15.3%

Table 6 provides the funded enrollment and capacity of home visiting programs within the State of Delaware. This table shows that PAT serves as the largest evidence-based home visiting program in the state overall and as supported by MIECHV.

Table 6. Inventory of Existing Home Visiting Programs, State of Delaware.

Program Name	Funder	Areas Primarily Served	Funded Enrollment Capacity	Number of Households that Received Services in FY 2019
HFA	MIECHV	Statewide	180	168
NFP	State Funds	Statewide	200	274
PAT	DOE, MIECHV	Statewide	235 (DOE) 304 (MIECHV)	349 (DOE) 424 (MIECHV)

A. Gaps in the Delivery of Early Childhood Home Visiting Services.

The following have been recognized as consistent gaps through survey findings as well as ongoing conversations with the home visiting field supervisors, community advisory board, and home visitors:

Client Attrition

Not surprisingly, client attrition has persistently adversely affected the ability of home visitors in assisting their clients and achieving robust program outcomes over time. The causes of client attrition are fairly diverse but generally center on the fact that the population targeted for home visiting services are highly vulnerable and quite mobile, which leads to a relatively high loss of contact.

Home Visiting Staff Attrition

Staff attrition also has been identified as an ongoing issue among the home visiting programs. In particular, competition with more lucrative professional opportunities in the hospital setting for nurse-trained home visitors and the interest of home visitors pursuing further education has been noted as common reasons for staff attrition across the home visiting programs. Findings from an August 2020 survey of home visitors echo these statements:

- "Funding to allow comparable compensation to teacher pay would assist in lowering staff turnover." – *Home Visitor; PAT (Parents as Teachers); Sussex County*

- "High turnover rate is exhausting." – *Home Visitor; CFF/HFA (Children and Families First, Healthy Families America; New Castle County*

- "Managing such large caseloads interferes with the quality of delivery [and leads to] burnout!" – *Home Visitor; CFF/HFA (Children and Families First, Healthy Families America; Sussex County*

The 2018 Community Needs Assessment for Head Start echoes this issue in the early childhood education setting:

- "Compensation in [early childhood education] is a big problem. Teachers qualify for the Early Childhood Assistance Program because they live in poverty. They qualify for food stamps. This makes an odd situation, where the parents don't have respect for us and won't come to us for help because we are in the same position financially as they are, facing the same stressors. Early childhood and childcare salaries are low, no benefits including retirement." – *Early Childhood Educator*

- "There are still not enough early childhood certified professionals or early childhood special needs. People are not going into the field and it's not valued. I know this because I asked the college for some students to come do [internships] and they didn't have any enrolled in the [early childhood education] program." – *Early Childhood Educator*

The PDG B-5 needs assessment has also noted these weaknesses in developing and maintaining a high quality stable workforce, noting:

- Professional development programming is not accessible or considered particularly valuable to educators., only 14 percent of trainings are located on-site at programs;
- Programs struggle to retain their workforce despite educators wanting to make work in the early childhood care space their long-term career; and
- Poor compensation does not incentivize quality applicants or retention/professional development within the current workforce.

Geographic Barriers

Geographic barriers have also played a role in reducing the potential enrollment of clients into home visiting programs. This is especially the case in Sussex County, which has a largely rural and isolated population. Although this gap has been mitigated to an extent through the enhanced focus of MIECHV, ECCS, and regional agencies (e.g., Sussex County Health Promotion Coalition) in western Sussex County in particular, limited transportation and outreach challenges remain an ongoing issue. In the August 2020 survey, a home visitor affirms this issue by stating:

– "Some of the families in the Hispanic communities are limited in the resources they can qualify for. For example it can vary from not having a means of transportation to get the resources or not qualifying for financial assistance for rent or housing due to citizenship status." – *Home Visitor; PAT (Parents as Teachers); New Castle County*

An early childhood educator stated the following, which was captured in the 2018 Community Needs Assessment for Head Start:

– "Public transportation in the state is not as good as it needs to be. It doesn't run as much outside of Wilmington as in the city. And there is nothing down state, in Sussex County. You have to take 2-3 buses to get where you want to go even in Wilmington." – *Early Childhood Educator*

Limited Cognition of Home Visiting

Though not as commonly identified as client and staff attrition, the limited understanding of home visiting programs outside of the maternal, infant, and early childhood setting has hindered the opportunity for home visiting programs to potentially enroll clients who meet the eligibility criteria and for whom home visiting services would likely provide health and socioeconomic benefits. This limited cognition of home visiting stems not just from the general population but also from staff at birthing hospitals and federally-qualified health centers who sometimes do not refer eligible and potentially interested families.

Table 7 presents results specific to this issue from an August 2020 survey of home visitors. As evidenced by this table, the home visitors tended to state that families did not know about home visiting services and that such services were not well advertised (i.e., the most commonly reported response to both statements was "Disagree", which is highlighted in light gray).

Table 7. Familiarity of Home Visiting, August 2020 Survey of Home Visitors.

Within the last year, in the jurisdiction where I work…	Strongly Agree	Agree	Disagree	Strongly Disagree
Families know about home visiting services (e.g. services provided, who is eligible etc.).	2 (4.8%)	15 (35.7%)	19 (45.2%)	6 (14.3%)
Home visiting services are well advertised.	2 (4.5%)	12 (27.3%)	19 (43.2%)	11 (25.0%)

In addition to the above-mentioned results, home visitors articulated the following relevant statements as part of the survey findings:

- "I think the supports are present, however, more advertising to families could be beneficial." – *Home Visitor; New Directions Early Head Start; New Castle County*

- "In light of our new COVID-19 climate, more intentional marketing and advertisement of home visitor is needed more than ever to support referrals from community partners, recruitment and retention (i.e., billboards, posters, mailers, signage in public areas like hospitals, daycares, schools, bus stops, social service offices, WIC)." – *Home Visitor; PAT (Parents as Teachers); New Castle County*

- "Recruiting families for the program tends to be tough. Many recruiting attempts get few to no applications. Running out of ideas." – *Home Visitor; New Directions Early Head Start; Kent County*

B. Extent Home Visiting Services Meet Needs of Families in Delaware.

Despite the aforementioned gaps, the home visiting programs are addressing many of the identified needs for their enrolled families. This has been demonstrated by both the robust program outcomes reported over time and home visiting satisfaction survey results.

Robust Program Outcomes

Overall, the MIECHV-supported sites fare well on the overwhelming majority of benchmarks, particularly early childhood-related benchmarks. The following are some of the successes reported during FY 2019 (i.e., October 1, 2018 to September 30, 2019):

- Over 90 percent of newly-enrolled mothers this year were documented as receiving a depression screening with the PHQ-9;
- Roughly 90 percent of prenatally enrolled mothers this year were reported as receiving a postpartum care visit within three months of delivery;
- 93.9 percent of primary caregivers enrolled were documented as receiving an observation of parent-child interaction by a home visitor using either the CHEERS or PICCOLO.
- 91.4 percent of children enrolled in home visiting were reported as receiving an ASQ screening at the age-appropriate time interval;
- 91.3 percent of enrolled children were reportedly in a household in which a family member was documented as reading, telling stories, and/or singing songs with the child most days during a typical week; and
- Well over 90 percent of newly-enrolled primary caregivers were documented as being

screened for intimate partner violence.

Table 8 shows specific results from an August 2020 survey of home visitors on their self-reported confidence in the provision of home visiting services. The most commonly chosen response is given in light gray highlight. This table indicates that almost all home visitors either "Strongly Agree" or "Agree" with each of these statements.

Table 8. Confidence of Home Visitors, August 2020 Survey of Home Visitors.

I am confident that I can…	Strongly Agree	Agree	Disagree	Strongly Disagree
Address the varied cultural needs of families.	20 (44.4%)	24 (53.3%)	1 (2.2%)	–
Address the needs of families of children with special needs.	19 (43.2%)	23 (52.3%)	1 (2.3%)	1 (2.3%)
Address the needs of families impacted by substance use/abuse.	19 (46.3%)	20 (48.8%)	2 (4.9%)	–
Support caregivers (i.e. mothers, fathers, other primary caregivers) who screen positive for intimate partner violence.	19 (46.3%)	19 (46.3%)	2 (4.9%)	1 (2.4%)

Table 9 on the following page lists results specific to the home visitors' perspective on their respective home visiting programs based on an August 2020 survey of home visitors. As in Table 8, the most commonly chosen response is given in light gray highlight. This table shows that the home visitors tended to either "Strongly Agree" or "Agree" with each of these affirming statements about their home visiting programs.

In addition to these insights, some of the relevant strengths listed in the recently completed PDG B-5 needs assessment include:

- Very few children were waitlisted for existing services among those families who have navigated the signup process;
- Families are highly satisfied with services provided by Child Development Watch family service coordinators and home visiting programs;

This is reverberated through comments such as this one reported in the PDG B-5 needs assessment:

– "I thought it was helpful and we absolutely loved our home visitor. My son really connected with her." – *Parent; Kent County*

Table 9. Quality of Home Visiting Programs, August 2020 Survey of Home Visitors.

The home visiting program I work for…	Strongly Agree	Agree	Disagree	Strongly Disagree
Has qualified staff providing services.	32 (71.1%)	12 (26.7%)	1 (2.2%)	–
Has enough staff providing services.	9 (22.0%)	17 (41.5%)	12 (29.3%)	3 (7.3%)
Has enough materials and resources to meet families' needs.	9 (20.0%)	26 (57.8%)	10 (22.2%)	–
Provides relevant training to their staff.	26 (57.8%)	17 (37.8%)	2 (4.4%)	–
Has low staff turnover.	9 (21.4%)	15 (35.7%)	13 (31.0%)	5 (11.9%)
Provides families with the skills they need to improve the health and the well-being of their young children.	27 (60.0%)	18 (40.0%)	–	–
Provides families with the resources (for example information about child development, parenting curriculum) they need to improve the health and wellbeing of their young children.	34 (73.9%)	11 (23.9%)	1 (2.2%)	–
Refers families to other community services when appropriate/necessary.	35 (76.1%)	10 (21.7%)	1 (2.2%)	–
Helps families build a strong relationship with their children.	34 (73.9%)	12 (26.1%)	–	–
Provides families with supports and resources to promote school readiness.	32 (69.6%)	14 (30.4%)	–	–
Collaborates with other organizations in the community to support the health and wellbeing of children and families.	31 (67.4%)	12 (26.1%)	3 (6.5%)	–
Works with families who speak languages other than English.	25 (54.3%)	18 (39.1%)	2 (4.3%)	1 (2.2%)

Substance Use and Opioid Dependency/NAS Linkages and Projects

In addition to these encouraging program outcomes and satisfaction survey results, MIECHV-supported home visitors have also recently shown their effectiveness in assisting clients identified as using opioids and/or other identified substances and NAS infants. As part of the State of Delaware MIECHV NAS Project (see "Activities to Strengthen System of Care for Addressing Substance Use Disorder" under the subsequent "Capacity for Providing Substance Use Disorder Treatment and Counseling Services" section), home visitors who had clients with opioid/substance misuse issues and/or with infants with NAS completed three rounds of shadow visits with their field supervisors to gauge their knowledge, ability, and comfort in addressing the specific needs of these families. The shadow visits occurred in three rounds following a series of trainings on the management of opioid dependency among perinatal women. The first round of training occurred in February and March 2018; a second round took place in July and August 2018; and a third round occurred in January and February 2019. Home visitors with one or two clients and who are enrolled in the project had one shadow visit in each of the three rounds. It

was anticipated that the shadow visits would occur for the same clients in at least two of the three rounds.

Presented below are excerpts of this feedback from the three shadow visit rounds. These excerpts showcase how the home visitors have helped meet the needs of these families.

- "While working with this family, I realized Mom was not very knowledgeable about the effects of drugs or methadone on her growing baby. Mom was also unfamiliar with the symptoms and behaviors of a baby born on drugs. This gave me the opportunity to educate mom uses what I learned in the training and I was more confident in relaying the information." – *First Shadow Round*

- "Client is hopeful and open to change. Client clearly identifies her past triggers and challenges. Client has verbalized a past history of crack and heroin abuse. Client stated she is aware it will take years for a full recovery and has set short and long term goals. Client states that she wants to continue sobriety for her kids and particularly her newborn son. Client stated he is her motivation to be a good mom." – *First Shadow Round*

- "Prior to the training, my understanding of treatment measures and identifying ways to treat individuals in recovery were based primarily sporadic information I received. Since the training, I am able to pinpoint, understand, and explain the different treatments available to those who struggle with opioid dependency. In this case, this training has been helpful because, as I follow-up on her success and address issues that may influence her recovery, I am able to make an informed reference to her particular method of treatment. Also, I am able to make suggestions and provide support based on other factors (mental health) that influence recovery." – *First Shadow Round*

- "I'm currently working with three families that are in recovery and dealing with the effects of NAS babies. Each case is unique in its rewards and challenges. With this training, I now have more knowledge and experience to share with them." – *First Shadow Round*

- "Working with this family has helped me understand the value for my family in using methadone as she weans herself off of it. They had been very open with this struggle and successes. Mother of five children but two live with her and her husband and she has seen better outcomes with the help of people who care for her well-being." – *First Shadow Round*

- "I have been visiting with [client] since 05/2017 and have been able to assist the family in learning to be observers in supporting their [index child's] development, in finding area resources such as a breastfeeding support group close to their home, the DMV to purchase an affordable car seat and have it fitted into their vehicle, and to navigate a supportive routine for their child. The information shared at the [training] helped me further understanding opioid dependency and the effects on pregnant mothers and their babies." – *First Shadow Round*

- "Mom and Dad were heroin addicts. Once it was discovered that Mom was pregnant, they went on methadone treatment. Dad lapsed and is now incarcerated. I started to work with Mom and child when child was 18 months old. Mom maintained methadone treatment til January 2018 when child turned 4 years. The training I attended in January focused on NAS at birth and protocols for Mom and child in hospital for delivery. I started with family well after the birth." – *First Shadow Round*

- "Over the last 6 months, I have continued to consistently visit the family participating in my shadow visits… We have been working on personal goals including mom finding a therapist/counselor to work on self-care, depression, and family stability (employment and education). Parent-child interaction is always a focus and mom has made gains over the last 6 months in being aware of her daughter's developmental stages and finding family activities to promote her growth and development. As a home visitor, I see the gains the family has made and look forward to our continued partnership to empower mom to reach for and achieve her goals." – *Second Shadow Round*

- "The training has helped me help parents become more successful with talking about their addiction and wanting to be a better parent. Breastfeeding has become more of a positive experience with helping parents (w/drug use of opioids) realize that with mom breastfeeding she is helping her baby throughout dependence of opioids as well as building a bond with her baby." – *Second Shadow Round*

- "I have worked with this family since August 2016. She has been raised by her great grandmother since birth mom has ben in and out of rehab her whole life. Really is not too familiar with mom. The transition of mom coming home has been hard as a parent educator we have provided mom with lots of support through resources to help stay clean. We have provided great grandma support as well through community resources." – *Second Shadow Round*

- "This client has been actively compliant with her sobriety and has planned to stay away from friends that are still using drugs. This client is very knowledgeable of parenting and environmental effects on children." – *Second Shadow Round*
- "During our home visits, I routinely follow up on her current participation in substance treatment (counseling, medication), help identify and validate her personal accomplishments/strengths and verify her progression. Also, I am able to effectively assist with identifying everyday stresses that can disrupt her recovery and support building positive coping strategies (stress management, fostering positive relationships, build self-esteem). In this particular case, it is important that I acknowledge her successes to build confidence, recognize positive social supports, provide support while she establishes attainable goals that will benefit the family, potentially influence child development and minimize child maltreatment, focusing on protective factors. I have connected mom with other agencies, including but not limited to, Narcotics Anonymous." – *Second Shadow Round*

- "The family I worked with included two parents with heroin addiction. When they found out they were expecting, they both sought methadone treatment. Unfortunately, the father

relapsed and engaged in criminal behavior resulting in a three-year prison term. I started working with the family when the child was 18 months old. The mom had continued methadone treatment, counseling, and cognitive behavior therapy. She was open in discussing her struggles. The training I received helped to inform me so I was better able to have conversations with Mom regarding addiction and the resources available that she was utilizing. By the time the child was 4 years old, the Mom had weaned from methadone and successfully remained sober. She continued to receive counseling and therapy. She felt proud and successful of her accomplishment." – *Third Shadow Round*

- "I have been working with the family for two years and are comfortable answering questions about their child's growth and development, mom's work on her sobriety, and healthy coping strategies she uses to manage stress." – *Third Shadow Round*

- "I have been working with this family for approximately two months now, since mom delivered. This family has been very productive and keeping visits and accepting advice as needed. This family learned a great deal about NAS during their stay at the hospital and it is very evident that mom uses several strategies/techniques and soothing baby and recognizing any NAS symptoms. Mom has been very active in her recovery after a relapse when returning home after delivery. Together, we were able to put together a goal plan for mom's recovery and getting set up with an IOP program for additional assistance. After mom's relapse, DFS initiated a safety plan for 30 days, which has since been successfully closed. Mom has ben weaning herself down from her methadone dose at her own rate. Aspects of the training that have been helpful are having an open mind and a listening ear, which has been very effective and working with this family. And addition being supportive and encouraging has helped build trust and rapport with this family. Reassuring mom of her comfort techniques has also been helpful." – *Third Shadow Round*

- "Working with the X family, I have learned along with mom the best ways to support mom in her recovery. Mom has grown in her awareness of her own mental health needs and is addressing them with support from [home visitation] and her counselor and Connections. Mom is also addressing her physical health issues and becoming aware of how they contributed to her addiction. Mom is working to improve her health and I encourage her self-care practices (recommended daily exercises, taking time for herself, creating a safe and welcoming home environment) in every visit. Connecting this mom with Stand By Me resources, the Sussex Goes Purple community, and supporting her as she created a strong circle of support has ben absolutely critical to her progress! In addition, the trainings on the brain and addiction have helped me develop an understanding of the healing she is experiencing in her mind and body." – *Third Shadow Round*

C. Gaps in Staffing, Community Resources, and Other Requirements for Delivering Evidence-Based Home Visiting Services

The results of an August 2020 survey of home visitors have identified the following gaps in the staffing and resources for delivering evidence-based home visiting services.

Accessibility and Availability of Home Visiting Services

The results to an August 2020 survey of home visitors suggests that although the home visitors tend to claim that home visiting services are easy for families to access, the home visitors generally state that there are not enough home visiting programs to meet everyone's needs and that there is a need to expand home visiting programming (Table 10).

Table 10. Accessibility and Availability of Home Visiting Services, August 2020 Survey of Home Visitors.

Within the last year, in the jurisdiction where I work…	Strongly Agree	Agree	Disagree	Strongly Disagree
Home visiting services are easy for families to access.	4 (9.5%)	22 (52.4%)	13 (31.0%)	3 (7.1%)
There are enough home visiting programs to meet everyone's needs.	1 (2.4%)	16 (39.0%)	20 (48.8%)	4 (9.8%)
There is a need for different home visiting programs than the ones currently provided.	6 (16.7%)	15 (41.7%)	10 (27.8%)	5 (13.9%)
There is a need to expand the current program I work for within Delaware.	14 (35.9%)	18 (46.2%)	4 (10.3%)	3 (7.7%)

Moreover, according to families surveyed through the PDG B-5 needs assessment, early childhood care and education (ECCE) programming has several weaknesses, namely:

- ECCE hours of service do not reflect family needs;
- There is an insufficient supply of ECCE programs by location and age groups served. To note, three percent of child care centers offer extended hours of care but represent 86 percent of the state's licensed program seats;
- The cost of ECCE is high and can make up a considerable portion of household income for families across income levels;
- Access to adequate financial assistance is limited, even for families that qualify for subsidies;
- Despite the 2019 reimbursement increase, point of care reimbursement rates have still not kept up with the cost of care and are not enabling programs to offer more affordable options;
- Families find that the ECCE system is often confusing and cumbersome;
- There is a perceived lack of support and coordination for children with special needs;
- A gap exists in culturally responsive supports for dual language learners;
- There is a lack of holistic understanding of parental and familial needs; and
- There is an underutilization of high-quality services and information resources.

Families interviewed through the PDG B-5 needs assessment echo the abovementioned weaknesses, articulating:

– "The hub. That's an idea that I hear all the time from parents. Trying to navigate all of the different services that a lot of them need and having to go to different places, fill out different forms that sometimes are redundant. It's overwhelming." – *Early Childhood Professional; New Castle County*

– "They send you to different places too much. I'm in a domestic violence situation and I need emergency housing and childcare. I don't have time to wait." – *Parent, Kent County*

Home Visiting Client Resources

In addition to accessibility and availability, the home visitors affirm that there are limited resources for their clients, namely housing, healthy food options, and health-related services as shown in Table 11.

Table 11. Home Visiting Client Resources, August 2020 Survey of Home Visitors.

Within the last year, in the jurisdiction where I work…	Strongly Agree	Agree	Disagree	Strongly Disagree
There is enough affordable housing to meet everyone's needs.	1 (2.3%)	2 (4.7%)	8 (18.6%)	32 (74.4%)
Families have easy access to healthy food options most days of the week.	5 (11.4%)	17 (38.6%)	20 (45.5%)	2 (4.5%)
All family members have access to health resources (including primary care, pediatric care, OB care, mental health and dental services) to meet everyone's needs.	3 (6.7%)	13 (28.9%)	15 (33.3%)	14 (31.1%)

In the survey results, the home visitors gave considerable feedback related to this issue. Much of this feedback has centered on resources for the clients, particularly during the ongoing COVID-19 crisis, as well as resources for the home visitors themselves related to the home visiting curricula and mental health treatment:

– "We could use more resources to share with our families during this time of COVID-19 when they are in need of more help than they needed before." – *Home Visitor; CFF/HFA (Children and Families First, Healthy Families America; Sussex County*

– "We are needed in homes with less 'stressors' as identified by the state, and wanted by these parents for support and educational benefits. We need funding for more staff or more hours for current staff, because families that meet even the current stressors are not aware of our programs and need services, but unfortunately, we can only serve so many at one time." – *Home Visitor; PAT (Parents as Teachers); Kent County*

– "Curriculum isn't always helpful, not enough parent child activities, families in constant crisis not able to focus on building parent child relationship." – *Home Visitor; CFF/HFA (Children and Families First, Healthy Families America; New Castle County*

– "Our recent shift to virtual home visiting has provided families with vital information, resources and support in the safest and most engaging manner possible. Consideration should be given to updating curriculum to more specifically address COVID-19 related issues/topics (SEL/Trauma-Informed Care/Mindfulness for adults and children), provide continued quality trainings/workshops (Rapid Response Virtual Home Visiting) to support our personal self-care/mental wellness as well as for the families we serve, practical trainings/demonstrations to share best virtual practices and use of technology,

and revising program policies and procedures (i.e., expected number of enrolled families, reporting requirements/timelines, visit duration) that effectively address managing workload for staff and families needs." – *Home Visitor; PAT (Parents as Teachers); New Castle County*

- "It is extremely challenging to work with families when their basic mental health needs are not met. There are multiple barriers for client to seek mental health treatment (transportation, stigma, lack of time, no child care). I would love to have dual services in our program in which a mental health provider can provide counseling and treatment for families. The families we serve have significant past trauma and present stresses, mental health is desperately needed." – *Home Visitor; CFF/HFA (Children and Families First, Healthy Families America; New Castle County*

The 2018 Community Needs Assessment for Head Start has affirmed these findings with an early childhood educator stating:

- "The waiting list for mental health services can be very long. They are not getting educational support for social//emotional, so then they get to school and are not ready." – *Early Childhood Educator*

IV. CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

The Delaware MIECHV program has the capacity to provide substance use disorder and treatment and counseling services through collaborations and services offered through the Delaware Division of Substance Abuse and Mental Health (DSAMH) and Department of Services for Children, Youth, and their Families' Division of Prevention and Behavioral Health Services (DSCYF/DPBHS).

Division of Substance Abuse and Mental Health (DSAMH)

The Division of Substance Abuse and Mental Health (DSAMH) is one of the eleven divisions within Delaware's Department of Health and Social Services (DHSS) and serves as the Single State Authority for both substance abuse and mental health services for the State of Delaware. The mission of DSAMH is to promote health and recovery by ensuring that Delawareans have access to quality prevention and treatment for mental health, substance use, and gambling conditions. DSAMH is organized into three operating units: the Delaware Psychiatric Center (DPC), two community mental health centers with six sites, and a variety of community-based substance abuse treatment programs. Their services include: community mental health treatment; counseling and support services; supported housing services that promote independent living and community integration; mobile crisis intervention services; inpatient psychiatric evaluation, diagnosis, and treatment; substance abuse treatment and prevention services; assessment and case management services for clients sentenced by the Drug Court; and problem gambling services.

Department of Services for Children, Youth, and their Families' Division of Prevention and Behavioral Health Services (DSCYF/DPBHS)

DSAMH collaborates with the Department of Services for Children, Youth, and their Families' Division of Prevention and Behavioral Health Services (DSCYF/DPBHS) in the planning and implementation of substance abuse and mental health services. DSAMH administers behavioral health services for the adult system (individuals 18 years of age or older) while DPBHS administers the behavioral health services for the youth system (individuals under age 17). The two divisions have developed a Memorandums of Understanding (MOU) to formalize the respective roles and responsibilities of each of the divisions. The DSCYF's mission is to assist children, youth, and families in making positive changes through services that support child and public safety, behavioral health and individual, family and community well being. Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include: prevention, early intervention, assessment, treatment, permanency, and after care. The Department leads a system of care approach (both community based and residential) that is child centered and assures effective, timely and appropriate support for Delaware's children. Each Division within DSCYF is mandated to provide services to targeted populations and to collaborate in the system of care.

The divisions in DSCYF are:

- **Division of Management Support Services (DMSS)** provides human resources, fiscal and management information support services in addition to collaborating with service divisions to provide or coordinate educational services for DSCYF clients in day and residential treatment programs;
- **Division of Family Services (DFS)** provides intervention services for abused, neglected and dependent children and youth; and
- **Division of Youth Rehabilitative Services (DYRS)** provides treatment, habilitation and rehabilitation for youth involved in the juvenile justice system, both pre- and post-adjudication.

A. Range of Treatment and Counseling Services

The following are treatment and counseling services supported by DSAMH and DSCYF/DPBHS that help meet the needs of perinatal women and families with young children:

Bridge Clinics

These walk-in clinics serve people when they need it, no appointment necessary. Licensed clinicians are employed to help connect individuals with services they need. From screening to treatment referrals to support services – such as transportation and housing – Bridge Clinics offer access and fast responses to help fill critical substance use disorder and other mental health needs when they happen. Prior to the development of these clinics, clients would experience a delay in treatment potentially leading to relapse. Currently, there are two clinics in the state and the goal is to have one in each county by the end of the next planning period.

Crisis Intervention Services (CIS)

Crisis Intervention Services (CIS) is offered through the Department of Substance Abuse and

Mental Health (DSAMH) for individuals who are experiencing distress and functional impairment in the community. CIS staff members meet the individual in crisis where the individual is to initiate the helping process in a safe and supportive manner. The goal of CIS is to divert individuals from the criminal justice system and psychiatric hospitalization, if applicable, and restore them to their adequate level of functioning by utilizing comprehensive screening and assessments, brief intervention, information and referral and linkages to community providers and/or wrap-around services. CIS collaborate with law enforcement agencies to maximize safety for the individual in crisis and the community. CIS provides on-going training to law enforcement agencies, community providers and other state agencies on emergency response, crisis intervention, de-escalation, screening and assessment, and community resources.

Early Childhood Mental Health Consultation (ECMHC)

ECMHC is a free service and partnership with providers of early care and education programs that is effective in addressing and supporting young children's social and emotional development in early care and education settings (2-5 years old). All consultants are licensed mental health professionals with experience working in early learning settings.

Intensive Family Consultation Service (IFC)

IFC is an intervention services designed to support families who are experiencing more complex issues in their lives. These multiple complex needs are associated with parent/child conflict, substance abuse, family instability associated with homelessness, single parent stressor and isolation, blended family stressors, unresolved mental health needs, absence of supports and resources, etc. IFC Services uses a team approach to assist the family in creating opportunities to acquire competencies that will permit them to mobilize supports necessary to cope, adapt, and grow in response to life's many challenges and empower families by giving them the tools needed to:

- Care for and protect their children;
- Improve their family functioning;
- Build connections to various support networks within their community; and
- Self-Advocate.

The DPBHS staff provides IFC Services statewide.

Prime for Life

Prime for Life is an evidenced based prevention education and motivational risk reduction program. It is used most with people who have had a legal or policy violation such as impaired driving, possession, or workplace violation, but it is relevant for everyone. Prime for Life helps foster attitudes, beliefs, and understanding that helps people reduce risk for any type of alcohol or drug problem. It also creates a unique self-assessment experience to help people be more aware of what they value, what they are risking, and how to protect the things that mean the most in their lives using evaluation data to validate success.

Project LAUNCH

Delaware Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) aims to promote the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive, and behavioral aspect of their development. The coordination of child-serving systems and the integration of behavioral and physical health services drive this work to

ensure children are thriving in safe, supportive environments and entering school ready to learn. Delaware Project LAUNCH focuses on neighborhoods that are feeder patters for Warner Elementary and Shortlidge Academy. These communities long identified with multiple environmental risk factors and gaps in services and supports for youth children, birth to 8 years, and their families. There are five core prevention and promotion strategies identified by SAMHSA for Project LAUNCH:

- Screening and assessment in a range of child-serving settings;
- Integration of behavioral health into primary care;
- Mental health consultation in early care and education;
- Enhanced home visiting with a focus on social and emotional wellbeing; and
- Family strengthening and parent skills training.

Promoting Safe and Stable Families Program (PSSF)

PSSF is a community-based family support and preservation program that provides consultation services to families who are at risk or in crisis due to one or a combination of stressors that may lead to child maltreatment. The family engages in the completion of a family drive planning process to address their core concerns and needs, identifying formal and informal support systems to successfully accomplish the family established goals increasing the family protective factor in providing safe and stable family environment. DPBHS contracts with the First State Community Action Agency, Connection in Sussex County, and Jewish Family Services of Delaware in order to provide this program within a community-based setting statewide.

Therapeutic Support for Families (TSF)

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/caregivers and children who are eligible for services through the Division of Prevention and Behavioral Health Services. TSF services are typically delivered in conjunction with other treatment services but may, in some instances, be the only service provided by the Division of Prevention and Behavioral Health Services. TSF goals will be included in the child and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals.

B. Gaps in Current Level of Treatment and Counseling Services Available to Home Visiting Service Populations.

It is essential to note that limited data exists to help us understand the scope of parental substance abuse in Delaware and related childhood outcomes. Nearly eight percent of Delaware households with children who responded to the 2016 National Survey of Children's Health (NSCH) reported that the child selected for the survey response had ever lived with anyone who had a problem with alcohol or drugs. Roughly one-third (29.7%) of Delaware respondents to the 2016 Behavioral Risk Factor Surveillance System who indicated that they are parents to one or more children reported past month binge drinking.

In an assessment of the FY 2020/2021 Delaware Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant, an increasing percent of victims in Delaware's child welfare system were identified as having an alcohol or drug abuse caregiver risk factor,

although some change in rates may be due to changes in reporting over time. In 2016, nearly four out of ten children who entered into the child welfare system were noted to have a caregiver with an alcohol abuse risk factor, and 37.2 percent had a caregiver with a drug abuse risk factor. While entry into the child welfare system does not necessarily indicate the presence of caregiver substance abuse, these data show that a significant number of children in Delaware who are in the care of the child welfare system had caregivers that abused alcohol or drugs prior to removal from their homes.

In the aforementioned Block Grant, DSAMH and it partners identified the following system and population needs and gaps:

- Better coordination among government agencies involved in the provision of primary prevention in the community;
- Coordinated transition plans for mental health and substance use disorder clients transition from a child system to adult system of care;
- Ensure a system of care that prioritizes pregnant women and women with children and develop new pathways to engage them in treatment; and
- Continue in the robust system transformation of the mental health and substance misuse disorder treatment systems to ensure a system where there is no closed door.

C. Barriers to Receipt of Substance Use Disorder Treatment and Counseling Services.

Reported Substance Misuse and Mental Health Status of Perinatal Women and Infants

In 2017, 450 notifications of prenatally exposed infant were reported to the Delaware Division of Family Services.[2] While marijuana is the most common substance among infants who have been exposed to a single substance, opioids are the most commonly identified substance among cases where the infant is exposed to two or more substances. Forty percent of the mothers who gave birth to prenatally exposed infants reported a history of involvement with the child welfare system as children. Additionally, 34 percent of the mothers had an existing mental condition and 28 percent of the mothers had a prior SEI birth.[3]

Selected Groups and Services Reportedly Served by Substance Abuse Treatment Services

Table 12A presents the number and percentage of groups reportedly served by substance abuse treatment services in both Delaware and the nation according to the 2018 National Survey of Substance Abuse Treatment Services (N-SSATS). As given in this table, although the percentage of facilities serving particular groups of interest for MIECHV services is comparable between the state and nation, it is essential to note that less than half reportedly provide services to pregnant or postpartum women and roughly one-third serve young adults, clients who have experienced sexual abuse, and clients who have experienced intimate partner violence (IPV) or domestic violence.

[2] Delaware Office of the Child Advocate, 2018.
[3] Delaware Investigation Coordinator Data, 2017.

Table 12A. Selected Groups Reportedly Served, 2018 National Survey of Substance Abuse Treatment Services (N-SSATS).

Group	Delaware	Nation
Substance Abuse Treatment Facilities Surveyed	**40**	**14,809**
Adult women.	**20** (50.%)	**7,239** (48.9%)
Pregnant or postpartum women.	**18** (45.0%)	**3,450** (23.3%)
Young adults.	**13** (32.5%)	**4,420** (29.8%)
Clients who have experienced sexual abuse.	**13** (32.5%)	**3,833** (25.9%)
Clients who have experienced IPV/domestic violence.	**13** (32.5%)	**3,821** (25.8%)

Table 12B lists the number and percentage of facilities by substance abuse treatment services in both Delaware and the nation according to the 2018 N-SSATS. Like Table 7A, the State of Delaware generally features comparable percentages to the nation. However, note that the state does not have any treatment facilities that provide childcare for clients' children and have a lower percentage of facilities that offer substance abuse education (82.5 percent compared to 96.7 percent nationwide) or smoking/tobacco cessation counseling (37.5 percent compared to 49.8 percent nationwide).

Table 12B. Selected Services Reportedly Offered, 2018 National Survey of Substance Abuse Treatment Services (N-SSATS).

Service	Delaware	Nation
Substance Abuse Treatment Facilities Surveyed	**40**	**14,809**
Screening for substance abuse.	**39** (97.5%)	**14,228** (96.1%)
Screening for mental health disorders.	**37** (92.5%)	**11,076** (74.8%)
Comprehensive substance abuse assessment or diagnosis.	**39** (97.5%)	**13,803** (93.2%)
Comprehensive mental health assessment or diagnosis.	**22** (55.0%)	**7,808** (52.7%)
Screening for tobacco use.	**24** (60.0%)	**9,917** (67.0%)
Outreach to persons in community who may need treatment.	**25** (62.5%)	**8,944** (60.4%)
Interim services for clients when admission not possible.	**18** (45.0%)	**6,757** (45.6%)
Case management services.	**28** (70.0%)	**12,309** (83.1%)
Social skills development.	**30** (75.0%)	**11,263** (76.1%)
Mentoring/peer support.	**22** (55.0%)	**8,571** (57.9%)
Childcare for clients' children.	–	**864** (5.8%)
Assistance w/obtaining social services (Medicaid, WIC, etc)	**27** (67.5%)	**8,943** (60.4%)
Employment counseling or training for clients.	**17** (42.5%)	**5,765** (38.9%)
Assistance in locating housing for clients.	**25** (62.5%)	**8,094** (54.7%)
Domestic violence – family or IPV services.	**17** (42.5%)	**5,712** (38.6%)
Substance abuse education.	**33** (82.5%)	**14,327** (96.7%)
Transportation assistance to treatment.	**20** (50.0%)	**6,496** (43.9%)
Mental health services.	**32** (80.0%)	**10,093** (68.2%)
Smoking/tobacco cessation counseling.	**15** (37.5%)	**7,374** (49.8%)

Perspectives of Home Visitors on Substance Use/Abuse

Findings to an August 2020 survey of home visitors indicate that home visitors have overwhelmingly reported seeing a rise in substance use/abuse and that services are available for this issue (Table 13).

Table 13. Perspectives of Home Visitors on Substance Use/Abuse, August 2020 Survey of Home Visitors.

Within the last year, in the jurisdiction where I work…	Strongly Agree	Agree	Disagree	Strongly Disagree
I have seen a rise in substance use/abuse.	8 (20.5%)	21 (53.8%)	9 (23.1%)	1 (2.6%)
There are services for expectant families and those with young children impacted by substance use/abuse.	7 (17.9%)	24 (61.5%)	7 (17.9%)	1 (2.6%)

In this same survey of home visitors, it is worth noting that some of the respondents gave feedback suggesting that improvements can be made on substance use/abuse involving both services and training:

- "Services are beneficial for clients who are ready to make changes and embrace support... some are not because they don't see value related to stressors addiction or resistance from being mandated to services at times." – *Social Worker; Delaware HOPE; Sussex County*

- "I do not feel versed in supporting violence in the home and substance abuse. More training would be helpful." – *Home Visitor; New Directions Early Head Start; New Castle County*

D. Opportunities for Collaboration with State and Local Partners.

The following have recently been identified as opportunities for collaboration with state and local partners for substance use disorder treatment and counseling services.

Delaware Division of Medicaid and Medical Assistance (DMMA)

The DMMA program is a critical partner in the opioid crisis response. DMMA continues to collaborate with the Division of Public Health (DPH), the Division of Substance Abuse and Mental Health (DSAMH) and other partners to reduce unnecessary opioid prescribing and expand access to evidence-based treatment services. The program covers all forms of Medication Assisted Treatment (MAT) without prior authorization. Naloxone is available to Medicaid beneficiaries with no copay. DMMA also eliminated benefit limits for chiropractic treatment of back pain, and is exploring options for acupuncture and massage therapy in alignment with the work of the Addiction Action Committee. The Medicaid Managed Care Organizations (MCOs) have initiated programs to increase outreach to individuals with substance use disorder and facilitate access to treatment as well as educate prescribers regarding prescribing guidelines, tapering dosages, and risks associated with benzodiazepines. This includes outreach to individuals who experience a non-lethal overdose or individuals with multiple prescription fills for naloxone. Finally, DMMA is working closely with the Department of Correction and

DSAMH to develop care delivery models that fully support successful re-entry to the community following incarceration.

Delaware Treatment and Referral Network (DTRN)

Delaware Treatment and Referral Network (DTRN) is a statewide, comprehensive referral network for behavioral health and substance use disorder treatment. Through this network, health care providers in Delaware have partnered to support members of the community in need of substance use disorder and behavioral health services. Using a digital referral system to expedite placement for patients, providers can eliminate the need for manual processes while seeking appropriate care. Once available services are identified, referring care teams can electronically transition patients to providers around the state that match the level of care needed. DTRN's electronic referral process also allows the sending and receiving care teams to coordinate supporting services such as transportation, housing, and employment, making the patient's transition as smooth as possible. DTRN's automated system provides an online inventory of services and wait times in order to meet patients' needs 24 hours a day, seven days a week.

Delaware Healthy Outcomes with Parent Engagement (Delaware HOPE)

Delaware HOPE is an expansion of Healthy Families Delaware, which is housed at Children and Families First. This program also uses nurses and social workers as home visitors to provide expectant and new mothers the education and support they need until their child turns three. Additionally, it uses peer recovery coaches to support the mother through addiction recovery and healing. This evidence-based program serves first time and subsequent pregnancy moms who are more than 28-weeks pregnant or have a newborn younger than three months.

START Initiative

In an effort to expand Delaware's ability to serve those needing access to evidence-based treatment at all levels of care, DSAMH has initiated the START Initiative. The intention of this initiative is to increase interconnectivity, improve referral and data sharing, and ensure reliable wrap-around services. DSAMH seeks to engage behavioral health service providers in quality improvement initiatives that will ensure a more comprehensive START initiative system across Delaware.

E. Activities to Strengthen System of Care for Addressing Substance Use Disorder.

The following are recently completed as well as current initiatives to strengthen the system of care relevant to addressing substance use disorder.

Aiden' Law

Aiden's Law (Delaware House Bill 140), was signed into law in June 2018. This law establishes a plan of safe care for substance exposed infants in Delaware, which mandates interagency collaboration to address the treatment needs of the family and the child, and to ensure that the child's well-bing and safety is monitored after the delivery.

Development and Implementation of Multisystem Healthy Action Committees (MSHAC)

The State of Delaware created a committee bringing together the Division of Public Health, Division of Family Services, and the Division of Substance Abuse and Mental Health. The group

is made up key leadership including all three Division Directors, two Deputy Directors and senior program directors including both the Title V Director and Deputy Director/MIECHV Project Director. The group decided to work on three key goals, a MOU, training for direct service staff and education.

The purpose of the MOU stems from both The Department of Health and Social Services and The Department of Services for Children, Youth and Their Families recognizing that each has an important role to improve the lives of families impacted by substance use disorder. The MOU was jointly developed for the agencies:

- To work as a team on shared client cases to attain the most positive outcome;
- To provide each client with the most comprehensive care; and
- To prevent duplication of activities.

The MOU states that each agency agrees to establish a multi-disciplinary coordination committee. The focus for the committee was training, messaging, case management, and the development of procedures. Since the development of this MOU, it has been decided that each of Delaware's counties will have a committee focused on the above-mentioned items.
Home visiting supervisors, treatment providers, Division of Family Services administrators, supervisors, and caseworkers have come together to form the Delaware Multisystem Healthy Action Committees (MSHAC) in each county. The initial kick off was held in September 2016 and quarterly meetings in each of our three counties continue to collaborate. The charge of MSHAC is to plan how to serve families with substance use disorder better through a multi-agency approach.

Agenda topics for these meetings have included sharing resources and educational materials, updates from local treatment providers, coordination of services and referrals, tips for using DFS hotline reporting, related state legislation, and even walking through substance abuse specific cases in each agency. Supervisors and agency representatives are asked to refer information back to their staff of professionals who work directly with substance abuse clients and families. Guest speakers have been invited quarterly and continue to enrich the knowledge of the committee. Topics and speakers relevant to this work are listed in Table 14 on the following page.

Table 14. Topics and Speakers (and Their Affiliations) at MSHAC Meetings.

Topic	Speaker
Substance Exposed Infants-Streams of Work in Delaware	Jennifer Donahue, Esquire, CWLS, Child Abuse Investigation Coordinator, Office of the Child Advocate
PROMISE Program	Wynne Hewitt, CSA of NCC Promise Assessment, DSAMH, DHSS
DFS Investigation Processes including DFS Hotline Specifics	Colleen Woodall, Investigative Supervisor, DFS, DSCYF
Peer Support Information	Holly Dixon, Peer Support Services Manager, DSAMH, DHSS
Oral Health and Substance Abuse	Gabrielle Hilliard, Oral Health Program Administrator, DPH, DHSS
Human Sex Trafficking	Yolanda Schlabach, Executive Director, Zoe Ministries
Agonist Based Medications for Addiction Treatment (MAT) in Pregnant and Parenting Women	Dr. Sherry Nykiel, Chief Psychiatrist and Director of Addiction Medicine, DHSS, DSAMH
Lisa Coldiron, Sussex County Health Coalition	Drug Free Community Committee Kick-off event-Seaford Goes Purple
Plan of Safe Care Implementation	Jennifer Donahue, Esquire, CWLS, Child Abuse Investigation Coordinator, Office of the Child Advocate
Social Media Platform for HelpIsHereDE.com	Alexandra Parkowski, Account Supervisor, Aloysius Butler & Clark
Tour of Treatment Centers such as Connections, Inc., Mommy and Me Houses	Heather Baker, BSN, RN, Family Resource Coordinator, Connections CSP

In addition, these meetings have allowed a venue for sharing of federal guidance, such as the Comprehensive Addiction and Recovery Act of 2016 requirement of the new Plan of Safe Care (POSC) template and its implementation by DFS liaisons placed on the birthing floors in Delaware's local hospitals. The DFS liaisons are members of this committee and give regular updates about their work such as caseload numbers and barriers for families. The POSC template has been shared with the committee and a list of home visiting provider contacts was passed on to the liaisons to ensure home visitors are included in the planning purposes of the POSC.

A focus for MSHAC meetings seemed to be touring treatment facilities to get a firsthand look at where their clients are seeking treatment and other resources their clients could be utilizing. The facilities toured offer many resources such as transportation, employment training, mental health services, food pantry offerings and more. The SEI liaisons and home visiting staff need to be aware of the resources provided. Relationships were also encouraged amongst the treatment counselors, DFS staff and home visitors. For example, if a client is falling asleep with her baby, call the pregnancy peer counselor to discuss dosing. Overall consensus between agencies is these meetings have helped improve communication, referrals, collaboration, and resources regarding substance abuse services.

Promoting Optimal Mental Health For Individuals Through Supports And Empowerment (Promise)

PROMISE targets individuals with behavioral health needs and functional limitations to offer an array of home and community-based services (HCBS) that are person-centered, recovery oriented, and aimed at supporting beneficiaries in the community. PROMISE will help improve clinical and recovery outcomes and reduce unnecessary institutional care through better care coordination, and thereby also reduce the growth in overall program costs. As a comprehensive individualized behavioral health program for adults 18 and over, PROMISE is designed to provide specialized- recovery oriented services for this specific population. The beneficiary has the key voice with support from their DSAMH care manager, natural supports (friends and family) and ACT/ICM/Crisp/Group Home staff (if applicable); to create their self-directed recovery plan. The recovery plan functions as a blueprint to their personal recovery story and will support the beneficiary in becoming successful, independent, active and engaged members in their communities. PROMISE currently contracts with providers to offer a variety of community based services such as:

- Care Management;
- Peer Support;
- Non-Medical Transportation;
- Community-Based Residential Supports Excluding Assisted Living;
- Community Psychiatric Support and Treatment; and
- Respite.

Delaware MIECHV NAS Project

With support of MIECHV Innovation funds, the Delaware MIECHV NAS Project was implemented from 2017 to 2019 to provide comprehensive MIECHV services to MIECHV-eligible perinatal women who use/have used opioids and infants with NAS. Based on strong theory on the effectiveness of MIECHV services toward improving health outcomes for at-risk maternal and infant health populations, the project aimed to demonstrate improvement in the following three priority areas:

- Recruitment, engagement, and retention of eligible families to MIECHV programs;
- Development and retention of a skilled MIECHV-funded home visiting workforce;
- Coordination of MIECHV-funded home visiting programs with community resources and supports, including comprehensive statewide and/or local early childhood systems.

Table 15 on the following page shows how this innovative project helped answer several of the needs underlying this public health concern at different stages of the life course for these at-risk MIECHV-eligible women and infants.

Table 15. How Project Addresses NAS At Different Stages of The Life Course.

Issue	NAS-Related Issue	How Project Addresses Issue
Opioid Use Prior to Pregnancy	The development of birth defects often results from exposures during the first few weeks of pregnancy, which is a critical period for organ formation. Given that (1) many pregnancies are not recognized until well after the first few weeks and (2) half of all pregnancies are unplanned,[4] all women who might become pregnant are at risk.	Home visitors who are educated on opioid use and NAS were able to help monitor the substance use and reproductive health and wellbeing of the MIECHV enrollees that they serve. The home visitors were able to refer enrollees who have substance abuse issues as well as assist enrollees seeking effective methods of contraception (e.g., LARCs).
Opioid Use During Pregnancy	While Oxycontin and prescription drugs were once the opioid treatments of choice, more women have recently turned to heroin, as prescription drugs have become more difficult to obtain.	Home visitors involved with this project were encouraged to refer enrollees with substance abuse issues to cessation programs. These enrollees were likely to be given methadone. As articulated by Nancy Oyerly, Director of Maternal Child Health at Nanticoke Memorial Hospital (Lewes, Delaware): "We're looking at early identification to get them into the methadone. At least that's better than being on heroin."
Opioid Use At Delivery	As stated by a Delaware-based clinician, "A lot of these women have had babies taken away before [due to use of illicit opioids]".	As above, enrollees referred to substance abuse cessation programs were likely be given methadone. Nancy Oyerly, Director of Maternal Child Health at Nanticoke Memorial Hospital (Lewes, Delaware) states: "If mothers are found on methadone at the time delivery, there's no potential legal backlash." Furthermore, through MIECHV services and NAS-related training, the home visitors were able to assist their prenatal clients on what to expect prior to and after delivery.

[4] Finer, L., Zolna, M. (2014). Shifts in intended and unintended pregnancies in the United States, 2001–2008. *Am J Public Health*, 104(Suppl 1): S43–8.

Issue	NAS-Related Issue	How Project Addresses Issue
Health of Postpartum Women Who Use/Have Used Opioids	A study on Florida mothers of infants with NAS found that none of the infants with NAS were documented to be exclusively breastfed at discharge and only 3.7 percent of these infants were receiving any breast milk. In addition to lower rates of breastfeeding, it is likely that these mothers experience higher rates of postpartum depression.	MIECHV programs educate and emphasize the importance of breastfeeding initiation and duration. Breastfeeding may decrease the incidence of NAS,[5] the need for pharmacological treatment,[6,7] and the length of the hospital stay.[8,9] Home visitors can also assist with lactation services referrals for postpartum depression.
Health of Infant with NAS	NAS symptoms include tremors, irritability, diarrhea, agitation, difficulty sleeping, temperature instability, and inconsolable crying. Hyperphagia is often present in infants with NAS, who may require intake of more than 150 calories per kilogram per day.[10,11,12]	Through NAS-related trainings, home visitors were able to assist enrollees on how to help improve the temperament of infants with NAS. Moreover, the home visitors were also able to help refer enrollees to infant health-related services as needed.
Health in Early Childhood For Children Who Had/Have NAS	Infants with NAS may be at a higher risk for hyperactivity, impulsivity, and attention-deficit issues as preschool-aged children and may have a higher rate of school absence, school failure, and other behavioral problems as school-aged children.[10,13]	Through existing MIECHV services as well as NAS-related trainings, home visitors are able to help improve the early childhood home environment, boost school readiness, and make appropriate referrals to early childhood services depending on the child's behavioral and developmental status.

[5] Welle-Strand, G., Skurtveit, S., Jansson, L., Bakstad, B., Bjarkø, L., Ravndal, E. (2013). Breastfeeding reduces the need for withdrawal treatment in opioid-exposed infants. *Acta Paediatr*, 102(11): 1060–1066.
[6] Dryden, C., Young, D., Hepburn, M., Mactier, H. (2009). Maternal methadone use in pregnancy: factors associated with the development of neonatal abstinence syndrome and implications for healthcare resources. *BJOG*, 116(5): 665–671.
[7] Abdel-Latif, M., Pinner, J., Clews, S., Cooke, F., Lui, K., Oei, J. (2006). Effects of breast milk on the severity and outcome of neonatal abstinence syndrome among infants of drug dependent mothers. *Pediatrics,* 117(6).
[8] Pritham, U., Paul, J., Hayes, M. (2012). Opioid dependency in pregnancy and length of stay for neonatal abstinence syndrome. *J Obstet Gynecol Neonatal Nurs*, 41: 180–190.
[9] Wachman, E., Byrun, J., Philip, B. (2012). Breastfeeding rates among mothers of infants with neonatal abstinence syndrome. Paper presented at Pediatric Academic Society Meeting; May 1–4, 2012; Boston, MA.
[10] Kocherlakota, P. (2014). Neonatal abstinence syndrome. *Pediatrics*, 134, e547.
[11] Hudak, M., Tan, R. (2012). Committee on Drugs; Committee on Fetus and Newborn. American Academy of Pediatrics Clinical Report. Neonatal drug withdrawal. *Pediatrics*,129 (2).
[12] Gaalema, D., Scott, T., Heil, S., et al. (2012). Differences in the profile of neonatal abstinence syndrome signs in methadone- versus buprenorphine-exposed neonates. *Addiction*, 107(suppl 1): 53–62.
[13] Sundelin Wahlsten, V., Sarman, I. (2013). Neurobehavioural development of preschool-age children born to addicted mothers given opiate maintenance treatment with buprenorphine during pregnancy. *Acta* Paediatr, 102(5): 544–549.

V. COORDINATION WITH TITLE V MCH BLOCK GRANT, HEAD START, CAPTA, AND PDG B-5 NEEDS ASSESSMENTS

A. How Coordination Occurred with Title V MCH Block Grant, Head Start, CAPTA, and PDG B-5 Needs Assessments.

Members of the Delaware MIECHV team also serve on the state's Home Visiting Community Advisory Board, which comprises of individuals who have been deeply involved in or have closely worked with the state's Title V MCH Block Grant, Head Start, CAPTA, and/or PDG B-5 needs assessments. Accordingly, these individuals have collaboratively shared resources from these needs assessments on an ongoing basis at in-person/online meetings and via e-mail. This section describes how the Delaware MIECHV team coordinated with stakeholders from these other needs assessments to inform this updated needs assessment.

Title V MCH Block Grant

A Steering Committee was assembled as part of the development of the Title V MCH Block Grant Needs Assessment. To ensure that the Steering Committee had the resources needed to make informed decisions through the carrying out of the needs assessment, the Delaware DPH and contractor John Snow Inc. generated several data-driven resources. These resources were made available to the committee stakeholders, including members of the Delaware MIECHV team that was tasked to complete this five-year MIECHV Needs Assessment:

- **Infographics**. Infographics were created for each National Performance Measure to help stakeholders better understand each measure, its objectives, and Delaware's baseline data for each.

- **Focus Group Study**. The Focus Group Study's overall objective was to learn from the study's various subgroups about the general health care and reproductive health needs and concerns of women in Delaware, in order to improve service delivery and the health outcomes of women, children, and their families.

- **Stakeholder Survey Report**. The Stakeholder Surveys provided internal and external professional stakeholders with an opportunity to weigh in on topic areas that they saw as a priority for the State of Delaware to address.

- **Key Informant Interviews**. The Key Informant Interviews were conducted on partners with specific maternal and child health knowledge who could provide a considerable amount of detailed information that could help improve the health and wellbeing of the MCH population. The objective was to solicit input regarding the needs, strengths and opportunities of partners to assist Delaware's women, mothers, children and families.

Head Start

The State of Delaware's Head Start and Early Head Start programs are housed within the Delaware Head Start Collaboration Office (HSCO). HSCO acts as a liaison between Head Start grantees, state governments, community partners such as the Delaware Early Childhood Council, school districts, state agencies, and organizations serving the homeless. This agency has made its 2018 Community Needs Assessment, which includes detailed interviews with parents, early childhood educators, and community members, available to the Delaware MIECHV team. In

addition, the 2018 Community Needs Assessment includes results from the Delaware Early Learner Survey (DE-ELS), which asks kindergarten teachers in the state to observe and record each child's knowledge and skills to determine any supports needed to succeed in kindergarten and beyond. The findings from this survey helped inform the five-year MIECHV Needs Assessment with respect to behavioral and developmental status and needs of children birth to age 3 years (i.e., prior to starting kindergarten).

CAPTA

The State of Delaware's cross-disciplinary group for CAPTA, the Child Protection Accountability Commission (CPAC), monitors Delaware's child protection system to ensure the health, safety, and wellbeing of Delaware's abused, neglected, and dependent children. As with Title V and Head Start, the Delaware MIECHV team received relevant materials from the Commission to inform this needs assessment, namely the most-recently completed strategic plan and the Children's Justice Act (CJA) Annual Progress Report.

PDG B-5

The federal Preschool Development Grant Birth through Five (PDG B-5) was awarded to Delaware in December 2018. This grant is designed to better prepare all children to enter kindergarten ready to learn. The grant will help Delaware strengthen its early childhood system as well as greatly improve student transitions from early childhood programs to the K-12 school system. The PDG B-5 has requirements that Delaware to complete a comprehensive, statewide birth-through-five needs assessment to determine the state's current early learning needs and priorities. From this, the state had to also develop a strategic plan to enhance Delaware's early learning system. Both this needs assessment and strategic plan were executed and completed throughout 2019 and 2020. Again, as in the abovementioned efforts, Delaware MIECHV stakeholders were either deeply involved or closely aligned with the development of the PDG B-5, and therefore, have integrated the results from the PDG B-5 into this MIECHV Needs Assessment.

B. Efforts to Convene Stakeholders to Review and Contextualize Results from Various Needs Assessments in Delaware.

Title V MCH Block Grant

The State of Delaware's Title V MCH Block Grant Needs Assessment process involved collecting information from stakeholders in a variety of ways, including focus groups with community members and a survey of, and key informant interviews with, stakeholders. Each source provides important perspectives, context, and data to help the Title V program identify priorities and detail the state's status on national performance measures.

Throughout 2019 and 2020, the State of Delaware's Title V Needs Assessment Steering Committee met to discuss and rank the national performance measures specific to the needs of the state. The task of this Steering Committee was as follows:

- To use a data-informed method to identify and prioritize Delaware's top health issues related to the health of women, infants, children and youth; and
- To incorporate stakeholder and public input into finalizing the priority areas by population domain for action planning.

As alluded to in the previous section, members of the Steering Committee are also concurrently involved with Delaware MIECHV on the administrative or programmatic levels. The relevant Title V MCH Needs Assessment material that were discussed and decided at these Steering Committee meetings were made available for this MIECHV needs assessment.

Head Start

The HSCO and Delaware MIECHV team communicated predominantly via e-mail to discuss results from the HSCO's 2018 needs assessment (the next needs assessment will be completed in 2021). Overall, HSCO and Delaware MIECHV stakeholders have identified the following through this discussion the need for both teams:

- To work together to serve homeless families in a coordinated way;
- To continue collaborating on the Delaware Early Child Council Healthy Young Children and Families sub-committee and on the Home Visiting Advisory Board; and
- To improve sharing of relevant Head Start information and resources with the MIECHV team and vice versa.

In addition, the HSCO staff members have stated that they have experienced the following service gaps that are relevant and applicable to the home visiting setting:

- Head Start children identified as needing services for evaluation and referral yet are not able to receive them in a timely manner. This might be a systems problem when children are identified in Head Start and referred to the school districts for services;
- Head Start does home visiting as a requirement of their grant. This might not be a duplication of services but the HSCO staff can certainly coordinate home visiting protocols so that Head Start staff feel better equipped to perform home visits in a systematic way with common language for families across programs; and
- Head Start should be among the top services for referrals for any home visitors. As stated by an HSCO staff member, "We need to make the referral system as streamlined as possible to be effective for families and to ensure enrollment in Head Start is done quickly for eligible families."

CAPTA

In Delaware, CPAC serves as the federally mandated Citizen Review Panel and CJA State Task Force. CPAC is responsible for making policy and training recommendations to carry out the objectives of the grant, for conducting a comprehensive evaluation every three years of the state's child welfare system, and for making recommendations for improvement of those systems. Members of this task force have communicated with Delaware MIECHV via e-mail to supply information relevant to substance abuse/misuse and child maltreatment via their recently-completed strategic plan and the Children's Justice Act (CJA) Annual Progress Report

PDG B-5

The PDG B-5 needs assessment engaged multiple internal and external stakeholders and data sets. The needs assessment paired qualitative findings with quantitative insights to capture the full picture of current challenges and opportunities in Delaware's early childhood setting. Overall, through the course of several months, over 410 stakeholders were convened and 22 in-depth family and professional interviews. The needs assessment that was generated from these efforts was shared with the Delaware MIECHV team as part of this needs assessment.

C. How Findings from Title V MCH Block Grant, Head Start, CAPTA, and PDG B-5 Informed MIECHV Needs Assessment Update.

Table 16 summarizes how the Title V MCH Block Grant, Head Start, CAPTA, and the PDG B-5 needs assessments helped inform aspects of this needs assessment and the MIECHV program overall going forward.

Table 16. Summary Table of Other Needs Assessments Informing This Needs Assessment.

Needs Assessment	Summary of Information Provided
Title V MCH	Emphasis on safe sleep and breastfeeding NPMs; social determinants
Head Start	What parents want in early childhood; pre-K developmental domains
CAPTA	Strategic, coordinated plan centered on reducing child maltreatment
PDG B-5	Early childhood care and education strengths and areas for improvement

Title V MCH Block Grant

For each of the 19 NPMs, respondents to a stakeholder survey were asked to rate the degree to which they agreed there was awareness in the state of the NPM as an issue, desire to work on the NPM, and whether progress was being made with regards to the NPM. As shown here, safe sleep and breastfeeding were clearly the most popularly reported of the NPMs, which aligns with benchmarks on which the Delaware MIECHV program has placed considerable emphasis.

Table 17. NPMs in Terms of Community Awareness, Desire to Address, and Progress.

National Performance Measure	Agree of Awareness *and* Desire to Address Issue *n* (%)	Agree Progress has Been Made on Issue *n* (%)
Safe Sleep	80 (73%)	72 (66%)
Breastfeeding	81 (75%)	70 (65%)
Smoking – pregnant women	87 (82%)	62 (58%)
Developmental screening	71 (66%)	60 (56%)
Well woman visit	75 (69%)	56 (51%)
Smoking in household	77 (73%)	55 (52%)
Risk appropriate perinatal care	65 (60%)	54 (50%)
Adequate insurance coverage	81 (76%)	51 (48%)
Bullying	84 (78%)	50 (46%)
Physical activity in children	81 (75%)	48 (44%)
Adolescent well visit	71 (66%)	47 (44%)
Medical home	66 (61%)	45 (42%)
Preventive dental visit – children/adolescents	62 (58%)	44 (41%)
Physical activity in adolescents	74 (69%)	44 (41%)
Low-risk Cesarean deliveries	45 (41%)	37 (34%)
Injury hospitalization prevention – adolescents	48 (44%)	34 (31%)
Injury hospitalization prevention – children	51 (47%)	34 (31%)
Transition	49 (45%)	32 (30%)
Preventive dental visit – pregnant women	39 (36%)	23 (21%)

Respondents were also given a chance to more openly describe the needs of the people in the communities in which they work. Table 18 contains a compilation of responses to the question, "What are the top 3 most important things that women, children, and families need to live their fullest lives?" The most frequently cited needs were for access to high quality healthcare, including having adequate health insurance that reduced barriers to primary and specialty care. Economic improvement, primarily via greater household income and income/work stability, was often cited as crucial, as was proper nutrition and exercise, safe and affordable housing, mental health services and support, and adequate, affordable, and flexible child care. Such results suggest that the Delaware MIECHV program should also consider strengthening its role on improving health equity and addressing social determinants of health for enrolled families.

Table 18. Categorized Open-Ended Responses to "What are the Top 3 Important Things that Women, Children, and Families Need to live their Fullest Lives?"

Number of Mentions	Top Three Important Things that Women, Children, and Families Need to Live Their Fullest Lives? (*n* = 88)
35	**Healthcare Access and Adequate Insurance.** Access to insurance/education about insurance, access to preventive services, specialty care, better access for infants/toddlers/CYSHCN, more medical providers – shortage, Medicare for All including males/access to Medicare.
32	**Healthcare Quality.** Proper and timely care, case management, prevention care, medical home, wraparound/integrated/follow-up care, appropriate referrals, continuing healthcare after adolescence, access to quality, standardized care.
37	**Economic Improvement.** Job opportunities, livable wage, access to/adequate resources, SDOH, financial security, remove poverty, increase subsidies, quality education and job skills, safety/safety from violence.
23	**Nutrition and Exercise.** Access to healthy food, food security, knowledge/understanding/education around healthy lifestyle (self-care, nutrition, exercise), neighborhood food options, food & water – pathway to overall health.
23	**Housing.** Affordable housing, stable housing, accessible housing,
15	**Mental Health and Substance Abuse.** ACES Awareness, trauma informed care, decrease substance use, access to AOD treatment, education on smoking cessation, ban vaping, mental health services, suicide prevention, emotional support for healthy relationships (including for women in recovery).
14	**Family Support and Child Care.** Safe, affordable child care, flexible (extended hours, weekends) child care, engaged parents/family, parental education on how to keep kids healthy, family empowerment, fatherhood involvement, increased family time, breast feeding education, safe sleep messaging, get rid of free O/D medication, more self-sufficiency and less handouts.
8	**Healthy Communities.** Ministering to overall needs, supportive communities, equitable communities, safe places to live and work, social support systems, healthy, thriving communities.
5	**Oral Health is Healthcare.** Dental screenings and treatment, Medicaid coverage for dental (adults), dental medical home, oral health.
5	**Respite Care.** Family medical leave, support for grandparents/caregivers raising children, information/resources/respite for caregivers of CYSHCN.
4	**Other.** Transportation, reproductive health, CYSHCN services.

Head Start

The results to the 2018 Community Needs Assessment and 2019 Delaware Early Learner Survey (DE-ELS) provided meaningful insights from Head Start for this updated needs assessment. This section includes additional relevant material from Head Start that were not otherwise featured in other sections of this needs assessment.

Head Start and Early Head Start asked for parent/guardian input as part of their 2018 Community Needs Assessment. Overall, their findings indicate:

- 100 percent of parents/guardians responding agree that their child care location is convenient;
- 96 percent report that the programs provided a safe place to learn that helped their children get ready for school by becoming more independent, learning basic concepts in language, and learning to share and cooperate; and
- 92 percent are satisfied with their classroom staff.

Moreover, the 2018 Community Needs Assessment uncovered the following programmatic-related results:

- While about half of the parent/guardians responding said they would prefer a 12-month program and that a 6-8 hour day would be better, 88 percent said the current hours and days of operation meet their family's needs;
- All sources of information provided by the programs to families were highly rated, with newsletters, parent handbooks, flyers, and monthly calendars the most appreciated; and
- Availability of programs specifically for fathers was around 50 percent or less, which may be more a matter of communication than existence of events;
- Roughly 80 percent agree the centers are friendly and welcoming for fathers; and
- Parents believe the program does a good job telling them how to be involved (policy council, volunteering, parent committee, family gatherings.). When they request information from the program on topics such as disabilities or child development, it is provided in a timely manner, and is useful and supportive of their family's values. Social media would be a welcome addition to the communication plans.

Health- and finance-related findings from parents/guardians include:

- Families report their biggest stressors are financial (75 percent), employment and medical/ dental health (30 percent each), education and job training (25 percent each), and housing (19 percent);
- Families say they need the most help with depression, family conflicts, financial planning, and goal setting;
- The most common physical complaints are eye/vision care, hypertension, and dental care; and
- The most common financial complaints are: earning a living wage, budgeting, recovering from bad credit, and having past due bills.

In addition, for the 2018 Community Needs Assessment, the feedback from community members included:

- Improve communication regarding what services are available from where;
- Improve availability of drug abuse rehabilitation services;

- Share professional development opportunities between organizations/providers;
- Offer joint parent workshops;
- Improve implementation of birth to age 5 years developmental screening and early intervention; and
- Increase access to the following resources: mental health resources for children, transportation for low-income families, longer hours of operation for childcare, family support/coaching, elder services, and help finding and paying for safe housing especially for homeless moms and kids;
- Poor education, drug addiction, and an unwillingness or inability of parents to keep appointments were identified as primary obstacles to serving the community. Resource shortages (budget, staff), long waiting lists, and lack of space were also cited;
- The families being served have many challenges of their own, and sometimes the priority becomes an immediate crisis in food, healthcare, or housing instead of attending a meeting with a teacher, a workshop, or a family event;
- Respondents also indicated there are too many programs addressing the same issues without collaboration; and
- Inadequate availability of transportation, jobs, and high-quality affordable Early Childhood Education (ECE) programs are also frequently reported.

Finally, as articulated in the Community Needs Assessment, a common theme for ECE staff is the need to either bring services to the children *or* bring the children to the services. Programs that provide ways for children and families to receive services including transportation to those services are the most successful. Programs that require parents to drive their children to these services outside of school hours see much lower adoption, for reasons identified earlier in this assessment (work schedules, lack of public transit, other transportation challenges). Almost all of the respondents said that at least some of the time they do not know where to refer families for one service or another. They asked for a community resource book so they would have that information at their fingertips. Respondents also mentioned the need for improved professional development options including topics and delivery methods. And, improving communication between ECE and public education is also an identified need.

For the DE-ELS, which is administered by kindergarten teachers within the first 30 days of kindergarten, the survey results suggest that increased emphasis be placed on improving cursory mathematics skills for children in advance of their entry into kindergarten (Table 19).

Table 19. DE-ELS Results, 2016-2019.

Domain	2016	2017	2018	2019
Social and Emotional	62%	55%	58%	72%
Physical	64%	64%	61%	78%
Language	54%	62%	53%	67%
Literacy	67%	69%	70%	85%
Cognitive	55%	54%	54%	65%
Mathematics	43%	44%	45%	52%

CAPTA

CPAC has established a strategic framework for carrying out Delaware's CAPTA-supported prevention activities (Table 20). The framework represents a select group of strategies based on the best available research/evidence to help prevent child abuse and neglect and is designed to help communities and states to prioritize prevention activities. As evidenced by this table, many of the strategies help support or align with MIECHV-related areas of focus (e.g., increase parenting skills to promote healthy child development). Making use of this strategic framework – as well as the increased emphasis statewide on substance use disorder, treatment, and counseling services – Delaware MIECHV has recently been and will continue to work more closely with CPAC to improve services related to preventing and reducing child maltreatment.

Table 20. CPAC Strategy Framework.

Strategy	Approach	Delaware	PCAD/Lead Agency	Areas for Growth
Increase economic supports to families	Increase household financial security Family friendly work policies	EITC Purchase of Care Paid parental leave for state employees	Support HB3	Establish relationships with non-traditional partners
Change social norms to support parents and positive parenting	Public engagement and education campaigns	DE Thrives QT30 ACEs/Trauma informed practices	Training and technical assistance Bullying prevention BE SMART/SOC Build family leadership Child Abuse Prevention Month activities	Public awareness campaigns Parent leadership activities
Quality early care and education	Preschool enrichment with family engagement Increased quality through licensing and accreditation	OEL/Stars Tiered reimbursement Professional development Head Start/Early Head Start Preschool Development Grant Assessment and Strategic Plan	Partnering with Parents (create first line of defense) Training and technical assistance Kindergarten Academies BE SMART	Parent engagement Increase the availability of quality childcare Expand mental health and behavioral health services to young children Decrease the preschool expulsion rate

Strategy	Approach	Delaware	PCAD/Lead Agency	Areas for Growth
Increase parenting skills to promote healthy child development	Early childhood home visiting Parent skill and family relationship approaches	Home visiting continuum Child Development Watch Birth to Three Early Childhood Comprehensive Systems Grant DSCYF/DFS differential response (teens, SEI) Parenting classes CFF, Child, Inc. Family Crisis Therapists	All Babies Cry Partnering with Parents Kindergarten Academies Parent Conferences Family Cafes Baby Showers BE SMART/SOC Adult education Foster Parent Training Kinship Care Training Training for professionals - Home visitors - Help Me Grow - Health Ambassadors - Parent educators	Create a robust continuum of evidence- based parenting programs for specific populations who are currently underserved involve family court and DFS in determining what is needed and where gaps exist Explore the feasibility of a universal, tiered home visiting system Develop differential response for families involved in chronic neglect
Intervention	Treatment services	PCIT/CMH Project Launch Early Childhood Mental Health Consultants		Support the provision of trauma informed services

In addition to this strategic framework, it is essential to note that the State of Delaware received In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse and Child Welfare (NCSACW) from September 2016 through September 2018. The two-year engagement focused on addressing infants with prenatal exposure and their families and implementing legislation, policies, and protocols to align state practice with federal changes in CAPTA. The project involved Delaware MIECHV stakeholders and the accomplishments/long-term outcomes of the project directly affect MIECHV programming within the state.

Major program goals for the IDTA include:

- **Goal 1: Address universal screening during pregnancy.** The core team along with partners conducted surveys of OB-GYNs and hospitals to better understand screening and

testing practices to identify substance disorders during pregnancy. They found inconsistent use of prenatal screening and testing across hospitals and providers.

- **Goal 2: Build a system of care to support providers working with pregnant women with substance use disorders**. The core team identified a need for increased multidisciplinary teaming to support pregnant women with substance use disorders and their infants. The core team applied for a Regional Partnership Grant (RPG) to support teaming between child welfare and substance use disorder treatment.

- **Goal 3: Implement a statewide protocol for plans of safe care (POSC).** The core team drafted Aiden's Law, which aligns local practice with federal changes in CAPTA. During IDTA, the law passed, and the team worked to implement the law through local practice changes, including implementing a statewide POSC protocol.

- **Goal 4: Maintain an awareness of the effects of stigma.** The core team is developing strategies to address stigma associated with parents with substance use disorders—especially pregnant women—and those on Medication-Assisted Treatment (MAT). The group is also working to redefine how child welfare is perceived, including clarifying the role of POSC.

The accomplishments from this project include:

- **Address universal screening during pregnancy.** The core team developed materials that highlighted the use of screening tools and legislation that requires prenatal care providers to discuss the dangers of substance use during pregnancy with their patients. The team also supported the Division of Public Health in developing materials for Obstetricians & Gynecologists (OB-GYNs) that outlined screening practices and tools. Additionally, the state rolled out the website "HelpisHereDE" which provides screening tools, information on addiction, and information on accessing substance use disorder treatment.

- **Build a system of care to support providers working with pregnant women with substance use disorders.** The core team developed the Delaware Healthy Outcomes with Parent Engagement (DE HOPE) model and applied for the RPG. The DE HOPE initiative provides a multidisciplinary team approach to serve families affected by prenatal substance exposure. They were awarded a five-year grant in 2017 and began oversight of implementation work.

- **Implement a statewide protocol for POSC.** The core team developed a POSC template and draft implementation guide. The state fully implemented POSCs at all birthing hospitals across the state after completing a three-hospital pilot, out-stationing Child Protective Services investigators at hospitals to develop the POSCs. They integrated and began tracking POSC elements into their database to align with federal CAPTA mandates, and Delaware's legislature passed Aiden's Law, which aligns state statutes with federal CAPTA legislation. The database tracks child welfare data related to fatalities and near fatalities. The database was expanded to include information about

notifications and POSCs, including referrals for the infant or caregiver. Additionally, the state developed and awarded a request for proposal to a community-based agency to implement POSCs for low-risk families screened out by DFS. The core team is also working with MAT providers to implement prenatal POSCs and to oversee low risk POSCs for mothers on MAT.

- **Maintain an awareness of the effects of stigma.** The state has begun working with recovery coaches to build support for POSCs and has provided integrated child welfare presentations to MAT providers and clients to discuss POSCs. Child welfare investigators have also begun meeting with pregnant clients at their MAT facilities to discuss the POSCs and their role in supporting families.

PDG B-5

Much of the PDG B-5 needs assessment material has been integrated into sections throughout this updated needs assessment. In addition to this information, the PDG B-5 needs assessment has provided a wealth of information in terms of strengths and areas for improvement toward improving the early childhood care and education within the State of Delaware. Many of these insights are relevant to Delaware MIECHV and will be incorporated into future initiatives and strategies by the program.

Recognized strengths include:

- Praise for www.mychildde.org, My Child DE, with interviewed individuals noting it as providing considerable information that is easy to search for families;
- Very few children waitlisted for existing services of those families who navigated the signup process;
- High satisfaction with services provided by Child Development Watch family service coordinators and home visiting programs; and
- Positive perceptions of the strong connections between educators/professionals and children.

Areas for improvement and potential opportunities for growth include:

- Developing a high-quality, stable educator workforce;
- Using data to understand child/family needs;
- Recognizing that the system is often confusing and cumbersome for parents and families, which results in an underutilization of high-quality services and information resources;
- Improving access to adequate financial assistance;
- Ensuring a unified governance exists for consistent program and service delivery; and
- Making certain that early childhood care and education programs are available, as there tends to be an insufficient supply of such programs by location and age groups served.

The PDG B-5 needs assessment also emphasized the importance of affordability and availability of early childhood care and education programs for community stakeholders, which system stakeholders tend to de-emphasize. System stakeholders generally placed greater emphasis on issues such as quality and governance.

VI. CONCLUSION

A. Major Findings of Statewide Needs Assessment Update.

The following noteworthy findings were uncovered through the comprehensive completion of this statewide needs assessment update:

- **Communities identified as at-risk are located in each of Delaware's three counties and are geographically spread across the state.** The independent method for determining at-risk communities recognized six zones to be targeted for MIECHV programming, of which two (East Dover and Smyrna/West Dover) are situated in Kent County, three (Southeast Wilmington, Central Wilmington, and East Wilmington) are located in New Castle County, and one (Georgetown/Seaford) is situated in Sussex County. Accordingly, all three of the state's counties have been classified as at higher risk as mandated by HRSA. It is also essential to note that these six zones comprise of both highly urban and rural regions of the state and have diverse and pervasive needs ranging from transportation barriers to limited educational attainment

- **Several evidence-based home visiting services are present in Delaware and provide services to families statewide.** Table 5 indicates that each of Delaware's three counties is served by at least one evidence-based home visiting program as well as at least one that is supported by MIECHV funds. Moreover, Table 6 shows that three evidence-based home visiting programs – Healthy Families America, Nurse-Family Partnership, and Parents as Teachers – provide services to hundreds of families throughout the state.

- **Home visiting programs have demonstrated sound program outcomes for their clients and home visitors alike.** Notably, the MIECHV-supported sites fare well on the overwhelming majority of benchmarks, particularly early childhood-related benchmarks. In addition, the results from an August 2020 survey of home visitors found that the respondents were confident in their self-reported ability to provide evidence-based home visiting and were generally pleased with the quality of existing home visiting programs.

- **Despite these sound program outcomes, there are several complex gaps that hinder the provision of robust home visiting services.** These gaps include client and staff attrition, geographic barriers, limited cognition of home visitation by outside stakeholders, and resources available to both home visitors and enrolled families. These gaps have been identified through discussions with both MIECHV staff and families as well as through a recent survey of home visitors.

- **The State of Delaware has a wealth of programs and initiatives focused on substance use disorder treatment and counseling services.** Many of these treatment and counseling services are available to families who are enrolled or eligible for evidence-based home visiting services and these services are generally accessible statewide. Moreover, there are opportunities for MIECHV to collaborate with state and local partners to ensure a more effective and more sustainable statewide approach toward addressing substance use disorder.

- **Stakeholders from other statewide needs assessments, namely for the Title V MCH Block Grant, Head Start, CAPTA, and PDG B-5 have provided additional insights for this MIECHV Needs Assessment. Correspondingly, this needs assessment can help inform and supplement the aforementioned needs assessments as well.** As a small state, Delaware has the benefit of having many of the same stakeholders participating in multiple maternal and child health efforts at the statewide administrative and programmatic levels. This helps immensely in the sharing of both data and information used across needs assessments, such as reports on relevant focus groups and surveys. It also helps reduce redundancy in the acquisition of this material. As evidenced by this needs assessment, the state's Title V MCH Block Grant Needs Assessment identified safe sleep and breastfeeding, which are directly linked to home visiting services, as among its most pressing national performance measures. Moreover, the needs assessment for Head Start helped provide a considerable amount of data and voices relevant to community needs while the CAPTA-supported strategy plan emphasized home visiting services as essential toward increase parenting skills to promote healthy child development. Finally, the PDG B-5 needs assessment provided a wealth of material on the current successes and gaps present in the early childhood care and education space within the state. Delaware MIECHV should consider all of these findings in its programming and strategies going forward.

B. Dissemination of Statewide Needs Assessment Update to Stakeholders.

Delaware MIECHV, Forward Consultants, and Aloysius Butler & Clark (AB&C), the contracted social marketing vendor, will work on the dissemination of the HRSA-approved needs assessment. Once approved, this dissemination will occur via hard print form, online via the Delaware maternal and infant health website (http://dethrives.com/), and potentially through social media outlets depending on the approval of the Delaware Home Visiting Community Advisory Board and the Delaware DPH.