State of Delaware
Department of Health & Social Services
Division of Public Health
Family Health & Systems Management Section
Maternal and Child Health Bureau

Affordable Care Act Maternal, Infant and Early Childhood Home Visiting
Updated State Plan

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
MATERNAL AND CHILD HEALTH BUREAU

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EXECUTIVE SUMMARY

Delaware's Maternal, Infant and Early Childhood Home Visiting Program leverages crucial partnerships to maximize Affordable Care Act (ACA) federal funding for home visiting. There are four existing programs that use home visiting as the primary mechanism of service delivery.

Table 1. Existing Programs in Delaware that use Home Visiting.

Program	Operating Agency	Funding Source
Healthy Families America (known programmatically as Smart Start)	Division of Public Health	Federal ACA Home Visiting grant & state general funds
Nurse-Family Partnership	Children & Families First	Evidence-Based Home Visiting Grantee (incorporated into ACA Home Visiting grant), state funds and donations from the not-for-profit and private sector.
Parents as Teachers	Department of Education	State funds
Early Head Start	Department of Education & University of Delaware	Federal funds (non-ACA) and state funds

Consistent with the collaborative nature of Delaware, even though only two programs receive ACA funding, all four home visiting programs will be partnering in Delaware's Maternal, Infant and Early Childhood Home Visiting (DMIEC-HV) Program. This cross-sectional commitment to operating a program that provides a continuum of home visiting program makes Delaware uniquely positioned to successfully implement the vision of the ACA.

Based on a comprehensive needs assessment (submitted September 2010) six at-risk communities (zones) were identified as benefiting particularly from targeted home visiting services. Three are located in the metropolitan city of Wilmington (Delaware's largest city) and three in the rural southern part of the state, Sussex County. Although services are available statewide, families residing in the six zones will receive priority service through the ACA grant funded program, Smart Start, operated through the Division of Public Health. Community input was incorporated into the determination of service delivery models. Through data collection, evaluation and quality improvement, Delaware will measure the positive impact of home visiting services of women, children and families.

SECTION I. IDENTIFICATION OF DELAWARE'S TARGETED AT-RISK COMMUNITIES

Identifying Delaware's At-Risk Communities

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 2000 census population ranging from 22,573 to 58,301. 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.

The median income reported in the 2000 census 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.

In the original needs assessment analysis the highest risk zones were located in the metropolitan City of Wilmington. Although the results were not surprising there was consensus among the Home Visiting Steering Committee that services were needed in other areas of the state, beyond the City of Wilmington. Therefore, a sub-analysis was performed for Kent and Sussex Counties only and the top three at-risk communities were identified based on the metrics identified in the Affordable Care Act. The needs assessment finding were vetted with stakeholders and community members through the Home Visiting Steering Committee and community engagement forums (further discussed in section 3). Based on feedback, it was determined that six zones, three from Wilmington and three from the Kent/Sussex counties would constitute the targeted communities for Delaware's Maternal, Infant and Early Childhood Home Visiting (DMIEC-HV) Program. A detailed assessment of the needs and existing resources of each of the six communities is provided below.

ZONE 1: Wilmington River Area

Zone 1 is located in the northeastern geographic region of the Wilmington metropolitan area. It includes the cities and towns of Bellefonte, Claymont, Edgemoor, and parts of Wilmington. It is comprised of zip codes 19703 and 19809 and census tracts 101.01, 101.02, 102, 103, 104, 105, 107, and 108.

Courtesy: Google Maps

Zone 1 was targeted as a high-risk community that would be supported by the MIECHV program as it had among the lowest performing maternal and child health indicators in Delaware. The following tables provide detailed data for Zone 1.

Age Breakdown				
Indicator	**Zone 1**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	31,334	**	863,832	**
Age: Under 5 years	2,282	7.28%	58,302	6.75%
Age: 5 to 9 years	1,782	5.69%	54,911	6.36%
Age: 10 to 14 years	1,999	6.38%	56,126	6.50%
Age: 15 to 19 years	1,869	5.96%	61,003	7.06%
Age: 20 to 24 years	1,568	5.00%	56,402	6.53%
Age: 25 to 34 years	4,658	14.87%	112,525	13.03%
Age: 35 to 44 years	4,652	14.85%	121,689	14.09%
Age: 45 to 54 years	4,906	15.66%	125,193	14.49%
Age: 55 to 59 years	2,078	6.63%	52,054	6.03%
Age: 60 to 64 years	1,520	4.85%	46,778	5.42%
Age: 65 to 74 years	1,729	5.52%	63,066	7.30%
Age: 75 to 84 years	1,440	4.60%	40,433	4.68%
Age: 85 years and over	851	2.72%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates.*

Race/Ethnicity Breakdown				
Indicator	**Zone 1**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	31,334	**	863,832	**
Race: One race	30,806	98.31%	863,832	98.28%
Race: Two or more races	528	1.69%	58,302	1.72%
White Non-Hispanic	21,402	68.30%	590,627	68.37%
Black Non-Hispanic	7,225	23.06%	173,903	20.13%
Hispanic	1,208	3.86%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 1**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	11.20	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	10.67%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	14.71%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 1**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	0.89%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 1**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	2.45%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 1**	**Delaware**
Number of Households	13,019	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$37,729	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	8.34%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	5.62%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	17.37%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	5.93%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Wilmington River Area has strengths and risk factors. Among the strengths are resources including:

- Claymont Family Health Services
- Claymont State Service Center/Community Center
- Strong network of churches and community-based organizations
- Invested school board and advisory board for the Mt. Pleasant School-Based Health Center
- Support of the Wilmington Consortium

Compared to the state as a whole, Wilmington River Area residents have a higher risk for the following:

3 Infant mortality

4 Low birth weight

5 Unemployment

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone.

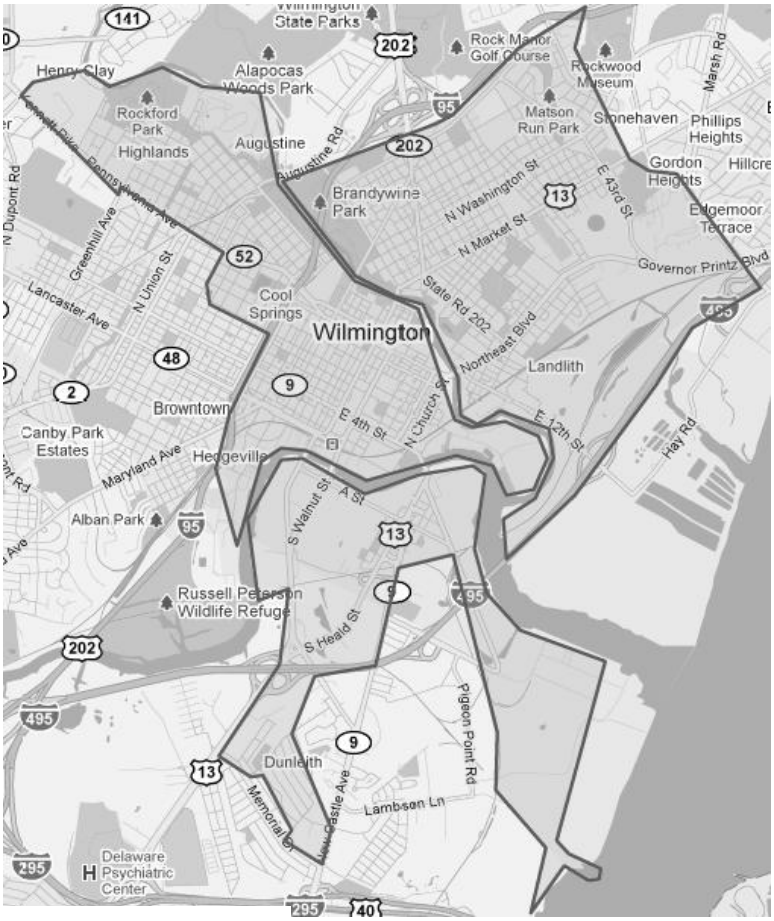
Table 2: Number and Types of Home Visiting Programs Statewide.

Home Visiting Agency	Home Visiting Model	Families Served Last Year	Referral Source	Referrals Made
Division of Public Health	Healthy Families America (known programmatically as Smart Start)	415 families with children under the age and/or during pregnancy	Hospitals, health care providers, Medicaid Managed Care	WIC, social services, child welfare, TANF, Medicaid
Children and Families First	Nurse-Family Partnership	91 clients	Smart Start, health care providers, CBO's	Housing assistance, Medicaid, TANF, employment assistance
Department of Education	Parents as Teachers	1,190 families	Schools, other home visiting programs	Medicaid, child welfare, TANF
Early Head Start	Department of Education and University of Delaware	306 families	CBO's, provides, social services	Housing assistance, mental health, TANF, adult education

Based on the community engagement forum feedback, residents of Wilmington River Area were concerned with crime, lack of good jobs available for young people, lack of family support for young women and children and the safety of neighborhoods. These themes were universal across all the community engagement forums in Wilmington, which highlights the shared concerns regarding economic viability and security. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at offering job placement/training and neighborhood social capital.

ZONE 3: Center City Wilmington

Zone 3 is located in the central geographic region of the Wilmington metropolitan area and exclusively consists of the City of Wilmington. It is comprised of zip codes 19801, 19802, and 19806 and census tracts 1, 2, 3, 4, 5, 6.01, 6.02, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 26, 27, and 154.



Courtesy: Google Maps

Zone 3 was chosen as a high-risk community because it had among the highest rates of child maltreatment and poor maternal and child health indicators in Delaware. Zone 3 shares a border with both Zone 1 and Zone 4, two other communities considered to be high-risk.

The tables on the following pages provide detailed age, race/ethnicity, and benchmark-related data for Zone 3.

Age Breakdown				
Indicator	**Zone 3**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	57,435	**	863,832	**
Age: Under 5 years	3,571	6.22%	58,302	6.75%
Age: 5 to 9 years	3,433	5.98%	54,911	6.36%
Age: 10 to 14 years	3,419	5.95%	56,126	6.50%
Age: 15 to 19 years	3,524	6.14%	61,003	7.06%
Age: 20 to 24 years	3,706	6.45%	56,402	6.53%
Age: 25 to 34 years	9,491	16.52%	112,525	13.03%
Age: 35 to 44 years	8,069	14.05%	121,689	14.09%
Age: 45 to 54 years	8,474	14.75%	125,193	14.49%
Age: 55 to 59 years	3,287	5.72%	52,054	6.03%
Age: 60 to 64 years	2,818	4.91%	46,778	5.42%
Age: 65 to 74 years	3,721	6.48%	63,066	7.30%
Age: 75 to 84 years	2,633	4.58%	40,433	4.68%
Age: 85 years and over	1,289	2.24%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Race/Ethnicity Breakdown				
Indicator	**Zone 3**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	57,435	**	863,832	**
Race: One race	56,505	98.38%	863,832	98.28%
Race: Two or more races	930	1.62%	58,302	1.72%
White Non-Hispanic	18,286	31.84%	590,627	68.37%
Black Non-Hispanic	34,839	60.66%	173,903	20.13%
Hispanic	2,965	5.16%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 3**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	14.19	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	15.10%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	18.07%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 3**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	1.13%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 3**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	5.26%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 3**	**Delaware**
Number of Households	24,645	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$27,900	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	19.18%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	18.08%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	28.46%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	11.15%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Center City Wilmington has strengths and risk factors. Among the strengths are resources including:

- Northeast State Service Center
- Porter State Service Center
- Henrietta Johnson Medical Center
- Westside Family Healthcare
- Wilmington Hospital Health Center
- Strong network of churches and community-based organizations
- Invested school board and advisory board for the Howard School-Based Health Center
- Support of the Wilmington Consortium

Compared to the state as a whole, Center City Wilmington residents have a higher risk for the following:

6 Child maltreatment

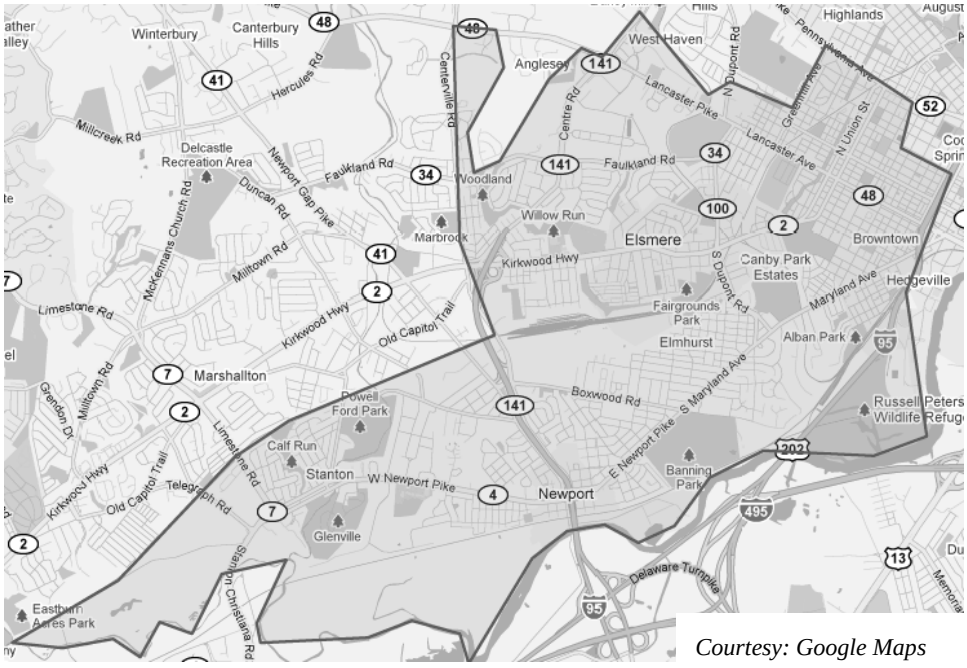
7 Poor maternal and child health

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone. Please see Table 2 for the number and types of home visiting programs operating statewide.

Based on the community engagement forum feedback, residents of Center City Wilmington were concerned with crime, lack of good jobs available for young people, lack of family support for young women and children and the safety of neighborhoods. These themes were universal across all the community engagement forums in Wilmington, which highlights the shared concerns regarding economic viability and security. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at offering job placement/training and building neighborhood social capital.

ZONE 4: Western Wilmington

Zone 4 is located in the central and western geographic region of the Wilmington metropolitan area. It includes the cities and towns of Elsmere, Newport, and parts of Wilmington. It is comprised of zip codes 19804 and 19805 and census tracts 14, 22, 23, 24, 25, 123, 124, 125, 126, 127, 129, and 130.



Courtesy: Google Maps

Note that many of the neighborhoods that are at-risk in Zone 4 are located in Wilmington with fewer in Elsmere and Newport. This zone shares a heavily populated border with Zone 3.

The tables on the following pages provide age, race/ethnicity, and benchmark-related data for Zone 4.

Age Breakdown				
Indicator	**Zone 4**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	43,735	**	863,832	**
Age: Under 5 years	3,381	7.73%	58,302	6.75%
Age: 5 to 9 years	2,834	6.48%	54,911	6.36%
Age: 10 to 14 years	2,740	6.27%	56,126	6.50%
Age: 15 to 19 years	3,054	6.98%	61,003	7.06%
Age: 20 to 24 years	2,783	6.36%	56,402	6.53%
Age: 25 to 34 years	7,372	16.86%	112,525	13.03%
Age: 35 to 44 years	5,886	13.46%	121,689	14.09%
Age: 45 to 54 years	5,944	13.59%	125,193	14.49%
Age: 55 to 59 years	2,141	4.90%	52,054	6.03%
Age: 60 to 64 years	2,277	5.21%	46,778	5.42%
Age: 65 to 74 years	2,333	5.33%	63,066	7.30%
Age: 75 to 84 years	2,079	4.75%	40,433	4.68%
Age: 85 years and over	911	2.08%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Race/Ethnicity Breakdown				
Indicator	**Zone 4**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	43,735	**	863,832	**
Race: One race	42,987	98.29%	863,832	98.28%
Race: Two or more races	748	1.71%	58,302	1.72%
White Non-Hispanic	25,243	57.72%	590,627	68.37%
Black Non-Hispanic	9,224	21.09%	173,903	20.13%
Hispanic	8,380	19.16%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 4**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	9.70	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	10.22%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	14.77%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 4**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	1.05%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 4**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	7.35%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 4**	**Delaware**
Number of Households	16,740	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$32,502	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	14.31%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	13.39%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	37.86%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	8.27%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Western Wilmington has strengths and risk factors. Among the strengths are resources including:

- Belvedere State Service Center
- Westside Family Healthcare
- Strong network of churches and community-based organizations
- Invested school board and advisory board for the Delcastle School-Based Health Center
- Support of the Wilmington Consortium

Compared to the state as a whole, Western Wilmington residents have a higher risk for the following:

8 Poverty

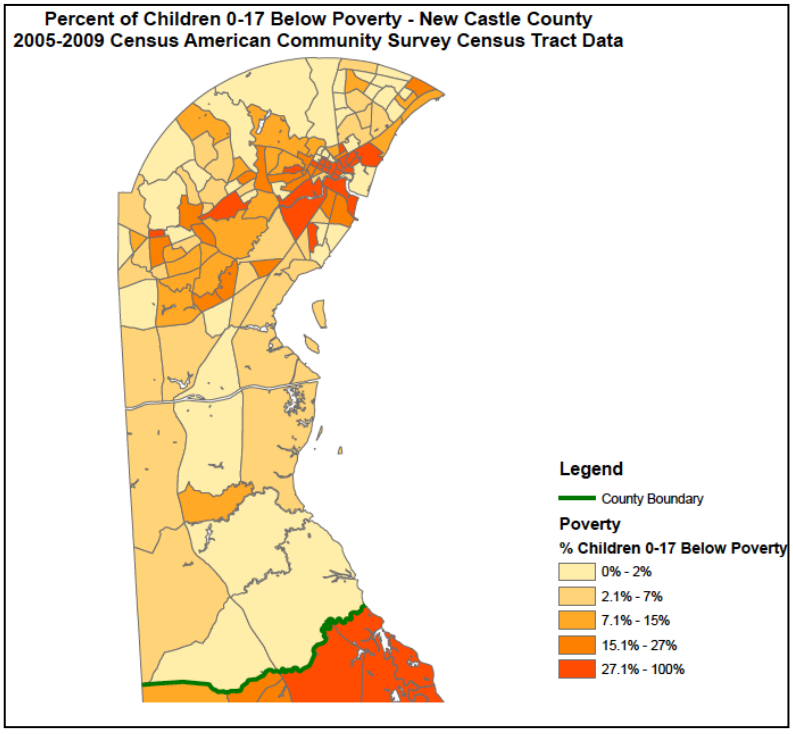
9 Having less than a high school education

10 Low birth weight

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone. Please see Table 2 for the number and types of home visiting programs operating statewide.

Based on the community engagement forum feedback, residents of Western Wilmington were concerned with crime, lack of good jobs available for young people, lack of family support for young women and children and the safety of neighborhoods. These themes were universal across all the community engagement forums in Wilmington, which highlights the shared concerns regarding economic viability and security. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at offering job placement/training and building neighborhood social capital.

The following map displays the percent of persons below poverty by census tract in New Castle County, the location of Zones 1, 3, and 4.



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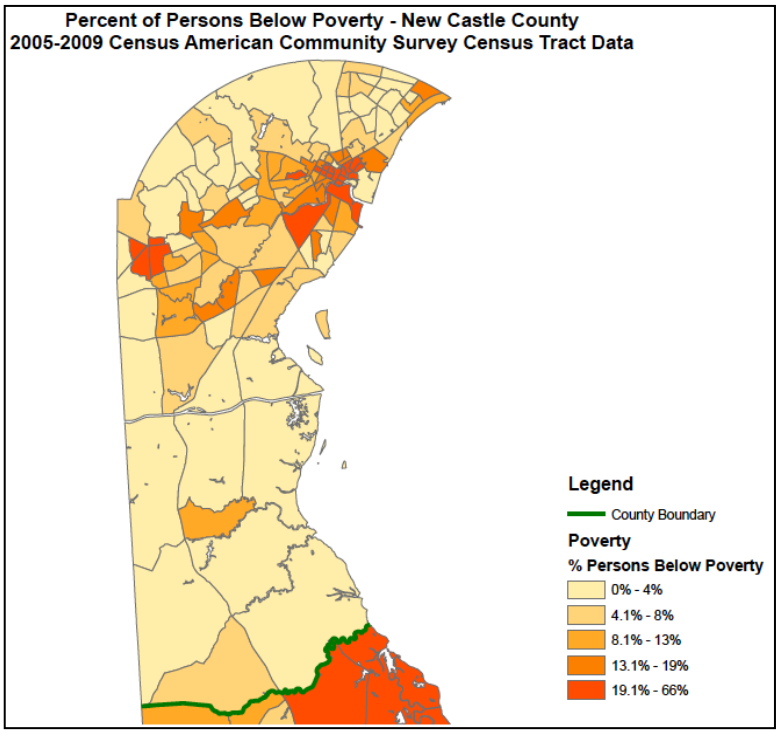
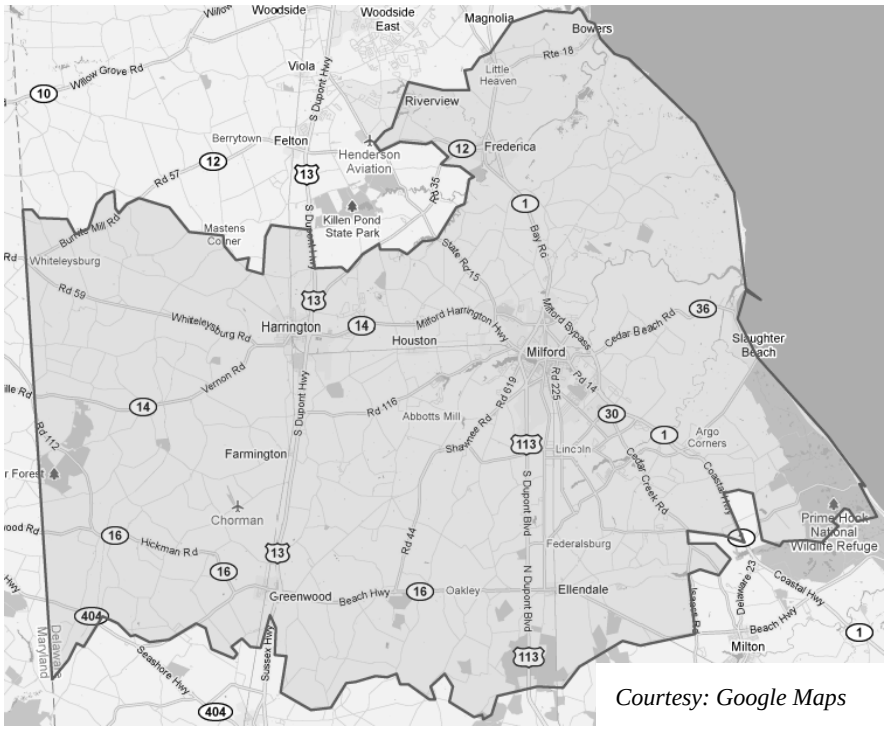
The following map displays the percent of children below poverty by census tract in New Castle County, the location of Zones 1, 3, and 4.



ZONE 15: Southern Kent & Northern Sussex

Zone 15 is located in the central geographic region of Delaware. It includes the cities and towns of Ellendale, Farmington, Greenwood, Harrington, Milford, and Slaughter Beach. It is comprised of zip codes 19941, 19942, 19946, 19950, 19952, 19954, 19960, and 19963 and census tracts 424, 425, 426, 427, 429, 430, 431, 501.01, 501.02, 501.03, 502, 503.01, and 503.02.



Courtesy: Google Maps

Among communities in Kent and Sussex counties, Zone 15 has among the highest percentages of residents over the age of 25 that did not complete high school.

The tables provide detailed age, race/ethnicity, and benchmark-related data for Zone 15.

Age Breakdown				
Indicator	**Zone 15**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	49,771	**	863,832	**
Age: Under 5 years	3,107	6.24%	58,302	6.75%
Age: 5 to 9 years	3,115	6.26%	54,911	6.36%
Age: 10 to 14 years	3,242	6.51%	56,126	6.50%
Age: 15 to 19 years	3,110	6.25%	61,003	7.06%
Age: 20 to 24 years	3,241	6.51%	56,402	6.53%
Age: 25 to 34 years	6,068	12.19%	112,525	13.03%
Age: 35 to 44 years	6,790	13.64%	121,689	14.09%
Age: 45 to 54 years	7,790	15.65%	125,193	14.49%
Age: 55 to 59 years	3,265	6.56%	52,054	6.03%
Age: 60 to 64 years	2,728	5.48%	46,778	5.42%
Age: 65 to 74 years	4,182	8.40%	63,066	7.30%
Age: 75 to 84 years	2,403	4.83%	40,433	4.68%
Age: 85 years and over	730	1.47%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Race/Ethnicity Breakdown				
Indicator	**Zone 15**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	49,771	**	863,832	**
Race: One race	48,951	98.35%	863,832	98.28%
Race: Two or more races	820	1.65%	58,302	1.72%
White Non-Hispanic	37,550	75.45%	590,627	68.37%
Black Non-Hispanic	8,181	16.44%	173,903	20.13%
Hispanic	2,872	5.77%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 15**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	8.03	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	8.19%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	13.08%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 15**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	0.89%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 15**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	3.59%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 15**	**Delaware**
Number of Households	18,995	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$30,681	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	10.91%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	10.45%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	24.75%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	6.84%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Southern Kent/Northern Sussex has strengths and risk factors. Among the strengths are resources including:

- Milford State Service Center
- Local churches and fraternal organizations
- Invested school board and advisory board for the Milford School-Based Health Center

Compared to the state as a whole, Southern Kent/Northern Sussex residents have a higher risk for the following:

11 Poverty

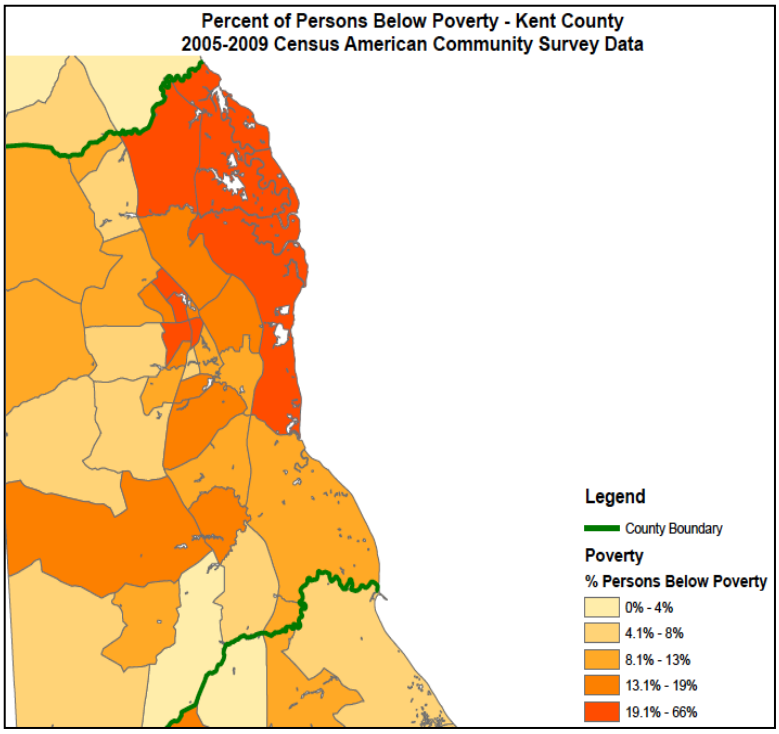
12 Having less than a high school education

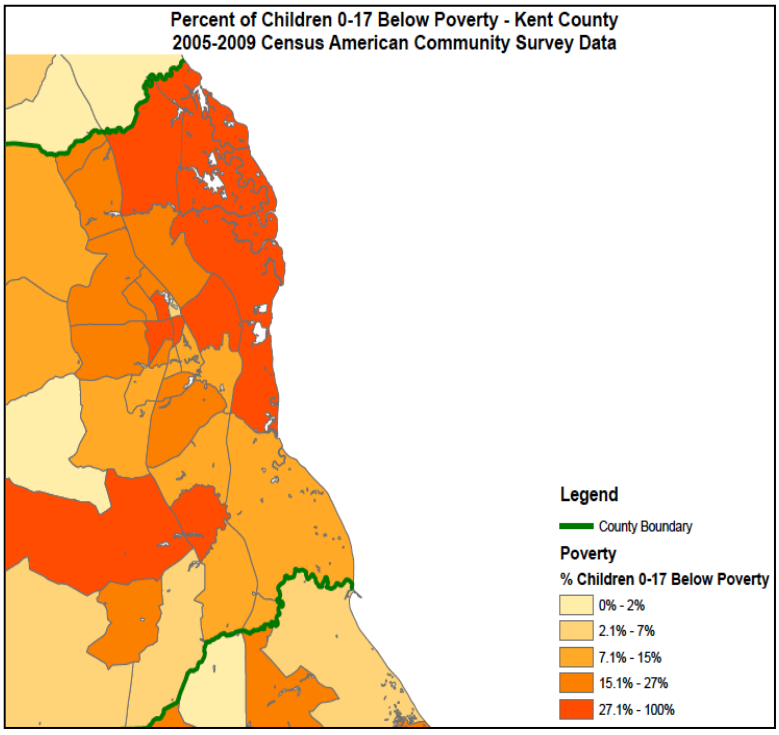
13 Unemployment

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone. Please see Table 2 for the number and types of home visiting programs operating statewide.

Based on the community engagement forum feedback, residents of Southern Kent/Northern Sussex were concerned with unemployment, cost of living, proper housing and access to education and health services. Given the relative small population size in Kent and Sussex Counties, only one community engagement forum was held. The concerns of residents highlight the economic insecurity in communities that rely on agricultural and food processing (namely poultry) industries. The geographic isolation and lack of public transportation makes access to services (health and social) a challenge. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at enhancing access to care and the built environment.

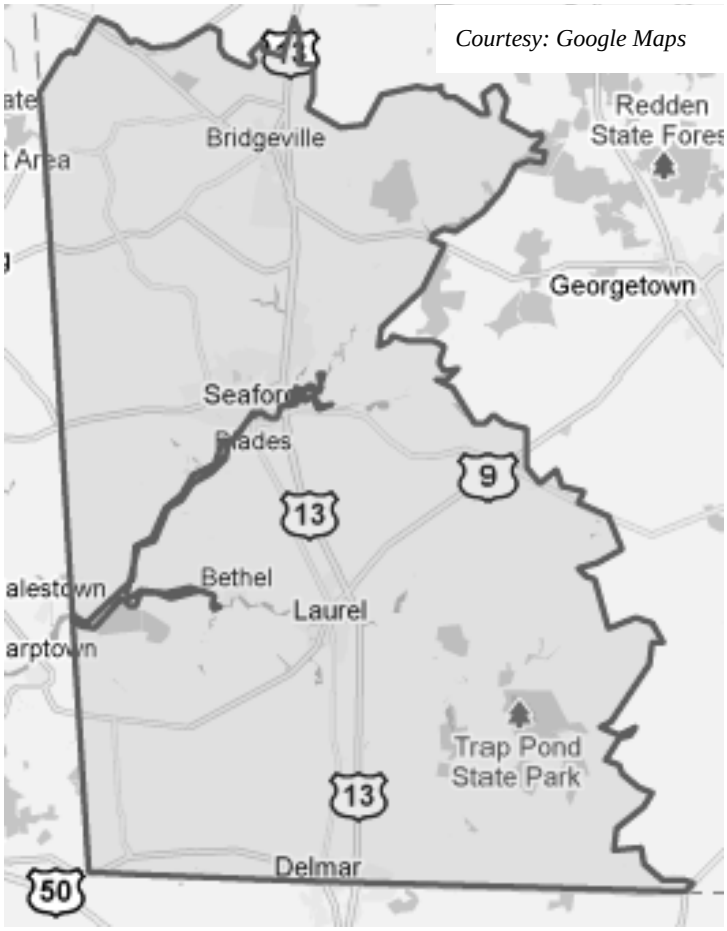
The maps on the following page display the percent of persons below poverty and the percent of children below poverty by census tract in Kent County. A portion of Zone 15 is located in Kent County.





ZONE 17: Western Sussex

Zone 17 is located in the southwestern geographic region of Delaware. It includes the cities and towns of Bethel, Blades, Delmar, Laurel, and Seaford. It is comprised of zip codes 19933, 19940, 19956, and 19973 and census tracts 504.01, 504.02, 504.03, 504.04, 517.01, 517.02, 518.01, 518.02, and 519.



Historically, Zone 17 has had one of the highest poverty rates (poverty calculated as residents below 100% federal poverty level) among zones located in Kent and Sussex counties. Among all communities in Delaware, Zone 17 has among the highest percentage of residents over the age of 25 that did not complete high school. The following tables provide detailed age, race/ethnicity, and benchmark-related data for Zone 17.

Age Breakdown				
Indicator	**Zone 17**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	45,026	**	863,832	**
Age: Under 5 years	3,817	8.48%	58,302	6.75%
Age: 5 to 9 years	2,997	6.66%	54,911	6.36%
Age: 10 to 14 years	2,967	6.59%	56,126	6.50%
Age: 15 to 19 years	3,101	6.89%	61,003	7.06%
Age: 20 to 24 years	2,644	5.87%	56,402	6.53%
Age: 25 to 34 years	5,073	11.27%	112,525	13.03%
Age: 35 to 44 years	5,679	12.61%	121,689	14.09%
Age: 45 to 54 years	6,229	13.83%	125,193	14.49%
Age: 55 to 59 years	3,072	6.82%	52,054	6.03%
Age: 60 to 64 years	2,560	5.69%	46,778	5.42%
Age: 65 to 74 years	3,596	7.99%	63,066	7.30%
Age: 75 to 84 years	2,391	5.31%	40,433	4.68%
Age: 85 years and over	900	2.00%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Race/Ethnicity Breakdown				
Indicator	**Zone 17**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	45,026	**	863,832	**
Race: One race	44,240	98.25%	863,832	98.28%
Race: Two or more races	786	1.75%	58,302	1.72%
White Non-Hispanic	31,809	70.65%	590,627	68.37%
Black Non-Hispanic	9,092	20.19%	173,903	20.13%
Hispanic	2,574	5.72%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 17**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	7.49	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	8.35%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	13.59%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 17**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	0.80%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 17**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	4.96%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 17**	**Delaware**
Number of Households	16,816	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$31,984	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	12.49%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	12.05%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	23.19%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	6.84%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Western Sussex has strengths and risk factors. Among the strengths are resources including:

- Bridgeville State Service Center
- Laurel State Service Center
- Shipley State Service Center
- Local churches and fraternal organizations
- Invested school board and advisory board for the Woodbridge, Laurel, Seaford and Delmar School-Based Health Centers

Compared to the state as a whole, Western Sussex residents have a higher risk for the following:

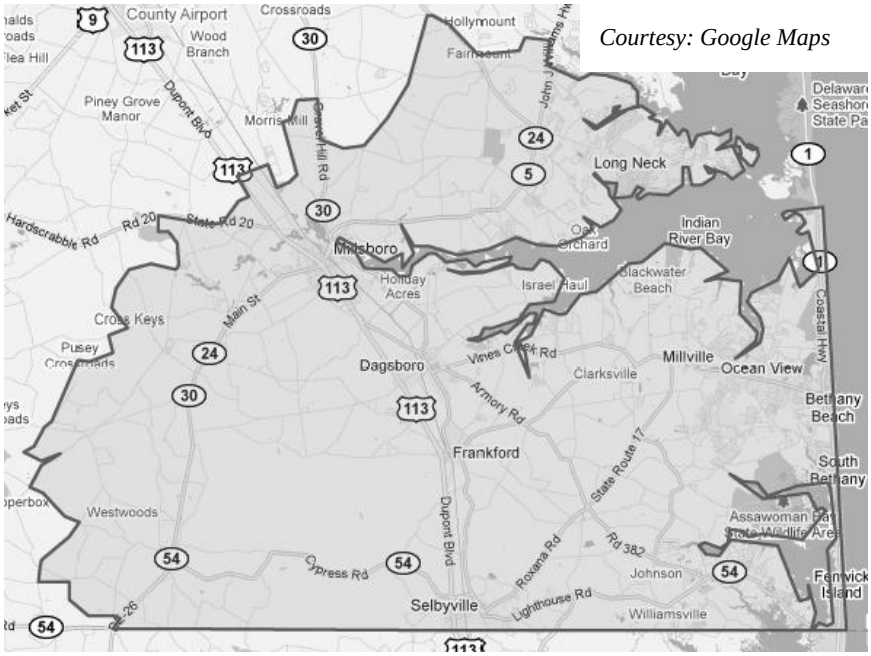
14 Poverty

15 Having less than a high school education

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone. Please see Table 2 for the number and types of home visiting programs operating statewide.

Based on the community engagement forum feedback, residents of Western Sussex were concerned with unemployment, cost of living, proper housing and access to education and health services. Given the relative small population size in Kent and Sussex Counties, only one community engagement forum was held. The concerns of residents highlight the economic insecurity in communities that rely on agricultural and food processing (namely poultry) industries. The geographic isolation and lack of public transportation makes access to services (health and social) a challenge. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at enhancing access to care and the built environment.

ZONE 18: Eastern Sussex



Courtesy: Google Maps

Zone 18 is located in the southeastern geographic region of Delaware. It includes the cities and towns of Bethany Beach, Dagsboro, Fenwick Island, Frankford, Long Neck, Millsboro, Ocean View, Selbyville and South Bethany. It is comprised of zip codes 19930, 19939, 19944, 19945, 19966, 19967, 19970, and 19975 and census tracts 506.02, 507.02, 512, 513.01, 513.02, 513.03, 513.04, 514, and 515. The following tables provide detailed demographic and benchmark-related data specific to Zone 18.

Age Breakdown				
Indicator	**Zone 18**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	48,495	**	863,832	**
Age: Under 5 years	2,596	5.35%	58,302	6.75%
Age: 5 to 9 years	2,265	4.67%	54,911	6.36%
Age: 10 to 14 years	2,282	4.71%	56,126	6.50%
Age: 15 to 19 years	2,368	4.88%	61,003	7.06%
Age: 20 to 24 years	2,153	4.44%	56,402	6.53%
Age: 25 to 34 years	3,764	7.76%	112,525	13.03%
Age: 35 to 44 years	5,171	10.66%	121,689	14.09%
Age: 45 to 54 years	6,327	13.05%	125,193	14.49%
Age: 55 to 59 years	4,082	8.42%	52,054	6.03%
Age: 60 to 64 years	4,567	9.42%	46,778	5.42%
Age: 65 to 74 years	7,473	15.41%	63,066	7.30%
Age: 75 to 84 years	4,141	8.54%	40,433	4.68%
Age: 85 years and over	1,306	2.69%	15,350	1.78%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Race/Ethnicity Breakdown				
Indicator	**Zone 18**		**Delaware**	
	Estimate	**Percentage**	**Estimate**	**Percentage**
Total Population	48,495	**	863,832	**
Race: One race	47,645	98.25%	863,832	98.28%
Race: Two or more races	850	1.75%	58,302	1.72%
White Non-Hispanic	40,982	84.51%	590,627	68.37%
Black Non-Hispanic	3,167	6.53%	173,903	20.13%
Hispanic	2,768	5.71%	57,807	6.69%

2005-2009 data. *American Community Survey 5-Year Estimates*.

Maternal and Newborn Health				
Indicator	**Numerator**	**Denominator**	**Zone 18**	**Delaware**
Infant Mortality	Feto-Infant Deaths, Age Less Than 1 Year	1,000 Live Births	9.52	8.54
Low Birth Weight Infants	Live Births Less than 2500 Grams	Total Live Births	7.34%	9.3%
Premature Birth	Live Births Before 37 Weeks	Total Live Births	14.31%	13.8%

2003-2007 data. *Delaware Health Statistics Center.*

Child Maltreatment				
Indicator	**Numerator**	**Denominator**	**Zone 18**	**Delaware**
Child Maltreatment	Reported Substantiated Maltreatment	Total Population Age 0-17 Years	0.88%	1.03%

2006-2008 data. *U.S. Department of Health & Human Services, Administration on Children, Youth and Families, Children's Bureau.*

Domestic Violence				
Indicator	**Numerator**	**Denominator**	**Zone 18**	**Delaware**
Domestic Violence	11th Graders who Witnessed Domestic Violence in the Past Month	11th Graders who Completed the 2009 YRBS	7.34%	5.16%

2009 data. *Delaware Youth Risk Behavior Survey.*

Family Economic Self-Sufficiency		
Indicator	**Zone 18**	**Delaware**
Number of Households in Zone	20,203	325,160
Annual Earnings in 2009 Inflation-Adjusted Dollars for Population 25 Years and over with Earnings	$30,212	$34,846
Percentage of Households with Poverty Status at Below Poverty Level in Past 12 Months	7.98%	9.58%
Percentage of Households receiving Food Stamps in Past 12 Months	5.99%	7.23%
Percentage of Population 18 to 24 Years with Less than High School Graduate	22.00%	18.13%
Percentage of Population 16 Years and over and in the Labor Force that are Unemployed	8.81%	7.23%

2005-2009 data. *American Community Survey 5-Year Estimates*.

As with all the six at-risk communities selected for the DMIEC-HV, Eastern Sussex has strengths and risk factors. Among the strengths are resources including:

- Pyle State Service Center
- Local churches and fraternal organizations
- Invested school board and advisory board for the Indian River School-Based Health Center

Compared to the state as a whole, Eastern Sussex residents have a higher risk for the following:

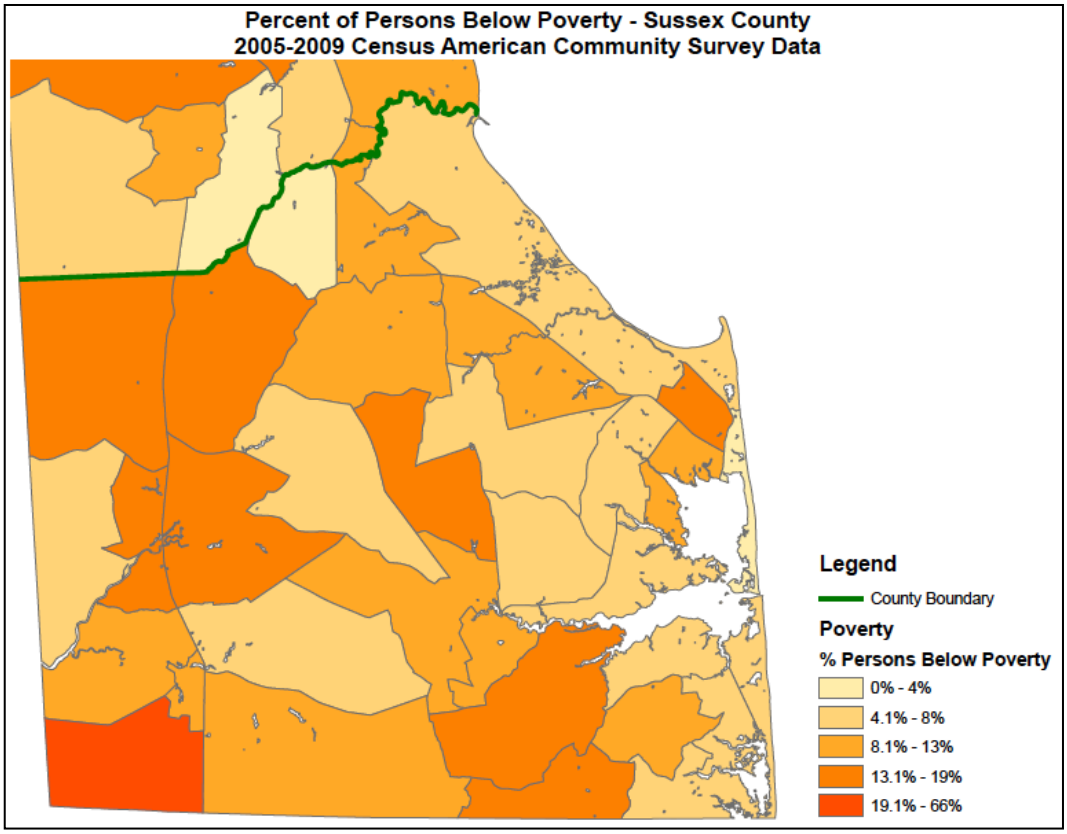
16 Domestic violence

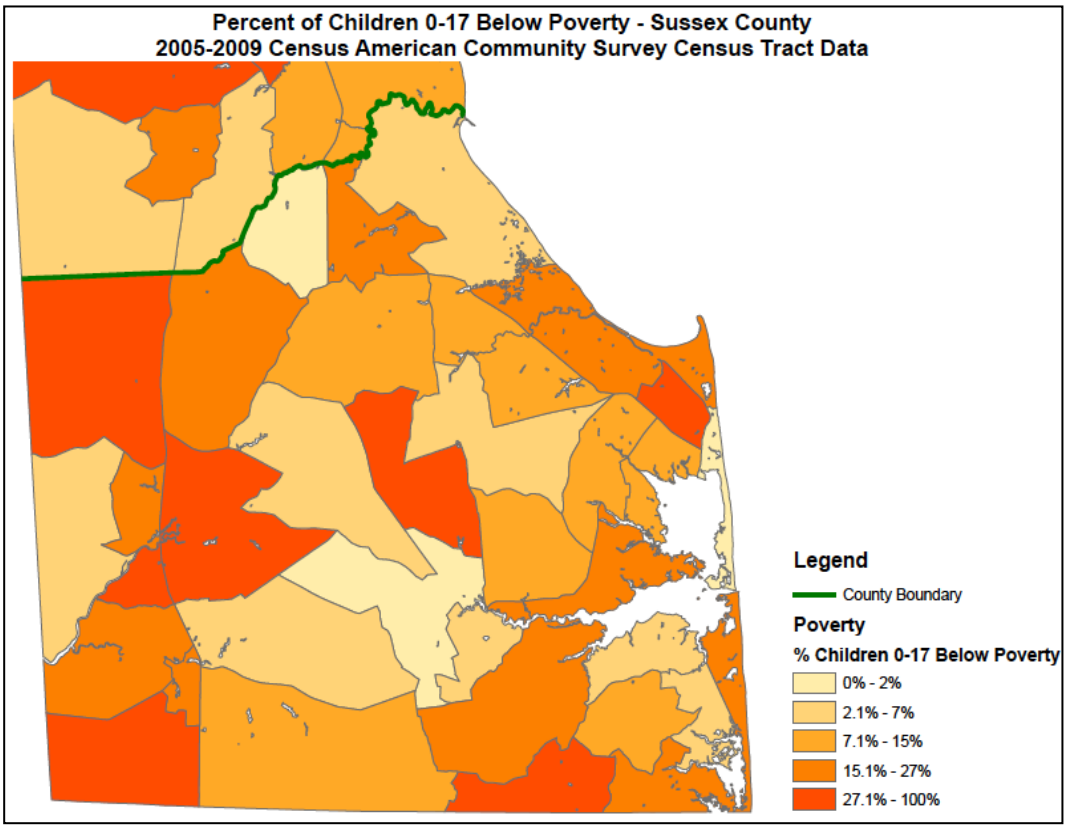
17 Having less than a high school education

There are four home visiting programs currently operating in this zone. There are no home visiting programs that have been discontinued since March 23, 2010. Given the small size of Delaware, all four home visiting programs operate statewide. Currently, there is no systematic reporting by geographic area. Therefore, the numbers of families served by program represents the statewide number, not the number for this particular zone. Please see Table 2 for the number and types of home visiting programs operating statewide.

Based on the community engagement forum feedback, residents of Eastern Sussex were concerned with unemployment, cost of living, proper housing and access to education and health services. Given the relative small population size in Kent and Sussex Counties, only one community engagement forum was held. The concerns of residents highlight the economic insecurity in communities that rely on agricultural and food processing (namely poultry) industries. The geographic isolation and lack of public transportation makes access to services (health and social) a challenge. In order to effect changes through home visiting services, it is crucial that DMIEC-HV also partner with initiatives aimed at enhancing access to care and the built environment.

The maps on the following page display the percent of persons below poverty and the percent of children below poverty by census tract in Sussex County. A portion of Zone 15 and all of Zones 17 and 18 are located in Sussex County.


Percent of Persons Below Poverty - Sussex County
2005-2009 Census American Community Survey Data
Legend
County Boundary
Poverty
% Persons Below Poverty
0% - 4%
4.1% - 8%
8.1% - 13%
13.1% - 19%
19.1% - 66%


Percent of Children 0-17 Below Poverty - Sussex County
2005-2009 Census American Community Survey Census Tract Data
Legend
County Boundary
Poverty
% Children 0-17 Below Poverty
0% - 2%
2.1% - 7%
7.1% - 15%
15.1% - 27%
27.1% - 100%

Plan for Coordination among Existing Programs and Resources in Selected Communities

Community engagement and leveraging partnerships in the selected communities will be critical for the long-term success of the DMIEC-HV program. It is clear that home visiting is not a panacea. It must be one piece of an overall strong early childhood system that promotes strong families through an assets-based approach. The Division of Public Health nurses have extensive experience partnering with community organizations. In many cases, the nurses themselves are residents of the communities they serve. Under the DMIEC-HV program structure, the linkages and referrals will be tracked and monitored along with building strategic partnerships in communities. Through the Office of Minority Health and Home Visiting Steering Committee, the DMIEC-HV will create an asset map for each zone, which identifies community-based and faith-based organizations that can serve as referral sources to and from the program.

DMIEC-HV within the Larger Early Childhood System

Given Delaware's size and culture, the terms local, community-wide and statewide are often interchangeable. Although there are marked differences between the northern and southern parts of the state, for many public health and social service programs there is a focus to deliver services equitably across the state. Differences in access to care and geographic barriers (lack of transportation) impact southern Delaware more than northern Delaware.

The DMIEC-HV has the advantage of two steering committees: one statewide and a second that is specific to the Division of Public Health. The statewide Delaware Home Visiting Community Advisory Board. The CAB is comprised of providers, policy makers, and other advocates and includes: Community-Based Child Abuse and Prevention (CBCAP) grantee, Child Welfare, Division of Child Mental and Behavior Health, Division of Public Health, ECCS Coordinator, United Way, Family Court, Child Death Review Board, Office of the Child Advocate, Christiana Health Systems, Federally Qualified Health Centers, University of DE School of Nursing, University of DE School of Urban Affairs and Public Policy, Medicaid managed care, three private foundations and other home visiting programs (Division of Public Health—Smart Start Program; Department of Education—Parents as Teachers; Early Head Start Programs; Resource Mothers Program).

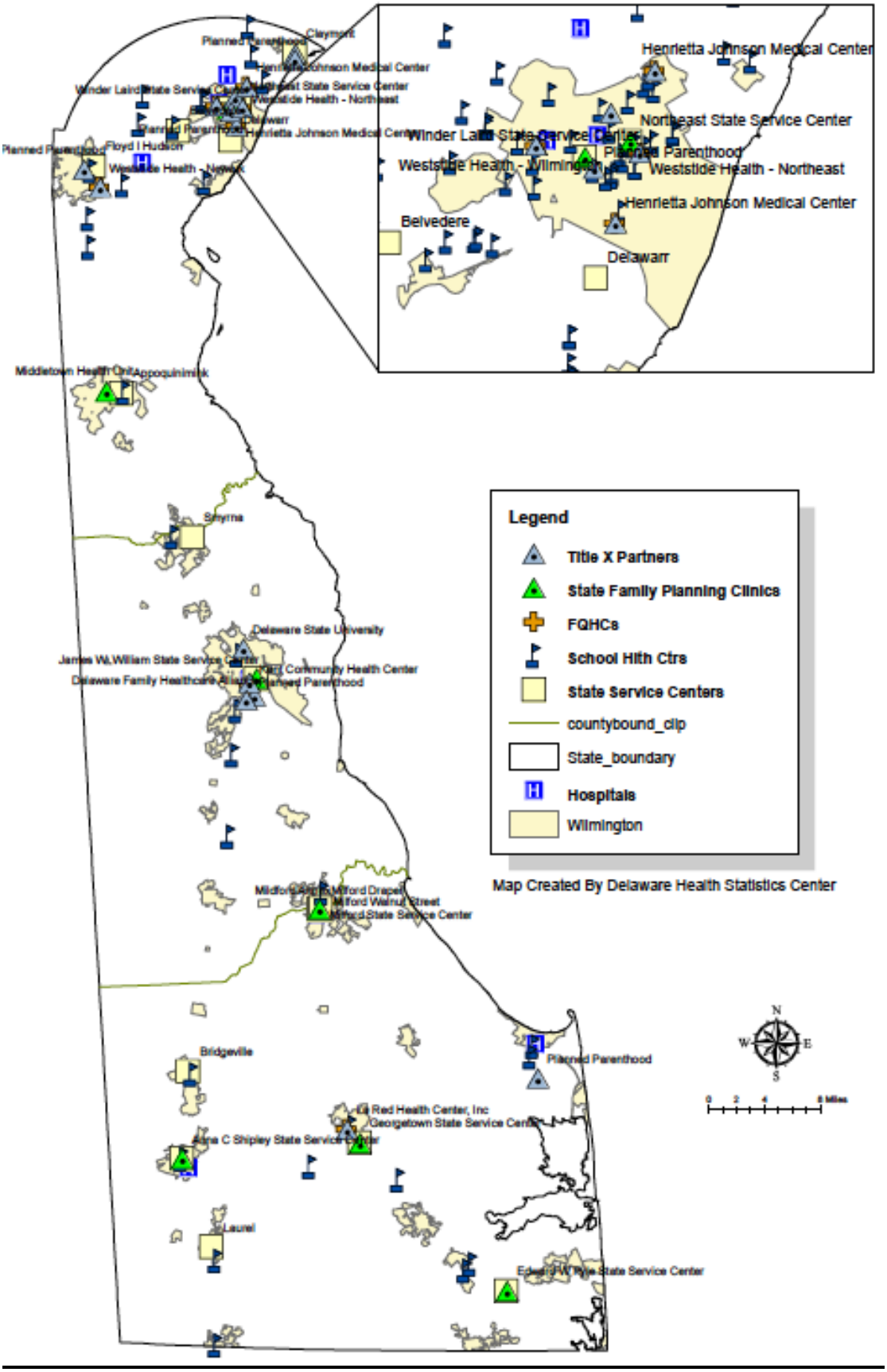
The DMIEC-HV is also connected to the statewide Early Childhood Council, established per Title 14 of the Delaware Code. The Department of Education liaison for the Home Visiting Steering Committee is also staff to the Early Childhood Council. This connection ensures that home visiting remains visible to the Council and engaged in the larger early childhood system. Although not a formal member of the Council, the Division of Public Health Maternal and Child Health (MCH) Bureau Chief serves in an advisory capacity to the Department of Health and Social Services designee to the Council. Additionally, the Early Childhood Comprehensive System (ECCS) program resides within the MCH Bureau and is a critical partner in early childhood systems-building, of which home visiting is a critical component.

Within the Division of Public Health (DPH) there is a Smart Start Steering Committee charged with transitioning Smart Start to an evidence-based model, Healthy Families America. DPH has implemented nurse home visiting based on best practice standards for over twenty years. Nurses are seasoned professionals with decades of experience and a wealth of knowledge serving pregnant women, children and families. With any system, there are challenges with change. Changing Smart Start to an evidence-based model has inherent challenges. These include new training, new policies, procedures, and a more rigorous data collection system. The Smart Start Steering Committee is composed of leadership across DPH to ensure that Healthy Families America is implemented with fidelity.

Communities Identified At-Risk but not Selected as an Intervention Zone

The community of Georgetown in Sussex County was identified as at-risk but was not selected as a targeted community for home visiting services. The challenge with Georgetown is that the data, in some cases based on 2000 census, does not reflect the current population that includes a significant number of newly-immigrated Latinos. Georgetown has a strong community-based system including a federally-qualified health center, La Red, and active faith-based organization, La Esperanza. With additional funding and resources, Georgetown would have been included as the seventh targeted community for home visiting services.

The map on the following page displays the locations of current health care services in Delaware.


Henrietta Johnson Medical Center
Northeast State Service Center
Winder Laird State Service Center
Planned Parenthood
Weststide Health - Wilmington
Weststide Health - Northeast
Henrietta Johnson Medical Center
Belvedere
Delawarr
Middletown Health Dril
Appoquinimink
Smyrna
Delaware State University
James W.William State Service Center
Dover Community Health Center
Delaware Family Healthcare
Planned Parenthood
Milford Drapel
Milford Walnut Street
Milford State Service Center
Bridgeville
Planned Parenthood
La Red Health Center, Inc
Georgetown State Service Center
Anna C Shipley State Service Center
Laurel
Edward W Pyle State Service Center
Legend
Title X Partners
State Family Planning Clinics
FQHCs
School Hlth Ctrs
State Service Centers
countybound_clip
State_boundary
Hospitals
Wilmington
Map Created By Delaware Health Statistics Center
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SECTION II: DELAWARE'S HOME VISITING PROGRAM GOALS AND OBJECTIVES

DMIEC-HV Goals and Objectives

Goal 1: Develop, implement and sustain a continuum of home visiting services statewide where the needs of families are met by the most appropriate program.

Objective 1.1. Through the Home Visiting Community Advisory Board, collaborate with evidence based home visiting programs, maternal health and early childhood partners, community agencies and advocates that facilitate the success of the home visiting continuum of services to implement ultimate systems improvements.

- 1.1.1 Identify and develop a single point of entry and centralized intake system.
- 1.1.2 Initiate planning for how all evidence based home visiting programs are aligned to strengthen care coordination and referral.
- 1.1.3 Develop a coordinated, longitudinal early childhood data system that links important information about pregnant women, children in the system, the programs that serve them, and the professional workforce that cares for and teaches them.
- 1.1.4 Identify core competencies for home visiting staff and implement statewide professional development training and technical assistance.

Goal 2: Transition Division of Public Health nurse home visiting to implement Healthy Families American in six at-risk zones.

Objective 2.1. Develop and implement Healthy Families America with fidelity to the model.

Goal 3: Improve maternal, infant and early childhood outcomes through targeted home visiting services.

Objective 3.1: Trained and caring home visiting professionals will provide intensive long term home visiting services to pregnant women initiated prenatally to address certain risk factors associated with poor birth outcomes.

- 3.1.1 Offer services that are voluntary, intensive, which are delivered over the long term (a minimum of 3 years and up to 5 years after the birth of the baby).

3.1.2 Assure that women have access to and are connected to services they need such as community outreach, transportation and medical and social services.

3.1.3 Encourage women to breastfeed and provide resources and support to assist with implementing their breastfeeding plans.

Objective 3.2 Ensure that all children age birth though five years served through Home Visiting programs in Delaware receive regular developmental screenings with a standardized screening tool.

3.2.1 Train home visitors in administering a periodic developmental screening tool (i.e. Ages in Stages) and make referrals to Early Intervention Services if a developmental concern is identified.

Objective 3.3 Support parents in their role as the child's first teacher by providing evidence-based parenting and child development information, coaching, and activities designed to promote positive parent-child interaction and child development skills.

3.3.1 Reassure families/mothers that learning to parent is ongoing and address family development including relationships and support, planning and problem solving, health and finances.

3.3.2 Encourage families/mothers to adopt and practice using developmentally age appropriate activities to help children learn and develop.

Objective 3.4 Through the administration of a standardize family assessment tool, identify the parents' past and current behaviors, beliefs, experiences and expectations that place them at risk of child abuse and neglect.

3.4.1 Train home visitors on recognizing and responding to child abuse and reporting to the Division of Family Services (child welfare).

Goal 4: Monitor home visiting system changes and challenges to ensure long-term sustainability.

Objective 4.1 Monitor home visiting systems changes/challenges and support short and long-term infrastructure.

4.1.1 Research opportunities for leveraged resources, alternative funding sources, cash contributions, in-kind services, and grant prospects

- Monitor and develop home visitor training core competencies.
- Forecast changes in target population.
- Forecast changes in technology for enhancing a shared data system.

Delaware's Home Visiting Logic Model is attached (Appendix A)

SECTION III: SELECTION OF PROPOSED HOME VISITING MODEL AND EXPLANATION OF HOW THE MODEL MEETS THE NEEDS OF TARGETED COMMUNITIES

The evidence-based home visiting models to be implemented in Delaware and how the model meets the needs of the communities proposed.

Based on a thorough analysis, Healthy Families America, an initiative of Prevent Child Abuse America (PCA America), is the evidence-based home visiting model selected by Delaware for implementation. In 1992, Prevent Child Abuse America, in partnership with Ronald McDonald House Charities and with financial support from the Freddie Mac Foundation, launched Healthy Families America, a framework for voluntary home visitation programs that is designed to improve the parenting skills of parents with newborns or small children, encourage child health and development, and prevent child abuse and neglect.

The purpose of HFA is to support states as they develop home visiting programs that aid new parents at the time their babies are born, and for families facing considerable challenges, through intense home visiting services during pregnancy and the critical early years of child development. Healthy Families America sites receive technical assistance and as an affiliate, receive ongoing training and professional development for home visitors. In addition, technical assistance is offered to establish quality assurance mechanisms, and supports state programs as they discuss ways to secure ongoing sustainable funding.

Healthy Families America sites must adhere to a set of critical program elements based on current knowledge and research. The critical elements include[1]:

- Initiate services prenatally or at birth
- Provide services, beginning intensively (at least one visit per week), and use well-defined criteria for determining whether to decrease or increase intensity of service
- Use a standardized assessment tool to systematically identify families who most need services
- Families voluntarily participate in the program
- Home visitors carry a light caseload (10-15 families)

[1] Healthy Families America Fact Sheet. (2001). U.S. Department of Justice. Office of Justice Programs. *Office of Juvenile Justice and Delinquency Prevention.*

- Families are linked to a medical provider (i.e. immunizations, well-child care) and, if needed, referrals to financial assistance, food and housing, school readiness programs, child care, job training programs, family support centers, substance abuse treatment, domestic violence shelters.
- Selecting and training home visitors (i.e. cultural competency, substance abuse, child abuse reporting, domestic violence, drug-exposed infants, and available community services and support.)

A wrap-around social support service, Resource Mothers, will further complement Delaware's Smart Start home visiting program. Resource Mothers, also operated by Children & Families First, are trained paraprofessionals who provide social and peer support for pregnant women. Often times, translation and transportation services are provided to clients, which is an excellent "base" supplement program that meets a significant number of clients that are identified as at-risk (i.e. language or transportation barriers).

Delaware's current and prior experience with implementing HFA and the capacity to support the model.

Delaware does not have prior experience with implementing Healthy Families America. However, a strong Public Health team that also includes external (public and private) partners has been assembled, with a vast array of program management, implementation, nursing, health and human services and evaluation expertise to support the implementation of the Healthy Families America framework.

Delaware's plan for ensuring implementation, with fidelity to the model, and a description of the following: overall approach to home visiting quality assurance; approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified; and anticipated challenges and risks of HFA, and the proposed response to the issues identified, and any anticipated technical assistance needs.

Healthy Families America (HFA) is based upon twelve research-based critical elements and ensures that affiliates adhere to consistent service implementation through an established Quality Assurance (QA) process. Delaware is currently reviewing a comprehensive Healthy Families America Self-Assessment Tool (SAT) to determine Smart Start's current status on quality, to assemble evidence necessary to illustrate implementation of the model and required standards and identify areas that need more work. For example, the tool identifies policies, procedures, and practices necessary for program implementation. The SAT tool is structured around each of the twelve critical elements and includes a section on Governance and Administration (GA). In addition, each critical element and GA consists of a series of best practice standards, which Delaware is striving toward. Several Smart Start program staff have volunteered to participate in an Implementation Workgroup, led by the MCH Deputy Director and the Smart Start Nurse Program Manager. The Implementation Workgroup reports to a Steering Committee. The Implementation Workgroup is very committed and engaged in a process of self-evaluation to review, modify and/or tailor its current business workflow processes, policies and procedures, forms and assessment tools, professional development and training, supervision, data collection and tracking, etc. The QA process is required every four years to maintain HFA accreditation and DPH is committed to assuring that it follows this process.

Critical Element #1: Initiate services prenatally or at birth.
This critical element is in agreement with the services currently provided.

Currently, Smart Start services are initiated prenatally and support the infant/child. However, more structure is needed on the target population and the enrollment timeframe. Currently, DPH offers three nurse home visiting programs: First Time Parent Home Visiting, Smart Start and Kids Kare. Each program has different criteria for inclusion; however, all three share a common purpose. Smart Start previously enrolled only pregnant women and Kids Kare enrolled only children. The goal is to prevent health and social problems that negatively impact infants, children, pregnant women and families. Under the new model, there will be one integrated program - **Smart Start**. Kids Kare and Home Visiting for first time parents as entities is

consolidating under one name, *Smart Start* and pregnant clients and children will continue to be served based on established criteria.

Based on Delaware's home visiting needs assessment, a target population was identified and will be defined as a part of the development of policy and procedures. A description of the ***target population*** will include applicable demographic data and will identify referral sources (e.g., prenatal clinics, MCOs, private providers, local hospitals, high schools, etc.), which will be included in the Smart Start Standards, Policies and Procedures manual (in development).

The descriptive parameters of the target population will be reviewed periodically and updated as changes in health statistics/data, funding, program structure and/or community demographics warrant. MOUs/Agreements may need to be entered with community agencies in order to assist with identifying potential clients and increase referrals.

Critical Element #2: Use a standardized (i.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should be administered within two weeks of the birth of the infant and should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, parental history of abuse in childhood, etc.).

A standardized risk assessment would facilitate the ability to obtain standardized data. There is opportunity to revisit our current risk assessment tools and data collection forms and adapt them as necessary to meet the HFA requirements. DPH has established a Home Visiting Steering Committee and a Smart Start Implementation Workgroup to provide oversight, perform analysis, and carry out implementation activities (i.e. revisions to assessment forms, data collection tools, training and program policies and standards).

We currently perform an in depth psychosocial risk factor assessment on all Smart Start families. In the family assessment, we are very focused on the family needs. As the trusting relationship is built with the family, increased information including the historical/current risks for child maltreatment or other poor childhood outcomes are shared. Part of the current assessment tool includes questions on involvement with the Division of Family Services.

<u>Critical Element #3:</u> Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

This critical element is in agreement with the services currently provided. Home visiting staff are persistent and encourage families to participate in accepting services and support services with a Public Health nurse, nutritionist, social worker and referrals are also made to wrap-around support services in the community.

Smart Start takes a multi-disciplinary team approach, whereby a Medical Social Worker is assigned to the family to provide social support, builds on the families support systems, links families with state government sister agencies, local community support services and other identified services or addresses needs to promote self-sufficiency.

Outreach efforts – DPH is administratively located in the Department of Health and Social Services. DPH aims to improve, protect and enhance the health of all women (across the lifespan), children, infants, adolescents and their families including fathers and children with special health care needs. DPH is a population based service agency and provides comprehensive, family-centered core essential public health services. This includes targeted outreach, primary prevention programs reaching everyone that might be affected or in need. DPH provides continued outreach to target high risk communities, such as going to schools, homes of pregnant women, engages in dialogue with community councils, advisory boards and coalitions. In addition, DPH meets with the primary medical community, clinics, hospitals and MCOs to recruit eligible clients, educates clients, and connects and refers Delawareans in need to the appropriate services.

Continuing to nurture community partners and including families in DPH Maternal and Child Health (MCH) decision-making roles will strengthen the program, build family trust and help the long-term viability of the home visiting program. MCH intends to create an annual report and feedback tool to assist in actively engaging and obtaining community input. Other Title V

programs effectively use a similar annual report that allows consumers and stakeholders to be informed about MCH activities and also provides input on MCH needs.

Critical Element #4: Offer services intensively (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long-term (i.e., three to five years).

Currently, services are planned and delivered to promote optimal pregnancy, post partum, child health outcomes, effective service delivery and seamless inter-agency referral and collaboration. However, at the current staff level, the HFA intensity level of at least once a week, may be something that the staff foresee as a challenge. DPH recognizes that in order to scale up the Smart Start program to an evidence based model requires staff and operational resources (home visitors, program management analyst, data entry, etc.), which will need to be considered for long-term sustainability.

The intensity of the visits address the needs of the pregnant woman, infant/child and her family, based on the assessment and developed care plan. Again, Smart Start's multi-disciplinary team includes a public health nurse, who is the medical case manager, a medical social worker who assists with social supports and referrals, and a nutritionist who assists with addressing the deficiencies in healthy lifestyles and promotes healthy eating habits.

Ongoing risk assessment/evaluation will assist with tailoring the care plan to determine whether to increase or decrease intensity of services.

Critical Element #5: Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served.

This critical element is something that is fulfilled at this time; however, there is a need to ensure that psycho-social development literature is available in every language served, as well as in a

pictorial format for illiterate clients. Most of our literature is translated in Spanish, meeting the needs of Delaware's local communities and growing Hispanic population.

We currently have bi-lingual interpreters on staff to make home visits with the Nurses, social workers, and nutritionists.

All nursing staff has a baccalaureate in education in addition to in-service education. Culturally competent training is provided to staff on an ongoing basis. Assessments are administered in a culturally appropriate manner.

Smart Start staff treats families with respect, understand families' current situations, values, and beliefs, acknowledge that families' background may be different from their own. DPH has an ongoing cultural competency training program offered through workforce development. Interestingly, the challenge of the HFA integration will be to tailor the program to the very different diversified cultures between southern Delaware and northern Delaware.

Critical Element #6: Services should focus on supporting the parent, as well as supporting parent-child interaction and child development.

This critical element is something that is currently provided through supportive care and therapeutic use of self-empathetic and reflective listening. In addition, referrals and encouragement for follow-through by the parent(s) is essential in order to support achievement of self-sufficiency.

Currently, a developmental assessment is performed on children in the home by nurse home visitors and is referred to child development watch if a developmental delay is identified. In addition, families are also referred to other community services and parenting education programs such as Early Head Start, Children and Families First (i.e. Resource Mothers) and Parents as Teachers.

Smart Start is looking forward to adopting evidence based and standardized curriculum that focuses on infant care and appropriate parenting techniques, and offers educational materials on positive behavior and ways to encourage children. It will be critical that staff continue to make referrals to other agencies, learn about new referral sources, and connect families with formal parenting classes.

Home visiting staff is required by law to report child abuse and neglect to DFS. The cases referred to DFS within the current population served are mostly due to unsafe environments, unable to meet minimally a degree of care standard (i.e. teen or mental health status), or the mother being involved in an unsafe situation.

Critical Element #7: At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.). Depending on the family's needs, they may also be linked to additional services, such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

This critical element is being provided, whereby we work with clients prenatally/post-partum to assure clients are linked (AP, post-partum infant care) with a medical home. However, this needs to be continually monitored and reassessed, and we need to consistently document that appropriate referrals are made.

Critical Element #8: Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their varying needs and to plan for future activities (i.e., for many communities, no more than 15 families per home visitor on the most intense service level. For some communities the number may need to be significantly lower (e.g., less than 10. or 12).

Caseloads at this time are not limited or regulated. The intensity of the visits will necessitate limiting caseloads. This will be an operational adjustment and the Smart Start Implementation Workgroup will need to address through the development of policies and procedures. Strong

supervision will also be necessary to monitor caseloads. Caseloads can be measured by a point system under HFA as noted in other state's programs. This will allow for a more rounded client base that incorporates intense client services with less intense client services allowing for more emotional, professional and educational support to the support worker. In addition, caseload limits will help to eliminate burnout and turn over.

The Nursing Director, program manager and agency leadership will need to address other field service responsibilities. The Field Service unit in DPH, which Smart Start is administratively operated under, currently serves many consumers other than those enrolled in the Smart Start program, and therefore, a thorough assessment of staff roles and responsibilities will need to be conducted.

Critical Element #9: Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

This critical element is being provided now; however, the staff feels very strongly that a consistent approach to education is important and is currently lacking.

Nursing staff education prep is at minimum- baccalaureate (BSN) education – pool of well-educated and qualified health professionals and have compassion and commitment to public health. Staff treats families with respect and acknowledges that families' background may be different from their own. Staff uses a variety of communication techniques in providing information to the family based on how that family can best understand. Staff recognizes that families have their own established values, structures, and functions.

To date, there is no requirement or formula on who must provide a home visit (e.g. nurse, other health professional, teacher, etc.), or how to choose a HFA Family Support Worker or Family Assessment Worker within the Smart Start program. A policy will have to be developed that will outline competencies, skills, abilities, and traits that are necessary when hiring to fill these positions.

<u>Critical Element #10:</u> Service providers should receive intensive training specific to their role to understand the essential components of supervision, family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).

This critical element is being provided now; however, the staff feels very strongly that a consistent approach to education is important and is currently lacking. All staff are well educated professionals. We need to continue to work to standardize in-service training with follow up from supervisory team, so that we deliver standardized services within the DMIEC-HV.

The Smart Start Home Visiting Steering Committee, and the Smart Start Implementation Workgroup will revisit home visiting training, new employee orientation and ongoing educational opportunities for staff in these pertinent areas– domestic violence, education in MCH state priority health issues, home visiting educational tools, the development of a family plan and risk assessments, conflict resolution, crisis management, coping and problem-solving skills, and prevent child abuse training.

Although Smart Start home visiting staff is required to have graduate degrees, the program will require more specific training as a HFA program. Ongoing training will need to be developed in the areas stressed in the HFA critical elements rationale and supporting literature sections**.** Having a bachelor's degree will not meet this requirement.

The need for ongoing initial training sessions will have to be addressed since turnover is to be expected. This training is required and to be done by someone certified to do the training.

<u>Critical Element #11:</u> Service providers should receive intensive training specific to their role to understand the essential components of supervision, family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).

The Smart Start staff support this critical element and feel it is a weak area in the current program. (See above to #10.)

<u>Critical Element #12:</u> Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with overburdened families. All service providers should receive basic training specific to their roles within the Healthy Families program and in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and services in their community.

DPH will need to address the core education - bio-health and social sciences, as well as nursing framework and conceptual/program under the Healthy Families America model.

Supervisors lead teams of 4-8 home visiting staff, make themselves available to take calls from the field, review cases on a monthly basis, bring intense multi-faceted and complex cases to the attention of the manager, and perform case reviews. There are informal meetings between the disciplinary team members to make adjustments to the intensity and care plan of the family. This Supervisory oversight is consistently monitored on an ongoing basis. However, HFA requires that Supervisors meet with each staff member 1.5 hours per week, which might be a challenge to accommodate on top of other Public Health responsibilities, but isn't something we cannot resolve.

Ongoing training and education, determination of skills and education for an employee, diversity and cultural sensitivity are areas that will need to be integrated into the Smart Start program's written policy and procedures manual. While Smart Start may be doing these things in the field currently, it isn't specifically addressed or documented that it is an expectation.

Technical Assistance

During this coming year, Prevent Child Abuse Delaware, in its role as the lead agency for the Community Based Child Abuse Prevention Grant, will be working with all Delaware home visiting partners to enhance the continuum of home visiting services that is available in the state, determining the quantity and quality of parent education programs available and will provide training and technical assistance as they increase their capacity to work effectively with families building protective factors. These efforts represent an important part of Delaware's long term, strategic planning that has been going on within the state and are important components of the family support continuum that we are working together to create. The following items are suggested components that could be included in a cross program professional development model, depending on the needs of the partner agencies, which will be identified through a survey.

This includes training and technical assistance for all DMIEC-HV programs on topics of mutual concern and interest:

a) Develop/adopt a set of core competencies to guide training and technical assistance activities.
b) Technical assistance can be provided in a variety of ways, including but not limited to:

- Telephone conversations
- E-mails
- One on one meetings
- Group meetings
- Webinars or video conference

c) Facilitate four quarterly meetings (i.e. "Networking Breakfast") with program supervisors/administrators; introduce the concepts of Reflective Supervision. Two groups of supervisors will be assembled with approximately 10 participants each. These groups would each meet for approximately eight, 3 hour sessions for a total of 24 hours/group.
d) Conduct four annual networking meetings for home visitors. Networking meetings for home visitors would take place 4x/year with two groups of approximately 15 participants/group/county (24 meetings total). Each meeting would be between 1.5 – 2 hours.
e) Provide technical assistance that is specific to the needs of individual programs and sites.
f) Engage additional partners with specific areas of expertise to provide training as needed.
g) Provide administrative support as needed to register participants for training, arrange space, etc.
h) Establish priorities and develop a schedule of wrap around and advanced trainings that includes topics like those listed below:
    a. Identifying and Assessing Parental Mental Health Issues
    b. Identifying and Assessing Parental Substance Abuse Issues
    c. Identifying and Assessing Domestic Violence in the Home
    d. Dealing with Children's Mental Health Issues
    e. Recognizing and Responding to Child Abuse and Neglect
    f. Child Development
    g. Connecting Families to Community Resources
    h. Trauma Informed Services
    i. Building Collaborative Relationships with Families
    j. Safety Issues in the Field
    k. Client Engagement and Retention
    l. Managing Angry and Resistant Clients
    m. Staff Retention
    n. Time Management

Delaware looks forward to working with our local and federal partners to refine and address its Technical Assistance needs for the DMIEC-HV.

SECTION IV: IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

Description of the process for engaging the at-risk communities around Delaware's proposed State Home Visiting Plan, including identifying the organizations, institutions or other groups and individuals consulted; *(Also, See Section 3)*

Background

Delaware took a mixed methods approach to engage the community into the DMIEC-HV planning and implementation process to assess and determine the fit of the model and the community's readiness to implement it. To supplement the different approaches, based on feedback from Delaware's Home Visiting CAB stakeholders, there was a desire to get input from individuals receiving or who have recently received home visiting services to design strategies to engage and recruit the target population. First, a series of four focus groups were held in late March targeting individuals receiving, or who have recently received, Home Visiting Services. Second, several paper/pencil surveys (a bi-lingual paper and pencil survey; a companion on-line version of the survey) were distributed targeting individuals receiving, or who have recently received, Home Visiting Services. The third effort was the launch of a series of Community Engagement forums targeting individuals who reside in high risk communities (Zones) defined through Delaware's comprehensive Needs Assessment process and based on eight key indicators including infant mortality, pre-term/low birth weight babies, unemployment, poverty, substance abuse rates, child abuse and domestic violence rates.

The findings of Delaware's home visiting needs assessment, as reviewed by the Home Visiting CAB, pointed toward the need for more information from those who use home visiting services. In direct response to the CAB feedback, MCH shifted resources to a contractor, Health Equity Associates ("HEA") who would design, facilitate and report on the findings of a series of home visits. The original plan devised in December of 2010 was based solely on focus group methodology on a highly aggressive time line. Key program partners reviewed the focus group plan and expressed concern with scope and timing of the plan in late January 2011. Based on this feedback, the plan was revised in February and was based on a mixed-methods approach using paper-and pencil surveys (in English and Spanish), a parallel on-line survey, and two focus groups (with Spanish language interpreter available) with an extended time line.

In late March, four focus groups were scheduled and recruited for by our key home visiting partners, Parents as Teachers, Smart Start staff, and Resource Mothers to collect feedback from individuals receiving, or who have recently received DMIEC-HV services.

Each focus group session was scheduled to last 1.5 hours and was held in a well-known community setting such as a federally-qualified health center. The sessions were tape recorded to assist in accuracy of reporting statements. A photographer was present at two sessions. Proper consent was gathered for collection of statements and images. The focus group questions were tailored after reviewing material shared by the Chapin Hall group out of University of Chicago and the 2004 Early Childhood Comprehensive Systems (ECCS) focus groups conducted in Delaware as to the intent, format and specific questions used. HEA had one main team and two "back up" facilitators. The focus groups were facilitated by a mid-senior career community health worker (CHW, African-American) woman and an early career, but experienced and bi-lingual CHW-educator community health advocate/educator (White). The back-up facilitators included the HEA President, a mid-career master's prepared CHES (White) and bi-lingual interpreter.

Home Visitor providers helped recruit participants. HEA provided a flyer and on-line registration services. The flyer outlined the purpose of the focus groups, eligibility criteria, location and time of the focus groups, and an incentive (a $20 gift card from Walmart). Home Visitor providers collected flyers and entered the registrant data into an on-line system. HEA made follow-up and reminder calls (and cell phone texts) to the registrants.

The goal was to recruit 12 participants for each session and achieve a participation rate of 50 to 75%, that is, 6-8 individuals attend the session. This recruitment approach was used with the Division of Public Health's 2004 Early Childhood Comprehensive Systems focus group process with success. The use of the on-line registration system helped reduce the administrative burden for the Home visitor providers.

Sessions were conducted on Friday and Saturday (10:00 am and 1:00 pm). Of the two groups set for Sussex County, the most southern county in the State of Delaware, (State Service Center,

Georgetown, Friday March 25, targeting high risk community Zones 15, 17, 18), two individuals attended each session. Of the two groups set for Wilmington (Westside Family Health Care, Saturday, March 26, targeting high risk Zones 1, 2, and 4), no one RSVP'd for the morning session and three individuals pre-registered for the afternoon session, but did not attend. Reminder phone calls (and texts) were attempted to the three individuals with two messages of non-working numbers and one wrong number was received. This presented a challenge to our focus group strategy to obtain feedback. The single and most important lesson learned was that this population is very transient.

Input from the Sussex sessions suggests that participants agreed to the home visiting services, but had no idea as to what to expect when the home visitor came the first time (a specific line of inquiry of the focus groups). The participants verbalized that they wanted all the advice/information they could get – but, didn't realize until they had several visits how rich of an array of education and support that they and their partner would receive. The young women interviewed were asked how they had heard about the program. Several paths to engaging with the programs emerged – word of mouth from a friend, recommendation by either a program representative or health care provider.

Recommendations

This feedback suggests that it may be useful to investigate how the referral to home visiting service is given, what information is shared about home visiting services and identify which community organization generated the referral. When asked about one thing they would change about the home visiting service that they received, the few individuals expressed the desire for more frequent home visits (more frequent than 1 x/month).

The feedback from the women interviewed also suggests several possible avenues to pursue with respect to increasing enrollment and retention. Potential participants need to know what to expect. If one does not what to expect, it is difficult to assess the risk and benefits of that choice. It is possible that information may need to be presented in multiple formats and venues in order to be "processed" and acted upon by potential participants. DMIEC-HV staff need to examine and document ("process map") how the different programs approach recruitment and

engagement. Examine written materials and protocols for oral explanations of the program. Consider use of testimonials, especially around "fear" and "mistrust" issues. Streamline and make consistent how the program is promoted.
Given the power of word of mouth, participants or recent participants could be given incentives for enrolling new participants who engage and remain in the program for some minimum period.

Participant "testimonials" should be used in program marketing and enrollment materials – especially around "fear" issues of "being told what to do" (versus support and advice), bias, and judgmental attitudes. Because other parts of this analysis reveal a desire for new mothers to have time with other new mothers, perhaps the use of "house parties" might be a way to recruit new participants. Each participant could bring one new recruit to a social gathering where attachment, information and support needs could be met.

One of the questions asked the participants to reflect on the entire period of home visiting services to elicit a valued, or most important, aspect of the whole experience. Respect, reinforcement and support were the three themes inherent in the responses of the young women.

Surveys[2]

An orientation to the survey process was delivered at the March 3 and 7 'In-service Home Visiting Training' meetings, which was attended by DPH leadership, Smart Start, Resource Mothers, Nurse Family Partnership and Parents as Teachers staff. The orientation included a written protocol for survey administration, background on the focus groups, example copies of surveys and bright yellow English/Spanish information cards that could be given to all program participants and return envelopes. The information cards listed date, time and location for the focus groups and contact information for a bi-lingual staff person who could accept reservations by phone or text. The cards also listed a link to the on-line survey.

The protocol training established how to introduce the survey to the family, how to ask for their participation, how to assist the family with completion (if asked for), and how to return the

[2] *State of Delaware Home Visiting Program Participant Feedback*. Winter/Spring 2011. May 30, 2011. Health Equity Associates, Inc.

completed surveys. The protocol was based, in part, on strategies previously used by "Parents as Teachers," an established home visiting program in Delaware. The survey administration time period was one month based on the premise that most families receive one visit per month. Each home visitor was to invite the participation of every family they visited during the survey period, thus number of visits made is the denominator for the response rate. The home visitor presented the survey, explained they would pick it up on the next visit and offered an envelope if the family wanted to do the survey. In cases where there was a known, or suspected, literacy issue, the home visitor offered to help the family complete the survey. The survey team understood that having the home visitor assist survey completion could introduce bias into the study and that it was a potential limitation of the study. This potential down-side to the study was offset, however, by a value of giving participants maximum opportunity to express themselves and provide input into this program. Further, the instrument included a number of open-ended questions where the respondent could offer perspectives unconstrained by multiple choice options. The themes determined through this process could become a foundation for further research on family perspective of home visiting services. Each respondent was given the chance to enter themselves into a random drawing for $20 gift cards (i.e. Walmart) that would be detached from the survey thereby ensuring confidentiality of responses.

The bi-lingual paper-and pencil and English on-line surveys were identical and were derived, in part and with permission, from work done by Dr. Deborah Daro of Chapin Hall on "Engagement and Retention Study – Participant Interview" research tool. The surveys incorporated multiple choice questions and a number of open-ended questions designed to encourage feedback from a participant's point-of-view, unencumbered by survey design or question bias. The main objective was to understand what the home visiting experience was like for participants with the desire to elicit information that would be helpful in understanding what engaged them at first and what kept them in the program. Because the surveys were administered to individuals engaged in the program, not to individuals who either rejected the program or who had left the program, it is not possible to draw direct conclusions about causes of attrition or lack of engagement. However, data suggesting possible lines of inquiry in future efforts was obtained.

The survey period began on March 7 and ran one month for Kent and Sussex Counties. New Castle County's survey period was from March 17 – April 18. Each Home Visitor was to visit each person in the program at least once during the survey period and present the opportunity to give feedback through either survey or focus group events. The home visitors would also apprise participants of the opportunity to participate in focus groups, offer an on-line survey option, offer assistance with completion of the survey and also give the participant a return envelope that could be used to keep responses private. The on-line survey was built and conducted with Survey Monkey (Premium) and was set-up to allow only one response per computer. While this feature potentially prevents a single user from making multiple entries, thereby skewing data, it can also limit access. Unfortunately, no family chose to use this method to provide feedback so the theoretical limitation of the "single use" option is moot.

Data entry started on March 26th, and analysis was completed in late April. A total of 371 surveys were completed and returned out of a total of 1199 home visits conducted during the survey period. This represents a 31% response rate. Half of the 371 respondents were from New Castle County with just over a third, 38.1% (149) from Sussex County. Nearly one quarter, 23.5% (87), surveys were completed in Spanish 84) or both Spanish and English (3). Overall, first time participants who completed surveys in Spanish comprised 90.5% of all those who completed a survey in Spanish. This is in contrast to the 66.2% "first time in program" rate seen for those who completed the survey in English.

Study Strengths

Chief among the strengths of this study were the strong response rate (31%), the participation of individuals who communicate in Spanish, exceptional collaboration of program partners, and the richness of qualitative data.

Limitations of Survey Approach

All studies have some type of limitations and the principal limitation of this study was that only individuals currently engaged or who had been in the program were targeted so that it is not possible to assess directly the reasons for lack of matriculation or for early attrition. A study of this type is intensive and requires significant resources. However, it is possible to glean

information what motivates individuals to seek and acquire services, what benefited many participants (key features to "sell" the program, and what, if anything, participants recommended as changes to the program.) While the number of responses from Sussex is encouraging, it is noted that Kent County is under-represented in these findings.

This instrument did not collect race or ethnicity data directly, nor did it collect age. The completion of a survey in Spanish implies that the respondent is of Hispanic origin however it is possible that individuals of Hispanic origin responded in English. What this approach can do is derive information about individuals who prefer to, or who can only, communicate in Spanish. This tool did not collect age although there is a fairly narrow age range and differentiation between narrow cohorts would likely be difficult given sample size. Future efforts could include these variables.

Survey Findings Overview

Table 2. Language by County

	New Castle		Kent		Sussex		Total	
	n	%	n	%	n	%	n	%
English	141	79.2	44	100.0	99	55.6	284	76.5
Spanish	37	20.8	0	0.0	50	44.4	87	23.5
Total	178	50.0	44	11.8	149	38.1	371	100.0

The Home Visiting program staff (i.e. Smart Start, Parents as Teachers, and Resource Mothers) contributed a tremendous amount of support throughout the entire survey process. The section and tables below profiles the respondents by program in which they are participating, which is the county where they live by the language of survey completion.

Table 3. Program by County by Language

English	New Castle		Kent		Sussex		Total	
	n	%	n	%	n	%	n	%
Parents as Teachers	129	91.5	43	97.7	70	70.7	242	85.2
Smart Start	5	3.5	0	0.0	15	15.2	20	7.0
Resource Mothers	7	5.0	1	2.3	14	14.1	22	7.7
Total	141	49.6	44	15.5	99	34.9	284	100.0
Missing = 1								

Spanish	New Castle		Kent		Sussex		Total	
	n	%	n	%	n	%	n	%
Parents as Teachers	34	91.9	0	0.0	42	84.0	76	87.4
Smart Start	3	8.1	0	0.0	1	2.0	7	8.0
Resource Mothers	0	0.0	0	0.0	7	14.0	4	4.6
Total	37	100.0	0	0.0	50	100.0	87	100.0
Missing = 0								

Table 4. Question 1 by Language of Survey Completion

Q1. Please tell us how you heard about home visiting? You may check more than one answer.	English		Spanish and Spanish/English		All	
	n	Valid %	n	%	Valid n	%
Parent or other relative	44	15.4	13	14.9	57	13.6
Friend	57	20.0	25	28.7	82	19.5
Neighbor	7	2.5	9	10.3	16	3.8
Someone at work	7	2.5	0	0.0	7	1.7
Doctor or health care provider	61	21.4	25	28.7	86	20.5
Another community service provider	38	13.3	13	14.9	51	12.1
Welfare caseworker	17	6.0	6	6.9	23	5.5
Other *	75	26.3	11	12.6	86	20.5
Cannot remember	11	3.9	1	1.1	12	2.9
Total Responses	317		103		420	
Missing = 0						

*For those who checked "Other," there was no open fields to collect that response. The large response, 20%, suggests that there is an important source of referral not included in list above, or possible confusion with the term "Another Community Service Provider" and key programs such as Parents as Teachers, Resource Mothers or Smart Start. Recommend programs be listed by name in future surveys.

Table 5. Question 2

Q2. What made you decide to accept home visiting? You may check more than one box. I wanted …	English		Spanish and Spanish/English		All	
	n = 285	Valid %	n =87	Valid %	n=372	Valid %
to be sure I was feeding my baby the right way	63	22.1	14	16.1	77	20.7
help knowing how to change and	38	13.3	12	13.8	50	13.4

Q2. What made you decide to accept home visiting? You may check more than one box. I wanted …	English		Spanish and Spanish/English		All	
	n = 285	Valid %	n =87	Valid %	n=372	Valid %
bathe my baby						
to know how to keep my baby safe at home	94	33.0	34	39.1	128	34.4
to know how to keep my baby safe outside of my home	63	22.1	20	23.0	83	22.3
help understanding ”normal” baby behavior	232	81.4	74	85.1	306	82.3
help in dealing with the changes in my life	97	34.0	24	27.6	121	32.5
help in understanding how other people were treating me	25	8.8	13	14.9	38	10.2
help in finding work	17	6.0	5	5.7	22	3.5
help in figuring out how to get back to work	10	3.5	3	3.4	13	3.5
help in figuring out how to get back to school	16	5.6	2	2.3	18	4.8
help with things like paying bills, finding a better place to live	21	7.4	2	2.3	23	6.2
to know what programs I could qualify for	41	14.4	14	16.1	55	14.8
to talk with someone who understood what I was going through	93	32.6	29	33.3	122	32.8
Other*	7	2.5	0	0.0	7	1.9
Total Responses	817		246		1063	
Missing	5		0		5	

*Although less than 1% of responses to this question were “Other,” recommend an open field for elaboration on the response be included in future surveys.

Table 6. Question 3

Q3. Who in your life supported you enrolling in a home visiting program? (multiple selections allowed)	English		Spanish and Bi-Lingual		All	
	n =285	Valid %	n =87	Valid %	n =372	Valid %
Parent or other relative	136	49.3	14	16.1	150	40.3
Partner	156	56.5	56	64.4	212	57.0
Friend	67	24.3	19	21.8	86	23.1
Neighbor	9	3.3	2	2.3	11	3.0
Health care provider	34	12.3	14	16.1	48	12.9
Caseworker	25	9.1	8	9.2	33	8.9
Someone from church	5	1.8	0	0.0	5	1.3
Other*	23	8.3	10	11.5	33	8.9
Total Responses	455		123		578	
Missing	9		0		9	

*For those who checked “Other,” there was no open fields to collect that response. The modest response, 8.9%, suggests that there is a source of referral not included in list above, or possible confusion with the term “Another Community Service

Provider" and key programs such as Parents as Teachers, Resource Mothers or Smart Start. Recommend programs be listed by name in future surveys.

Table 7. Question 4

Q4. Was there anyone in your life who discouraged you from enrolling in the home visiting program? You may check more than one box.	English		Spanish and Bi-Lingual		All	
	n=46	Valid %	n=13	Valid %	n=59	Valid %
Parent or other relative	6	13.0	1	7.7	7	11.1
Partner	10	21.7	1	7.7	11	17.5
Friend	3	6.5	0	0.0	3	4.8
Neighbor	0	0.0	0	0.0	0	0.0
Health care provider	0	0.0	1	7.7	1	1.6
Caseworker	1	2.2	0	0.0	1	1.6
Someone from church	0	0.0	0	0.0	0	0.0
Other*	30	65.2	10	76.9	40	63.5
Total Responses	46		13		59	
Missing	239		74		133	

*****An open field was not provided for respondent to elaborate on the response. Thirty respondents, or two-thirds of those who reported another person(s) discouraged them did not specify who discouraged them from home visiting services. This may be an effect of the home visitor's participation in disseminating and collecting surveys, even though #10 envelopes had been provided to home visitors to promote confidentiality.

Open-Ended Questions

A series of open-ended questions were included in the survey to approximate some of the input the MCH Bureau may have been able to garner through focus groups. A sample of the questions and a summary of the responses follow in the section below.

Q5. Can you please share with us the part of parts of home visiting you liked best? [open ended]

Table 8. Question 5

Q.5 – Multiple selections were given and coded n=374 valid respondents	n	%
Advice, warmth, support, encouragement, convenience	123	32.89
Mother's learning	114	30.48
Information	64	17.11
Activities	56	14.97
Relationship with educator, bonding with child	52	13.90
Child's learning	28	7.49
Materials	19	5.08
Better mother	16	4.28
Other*	8	2.13

Other responses, presented below as written by the respondents, included:

- The developmental assessments. Ability of the home visitor to observe child in their home environment.
- After speaking with the parent educators about my son and the things he does, it was nice for them to see him.
- The sharing of information. The help with paperwork with WIC & Medicaid.
- Privacy, no "interruptions."
- Watching videos.
- Just having someone to come out and teach you things you need to know about having a baby.
- The transportation.
- I liked that my worker was caring and I got the services I needed.
- They come to your home. They have been very informative and even pointed out some things to question our doctor about that turned out helping our child.
- I enjoy learning all kinds of relevant information about early childhood and finding out about different opportunities/events in the community.

Q7. Thinking back to when you first started to receive home visits, what was the most valuable to you? [open ended]

This question asked the respondent to recall the beginning of their home visiting experience and identify the most valuable component to the respondent, note use of the word "you" in the question. This word choice leads the respondent to give a "parent" focused response. The two main themes of responses were learning/information for the mother/parent and a cluster of responses relating to support. "Reinforcement" was used to code responses which were specific to the DMIEC-HV staff member observing a parent use knowledge or skills that were previously taught and then applied at another point in time.

Table 9. Question 7

Q7 – multiple responses given and coded N= 361 valid respondents	n	%
Coaching, parent learning, information, knowledge, normal baby behavior	197	54.6
Support, Confidence, Time, Help, Understanding	130	36.0
Other*	36	10.0
Child development	29	8.0
Reinforcement	26	7.2

All or everything was valuable	9	2.5

*The "other" responses were quite varied and difficult to collapse into a category; examples are listed below for ease in reference by the reader.

- Liked the school supplies that P.A.T. gave my child.
- Understanding her sight and what helped develop it best. Also home made things and ideas for her.
- The developmental evaluation of my son.
- Knowing that I'm not the only one who is raising grandchildren. Also knowing that the child is on the right track.
- All or everything was valuable
- Knowing age appropriate expectations. - A base to share conversations w/ husband about babies development.
- It's more convenient because I travel on a day to day basis.
- Spend more time with my kids. And play with them.
- Respectful, nurse and very nice.
- The nurse always came. Very organized.

Q8. Did your needs change over the time you received home visits? If so, what changed? [open ended]

This question was intended to elicit information about the experience of the parent as the program was unfolding. The responses related mostly to needing to know new or different information relating to the child's development. There were few responses relating to other themes, see Table below for more information.

Table 10-Question 8

Q8 – multiple responses given and coded n=169 valid respondents	n	%
Child's learning	41	24.3
Parent's learning	36	21.3
Major life event, moving, new baby, separation from partner	22	13.0
Knowledge of normal baby behavior	24	14.2
Reinforcement	18	10.7
Other	15	8.9
Support, Confidence, Time, Help	14	8.3
A lot or All (but not specific example)	2	1.2

A sense of personal transformation emerged from the responses to this question which, while framed in terms of "needs," was answered more in the sense of "what changed" – and in many cases it was the person's ability to parent. Listed below is a sampling of telling responses.

- Change the way I deal with my children.
- Yes, now I paid more interest in my child and what his needs are.
- I became more prepared for everything.
- To have more security around to care for my child.
- I changed because I learned to play and how to care.
- I was able to teach my daughter to learn day to day.
- After learning my son was not delayed, the focus changed to learning about what to expect and how to handle certain behaviors.
- Yes. At first I was interested in her physical development, now I am more focused on cognitive skills.
- I understood more on how to deal with temper. Life became easier.
- "Change many things because I learn to speak to my son."
- "Yes they change because I learn how to discipline my son."
- "Help me to develop as a mother."
- My needs changed from validation as a parent to developmental checks on my child.
- My needs changed from validation as a parent to developmental checks on my child.
- Now it is easier for me to help my child in the school.

Q9. Looking back now, is there any specific thing that you can say was the most important part of the experience? [open ended]

Note that this question asks the respondent to reflect back over the entire experience and asks for the most important part of the experience (in general, not just for the parent/respondent). Multiple responses were coded. A parent's learning and general knowledge was cited by nearly two-thirds of the respondents as the most important part of the experience, specifically, 214 of the 326, or 65.64%, gave this answer. The second leading response was a child's learning with 25.8% (84).

Table 11. Question 9

Q9 – multiple responses given and coded n=331 valid respondents	N	%
Parent's learning, general knowledge	214	65.6
Child's Learning	84	25.8
Support, Help	66	20.3
Relationship – Child to Educator or Parent to Educator	62	19.0
Access to Pre-Natal Care	32	9.82
Screenings, Evaluations, Pamphlets, Handouts	28	8.59
Child's Speech, Talking, Child Safety	25	7.67

Community Engagement Forums

Zip codes across Delaware were aggregated into 18 geographic high risk "zones." The following health indicators were assessed for each zone. (Letters following each health indicator are used for shorthand identification later in this report.)

- Child maltreatment (A)
- Domestic violence (C)
- High school completion (D)
- Infant mortality (B)
- Low birth weight infants (F)
- Poverty (G)
- Premature births (H)
- Substance abuse (I)
- Unemployment (J)

As a result of this assessment, six zones were identified as being especially at risk. (These are shown in table 12)

Following the identification of the six zones, four "Community Forums" were commissioned in order to solicit community input into the Home Visiting model selection process. Three forums were held at the offices of Aloysius Butler & Clark in Wilmington, and one at the Georgetown Comfort Inn and Suites in Georgetown. Separate forums were held for Central Wilmington, East Wilmington and Northeast Wilmington. The Georgetown forum included residents of Kent and

Sussex counties from the communities of Laurel, Seaford, Dagsboro, Millsboro, Milford and Harrington.

The research objective of the Community Engagement forums was to solicit community input into the evidence based model selection process by capturing opinions, ideas and suggestions from affected community residents regarding how the program should be structured, and what services would best meet the needs of residents of the at risk community zones. Delaware strongly feels that the most effective way to achieve this goal was to actively engage those living in the community in a comfortable setting, talk to those who are interested in maternal and child health issues, and hear from community members who understand firsthand the community that they live in.

In each community forum, 10 participants were recruited according to very specific criteria that were developed by analyzing the demographics with respect to race, income and education for each forum area. Age was purposely skewed to individuals of childbearing age. Criteria included:

- Respondent age range of 18 to 44.
- Respondents should be parents of children aged 0 to 5, currently expectant parents, or planning to have children within the next five years.
- Recruit a total of 10 respondents per group, at least 6 females and 3 males.
- Try for a mix of education and income (High school completion, GED, some college, 4 yr college graduate, post graduate; less than $30K, more than $30K, more than $50K).
- Try for a mix of respondents who have health insurance (HMO, Medicaid) and those who are uninsured.
- Respondent incentives of $75 per person.

Respondents were also recruited by posting flyers in several Public Health clinics in the target Zones and potential participants were also identified through DPH's Office of Minority Health. The object of the demographic analysis and specific recruiting requirements was to ensure that the forum included a representative sample of the kind of people who lived in the specific high risk communities ("Zones").

The individuals were asked to arrive at least 15 to 30 minutes before the scheduled session, and were provided with light refreshments while waiting. At the end of the session, participants were paid an incentive ($75) as compensation for their time and participation. The community forums lasted about 2 hours each, and were held in the evenings to accommodate and provide flexibility to participants. Groups were videotaped in order to have a record of the research and audio taped so the moderator could listen to tapes and prepare a summary report of the discussion. The moderator listened to each tape, analyzed the findings and prepared a written report on the highlights of the discussion.

Table 12. At-Risk Community Zones

Zone	Location	Zip codes	Number of indicators in top 5 ranking	Indicators (by code—see above)
4	Central Wilmington	19804, 19805	8	A, C, D, F, G, H, I, J
3	East Wilmington	19801, 19802, 19806	7	A, D, B, F, G, H, J
1	Northeast Wilmington	19703, 19809	5	A, E, F, H, I
17	Sussex: Laurel, Seaford	19933, 19940, 19956, 19973	7	A, D, F, G, H, I, J
18	Sussex: Dagsboro, Millsboro	19930, 19939, 19944, 19945, 19966, 19967, 19970, 19975	6	A, C, D, E, H, I
15	Kent/Sussex: Milford, Harrington	19941, 19942, 19946, 19950, 19952, 19954, 19960, 19963	5	A, D, E, G, I

Specific details of the individual community forums are:

Forum 1

The first forum was held at the offices of Aloysius Butler & Clark in Wilmington, Delaware, on April 19, 2011. There were 10 participants: four men and six women. Seven participants were Caucasian, two African-American and one Hispanic. Ages ranged from 24 to 41. Annual household income ranged from less than $25,000 per year to $75,000–$100,000 per year. Five of the individuals resided in zip code 19805 and five in zip code 19804.

Forum 2

The second forum was held on April 20, 2011, at the Georgetown Comfort Inn and Suites in Georgetown, Delaware. There were nine participants: four women and five men. Eight participants were Caucasian and two were African-American. Ages ranged from 24 to 39 years old. Annual household income ranged from less than $25,000 to $75,000–$100,000 per year. Zip codes represented included 19960, 19963, 19966, 19950, 19945, 19973, 19970 and 19952.

Forum 3

The third forum was held on April 21, 2011, at 6 PM in the offices of Aloysius Butler & Clark in Wilmington, Delaware. There were seven participants: three women and four men. Two of the participants were Caucasian and five were African-American. Ages ranged from 21 to 33 years old. Annual household income ranged from less than $25,000 to $75,000–$100,000 per year. Participants resided in zip codes 19801, 19802 and 19806.

Forum 4

The fourth forum was held on April 21, 2011, at 8 PM in the offices of Aloysius Butler & Clark in Wilmington, Delaware. There were 10 participants: seven women and three men. Ages ranged from 22 to 39 years old. Eight of the participants were Caucasian and two were African-American. Annual household incomes ranged from less than $25,000 per year to more than $100,000 per year.

Agenda and Discussion

The forums were moderated by Dr. Devona Williams, an experienced moderator with more than 25 years of experience in the fields of public policy, planning and public affairs. Each forum followed a preapproved agenda.

Participants were asked to discuss what they thought the needs were in their community for pregnant women and families in the prenatal, postpartum and developmental stages of child rearing. They were asked to discuss:

- The kind of information that would be valuable to parents,
- Any specific challenges to pregnant women in their individual communities,
- Any specific support programs that were available to pregnant women in their communities, and
- Their reaction to various types of home visit programs to support new mothers, babies and families.

Following those discussions, participants were shown descriptions of seven different Home Visiting programs that met the criteria for evidence of effectiveness for DMIEC-HV program and asked who they felt would benefit from that type of service, and if they thought the program would work for pregnant women and families in their communities. Participants were asked to comment on each best promising model/approach, select the model that closely matched the needs of their specific community and more importantly, the model that would have maximum impact. The descriptions were developed based on information profiles made available on the HomVEE website (http://www.acf.hhs.gov/programs/opre/homvee) .

Summary of Findings

The following page lists the results we found from the forums and surveys. We believe this information is valuable to improving and enriching DMIEC-HV programs. We will use the feedback to strengthen the programs and better tailor them to individual needs. All DMIEC-HV program staff will review findings and incorporate results into the upcoming data collection process, CQI activities, as well as daily activities.

What kind of information would be valuable to a young woman who's just learned that she is pregnant?

- Types of information that participants thought would be valuable included:
  - ✓ Information about what to expect regarding health issues. How to take care of themselves to stay healthy. What kinds of physical and emotional changes to expect.
  - ✓ Nutrition information, what a pregnant mother should eat, and things she should stay away from such as tobacco, drugs and alcohol.
  - ✓ Health information such as the necessity of prenatal care, how to find a pediatrician and how frequently to have prenatal visits with her physician.
  - ✓ Financial information such as what to expect as far as financial requirements for the child and resources that may be available for low-income families. Also mothers-to-be should make financial plans to cover the time they will be away from work and without income.
  - ✓ Any possible restrictions on physical activities.
  - ✓ Stress management.
  - ✓ Insurance programs that might be available.
  - ✓ A realistic depiction of the responsibilities they will soon have for taking care of the child.
  - ✓ Some participants suggested that before becoming pregnant a young woman should carefully consider the support available from her family, and especially whether she is ready to have a baby with her current partner.

What kind of help would've been useful to you at that time?

- Types of help that would have been useful included:
  - ✓ Better support system from family and others.
  - ✓ Information on how to care for a baby, i.e. holding, bathing, feeding, what to do when they cry, etc. Practical, hands-on experience.
  - ✓ Being aware of how big a responsibility being a parent is, financially, emotionally and otherwise, and how hard work it is.
  - ✓ Information on how partners can better communicate with each other during pregnancy.
  - ✓ Information on weight gain and weight management during pregnancy.

- ✓ A strong recommendation to wait until after schooling is completed and a career started before having a child.
- ✓ A 24-hour hotline for those questions a pregnant mother might be embarrassed to ask her parents or a physician. Hotline would involve anonymity so the caller wouldn't have to worry about being embarrassed.

Was there something you needed to know that you didn't learn about until later?

- Respondents said that they wish they had known more about the financial obligations of having a child and how expensive they really are.
- How having a child would change the relationship between the parents.
- What they needed to do to prepare for the financial responsibility for having a child.
- For those who give birth while in high school, more support for pregnant students in high school.
- Some participants said that the most important information they were lacking had to do with the character of the person they chose to have the child with. In some instances partners may not have the emotional stability to stay with the mother after the child is born.

What are the biggest challenges faced by a woman who is about to become a mother for the first time?

- Challenges include:
  - ✓ Stress of having to care for her new baby and lack of sleep.
  - ✓ Being unprepared for negative changes in her body image, and how to deal with those changes.
  - ✓ How to deal with postpartum depression.
  - ✓ Need to find day care.
  - ✓ Balancing work, day care and other activities of daily living.
  - ✓ For low-income parents, how to find additional financial resources to cover the extra costs associated with having a baby.
  - ✓ Dangers associated with living in crime-ridden neighborhoods.
  - ✓ Lack of appreciation by the community of the negative consequences of young teens becoming pregnant.

- ✓ Fathers failing to take financial or emotional responsibility for the pregnancy and the child.
- ✓ Multicultural neighborhoods limit the amount of support that's available from some neighbors who may be experienced parents because they speak different languages.
- ✓ Understanding that she may have difficulties changing from a "partying lifestyle" to one that is responsible and nurturing for the child. The need to place the child first in her life.
- ✓ How to deal with in-laws who often may have different opinions about child rearing from the parents.
- ✓ How to deal with separation while she has to be away at work.

Do you think pregnant women in your community face any specific challenges that are different from other communities in the state?

- Perceived unique challenges include:
  - ✓ Poverty or making just a little too much money to qualify for day care and other support programs.
  - ✓ High-crime neighborhoods and friends who are a bad influence.
  - ✓ Acceptance and endorsement of teenage pregnancy by some community members who should be encouraging teenagers to wait to have babies.
  - ✓ Fathers who fail to accept financial and emotional responsibility.
  - ✓ Lack of adequate family or other support systems.
  - ✓ Increasing numbers of bilingual families, which reduces the ability of all community members to communicate and bond with one another.
  - ✓ Lack of a child-/parent-friendly attitude in local workplaces.
  - ✓ Lack of jobs, especially in Sussex County and in the wintertime, when business there is slow.
  - ✓ For very young teenage girls, a general lack of self-esteem that allows them to be easily persuaded by men in the community to have sex and become pregnant.

Are there any specific support programs or other things that may help women in your community to have a healthy baby?

- Participants mentioned:
  - ✓ Wilmington Health Clinic for Women
  - ✓ The WIC program
  - ✓ Medicaid
  - ✓ The Boys and Girls Clubs
  - ✓ The Nurses 'n Kids program
  - ✓ Catholic Charities
  - ✓ The Early Childhood Center of Delaware
  - ✓ Planned Parenthood
  - ✓ YMCA

Do you think the community is supportive of pregnant women in your community?

- While some participants perceive that the community is responsible toward and supportive of pregnant women, others say they believe that the older generation is not supportive of young pregnant women, especially teenagers who become pregnant. In some areas there is a need not only for support services, but also an overall helpful attitude toward pregnant women in the community.
- Some churches are supportive of their members who are expectant parents.
- Some participants perceive unhelpful or arrogant attitudes in staff of programs that are supposed to help. These kinds of situations cause clients to mistrust programs.
- Some participants perceive that young teenage mothers are more likely to receive support through the state than are older mothers. They do not see communities providing broader support in the same way that communities support, for example, job growth programs through career fairs.

Do you think pregnant women in your community who are at risk of having a baby born too soon or too small would be open to receiving home visits by a nurse or trained health professional?

- Most participants thought that women who are targets of the program would be receptive to having home visits by a nurse or other trained professional. However, some people may be uncomfortable having a stranger in their home, or they may feel uncomfortable because they have some undesirable personal issues, such as say alcohol or drug abuse, which they may not want to reveal. Others may decline the program out of a sense of pride that they do not need someone to "check up on their child."

  Some women live in such poor conditions that they may be ashamed to even have someone in their home. Such people might respond better to a program in which they can go to a central site to participate.

What do you think they would want to get from a home visit?

- Respondents thought that pregnant women would be looking for:
  - ✓ Advice, encouragement and comfort.
  - ✓ A nonbiased, confidential resource who could direct them to available resources.
  - ✓ Reassurance, guidance and emotional support.
  - ✓ Coupons for formula.
  - ✓ Program staff could evaluate homes for child safety.
- Some concerns expressed were:
  - ✓ Women with resources and good health insurance may not need the program.
  - ✓ Women at the early stage of pregnancy may not know that they are at risk.
  - ✓ Staff members must be low-key, approachable and able to make the client feel at ease.
  - ✓ Some participants believe the doctors' offices should be better informed regarding programs that are available to help new mothers such as WIC.
  - ✓ Transportation programs should be available to help new mothers keep medical appointments, etc.

How often should the visits be?

- Suggestions regarding visit frequency ranged from weekly to biweekly to monthly. Some participants thought that the visit frequency probably should increase as the pregnancy progresses.

What is the best kind of person to visit and provide the necessary information?

- Participants believe that the visiting person should be a nurturing clinical professional, a woman and preferably someone who has been pregnant before. A visiting staff member could be a midwife, counselor, pediatrician or religious person. The person should be upbeat, cheerful, nonjudgmental and compassionate.

  Many participants are suspicious of social workers because of previous negative interactions, and fear that social workers would be there to judge or criticize.

<u>Postpartum Stage</u>

What kind of help can be provided by this program to help new or expecting parents become more comfortable with taking care of a new child?

- Suggestions included:
  - ✓ Information about changes a woman's body goes through after pregnancy.
  - ✓ Information about breastfeeding.
  - ✓ How to do day-to-day things with the baby—changing a diaper, giving a bath, feeding, etc.
  - ✓ Identifying needs of the baby. Learning how babies communicate with their parents (through crying).
  - ✓ Information on financial management.
  - ✓ Information on techniques that single mothers successfully use in order to manage a family.
  - ✓ Consider "pregnancy fairs," similar to career fairs, where people can get general information in a group setting on prenatal care, postpartum care and child care.

- ✓ Program staff should visit mothers in the hospital immediately after birth in order to make sure that the mother knows how to properly care for the baby. Also, because the mother will have already met the visiting staff member, she will be more comfortable when the staff person visits her at home.

What kind of information would be valuable to a young woman who has just given birth to her first child?

- Suggestions include:
  - ✓ How to care for a new baby—feeding, clothing, bathing, sleeping, what to do when they cry, etc.
  - ✓ Lists of assistance programs available to parents and how to apply for them.
  - ✓ Information regarding where to get the best deals on baby supplies.
  - ✓ Develop a parent mentoring program.
  - ✓ Develop a website to help new parents with common questions.
  - ✓ What the mother can do to help regain her figure.
  - ✓ Information about the developmental path for the child, including information on the dangers of the use of tobacco, alcohol and drugs by nursing mothers.
  - ✓ Information about sleeping arrangements—baby should never sleep with parents.
- Consider using some method to "feed" information to the mother over a period of time, instead of all at once right after delivery. Some mothers may find the amount of information they receive overwhelming and may be unable to absorb everything they need to know. Consider production of a CD, DVD or website for new mothers to use for answering everyday questions. Consider a telephone hotline that mothers can call to ask questions anonymously so they can avoid feeling embarrassed by asking their doctor, family or other support system members.

Does your community have any assets or programs that can be used to support new families?

- Community assets included those mentioned below.
  - ✓ Catholic Charities
  - ✓ The West End Neighborhood House

- ✓ Brandywine Counseling
- ✓ Door of Hope
- ✓ Bayhealth Center (unknown program)
- ✓ Northeast Building (The Northeast Community Center?)
- ✓ Children and Families First
- ✓ Child Inc.

Would it have been useful to you to have a skilled professional visit you shortly after the birth of your child to answer any questions or to address any concerns?

- Participants had mixed opinions about whether or not it would have been useful to have a skilled professional visit them shortly after the birth of their child. For parents with a good family support system, the visits are probably not necessary. For those that do not have a good support system, or for those with special problems with her children, such visits probably would be useful.
- Participants said that some insurance companies offer home visits to new parents. Others said home visits might be helpful to address specific problems. Still others said that hospitals provide new mothers so much information before they leave, that they never had a question.

What kinds of male mentoring or fatherhood support would be effective to support your role as a new father or expectant parent?

- It might be useful to have experienced fathers who can coach and counsel new fathers.
- One participant thought that some new fathers may be "too proud" to accept mentoring from an older man about how to be a good father.
- Some new fathers receive support from the churches.
- Participants suggested parenting classes for fathers or group meetings where fathers or prospective fathers could learn about families and childcare in a supportive, nonjudgmental environment. Many participants believe that group functions would serve fathers more effectively than individual programs.
- One participant observed that most programs are aimed at mothers, and that if more programs were available for mentoring fathers-to-be, perhaps the number of fathers who abandoned families might be decreased.

- Men should be made aware of the physical and emotional changes that women go through while they're pregnant, and especially after delivery. They should be made aware of the dangers and symptoms of postpartum depression so they can assist if that occurs rather than be concerned or feel left out.
- Fathers should be told of the social importance of fatherhood and be helped to understand their role, even if mothers do much of the direct caregiving.

Developmental Stage

What kind of information would be helpful for a parent who has a child who is one or two years old?

- Responses included:
  - ✓ Information on proper nutrition.
  - ✓ Information on child safety and "childproofing" a residence. How to deal with active toddlers.
  - ✓ Information on parenting skills, especially on learning patience. Guidelines on disciplining a child and especially on the dangers of shaking a young child. How to deal with temper tantrums, crying and inappropriate behavior.
  - ✓ Tips on how to socialize children. Parents need to keep in mind that children copy their undesirable behaviors such as cursing, smoking, drinking, etc.
  - ✓ Information on hyperactivity.
  - ✓ Information on stimulating a child for good development and on what to do if they suspect that their child is developing inappropriately.
  - ✓ Information to help the parent assess whether or not the child is receiving appropriate medical care and preventive services.
  - ✓ Information about hearing loss due to ear infection.
  - ✓ Information on specific state-sponsored public assistance programs that might be available.
  - ✓ The importance of reading to a child.
  - ✓ Limiting the amount of TV a child watches.
  - ✓ Information on state-sponsored programs and sources of information.
  - ✓ How to deal with fevers, ear infections, vaccinations and regular checkups.

- ✓ Information on potty training.

What kinds of things can be done to build trust between the new parents and the program staff so parents can be assured that staff is there to help and not criticize or spy on them?

- Responses included:
  - ✓ Potential clients should be assured that the program is not temporary and will be there when they need it.
  - ✓ Staff needs to build a good rapport with individual clients.
  - ✓ Consider online testimonials by existing clients so prospective clients can get an idea of how other people feel.
  - ✓ Services need to be delivered consistently and fairly, i.e. all clients should be treated alike.
  - ✓ Staff should act professionally and treat clients with respect.
  - ✓ Privacy must be ensured.
  - ✓ Staff should be trained in trust-building skills, because clients who don't trust people in general will have a difficult time trusting program staff.
  - ✓ Consider implementing seminars or study groups consistent with the particular stage the new parents are going through, i.e. expecting, postpartum and developmental.
  - ✓ The program must be voluntary.
  - ✓ Also, program staff must feel comfortable going into communities where they normally may feel uncomfortable.
  - ✓ Perhaps the most effective way of building trust is word of mouth from satisfied clients.
  - ✓ Consider having the client complete a pre-registration questionnaire so the visiting staff person knows that person's strengths and weaknesses before visiting.

Delaware Helpline and the 211 access number

- In all four groups, only about three or four participants in total were familiar with the 211 Delaware Helpline access number. Only about twice that number were aware of Delaware Helpline at all.

Participant assessment of various programs.

- Respondents were asked to identify a favorite program. The table below shows the overall preferences for the programs. (Note there are only 35 votes because one person did not choose a preference.)

Program	Number Preferring
Healthy Families America	9
Healthy Steps	7
HIPPY	6
Early Head Start	5
Parents As Teachers	3
Nurse Family Partnership	3
Family Check-Up	2

- Respondents were asked who they thought would benefit from each particular program. There were no discernible patterns in the responses.

Will the programs work?

Respondents were asked to judge whether or not they thought the programs would work in their community. Responses to that question are summarized in the table below. In all four groups participants thought Healthy Steps was most likely to work (8 yes votes), followed by Parents As Teachers (7 yes votes), Nurse Family Partnership (6 yes votes) and Family Check-Up (6 yes votes).

Table 13

	Yes	No	Possibly	N/A
Healthy Steps	8	1	1	0
Parents As Teachers	7	1	1	1
Nurse Family Partnership	6	1	3	0
Family Check-Up	6	2	1	1
HIPPY	5	4	1	0
Healthy Families America	4	3	3	0
Early Head Start	4	4	2	0

Other Comments

- One participant suggested using direct mail to notify residents of high-risk areas of the program's existence. Information about programs could be distributed in public places like post offices and libraries. Also, consider using Facebook and Twitter to publicize the program.
- Program should not target only the lower socioeconomic areas. Problems with children can occur at any household income level.
- One participant recommended an incentive to make sure that participants complete the program, similar to the kinds of financial incentives used by Career Team.
- Participants feel these types of programs should not be limited only to very low-income people.

By holding these community engagement forums, Delaware concludes that Healthy Families America is the right framework for transforming Public Health's Smart Start program to an evidence based program, which builds upon existing resources and demonstrates measurable positive outcomes for pregnant women, infants and their families.

- **Delaware's approach to development of policy and to setting standards for the DMIEC-HV program;**

Delaware is using a six stage process to assist with our implementation efforts and our plans to develop a successful early childhood home visitation system.[34]

Stage One: Form a Planning Group

Stage Two: Build Trust and Ownership

Stage Three: Think Strategically and Plan

Stage Four: Design Your Program

Stage Five: Promote and Maintain Program

Stage Six: Delivery of Services

As of 2008, Delaware's home visiting administering agencies have collaborated to create a continuum of home visiting services where families are referred to the program that is most in line with their needs and transition seamlessly to a different service if/when needed. With strong support from the state executive branch (e.g. Lt. Governor's Office), key state agencies (e.g. DPH, Department of Education and Department of Services for Child, Youth & their Families) and advocacy organizations (Children and Families First and Community-Based Child Abuse Prevention organization); Delaware is well poised to implement the intent and goals of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program. Delaware's capacity to assemble the needed data is facilitated by the existing leadership network for home visiting services. Key organizations that deliver home visiting programs, along with partners, work collaboratively on the Delaware CAB, in place since 2008. Organizations with data needed for the assessment are members of the CAB and have agreed to provide data or facilitate access to required data.

Delaware stakeholders have "buy-in to the benefit of home visiting, have a shared understanding of the needs of new parents in the community, and are knowledgeable about existing resources available to address new and expectant parent's needs. Therefore, the initial consensus building

[3] Healthy Families America Site Development Guide (2000). Prevent Child Abuse America. www.preventchildabuse.org

[4] Key Components of a Successful Early Childhood Home Visitation System. Zero to Three. National Center for Infants, Toddlers and Families.

and partnership development steps have taken place and will continue to foster and expand the family support system in the community. In addition, this group is committed to looking beyond the obvious partnership base (i.e. Fatherhood Coalition) and will consider adding those individuals and organizations who can help build a broad early childhood foundation necessary for implementation and sustainability.

The CAB is comprised of providers, policy makers, and other advocates and includes: CB-CAP, Child Welfare, Division of Child Mental and Behavior Health, Division of Public Health, ECCS Coordinator, United Way, Family Court, Child Death Review Board, Office of the Child Advocate, Christiana Health Systems, Federally Qualified Health Centers, University of DE School of Nursing, University of DE School of Urban Affairs and Public Policy, Medicaid managed care, three private foundations and other home visiting programs (Division of Public Health—Smart Start Program; Department of Education—Parents as Teachers; Early Head Start Programs; Resource Mothers Program).

A table of the primary members and roles' of the Community Advisory Board can be found in "Appendix F".

Through the CAB, members share their expertise, discuss each other's systems and programs and explore a successful referral and linkage process, identify common data variables for a coordinated early childhood data collection system, plan for professional workforce development and competencies for home visitors, explore outreach and public engagement strategies, and discuss long-term sustainability. As a result of many discussions, a Home Visiting Decision Tree Matrix (See Appendix "B") was developed to align and coordinate multiple home visiting programs, identify key components for a single point of entry and referral system, and to evaluate the current systems' capacity or incapacity to support pregnant women, children and their families. Another work product of the CAB was the development of the Home Visiting Program Comparison Table, which is an inventory and "cross-walk" of Delaware's existing home visiting program models, program standards, populations served, geographic area covered, and basic services provided.

It is the intention of the CAB to assemble a smaller committee to discuss policies and standards that is more directly responsible for implementation, oversight and support of a continuum of home visiting services. This committee will report back to the full CAB and provide recommendations for consideration.

Smart Start – Division of Public Health

In 1987, the Health Care Financing administration (HFCA) issued a clarification to State Medicaid programs to further define the scope of services that Medicaid was mandated to provide pregnant women, as well as those services that Medicaid was given the option to cover. These optional services, called "extended services to pregnant women" were limited to conditions that may complicate pregnancy.

Delaware elected to offer these optional services to high-risk pregnant women and as of July 1, 1988, amended its State plan to expand the normal pregnancy-related and postpartum services to include services for any other medical conditions that might complicate pregnancy. Smart Start services include nutrition assessment, nursing assessment and social services. In 1989, the Division of Public Health began Smart Start services for pregnant women.

On January 1, 1996, Medicaid began a system of managed care for services provided to many of its recipients, including pregnant women. Managed Care Organizations (MCO's) contracted with the Division of Public Health to provide Smart Start services to their clients. A comprehensive multidisciplinary care (case) management model of service delivery is designed to address the needs of clients.

Our vision, as an affiliate of Healthy Families America, is an integrated nurse home visiting program that improves the health and well-being of women, infants, children, and families. Home visits will deliver a variety of services and support in the home, and will also aim to improve parents' capacity and skills and children's health and developmental outcomes. This integrated program is Smart Start, which will consolidate other DPH home visiting programs (i.e. Kids Kare and Home Visiting for first time parents) under one name. Pregnant women and

children will continue to be served based on established criteria. Smart Start intends to use only evidence-based strategies and standardized assessments in order to measure client impact. These include:

- Standardized depression assessment
- Evidence–based curriculum
- Uniform up-to-date educational materials for clients
- Annual continuing education and best practices training for home visiting staff

Over the past two years, the DPH's MCH Director, MCH Bureau Chief, Director of Nursing and Directors of Northern and Southern Health Services have led an internal workgroup to modify and improve DPH home visiting services. This internal workgroup will continue its work to implement a research-based best practice program, one that integrates home visiting services under one name, one shared vision and one set of eligibility criteria to improve the health and well-being of women, infants, children and families, called Smart Start. An internal Smart Start Home Visiting Program Steering Committee provides oversight and direction of a formalized state-wide Smart Start Implementation Workgroup. Brief descriptions of the structure of Smart Start Steering Committee & Implementation Work Groups are highlighted below.

Smart Start Steering Committee

i. Provide overall direction
ii. Help to define Work Groups and designate lead facilitators
iii. Support/serve as Work Group participant(s)
iv. Generate and facilitate discussion to help develop short and long-term goals
v. Review & formalize work group recommendations
vi. Make decisions on Implementation Plan

- Liaison to the Home Visiting Community Advisory Board
- Grant writing
- Liaison with third party payers to determine long-term sustainability financing model
- Evaluation/assessment
- Identify resources, costs, staff, program sustainability and structural challenges
- HFA transition oversight

- Oversight of the development of a data system

Smart Start Implementation Work Group

To keep the Implementation Work Group at a manageable size and to accomplish many hands-on tasks, the Implementation Workgroup split into smaller sub-workgroups. Each Work Group is assigned a lead facilitator and is encouraged to invite additional representatives from different units in the Division of Public Health that have the knowledge and expertise for critical input and discussion. A timeline for work group meetings and tasks was developed for a one year period. The workgroup reports on progress made on a monthly basis to the full Smart Start Implementation Workgroup.

Functions include, but are not limited to:

- Implement, review, revise, and monitor Quality Assurance and Training and Technical Assistance Plans;
- Develop the policies and procedures and make recommendations to the Steering Committee for incorporation in the overall Plan;
- Oversee training and technical assistance for the Smart Start/HFA;
- Review annual status reports and other statewide data sets as appropriate, and review the assessments during the credentialing and re-credentialing processes, (TBD)
- Advise program manager on the effective implementation of training, technical assistance, quality assurance plans, and other areas of program functioning,
- Designate ad-hoc work groups as needed to address specific issues. These smaller workgroups report to the full Smart Start Implementation Workgroup, and issues that cannot be addressed are elevated to the Steering Committee.
- Serve as a forum for communication among state trainers, program manager, MCH Deputy Director, home visiting staff (Nurses, social workers, nutritionists).

Data & Information Management Sub-Work Group

This work group gathers the information and data to help establish a data management system that facilitates data collection and tracking. Information gathered by this group will be the basis

for many of the other work groups' efforts. Therefore, completion of this group's tasks should be a priority. Tasks include:

- Develop business requirements and case summary for IT development process
- Collect reliable, comprehensive, statewide data to monitor current conditions and predict future needs
- Collect and review regional and national best practice data systems
- Develop reporting capability/data collection strategy and tracking system
- Data system must have web-based capability, case management note taking, etc.
- Develop Timeline
- Catalogue home visiting program data (i.e. NFP, PAT, SS, Resource Mothers, Head Start) and keep it in one place
- Discuss potential partnerships that we can establish and connect to in order to reduce burden on respondents to surveys, questionnaires, and general inquiries

Training and Curriculum Sub-Work Group

This work group will also assess the level of skill, education and training for a competent home visiting workforce. In addition, this work group is responsible for identifying and compiling best practices for recruitment and retention strategies. Tasks include:

- Coordinate HFA training for home visiting staff
- Coordinate Partners for a Healthy Baby Curriculum training for home visiting staff
- Explore training and mentorship opportunities
- Workforce skills, education, and training inventory
- Review 'Just in Time Parenting" newsletters
- Discuss curriculum orientation
- Develop a timeline
- Behavioral health skills training
    - Explore the core home visiting core competencies
    - Leadership development & trained supervisors/managers (i.e. recognizing a multi-generational workforce)
- Examine training program development and career progression

- Identify best practice models and evaluate

Policy and Procedures Sub-Work Group

This work group will develop a program policy manual that includes operational procedures. This work group should also identify duties of home visiting staff, including time spent on home visiting and other public health duties. Tasks include:

- Align Smart Start operational manual with HFA standards (there is flexibility of initiation into the program. Eighty percent of families must enroll during prenatal period and 20% can enroll over the age of 3 months.
- Clear policy is required when transitioning from one home visiting program to the next (i.e. Smart Start transition to Parents as Teachers).
- Initiation of the program. Ideally, clients start prenatally but may begin at any point.
- Criteria for increasing/decreasing service intensity over time
- Can services be provided over the phone? What are the indications when this is appropriate?
- Clients remain in the program from prenatal period through 1 year of age (TBD). If there are additional health or family risks (e.g. substance abuse) the child can remain through age 2.
- Case loads are not to exceed 15 families with health/social risks. Case loads not to exceed 10 families with mental health/nutrition only – where nurse serves in case oversight role only for ancillary staff.
    - Determine "creative outreach" to ensure weekly visits during first 6 months of program enrollment
    - Strategies to meet 75% engagement goal on a monthly basis.
    - Determine Level 1 and Level 2 engagement (level 1=high intensity and level 2= outreach)
    - Criteria for case closure
    - Identify best practice models and evaluate
    - Review Forms
    - Develop a timeline

An overall project timeline is attached (See Appendix "C"), which is subject to change.

♦ **A plan for working with the national model developer and a description of the technical assistance and support to be provided through the national model.**

As an affiliate of Healthy Families America (HFA), Prevent Child Abuse America assigns a Regional Coordinator to each state to provide support and guidance on the implementation process and ensure program quality and development. To cover the costs associated with the provision of technical assistance to HFA sites, affiliated sites are responsible for an annual affiliation fee. Additionally, HFA program sites are responsible for the costs associated with the HFA Peer Review Team to perform an on-site review during the accreditation process.

HFA national staff are available to provide individual on-site technical assistance to programs at any time upon request. However, there is a cost for on-site technical assistance**:** $1250 fee per day, with a full day minimum, plus all related staff travel and materials.

HFA national center staff provide the following technical assistance to members of the HFA network:

- Provide guidance around outcome tool selection;
- Conduct literature reviews for pertinent articles;
- Answer questions about research, evaluation, data management; and
- Link members of the network to evaluation experts and resources;
- Provide access to an evaluation database which provides information on evaluations that have been done;
- Conduct conference presentations and workshops.
- Learn about the accreditation process, completion of the self-study, standards interpretation, and/or the process

Smart Start Delaware is keeping a list of technical assistance needs. One primary technical assistance request is around program evaluation, especially with respect to internal evaluation methods in a context of continuous quality improvement. A second primary technical assistance request focuses on the general issue of attrition of families and relates to a more intensive

external evaluation strategy (such as the ChapinHall engagement survey process, which was substantive and represented a significant investment of funding).

♦ **A timeline for obtaining the curriculum or other materials needed.**

Smart Start Delaware plans to purchase the ***Florida State University's Center for Prevention & Early Intervention Policy Partners for a Healthy Baby Curriculum*** by Summer 2011 and will plan an orientation for new and existing staff to introduce them to the materials and incorporate the instruction manual into their home visits. An estimated timeline is below:

- Price quote received 5/27/11
- Purchase Order created 5/31/11
- Fiscal Processing time 2 weeks 6/15/11
- Approved purchases order faxed to FSU Center for Prevention & Early Intervention Policy 6/16/11
- Allow 4 weeks for delivery
- Delivery of curriculum 7/14/11
- Staff Orientation Fall 2011

Florida State University's *Partners for a Healthy Baby* (available in both English and Spanish) Home Visiting Curriculum, a research-based, practice-informed curriculum used in evidence-based programs that have achieved positive outcomes was selected as the primary evidence based curriculum for Smart Start Delaware to promote knowledge about positive parenting skills. Several different curricula was reviewed based on a thorough assessment and was selected to meet the individual needs of the family, with attention paid to cultural, linguistic, cognitive factors, and the interests of the family. The Partners for a Healthy Baby curriculum materials are sensitive to diverse learning styles and levels, cognitive abilities, primary languages, and cultures among the families served in Delaware. The choice of curriculum reflects respect for diversity and is individualized to meet the unique needs and interests of the family whenever possible. The curriculum is based on best practices in child development, parent-child interactions and parenting practices.

Smart Start Delaware also plans to incorporate *Just in Time Parenting* newsletters, research-based age-paced information that helps guide and educate parents on healthy pregnancies and child development (social, emotional, physical, and intellectual based on developmental milestones), which is a publication of the University of Delaware's Cooperative Extension Program.[5]

Home Visitors will have access to an array of books, videos, resource files and best practices in child development, parent-child interactions and parenting practices. Every effort will be made to stay current with the research and materials will be updated on a regular basis. Materials given to families will also be in accordance with the recommendations of the American Academy of Pediatrics (AAP). Smart Start Delaware will include in the policy and procedures manual that additional curricula and materials used in home visitation must first be approved by the Program Supervisor prior to use to assure quality, consistency and agreement with the AAP.

♦ **A description of how and what types of initial and ongoing training and professional development activities will be provided by the State or the implementing local agencies, or obtained from the national model developer.**

Smart Start DE (SS DE) will ensure that new staff, volunteers and interns receive orientation specific to their role prior to direct work with families utilizing the Smart Start DE Orientation. SS DE Supervisors ensure that all new direct service staff are registered for Healthy Families America (HFA) Core Training upon hire. SS DE annually updates a Program Training Plan that assures access to required trainings in a timely manner for all home visitors and program Supervisors. The training plan is based on requirements determined by the program management and HFA. HFA Certified trainers provide Core Training for home visitors, supervisors, and program managers. Core Trainings will be held as needed. Additional wrap-around training sessions will be scheduled as needed and will be based on resources available.

[5] *Just in Time Parenting*. University of Delaware, Cooperative Extension Program. Patricia Tanner Nelson, Ed.D., Extension Family and Human Development Specialist, University of Delaware. http://www.parentinginfo.org/index.php

An Individual Training Plan (ITP) will be created for each direct service employee, based on the Healthy Families America training requirements, which will document completed trainings and training gaps for orientation, 6-month, 12-month and on-going wrap-around training requirements. The ITP will also indicate which trainings have been entered in the an on-line Training tracking system. The ITPs are used by the Home Visiting Coordinator to analyze training strengths and gaps for the program. Supervisors and staff will use their ITPs to analyze each staff person's training needs and set individual professional development goals.

As previously mentioned, Prevent Child Abuse Delaware will be working with all Delaware home visiting partners to enhance the continuum of home visiting services by providing training and technical assistance as they increase their capacity to work effectively with families building protective factors.

♦ **A plan for recruiting, hiring, and retaining appropriate staff for all positions.**

The State of Delaware's hiring policy is that programs actively recruit, employ, and promote qualified personnel and administer its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, sexual orientation, handicap, or religion of the individual under consideration. In addition, recruitment and selection practices are in compliance with Delaware law and the State of Delaware's hiring policies and procedures and include:[6]

- Notification of its personnel of available positions before or concurrent with recruitment elsewhere,
- Utilization of standard interview questions that comply with employment and labor laws, and
- Verification of two to three references and credentials.

Screening and selection of a program manager considers characteristics including, but not limited to:

A. A solid understanding of and experience in managing staff,

[6] Office of Management and Budget/Human Resource Management, State of Delaware. State job descriptions, essential functions and qualifications for a Nurse, Nurse Supervisor, Social Worker and Nutritionist are available at http://www.jobaps.com/de/auditor/classreports.asp

B. Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development, and
C. A Bachelor's degree in human services administration or related field or an equivalent combination of education and experience is required (Master's degree preferred).

Screening and selection of nursing supervisors considers characteristics including, but not limited to:

- A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments,
- Knowledge of infant and child development and parent-child attachment,
- Experience with family services that embrace the concepts of family centered and strength-based service provision,
- Knowledge of maternal-infant health and dynamics of child abuse and neglect,
- Experience in providing services to culturally diverse communities/families,
- Experience in home visitation with a strong background in prevention services to the 0-3 age population, and
- A Bachelor's degree or higher in Nursing and at least two years experience as a Registered Nurse in Public Health Nursing OR a Masters degree or higher in Nursing and at least one year experience as a Registered Nurse in Public Health Nursing.
- Possession of a Delaware Registered Nurse license OR multi-state compact license.
- Knowledge of staff supervision which includes planning, assigning, reviewing, and evaluating the work of others.

Screening and selection of direct service staff and volunteers/interns (if performing the same function as direct service staff) considers characteristics including, but not limited to:

- Experience in working with or providing services to children and families,
- Ability to establish trusting relationships,
- Acceptance of individual differences,
- Experiences and willingness to work with the diverse population(s) present among the program's target population,
- Knowledge of infant and child development, and

- A high school diploma or GED (AA degree or Bachelor's degree preferred) and a combination of experience or qualifications as required by agency or program site.

♦ **If subcontracts will be used, a plan for recruitment of subcontractor organizations, and a plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

N/A at this time.

♦ **A plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.**

One of the Healthy Families America critical elements is that all service providers *"receive ongoing effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives".* Staff will also be required to receive orientation to their roles as these relate to the program's goals, services, policies and operating procedures (including forms, evaluation tools, and data collection), and the philosophy of home visiting/family support prior to direct work with children and families or supervision of staff.

Smart Start plans to provide regularly scheduled individual supervision sessions for each home visitor for a minimum of 2 hours per week, also a Healthy Families America requirement. Also under consideration, is that at least one hour per week of individual supervision will be provided for home visitors who work part-time. Scheduled supervision will not be split into more than two regular sessions.

To maximize time and resources of staff, often traveling up and down the state, flexibility will be very important. Supervision of home visitors who are not housed in the same physical location as their supervisor, or require a flexible alternative to meeting in person, shall be conducted weekly and may be in person, by phone or by webcam.

♦ **The estimated number of families served.**

Smart Start Delaware estimates that a total of 525 families will be served over the period of one year. This is based on approximately 35 home visitors carrying a maximum caseload of 15 families per year.

- **A plan for identifying and recruiting participants.**

Written agreements with hospitals and/or other appropriate entities will be essential to identifying and recruiting participants largely due to the fact that they provide access to first birth families. Organizational relationships with other community entities allow all first-birth families to be offered screening to establish eligibility for services. Delaware will identify strategies to increase the percentage of families screened/identified. The screening process includes giving parents information about newborn health and safety, community resources for families, parenting and child development information, and individualized referrals to appropriate services.

Based on respondent and focus group feedback, confirmed through discussions with home visitor staff, it appears that there is an opportunity to create a protocol with a standard message for describing the program, its benefits and what to expect on the first visit. This may help expecting parents to enroll into the program. The data also shows that in Sussex County, health care providers were more likely to be a source of information on the program, and therefore promoting the program to local health care providers will be important. The individuals who self selected to respond to the surveys or focus groups almost universally expressed substantial enthusiasm for the program. While it is possible that some degree of Hawthorne effect was in play, the sincerity and strength of point of view expressed in the focus groups was noted. It is recommended that current participants be approached to solicit testimonial statements, audio recordings or other methods of capturing their words and engage them in recruiting other potential participants; possibly even consider using YouTube and other social media as well as traditional mass media. Another variation could include sponsoring mother or mother and partner small group discussions with a component on how to enroll in Home Visiting program.

- **A plan for minimizing the attrition rates for participants enrolled in the program.**

To ensure a healthy pregnancy and a healthy baby, women and their families should be actively engaged throughout the entire intervention. Ideally, the mothers or expecting mothers and their family members in the home should be prepared with strategies for countering non-supportive individuals. Home Visitors will assist families with developing a support network (i.e., family,

friends, faith-based organizations). Further, based on expressions of valuing social support and interaction in the community engagement forums, surveys, and focus groups, it is possible that having some type of small group sessions would offer increased support and potentially offset forces that might dissuade individuals from continuing with the program.

Delaware plans to explore the option of providing incentives to participants who agree to participate in the program as well as the data collection component of the project, assuming that the provision of incentives is approved by the model developer.
Additionally, it might be prudent to develop an "exit" interview with those who leave the program to determine more precisely the reasons for disengaging with the program.

- **An estimated timeline to reach maximum caseload in each location.**

Smart Start Delaware was established in the mid-1990's, and therefore is a mature home visiting program. Therefore, all staff have an existing caseload. The transition to Healthy Families America will require limited or maximum caseloads per home visitor. Healthy Families America requires that staff carry a maximum caseload of 10-15 families per home visitor. Based on research, limited caseloads assure that home visitors have an adequate amount of time to spend with each family to meet their varying needs. The intensity of the visits will necessitate limiting caseloads and will be an operational adjustment. Smart Start Delaware plans to reach the maximum caseload by Spring 2012.

- **An operational plan for the coordination between HFA and other existing programs and resources in those communities, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.**

Through partnerships with key stakeholders across the state and utilizing existing community based services and referral sources, Delaware is well positioned and is already taking actionable steps to coordinate existing evidence-based home visiting services targeting communities at-risk identified through the statewide needs assessment. The Delaware Home Visiting Community Advisory Board (CAB) has developed a ***Home Visiting Decision Tree Matrix*** that clearly delineates and visually explains how we plan to operationalize coordinating all home visiting programs in the state (See Appendix B).

The beauty of the committed stakeholders and partners in the Delaware Home Visiting Community Advisory Board (CAB) is that ongoing collaboration and discussion will assist with identifying any service gaps, programs and resources in those communities (i.e. health, mental health, early childhood development, substance abuse, domestic violence, child welfare, education, and other social and health services), address any barriers/challenges, and promote coordinated referrals.

- **A plan for obtaining or modifying data systems for ongoing continuous quality improvement (CQI).**

As of this writing, negotiations and contract development are underway with a technology solutions vendor, Core Solutions, Inc., to implement application enhancements to the Division of Public Health's Clinical Electronic Medical Record application. The system enhancement will include data management, program-specific reporting and assessment functionality for the Smart Start Program/Healthy Families America home visiting program. The enhancement will include added capacity to capture and extract more complex analytical program data in an effort to support grant funding reporting requirements as well as program accreditation requirements. In addition, web-based functionality will be built into the system to interface and coordinate with other home visiting programs (i.e. Parents as Teachers and Nurse Family Partnership) in Delaware.

The complete continuous quality improvement plan is included in section 7.

SECTION V: PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS

Benchmarks. The tables on the following pages correspond to each of the six requisite benchmarks and demographic and service utilization data table:

0. Maternal and Newborn Health;
1. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits;
2. School Readiness and Achievement;
3. Domestic Violence;
4. Family Economic Self-Sufficiency;
5. Coordination and Referrals for Other Community Resources and Supports;

- Demographic and Service Utilization Data.

Constructs, Indicators, and Objectives. Each of these benchmark tables features a list of constructs, and each of these constructs features an indicator, or operational definition, of the construct. Whether the indicator is an "outcome" or "process" measure is specified in brackets following each indicator. Adjacent to each construct and indicator is the objective or desired goal for successful achievement of the indicator. The achievement of each of these objectives – and ultimately, constructs and indicators – can be assessed through the percent calculation (numerator divided by denominator) aligned with each construct. Each of the constructs also includes the question and responses used to elicit data for the program. Percents, questions and responses, and data sources are described below in more detail. The objectives for the "Maternal and Newborn Health" constructs were adopted from *Healthy People 2020* guidelines[7]. Objectives for all other constructs incorporate suggestions from *Appendix D: Specific Guidance Regarding Individual Benchmark Areas*[8].

Questions and Responses. Many of the constructs include a question and a set of responses that will be used by the home visitor to obtain the program-level data. As given in Table 14, each of the data sources for these questions has been validated by government and/or reporting agencies and serves as an appropriate source to measure the construct based on the particular population assessed. Note that some sources are used for several constructs (e.g. HFPI, LSP, PRAMS)

[7] US Department of Health and Human Services. (2010). *Healthy People 2020: Maternal, Infant, and Child Health.* Retrieved from Healthy People website: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=26.
[8] In Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

while others are references to a survey instrument that is specific to one construct (e.g. use of the CES-D to assess postpartum depression, use of the CTS-2 to document the prevalence of intimate partner violence).

Table 14. Data Sources by Benchmark

Benchmark	Data Sources	Validated By	Why Appropriate
A. Maternal and Newborn Health	Behavioral Risk Factor Surveillance System (BRFSS)[9]	Centers for Disease Control and Prevention (CDC)	Collects data on health behaviors, practices, and access.
	Center for Epidemiologic Studies Depression Scale (CES-D)[10]	National Institute of Mental Health (NIMH)	Provides for screening of symptoms related to depression. High internal consistency reliability.
	Pregnancy Risk Assessment Monitoring System (PRAMS)[11]	Centers for Disease Control and Prevention (CDC)	Measures maternal attitudes before, during and after pregnancy.
B. Child Abuse, Neglect, or Maltreatment	Delaware Department of Services for Children, Youth, and Their Families (DSCYF)[12]	State of Delaware	Collects data on child abuse, neglect, and maltreatment in Delaware.
C. School Readiness and Achievement	Ages and Stages Questionnaires (ASQ-3 and ASQ:SE)[13]	Center on Human Development, University of Oregon	Screens developmental and social-emotional wellbeing of children.
	Healthy Families Parenting Inventory (HFPI)[14]	Health Resources and Services Administration (HRSA)	Demonstrates success in home visiting programs (particularly for State of Arizona).
	Life Skills Progression (LSP)[15]	Agency for Healthcare Research and Quality (AHRQ)	Features item on parent knowledge of child's development.

[9] Behavioral Risk Factor Surveillance System (BRFSS). (2011). BRFSS: Turning Information into Health. Retrieved from CDC website: http://www.cdc.gov/brfss/index.htm.
[10] Radloff, L. (1977). "The CES-D Scale: A Self-Report Depression Scale for Research in the General Population." *App Psychol Meas*, 1, 385-401.
[11] Pregnancy Risk Assessment Monitoring System (PRAMS): Home. (2011). *What Is Prams?* Retrieved from CDC website: http://www.cdc.gov/PRAMS/index.htm.
[12] State of Delaware. (2011). *Department of Services for Children, Youth, and Their Families*. Retrieved from State of Delaware website: http://kids.delaware.gov/default.shtml.
[13] Ages and Stages Questionnaire (ASQ). (2011). *What is ASQ?* Retrieved from Ages and Stages website: http://www.agesandstages.com/asq/index.html.
[14] Administration for Children and Families. (2011). *Healthy Families America: Implementation in Brief*. Retrieved from CDC website: http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=10&mid=3#intensitylength.
[15] *Life Skills Progression™ (LSP): An Outcome and Intervention Planning Instrument for Use with Families at Risk*, by L. Wollesen and K. Peifer. Copyright © 2006 Paul H. Brookes Publishing Co., Inc. All rights reserved.

	American Academy of Pediatrics (AAP) *Bright Futures*[16]	American Academy of Pediatrics (AAP)	Presents table with child physical health and development standards.
D. Domestic Violence	Revised Conflict Tactics Scale (CTS-2)[17]	University of New Hampshire (UNH)	Identifies intimate partner violence.
E. Family Economic Self-Sufficiency	Life Skills Progression (LSP)	Agency for Healthcare Research and Quality (AHRQ)	Provides items on employment, health coverage, and income.

[16] Bright Futures. (2011). *Recommendations for Preventive Pediatric Health Care*. Retrieved from AAP website: http://brightfutures.aap.org/.

[17] Straus, M., Sherry L. Hamby, S., and Sugarman, D. (1996). "The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data." *J of Fam Iss*, 17, 283-316.

Table 15 below lists the population for which the data source is standardized or normed, the training required to use and score the data source, and the reliability and validity of the data source.[18,19]

Table 15. Information on Standardization, Training, Reliability, and Validity for Survey Instrument Tools

Data Sources	Standardized	Training Required	Reliability	Validity
Ages and Stages Questionnaires (ASQ-3)	Families with children between ages 4 to 36 months from both risk and non-risk populations whose families are educationally, economically, and ethnically diverse (primary sample derived between 1980 and 1988).	Questionnaires are written at a 6th grade reading level for parents to easily understand and administer. Each questionnaire takes 15 minutes to administer and approximately 1 minute to score. Interpretation of scores requires professionals or trained paraprofessionals.	*Internal consistency reliability (Cronbach's alpha)*: Communication (.63 to .75); Gross Motor (.53 to .87); Fine Motor (.49 to .79); Problem Solving (.52 to .75); Personal-Social (.52 to .68). *Test-retest reliability*: Percent agreement between administrations was 94 percent. *Inter-rater reliability*: Percent agreement between observers was 94 percent.	*Concurrent validity*: Percent agreement between the ASQ and other measures (the Revised Gesell and Armatruda Developmental and Neurological Examination and the Bayley Scales of Infant Development) was 84 percent overall and ranged from 76 percent for the 4-month questionnaire to 91 percent for the 36-month questionnaire.

[18] Much of this information was drawn from the Administration for Children & Families website at the U.S. Department of Health and Human Services: http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_impa.html.

[19] BRFSS and PRAMS are not included in this table as questions from these CDC-designed surveys can change annually and to the state's discretion.

Data Sources	Standardized	Training Required	Reliability	Validity
Ages and Stages Questionnaires (ASQ:SE)	Compared with 2000 Census figures, the normative sample underrepresents Caucasians and overrepresents individuals of mixed ethnicity and has higher percentage of well-educated mothers and low-income families.	It can be administered by parents, childcare providers, and preschool teachers (10 to 15 minutes per questionnaire). Scoring should be done by a paraprofessional, and should only take a few minutes per questionnaire.	*Internal consistency reliability (Cronbach's alpha)*: The alphas for the questionnaires were .82 overall, .69 (6-month), .67 (12-month), 18-month (.81); 24-month (.80); 30-month (.88); 36-month (.89); 48-month (.91); 60-month (.91). *Test-retest reliability*: Percent agreement between scores by the same rater on two occasions is 94 percent.	*Concurrent validity*: Percent agreement of ASQ:SE with similar established tools ranged from 81 to 95 percent and was 93 percent overall.

Data Sources	Standardized	Training Required	Reliability	Validity
Center for Epidemiologic Studies Depression Scale (CES-D)	The possible range of total scores is from 0 to 60, with higher scores indicating greater distress. Radloff, the author of the scale, suggests that that a total score of 16 be used as the cutoff to indicate "case" depression.	No training is required. The scale takes about 10 minutes to complete, and only a few minutes to score.	*Internal consistency reliability (Cronbach's alpha)*: Ranged from .84 to .90 in field studies. *Test-retest reliability*: Ranges from .51 to .67 in 2- to 8-week intervals and .41 to .54 in 3-to 12-month intervals.	*Concurrent validity*: Studies have examined the degree to which CES-D scores are in agreement with other measures of depression. These studies found CES-D to have correlations ranging from .50s to .80s with the Hamilton rating scale, .30s to .80s with the Raskin rating scale, .40s to .50s with the Lubin Depression Adjective Checklist, .60s and .20s, respectively, with the Bradburn Affect Balance Scale's Negative Affect and Positive Affect Scales, .50s with the Langner scale and .43 with the Cantril life satisfaction ladder.

Data Sources	Standardized	Training Required	Reliability	Validity
Healthy Families Parenting Inventory (HFPI)	The respondents who participated in the development of this scale included 337 ethnically diverse mothers of newborns, single and married, averaging 23 years of age, with average annual incomes of $13,500. Norms are not currently available.	No training is required.	*Internal consistency reliability (Cronbach's alpha)*: The HFPI subscales (i.e., Social Support, Problem-Solving, Depression, Personal Care, Mobilizing Resources, Role Satisfaction, Parent/Child Interaction, Home Environment, and Parenting Efficacy) have alpha coefficients ranging from 0.76 to 0.86, indicating excellent internal consistency.	*Construct validity*: All nine subscales (i.e., Social Support, Problem-Solving, Depression, Personal Care, Mobilizing Resources, Role Satisfaction, Parent/Child Interaction, Home Environment, and Parenting Efficacy) have good construct validity, correlating poorly with measures with which they should not correlate, and low to moderately with other subscales on the instrument.
Life Skills Progression (LSP)[15]	Designed to target at-risk and high-risk parents and their children from pregnancy to age 3 years who are living in poverty.	In just 5–10 minutes, an experienced professional familiar with the family can record information on 43 scales.	*Interrater reliability test*. The estimated final reliability was 90%.	*Construct validity*: Based on alpha values, the construct validity for each of the subscales is acceptable to excellent: Relationships (0.9407), Education (0.7786), Health and medical care (0.8981), Mental health (0.9852), Basic essentials (0.9427), Infant/toddler development (0.9407), and all items (0.9386).

Data Sources	Standardized	Training Required	Reliability	Validity
Revised Conflict Tactics Scale (CTS-2)	Not normed.	An individual with roughly a 6th grade reading level can complete the scales.	*Internal reliability (Cronbach's alphas)*: Overall Physical Assault Scale: .55; Psychological Aggression: .60; Nonviolent Discipline: .70; Neglect Scale: .22; Severe Physical Assault Subscale: -.02. The authors attribute the low neglect and severe assault alphas to the infrequency of the events that make up the scales, thereby reducing the likelihood for high inter-item correlations.	*Construct validity*: The authors tested for construct validity by examining the direction of the relationship between subscale scores and demographic characteristics associated with child maltreatment, such as age of parent, age of child, race/ethnicity, and gender of parent. The directions of the relationships were consistent with previous findings.

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Home visiting staff will hand out the questions and particular survey instruments and then will record the responses and survey entries made by a member of a family receiving home visiting services into a home visit record. At this time, the home visit record will be a paper form that the home visitor will have to enter information in by hand (i.e., by pen or pencil). However, the use of an electronic tablet or notebook to host the home visit record is being explored.

Numerators and Denominators. The numerator values will be obtained from the answers to the questions and surveys administered by home visitors and recorded on the home visit record (e.g. number of women in the home visiting program who received prenatal care in the first trimester). The denominator values will be ascertained based on the data collected by home visitors (e.g. pregnant women in the home visiting program). The personnel responsible for data analysis ("data personnel") will calculate the denominators. These percent calculations represent the metrics most appropriate to the objectives proposed since these values are based on the questions and responses derived from validated and applicable data sources (see *Questions and Responses* section).

Note that in the "Child Abuse, Neglect, or Maltreatment" benchmark table, the source of data for constructs B.5, B.6, and B.7 will be the Delaware Department of Services for Children, Youth, and Their Families (DSCYF). The data personnel will match data provided by this agency to the eligible families in the home visiting program. A Memorandum of Understanding (MOU) with DSCYF is provided in the Appendix H.

Plan to Collect Data. Home visitors will collect data on eligible families that have been enrolled in the program and are receiving services funded with the MIECHV Program funds. Numerator and denominator data for all six (6) benchmark areas will be collected on a quarterly basis. Each of these benchmarks will be applicable to enrolled families that meet a certain criteria (e.g., "A. Maternal and Newborn Health" for families with newborns, "C. School Readiness and Achievement Areas" for families with toddlers and young children).

To reduce the burden of data collection and analysis but also to ensure home visits occur on a regular basis, it was decided that the benchmarks would be assessed on a quarterly basis.

Although home visitors will report data on these benchmarks every three months, the home visitors will invariably provide the applicable home visiting services specific to each participating household throughout each quarter. The data personnel will collect the data submitted by the home visitors every quarter and generate the respective denominators based on data from the most recent home visit within the three month period. Quarterly measurement of these benchmarks will help create a sufficient dataset between the 1- and 3-year benchmark-reporting period.

The option of providing incentives to eligible families who agree to participate in the data collection component of the project is being explored. To agree to participate, these eligible families must sign the home visiting IRB consent form. For this incentive plan to occur, the model developer must approve the provision of incentives.

Plan to Analyze Data. The numerators will be divided by the denominators and this value will then be converted to a percent to represent the objective. These percent values will help measure the progress and success of the program. These values will also be compared with relevant values reported by agencies such as the State of Delaware's Domestic Violence Coordinating Council (DVCC), early childhood comprehensive systems (ECCS) initiatives, and PRAMS. Data personnel will conduct comparative assessments when data is available from both the home visiting program and the relevant local and state agencies.

On a quarterly basis, data personnel will meticulously analyze the percent values based on the service utilization and demographic indicators listed in Table 0. Disaggregating the values based on these indicators (e.g. parent's race and ethnicity, parent's education, child's sex) will help elucidate the amount of progress varying demographic categories are making throughout the program.

Finally, to gauge improvement in the percent values throughout the home visiting program, each construct will have two baseline values: an *internal* baseline value established at Month 3 and an *external* baseline value established at Month 12 (Year 1). The internal baseline value represents the measure for which improvement will be compared for home visitors as well as CQI purposes.

This value is set at Month 3 as this gives sufficient time for the home visitors to become familiar with their home visiting communities and because the home visitors will first report data on all benchmarks at this time point. Data personnel will gauge improvement with Month 3 values, making certain to stratify households by demographic indicators, length of time enrolled in the program, and frequency of home visits (Table 0) as such indicators will likely have an effect on the results.

The external baseline value at Month 12 (Year 1) will be compared to the value at Month 36 (Year 3) as mandated by the home visiting program. This comparison will demonstrate whether the program yielded improvement in at least four benchmark areas by the end of three years.

Figure 1 outlines the data collection and analysis plan:

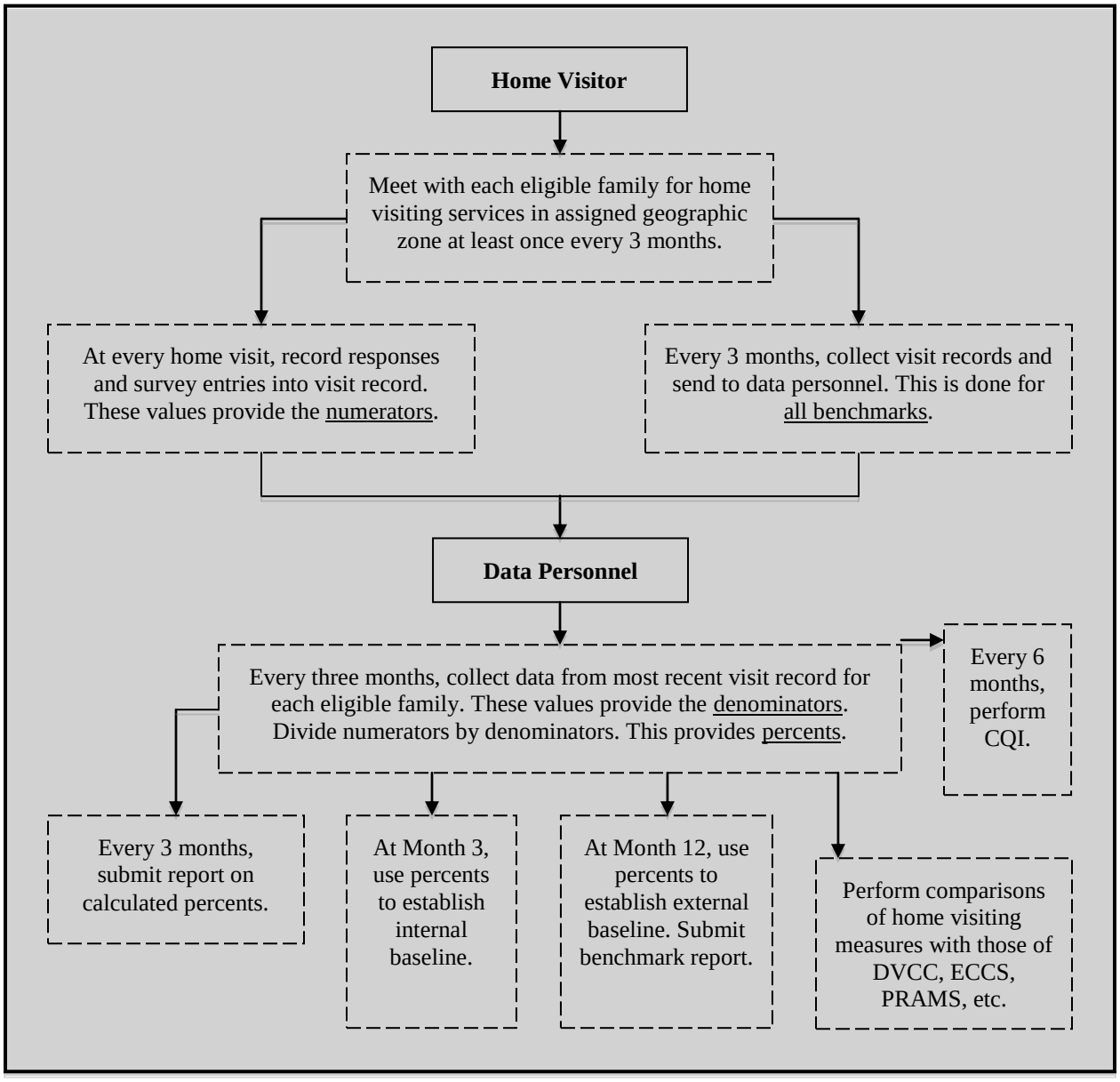
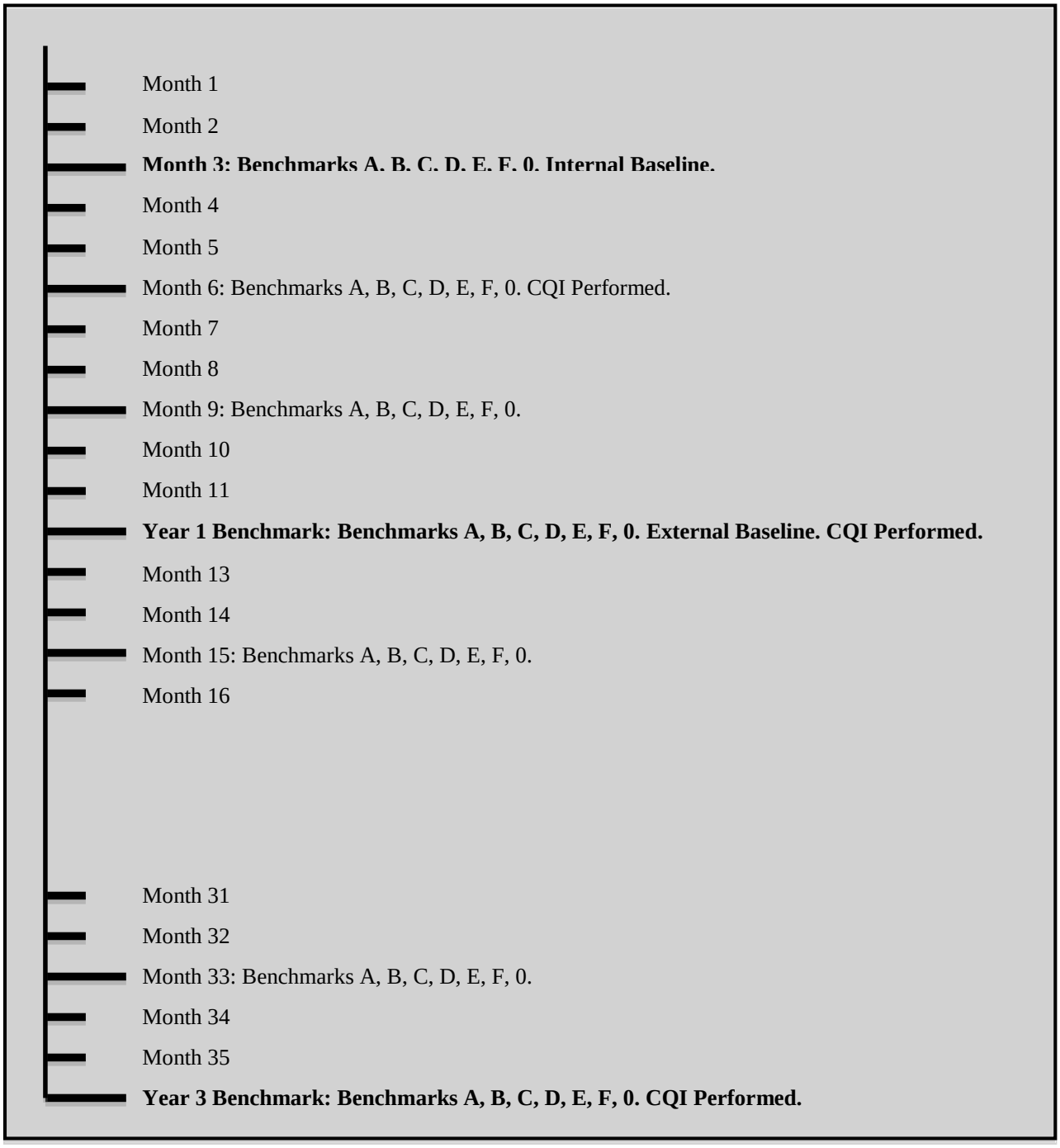


FIGURE 1: DATA COLLECTION AND ANALYSIS PLAN.

Figure 2 provides the timeline for this data collection and analysis plan. As shown in the figure, baselines will be established at Month 3 and Month 12 and CQI will be performed every six months.

FIGURE 2: TIMELINE FOR HOME VISITING DATA COLLECTION AND ANALYSIS.



Quality of Data Collection and Analysis. To ensure high standards in the data collection process, the home visiting staff will consist of registered nurses (RNs) that are licensed to practice in the State of Delaware. Prior to commencing home visitations, each home visiting nurse will complete a basic training by Healthy Families America (HFA)-certified trainers that parallels the training model for the Healthy Families Alaska (HFAK) program.[20] Home visiting staff will also be trained to not place individuals at risk of harm and are compliant with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA.

Because the data analysis segment requires the use sophisticated statistical methods and data management, it is required that the data personnel have at least a Masters degree in Public Health, Public Policy, or Policy Administration as well as extensive experience in program evaluation. The data personnel must also have successfully completed the Collaborative Institutional Training Initiative (CITI) courses on the Protection of Human Research Subjects and on Health Information Privacy and Security (HIPS) in order to be compliant with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. Moreover, the data personnel must be responsive to requests by the State of Delaware if, for example, questions arise in the data reports or during the CQI process. To meet these needs, APS Healthcare Bethesda, Inc. ("APS") will serve as the sole-source evaluation specialist and will provide staff members to serve as data personnel. APS has had prior contractual experience with the Delaware Division of Public Health (DPH) and has successfully demonstrated to DPH a highly proficient capability of completing evaluation projects in a timely and professional manner.

Since objectives will be calculated every three months, a quarterly report can be generated and be used for continuous quality improvement (CQI) at the local program level, community level, and ultimately, state level. The plan for CQI is provided in Section 7.

Finally, to ensure timeliness in the monthly, quarterly, and annual collection and reporting of data, the time estimated for the completion of analytic-related activities by data personnel will be 3 business days after home visit record delivery by the home visitors.

[20] Duggan, A., Caldera, D., Rodriguez, K., Burrel, L., Rohde, C., Crowne, S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse & Neglect*, 31, 801-827.

Anticipated Barriers or Challenges. In this benchmark reporting process, the aggressive timeline of collecting and reporting data on a quarterly basis may be a challenge. Nevertheless, since many of the communities in which the home visiting program is taking place are within close proximity to one another (Wilmington metropolitan area), it is possible for the home visitors and program administrators involved in these benchmark areas to meet consistently and work with a small set of local stakeholders.

A. MATERNAL AND NEWBORN HEALTH

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
A.1	**Prenatal Care:** Percent of pregnant women who receive prenatal care in the first trimester. [Process]	Increase the percent of pregnant women served by the home visiting program who receive prenatal care in the first trimester from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of pregnant women in the home visiting program at the time of quarterly report who chose response "1". **Denominator**: Number of pregnant women in the home visiting program at the time of quarterly report who chose response "1", "2", "3", or "4".	"How many weeks or months pregnant were you when you had your first visit for prenatal care?"	1. At less than 3 months/12 weeks. 2. Between 3 months/12 weeks and 6 months/24 weeks. 3. At more than 6 months/24 weeks. 4. Never had prenatal care. 5. Unknown or refuse.	PRAMS
A.2	**Parental Use of Tobacco:** Percent of parents who use tobacco. [Process].	Decrease the percent of parents served by the home visiting program who use tobacco from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of parents in the home visiting program at the time of quarterly report who chose response "2", "3", or "4". **Denominator**: Number of parents in the home visiting program at the time of quarterly report who chose response "1", "2", "3", or "4".	"During the past 30 days, how many days per week did you use tobacco or smoke a cigarette, even one or two puffs?"	1. No tobacco in past 30 days. 2. 1-3 cigarettes and/or tobacco products per week. 3. 4-6 cigarettes and/or tobacco products per week. 4. More than 6 cigarettes and/or tobacco products per week. 5. Unknown or refuse.	BRFSS, PRAMS

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
A.3	**Preconception Care:** Average number of specific health behaviors or risks discussed with a doctor, nurse, or other health care worker among pregnant women. [Outcome]	Increase the average number of specific health behaviors or risks discussed with a doctor, nurse, or other health care worker among pregnant women served by the home visiting program from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Sum of the number of "Y" responses for each pregnant woman in the home visiting program at the time of quarterly report. (For example, if a woman had 4 "Y" responses and 2 "N" responses, then her number of "Y" responses would be 4. If another woman had 3 "Y" responses and 3 "N" responses, then her number of "Y" responses would be 3. The sum of "Y" responses for these two women would be 4+3 = 7). **Denominator**: Number of pregnant women in the home visiting program at the time of quarterly report who answered all six responses.	"Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each item, circle Y (Yes) if someone talked with you about it or N (No) if no one talked with you about it. a. Taking vitamins with folic acid? b. Being a healthy weight? d. The risks of smoking (whether or not you smoke)? e. The risks of drinking alcohol (whether or not you use alcohol)? f. The risks of using illegal drugs (whether or not you use illegal drugs)?"	a. Y or N. b. Y or N. c. Y or N. d. Y or N. e. Y or N. f. Y or N.	PRAMS
A.4	**Inter-birth Intervals:** Percent of pregnant women who became pregnant at least 18 months after a previous birth. [Process]	Increase the percent of pregnant women served by the home visiting program who became pregnant at least 18 months after a previous birth if a previous birth occurred from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of pregnant women in the home visiting program at the time of quarterly report who became pregnant at least 18 months after a previous birth. **Denominator**: Number of pregnant women in the home visiting program at the time of quarterly report who became pregnant after a previous birth.	N/A. Data will be collected from birth certificate data and matched to families in the home visiting program.	N/A. Data will be collected from birth certificate data and matched to families in the home visiting program.	N/A

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
A.5	**Screening for Maternal Depressive Symptoms:** Percent of postpartum women (between time of birth and 6 months after birth) that are screened for postpartum depression with the CES-D. [Process]	Increase the percent of postpartum women (between time of birth and 6 months after birth) served by the home visiting program that are screened for postpartum depression with the CES-D between year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report that were screened for postpartum depression with the CES-D. **Denominator**: All postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report.	Questions from CES-D survey.	Responses from CES-D survey.	NIH
A.6	**Breastfeeding:** Percent of postpartum women (between time of birth and 6 months after birth) who breastfeed their infants. [Process]	Increase the percent of postpartum women (between time of birth and 6 months after birth) served by the home visiting program who breastfeed their infants at six months of age from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1". **Denominator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1", "2", or "3".	"Are you breastfeeding or feeding pumped milk to your new baby?"	1. Yes, I am breastfeeding or feeding pumped milk to my new baby. 2. No, I am not breastfeeding or feeding pumped milk to my new baby. I am using formula. 3. No, I am not breastfeeding, feeding pumped milk, or using formula for my new baby. 4. Unknown or refuse.	PRAMS

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
A.7	**Well-Child Visits:** Percent of postpartum women (between time of birth and 6 months after birth) with a child (age between birth to six months) who had a well-child visit. [Process]	Increase the percent of postpartum women (between time of birth and 6 months after birth) served by the home visiting program with a child (age between birth to six months) who had a well-child visit from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1". **Denominator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1", "2", or "3".	"Has your new baby (birth to age six months) had at least one well-baby checkup or have a stable medical home?"	1. Yes, my new baby (birth to age six months) had at least one well-baby checkup or has a stable medical home. 2. No, my new baby (birth to age six months) has not yet had at least one well-baby checkup or a stable medical home BUT WILL by age six months. 3. No, my new baby (birth to age six months) has not had at least one well-baby checkup or a stable medical home AND WILL NOT by age six months. 4. Unknown or refuse.	PRAMS
A.8	**Maternal and Child Health Insurance Status:** Percent of postpartum women (between time of birth and 6 months after birth) who have either Medicaid or private	Increase the percent of postpartum women (between time of birth and 6 months after birth) served by the home visiting program who have either Medicaid or private health insurance coverage from the year 1	**Numerator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1".	"Have you [mother] had private health insurance or Medicaid for at least 5 out of the last 6 months?"	1. Yes, I have had private health insurance or Medicaid for at least 5 out of the last 6 months. 2. No, I have had private health insurance or Medicaid BUT FOR	PRAMS

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
	health insurance coverage. [Process]	baseline to the 3-year benchmark reporting period.	**Denominator**: Number of postpartum women (between time of birth and 6 months after birth) in the home visiting program at the time of quarterly report who chose response "1", "2", or "3".		LESS THAN 5 out of the last 6 months. 3. No, I do not have private health insurance and am not on Medicaid and never had coverage on either over the last 6 months. 4. Unknown or refuse.	

B. CHILD INJURIES, CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT VISITS

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
B.1	**Visits for Children to the Emergency Department from All Causes:** Percent of households that reported having a child visit the emergency room for any cause. [Process]	Decrease the percent of households served by the home visiting program that reported having a child visit the emergency room for any cause from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program with children at the time of quarterly report who chose response "2" or "3". [Stratify by age of child]. B.1.1. Child age 0-12 months. B.1.2. Child age 13-36 months. B.1.3. Child age 37-84 months. **Denominator**: Number of households in the home visiting program with children at the time of quarterly report who chose response "1", "2", or "3". [Stratify by age of child]. B.1.1. Child age 0-12 months. B.1.2. Child age 13-36 months. B.1.3. Child age 37-84 months.	"During the past 12 months, did your child have a visit to the emergency room for any reason?"	1. No, during the past 12 months, my child did not have a visit to the emergency room. 2. Yes, during the past 12 months, my child had a visit to the emergency room AND he/she was covered by private health insurance or Medicaid. 3. Yes, during the past 12 months, my child had a visit to the emergency room BUT he/she was not covered by private health insurance or Medicaid. 4. Unknown or refuse.	N/A
B.2	**Visits of Mothers to the Emergency Department from All Causes:** Percent of mothers that reported a visit to the emergency room for any cause. [Process]	Decrease the percent of mothers served by the home visiting program that reported a visit to the emergency room for any cause from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of mothers in the home visiting program at the time of quarterly report who chose response "2" or "3". **Denominator**: Number of mothers in the home visiting program at the time of quarterly report who chose response "1", "2", or "3".	"During the past 12 months, did you [mother] have a visit to the emergency room for any reason?"	1. No, during the past 12 months, I did not have a visit to the emergency room. 2. Yes, during the past 12 months, I had a visit to the emergency room AND was covered by private health insurance or Medicaid. 3. Yes, during the past 12 months, I had a visit to the emergency room BUT I was not covered by private health insurance or Medicaid. 4. Unknown or refuse.	N/A

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
B.3	**Information Provided or Training of Participants on Prevention of Child Injuries:** Percent of households who receive information or training on injury prevention. [Process]	Increase in the percent of households served by the home visiting program who receive information or training on injury prevention between year 1 and the 3-year benchmark-reporting period from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program with children at the time of quarterly report that have received information or training on injury prevention. **Denominator**: Number of households in the home visiting program with children at the time of quarterly report.	N/A. Home visitor provides information or training on injury prevention.	N/A. Home visitor provides information or training on injury prevention.	N/A
B.4	**Incidence of Child Injuries Requiring Medical Treatment:** Percent of households that reported having a child who had injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations). [Process]	Decrease the percent of households served by the home visiting program that reported having a child who had injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program with children at the time of quarterly report who chose response "2" or "3". [Stratify by age of child]. B.4.1. Child age 0-12 months. B.4.2. Child age 13-36 months. B.4.3. Child age 37-84 months. **Denominator**: Number of households in the home visiting program with children at the time of quarterly report who chose response "1", "2", or "3". [Stratify by age of child]. B.4.1. Child age 0-12 months. B.4.2. Child age 13-36 months. B.4.3. Child age 37-84 months.	"During the past 12 months, did your child have injuries requiring medical treatment?"	1. No, during the past 12 months, my child did not have injuries requiring medical treatment. 2. Yes, during the past 12 months, my child had injuries requiring medical treatment AND my child received medical treatment from a health care provider. 3. Yes, during the past 12 months, my child had injuries requiring medical treatment BUT my child did not receive medical treatment from a health care provider. 4. Unknown or refuse.	N/A

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
B.5	**Reported Suspected Maltreatment for Children in the Program:** Percent of children who are reported in a case of suspected maltreatment. [Process]	Decrease the percent of children served by the home visiting program who are reported in a case of suspected maltreatment from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children in the home visiting program at the time of quarterly report who have injuries reported in a case of suspected maltreatment. [Stratify by age of child and maltreatment type]. B.5.1. Child age 0-12 months. B.5.2. Child age 13-36 months. B.5.3. Child age 37-84 months. B.5.4. Type: medical. B.5.5. Type: neglect. B.5.6. Type: physical. B.5.7. Type: psychological. B.5.8. Type: sexual. **Denominator**: Number of children in the home visiting program at the time of quarterly report. [Stratify by age of child]. B.5.1. Child age 0-12 months. B.5.2. Child age 13-36 months. B.5.3. Child age 37-84 months. For B.5.4, B.5.5, B.5.6, B.5.7, and B.5.8, all children in the home visiting program.	N/A. Data will be collected and matched to families in the home visiting program.	N/A. Data will be collected and matched to families in the home visiting program.	DSCYF

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
B.6	**Reported Substantiated Maltreatment (Substantiated/Indicated/Alternative Response Victim) for Children in the Program:** Percent of children who are reported in a case of substantiated maltreatment. [Process]	Decrease the percent of children served by the home visiting program who are reported in a case of substantiated maltreatment from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children in the home visiting program at the time of quarterly report who have injuries reported in a case of substantiated maltreatment. [Stratify by age of child and maltreatment type]. B.6.1. Child age 0-12 months. B.6.2. Child age 13-36 months. B.6.3. Child age 37-84 months. B.6.4. Type: medical. B.6.5. Type: neglect. B.6.6. Type: physical. B.6.7. Type: psychological. B.6.8. Type: sexual. **Denominator**: Number of children in the home visiting program at the time of quarterly report. [Stratify by age of child]. B.6.1. Child age 0-12 months. B.6.2. Child age 13-36 months. B.6.3. Child age 37-84 months. For B.6.4, B.6.5, B.6.6, B.6.7, and B.6.8, all children in home visiting communities.	N/A. Data will be collected and matched to families in the home visiting program.	N/A. Data will be collected and matched to families in the home visiting program.	DSCYF

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
B.7	**First-time Victims of Maltreatment for Children in the Program:** Percent of children who had a maltreatment disposition of "victim" and never had a prior disposition of "victim". [Process]	Decrease the percent of children served by the home visiting program who had a maltreatment disposition of "victim" and never had a prior disposition of "victim" from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children in the home visiting program at the time of quarterly report who had a maltreatment disposition of "victim" and never had a prior disposition of "victim". [Stratify by age of child]. B.7.1. Child age 0-12 months. B.7.2. Child age 13-36 months. B.7.3. Child age 37-84 months. B.7.4. Type: medical. B.7.5. Type: neglect. B.7.6. Type: physical. B.7.7. Type: psychological. B.7.8. Type: sexual. **Denominator**: Number of children in the home visiting program at the time of quarterly report. [Stratify by age]. B.7.1. Child age 0-12 months. B.7.2. Child age 13-36 months. B.7.3. Child age 37-84 months. For B.7.4, B.7.5, B.7.6, B.7.7, and B.7.8, all children in home visiting communities.	N/A. Data will be collected and matched to families in the home visiting program.	N/A. Data will be collected and matched to families in the home visiting program.	DSCYF

C. SCHOOL READINESS AND ACHIEVEMENT

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
C.1	**Parent Support for Children's Learning and Development:** Average score of the Home Environment subscale of the HFPI. [Outcome]	Increase the average score of the Home Environment subscale of the HFPI among households served in the home visiting program from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Sum of scores of the Home Environment subscale of HFPI (questions 48-57) among households in the home visiting program with children at the time of quarterly report. **Denominator**: Number of children in the home visiting program that were assessed with the HFPI at the time of quarterly report.	Home Environment subscale of HFPI: Questions 48-57.	Home Environment subscale of HFPI: Responses to questions 48-57.	HFPI
C.2	**Parent Knowledge of Child Development and of Child's Developmental Progress:** Percent of children who have parents with knowledge of the child's development and of the child's developmental progress. [Outcome]	Increase the percent of households served in the home visiting program who have parents with knowledge of the child's development and of the child's developmental progress from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households with children in the home visiting program for which the home visitor has assigned a response of "1" or "2". **Denominator**: Number of households with children in the home visiting program for which the home visitor has assigned a response of "1", "2", "3" or "4".	Question for Home Visitor: What is the degree of the parent's knowledge of child development and of the child's developmental progress?	1. Parent applies or child development ideas. Parent is interested in child's development skills and uses appropriate toys/books. 2. Parent is open to child development information and provides some toys, books, and play. 3. Parent has little knowledge of child development and has limited interest in development. 4. Parent has no knowledge of child development, and ignores or refuses information.	LSP

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
C.3	**Parenting Behaviors and Parent-Child Relationship:** Average score of the Parent/Child Interaction subscale of the HFPI. [Outcome]	Increase the average score of the Parent/Child Interaction subscale of the HFPI among households served in the home visiting program from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Sum of scores of the Parent/Child Interaction subscale of HFPI (questions 38-47) among households in the home visiting program with children at the time of quarterly report. **Denominator**: Number of children in the home visiting program that were assessed with the HFPI at the time of quarterly report.	Parent/Child Interaction subscale of HFPI: Questions 38-47.	Parent/Child Interaction subscale of HFPI: Responses to questions 38-47.	HFPI
C.4	**Parent Emotional Well-Being or Parenting Stress:** Average score of the Parenting Efficacy subscale of the HFPI. [Outcome]	Increase the average score of the Parenting Efficacy subscale of the HFPI among households served in the home visiting program from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Sum of scores of the Parenting Efficacy subscale of HFPI (questions 58-63) among households in the home visiting program with children at the time of quarterly report. **Denominator**: Number of children in the home visiting program that were assessed with the HFPI at the time of quarterly report.	Parenting Efficacy subscale of HFPI: Questions 58-63.	Parenting Efficacy subscale of HFPI: Responses to questions 58-63.	HFPI
C.5	**Child's Communication, Language and Emergent Literacy:** Percent of children who exhibit adequate communication,	Increase the percent of children served by the home visiting program who exhibit adequate communication, language, and emergent literacy as described by the ASQ-3 from the year 1	**Numerator**: Number of children served by the home visiting program that are above the scoring cutoff for the Communication section of the age-appropriate ASQ-3 at the time of quarterly report.	Communication section for ASQ-3: Questions based on age-specific ASQ-3.	Communication section for ASQ-3: Responses to questions based on age-specific ASQ-3.	ASQ-3

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
	language, and emergent literacy as described by the ASQ-3. [Outcome]	baseline to the 3-year benchmark reporting period.	**Denominator**: Number of children in the home visiting program that were assessed with the ASQ-3 at the time of quarterly report.			
C.6	**Child's General Cognitive Skills:** Percent of children who exhibit general cognitive skills as described by the ASQ-3. [Outcome]	Increase the percent of children served by the home visiting program who exhibit general cognitive skills as described by the ASQ-3 from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children served by the home visiting program that are above the scoring cutoff for the Problem Solving section of the age-appropriate ASQ-3 at the time of quarterly report. **Denominator**: Number of children in the home visiting program that were assessed with the ASQ-3 at the time of quarterly report.	Problem Solving section of ASQ-3: Questions based on age-specific ASQ-3.	Problem Solving section of ASQ-3: Responses to questions based on age-specific ASQ-3.	ASQ-3
C.7	**Child's Positive Approaches to Learning Including Attention:** Percent of children who exhibit positive approaches to learning including attention as described by the ASQ:SE. [Outcome]	Increase the percent of children served by the home visiting program who exhibit positive approaches to learning including attention as described by the ASQ:SE from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children served by the home visiting program that have a "most of the time" response to "are interested in things around him/her" in the ASQ:SE. **Denominator**: Number of children in the home visiting program that were assessed with the ASQ:SE at the time of quarterly report.	Question based on age-specific ASQ:SE: 12 Months: Q11, 18 Months: Q10, 24 Months: Q10, 30 Months: Q14, 36 Months: Q10, 48 Months: Q9, 60 Months: Q10.	Response to question based on age-specific ASQ:SE: 12 Months: Q11, 18 Months: Q10, 24 Months: Q10, 30 Months: Q14, 36 Months: Q10, 48 Months: Q9, 60 Months: Q10.	ASQ:SE
C.8	**Child's Social Behavior, Emotion Regulation, and Emotional Wellbeing:** Percent of children who exhibit adequate social	Increase the percent of children served by the home visiting program who exhibit adequate social behavior, emotion regulation, and emotional wellbeing as described by the ASQ:SE	**Numerator**: Sum of scores of the Self-regulation behavioral area of ASQ:SE among children in the home visiting program that were assessed with the ASQ:SE at the time of quarterly report.	Self-regulation behavioral area of ASQ:SE: Questions based on age-specific ASQ:SE.[21]	Self-regulation behavioral area of ASQ3: Responses to questions based on age-specific ASQ:SE.	ASQ:SE

[21] See page 6 of the "Overview of the ASQ:SE" for questions in the self-regulation behavioral area.

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
	behavior, emotion regulation, and emotional wellbeing as described by the ASQ:SE. [Outcome]	from the year 1 baseline to the 3-year benchmark reporting period.	**Denominator**: Number of children in the home visiting program that were assessed with the ASQ:SE at the time of quarterly report.			
C.9	**Child's Physical Health and Development:** Percent of children who exhibit adequate physical health and development based on a set of seven physical health and development measures. [Outcome]	Increase the percent of children served by the program who exhibit adequate physical health and development from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of children served by the home visiting program that are within a normal range for the following services: C.9.1. Body Mass Index (BMI) C.9.2. Head Circumference C.9.3. Height C.9.4. Weight AND are at or above the threshold for an "adequate" result for the following services: C.9.5. Physical Exam (Physic) C.9.6. Hearing C.9.7. Vision **Denominator**: Number of children served by the home visiting program that have values reported for all seven physical health and development measures.	Screening for the following services: C.9.1. BMI C.9.2. Head Circumference C.9.3. Height C.9.4. Weight C.9.5. Physical C.9.6. Hearing C.9.7. Vision	Values recorded from the screening of the following services: C.9.1. BMI C.9.2. Head Circum C.9.3. Height C.9.4. Weight C.9.5. Physical C.9.6. Hearing C.9.7. Vision	AAP

D. DOMESTIC VIOLENCE

	Construct: Indicator	Objective	Percent Calculation	Questions	Responses	Source
D.1	**Screening for Domestic Violence:** Percent of households that are screened for domestic violence.	Increase in the percent of households served by the home visiting program who are screened for domestic violence from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households served by the home visiting program at the time of quarterly report in which domestic violence was screened through use of the Revised Conflict Tactics Scale (CTS-2). **Denominator**: Number of households served by the home visiting program at the time of quarterly report.	Questions from CTS-2.	D.1.2. Responses to questions from CTS-2.	UNH
D.2	**Of Households Identified for the Presence of Domestic Violence, Number of Referrals Made to Relevant Domestic Violence Services (e.g., Shelters, Food Pantries):** For households identified with the presence of domestic violence, the percent of referrals made to relevant domestic violence services.	For households identified with the presence of domestic violence, increase the percent of referrals made to relevant domestic violence services from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households served by the home visiting program at the time of quarterly report in which domestic violence was identified through use of the Revised Conflict Tactics Scale (CTS-2) and referrals were made to relevant domestic violence services as documented in a home visit record. **Denominator**: Number of households served by the home visiting program at the time of quarterly report in which domestic violence was identified through use of the Revised Conflict Tactics Scale (CTS-2).	N/A	N/A	N/A

	Construct: Indicator	Objective	Percent Calculation	Questions	Responses	Source
D.3	**Of Families Identified for the Presence of Domestic Violence, Number of Families for which a Safety Plan was Completed:** For households identified with the presence of domestic violence, the percent of safety plans completed.	For households identified with the presence of domestic violence, increase the percent of safety plans completed from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households served by the home visiting program at the time of quarterly report in which domestic violence was identified through use of the Revised Conflict Tactics Scale (CTS-2) and safety plans were completed as documented in home visit record. **Denominator**: Number of households served by the home visiting program at the time of quarterly report in which domestic violence was identified through use of the Revised Conflict Tactics Scale (CTS-2).	N/A	N/A	N/A

E. FAMILY ECONOMIC SELF-SUFFICIENCY

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
E.1	**Household Income and Benefits:** Percent of households with household income that meets expenses. [Outcome]	Increase in the percent of households served by the home visiting program with household income that meets expenses from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program at the time of quarterly report who chose response "1" or "2". **Denominator**: Number of households in the home visiting program at the time of quarterly report who chose response "1", "2", "3" or "4".	"What best describes how your household income meets your expenses during the past 30 days?"	1. Adequate income to meet expenses. 2. Moderate income to meet expenses most of the time. 3. Low income because of seasonal employment. 4. Income from TANF and/or child support, SDI. 5. Unknown or refuse.	LSP
E.2	**Employment of Adult Members of the Household:** Percent of households with at least one adult working for pay at a job (or business). [Outcome]	Increase in the percent of households served by the home visiting program with at least one adult working for pay at a job (or business) from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program at the time of quarterly report who chose response "1" or "2". **Denominator**: Number of households in the home visiting program at the time of quarterly report who chose response "1", "2", "3" or "4".	"What best describes the employment of one of the adults in your household during the past 30 days? Choose the adult with the "lowest" answer (e.g., if one adult would be a "1" and another adult would be a "2", choose "1").	1. Stable employment with adequate salary and benefits. 2. Stable employment in a low-income job. 3. Occasional, seasonal, or multiple entry-level jobs. 4. Unemployed, unskilled, or no work experience. 5. Unknown or refuse.	LSP
E.3	**Health Insurance Status:** Percent of households that have Medicaid or private health insurance. [Outcome]	Increase in the percent of households served by the home visiting program that have Medicaid or private health insurance from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Number of households in the home visiting program at the time of quarterly report who chose response "1" or "2".	"What best describes the health insurance status of the members in your household?"	1. Private insurance with or without co-pay for self/others. 2. Medicaid full-scope benefits with or without Share of Cost OR state-subsidized or partial-	LSP

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
			Denominator: Number of households in the home visiting program at the time of quarterly report who chose response "1", "2", "3" or "4".		pay coverage. 3. Medicaid for pregnancy or emergency only. 4. None/unable to afford care or coverage. 5. Unknown or refuse.	

F. COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
F.1	**Number of Households Identified for Necessary Services:** Percent of households screened for needs, particularly those relevant for affecting participant outcomes. [Process]	Increase in the percent of households served by the home visiting program screened for needs, particularly those relevant for affecting participant outcomes from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Households in the home visiting program at the time of quarterly report that are screened for needs as documented in home visit record. **Denominator**: All households in the home visiting program at the time of quarterly report.	N/A	N/A	Home Visit Record
F.2	**Number of Households that Required Services and Received a Referral to Available Community Resources:** Percent of households identified for necessary services that required services and received a referral to available community resources. [Outcome]	Increase the percent of households served by the home visiting program identified for necessary services that required services and received a referral to available community resources from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Households in the home visiting program at the time of quarterly report identified for necessary services that required services and received a referral to available community resources as documented in home visit record. **Denominator**: Households in the home visiting program at the time of quarterly report identified for necessary services.	N/A	N/A	Home Visit Record
F.3	**MOUs:** Number of formal agreements with other social service agencies.	Increase in the number of formal agreements with other social service agencies from the year 1 baseline to the 3-	**Numerator**: N/A. This construct measures changes in number rather than changes in percent.	N/A	N/A	Home Visit Record

	Construct: Indicator	Objective	Percent Calculation	Question	Responses	Source
	[Process]	year benchmark reporting period.	**Denominator**: N/A. This construct measures changes in number rather than changes in percent.			
F.4	**Information Sharing:** Number of social service agencies that engage in regular communication with the home visiting provider. [Process]	Increase in the number of social service agencies that engage in regular communication with the home visiting provider from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: N/A. This construct measures changes in number rather than changes in percent. **Denominator**: N/A. This construct measures changes in number rather than changes in percent.	N/A	N/A	Home Visit Record
F.5	**Number of Completed Referrals:** Percent of households identified for necessary services with a verified receipt of service. [Outcome]	Increase the percent of households served by the home visiting program identified for necessary services with a verified receipt of service from the year 1 baseline to the 3-year benchmark reporting period.	**Numerator**: Households in the home visiting program at the time of quarterly report identified for necessary services with a verified receipt of service as documented in home visit record. **Denominator**: Households in the home visiting program at the time of quarterly report identified for necessary services.	N/A	N/A	Home Visit Record

0. DEMOGRAPHIC AND SERVICE UTILIZATION DATA

	Stratifying Variable	Numerator	Denominator	Question	Responses	Source
0.1	Household location.	Families participating in the home visiting program at the time of quarterly report stratified by location of residence. 0.1.1. Zone 1. 0.1.2. Zone 2. 0.1.3. Zone 3. 0.1.4. Zone 4. 0.1.5. Zone 5. 0.1.6. Zone 6.	All families participating in the home visiting program at the time of quarterly report.	"What is the zip code of your residence?"	1. 19703 2. 19801 3. 19802 4. 19804 5. 19805 6. 19806 7. 19809 8. 19930 9. 19933 10. 19939 11. 19940 12. 19941 13. 19942 14. 19944 15. 19945 16. 19946 17. 19950 18. 19952 19. 19954 20. 19956 21. 19960 22. 19963 23. 19966 24. 19967 25. 19970 26. 19973 27. 19975 28. Unknown or refuse.	Home Visit Record

	Stratifying Variable	Numerator	Denominator	Question	Responses	Source
0.2	Parent's race and ethnicity.	Families participating in the home visiting program at the time of quarterly report stratified by race and ethnicity. 0.2.1. Both parents/guardians BNH. 0.2.2. Both parents/guardians H. 0.2.3. Both parents/guardians WNH 0.2.4. Both parents/guardians Other 0.2.5. Parents/guardians have different race/ethnicities.	All families participating in the home visiting program at the time of quarterly report.	"What are the race and ethnicities of the parents/guardians of the household?"	1. Both parents and guardians are BNH. 2. Both parents and guardians are H. 3. Both parents and guardians are WNH 4. Both parents and guardians are not BNH, H, or WNH but share the same race and ethnicity (e.g., both parents and guardians are A or both are NA). 5. Both parents and guardians have different race and ethnicities.	Home Visit Record
0.3	Parent's education.	Families participating in the home visiting program at the time of quarterly report stratified by highest educational attainment of either parent/guardian. 0.3.1. Less than high school. 0.3.2. Some high school, not grad. 0.3.3. High school graduate. 0.3.4. Some college, not grad. 0.3.5. College graduate or higher.	All families participating in the home visiting program at the time of quarterly report.	"What is the highest educational attainment of all adults in your household?"	1. Less than high school. 2. Some high school, but did not graduate. 3. High school graduate. 4. Some college, but not a graduate. 5. College graduate or higher.	Home Visit Record
0.4	Child's sex.	Children in the home visiting program at the time of quarterly report stratified by sex. 0.4.1. Female children. 0.4.2. Male children.	All children in the home visiting program at the time of quarterly report.	"What are the numbers of children in your household by sex?"	1. __ female child(ren). 2. __ male child(ren).	Home Visit Record
0.5	Primary language in child's household.	Children in the home visiting program at the time of quarterly report stratified by primary language in household. 0.5.1. English. 0.5.2. Spanish. 0.5.3. Other.	All children in the home visiting program at the time of quarterly report.	"What is the primary language spoken in the household?"	1. English. 2. Spanish. 3. Other _____	Home Visit Record

	Stratifying Variable	Numerator	Denominator	Question	Responses	Source
0.6	Length of participation in home visiting program.	Families participating in the home visiting program stratified by duration in program at the time of quarterly report (as program progresses, stratified numerator values will be populated). 0.6.1. Duration of 1-3 months. 0.6.2. Duration of 4-6 months. 0.6.3. Duration of 7-9 months. 0.6.4. Duration of 10-12 months. 0.6.5. Duration of 13-15 months. 0.6.6. Duration of 16-18 months. 0.6.7. Duration of 19-21 months. 0.6.8. Duration of 22-24 months. 0.6.9. Duration of 25-27 months. 0.6.10. Duration of 28-30 months. 0.6.11. Duration of 31-33 months. 0.6.12. Duration of 34-36 months.	All families participating in the home visiting program at the time of quarterly report.	N/A. This will be completed by the home visitor.	N/A. This will be completed by the home visitor.	Home Visit Record
0.7	Number of sessions/visits in home visiting program.	Families participating in the home visiting program stratified by number of sessions/visits at the time of quarterly report. 0.7.1. Between 0-3 visits. 0.7.2. Between 4-6 visits. 0.7.3. Between 7-9 visits. 0.7.4. Between 10-12 visits. 0.7.5. Between 13-15 visits. 0.7.6. Between 16-18 visits. 0.7.7. Between 19-21 visits. 0.7.8. Between 22-24 visits. 0.7.9. Between 25-27 visits. 0.7.10. Between 28-30 visits. 0.7.11. Between 31-33 visits. 0.7.12. Between 34-36 visits.	All families participating in the home visiting program at the time of quarterly report.	N/A. This will be completed by the home visitor.	N/A. This will be completed by the home visitor.	Home Visit Record

SECTION VI: PLAN FOR ADMINISTRATION OF THE HOME VISITING PROGRAM

Delaware currently operates five home visiting programs through four administering agencies. These include:

No.	PROGRAM	OPERATING AGENCY
1	Nurse-Family Partnership	Children & Families First
2	Smart Start (Healthy Families America model)	Division of Public Health
3	Parents as Teachers	Department of Education
4	Early Head Start/Head Start	Department of Education & Univ. of Delaware
5	Resource Mothers (Healthy Families America)	Children & Families First

As of 2008, Delaware's home visiting administering agencies have collaborated to create a continuum of home visiting services where families are referred to the program that is most in line with their needs and transition seamlessly to a different service if/when needed. With strong support from the state executive branch (e.g. Lt. Governor's Office), key state agencies (e.g. Division of Public Health and Department of Services for Child, Youth & their Families) and advocacy organizations (Community-Based Child Abuse Prevention organization); Delaware is well poised to implement the intent and goals of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program.

Role of the Delaware Home Visiting Community Advisory Board (CAB)

Key organizations that deliver home visiting programs, along with partners, work collaboratively on the **CAB**, in place since 2008. The CAB advocates for the DMIEC-HV program and its goals, supports a continuum of home visiting services, reports on each the program's successes, challenges, and discusses solutions. The CAB is comprised of providers, policy makers, and other advocates and includes: CB-CAP, Child Welfare, Division of Child Mental and Behavior Health, Division of Public Health, ECCS Coordinator, United Way, Family Court, Child Death Review Board, Office of the Child Advocate, Christiana Health Systems, Federally Qualified Health Centers, University of DE School of Nursing, University of DE School of Urban Affairs and Public Policy, Medicaid managed care, three private foundations and other home visiting programs (Division of Public Health—Smart Start Program; Department of Education—Parents as Teachers; Early Head Start Programs; Resource Mothers Program). [See Appendix "C" for list of members, title, and affiliated organization].

Role of the Smart Start/Healthy Families America Steering Committee

The Smart Start Steering Committee is an internal committee of the Division of Public Health and is responsible for guiding, overseeing, and monitoring overall program implementation of Smart Start/HFA statewide to follow the Healthy Families America (HFA) critical elements.

Responsibilities include, but are not limited to:

vii. Provide overall direction
viii. Help to define Work Groups and designate lead facilitators
ix. Support/serve as Work Group participant(s)
x. Generate and facilitate discussion to help develop short and long-term goals
xi. Review & formalize work group recommendations
xii. Make decisions on Implementation Plan

- Liaison to the Home Visiting Community Advisory Board
- Grant writing
- Liaison with third party payers to determine long-term sustainability financing model
- Evaluation/assessment
- Identify resources, costs, staff, program sustainability and structural challenges
- HFA transition oversight
- Oversight of the development of a data system

Role of the Smart Start/Healthy Families America Implementation Workgroups

The Smart Start Implementation Workgroup is an internal committee of the Division of Public Health and reports to the Steering Committee. Responsibilities include, but are not limited to:

- Implement, review, revise, and monitor Quality Assurance and Training and Technical Assistance Plans;
- Develop the policies and procedures and make recommendations to the Steering Committee for incorporation in the overall Plan;
- Oversee training and technical assistance for the Smart Start/HFA;
- Review annual status reports and other statewide data sets as appropriate, and review the assessments during the credentialing and re-credentialing processes, (TBD)
- Advise program manager on the effective implementation of training, technical assistance, quality assurance plans, and other areas of program functioning,
- Designate ad-hoc work groups as needed to address specific issues. These smaller workgroups report to the full Smart Start Implementation Workgroup, and issues that cannot be addressed are elevated to the Steering Committee.
- Serve as a forum for communication among state trainers, program manager, MCH Deputy Director, home visiting staff (Nurses, social workers, nutritionists).

Staffing Plan

The project will be overseen by Title V MCH Director, Alisa Olshefsky, MPH. Ms. Olshefsky will dedicate .10 FTE in-kind to supervision and oversight of the Affordable Care Act Maternal, Infant and Early childhood Home Visiting project. Ms. Leah Jones, MPA, who serves as the MCH Bureau Chief will be responsible for day-to-day implementation of the project. Ms. Jones will dedicate .25 FTE in-kind to the project. Resumes for Ms. Olshefsky and Ms. Jones are located in Appendix "G".

Three paid positions are requested, one in year 1 and two in year 2. These include:

1. 2.0 FTE Registered Nurse III – Public Health Nursing (1.0 FTE in Year 1 and an additional 1.0 FTE in Year 2)
2. 1.0 FTE (Year 2) Nursing Supervisor – Public Health Nursing

The RN III's will serve as home visitors within the DPH home visiting program, Smart Start/Healthy Families America site. Formal accreditation will occur in August 2013. The Nursing Supervisor will supervise nurse home visitors and assist with case loads, training and case consultation.

Under development, is the creation of a Program Manager to oversee the Smart Start/HFA program once it is fully implemented. The Program Manager's role will be essential in ensuring programmatic, operational, and fiscal oversight. (Eileen T. Dombrowski is currently transitioning into the role of Program Manager of the Smart Start/HFA program. Resume is included under Key Personnel in "Appendix G".)

Job Descriptions for Key Personnel

Registered Nurse III - Public Health Nursing

- Possession of a Bachelors degree or higher in Nursing and at least one year experience as a Registered Nurse in Public Health Nursing OR a Masters degree or higher in Nursing.
- Possession of a Delaware Registered Nurse license OR multi-state compact license.

The intent of the listed knowledge, skills and abilities (KSA) is to give a general indication of the core requirements for all positions in the class series; therefore, the KSA's listed are not exhaustive or necessarily inclusive of the requirements of every position in the class.

- Knowledge of the principles, practices, and procedures of registered nursing.
- Knowledge of quality assurance techniques.
- Knowledge of the specific program area of practice.
- Knowledge of individual/group dynamics.
- Skill in providing health care instruction and guidance to individuals, families, community groups and/or nursing home facilities.
- Skill in accurate documentation.
- Ability to plan, implement and evaluate nursing care plans.
- Ability to complete records and reports in a timely manner.
- Ability to establish and maintain effective relationships with individuals, families and co-workers.

- Ability to interpret data and apply the appropriate problem solving techniques.

In addition to the above knowledge, skills and abilities, the Registered Nurse III requires:

- Skill in making independent judgments in complex situations.
- Ability to plan, assign and review the work of staff.

In addition to the above knowledge, skills and abilities, the Nurse Supervisor requires:

- Knowledge of the principles and practices of supervision.
- Skill in directing the work of others to include evaluating team effectiveness and re-directing resources and adjusting priorities to meet team objectives.
- Ability to provide leadership and motivate staff.
- Ability to determine adequate staffing requirements, and adjust staffing patterns as needed.

Research Data Analyst (contractual position)

A Request for Proposals (RFP) will be issued to obtain a full-time master's degree level research analyst to work within the Division of Public Health / Maternal and Child Health Bureau. The contract is budgeted at the level of salary and benefits that corresponds to a Research Specialist III (Pay Grade 17) in the state's occupational classification system (Salary $49,005; Health Insurance and Benefits $23,206). The Research Analyst will work 37.5 hours per week.

Essential Functions:

- Develops research designs and determines the information needed. Determines appropriate data sources, data reliability, sampling techniques and collection methods. Selects appropriate methods in analyzing and evaluating data.
- Collects and analyzes data for Smart Start Home Visiting Program and other related child health programs.
- Maintains databases for the Smart Start Home Visiting Program and other related child health programs.
- Performs literature searches on laws, previous studies, and compiles available statistics.
- Prepares comprehensive analytical and statistical reports.

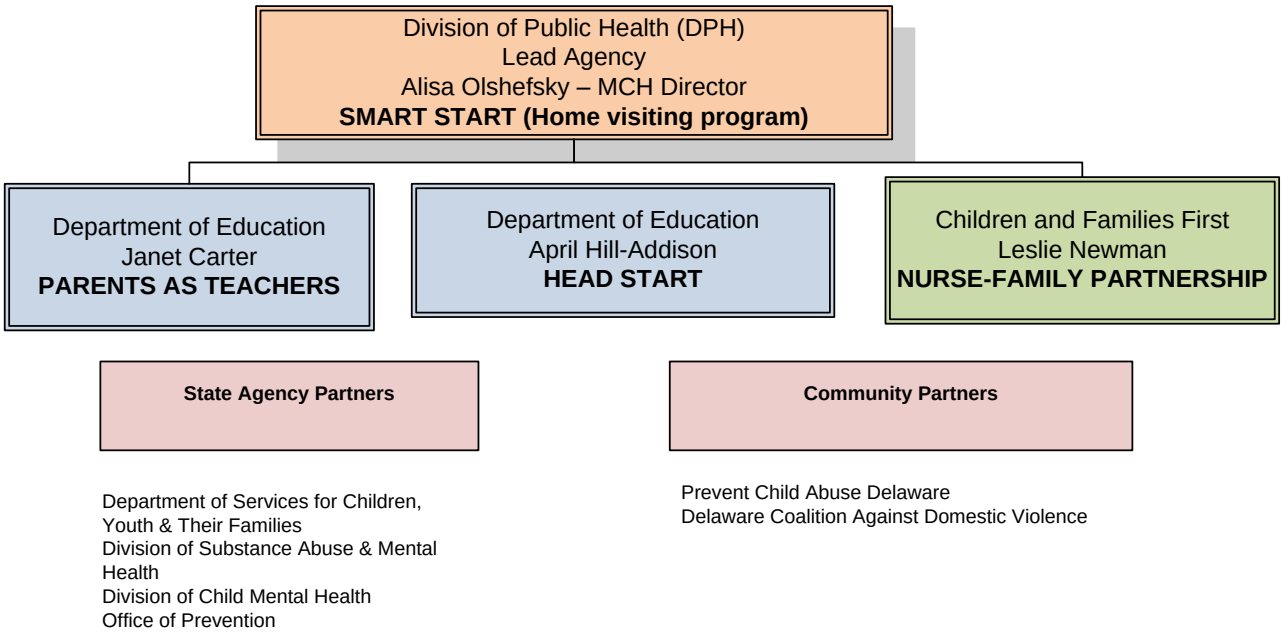
Requirements:

- Experience in designing studies which includes determining study goals and

objectives, information needed, data sources, sampling and collection methods.

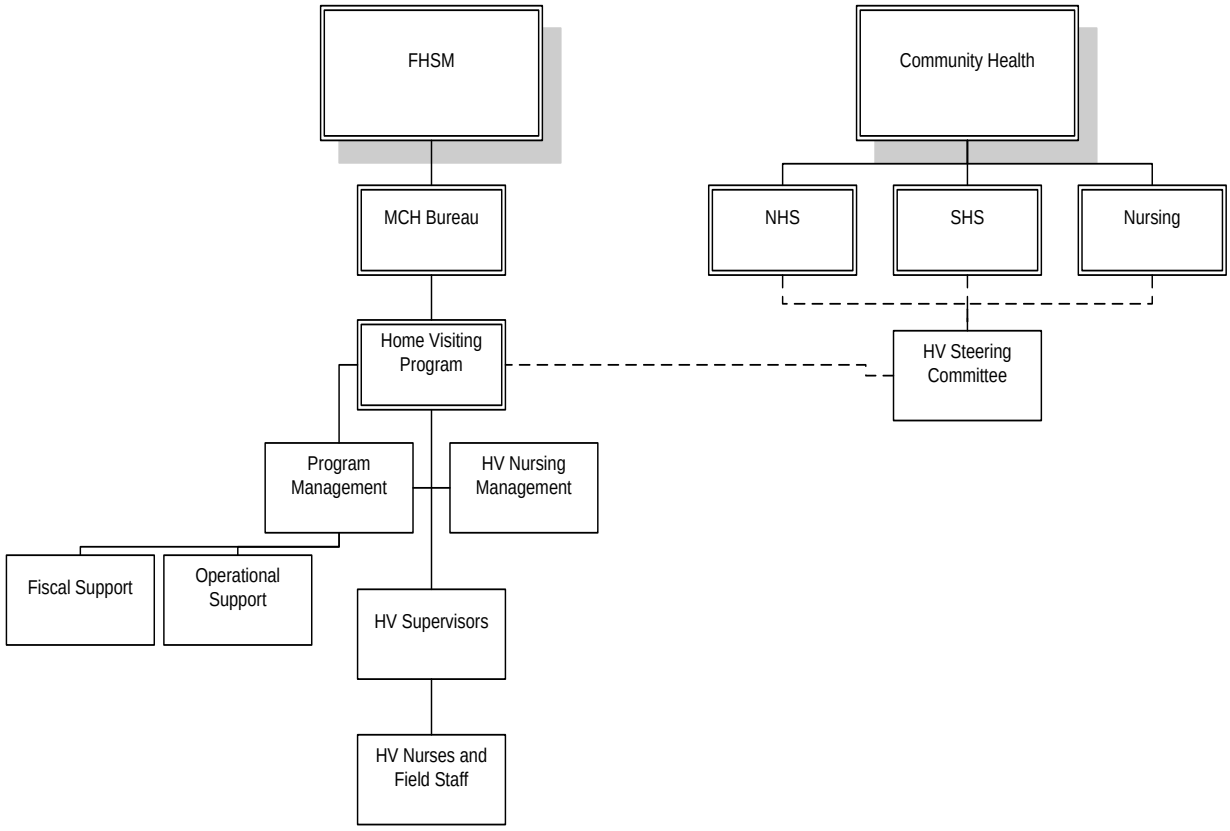
- Experience in conducting studies which includes evaluating operations, programs, services, policies and procedures to determine efficiency, effectiveness, whether goals and objectives are met and compliance with laws, rules, regulations, policies and procedures.
- Experience in making recommendations for continuation or changes to operations, programs, services, policies or procedures based on findings.
- Experience in interpreting laws, rules, regulations, standards, policies, and procedures.
- Experience in descriptive statistics such as the mean, median, mode or standard deviation.
- Experience in inferential statistics such as correlation, t-tests, f-tests or analysis of variance.
- Experience in using statistical software such as SPSS or SAS.
- Experience in narrative report writing.

Project Organizational Chart



Smart Start/Healthy Families America, Division of Public Health Organizational Chart

Organizational Structure of the Home Visiting Program



Delaware is poised and ready to comply with the Healthy Families America model-specific prerequisites for implementation, and has an established governance structure internally and externally to establish a successful program that is integrated within the early childhood system. A very thorough description of Smart Start's plan for complying with the model specific pre-requisites through implementation, with fidelity to the model, is outlined in Section 3. The Home Visiting Decision Tree Matrix (Appendix "B") serves as an overall plan for coordination of referrals, assessment, and intake processes across the five different home visiting program models in Delaware. Delaware plans to develop a Centralized Intake ("single point of entry") system, which will be essential to triage and refer families to the most appropriate program.

Stakeholders have agreed to partner with DPH (State's Title V agency and Governor appointed entity) to carry out the home visiting program and expressed this endorsement through the attached Memorandum of Concurrence. Delaware's Updated State Plan was coordinated with the State Early Childhood Advisory Council Plan, the work of the Early Childhood Comprehensive Systems, and other early childhood plans (MCH Title V, Head Start and Child Abuse Prevention) to identify common areas of intersection and ensure that the home visiting implementation activities are coordinated with these existing initiatives.

SECTION VII: PLAN FOR CONTINUOUS QUALITY IMPROVEMENT

Continuous Quality Improvement (CQI) is a systematic approach to specify the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance.

We are committed to perform CQI every six months through use of a detailed data collection plan and a set of proven CQI strategies. Delaware will use CQI to identify high-priority opportunities for improvement, apply a structured approach to continuous review and evaluation of key home visiting processes and personnel, and develop a plan for improvement to execute strategies for high performance that will ultimately benefit families. CQI will be utilized at the local, community, and statewide levels. Delaware will develop CQI reports that address opportunities, changes implemented, data collected, and results obtained.

As described in Section 5, Delaware plans to implement a sophisticated data collection and analysis process. DMIEC-HV Program staff will gather information from each household they visit. A third party evaluator, APS Healthcare Bethesda, Inc. ("APS"), will be used to conduct the CQI evaluation and analysis. This will help to ensure that no bias or conflicts of interest exist. Collaborating with home visiting staff, APS will develop the materials used to collect data to ensure efficiency and effectiveness. All staff will use the same materials to control for quality assurance. Delaware will also identify a CQI program manager, who will work with APS on all activities and to act as a liaison to the home visiting staff.

A series of training sessions will be held to ensure high standards in the data collection and analysis for all personnel responsible for data management and data analysis. The trainings will educate staff on the database for data entry as well as the materials that will be used for data collection. DMIEC-HV staff will have ample time to test out the database and materials and give feedback to APS. APS will incorporate the feedback into the revisions before finalizing the materials.

The Long Term Goals of CQI

CQI is a continuous process that involves all home visiting stakeholders. Delaware is committed to the process and believes it will result in positive outcomes and increased success. Measuring

results and data every six months will allow Delaware to easily track progress and allow for incremental changes to be made along the way to maximize program impact.

The long-terms CQI goals are as follows:

- Enrolling more families into the Delaware programs.
- Providing continuous services for a longer period of time.
- Increasing the number of staff, including adding bilingual staff or community health workers.
- Improving rates of families achieving success.
- Improving rates of families accessing care.
- Expanding opportunities for staff development.
- Increasing capacity to outreach to and build relationships with community partners.
- Updating website or outreach materials to disseminate research and best practices.

The reports that are produced annual and biannually will update all stakeholders on the progress that is being made and what is being done to achieve high rates of success.

Data Collection for CQI Purposes

The DMIEC-HV staff will ask a set of standardized questions to gather data on demographic, utilization and background information and set a baseline for analysis. DMIEC-HV staff will visit each family at least once a month. At each of the first three months, the staff will collect information from these tables:

E. Family Economic Self-Sufficiency;

F. Coordination and Referrals for Other Community Resources and Supports;

0. Demographic and Service Utilization Data.

Details of each of these tables are provided in Section 5.

Concurrently during these three months, the home visitors will provide home visiting services specific to the needs of each family. At three months, the home visitors will then collect the applicable data from these tables:

A. Maternal and Newborn Health;

B. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits;

C. School Readiness and Achievement;

D. Domestic Violence.

Details of each of these tables are provided in Section 5.

The staff will provide each family with the necessary tools, information, and resources needed to assist the family with their specific challenges.

At the end of each month, the staff will input the data into the database. After six months of data entry, the data will be analyzed for trends and reporting inconsistencies (e.g. a home visitor has not visited a participating home assigned to him/her for more than a designated amount of time). A standardized report will be produced that is based on the materials and checklists used by the home visiting staff.

Analysis of Data

APS will perform data analysis every six months or as needed. The six-month timeframe is used to ensure there is enough data to support findings and trends. A comprehensive analysis will be performed annually to produce a report with all findings and trends from the year. This report will compare data with that of the internal baseline (the internal baseline is defined in Section 5). After amassing two years of data, a report will be produced comparing the first year with the second year of the program to highlight the progress made. This will be repeated annually. The standardized reports will update stakeholders on areas where goals are being met, areas of concern, and what still needs to be accomplished. They will be used to make incremental and larger scale changes to programs.

Data on utilization and demographics

The data will be analyzed by:

- Household location.
- Parent's race and ethnicity.
- Parent's education.
- Child's sex.
- Primary language in child's household.
- Length of participation in home visiting program.
- Number of sessions/visits in home visiting program.
- Household income and benefits
- Employment of adult members of the household
- Health insurance status
- Number of households identified for necessary services.
- Number of households that required services and received a referral to available community resources.
- MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community.
- Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies.
- Number of completed referrals

Data on Staff

The data will be analyzed by each staff member to report:

- Frequency of total visits.
- Frequency of visits to each household.
- Type of intervention suggested.
- Frequency of follow-up visits.
- Frequency of closed cases.
- Need to consult with additional colleagues/managers on case.
- Time spent at each household at each visit.

Data on Type of Visit/Intervention

The data will be analyzed by:

- Table (A-E).
- Construct within tables A-E.
- What type of intervention(s) was suggested for each household.
- The type of referral to community resources was made.
- Household progress/compliance with suggested intervention(s).
- If suggested intervention(s) failed, what new intervention(s) was suggested.
- Are certain areas of Delaware more prone to specific challenges/issues.
- Do certain social determinants in households impact outcomes.

Benchmarking

APS will use the data analyzed for comparison within the home visiting programs and comparison with similar programs in other states. This will allow DMIEC-HV staff to develop plans on how to make improvements or implement specific best practices. Based on discussions with home visiting partners nationwide, APS will research which programs are most comparable to Delaware when deciding methods for comparison. APS will take into account, for example, the difference in home visiting scope and demographic make-up of the states.

Benchmarking will also be used to see if there are major differences in the type of care provided within the program. More experienced staff members may be able to share best practices and lessons learned with staff that are not achieving as high rates of success.

Percolating

The data analysis will produce reports for staff that will rank households by priority of needing care. Staff can use the information to determine the frequencies of visits, length of visits and to develop strategies for interventions. This will ensure better time management and efficiency of home visiting personnel.

Annual Home Visiting Staff Survey

APS will conduct a survey once a year to evaluate the effectiveness and service of the home visiting staff members. The survey will be distributed to each household by mail. Each household will be provided with an envelope that will contain the return address and pre-paid postage to be used to mail the completed survey back for analysis. The goal of the survey is to measure how the families rate the care and assistance they receive from the program and program staff. The results will be used to improve processes, best practices among program staff, as well serve as performance measurement for program staff. Furthermore, this survey plan serves as an effective way for the families to feel involved in the CQI process and allows them an open forum share their input. APS will work with home visiting stakeholders to develop the survey methodology and the implementation plan.

Sharing Results

It is essential that the results from CQI activities be shared with all home visiting stakeholders, providers, and DMIEC-HV program staff. The results will be shared various ways to ensure as many people as possible see the results.

Website

A website will be developed that contains information for families on available community resources, access to the latest research on all six benchmark areas, connect families with other families that may experience similar challenges, and allow families a place to ask questions that will be answered by certified home visiting staff. The results from the CQI standardized and annual reports will be posted on the website.

Workshops

Twice a year, APS will hold workshops to share the results of the data analysis with the DMIEC-HV program staff and stakeholders. APS will discuss the trends in the data and the strength and challenges identified in the analysis. Staff can ask APS any questions on the CQI process and offer suggestions on how to improve it.

Learning from Leaders: Staff from all over the state, identified as having high rates of success, will share stories and tools that they use to ensure families are getting the help and support they need. Stakeholders will be able to ask any questions they have and receive honest and direct answers on how to improve skills.

Brainstorming Sessions: Program staff will have the chance to discuss what is working with the program, what are common challenges, and what may need to change. Home visiting staff from different counties can discuss what is and is not working well and begin to implement best practices and proven strategies state-wide. These ideas will be incorporated into program and policy changes.

The following table outlines the proposed CQI activities over the 36 month measurement period. The table will assist in ensuring DE is on track to accomplishing its goals and objectives.

Table 16: Delaware CQI Process

Objective	Activity	Process Measure	Accountability	Time Frame
Develop a comprehensive dataset that will aid in decision making, policy and program changes in Home Visiting	Create a sophisticated data collection system and database	Successful recruitment of a third party evaluator and dedicated CQI manager	Third party evaluator- APS, and CQI manager	Months 0-1
Ensure high CQI standards for data management and data analysis	Develop standardized materials and language that all home visiting staff will use to collect data	Train all personnel on data management and collection	APS and CQI manager	Months 0-1
Gain a better understanding of the families Delaware serves	Collect utilization demographic information and meet with all households to determine areas of concern	Staff has met with each family in the program at least 3 times and imputed data	Home Visiting Personnel	Months 1-3

Objective	Activity	Process Measure	Accountability	Time Frame
Increase rate of families achieving success and accessing care	Provide households with appropriate interventions and strategies, increase use of bi-lingual materials and resources	See an increase in positive outcomes through bi-annual and annual reports	APS, CQI manager and Home Visiting Personnel	Months 3-36
Increasing capacity to outreach to and build relationships with community partners	Involve community partners in the programs and policy changes	Regularly share results from the programs with community members	CQI manager and Home Visiting Personnel.	Months 3-36
Expand opportunities for staff development	Staff attend workshops and trainings	Staff report higher rates of success with households, households give staff high ratings on annual survey	CQI manager and Home Visiting Personnel	Months 12, 24
Increase number of families involved in programs and increase length of time served	Produce percolator reports that rank families in order of priority	Staff are more efficient in care they provide and in determining priority households	APS. CQI manager and Home Visiting Personnel.	Months 3-36
Increase communication throughout the community and state about the Home Visiting Program	Produce bi-annual and annual reports to disseminate information	Share results/reports and hold open forums through trainings, workshops, and website	APS, CQI manager and Home Visiting Personnel	Months 3-36
Achieve significant rates of improvement in programs success from year 1 to year 2 to year 3	Run sophisticated analyses that compare data between each year to the internal baseline.	Perform comprehensive data analysis after each year of program as well as benchmarking to measure success	APS, CQI manager and Home Visiting Personnel	Months 12, 24, 36

SECTION VIII: TECHNICAL ASSISTANCE NEEDS

Technical assistance may be requested in the following areas:

- Implementing home visiting programs that meet requirements for evidence and effectiveness;
- Continuous quality improvement/quality assurance
- Creating and maintaining data and information systems to monitor effectiveness of evidence-based home visiting programs;
- Evaluation of outcomes;
- Development of a Centralized Intake system
- Developing core competencies for Home Visitors; training and professional development
- Fatherhood engagement
- Incentives or strategies for minimizing attrition rates for participants enrolled in the program and to ensure their participation in data collection
- Communication and marketing
- Long-term program sustainability

Through the affiliation process, HFA offers substantial technical assistance to ensure the model is implemented with fidelity and staff are trained by HFA-experienced staff.

SECTION IX: REPORTING REQUIREMENTS

Delaware assures that it will comply with the legislative requirement for submission of an annual report to the Secretary regarding the activities carried out under the program. The reports submitted will address progress made under each program goal and objective, barriers to progress, strategies to overcome barriers, updates/revisions, and program updates (i.e. planning, implementation, administration, evaluation, data collection, CQI efforts, technical assistance needs, etc.).

SECTION X: APPENDICES

Appendices

A) DE Home Visiting Logic Model

B) Home Visiting Decision Tree Matrix

C) Smart Start Transition Timeline

D) DMIEC-HV Program Budget

E) Memorandum of Concurrence

F) Delaware Home Visiting Community Advisory Board (CAB) Membership

G) Biographies of Key Personnel

H) Memorandum of Understanding with the Department of Services for Children, Youth and Their Families

Appendix A

DELAWARE HOME VISITING LOGIC MODEL

Planned Work ***Intended Results***

			Outcomes		
Inputs	**Activities**	**Outputs**	**Initial – Intermediate**	**Intermediate**	**Impact**
Funding Smart Start/Healthy Families America Early Headstart Nurse Family Partnership Parents as Teachers Resource Mothers Community Partners (Prevent Child Abuse DE, Delaware Coalition Against Domestic Violence) State Agency Partners (Department of Services for Children, Youth and Their Families, Division of Substance Abuse & Mental Health, Division of Behavioral Health and Prevention) Community resources	Health & nutrition education Risk assessments Parenting support Nursing assessments of health status or risks Central Intake, Care coordination and referral process Assessing unmet needs and linking pregnant women and families to services Helping to	Educational/Training modules Reproductive life plans Birthing plans Risk reduction goals Nutrition guides Physical activity goals Stress reduction exercises Enrollment in Medicaid or CHIP for those who qualify	↑ Knowledge about having a healthy pregnancy and healthy baby ↑ Awareness of risk behaviors ↑ in consumption of fruits and vegetables ↑ treatment for depression and mood disorders ↑ early entry into prenatal care ↑ women keeping postpartum visit ↑ daily folic acid consumption during pregnancy ↑ intention to exclusively breastfeed	↓ Prematurity ↓ Low birth weight ↑ Management of chronic diseases ↓ Substance abuse during pregnancy including alcohol, tobacco and inappropriate use of prescription drugs ↑ Report Separate Sleeping ↓ BMI over 30 ↑ Exclusive breastfeeding from 0-6 months of birth ↓ Unintentional childhood injuries ↑ Proper birth spacing and/or use of family	Reduced infant mortality Reduced disparity in birth outcomes between AA and White women Healthier women of reproductive age Healthier infants and children Reduced child neglect and maltreatment Integrated health and social service network for home visiting Families are connected to quality information and social support services

	overcome barriers to care Training and modeling proper infant care Collect and share data across programs to measure outcomes and improve quality of home visiting services Adopt core competencies shared among prenatal, infant and early child hood providers Local networking opportunities across the home visiting continuum Nutrition assessments and counseling Mental health assessments and counseling Goal setting			planning services ↑ Children 0-5 with health insurance ↓ Domestic violence ↑ Children 0-5 who complete well-child visits ↑ Children 0-5 who are on track with their immunizations ↑ Children 0-5 receiving comprehensive developmental screening and referral to early intervention services, mental health and other support services ↑ Children 0-5 develop appropriate language and cognitive abilities ↓ Child abuse and neglect reports ↑ Families providing a safe home (safe sleep environment, car seats, fire alarms, etc.) Established continuum of services based upon pregnant women, families and children 0-5 needs between the home visiting	

				network, ensuring timely and coordinated referrals and seamless enrollment across home visiting programs	

Relationship with other programs

Smart Start continues to be an important resource both internally and externally.

A new partner will be the Infant Mortality funded Healthy Women/Healthy Babies Program (HWHB). Women can qualify for free preconception, prenatal and internal care through agencies participating in HWHB. There will be strong communication and collaboration between both programs for referrals and follow-up.

Resource Mothers currently has limited overlap with Smart Start. However, Delaware plans to integrate this program into Smart Start. Resource Mothers are lay health workers who provide social support for pregnant women. Often times they provide translation or transportation services. This program is an excellent "base" program in that it meets limited needs that a large proportion of the at-risk population may have (e.g. language or transportation barriers). Resource Mothers are not equipped to provide the level of health education, assessment and intervention that a public health nurse provides. Although women may receive services by a Resource Mother and a Smart Start nurse, they are not duplicative services.

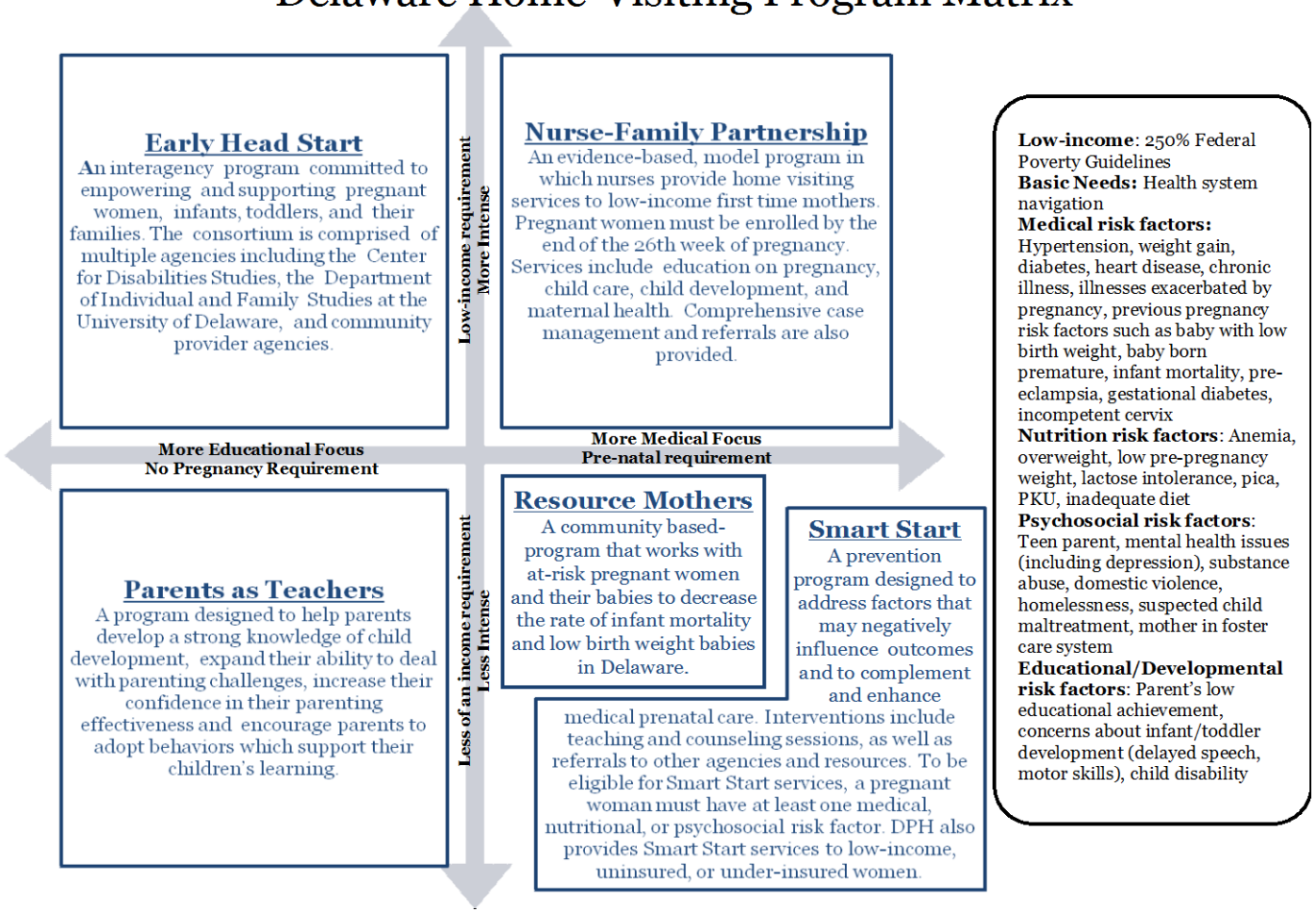
Nurse-Family Partnership is an evidence-based nurse home visiting model being implemented in Delaware by Children and Families First. The target group is low-income, first-time pregnant women who are no more than 28 weeks along in their pregnancy. Nurses remain with their clients until the child's second birthday. Each nurse follows no more than 25 clients. The program has been proven to positively impact maternal economic viability and improve infant health. To ensure there is no duplication or overlap between Smart Start and NFP the following measures will take place:

- Automatic referral of any woman eligible for NFP to Children and Families First. If they qualify for NFP and Children and Families First accepts them, Smart Start will not provide any service for the woman or infant.
- Active participation in the Home Visiting Community Advisory Board (CAB). The MCH Director, Nursing Director and Smart Start Director for Northern Health Services are members of the CAB. This partnership will ensure good communication and collaboration, thus, promoting seamless transition of clients who quality for NFP and those who do not qualify for NFP and need Smart Start services.

It is important to note that given NFP's strict eligibility criteria and the cap on the number of clients one NFP nurse can serve (n=25) there is no doubt Smart Start services will be in more demand than ever.

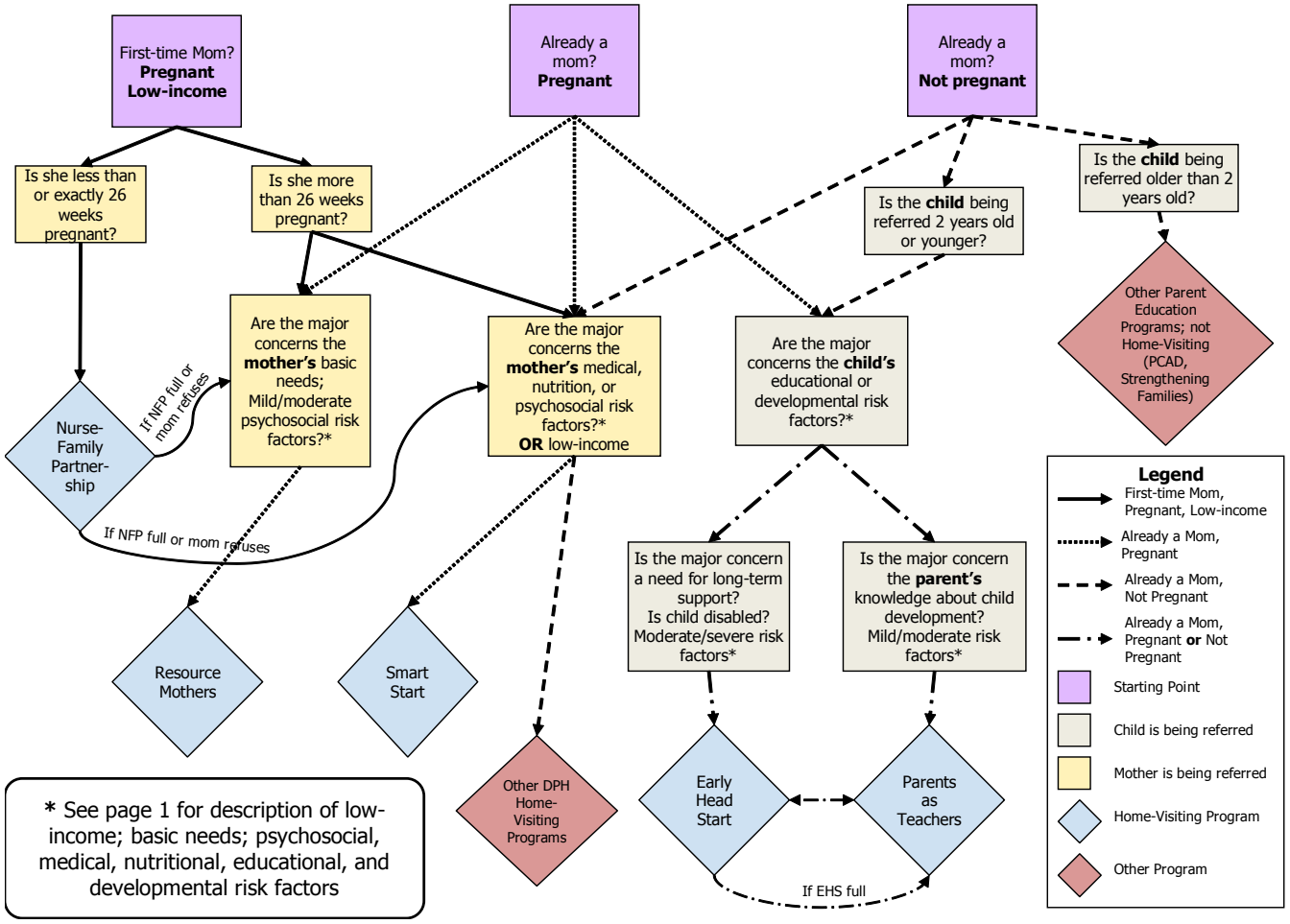
Appendix B

Delaware Home-Visiting Program Matrix



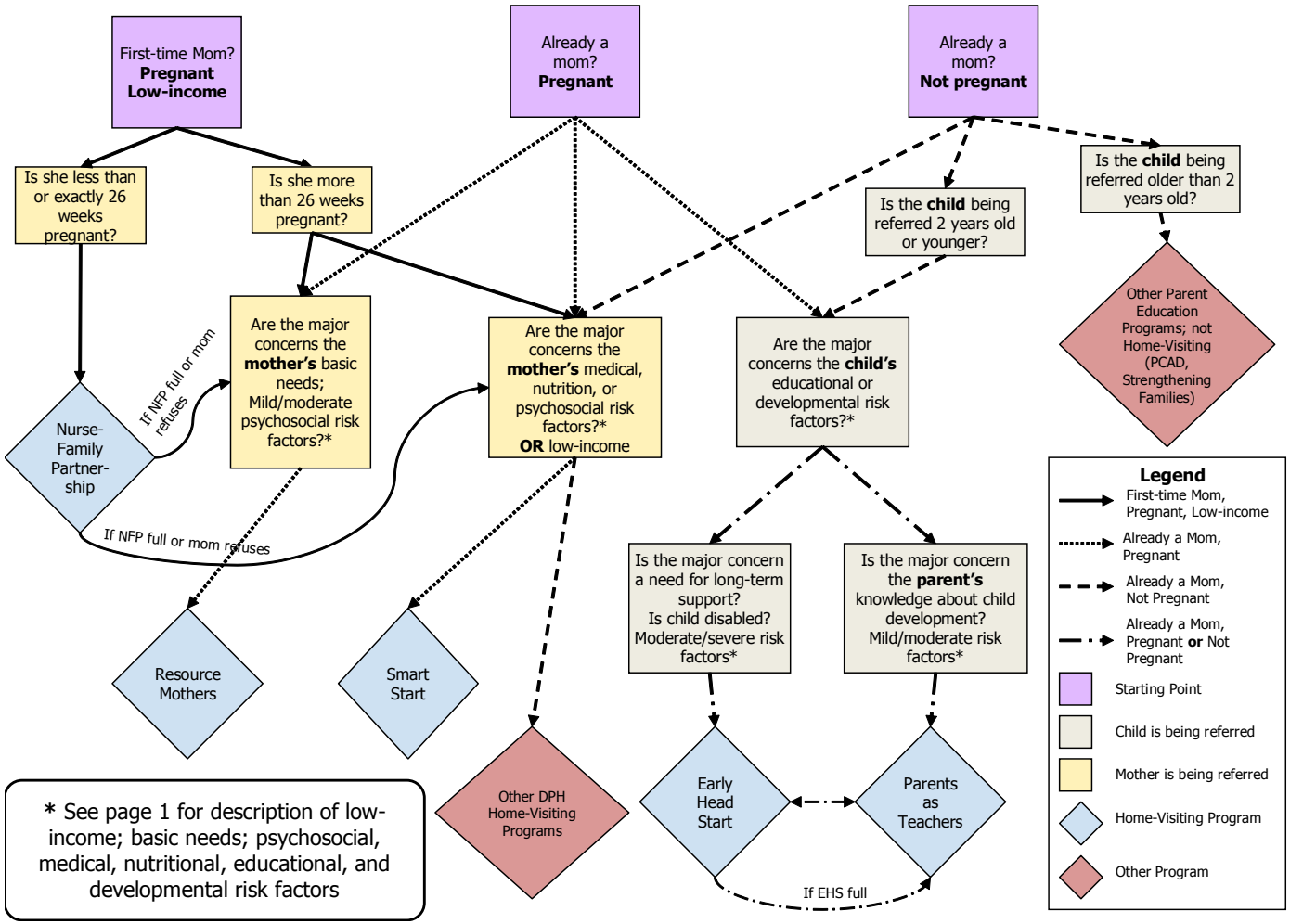
Low-income: 250% Federal Poverty Guidelines
Basic Needs: Health system navigation
Medical risk factors: Hypertension, weight gain, diabetes, heart disease, chronic illness, illnesses exacerbated by pregnancy, previous pregnancy risk factors such as baby with low birth weight, baby born premature, infant mortality, pre-eclampsia, gestational diabetes, incompetent cervix
Nutrition risk factors: Anemia, overweight, low pre-pregnancy weight, lactose intolerance, pica, PKU, inadequate diet
Psychosocial risk factors: Teen parent, mental health issues (including depression), substance abuse, domestic violence, homelessness, suspected child maltreatment, mother in foster care system
Educational/Developmental risk factors: Parent's low educational achievement, concerns about infant/toddler development (delayed speech, motor skills), child disability

New Castle County Home-Visiting Referral Decision Tree

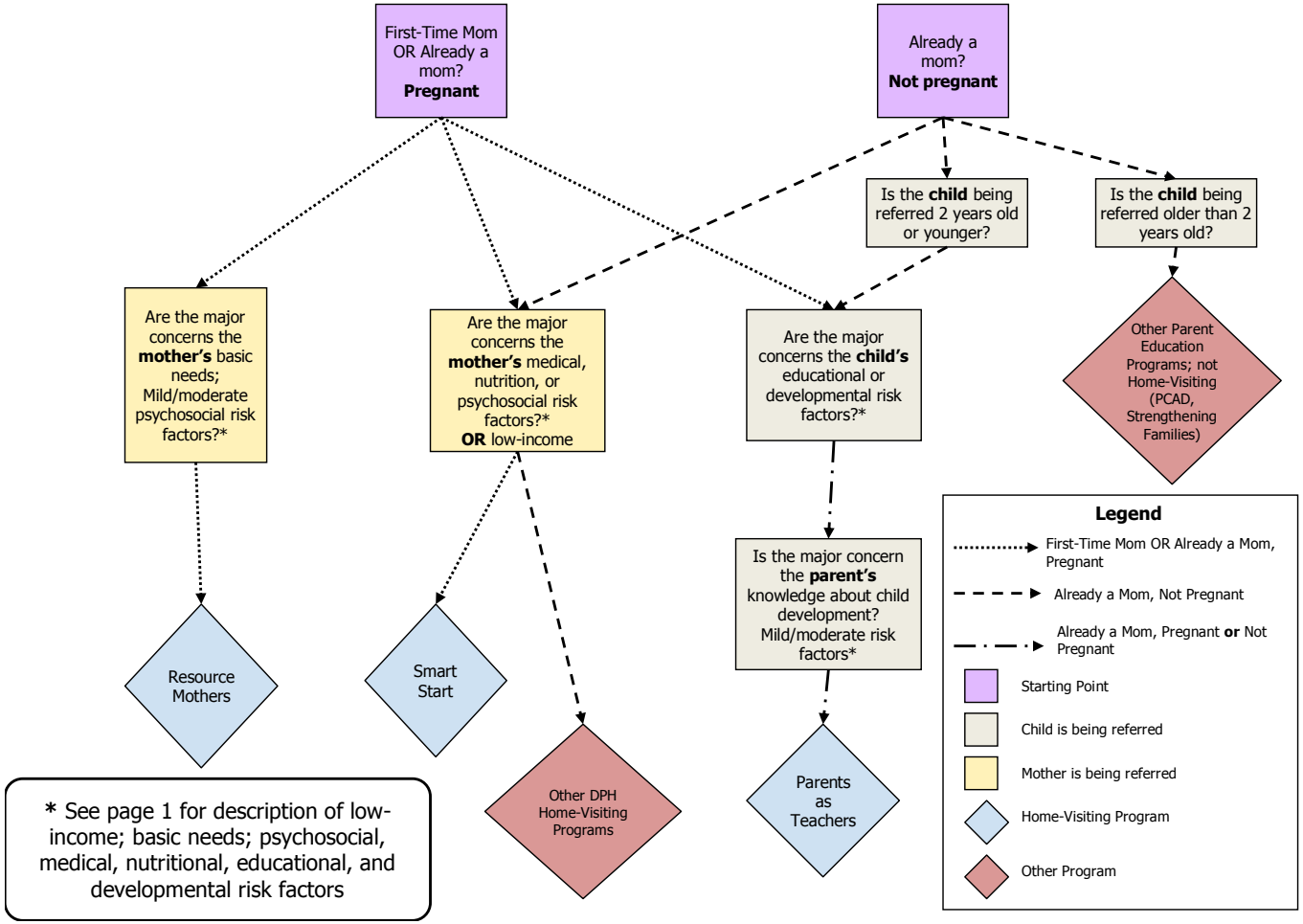


* See page 1 for description of low-income; basic needs; psychosocial, medical, nutritional, educational, and developmental risk factors

Kent County Home-Visiting Referral Decision Tree



Sussex County Home-Visiting Referral Decision Tree



Appendix C

Smart Start Transition to Healthy Families America – Milestones & Timeline
As of June 2011

TIMELINE

Project Start Date: August 2010 **Project Period End Date: September 2011**

Milestones	Responsibility	Date	Status/Comments
PHASE I Research and Analysis			
Affordable Care Act Home Visiting Program Grant Award	Alisa/Leah	July 2010	complete
Formation of Smart Start Steering Committee	Alisa	July 2010	complete
Formation of Smart Start Implementation Workgroup	Leah	August 2010	complete
Statewide level			
HV Community Advisory Board		Ongoing	
- Focus Groups - Gather input from parents, health care providers and child care providers at local and state level on concerns/issues - Provide HFA training and TA and wrap-around training - Encourage development of full continuum - Identify general system concerns and develop solutions - Identify single point of entry and centralized intake system - Develop Central Intake process	- HEA – Sue Myers; Helen; Leah - Leah will coordinate HFA training with support from LaWanda; contract with Prevent Child Abuse DE for wrap-around training - Alisa/Leah to discuss central intake with Leslie Newman (C&FF) - Leah/LaWanda to discuss Resource Mothers with C&FF	- Jan- Feb 2011 - March- May 2011 - March 2011 - July 2011	

- Review current Resource Mothers program parameters and affiliate with HFA Smart Start - Develop and coordinate shared data and electronic system (i.e. Data Cube)	- Alisa/Leah to coordinate with DOE on Data Cube	- Ongoing	
Internal (Division of Public Health)			
SS Steering Committee		Ongoing	
xiii. Provide overall direction xiv. Help to define Work Groups and designate lead facilitators xv. Support/serve as Work Group participant(s) xvi. Generate and facilitate discussion to help develop short and long-term goals xvii. Review & formalize work group recommendations xviii. Make decisions on Implementation Plan • Liaison to the Home Visiting Community Advisory Board • Grant writing • Liaison with third party payers to determine long-term sustainability financing model • Evaluation/assessment • Identify resources, costs, staff, program sustainability and structural challenges • HFA transition oversight • Oversight of the development of a data system	Alisa Leah Nursing Director Northern and Southern Health Service Administrators		
SS Implementation Workgroup			

♦ Implement, review, revise, and monitor Quality Assurance and Training and Technical Assistance Plans; ♦ Develop the policies and procedures and make recommendations to the Steering Committee for incorporation in the overall Plan; ♦ Oversee training and technical assistance for the Smart Start/HFA; ♦ Review annual status reports and other statewide data sets as appropriate, and review the assessments during the credentialing and re-credentialing processes, (TBD) ♦ Advise program manager on the effective implementation of training, technical assistance, quality assurance plans, and other areas of program functioning, ♦ Designate ad-hoc work groups as needed to address specific issues. These smaller workgroups report to the full Smart Start Implementation Workgroup, and issues that cannot be addressed are elevated to the Steering Committee. ♦ Serve as a forum for communication among state trainers, program manager, MCH Deputy Director, home visiting staff (Nurses, social workers, nutritionists).	Leah Jones, Co-Chair Terry Dombrowski, Co-Chair LaWanda Walker, Management Analyst ECCS Administrator Nurses (North and South Health Services) Social Workers Nutritionists	August 2010 – September 2011	Go Live date, whereby the transition phases are fully implemented
Data Team			
• Identify common data sets that we currently collect • Develop a plan for common data collection and tracking • Develop business requirements, business case • RFP and/or vendor decision • Policies and procedures • Development Phase I - JAD sessions and/or development discussions	Leah Jones Alvera Arronson, Management Analyst III (Chair) Crystal Sherman, State Systems Development Initiative Administrator	Dec –Feb 2011 Feb 2011 Sept 2011	

• Phase II-testing • Phase III – Go Live • Initiate standardized data collection system		Nov 2011	
Policy and Procedures Team			

• Review & Update Smart Start manual
  • Get an electronic copy of SS manual
  • Update and write new policies and procedures and incorporate HFA requirements Update/Add Screening tools, forms
  • Identify current successful referral and linkages practices and tools: screening/intake, referrals, coordination, tracking, caseload limits, staff capacity
  • Recommend key components for appropriate, coordinated ENTRY to Smart Start
  • Recommend key components for appropriate, coordinated and seamless "handoff" between programs (i.e. timing, overlap, multi-disciplinary team, continuation for some families due to SA, MH, # visits, location, charting issues, case information)
  • Identify gaps in community supports for families (i.e. How can Resource Mothers support SS?)
  • Modify screening tools
  • Identify points of universal screening and periodic screening
	Kris Bennett, Director of Nursing)/Barb Mengers, Nurse Supervisor (Co-Chairs)
	
	Leah Jones
	LaWanda Walker
		First Draft of Policy and Procedures Manual by July 2011	

Training and Curriculum Team			
• Identify core training topics required by HFA and topics that assist in the development of training modules and monitor training outcomes: Community collaboration Mental health – adult/child Child Development Screening and working with the medical home Substance Use: risks, effects in pregnancy and early childhood development Identifying risks using screening tools (i.e. mental health, family violence, substance use, perinatal depression) Creating home environments that promote health early childhood development Child abuse and neglect: risks, recognition, and reporting Community resources and effective referrals CYSHCN – services and families, linkages, referrals • Plan In-service training • Train staff and implement use of tools • Development of HFA on-site core training • Provide core training • Plan wrap-around training • Develop a tracking system of training completed for all SS staff	Lisl Phelps, Nurse Consultant Bonnie MacCleod, Nurse Consultant (Co-Chairs) Terry Dombrowski, Northern Health Services Clinic Manager (*and Smart Start Program Manager)* Leah Jones LaWanda Walker	Jan –April 2011 Jan –March 2011 March 2011 April –July 2011 May –June 2011	
• Develop staff development/system enhancement topics (“wrap-around” training) • Contract with Prevent Child Abuse – “wrap around training” • Purchase Partners for a Healthy Baby curriculum and Just in Time Parenting Newsletter (JITP)		April 2011 (Modify based on staff input) May 2011 August 2011	
Review findings with SS Steering Committee		Ongoing	

Review & Formalize Recommendations		January 2011	
Ensure collaboration among key partners/stakeholders (i.e. Home Visiting Community Advisory Board)		Ongoing	
PHASE II Phased-in Implementation			
Determine operational procedures based on Healthy Families America critical elements and ensure they are implemented consistently		February 2011	
Implement staff development, training, and standardized curriculum to develop staff core competencies (subject to change)		February – March 2011	
Identify and implement common areas of intersection for "continuum of care" home visiting system model (i.e. central point of intake, database/data collection system, I&R)		July 2011	
PHASE III Outreach and Monitoring			
Develop a Marketing/Outreach Plan		July 2011	
Develop an Evaluation Plan		July 2011	
Monitor systems changes/challenges and be proactive – support new infrastructure: • Leverage new funding sources • Forecast changes in clientele • Forecast changes in technology for data system • Monitor and develop staff training core competencies		Ongoing	

TIMELINE SUBJECT TO CHANGE

Appendix D

BUDGET (July 15, 2010-September 30, 2012)

Home Visiting Budget July 15, 2010 - September 30, 2012

	YR 1	YR 2
Personnel		
BP # 2833 Nursing Supervisor		$51,829
BP # 2715 Registered Nurse III	$51,661	$51,661
BP # 3031 Registered Nurse II	$42,305	$42,305
Subtotal	*$93,966*	*$145,795*
Insurance	$16,769	$25,154
Fringe (26.77%)	$25,343	$38,015
Total Personnel	**$136,078**	**$208,964**
Contractual	**$1,066,494**	**$987,703**
Children & Families First	$673,000	$673,000
HFA Affiliation Costs		
Training @$500/person	$22,500	$13,340
Materials	$7,000	$14,816
Trainer travel/accommodations	$2,500	$2,500
Accreditation ($325/year)	$325	$325
On-site HFA Technical Assistance	*$1200*	*$1200*
Subtotal	*$33,525*	*$32,181*
Prevent Child Abuse DE		
Technical Assistance and Training	$49,400	$49,400
APS Healthcare (Epidemiology contractor)	$128,358	$65,911
Core Solutions (Data System vendor)	$75,000	$75,000
Aloysius Butler & Clark (Marketing and Communications vendor)	$35,000	$20,000
Research Data Analyst (contractual position)	$72,211	$72,211

Supplies		**$35,196**	**$27,500**
$50/year/person		$2,500	$2,500
Educational Supplies - Partners for a Healthy Baby Curriculum: before baby arrives, first six months, 7-12 months, 13-18 months price quote for 50 home visitors, administrators, and program manager		$17,696	$10,000
Educational Supplies - Just in Time Parenting newsletter series		$15,000	$15,000
Equipment (35 Apple IPads @ $629/person + $29.99 monthly service charge for unlimited data in Yr 1. 15 additional Apple Ipads @ $629/person + $29.99 monthly service charge for 50 home visitors in Yr 2.)		**$28,311**	**$27,429**
Travel (1-2 staff representatives to attend two Grantee meetings, which require three days of attendance each.)		**$0**	**$7,793**
Other		**$3,886**	**$4,548**
Personnel costs @ $165.50 per fte per qtr		$1,324	$1,986
Audit Fee (.002 of budget)		$2,562	$2,562
Indirect Costs		**$10,928**	**$16,956**
Indirect costs (based on salaries only) fy11	11.63%		
TOTAL BUDGET		**$1,280,893**	**$1,280,893**
Initial Funding - July 15, 2010-September 30, 2010			
YR 1 - October 1, 2010-September 30, 2011			
YR 2 - October 1, 2011 - September 30, 2012			

BUDGET JUSTIFICATION

CATEGORY	AMOUNT	JUSTIFICATION
Personnel	**$136,078**	
2 Registered Nurse Positions	$93,966	Two nurses will serve as home visitors for the DPH program, Smart Start. Smart Start is currently ongoing certification for

		Healthy Families America.
Insurance	$16,769	Health insurance through the state of Delaware plan
Fringe	$25,343	Fringe benefits at a rate of 26.77%
Contractual	**$1,066,494**	
Children and Families First	$673,000	CFF is an EBHV grantee and per the guidance, $673,000 is allocated to each grantee.
Health Families America Affiliation/Training Costs	$33,525	DPH's home visiting program – Smart Start and the CFF program – Resources Mothers are undergoing affiliation to be come Healthy Families America (HFA) sites. • Forty-five staff will be trained at a cost of $500 per person. • Materials (curriculum costs) are $7,000 • HFA travel costs are $2,500 • HFA annual accreditation is $325 • HFA on-site technical assistance $1200
Prevent Child Abuse Delaware	$49,400	Prevent Child Abuse Delaware (CB-CAP entity) will receive $49,400 to serve as central intake for home visiting referrals statewide.
APS Healthcare	$128,358	APS will provide contracted epidemiological, evaluation and research assistance to the project. This includes data and analysis for the needs assessment.
Core Solutions (Data System)	$75,000	Core Solutions is the contractor selected to develop and maintain the home visiting data system within DPH. Core Solutions is also the EMR for the Division of Public Health and has modules created to collect Birth to Three program data.
Aloysius Butler & Clark	$35,000	Development of brochures and outreach and marketing materials for the Smart Start home visiting program.
Research Data Analyst	$72,211	A Request for Proposals (RFP) will be issued to obtain a full-time master's degree level research analyst to work within the Division of Public Health / Maternal and Child Health Bureau. The contract is budgeted at the level of salary and benefits that corresponds to a Research Specialist III (Pay Grade 17) in the state's occupational classification system (Salary

		$49,005; Health Insurance and Benefits $23,206). The Research Analyst will work 37.5 hours per week. A position description is included as an attachment to this application.
Equipment	**$28,311**	To minimize the data collection burden on the home visitors, 35 Apple IPads @ $629/person will be purchased (one-time cost) in the first year + $29.99 monthly service charge/person for unlimited data.
Supplies	**$35,196**	
	$2,500	Supplies at $50 per person for 50 home visiting staff, administrators and the program manager.
	$17,696	Educational Supplies - Partners for a Healthy Baby Curriculum: before baby arrives, first six months, 7-12 months, 13-18 months price quote for 50 home visitors, administrators, and program manager
	$15,000	Just in Time Parenting Newsletter series
Other	**$3,886**	
Personnel costs	$1,324	DPH personnel costs are $129.75 per FTE per quarter. These include costs for computer maintenance and support services.
Audit fee	$2,562	The audit fee is .002 of the budget and covers DPH costs associated with auditing.
Indirect Costs	**$10,928**	Indirect costs are for salary only. A total of 13.02% covers state, departmental and division overhead.
Total Year 1 Budget	**$1,280,893**	

Maintenance of Effort (MOE) Baseline Expenditure:

Delaware was spending $1,169,639 on home visiting services from State general funds as of March 23, 2010. The MOE is composed of the following:

Department of Education Parents as Teachers Program = $1,121,600

Division of Public Funding of Nurse Family Partnership through Children and Families First = $48,039

Total = $1,169,639

There have been no changes in the MOE as of March 23, 2010 to date.

Appendix E
Memorandum of Concurrence

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

FAMILY HEALTH AND SYSTEMS MANAGEMENT

June 9, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857

Subject: Delaware's Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Updated State Plan

Dear Dr. Yowell,

On behalf of the Delaware Division of Public Health I am pleased to submit the ACA Maternal, Infant, and Early Childhood Home Visiting Program Updated State Plan. This State plan fulfills the third requirement of the ACA legislation as described in HRSA-10-275.

Delaware's Updated State Plan was coordinated with the Child Abuse Prevention and Treatment Act designee, Division of Substance Abuse and Mental Health, Division of Social Services (administers TANF and SNAP), the Division of Public Health's Title V and Injury Prevention programs, and the Delaware Statistical Analysis Center who compiles crime data in the City of Wilmington and some statewide data on Operation Safe Streets and the Governor's Task Force (OSS/GTF), a statewide crime reduction initiative. Supplemental information was also included from partners such as Children and Families First (Evidence-Based Home Visiting Grantee), community stakeholders and sister agencies serving children and families in the areas of child abuse and neglect, mental health and substance abuse prevention.

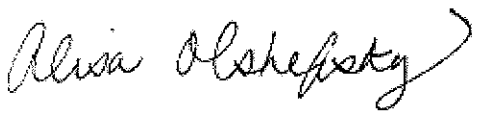
The representatives of the following organizations concur with the Updated State Plan, support the implementation of statewide home visiting in Delaware and are committed to this process as a collaborative partner as is demonstrated by their signatures on page 2 -4.

- Director of the Delaware's Title V agency;
- Director of Delaware's Title II of the Child Abuse Prevention and Treatment Act (CAPTA);
- The State's child welfare agency (Title IV-E and IV-B) – Division of Family Services, Department of Services for Children, Youth and Their Families
- Director of Delaware's State Agency for Substance Abuse Services; and,

- The State's Child Care and Development Fund (CCDF) Administrator;
- Director of Delaware's Head Start Collaboration Office
- The State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act
- The State's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 lead agenc(ies);
- The State's Elementary and Secondary Education Act Title I or State pre-kindergarten program;
- The State's Medicaid/Children's Health Insurance program (or the person responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program)

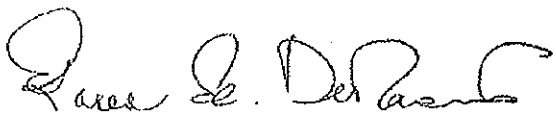
Thank you for the opportunity to enhance services to Delaware's children and families in communities at risk through evidence-based home visiting. We look forward to developing a high-quality, well-coordinated early childhood system that supports the long-term health and well-being of children and families.

Sincerely,



5/20/11
Date

Alisa Olshefsky, M.P.H.
Section Chief
Family Health & Systems Management
Division of Public Health
Title V Director



5/23/11
Date

Karen DeRasmo
Executive Director
Prevent Child Abuse Delaware
CB-CAP

5/31/11

Vivian L. Rapposelli
Cabinet Secretary
Department of Services for Children, Youth and Their Families
State's child welfare agency & CAPTA

Date

5/31/11

Kevin A. Huckshorn, RN, MSN, CADC
Director
Division of Substance Abuse & Mental Health
Director of State Agency for Substance Abuse Services

Date

5-19-11

Barbara McCaffrey
Social Service Senior Administrator
Division of Social Services
State's Child Care and Development Fund (CCDF) Administrator

Date

5/23/11

April Hill-Addison
Director
Delaware Head Start Collaborative Office
Department of Education
Director of Head Start Collaboration Office

Date

Dan Rich — May 23, 2011
Dan Rich
Date
Chair
Delaware Early Childhood Council
State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act

Jim Lesko — 5/23/2011
Jim Lesko
Date
Director
Early Development & Learning Resources
Department of Education
State's Elementary and Secondary Education Act Title I or State pre-kindergarten program

Rosanne Griff-Cabelli — 5/20/11
Rosanne Griff-Cabelli
Date
Part C Coordinator
Division of Management Services
State's Individuals with Disabilities Education Act (IDEA) Part C

Verna Thompson — 5/20/11
Verna Thompson
Date
Early Childhood Specialist
Part B Coordinator
Early Childhood Office
Department of Education
State's Individuals with Disabilities Education Act (IDEA) Part B

Rosanne Mahaney — 5/20/11
Rosanne Mahaney
Date
Director
Division of Medicaid and Medical Assistance
State's Medicaid/Children's Health Insurance program

Appendix F
DMIEC-HV Community Advisory Board Members

Name	Agency or Affiliation	Role
Vicky Kelly Psy.D., LCSW, MHA	Deputy Director, Division of Prevention and Behavioral health, Children's Dept.	CFF Consultant; represent Department of Services for Children, Youth and their Families
Paul Solano Ph.D.	University of DE	Local Evaluator
Leslie Newman	CEO of CFF	Leveraging public and private support for project; member of DE Children's Policy Council and other advisory groups
Karen DeRasmo	CB-CAP	Technical assistance; funding; collaboration on inventory, centralized intake, and provider forum
Judy Herman Ph.D., RN	School of Nursing, UD	Chair nurse recruitment subcommittee; develop focus groups for process evaluation; assist with cross site child and family outcome evaluation
Alisa Olshefsky, MPH	Director Maternal & Child Health/Div. Public Health	Identify public funds; access to epidemiologists with statistics from electronic birth records; leverage funding support
Norma Everett	Nemours Health and Prevention Services	Technical assistance
Roseanne Griff-Cabelli	Child Development Watch, Part C, Public Health	Technical assistance; coordination of care
Dr. David Paul	Chair, Healthy Mother And Infant Consortium	Technical assistance
Leah Jones	Deputy Director, Maternal & Child Health/Div. Public Health	Technical assistance
Deb Ehrenthal MD	Director Maternal Health, Healthy Beginnings Program, Christiana Care Health System	Technical assistance; collaborate on screening tool; collaborate on training plan for health providers
Terry Dombrowski RN	Nurse Program Manager for Smart Start Program, Div. Public Health	Technical assistance; collaborate on inventory, centralized intake, and provider forum; participate in nurse recruitment,
Janet Carter	Program Administrator, Dept. of Education, Parents As Teachers Program and Head Start	Collaboration on inventory, centralized intake, and provider forum
Amy Harter	Supervisor, Early Head Start, University of DE	Collaboration on inventory, centralized intake, and provider forum
Tara Taylor	CFF, Program Manager of Resource Mothers Program	Collaboration on inventory, centralized intake, and provider forum
Donna Bratton	CFF, IT Team	Developed electronic survey for Inventory
Christine Cannon	Retired Nurse and Member of Arsht	Technical assistance

	Cannon Fund	
Maryann Younger	United Way of DE	Local Funding, 211/DE Helpline
TBD - Vacant	Div. of Public Health/ ECCS Coordinator/ Help Me Grow/Project LAUNCH	Technical assistance; collaboration in planning inventory, centralized intake, and provider forum
Anne Pedrick	Director of Child Death, Near Death, & Stillborn Commission	Technical assistance, statistics on child death and related outcomes
Rosalie Morales	Office of the Child Advocate	Technical assistance, family court statistics, collaboration on inventory and centralized intake
Kirsten Olson	CFF, Director of Development	Planning for public relations; development of statewide marketing plan; and communication. Leveraging private funding.
Kelli Ensslin, Esq.	Office of Child Advocate	Technical assistance
Vikki Benson	Manager, NFP	Feedback on program
Midge Barrett	Formerly with Nemours, Independent consultant, Board President of Delaware Ecumenical Council on Children and Families	Interested citizen
Dick Christopher	President, Patterson Schwartz Real Estate Member, Nemours Board	Interested citizen Leverage private funding
Pat Nelson	University of DE Cooperative Extension, Great Beginnings, Just in Time Parenting Newsletter	Interest in parent education and child development
Carol Post	DCHDV	Interest in domestic violence Technical assistance and training
Kathy Cannatelli	Christiana Care	Interest and provider of maternal and child health
Heidi Beck	Early Head Start	Interest in child development, school readiness, and parent education
Catherine Townsend	Delaware Physicians Care, Inc.	Medicaid MCO
Whitney Williams	Parents As Teachers (NCC)	Interest in parent education and child development
Janet Cornwell	PAT (Kent/Sussex)	Interest in parent education and child development

Appendix G
DMIEC-HV Key Personnel Biographies

1) Alisa Maria Olshefsky, M.P.H

2) Leah A. Jones, M.P.A

3) Eileen T. Dombrowski, M.S.N

BIOGRAPHICAL SKETCH

NAME	POSITION TITLE
Alisa Maria Olshefsky, M.P.H.	**Section Chief – Family Health and Systems Management**

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
California State University, San Marcos, CA	BA	2002	Social Science/Sociology
San Diego State University, San Diego, CA	MPH	2005	Health Services Administration

A. PROFESSIONAL EXPERIENCE

Clinical Trials Coordinator 1996
Internal Medicine Associates-San Diego, CA

Health Educator 1997
Professional Medical Supply-El Cajon, CA

Senior Community Health Program Representative/ Immunization Consultant 1997-2001
Division of Community Pediatrics-University of CA, San Diego

Community Health Program Supervisor/ Evaluation Manager 2001-2006
Division of Community Pediatrics-University of California, San Diego

Lead Instructor 2003-2005
Mother, Child and Adolescent HIV Program-University of California, San Diego

Chronic Disease Bureau Chief 2006
Delaware Department of Health and Social Services/ Division of Public Health, Dover. DE

Family Health and Systems Management Section Chief 2008
Delaware Department of Health and Social Services/ Division of Public Health, Dover. DE

B. CONSULTING EXPERIENCE

Health Education Consultant 2001-2002
Parent's Institute-San Diego, CA

Editor 2004
San Ysidro Health Center

Surveillance Project Director 2005-2006
San Ysidro Health Center and California Department of Health

C. PUBLICATIONS

Zuniga ML , Blanco ES, Sanchez L, Carroll S, **Olshefsky AM**,. (2009). Preventing HIV and Other Sexually-Transmitted Infections and Reducing HIV-Stigmatizing Attitudes in High-Risk Youth: Evaluation of a Comprehensive Community-Based and Peer Facilitated Curriculum. Journal of Vulnerable Children & Youth Studies, 4(4), 333-345.

Torres K, Zive M, Scolari R, **Olshefsky AM**, Zuniga ML. (2008). Acceptance of a Nutrition Curriculum for HIV-Positive Latinos Living on the US/Mexico Border. Journal of Transcultural Nursing, 19(2), 107-113.

Olshefsky AM, Zive M, Scolari R, Zuniga M. (2007). Promoting HIV Risk Awareness and Testing in Latinos Living on the US Mexico Border: The Tu No Me Conoces Social Marketing Campaign. AIDS Education and Prevention, 19(5), 422-435.

Zuniga ML, Baldwin H, Uhler D, Brennan J, **Olshefsky AM**, Mathews WC. (2007). Supporting Positive Living and Sexual Health: A Behavioral Intervention. Journal of AIDS & Behavior, 9(11), S58-71.

Zuniga de Nuncio ML, Organista KC, Scolari R, **Olshefsky AM**, Schulhof R. (2006). Exploring Care Access Issues for HIV+ Latinos Living in the San Diego/Tijuana Border Region. Journal of HIV/AIDS and Social Services, 5(2), 37-54.

D. RESEARCH SUPPORT

Zúñiga, Maria Luisa - Principle Investigator 7/1/200- 6/30/2005
Southern California Border HIV/AIDS Project
Major goals: Improve access to HIV care for Latinos/as in the US/Mexico border region.
Role: Evaluation Manager

Zúñiga, Maria Luisa - Principle Investigator 10/2003- 9/30/2007
Primary Prevention with Positives Behavioral Modification Project
Major goals: Reduce transmission of HIV by targeted prevention interventions.
Role: Evaluation Manager

Zúñiga, Maria Luisa - Principle Investigator 2/1/2004-1/31/2006
Peer Education and Empowerment Program
Major goals: Reduce HIV transmission and unplanned pregnancies among high-risk youth.

Role: Evaluation Manager

Zúñiga, Maria Luisa - Principle Investigator 10/1/04-9/30/2007
Teen Choices Mentoring Program
Major goals: Increase academic achievement and overall well-being of at-risk youth by mentoring.
Role: Evaluation Manager

Inter-agency Subcontract 11/2003- 1/1/2006
Continuous Quality Improvement Workshop
Major goals: Work with community based organization to create and implement continuous quality improvement programs.
Role: Lead Instructor

Leah A. Jones, M.P.A. is the Maternal and Child Health Bureau Chief with the Delaware Health and Social Services' Division of Public Health, within the Family Health and Systems Management Section, which houses most maternal and child health programs. Leah is responsible for direct oversight of the Title V Maternal and Child Health Block Grant Program, the State Systems Development Initiative, the Children with Special Health Care Needs Program, Early Childhood and Comprehensive Systems, the Autism Registry and the Birth Defects Registry and the Newborn Screening Programs (Metabolic and Hearing).

As the Director of Planning & Policy for the Delaware Health Care Commission, main responsibilities included research and policy development of complex and dynamic issues of the financing and delivery of health care; Consensus building and encouraged public-private collaboration around important health policy issues; Assisted in the coordination of Commission activities; Project management of health professional workforce development activities, including the State Loan Repayment Program; and Support to the Commission and its committees in carrying out short and long-term work plans.

Leah was born and raised in Connecticut, and moved to the State of Delaware to attend the University of Delaware, where she obtained a BS with a major in Family and Community Services with a focus in Gerontology. Leah also completed her Masters in Public Administration in 2001 from the University of Delaware with concentrations in Health Policy and State & Local Government Management. During her graduate studies, Leah served as a Legislative Fellow with the Delaware General Assembly in the Senate and supported the Senate Health & Social Services Committee with legislative research and policy analysis. In addition, she interned for the Delaware Health Care Commission and assisted with several different health care policy initiatives and research projects as a graduate research assistant. Post graduate work, Leah was employed with the Delaware Health and Social Services' Division of Services for Aging and Adults with Physical Disabilities, as the Caregiver Program Administrator for Delaware's Family Caregiver Support Program under the federal guidelines of the Older Americans Act for over three years and was responsible for program development and management, implementation, and evaluation. Leah also worked as the Executive Assistant to Cabinet Secretary Vincent P. Meconi, Delaware Health and Social Services, under Governor Ruth Ann Minner's Administration.

EILEEN T. DOMBROWSKI
5 Green Meadow Court
Newark, Delaware 19711
Telephone: (302) 737-4456 **RESUME OF QUALIFICATIONS**

EMPLOYMENT HISTORY:
. Current Position: Clinic Manager, Community Services, DPH, 1/2002-present

Current Duties:

- Supervises directly or indirectly all Community Services staff who: provide home-based care-management services focusing on predominately high-risk pregnant women, infants & their families; HIV/AIDs team that provides case management services for those living with HIV/AIDS; Investigation of Communicable Diseases, and office support staff assigned to Community Services.
- Provides annual performance plans & evaluations for all directly supervised staff
- Monitors annual performance plans & evaluations for all indirectly supervised staff
- Assures management coverage during administrator's absence
- Provides coverage for other clinic managers
- Keeps NHS Administration informed of all client-focused issues where the Deputy Attorney General is involved, provides direction for legal issues, e.g. subpoenas
- Develops management plan for area of responsibility to include program implementation, staffing coverage and quality assurance.
- Develops policies and procedures to implement programs at the community and or clinic level .e.g. developed the HIPAA guidelines for field staff
- Develops, monitors contracts.
  - Provides leadership in the Smart Start/ Kids Kare/ Home Visiting Program and Communicable Disease review process and actively leads/supports implementation of recommended changes as appropriate
  - Provided leadership and direction to staff , and developed protocols and guidelines for the implementation of the Home Visiting Program for first time parents in July 2005.
  - Actively supports the existing relationship with DFS by operationally supporting DFS MOU guidelines for field services
  - Participates in the development of internal policies & procedures for Smart Start, Kids Kare, HIV/AIDS case management services, Communicable Disease Investigations, Home Visiting Program for first time parents and/or field guidelines and other across the board NHS/DPH/DHSS activities
  - Provided leadership and direction to staff for the implementation of the pilot program for FIMR, Home Visiting Program for 1st time parents, Cribs 4 Kids Program, H1N1 immunization program in elementary schools.
  - Identifies programmatic priorities for Smart Start and Kids Kare, HIV/AIDS case management, Communicable disease, and Home Visiting Program & monitors through quality assurance
  - Utilizes QA findings as opportunity for process/system improvement

- Provides regular reports reflecting clients served & services provided to Deputy & County Administrators
- Provides QA/QI reports to Deputy & County Administrators
- Continues to give direction for and support operations of the Community Services (CS) Policy Committee, CS Quality Assurance Committee, CS Education Committee and CS Employee Recognition Committee
- Assumes responsibility for PHN coordination of Red Cross Shelter disaster response as needed
- Maintains appropriate staffing coverage for all services by working closely with other clinic managers as needed
- Becomes knowledgeable about issues impacting infant mortality & morbidity . Participating on the Healthy Mothers Healthy Infants consortium as a result of involvement of Infant Mortality Task Force.
- Participates in planning for local DPH bioterrorism response activities, appointed manger of Records management Section of the NEHC, and successfully managed the Smallpox Immunization process in New Castle County as well as managing mass flu clinics, and Red Cross shelters.
- Participates in health planning for the City of Wilmington, New Castle County and/or Delaware
- Participates in local community meetings, events & task forces to represent DHSS/DPH (to include the New Castle County Perinatal Outreach Committee, Wilmington Healthy Start monthly consortium meeting), and March of Dimes Planning group.
- Recommends programs and services to meet the community's needs
- Encourages staff participation in community activities focused on identified areas of need such as infant mortality & morbidity and HIV/AIDS
- Remains knowledgeable of trends that may impact DPH services
- Works with central office Program Managers, as appropriate, coordinating program activities at the local level & maintaining the local role with the community
- Strives to include all necessary individuals and/or agencies when coordinating organizational or community partners
- Monitors supply, contract and grant expenditures for unit.
- Develops budget for contracts and other expenditures.
- Develops spending plan for budget.
- Maintains appropriate & adequate supplies for all programs with Community Services
- Maintains fiscal records and submits readily upon request
- Provides data collection and data analysis for specific programs, such as Field services, Smart Start, Kids Kare, and HIV Case Management, and Home Visiting Program.
- Monitors contracts for services, as needed
- Participates as member of team for site visits for contracts for Infant Mortality Task Force Recommendations
- Assists other managers with site visits for contract audits

Team Leader, DPH/ Community Services
4/96 to 1/2002

. Team Leader duties include supervision of 6 nurses, 2 social workers, 1 outreach worker, 1 interpreter in the provision of home-based maternal/child services. Triage, assignment of cases, evaluation of staff. Assisting manager with grant writing, committee work, developing and implementing standards.

PHNIII, DPH/ Community Services 8/86 to4/96
Duties as PHNIII included provision of home-based services to high-risk pregnant women and their families. Making critical assessments of health and psycho-social needs of families and communities. Develops plans, provides case management and/or delivers care in complex situations as part of Community Services Team. Performs as liaison with managed care organizations and other community agencies

University of Delaware 3/77-12/78 & 10/82- 5/83
Duties: Teaching, managing, and guiding senior BSN nursing students in Community Health Nursing experience in maternal/child home and clinical settings. Daily supervision of patient care, documentation of standards, student evaluations, problem solving, and grading of student assignments.

University of Delaware 1/2001- Sept 2003
Course Coordinator/Adjunct Faculty
Coordination of Nursing 442 Community Health Nursing for RN to BSN distance learning students. Currently class is in video format and duties include directing students, grading assignments, and preceptoring students through course. Present duties include adapting the class for WeB-CT format, preparing the delivering the class content, revising the curriculum, evaluating the students performance, and exploring the technology to promote community health principles and practice to distance students in a problem-based learning theory.

Division of Public Health , Public Health Nurse III 7/69-6/75
nursing care plans and delivery of services of health teaching and disease promotion through home visits and clinical services. Provided home -based services for high-risk families, taught childbirth classes at DAPI, and supervised clinical services including TB,STD,WIC, Child Health. Duties included assisting with exams, completing assessment, giving immunizations and medications,and other procedures as well as direct supervision of staff. Supervised orientation of new staff and students.Collaborated with other agencies.

Education
University of Delaware
Newark, De
9/65-6/69
Nursing
BSN

University of Delaware

Newark, De
9/96-12/2000
Nursing Administration
MSN

Appendix H

Memorandum of Understanding with the Department of Services for Children, Youth & Their Families

MEMORANDUM OF UNDERSTANDING
BETWEEN
DIVISION OF PUBLIC HEALTH
AND
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES

This Memorandum of Understanding (MOU) between the Division of Public Health, hereafter referred to as DPH, and the Department of Services for Children, Youth and Their Families, hereafter referred to as DSCYF, has been jointly developed for the agencies. This MOU and the policies established herein will go into effect on the date this document is signed or on June 7, 2011, whichever occurs later.

This MOU shall not be altered, changed, modified or amended except by written consent of both parties to the Agreement. This MOU is to remain in effect for 5 years from the effective date unless terminated or amended. Either party may terminate this MOU through written notice to the other, at least 30 days prior to the effective date of such termination.

Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Agreement unless stated to be such in writing, signed by an authorized representative of the Department and attached to the original Agreement.

Purpose

This MOU is entered into for the purpose of improving the maternal and child health public health service delivery and public health outcomes for underserved populations throughout the State of Delaware. In particular, the implementation of this MOU seeks to ensure measurement of key indicators for families who receive nurse home visitation services, one of those being the prevention of child maltreatment. In accordance with the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Grant, the DPH and DSCYF agree to collaborate in sharing data on families served through DPH's home visiting program.

Responsibilities

Whereas, the Division of Public Health (DPH) is the agency responsible for administering the Title V Maternal and Child Health Block Grant and has further responsibility for the following services: home visitation, enhanced services for at-risk pregnant women and health promotion for maternal/infant health,

and whereas the Department of Services for Children, Youth and Their Families (DSCYF) through its Division of Family Services (hereafter referred to as DFS) is

responsible for child welfare (Title IV-E and IV-B) and administering the Child Abuse Prevention and Treatment Act (CAPTA) in the State of Delaware,

and whereas the DPH and DSCYF/DFS agencies are jointly charged with direct responsibility to achieve improved outcomes in child health, including the prevention of child maltreatment,

now, therefore, be it resolved that the Division of Public Health and the Department of Services for Children, Youth and Their Families/Division of Family Services agree to the following:

- DPH will enroll at-risk pregnant and post-partum women in home visiting services.
- DPH will solicit voluntary participation in the evaluation of the home visiting program through the use of an Institutional Review Board (IRB) approved informed consent document. Documentation of IRB approval will be provided to DSCYF/DFS.
- The informed consent document will include authorization to receive information from DSCYF/DFS on reported suspected maltreatment and substantiated maltreatment of children enrolled in the home visiting program.
- DPH will maintain copies of all signed informed consent documents for clients enrolled in the home visiting program and provide these to DSCYF/DFS as requested.
- DSCYF will provide DPH with data on the number of reported and substantiated cases of child maltreatment for children/families enrolled in the home visiting who have signed an informed consent document allowing the release of this information to DPH. This information will be provided in aggregate without identifying specific clients.

The parties agree that no information obtained pursuant to this Agreement may be released in any form except in compliance with applicable laws and policies on the confidentiality of information and except as necessary for the proper discharge of the agencies' obligations under this Agreement.

Certification:

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Rita M. Landgraf

Rita M. Landgraf
Cabinet Secretary
Department of Health & Social Services

6/3/11

Date

DIVISION OF PUBLIC HEALTH

Paul R Silverman

for **Karyl T. Rattay, MD, MS, FAAP, FACPM**
Director
Division of Public Health

6/3/11

Date

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

Vivian L. Rapposelli
Cabinet Secretary

6/6/11

Date

Laura Miles

Laura Miles
Director
Division of Family Services

6/3/11

Date