



**Delaware Child Death Review Commission**  
**State of Delaware**  
**Home Visiting Committee Report**



Final Report

March 14, 2022

## Acknowledgments

The CDRC would like to thank the many individuals who provided their thoughts, time, and energy to this report. It was a collaborative effort from many different agencies and entities. Many individuals prepared reports, presentations, and shared their passion for home-visiting services. A special thanks to the Lt. Governor Bethany Hall-Long for her continued advocacy to improve home visiting for families in Delaware.

## Membership

### **Committee Chair**

Aleks Casper, Child Death Review Commissioner (CDRC), Fetal Infant Mortality Review (FIMR) NCC Chair

### **Committee Members**

Stephen M. Groff, Director, Division of Medicaid and Medical Assistance (DMMA)  
Kathleen Dougherty, Chief, Manage Care Operations

Karen DeRasmo Executive Director, Prevent Child Abuse Delaware  
Kellie Turner, Acting Executive Director

Kelly Ensslin, MSW, Esq., CWLS, Chief of Legal Services, Office of the Child Advocate

The Honorable Lt. Governor Bethany Hall-Long  
Staff members Edwin Hernandez-Vargas and Georgina Class-Peters

Kimberly Krzanowski, Director, Office of Early Learning, Department of Education

Trinette Ramsey, Division of Family Services

Leslie Newman, Chief Executive Officer, Children & Families First (CFF)  
Kirsten Olson, Chief Executive Officer, CFF

Amber D. Shelton, Ph.D., Office of Early Learning, Delaware Department of Education

Crystal Sherman, Chief, Maternal and Child Health Bureau, Division of Public Health (DPH)

Christine Stoops, Co-State Leader for Delaware Parents as Teachers

Megan McNamara Williams, Health Care Association

Christy Wright, Home Visiting Program Administrator, DPH

### **Child Death Review Staff**

Kim Liprie, Child Death Review Coordinator

Anne Pedrick, MS, Executive Director

Marilyn Sherman, MSN, RNC, CPHQ, Nurse Educator

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## Executive Summary

At the February 22, 2019, quarterly CDRC meeting, the CDRC annual report<sup>1</sup> data was reviewed, highlighting high-risk families' ongoing underutilization of home visiting. A motion was accepted that a committee would be established with the following charge: *Establish a home visiting (HV) committee to overcome barriers to establish a HV service system for at-risk families. The committee shall address referrals, services, funding, and outcome measures.* Once established, this core committee would review previous recommendations from the Child Protection Accountability Commission (CPAC) and the CDRC from the 2018 Joint Commission retreat. In addition, this core group would be educated broadly on what occurs nationally and locally regarding home visiting. It was expected that this analysis would take eighteen months to draft a report. However, the pandemic and staff turnover slowed down the timeline for release. The goal of the full report was to develop strong recommendations to address the barriers in providing Delaware families with evidence-based home visiting services. To that end, the committee has accomplished its goal. However, the recommendations highlight a need for resources and systems improvement to make the services readily available to all Delaware families and alleviate referral gaps. We can and must do better to meet the needs of Delaware's children and families. The committee identified several areas for continued improvement.

Recommendations include the following:

- 1. The State of Delaware should increase funding to expand the current evidence-based or promising practice home visiting programs.**
- 2. The Division of Public Health shall establish a full-time, Home Visiting Outreach Director position or an Office of Home Visiting**
- 3. The Department of Education should consider embedding Parents as Teachers programs into child care centers.**

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<sup>1</sup> [Reports - Child Death Review Commission - Delaware Courts - State of Delaware](#)

4. **The Department of Services for Children, Youth, and Their Families shall include eligible evidence-based home visiting programs in their state implementation plan of the Family First Prevention Services Act.<sup>2</sup>**
5. **The Delaware Perinatal Quality Collaborative should work with the Delaware Birthing Hospitals to implement policies that allow nurses to educate and refer parents to home visiting based upon presenting high-risk concerns.**
6. **The Division of Public Health should review this report and utilize as a reference when writing their future Home Visiting Annual Report<sup>3</sup>.**

## Background and Committee Purpose

The Child Death Review Commission (CDRC) 's primary purpose is to prevent future child and maternal deaths. This process involves a retrospective system review intended to provide meaningful, prompt, system-wide recommendations to prevent future deaths and improve services to families. As a result of its work, the CDRC has been tracking the utilization of home visiting in the fatality review panels since 2015<sup>4</sup>. In reviewing a child's death, high-risk families are often not referred to home visiting, or they do not accept the services given to them. Evidenced-Based Home visiting is a protective factor against child death and other poor outcomes. It has also been linked to improving maternal health<sup>5</sup>.

"Home visiting is a prevention strategy used to support pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent child abuse and neglect."<sup>6</sup> As seen in Chart 1 below, from the Federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)<sup>7</sup>, Performance measures impacted by home visiting are comprehensive for maternal and child health and correlate with the purpose of CDRC. #

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<sup>2</sup> [Family First Prevention Services Act \(ca.gov\)](#)

<sup>3</sup> [Bill Detail - Delaware General Assembly](#)

<sup>4</sup> [CDRC-2020-Home-Visiting-infographic.pdf \(delaware.gov\)](#)

<sup>5</sup> [Home Visiting Evidence of Effectiveness \(hhs.gov\)](#)

<sup>6</sup> [Home Visiting: Improving Outcomes for Children \(ncsl.org\)](#)

<sup>7</sup> <https://mchb.hrsa.gov/sites/default/files/mchb/about-us/program-brief.pdf>

**Figure 2: Benchmark Domains and Associated Performance Measures**



Chart 1

"Home visiting improves maternal and child health and has been shown to reduce infant mortality, preterm births, and emergency room utilization." Home visitors educate parents about postpartum care, infant safe sleep practices, screen for maternal depression<sup>8</sup> and intimate partner violence. According to the American Congress of Obstetricians and Gynecologists (ACOG), between 14% and 23% of women experience depression during pregnancy<sup>9</sup>. If the depression is not treated, preterm birth and delayed infant development are likely increased.<sup>10</sup> These services are voluntary and can be conducted by nurses, social workers, early childhood educators, or other professionals depending upon the type of program.

#### CDRC Delaware home visiting data

The CDRC only sees the worst outcomes when an infant has died, but many of these families are high-risk with many social determinants of health that could impact their health. As stated above, the research supports that home visiting reduces preterm birth and death risk.

The 2021 data (released in the CDRC annual report- May 2022) are captured below in Chart 2.

<sup>8</sup> [Pregnancy-to-Postpartum v05.pdf \(ncsl.org\)](#)

<sup>9</sup> [Depression During Pregnancy: American Pregnancy Association](#)

<sup>10</sup> [Depression of either parent during pregnancy linked to premature birth -- ScienceDaily](#)

**CDRC FIMR Home Visiting data**

	<b>2021</b> (n=60 cases)	<b>2020</b> (n=52 cases)	<b>2019</b> (n=58 cases)	<b>2018</b> (n=45 cases)
Home visiting referral made	4%	14%	4%	2%
Lack of home visiting (eligible)	61%	44%	60%	58%

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**CDRC Child Death Review (CDR) and Sudden Death in the Young (SDY) Infants-Home Visiting data**

	<b>2021 (n=9)</b>	<b>2020 (n=13)</b>	<b>2019 (n=13)</b>	<b>2018 (n=16)</b>
<b>Home visiting referral made</b>	22%	42%	46%	50%
<b>Home visiting enrollment</b>	22%	15%	0%	19%

Chart 2

In addition to the CDRC data, several recommendations regarding the improvement of home visiting have been made by the CDRC and CPAC in Joint Commission Action Plans.

2016-2017 Action Plan

1. Consider requiring birthing hospitals to make an evidence-based home visiting program referral for every at-risk newborn at discharge. Train home visiting staff to recognize child abuse risk factors and report visit findings to the medical provider for the newborn, including the inability to schedule or complete a visit.

Agency Responsible: Delaware Home Visiting Community Advisory Board, Delaware Healthy Mother & Infant Consortium; Timeframe: 12 months

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2018-2019 Action Plan

1. Create an automatic medical referral for evidence-based home visiting services in the standard nursing admission orders for every Delaware birthing hospital when the mother comes into labor and delivery, and the newborn is at risk. This referral should have a pre-checked box with the ability to opt-out if delineated risk factors are not present.

Agency Responsible: CDRC/Delaware Perinatal Quality Collaborative (DPQC); Timeframe: 12-18 months.

Update: CDRC presented this recommendation to the DPQC on 8/23/18. A nurse cannot give this referral but must come from a physician. DPQC decided that this issue needed to go before the Home Visiting Community Advisory Board (HVCAB). Their determination that nurses could not implement the referrals was consistent with DPQC.

Path forward: See recommendations for the proposed resolution of this recommendation.

2. Advocate to DHSS and the General Assembly for Medicaid reimbursement for all evidence-based home visiting providers in Delaware.<sup>11</sup>

Agency Responsible: CDRC/DPH; Timeframe: 12-18 months.

<sup>11</sup> [Medicaid and Home Visiting - Center for American Progress Home-Visiting-Brief.pdf \(nashp.org\)](#)

[How Are States Using Medicaid to Pay for Home Visiting? New Paper Offers More Clarity – Center For Children and Families \(georgetown.edu\)](#)

Update: DPH and DMMA are collaborating and have been accepted to participate in a Technical Assistance opportunity offered by National Academy for State Health Policy for one year to explore Medicaid reimbursement for evidence-based home visiting.

Path forward: DPH and DMMA will continue to address this issue. These issues were beyond the purview of this committee.

3. Send a survey to providers to identify the type of electronic medical record and include the code to allow providers to automatically download the encrypted evidence-based home visiting referral form for all pregnant women.

Action by the Office of the Child Advocate-Ask IC to consider incorporating into the Infants with Prenatal Substance Exposure work. Timeframe: 12-18 months.

Update: Survey on hold pending meeting with the HVCAB next month to discuss an appropriate referral process from medical providers. The home visiting referral is included in the Plan of Safe Care for all pregnant women eligible for such a Plan. This was also assigned to the HVCAB when the recommendation was initially introduced. However, it was transferred to the CDRC Executive Committee. Despite being distributed twice to providers, a survey was distributed with very poor responses.

Path forward: See recommendations for the proposed resolution of this recommendation.

4. Include the evidence-based home visiting referral form in the treatment plan developed by medication-assisted treatment (MAT) providers.

Action by the Office of the Child Advocate-Ask IC to consider incorporating into the Infants with Prenatal Substance Exposure work. Timeframe: 12-18 months.

Update: The three primary MAT providers in Delaware have been trained to prepare Plans of Safe Care, including home visiting referrals. These providers are now preparing the Plans and making the referrals for home visiting in the prenatal period.

Path forward: Resolved

5. Provide training to DFS works on the available evidence-based home visiting programs and consider referrals as part of the child safety agreement for children six months and under.

Action by the Office of the Child Advocate-Ask DFS to consider in annual training of DFS workers or ask IC to consider incorporating into the Infants with Prenatal Substance Exposure training. Timeframe: 12-18 months.

Update: DFS and IC have trained all DFS workers, who will be handling cases with infant prenatal substance exposure, on the home visiting referral process through the Plan of Safe Care.

Path forward: Resolved

As a result of the CDRC data and the previous recommendations, the following charge was given by the CDRC in February 2019 to establish a CDRC Home Visiting Committee with the following charge:

***Establish a home visiting (HV) committee to overcome barriers to establish a HV service system for at risk families. The committee shall address referrals, services, funding and outcome measures.***

## Summary of CDRC Home Visiting Committee Meetings

The core committee met six times during the course of three years and gained a deeper understanding of the barriers and needed system improvements to improve home visiting in Delaware. A lot of the deep analysis and work was conducted by the Innovation Subcommittee (See Appendix 1). At the February 2, 2022, meeting, the core committee unanimously approved the innovation committee report. In addition, the core committee unanimously agreed with the Executive Committee's decision (November 2021) to conclude the work of this core committee. This core committee and the innovation committee have put forth the best recommendations and will now defer unmet goals to those agencies whose purview allows them to accomplish further improvements. What follows are summaries of the Committee's meetings, where the current and promising practices for home visiting were discussed. The committee's recommendations follow the summary of these meetings.

### The meeting of June 11, 2019

An overview of the Findings/Recommendations from the CDRC/CPAC Joint Commission meeting was discussed as the impetus for this committee convening. This committee was created to explore how to increase home visiting referrals and collect data to support the needs, explore sustainability and capacity issues and outcomes. The occurrence of mental health and substance use has increased and linking families with evidence-based home visiting should be best practice. Other participants needed for this group were discussed. It was decided that this core group would oversee the following subcommittees:

- Group One- Health Care System: This group will include a representative from each health care system, ACOG, AAP, nurse, family doctor, /FQHC representative, a nurse from Christiana Care, and Delaware Health Care Association (DHCA). The focus of this group would be to look to families who are lost to follow up and close the gap to referral and engagement.
- Group Two- Reimbursement/Sustainability/MCO's/Medicaid: This group will include a representative from public health, DFS, and TANF (Social Services).

- Group Three- Universal Innovative Models: This group will include a representative from OCA and Children and Families First.

The need for a "care coordinator" or "director" position within DPH was discussed. If this individual could coordinate a centralized intake or database, better data could be collected. This has been a consistent theme throughout this committee's work and other issues seen by the CDRC. The four evidence-based home visiting programs were discussed briefly. See Appendix 1 for program eligibility.

## The meeting of July 12, 2019

During this meeting, presentations from the four evidenced-based home visiting programs presented the following information:

- Overview and Eligibility Requirements.
- How is the referral processed currently? How many referrals? Current Enrollment? Capacity?
- Where does the funding come from, and what requirements?
- Current enrollment and projected memberships?

## The meeting of September 23, 2019

The following recommendation from the 2018-2019 Joint Commission Action Plan was discussed at this meeting. *Create an automatic medical referral for evidence-based home visiting services in the standard nursing admission orders for every Delaware birthing hospital when the mother comes into labor and delivery, and the newborn is at risk.*

Megan McNamara Williams provided an update that she reached out to Jennifer Sing (Deputy Attorney General for the nursing board) and inquired if nurses across the health care system could have the authority to refer patients into home visiting programs. From a Division of Professional Regulation and practice standpoint, there seems to be no reason why they cannot make a referral to home visiting. Jennifer did not see anything in the statute<sup>12</sup> prohibiting a referral

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<sup>12</sup> [Delaware Code Online](#)

to home visiting programs. Each hospital would need to look within their healthcare system's bylaws to see if the nursing authority was limited for this type of referral. Megan would share this with the Health Care Association's policy committee upcoming meeting.

The committee also reviewed the current referral data from the various programs. This led to a discussion regarding the referral process itself. Further discussion included the following topics, hospitals not referring to home visiting without an order, Medicaid not reimbursing for Healthy Families America, lack of one universal intake, not enough resources, or programs if every family did want to participate. There is also confusion between Evidence-Based Home Visiting programs, promising national practices from other states, and skilled nursing. It was discussed that seventeen other places around the country have a universal strategy to provide home visiting in one form or another. A lot of research around the country is regarding precision home visiting and having a "menu" for all families with different needs. One concern is the disproportionate number of families that have poor outcomes in their history, and these families often fall through the cracks. The concern would be how these families can be engaged? An evidence-based model may not be a good fit for families with high risk. An example of this would be the Delaware HOPE program, staff state that the women with MAT have so much going on in their lives that adhering to the fidelity of an evidence-based model can be a barrier.

## The meeting of February 26, 2020

Megan McNamara Williams updated the committee of the Healthcare Association's policy committee. They have agreed to move forward with the standards around this issue. It was also discussed if this should go back to the Delaware Perinatal Quality Collaborative to address this issue.

The Lt. Governor discussed the opportunity to engage in work around electronic health records and leverage the community health worker network, especially with some of the state's

behavioral health initiatives. A future goal would be to have this form automated and sent directly to a centralized intake.

Aleks and Anne presented knowledge learned from the National Home Visiting Conference and shared materials. In addition, Caitlin Gleason presented a comprehensive overview of the birth to 5 Preschool Development Grant<sup>13</sup>. Crystal Sherman presented the work of the Innovation subcommittee. Social media and marketing to parents were discussed, but the goal is to provide consistent information for consumers and obstetric and pediatric physicians. See Appendix 2 for the latest referral form for professionals shared at the meeting<sup>14</sup>.

## The meeting of September 9, 2020

As a result of the COVID-19 pandemic, there was a delay in this committee meeting. Megan McNamara Williams could not address the nursing orders further within the Healthcare Association's policy committee. She suggested directing this issue to the DPQC. Crystal Sherman and Christy Wright presented an update from the Innovation subcommittee.

At this meeting, the recommendation from the 2018-2019 Joint Commission Action Plan was addressed. *Send a survey to providers to identify the type of electronic medical record and include the code to allow providers to automatically download the encrypted evidence-based home visiting referral form for all pregnant women.* The group decided that a physician/provider assessment survey (See Appendix 3) should be distributed to determine providers' needs or barriers in referring to home visiting. Home Visiting programs are currently at 85% capacity, and the concern is increasing referrals without available programs would leave some families not receiving services as needed. At this meeting, the discussion continued of having an Outreach Coordinator or Home Visiting Director to engage providers, marketing, door to door personal connection with providers.

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<sup>13</sup> [Preschool Development Grant \(Birth to Five\) – Delaware Department of Education](#)

<sup>14</sup> [Provider Info - Delaware Thrives \(dethrives.com\)](#)

The innovation subcommittee drafted the survey and worked with ACOG for local distribution. The survey was distributed twice with only a total of four responses. This was during the coronavirus pandemic, so this may have contributed to the poor response from the medical providers. Further discussion ensued regarding the creation of the reimbursement committee being created, and the participants needed.

## 2021 Committee Work

There were significant delays during the first half of 2021 as Marilyn Sherman (CDRC staff) to this committee was unable to continue working for CDRC. A new nurse educator, Pam Jimenez, was hired (July 2021) and began reviewing the minutes, watching the virtual Home Visiting Conference, and acquainting herself with the home visiting arena. She started to finish and write a draft of the Innovation subcommittee report. However, she also resigned from a position with another entity in December 2021 and therefore was never able to assist the CDRC home visiting core committee.

## The meeting of February 2, 2022

The Innovative subcommittee draft report was presented to the Home Visiting Committee. The committee unanimously voted to approve the report and recommendations. In addition, the Chair of the core committee shared that the CDRC Executive Committee had a discussion in November 2021 regarding the other two subcommittees. Since other entities are covering the Medicaid reimbursement for home visiting issues, they decided that the core group does not need to address this concern. The Division of Public Health, DMMA, and Managed Care Organizations (MCO) have been working during 2021 on technical assistance from the National Academy for State Health Policy<sup>15</sup>. Examples for that group to review would be the following two states:

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<sup>15</sup> [NASHP - The National Academy for State Health Policy](#)

- New Jersey's legislation<sup>16</sup> established a three-year Medicaid home visitation pilot project to provide information, support, and essential referrals to health and social services to families and young children.
- Colorado's Prenatal Plus Program is funded with state funds for pregnant women who meet criteria and are Medicaid eligible. The program's goal is to improve birth outcomes by promoting early access to prenatal care and reducing the number of low-birth-weight infants. "A 2002 study by the Colorado Health Sciences Center found that each dollar spent on the program saved Medicaid approximately \$2.48 in an infant's first year of life"<sup>17</sup>. The rate of low-birth-weight infants born to Prenatal Plus Program participants was 22.5% lower than women without Prenatal Plus services<sup>18 19</sup>.

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In addition, the CDRC Executive Committee agreed that the Health Care Systems issues would be best suited for the DPQC since all birthing hospitals attend those monthly meetings. Also, Referral Data and Capacity Data are presented at the quarterly Evidenced-based Home Visiting Community Action Team. Many groups realize the importance and necessity of continuing the improvement of home visiting in Delaware. However, an assurance was made that CDRC staff will continue to participate in these meetings so that issues are at the forefront with advocacy for improvement and from the CDRC.

## Final Summary and Recommendations

In summary, the Home Visiting Committee subcommittee found variations in referral processes, payment methods, data collections, and agency oversight. These variations made it difficult to understand the Delaware landscape for evidence-based home visiting. Funding for

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<sup>16</sup> [Office of the Governor | Governor Murphy Signs Landmark Legislation to Improve New Jersey's Maternal and Infant Health Outcomes \(nj.gov\)](#)

<sup>17</sup> [SmartInvestments914.pdf \(ncsl.org\)](#)

<sup>18</sup> [Prenatal-Plus-Program.pdf \(amchp.org\)](#)

<sup>19</sup> [Prenatal Plus Program | Larimer County](#)

home visiting comes from many different sources (Federal and State) and is housed in several different state agency budgets. In addition, home visiting programs are also housed in various agencies, public and private.

The most significant effort of the committee was the innovative subcommittee's recommendations that will improve the process and a continuum of care with a universal approach for all families, not just those who are high-risk. Delaware is known for working together collaboratively, and this will take a joint effort between DPH, DMMA, MCOs, private agencies, and legislators to ensure these recommendations are implemented. Legislators can play a crucial role in supporting evidence-based home visiting programs and promising practices to support new parents, pregnant moms, and families. This report can serve as a new path for a more considerable, statewide coordination investment in home visiting by policymakers, advocates, and public and private funders in building a universal tiered approach.

Recommendations include the following:

**1. The State of Delaware should increase funding to expand the current evidence-based or promising practice home visiting programs.**

- Adding additional programs to the continuum would allow for a universal tiered approach to offer home visiting programs to all Delaware families while utilizing a health equity approach. The Division of Public Health will ensure a tiered approach to home visiting by implementing programs that range in intensity. This will include evidence-based/promising practice home visiting programs, skilled nursing, and programs considered a "light touch" for families. A continuum of care will be offered from a more robust mix of funding streams. An example would be the Los Angeles County continuum of home visiting<sup>20</sup>. Another great example would be the Family Connects program. Their vision is to provide access to a continuum of community based care to support healthy children and their families<sup>21</sup>.
- Engage with the Delaware Early Childhood Council (DECC) and their work on a report that includes a recommendation to establish a universal tiered home visiting system. According to the 2020-2025 DECC strategic plan, this is a stated goal. The strategic plans were created based on a comprehensive community needs assessment that examined Delaware's early childhood system and relevant programming.<sup>22</sup>

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<sup>20</sup> [summary of Outcomes Research: \(homevisitingla.org\)](https://www.homevisitingla.org/)

<sup>21</sup> [Home - Family Connects International](https://www.familyconnects.org/)

<sup>22</sup> [ECC DECK FINAL PDF TINA.pdf \(doe.k12.de.us\)](https://www.doe.k12.de.us/ecc-deck-final-pdf-tina.pdf)

## **2. The Division of Public Health shall establish a full-time Home Visiting Outreach Director position or an Office of Home Visiting.**

- Currently, there is a Home Visiting Program Coordinator. However, the committee feels that there needs to be a Director or expanded staff such as an Office of Home Visiting. This individual or small Office would be responsible for the following:
  - Ensuring a tiered continuum approach to home visiting is offered to Delaware families. This includes the various programs mentioned in Recommendation 1a.
  - Provide statewide targeted outreach with coordination between all home visiting programs. This would include obstetrical, pediatric offices, and community-based organizations.
  - Develop a risk-based triage document that can be utilized by hospitals and others in determining the necessity of a referral.
  - Explore the feasibility of a centralized intake process so referrals are processed timely and the best fit for the family.
    - Currently, some referrals go directly to the individual home visiting program, so referral and acceptance data are kept in various places. Other times, the referrals go to 211. The CDRC fatality review programs can often not locate data or accurate history when requested since there is not a centralized process. This makes the referral and acceptance data skewed.
  - Standardize statewide home visiting referrals, process, and data collection.
  - Develop a statewide media campaign that would include a one-page infographic.
  - Target challenges with referrals from medical providers. In addition, they would assess and understand barriers by creating strategies for client engagement through entry and program continuation.
  - Maintain and update the current website to include the entire continuum of home visiting services.
  - Develop a tool kit or training for agencies implementing evidence-based/promising practice home visiting for staff recruitment. The training could include a 101 on home visiting and the home visitor's role. This training could be provided virtually to other state agencies, providers, etc. Some of this work has already been done with DFS and other entities. Also, many videos and resources are located on [DEThrives.com](http://DEThrives.com).

## **3. The Department of Education should consider embedding Parents as Teachers programs into childcare centers.**

- A great example of this is the Alabama Healthy Kids Program<sup>23</sup>. It is a program that connects with parents at the childcare center.

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<sup>23</sup> [Parents As Teachers - Preschool & Daycare Center Serving Greenville, AL \(healthykidsal.org\)](http://ParentsAsTeachers-Preschool&DaycareCenterServingGreenville,AL(healthykidsal.org))

**4. The Department of Services for Children, Youth, and Their Families shall include eligible evidence-based home visiting programs in their state implementation plan of the Family First Prevention Services Act.<sup>24</sup>**

- The Department has begun work on the statewide plan, and federal technical assistance is available to implement this approach. The home visiting programs (HFA, PAT, and NFP) are all included in the prevention plan as services provided in the state; however, the plan does not indicate that they will be seeking reimbursement for these services. The current understanding is that DSCYF cannot be reimbursed for these programs as they do not directly contract for these services, and they are services already available in the community. Other states are using it to fund some of their home visiting programs that already existed in the community before the funding.

**5. The Delaware Perinatal Quality Collaborative should work with the Delaware Birthing Hospitals to implement policies that allow nurses to educate and refer parents to home visiting based upon presenting high-risk concerns.**

- During the September 23, 2019 meeting, it was confirmed that nurses are not prohibited from making a referral. However, hospitals may need to amend their bylaws or policies to allow this to happen. Therefore, the DPQC will be asked to bring this before their group to ensure the completion of this recommendation. An option to explore for payment of the screening by a nurse navigator<sup>25</sup> is the Z codes<sup>26</sup> currently used by Christiana Care to screen for social determinants of health.

**6. The Division of Public Health should review this report and utilize as a reference when writing their future Home Visiting Annual Report<sup>27</sup>.**

- Senate Concurrent Resolution 50 was signed on 6/29/21 and directed the Department of Health and Social Services to produce an annual report on the status of Delaware's Home Visiting Programs. This report is to include a summary of current practices and challenges, as well as program recommendations.

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<sup>24</sup> [Family First Prevention Services Act \(ca.gov\)](#)

<sup>25</sup> Upcoming Recommendation in the 2021-Annual Report. Birth hospitals and large practices should consider employing an obstetric navigator to improve care coordination for women with multiple comorbidities. These navigators would also have the ability to screen and refer to Home Visiting and could use Z codes<sup>25</sup> for reimbursement through Medicaid.

<sup>26</sup> [V Codes \(DSM-5\) & Z Codes \(ICD-10\) - PsychDB](#)

<sup>27</sup> [Bill Detail - Delaware General Assembly](#)

# Appendix 1



Evidence Based Home Visiting Model	Operating Agency
Healthy Families America (HFA)	Children & Families First
Parents as Teachers (PAT)	Christina School District Polytech School District Lake Forest School District - DECC
Nurse-Family Partnership (NFP)	Children and Families First
Early Head Start (EHS)	Department of Education University of Delaware

Program Name	28 Weeks Gestation Or Less	1st Time Pregnancy	Subsequent Pregnancy Or Have Child 7 Months of Age or Younger	Substance Abuse	Low Income	Child 36 Months Or Younger	Medicaid Eligible	Family Stressor(s)	Location Served
HFA-CFF			✓	✓			✓		Statewide
PAT-Polytech				✓				✓	Kent and Sussex Counties
PAT-DECC				✓				✓	Kent and Sussex Counties
PAT-Christina School District				✓				✓	New Castle County
Nurse-Family Partnership	✓	✓		✓	✓				Statewide
Early Head Start				✓	✓	✓			Statewide

### Family Stressor(s), must be at least one of the following:

- Teen parent
- Child w/disability or chronic health condition
- Parent w/disability or chronic health condition
- Parent w/mental health issue(s)
- Low educational attainment
- Low income
- Recent immigrant or refugee family
- Substance use disorder
- Housing instability
- Very low birth weight
- Intimate partner violence
- Child abuse or neglect
- Death in the immediate family
- Foster care or other temporary caregiver
- Military deployment
- Parent incarcerated during the child's lifetime



**Nurse Family Partnership**  
(302) 604-6301

**Parents as Teachers**  
(302) 735-4295

**Healthy Families Delaware Children & Families First**  
(302) 604-6318

**Early Head Start**  
(302) 735-4295

## Appendix 2



**home visiting**

# REFERRAL FORM

Complete this form and fax to 302-295-5988 or email [Helpmegrow@uwde.org](mailto:Helpmegrow@uwde.org).  
Potential clients can self-refer by calling 2-1-1 or texting 302-231-1464.

**If referral is under 18**

\_\_\_\_\_  
PARENT OR LEGAL GUARDIAN CONTACT NAME

Is it Ok to contact this person in reference to this referral?

Yes  
 No

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
CITY OF REFERRAL

\_\_\_\_\_  
CLIENT NAME      \_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
REFERRER'S PHONE (AREA)      \_\_\_\_\_  
EMAIL ADDRESS

\_\_\_\_\_  
CITY/STATE      \_\_\_\_\_  
ADDRESS 1      \_\_\_\_\_  
ADDRESS 2

\_\_\_\_\_  
CITY      \_\_\_\_\_  
STATE      \_\_\_\_\_  
WORK PHONE      \_\_\_\_\_  
CELLPHONE

**Preferred method of communication**  Client prefers text  Client prefers phone call  Client prefers email

\_\_\_\_\_  
CHILD'S NAME      \_\_\_\_\_  
CHILD'S DATE OF BIRTH

**Primary Language**  English  Spanish  Creole  Other: \_\_\_\_\_  
OTHER LANGUAGE

**Race**  African American  Asian  Biracial  Caucasian  Hawaiian/Pacific Islander  
 Hispanic  Native American  Other: \_\_\_\_\_  
OTHER ETHNICITY/RACE

**Marital Status**  Single  Married  Separated  Divorced  Widowed

**Does client receive any of the following?**  Medicaid  TANF  Food Stamps  WIC

\_\_\_\_\_  
CITY      \_\_\_\_\_  
POSTAL ZIP CODE

**Some Potential Risk Factors for Consideration to Make a Referral** (please check those that apply):

Is the client being referred involved with DFS?  Yes  No  
 If yes, is there a Plan of Safe Care (POSC) in place?  Yes  No

- |                                                                           |                                                             |                                                                          |
|---------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Teen parent                                      | <input type="checkbox"/> Low income                         | <input type="checkbox"/> Child abuse or neglect                          |
| <input type="checkbox"/> Child w/ disability or chronic health condition  | <input type="checkbox"/> Recent immigrant or refugee family | <input type="checkbox"/> Death in the immediate family                   |
| <input type="checkbox"/> Parent w/ disability or chronic health condition | <input type="checkbox"/> Substance use disorder             | <input type="checkbox"/> Foster care or other temporary caregiver        |
| <input type="checkbox"/> Parent w/ mental health issue(s)                 | <input type="checkbox"/> Housing instability                | <input type="checkbox"/> Military deployment                             |
| <input type="checkbox"/> Low educational attainment                       | <input type="checkbox"/> Very low birth weight              | <input type="checkbox"/> Parent incarcerated during the child's lifetime |
|                                                                           | <input type="checkbox"/> Intimate partner violence          |                                                                          |

\_\_\_\_\_  
NAME OF PERSON      \_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
CITY & ADDRESS      \_\_\_\_\_  
STATE/ZIP



## **Appendix 3**

### **Delaware Child Death Review Commission Universal Innovative Model/Programs Home Visiting Subcommittee Recommendation report January 20, 2022**

#### Membership

##### Committee co-chairs:

Crystal Sherman, Bureau Chief, Maternal and Child Health, Division of Public Health (DPH)  
Christy Wright, Home Visiting Program Administrator, DPH

##### Child Death Review Commission (CDRC) Staff:

Anne Pedrick, Executive Director  
Marilyn Sherman, Nurse Program Consultant  
Pamela Jimenez, Nurse Program Consultant

Karen DeRasmo, Executive Director, Prevent Child Abuse Delaware  
Kelly Ensslin, Chief of Legal Services, Office of the Child Advocate  
Kirsten Olson, Chief Executive Officer, Children and Families First  
Trinette Reddinger, Treatment Program Manager, Division of Family Services  
Caroline Roben-Ph. D, Director of ABC Dissemination, University of DE  
Kellie Turner, Acting Executive Director, Prevent Child Abuse Delaware

#### Background and Subcommittee Purpose

The Universal Innovative Model/ Programs subcommittee developed from the main home visiting (HV) committee to overcome barriers to establishing an HV service system for at-risk families. The committees are challenged to address referrals, services, funding, and outcome measures.

In January 2020, the working subcommittee began its work, and meetings ensued. After reviewing the data related to the current state of home visiting programs and research related to other working programs in the United States, the subcommittee has agreed to several

recommendations. The subcommittee's findings and recommendations follow the summary of these meetings.

#### The meeting of January 17, 2020

The initial meeting included information regarding the mission and background of the development of the committee, including the subcommittees. The subcommittee was provided the history of the CDRC to understand the overall larger perspective. The main HV committee will oversee three workgroups (Innovation, Reimbursement, Health Care Systems). The gaps and lack of utilization of the programs available were discussed. This meeting indicated all HV programs were at capacity. National programs were discussed, along with the possibility of having a central website to help families become familiar with the available programs. This would also give a method to connect through the website to various programs. There was a presentation of the Attachment and Biobehavioral Catch-Up intervention program. This program helps caregivers nurture and respond sensitively to their infants and toddlers to foster their development and form strong and healthy relationships. This could be used through Federal Community Based Child Abuse Prevention dollars to implement this model to keep children out of foster care. This could also be a more readily available program to high-risk families. The further discussion also included what an HV-tiered system would look like for Delaware? The chairs of the committee were named and approved.

#### The meeting of April 14, 2020

CDRC home visiting data from fatality reviews were presented to the subcommittee. For Sudden Death in the Young panel 2019: 46% of the cases had a referral made, but no parent enrolled in an HV program. For Fetal Infant Mortality Review- 60% of the cases lacked an HV

referral, and 33% WIC eligible. Discussion ensued regarding the referral process and acceptance rate analysis.

The various programs shared at the HV national conference were presented to the group. A popular program was a slide from the Los Angeles program, which considers HV in a central hub and then provides precision home visiting programs for each family-specific need (soft-touch vs. high needs).

#### The meeting of June 16, 2020

The topics of referrals and engagement continued at this meeting after reviewing the quarterly data. The subcommittee continued to delve into the nuances of the various HV programs. The Nurse-Family Partnership currently has a mobile application being used for mothers. A topic of discussion was should there be a central "app" to accompany a central website. The committee also suggested more state funding for HV because, currently, all programs are at capacity. There also needs to be targeted engagement for high-risk families and smaller caseloads required by the Federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECV)<sup>28</sup>.

#### The meeting of August 11, 2020

The group discussed the significance of the current retention rate (85%), engagement, and expansion of access to some communities to identify recommendations. CDRC staff reviewed the Children and Families First, and DE Thrives websites and noted significant efforts to engage providers about the programs on those sites. Nurse-Family Partnership and others have already presented to the Delaware Healthy Mother and Infant Consortium (DHMIC), Nemours, Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Health Ambassadors. The targeted relationships are aware of the programs available. It was suggested that

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<sup>28</sup> [The Maternal, Infant, and Early Childhood Home Visiting Program \(hrsa.gov\)](https://www.hrsa.gov)

an assessment survey for providers might help since that is the group struggling with referrals. This survey was developed and approved by the HV innovation subcommittee. It was distributed to the ACOG membership twice to solicit feedback from medical providers. Unfortunately, the subcommittee only received two responses.

Several pathways for referrals include 211-Help Me Grow, and Unite Us. Discussion ensued regarding one centralized intake, such as the Division of Family Services, for their child abuse reporting line. Several members felt that the individual connections helped to make the programs work. However, concern was raised that with agency turnover, some professionals may not know who to contact when making a referral.

As a result of this discussion from this meeting and previous meetings, the Committee discussed the following recommendations:

1. The State of Delaware should increase funding to expand the current evidence-based or promising practice home visiting programs.
  - Adding additional programs to the continuum would allow for a universal tiered approach to offer home visiting programs to all Delaware families while utilizing a health equity approach. The Division of Public Health will ensure a tiered approach to home visiting by implementing programs that range in intensity. This will include evidence-based/promising practice home visiting programs and programs considered a "light touch" for families. A continuum of care will be offered from a more robust mix of funding streams. An example would be the Los Angeles County continuum of home visiting<sup>29</sup>. Another great example would be the Family Connects program. Their vision is to provide access to a continuum of community based care to support healthy children and their families<sup>30</sup>.
  - Engage with the Delaware Early Childhood Council (DECC) and their work to establish a universal tiered home visiting system. According to the referenced 2020-2025 DECC strategic plan, this is a stated goal assigned to a committee. The strategic plans were created based on a comprehensive community needs assessment that examined Delaware's early childhood system and relevant programming.<sup>31</sup> **This was updated for the final core committee report.**

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<sup>29</sup> [summary of Outcomes Research: \(homevisitingla.org\)](https://www.homevisitingla.org/)

<sup>30</sup> [Home - Family Connects International](https://www.familyconnects.org/)

<sup>31</sup> [ECC DECK FINAL PDF TINA.pdf \(doe.k12.de.us\)](https://www.doe.k12.de.us/ECC_DECK_FINAL_PDF_TINA.pdf)

2. The Division of Public Health shall recruit a full-time Home Visiting Outreach Coordinator position.

This individual would be responsible for the following:

- Ensuring a tiered continuum approach to home visiting is offered to Delaware families.
  - Provide statewide targeted outreach with coordination between all home visiting programs. This would include obstetrical, pediatric offices, and community-based organizations.
  - Develop a risk-based triage document that can be utilized by hospitals and others in determining the necessity of a referral.
  - Explore the feasibility of a centralized intake process so referrals are processed timely and the best fit for the family.
    - Currently, some referrals go directly to the individual home visiting program, so referral and acceptance data are kept in various places.
  - Help standardize statewide home visiting referrals, process, and data collection.
  - Develop a statewide media campaign that would include a one-page infographic.
  - Target challenges with referrals from medical providers. In addition, they would assess and understand barriers by creating strategies for client engagement through entry and program continuation.
  - Maintain and update the current website to include the entire continuum of home visiting services.
3. The Division of Public Health with the Home Visiting Community Advisory Board will develop a tool kit or training for agencies implementing evidence-based/promising practice home visiting for staff recruitment. The training could include a 101 on home visiting and the home visitor's role. This training could be provided virtually to other state agencies, providers, etc. **This recommendation was combined with Recommendation 2 for the final report.**
  4. The Department of Education should consider embedding Parents as Teachers programs into child care centers. A great example of this is in Alabama<sup>32</sup>.
  5. The Department of Services for Children, Youth, and Their Families shall include eligible evidence-based home visiting programs in their state implementation plan of the Family First Prevention Services Act.<sup>33</sup> The Department has begun work on the statewide plan, and federal technical assistance is available to implement this approach.
  7. The Delaware Perinatal Quality Collaborative should work with the Delaware Birthing Hospitals to implement policies that allow nurses to educate and refer parents to home visiting based upon presenting high-risk concerns.

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<sup>32</sup> [Parents As Teachers - Preschool & Daycare Center Serving Greenville, AL \(healthykidsal.org\)](#)

<sup>33</sup> [Family First Prevention Services Act \(ca.gov\)](#)

## Innovative Research and Information

A few promising practice examples are listed here, but this committee explored many national options.

1. HV program through the DPH of North Carolina:

The Division of Public Health also houses the Evidence-Based Family Strengthening Programs Program Coordinator. Care Coordination for Children (CC4C): An At-Risk Population Management Program for Children Birth to 5 Years of Age Care Coordination for Children (CC4C) is a new program that transitions Child Service Coordination, a targeted case management program, into an at-risk population management model in partnership with Community Care of North Carolina (CCNC). CC4C staff serves children from birth to 5 years of age, who meet the following priority risk factors: (1) children with special health care needs/CSHCN (Title V definition); (2) children exposed to toxic stress in early childhood including, but not limited to extreme poverty in conjunction with continuous family chaos, recurrent physical or emotional abuse, chronic neglect, severe and enduring maternal depression, persistent parental substance abuse or repeated exposure to violence in the community or within the family; (3) children in the foster care system; and (4) children who are high cost / high users of services. Referrals originate from the medical home, community organization, or family. CCNC-identified Medicaid claims trigger referrals based on high-cost utilization. (X02MC19387 - North Carolina Home Visiting)

2. LA county program serving 650,000 families- Welcome Baby program and B-5 Since January 2019, the first 5 LA<sup>34</sup> and the Blue Shield of California Promise Health Plan<sup>35</sup> have been engaged in a home visiting partnership program. First 5 LA provides this program. In this pilot, physicians at two primary care clinics run by Blue Shield of California Promise Health Plan directly refer women in the Los Angeles County, Antelope Valley region (an area of high priority for both organizations) to First 5 LA's home visiting program immediately upon pregnancy diagnosis. The program includes nine prenatal and postpartum home-based visits, including a hospital visit at the time of the child's birth, and extends to nine months postpartum. The goal is to improve parents' knowledge and skills; help them develop their social support systems; improve access to education, health, and community services; and provide a measurable impact on health care utilization and family outcomes. This collaboration highlights the importance of family-centered care to both organizations and a commitment to models of care to serve the maternal-child dyad better. Early results show positive outcomes for members who enrolled in home visiting services. These results will provide information for partnering to expand countywide and create a structure for evaluation and reimbursement. This type of collaboration with Blue Shield of California Promise Health Plan will require First 5 LA to develop the infrastructure & support for technology systems that will facilitate referrals and allow a mechanism for quality data collection and reimbursement, including linking the member to a health plan with their Medicaid ID, sharing program enrollment information with the health plan, indicate in the health plan care management system that the member is enrolled in the program, and integrate the home visit health screening results into the member's record. This program aims to bolster health system engagement in preventable services. As a Two-Generation model, it is a platform for providing developmental

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<sup>34</sup> [Home - First 5 Los Angeles \(first5la.org\)](https://www.first5la.org)

<sup>35</sup> [Overview BACKUP | Blue Shield of CA \(blueshieldca.com\)](https://www.blueshieldca.com)

screening for children, reducing the impact of parental depression or resource deprivation on children's health, and enhancing parental capacity to support children's health<sup>36</sup>.

3. The Universal HV model began as a pilot under Durham Connects<sup>37</sup> and has been replicated under the name Family Connects. This universal nurse home visiting model is available to all families with newborns residing within a defined service area. The model aims to support families' efforts to enhance maternal and child health and well-being with the potential to reduce rates of child abuse and neglect. The program consists of 1-3 HV visits between 2-12 weeks of age with follow-up phone contacts with families and community agencies to confirm families' successful linkages with community resources. Initial contact occurs in the hospital or birthing center to increase referral rates and establish relationships. The initial home visit takes between 90-120 minutes and consists of a nurse-led physical health assessment of the mother and newborn, screening of family's mental health and potential risk factors associated with mother's and infant's health and well-being and may offer direct assistance (such as guidance on infant feeding, childcare, safety, and sleeping). Should a notable risk arise, the nurse connects the family to the appropriate community resources. Program staff collaborates with the local social services department and other local agencies that serve families with children from birth to age five years.

**Benefits:**

1. All families with newborns are eligible to receive services
2. Research indicates 70 % agree to referral if engaged before hospital/birthing center discharge
3. Cost-Effective- Estimated costs between \$ 500-700 per infant for three years.
4. Early referral to needed resources
5. Early Identification of postpartum depression
6. Potential to decrease abuse and neglect
7. Promotes overall well-being

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<sup>36</sup> [2020-IMI-Two Generation Approach-Fact-Sheet UPDATED.pdf \(first5la.org\)](#)

<sup>37</sup> [Family Connects Durham | Center for Child & Family Health \(ccfhnc.org\)](#)

<https://www.surveymonkey.com/r/LJ953BK>



The Child Death Review Commission of Delaware (CDRC) Home Visiting Committee has been tasked with the following mission: *Establish a home visiting (HV) committee to overcome barriers to establishing a HV service system for at-risk families. The committee shall address referrals, services, funding, and outcome measures.* As part of that work, a workgroup (Home Visiting Innovation) has been established to overcome barriers in establishing a home visiting program for at-risk families in Delaware (specifically prenatal, birth to age 5).

Would you please consider answering these few questions related to home visiting programs that you may be aware of in the state of Delaware to assist us in understanding your needs as a maternal child and pediatric provider? All feedback is confidential and appreciated. Please submit by March 1, 2021. It is estimated that this survey will take one minute of your time.

1. Have you made a referral to the 211 or Help me Grow program in the past year?  
Yes or No
  
2. In your practice, who initiates the referral to a Delaware Home Visiting Program?  
(Check as many as apply)
  - Physician or provider
  - Office Staff
  - Nurse in the hospital
  - Social worker
  - Patient
  - Other (specify)
  
3. How can Home Visiting Programs assist your practice/office in understanding the various programs? (prenatal, birth to age 5)?  
(Check your preferences)
  - A personal visit by navigators or program facilitators
  - Handouts/brochures for patients
  - Website/ phone numbers
  - Email information & resources
  - Other- please describe
  
4. Would you like a Home Visitor to contact you for more information? (yes/no).
  - a. If yes, provide contact information at the Bottom of Form