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Practice Summary & Implementation Guidance

Delaware State Peer Support Doula Model

Delaware's peer support doula model, developed through the state's SMHI initiative and informed by DPQC analyses, mortality reviews, and lived-experience input, provides trauma-informed peer recovery and doula support to pregnant and postpartum women with SUD to improve care coordination, treatment engagement, and maternal and infant health outcomes amid rising overdose-related maternal deaths and severe maternal morbidity.

Location	Topic Area	Setting
Delaware	Mental Health & Substance Use	Clinical, Community

Population Focus	Date Added
Women & Maternal	April 2026

Contact Information
Naa Dede Hesse, Delaware Department of Health and Social Services, 302-608-5738, naadede.hesse@delaware.gov

Section 1: Practice Summary

PRACTICE DESCRIPTION

Delaware's peer support doula model was developed through Delaware's State Maternal Health Innovation (SMHI) initiative and Maternal Health Strategic Plan to address rising maternal morbidity and mortality among pregnant and postpartum women with substance use disorder (SUD). Data from the Delaware Maternal and Child Death Review Commission identified overdose as the leading cause of maternal death in the state for five consecutive years, with many deaths occurring in the late postpartum period. Severe maternal morbidity (SMM) rates have also increased across Delaware hospitals. Reviews of infant and neonatal deaths further show that many are associated with unsafe sleep environments, particularly among families affected by SUD, highlighting the need for additional education and support for high-risk families.

The model was informed by statewide analyses from the Delaware Perinatal Quality Collaborative (DPQC), findings from Maternal Mortality Review and Fetal and Infant Mortality Review panels and listening sessions with women who experienced pregnancy while actively using substances or in recovery. These discussions identified key barriers including stigma, fragmented care systems, housing and transportation instability, and confusion around the Plan of Safe Care for substance-exposed infants. Participants consistently emphasized the value of peer support doulas, individuals with lived experience who provide emotional support during pregnancy and postpartum, help women navigate health and social service systems, and offer a supportive presence during labor and delivery.

The program focuses on perinatal women with SUD, who often face intersecting challenges such as mental health conditions, trauma histories, unstable housing, and difficulty accessing coordinated prenatal and postpartum care. Peer support doulas provide continuous emotional, informational, and practical support throughout pregnancy, labor and delivery, and up to one year postpartum. They assist women in navigating obstetric care, substance use treatment, home visiting programs, pediatric care, and social services. Grounded in trauma-informed care and lived-experience leadership, the model integrates peer recovery support with traditional doula services to strengthen care coordination, improve engagement in treatment and maternal health services, and ultimately reduce severe maternal morbidity and maternal mortality.

CORE COMPONENTS & PRACTICE ACTIVITES

The peer support doula integration practice includes several core components that function together to improve care engagement and maternal outcomes among perinatal women with substance use disorder (SUD). First, the model recruits and trains peer recovery support specialists, individuals with lived experience of recovery, to become certified doulas who can provide continuous, one-on-one emotional, informational, and physical support throughout pregnancy, labor, delivery, and the postpartum period. Second, peer doulas conduct individualized care planning activities with participants, including developing birth plans and Plans of Safe Care, screening for social determinants of health and mental health needs, and helping women navigate treatment, social services, and maternal health resources. Third, the practice embeds peer doulas within an integrated perinatal care network where they collaborate with obstetric providers, substance use treatment programs, home visiting programs, pediatric providers, and clinical care coordinators to ensure continuity of care across prenatal, delivery, and postpartum settings. Fourth, the practice includes structured referral and enrollment systems so that perinatal women with SUD are identified and connected to doula services early in pregnancy and remain supported through the high-risk postpartum period.

Finally, the model incorporates ongoing monitoring and evaluation activities, such as tracking documentation of safety plans, assessing changes in recovery capital using validated tools, and monitoring maternal morbidity and mortality outcomes, to measure program implementation and impact. In addition to these measures, the evaluation includes secondary indicators focused on immediate neonatal outcomes, including rates of neonatal opioid withdrawal syndrome (NOWS), implementation of the Eat, Sleep, and Console (ESC) care model, and the proportion of infants requiring pharmacologic treatment. Additional indicators assess maternal and health care provider satisfaction with the collaborative care model involving peer doulas, as well as trends in infant health outcomes and infant mortality in Delaware. Collectively, these observable and measurable components operationalize the underlying logic of the intervention: that peer-based, trauma-informed support combined with coordinated care navigation can improve engagement in treatment and maternal health services, strengthen recovery supports, and ultimately reduce severe maternal morbidity and mortality among women with SUD while also improving early infant health outcomes.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Peer Recovery Doula Workforce Development	Recruit peer recovery support specialists and train them as certified doulas. Provide training on trauma-informed care, SUD in pregnancy, maternal warning signs, and motivational interviewing.	Peer recovery specialist's complete doula certification and SUD-focused training. Trained doulas provide continuous emotional, informational, and physical support to enrolled participants during pregnancy, labor, delivery, and postpartum.
Individualized Care Planning and Participant Support	Develop individualized care plans including birth plans and Plans of Safe Care. Conduct screening for social determinants of health and mental health needs. Provide guidance on treatment and maternal health services.	Peer doulas conduct structured intake and follow-up sessions with participants to develop and update care plans. Doulas complete SDOH screening, provide maternal health education, and assist participants with accessing treatment and social services.
Integrated Perinatal Care Coordination	Coordinate services among obstetric providers, SUD treatment programs, pediatric providers, home visiting programs, and case managers. Support communication and care planning across providers.	Peer doulas communicate with clinical and community providers and support referrals, appointment scheduling, and service follow-through to ensure continuity of care across prenatal, delivery, and postpartum settings.
Referral and Enrollment Systems	Identify eligible perinatal women with SUD and connect them to doula services through hospitals,	Formal referral pathways enable early identification and enrollment of participants. Doulas initiate services during pregnancy

	prenatal clinics, treatment providers, and community programs.	and maintain engagement through the postpartum period.
Monitoring and Continuous Quality Improvement	Track implementation and participant outcomes, including safety plan documentation, recovery capital, and maternal health outcomes. Conduct program evaluation and quality improvement.	Program staff collect standardized data (e.g., safety plan documentation, recovery capital measures) and review results through routine reporting and quality improvement processes to monitor implementation and outcomes.

COMMUNITY WELLNESS

The peer support doula practice reduces barriers to care and strengthens community well-being by centering the voices of women with lived experience of substance use disorder (SUD), improving care coordination, and embedding peer-based support within Delaware's maternal health system. Listening sessions with women who experienced pregnancy during active substance use or recovery identified barriers including provider stigma, fragmented care systems, transportation challenges, and confusion around the Plan of Safe Care. These findings informed the peer support doula model, which integrates trained peer recovery specialists into the perinatal care network to provide trauma-informed support, facilitate referrals, and help women navigate health and social services.

Evaluation activities assess program impact by tracking increases in documented safety plans for SUD-exposed pregnancies, improvements in recovery capital using the Brief Assessment of Recovery Capital (BARC-10), and trends in maternal mortality and severe maternal morbidity (SMM). The evaluation also examines infant outcomes such as breastfeeding rates, safe sleep behaviors, and birth outcomes. Baseline data from 2022–2024 are being compared with outcomes from 2026–2028 using a difference-in-differences design, with findings shared through dashboards and quarterly reviews to support continuous quality improvement.

The program is also driving system-level change by integrating peer doulas into hospital workflows, referral networks, and maternal health initiatives statewide. These partnerships strengthen coordination across clinical providers, behavioral health services, home visiting programs, and community organizations, expanding access to culturally responsive care for perinatal women with SUD and promoting improved outcomes for women, infants, and families in Delaware.

EVIDENCE OF EFFECTIVENESS

Success for the peer support doula practice is defined as improving engagement in care and recovery supports for perinatal women with substance use disorder (SUD) while contributing to reductions in severe maternal morbidity (SMM), maternal mortality, and neonatal morbidity and mortality in Delaware. The model strengthens the maternal health system by integrating peer support doulas, individuals with lived experience of recovery, into the perinatal care network to provide trauma-informed support, improve care coordination, and help women navigate health and social service systems.

Program success is measured through several key indicators. These include increases in the percentage of SUD-exposed perinatal women with documented safety plans and improvements in recovery capital measured through the Brief Assessment of Recovery Capital (BARC-10) at program intake and completion. As of May 2026, data to demonstrate effectiveness is forthcoming.

The evaluation also monitors trends in maternal mortality and SMM among SUD-exposed perinatal women using hospital discharge data and maternal mortality review findings. These measures are tracked through quarterly dashboards shared with the Delaware Perinatal Quality Collaborative and other partners to support continuous quality improvement and assess the program's contribution to improved maternal and infant outcomes.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

The following are collaborators and partners involved in this initiative.

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this collaborator have lived experience/come from a community impacted by the practice?**
Impact Life	Community organization implementing the peer support doula model and providing recovery-focused services to pregnant and parenting women with SUD.	Recruits and supervises peer recovery specialists trained as doulas, provide participant support services, and administer program assessments such as the BARC-10.	Yes. Peer recovery specialists employed by Impact Life have lived experience with substance use recovery and support women navigating pregnancy and recovery.
Delaware Perinatal Quality Collaborative (DPQC)	Statewide perinatal quality improvement collaborative that supports integration of the practice into hospital and clinical systems.	Coordinates hospital partners, shares evaluation data through learning meetings, and supports system improvements related to maternal health and SUD care.	Indirectly. DPQC partners with organizations and stakeholders representing populations most impacted by maternal morbidity and SUD.
Delaware Division of Public Health (DPH)	Provides statewide leadership and alignment with maternal health initiatives and Title V priorities.	Supports program oversight, maternal health surveillance, and coordination across state programs serving perinatal women with SUD.	Indirectly. DPH works closely with community partners and programs serving the target population.
Delaware Division of	Key partner in the implementation of Plans of Safe Care for substance-exposed	Collaborate with doulas and partners to improve documentation and	Indirectly. DFS works with families affected by

Family Services (DFS)	infants and family safety planning.	coordination of safety plans for participating families.	substance exposure and child welfare involvement.
Delaware Division of Medicaid and Medical Assistance (DMMA)	Medicaid covers a large proportion of pregnant and postpartum women in Delaware, including many with SUD. Partnering with DMMA helps align the peer support doula model with Medicaid policy, reimbursement pathways, and care coordination systems	Collaborates with state agencies and healthcare partners to improve care coordination and service access for pregnant and postpartum women with SUD. This includes aligning Medicaid managed care coordination and referral systems with the peer support doula model.	Indirectly. DMMA is a state agency and does not represent lived experience directly. However, it administers Medicaid services for many low-income pregnant and postpartum women who are directly impacted by the program
Maternal Health Task Force & Women with Lived Experience	Ensures the model reflects the needs of pregnant and postpartum women with SUD.	Listening sessions and ongoing feedback from women with lived experience inform program design and implementation.	Yes. Women who experienced pregnancy during active substance use or recovery provided direct input on barriers and needed supports.

REPLICATION

Delaware's peer support doula integration has not been directly replicated from an existing model but was substantially informed by elements of Project Nurture in Oregon (see reference in Appendix), which demonstrated the value of integrating peer support, care coordination, and trauma-informed perinatal services for pregnant and postpartum women with substance use disorder. Delaware adapted these core concepts to fit its own healthcare and social service systems by embedding peer recovery support specialists trained as doulas within statewide maternal health, obstetric, pediatric, and substance use treatment networks, while also incorporating Delaware-specific priorities identified through mortality reviews, DPQC analyses, and lived-experience listening sessions, including overdose prevention, Plan of Safe Care navigation, postpartum engagement, and safe sleep education.

INTERNAL CAPACITY

Implementation of Delaware's peer support doula integration required both direct service personnel and systems-level implementation staff to support care coordination, workforce development, and cross-sector collaboration. At the direct service level, the practice relies primarily on peer recovery support specialists who are additionally trained and certified as doulas to provide continuous emotional, informational, and practical support throughout pregnancy, labor and delivery, and up to one year postpartum. These peer support doulas

require lived experience with recovery, strong interpersonal communication skills, knowledge of trauma-informed care, motivational interviewing, maternal warning signs, and familiarity with substance use disorder (SUD) treatment systems and maternal-child health services. The model also depends on clinical care coordinators, obstetric providers, pediatric providers, SUD treatment professionals, home visiting staff, and case managers who collaborate with peer doulas to support integrated care planning and referral follow-through. While the exact staffing ratio may vary by setting, the model requires at minimum a dedicated program lead or coordinator to oversee implementation, maintain referral networks, coordinate training activities, and facilitate communication across partnering systems. Additional personnel supporting implementation included Maternal Health Task Force members, DPQC leadership, evaluation staff, and public health administrators who guided planning, quality improvement, and monitoring activities.

PRACTICE TIMELINE

The following are the pre-implementation, implementation, and sustainability timelines for this initiative.

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Conduct statewide SWOT analyses, maternal mortality reviews, and listening sessions with women with lived experience to identify barriers and workforce needs.	3–6 months	DPQC, Maternal Health Task Force, DHSS/DPH leadership
Develop integrated maternal health framework and establish partnerships among obstetric providers, SUD treatment providers, home visiting programs, pediatric providers, and Medicaid stakeholders.	3–6 months	Maternal Health Task Force, healthcare systems, Medicaid MCOs
Recruit peer recovery support specialists and develop specialized doula and trauma-informed care training curriculum.	2–4 months	Program coordinator, doula trainers, behavioral health leaders

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Train peer recovery support specialists as certified doulas with competencies in SUD in pregnancy, trauma-informed care, motivational interviewing, maternal warning signs, and care navigation.	2–3 months initially with ongoing refreshers	Doula trainers, behavioral health specialists, program leadership
Launch referral and enrollment systems connecting pregnant and postpartum women with SUD to peer doulas through hospitals, prenatal clinics, treatment programs, and community organizations.	Ongoing throughout implementation	Program coordinator, hospitals, prenatal clinics, community partners
Provide individualized care planning, Plans of Safe Care, care coordination, postpartum follow-up, and linkage to treatment and social services while monitoring implementation and outcomes.	Continuous; pregnancy through 12 months postpartum	Peer support doulas, care coordinators, evaluation staff

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Maintain statewide cross-sector collaboration and continuous quality improvement processes using maternal and infant outcome data, recovery capital measures, and stakeholder feedback.	Quarterly and ongoing	DPQC, evaluation staff, Maternal Health Task Force

Develop sustainable financing strategies, including Medicaid reimbursement pathways and integration into hospital and public health workflows.	6–12 months and ongoing	DHSS/DPH leadership, Medicaid leadership, healthcare administrators
Provide ongoing workforce supervision, peer support, continuing education, and stigma-reduction training to sustain workforce competency and retention.	Ongoing annually	Program leadership, supervisors, training partners

PRACTICE COST

The Delaware Peer Support Doula Model was developed through the State Maternal Health Innovation (SMHI) Program and leverages existing partnerships among the Delaware Division of Public Health, healthcare providers, community-based organizations, and recovery support services. Practice costs vary depending on the number of peer support doulas employed, training requirements, supervision structure, geographic coverage, and available community resources.

Major start-up costs may include recruitment and training of peer support doulas, certification and credentialing expenses, development of protocols and workflows, stakeholder engagement activities, program management, data collection systems, and development of educational and referral materials.

Ongoing annual costs generally include personnel salaries and benefits for peer support doulas and supervisory staff, continuing education and professional development, participant outreach and engagement activities, transportation support, data management and evaluation, quality improvement activities, administrative support, and program coordination.

Because implementation costs vary significantly based on local workforce capacity, service delivery model, and existing infrastructure, a standardized budget may not accurately reflect the resources required in other settings.

LESSONS LEARNED

A key lesson from implementing the peer support doula practice is that integrating individuals with lived experience into the maternal health workforce helps build trust and improves engagement among pregnant and postpartum women with substance use disorder (SUD). The practice works best when peer doulas are embedded within a coordinated perinatal care system that connects obstetric care, treatment providers, and social services.

Implementation revealed challenges related to fragmented care systems, stigma surrounding substance use during pregnancy, and inconsistent understanding of the Plan of Safe Care. The program addressed these

barriers by positioning peer support doulas as care navigators who help coordinate services and by expanding provider education on trauma-informed care and SUD in pregnancy. Partners also worked to improve communication and collaboration with agencies responsible for safety planning to clarify processes and reduce confusion among providers and participants.

Future implementation would benefit from establishing clearer care coordination structures and referral pathways earlier in the planning process. Expanding provider education about SUD and the role of peer support doulas at the outset could also help reduce stigma and strengthen referrals. In addition, investing earlier in shared data systems and communication tools would support stronger coordination across agencies and improve monitoring of participant outcomes.

NEXT STEPS

Plans for continuing the peer support doula practice focus on expanding access for pregnant and postpartum women with substance use disorder (SUD) and strengthening its integration within Delaware's maternal health system. The model will continue recruiting and training peer recovery specialists as doulas and embedding them within the perinatal care network to support care coordination across clinical and community partners. Ongoing evaluation, tracking safety plan documentation, recovery capital (BARC-10), and maternal morbidity outcomes, will guide expansion and continuous quality improvement.

Future improvements will focus on strengthening care coordination, expanding provider education on SUD in pregnancy, and improving collaboration between peer doulas and clinical providers. Efforts will also prioritize better data-sharing and referral systems to support communication and care planning across agencies. These improvements aim to ensure more coordinated support for women with SUD throughout pregnancy and the postpartum period.

APPENDIX

- John McConnell K, Kaufman MR, Grunditz JI, Bellanca H, Risser A, Rodriguez MI, Renfro S. Project Nurture Integrates Care and Services to Improve Outcomes for Opioid-Dependent Mothers and Their Children. Health Aff (Millwood). 2020 Apr;39(4):595-602. doi: 10.1377/hlthaff.2019.01574. PMID: 32250679.