Maternal and Child Health Services Title V Block Grant

Delaware

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Delaware Health & Social Services
Division of Public Health
Family Health Systems
Maternal and Child Health Bureau

July 15, 2025

Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18-31
Rockville, MD 20857
ATTN: MCH Block Grant

Dear Sir/Madam,

State of Delaware 2025 Maternal and Child Health Services
Title V Block Grant Program

With this letter of transmittal, please find the Application Face Sheet (standard Form 424) for the State of Delaware's Federal Fiscal Year 2025 Maternal and Child Health Services Title V Block Grant Application.

Please feel free to contact me at (302) 608-5754 or via e-mail leah.woodall@delaware.gov, if you have any questions or comments regarding the information presented in the application.

Sincerely,

Leah A. Jones, MPA
Chief, Family Health Systems
MCH Director
Family Health Systems
Delaware Division of Public Health
1351 N. West Street
Dover, DE 19904
(302) 608-5754

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Delaware's Title V Program and Framework

Delaware's Title V Maternal and Child Health Block Grant is administered by the Delaware Department of Health and Social Services, Division of Public Health, Family Health Systems. We partner with Health Resources and Services Administration to promote the health of all mother and children, including children and youth with special health care needs. There are three Bureaus within the Family Health Systems: Family Health Research & Epidemiology Bureau, Adolescent & Reproductive Health Bureau, and the Maternal and Child Health Bureau. These sections implement programs that improve the health of women, infants, children, adolescents, children and youth with special health care needs, and their families. In addition, the Title V program relies on other state agencies, community-based organizations, local partnerships, stakeholders, and numerous organizations to implement activities and create coordinated systems of care for MCH populations. Title V also leverages multiple federal and state funds to coordinate activities across multiple funding sources to maximize impact.

Needs Assessment

To conduct our comprehensive Needs Assessment of our priority issues and stakeholder needs, MCH focused on four characteristics. A clear leadership structure for assembling data from both public and private sources, including data from family organizations. Engagement of stakeholders representing various communities, including those that face the greatest barriers to access, for soliciting meaningful programmatic input. A structured priority-setting process that involves the varied communities and families already identified. And collaborative program planning, implementation, evaluation/assessment, and continuous quality improvement.

To carry out the required Five-Year Needs Assessment, we used a systematic approach in developing a working framework, using epidemiological and qualitative approaches to determine priorities, incorporating data, clinical cost-effectiveness, and patient, provider, and stakeholder perspectives. We also looked at available capacity in determining health interventions. With this approach, Delaware tried to balance the clinical, ethical, and economic considerations of need - what should be done, what can be done, and what can be afforded when determining evidence-based health interventions and capacity.

Priorities

The following Title V priority needs within each health domain have been identified by the 2025 Needs Assessment Process:

Women/Maternal Health

Postpartum Visit:

- Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.

Perinatal Care Discrimination:

- Women have access to safe and supportive patient centered care, where their concerns are listened to, and they are included as partners in health decision making.

Through a partnership with the Delaware Healthy Mothers and Infants Consortium (DHMIC), there has been much work to educate our population about preconception health, in which preventive health visits play a key role. This work includes social media outreach around the theme that "Health Begins Where You Live, Learn, Work & Play." Over the last few years, DPH has been working with the DHMIC Chair and Vice Chair and membership to implement a 5-year DHMIC Strategic Plan and revisit the governance infrastructure and onboarding process, which includes a well women care initiative and an aspirational goal to eliminate health disparities as a priority. We also continue to support fairly new DHMIC leadership and members, implemented Healthy Women Healthy Babies (HWHB) 3.0 program model to focus on a) performance/value based care b) address the social determinants of health c)

coordinate and provide referral linkages with community health workers and d) strengthen integration of behavioral health and the fourth trimester benchmarks into the model, as well as continue to train and deploy community health workers deployed in high risk zones to support HWHB to link women of reproductive age to maternal and child health support and services.

We will continue to educate and counsel women of reproductive age about all contraceptive methods that are safe and appropriate for them, including the most effective methods, long-acting reversible contraceptives (LARCs). DPH continues to work with partners to implement a law passed three years ago that allows pharmacists in DE, along with 11 other states, to administer or dispense contraceptives under a standing order from DPH in addition to an implementation plan of regulations finalized this year. Delaware will continue to refine and implement the HWHB program 3.0, providing preconception, nutrition, prenatal, postpartum and psychosocial care for women at the highest risk focused on value-based care by monitoring a core set of benchmark indicators. In partnership with Maternal and Child Death Review Commission, promote, educate and roll out and distribute maternal health warning signs materials and toolkit to providers. Delaware will evaluate our interventions such as Medical Legal Partnership, HWHBs 3.0, and community health workers to address the social determinants of health, and exploring implementation of the evidence based home visiting model, Family Connects, to determine sustainable system of care for maximum impact on improving maternal and infant health outcomes.

Perinatal/Infant Health

Housing Instability:

- Ensure women and their families facing housing instability are connected to essential resources and services that can improve their housing outcomes.

Following the 2025 Needs Assessment process, a new priority was identified within the Perinatal Health Domain: reducing the percentage of pregnant women and children experiencing housing instability. This priority aligns with Healthy People 2030 Objective 4, which aims to decrease the proportion of families spending more than 30% of their income on housing (baseline of 34.6% in 2017 to a target of 25.5%).

The SDOH Health Committee of the DHMIC is focused on housing stability for pregnant and parenting women. Homelessness and housing instability increases the risk of pregnancy complications and worse health for mothers and babies. Over the last year, the housing workgroup was established under the DHMIC SDOH Committee, and is comprised of housing authorities, housing alliance, managed care entities, Delaware Coalition Against Domestic Violence, University of Delaware, Governor's Office, and two sections within DPH, and developed a set of core recommendations:

1. As part of Delaware's **central intake waiting list**, indicate and prioritize high-risk pregnant women who are unstably housed for HUD's Housing Choice Vouchers.
2. Utilize **TANF Surplus dollars** to create a pilot program with the Division of Public Health as the referring entity to obtain state rental assistance program, SRAP, vouchers for high-risk unstably housed pregnant women.
3. Support multiple **safe and secure options along the continuum**, including maternity villages/homes, voucher assistance, and permanent supportive housing.
4. Advocate to remove **restrictive zoning** to increase the affordable housing stock in Delaware, and support expansion of **home ownership** programs operated by housing authorities.

In the coming year, DHMIC and DPH and stakeholders will review our current interventions and framework for addressing well woman care, postpartum care as a key period of risk, and housing stability for pregnant women.

Child Health

Developmental Screening:

- Children receive developmentally appropriate services in a well-coordinated early childhood system.

Medical Home:

- Families know what a medical home is and have access to a medical home for their children.

To achieve a developmentally appropriate and well-coordinated services for children and their families, the Early Childhood Comprehensive Systems program focused on gaps and challenges observed within the developmental screening continuum. The program addressed education and training of providers at different stages/phases within the developmental health continuum such as pediatricians, early intervention and special education professionals

including parents and childcare providers. Additionally, the program embarked on a continuous quality improvement effort to enhance existing processes such as the referral process while bolstering provider knowledge regarding developmental screening, referrals to early intervention and importance of the feedback loop including the navigation and linkage to resources.

Looking ahead, the program will focus on promoting the centralized access point (HMG@211) to increase community utilization and address the challenges physicians encounter in referrals. We will continue with community and family education and training to build confidence and resilience. We will seek partnerships in emerging areas such as child mental health to address gaps within the system, especially for families on the wait list. We will also work toward a shared approach to aligned and reinforced messaging around early childhood development and data collection and analysis.

The MCHB program has had numerous successes in accomplishing its goals and objectives in engaging families on developmental screening through education and other outreach efforts. Through partnerships with programs with mutually beneficial and shared goals, the program has successfully reached out to high-risk and vulnerable populations. Our challenge for the coming application year is to develop strategies which will decrease and eliminate some of the gaps in the early childhood system.

Adolescent Health

Mental Health Treatment:

- Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening(s).

Delaware's Title V Maternal and Child Health Program prioritizes adolescent health as part of its Five-Year State Action Plan, aligning with National and State Performance Measures to improve access to preventive, physical, and behavioral health care. Delaware certifies all school-based health centers (SBHCs) statewide and contracts with centers in every public high school and two high-need elementary schools.

The main goal of SBHCs is to improve student health and well-being by providing on-site access to essential healthcare services. SBHCs make care more convenient, particularly for underserved students, reduce health disparities, and offer services that support both physical and mental health. In addition, they provide care coordination—working with families and identifying community-based primary care providers to support a smooth changeover after high school. Prevention and health education services offered further promote wellness.

Despite significant workforce shortages and high staff turnover, SBHC teams continue to deliver high-quality, evidence-based care by collaborating closely with school staff, engaging families in feedback and planning, and maximizing hospital system infrastructure to expand services. They continue to think creatively and navigate the legislative system to advocate for policy changes through the Delaware School-based Health Alliance. Stories of impactful provider work are shared across the SBHC network to build community, spread best practices, and reinforce common goals.

SBHCs also contribute to broader school wellness, partnering with school staff for greater impact. Program evaluation tracks utilization, outcomes, and satisfaction to inform continuous improvement. Delaware's approach integrates youth, family, and community voices in the development and delivery of services, ensuring that all adolescents have the opportunity to achieve their full health and academic potential.

Children and Youth with Special Health Care Needs (CYSHCN)

Medical Home:

- All children, with and without special health care needs, have access to a medical home model of care.

Shift to Adult Health Care:

- All CYSHCN receive the necessary organized services to make the shift to adult health care.

The CYSHCN programmatic framework will focus on six core indicators throughout the 5 population domains of the MCH Title V guidance. The CYSHCN program will be intentional in developing a crosswalk across the 5 domains. Delaware has executed a competitive request for proposal, which will result in the selection of a vendor which will

serve as the fiduciary of selected mini-grantees serving CYSHCN. The Mini-grantees and Family Leadership Network (FLN) members will address our two selected NPMs.

The CYSHCN program goals for Yr. 2025 -2030, is to increase the number of adolescents with special health care needs served by mini-grantees with a plan that prepares them for the adult health system of care. One of the strategies for addressing the shift into an adult health system of care will be by the mini-grantees educating the adolescents they serve with special health care needs on the importance of a plan when becoming an adult. Also, the FLN members will customize a plan tool kit to educate families on the questions to ask their doctors regarding shifting to adult health care. The universal NPM that will be addressed by all domains is the Medical Home for CYSHCN with and without special health care needs. Focusing on children having access to a medical home model of care will also be a priority for the next 5 years. One of the strategies will be to utilize universal practices to promote all children and CYSHCN have access to care that meets the medical home model of care criteria, which includes comprehensive care, patient-centered, coordinated care, accessible services, quality and safety. Another strategy will be for the Family SHADE program to collaborate with Family To Family to educate health care providers and build partnerships by providing educational sessions on medical home model of care. The CYSHCN program will be intentional in supporting and assuring comprehensive, coordinated and family-centered services for CYSHCN and their families.

Cross Cutting/Systems Building

Workforce Development:

- Multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future.

Identified during the 2025 Needs Assessment, Delaware aims to build MCH capacity and support the development of a trained and qualified workforce by providing professional development opportunities. Our goal is to strengthen our Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities. We plan to develop an Accountability Matrix, which provides specific workgroup, contact, and data information about each NPM to ensure no overlap and to track progress. We will also create ongoing learning resources and videos to internal employees as well as partners to address topics such as: onboarding, burnout, Title V resources, technical assistance opportunities, and more. Additionally, we plan to periodically survey and deliver to our internal and external partners the needed training opportunities that are requested to develop our workforce and address actual competency needs.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Delaware receives approximately $2M annually to complement the $10M in state MOE match funds. Title V Maternal and Child Health (MCH) funding serves as the backbone funding source for addressing essential MCH and public health programs and priorities addressing infrastructure and systems coordination across all MCH domains. The funding supports 13.5 FTEs across the Division including early intervention specialists, nutritionists, nurses, fiscal and administrative support positions. The types of services and initiatives these staff support include chronic disease prevention, access to care, and services for children and youth with special health care needs.

Title V staff and funded contracts support our efforts to improve health outcomes, support policies that foster state health department transformation to lead the way towards innovative, community-based solutions. The evolution of our health care system has necessitated that public health agencies make the transformation from safety-net medical direct service providers to more innovative, community-based models which include programs for universal developmental screenings, care coordination and home visiting. Using a population health framework allows Delaware to implement upstream, data-driven strategies to respond to broad community health needs and evaluate and monitor emerging population health trends. Delaware ensures preventive health services for women and children – including well-child services and screenings, prenatal care and comprehensive services for children and youth with special health care needs.

Examples of programs supported in recent years include:

- **Mini-Grantee Program**: This initiative aims to improve systems and standards of care for children with special healthcare needs. In its first year, two community-based organizations were selected, with a total of four organizations awarded funding in subsequent years, including the most recent cycle.
- **Healthy Women, Healthy Babies (HWHB)**: This program offers enhanced services to women who are pregnant, planning a pregnancy, or seeking to improve their overall health. Services focus on personal health and wellness, nutrition, family planning, mental health, and prenatal care.

Data collection and evaluation are essential components of innovative programming. Due to the absence of a MCH Epidemiologist, we have contracted with a vendor to develop data collection and evaluation plans, as well as to report on key findings. Additionally, education and outreach about Title V programs are critical. To support these efforts, we have engaged a local marketing firm to promote available programs through social media and to assist in developing dissemination strategies for sharing evaluation results and insights.

III.A.3. MCH Success Story

Expanding Access to Training through an Enhanced Learning Management System

Over the past few years, Family Health Systems (FHS) has partnered with TAPP Network to create a user-friendly training platform for both internal staff and external partners. In collaboration with the state of Delaware, this effort led to the development of a customized Learning Management System (LMS) that offers on-demand training and certification. Integrated with a marketing automation platform, the LMS enables automated email communications based on users' registration status and training progress.

Currently, the LMS hosts training modules for healthcare providers and staff involved in the *Safe Arms for Babies* initiative and the non-clinical *Delaware Contraception Access Now (DECAN)* program.

The platform is now undergoing an upgrade to support the professional development of Family Support Specialists (FSS) working in Delaware's Home Visiting Programs. This enhanced system provides standardized, on-demand training through video, audio, interactive courses, and real-time progress tracking.

Building on the existing LMS infrastructure, the upgraded platform offers a consistent and scalable onboarding solution for new Home Visitors—often the first point of contact with the Delaware Division of Public Health (DPH). Tailored specifically for the Home Visiting Program, the LMS features a streamlined user interface, simplified registration, and interactive course elements such as quizzes and downloadable resources to support knowledge retention.

While Delaware supports four evidence-based home visiting models, the core onboarding experience is standardized across programs, with minor variations for agency-specific needs. In light of ongoing challenges related to staff turnover, the LMS provides a cost-effective, reliable way to deliver high-quality onboarding for FSS.

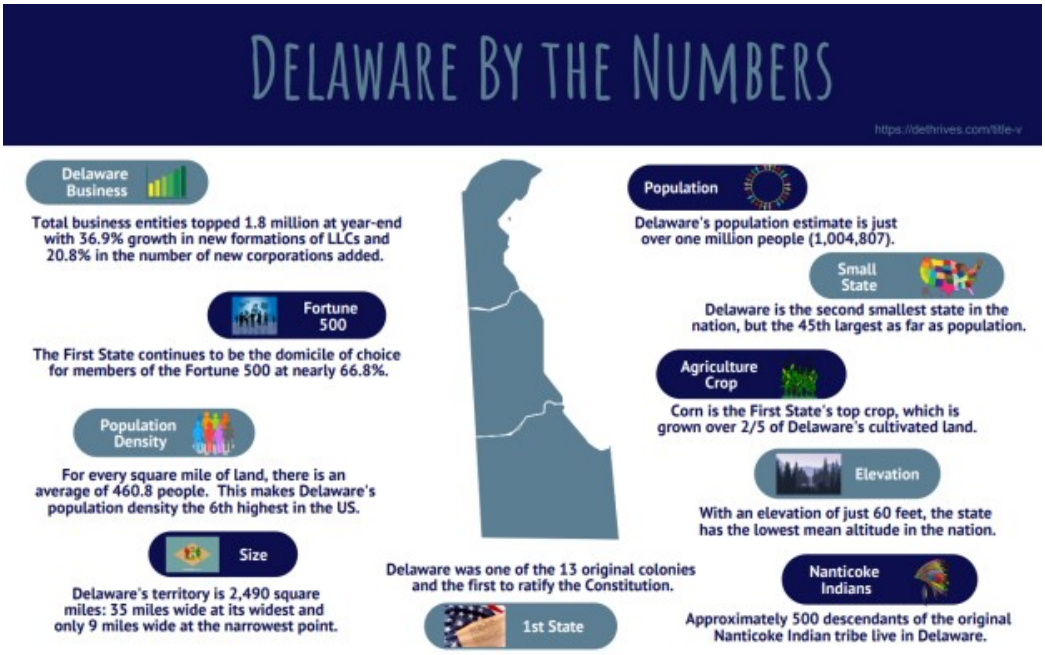
In partnership with TAPP Network, FHS is producing engaging, professionally designed training content, including an animated program overview video, up to 50 custom-designed slides, AI-generated voiceovers, and a clearly organized content structure.

Integrated with the Home Visiting App and HubSpot, the LMS also will support automated progress tracking, email reminders, and workflow management—ensuring FSS stay on track throughout their training journey.

We look forward to launching the new FSS training later this year and continuing to expand the LMS to serve all Maternal and Child Health (MCH) programs.

III.B. Overview of the State

III.B.1. State Description



Delaware is a small but densely populated Mid-Atlantic state with an aging, and increasingly urban population. Its economy benefits from strong finance, corporate services, manufacturing, and agriculture sectors. Urbanization is concentrated in the north, while the south remains rural with booming tourism. The state faces challenges including aging demographics, housing affordability, and workforce adequacy.

Geographically, the state's area encompasses only 1,982 square miles, ranking Delaware 49th in size among all states. Delaware is bordered by New Jersey, Pennsylvania, and Maryland, as well as the Delaware River, Delaware Bay, and Atlantic Ocean. Centrally located between four major cities, Wilmington, the state's largest urban center, is within an hour's drive to Baltimore, MD and Philadelphia, PA and withing two hours driving distance from New York City and Washington, D.C.
Delaware's population as of July 1, 2024, was 1,051,917, according to the Census. These figures suggest a consistent growth trend, with Delaware's population increasing by over 6% since 2020. The First State was above the national growth rate of 7.4%, ranking 12th among all states in population growth rate from 2010 to 2020 and first among Northeast and Mid-Atlantic states. According to estimates from the U.S. Census Bureau, in 2024, 62% of Delaware residents were White and 22% were Black. The Hispanic population is steadily increasing, from 10.1% in 2022 to 11.1% in 2024. About 20.5% of Delawareans are children under the age of 18 and 5.3% were under the age of five.

Of Delaware's three counties, New Castle County, is the most northern county, is the largest in population with about 588,093 residents or about 57% of the state's total population. New Castle County has a large population of African American residents (nearly 28%) and within the city of Wilmington, the state's largest concentration of African American residents (about 57% of the city's population). New Castle County also has a large population of Hispanic residents, 12%. Kent County, home to the state's capital of Dover, has an estimated 189,789 residents (62% White and 30% Black). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2022 population was approximately 263,509 (83% White, 12% Black). Like New Castle, Sussex County also has a growing Hispanic population, estimated at 9.6% for 2022 and 11.4% in 2024. Sussex County has experienced significant population growth, with an 11% increase from 2020 to 2023.

As of 2023, Delaware is estimated to have approximately 190,000 women of childbearing age. and over 250,000 children and adolescents aged 0-21 years of age. Data shows 10,725 births for 2023. As of the most recent data, approximately 22.3% of children aged 0–17 in Delaware are identified as having special health care needs. This figure is based on the 2022–2023 National Survey of Children's Health and is consistent with Delaware's ranking

among the states with the highest prevalence of such needs.

As of 2023, approximately 15.2% of Delaware children under 18 were living in poverty, marking a slight increase from 12.9% in 2022. The poverty rate for children under 5 years old was 15.3% in 2023, up from 13.3% in 2022. The median family income in 2022 was $98,000 for all Delawareans, the median family income for non-Hispanic white was $113,200, $78,800 for Black or African American, and $51,800 for Hispanic or Latino. Approximately 12.6% of Delawareans (about 125,370 individuals) experienced food insecurity. For children under age 18 in the state, the food insecurity rate was higher, at 19.7%. However, since the conclusion of SNAP's emergency allotments in February 2023, concerns have risen about the re-emergence of higher rates of food insecurity with our Food Bank of Delaware seeing an increase in visitors.

In 2023, there were 10,725 births in Delaware, a slight decrease from 10,883 in 2022. 10,389 were to Delaware residents and 336 were to non-residents. Additionally, 507 births to Delaware residents occurred out of state, for a total of 10,389 Delaware resident births, 37 more Delaware resident births than in 2020. The recent national declines in general fertility and live birth rates were also apparent in Delaware statistics. From 2008 to 2022, the general fertility rate (number of births per 1,000 women aged 15-44 years) declined from a high of 66.8 to 55.5 births per 1,000 women aged 15-44. The birth rate of women aged 15-19 (teens) exhibited the largest decline at 63 percent followed by women aged 20-24 that decreased 37 percent and women aged 25-29 that decreased 27 percent. During this period women in the 40-44 aged group had the largest increase at 42 percent. Since 2008 the number of births to women aged 30-34 has not significantly changed.
In 2022, private insurance or Medicaid were listed as the primary source of payment in 95% of all live births; the remaining 5 percent were split between other, other government coverage, unknown, and self-pay. In 2022, in all race categories, 65% of women over thirty had private insurance as their primary source of payment. Medicaid was still the primary source of payment for the 77.2% of mothers under 20, covering 78.8% of non-Hispanic black mothers, and 68.7% of non-Hispanic white mothers in that age group.
As in previous years, the primary source of payment for delivery in 2022 varies tremendously based on marital status: The number of single non-Hispanic white women who used Medicaid as their primary source of payment at 57.4% was more than five times that of non-Hispanic white married women at 10.5%. The number of single non-Hispanic black women who used Medicaid as their primary source of payment at 68.7% was more than two times that of non-Hispanic black married women at 31.3%. The percentage of single women of other non-Hispanic races who used Medicaid as their primary source of payment 66.7% was more than four times higher than among married women of other non-Hispanic races at 15.9%. The number of single Hispanic women who used Medicaid as their primary source of payment at 77.7% was higher than Hispanic married women at 54.3%. The five-year average of births to unmarried women remained the same at 47.6%. (Delaware Vital Statistics Annual Report, 2022)

Healthcare Landscape
According to the 2024 Annual America's Health Rankings Report, Delaware ranks 21st in the nation in overall health outcomes. The report lists Delaware's strengths as a 40% decrease in teen births (from 24.4 to 14.7 births per 1,000 females ages 15-19 between 2013 and 2022) and 26% decrease in uninsured (from 8.8% to 6.5% of population between 2012 and 2023). The challenges list for Delaware were an increase in frequent mental distress (from 11.1% to 14.2% of adults between 2013 and 2023) as well as an 16% increase in obesity (from 30.7% to 35.7% of adults between 2014 and 2023).

Although Delaware is a relatively small state, disparities exist between its three counties regarding healthcare access. Access to health care services poses an issue for many uninsured, underserved and otherwise at-risk populations in Delaware. A myriad of factors affect access to health care, including lack of health insurance, lack of providers, an overall mal distribution of providers, etc. The Health Resources and Services Administration/Bureau of Health Workforce designated the following as Health Professional Shortages Areas (HPSAs). Regardless of their location, Federally Qualified Health Centers (FQHCs) are also automatically designated as HPSAs. In addition, many of the state correctional facilities are designated as HPSAs.

New Castle County:
- 4 Primary Care HPSAs
- 1 Dental HPSA

Kent County *in its entirety* is a:
- Medically Underserved Population
- Primary Care HPSA
- Dental HPSA

Sussex County *in its entirety* is a:
- Medically Underserved Area
- Primary Care HPSA
- Dental HPSA

- Mental Health HPSA

Delaware's hospital system is relatively small but well-integrated, providing essential health care services across the state's three counties (New Castle, Kent, and Sussex). Despite its size, the system offers a range of medical specialties, advanced care options, and community health initiatives. Delaware has 3 FHQCs at 11 different locations across the state, 6 hospitals, 1 children's hospital, 7 urgent care centers with 15 locations and the Division of Public Health has several clinics across the state providing array of services. Delaware has one level IV neonatal intensive care unit (NICU) located at the children's hospital and one level III NICU at Christiana Care, both located in New Castle County. A complete guide to health care in Delaware can be found here, DHSS_Healthcare_Access_Guide.pdf (delaware.gov).

Current challenges include nursing and provider shortages, ensuring care in remote areas remains a priority, particularly in Sussex County, and ongoing efforts to address social factors, including housing, food insecurity, and chronic disease prevention.

Services for CYSHCN

In Delaware, infants and toddlers with disabilities are served by Part C of IDEA, known as the Birth to Three Program in Delaware as well as by evidence-based home visiting programs. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. The Birth to Three program provides developmental assessments of children birth to 3 years of age along with service coordination for developmental services and therapies. The program is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and Nemours Children's Hospital (the only children's hospital in Delaware) working together to provide early intervention to young children with special health care needs and their families.

The Children and Youth with Special Health Care Needs Director (CYSHCN) sits in the Division of Public Health's Maternal and Child Health Bureau in the Family Health Systems Section. This position is essential as it functions to bolster and cultivate family and professional partnerships by working closely with family-led organizations. Delaware's Birth to Three system works in coordination with the CYSHCN Director who oversees the Newborn Metabolic and Hearing Screening programs to ensure policies and procedures are in place for appropriate and timely receipt of needed intervention services. Delaware's Family SHADE is a collaborative alliance of family partners and organizations committed to improving the quality of life for children and youth with special health care needs, and their caregivers, by connecting families and providers to information, resources, and services; advocating for solutions to recognized gaps in services; and supporting its member organizations. Family SHADE is contractually lead by our Parent Information Center. In 2021, Family SHADE developed a process to award mini grants to community organizations to implement small place-based interventions to drive innovation and if proven effective brought to scale. Parent Information Center selected two community-based organizations to receive an award in 2022 and awarded four more community agencies a mini-grant this year.

Context for Title V within the State

Governor Matthew Meyer took office as Delaware's 75th Governor in January 2025. Governor Meyer heads the Executive Branch of state government in Delaware. Within the Executive Branch, the Delaware Department of Health, and Social Services (DHSS) is a cabinet-level agency and is led by Secretary Josette Manning. The Delaware Department of Health and Social Services is one of the largest agencies in state government. DHSS has 11 divisions and employs more than 4,000 individuals in a wide range of public service jobs. In one way or another DHSS affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

The Division of Public Health (DPH) is one of the largest divisions within DHSS and home to Title V, the agency is responsible for planning, program development, administration, and evaluation of maternal and child health (MCH) programs statewide. DPH was mostly recently led by Karyl T. Rattay, MD, MS, FAAP. FACPM who served as the Division Director for thirteen years. Steve Blessing was appointed last year; Steve led the Emergency Medical Services unit in DPH for several years and previously served as a Deputy Director for DPH. DPH remains steadfast to its mission, which is to protect and promote the health of all people in Delaware. Because Delaware does not have county or local health departments, DPH administers both state and local public health programs. Within DPH, the Family Health Systems (FHS) section has direct oversight of Title V, including the Children and Youth with Special Health Care Needs (CYSHCN) program.

The Division of Public Health 2019-2023 Strategic Plan is currently still being used to provide a clear and proven path for the division to continue to lead the state's public health system. We are collaborating across multiple

sectors and leveraging data and resources to address policies as well as social, environmental, and economic conditions that affect health. Four strategic priorities were identified, of which the strategic plan is based: Promote Healthy Lifestyles; Improve Population Health and Reduce Health Care Costs. DPH staff are actively implementing this strategic plan by improving our services, participating in robust workforce development activities, and practicing the LeadQuest 10 Principles of
Personal Leadership. The State Health Improvement Plan (SHIP) and the State Health Assessment (SHA) are statewide initiatives facilitated by the University of Delaware, involving over 100 active participants, including hospital systems such as Christiana Care and La Red Health Center, state agencies, and community partners like Delaware HIV Consortium and Delaware Coalition Against Domestic Violence. In June, DPH established a formal SHIP/SHA Committee to ensure shared responsibility and inclusive representation across the division. To ensure broad and meaningful engagement, Director Blessing is requiring every Section be represented, to actively participate.

Public Health has a unique lens. Our guiding principles call upon us to engage in population-based activities to strengthen community-based public health. Research continues to tell us that while 95 percent of our healthcare dollars are spent on acute care, these dollars account for only 10 percent of improvements to our health status. For sustainable results, our future efforts must include collaborating with communities to improve their ability to identify the most important determinants of health, to develop strategies to address them, and to implement those strategies. This strategic plan is evidence of our commitment to working strategically with our partners to achieve our vision of healthy people in healthy communities.
Simultaneously, the Division engaged in maintaining its accreditation status by the Public Health Accreditation Board (PHAB). As an accredited public health agency, over the last severa; years we have made continuous progress. We report on that progress in annual reports to the PHAB. The Division of Public Health officially begun the journey to become reaccredited last. Once again, we have assembled DPH PHAB Domain Teams and have begun organizing to develop and collect required reaccreditation documents. Like our first and second accreditation run, we compared the 12 PHAB Domains national public health service standards with public health services we provide in Delaware. These PHAB standards are based on the long-standing 10 Essential Public Health Services. The DPH Domain Teams met and developed narratives and capture documents describing how we implement public health services in Delaware in preparation for our submission. Our last application was submitted and several DPH staff participated in interviews with the PHAB accreditation board in July 2022.

All areas within Domains 1-12 were identified as met, however there were some provided narratives or documents that were identified as not fully meeting the criteria but did not impact the overall domain score. The Office of Performance Management is reviewing these so adjustments can be made going forward.
Findings and Areas of excellence regarding MCH related work:

- DPH identifies and addresses health inequities through studies such as *The State of Our Union: Black Girls in Delaware* and *The Healthy Women Healthy Baby program.*
- DPH, in partnership with Delaware lawmakers, informs the public of the health implications of specific laws, e.g., SB-201 would lower infant mortality.
- DPH ensured programs and strategies use evidence-based practices (as available).

In Delaware, there is an increased effort to address health disparities and with good reason. Here are just a few examples of the disparities that exist within our state.

- **Infant Mortality.** The annual infant mortality rate for 2022 was 7.5 per 1,000 live births as compared to 5.6 per 1,000 for the U.S. The five-year infant mortality rate (2018-2022) was 5.9 per 1,000 (10.6 per 1,000 for Black non-Hispanics and 3.9 per 1,000 for White non-Hispanics). The five-year Black infant mortality rate decreased from 12.6 per 1,000 (2012-2016) to 10.6 per 1,000 live births (2018-2022) while the five-year White infant mortality rate decreased from 4.6 per 1,000 (2012-2016) to 3.9 per 1,000 live births (2018-2022). The five-year Black to White disparity ratio was about 2.7 times.
- **Breastfeeding.** According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2022 data, the percentage of women who ever breastfed increased by 9% from 79.2% in 2012 to 86.4% in 2022 and currently breastfeeding (i.e., at the time of survey) increased by 15% from 48.8% in 2012 to 56.1% in 2022 among women with a recent live birth. There were differences in breastfeeding rates by race and ethnicity. For instance, based on PRAMS data, the 2022 prevalence of ever breastfed among Black non-Hispanics was 79.0% as compared to 87.2% among White non-Hispanics and 89.9% among Hispanics. With that said, there were similarities in the 2022 prevalence of currently breastfeeding (or at the time of survey) by race/ethnicity; specifically, this percentage among Black non-Hispanics was 57.1% as compared with 54.9% among White non-Hispanics and 56.1% among Hispanics.

- **Teen Births.** The teen birth rate in the U.S. in 2022 was 13.6 per 1,000 females aged 15-19 years and the corresponding teen birth rate in Delaware in 2022 was 14.7 per 1,000 females aged 15-19 years. Between 2017 and 2021, the teen birth rate in Delaware was 16.1. The disparity ratio in teen birth rates was 3 times for Black teens (26.7 per 1,000 females aged 15-19 years) to White teens (8.6 per 1,000 females aged 15-19 years). Despite the racial disparities, Delaware has made great, long-term strides in improving the teen birth rates among White non-Hispanic, Black non-Hispanic, and Hispanic teens through several population-based health interventions. In fact, between 1991 and 2020, the teen birth rate declined by approximately 85 % for White non-Hispanics, decreased by approximately 86 % for Black non-Hispanics, and decreased by 72% for Hispanics.
- **Overall Health of Women of Childbearing Age**. According to the Behavior Risk Factor Surveillance System (BRFSS), the prevalence of good/excellent health among women of childbearing ages (18-44 years) increased from 83.3% in 2017 to 87.8% in 2021. Except for those who were high school graduates or had a GED, all other educational categories had higher prevalence of good/excellent health. Between 2017 (71.8%) and 2021 (88.4%) the percent of women of childbearing age with less than a high school education reported a 23% increase in good/excellent health as compared to those who attend college or technical school during 2017 (81%) and 2021 (86.2%), which had a modest increase of 6.4%. In 2021, 98.8% of women of childbearing age who identified as other race (non-Hispanic) reported good/excellent health as compared to 87.6% White (non-Hispanic), 82.1% Black (non-Hispanic), and 85.5% Hispanic women. During 2017-2021, there was over 11 percentage-point increase in good/excellent health among other race (non-Hispanic) and 9-percentage-point increase among Hispanic women as compared to 4 percentage-point increase among White (non-Hispanic) and less than half a percentage-point increase among Black non-Hispanic women.
- **Overall, Health Women of Childbearing Age**. According to Behavior Risk Factor Surveillance System (BRFSS) 2017-2021 data, the prevalence of good/excellent health among women of childbearing ages (18-44 years) increased from 83.3% in 2017 to 87.8% in 2021. Except for those who were high school graduate or GED, all other educational categories had higher prevalence of good/excellent health. Between 2017 (71.8%) and 2021 (88.4%) the percent of women of childbearing age with less than a high school education reported a 23% increase in good/excellent health as compared to those who attend college or technical school during 2017 (81%) and 2021 (86.2%), which had a modest increase of 6.4%. In 2021, 98.8% of women of childbearing age who identified as other race (non-Hispanic) reported good/excellent health as compared to 87.6% White (non-Hispanic), 82.1% Black (non-Hispanic), and 85.5% Hispanic women. During 2017-2021, there was over 11 percentage-point increase in good/excellent health among other race (non-Hispanic) and 9-percentage-point increase among Hispanic women as compared to 4 percentage-point increase among White (non-Hispanic) and less than half a percentage-point increase among Black non-Hispanic women.
- **Smoking.** According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2022 data, the prevalence of smoking before pregnancy among women with a recent live birth declined by 63% from 27.2% in 2012 to 10.2% in 2022. Similarly, the prevalence of smoking during the last three months of smoking among women with a recent live birth declined by 56% from 14.4% in 2013 to 6.4% in 2022. In addition, in 2012, over 1 in 3 (34.5%) White non-Hispanic women with a recent live birth smoked before pregnancy as compared to 1 in 4 (24.8%) Black non-Hispanic women. In 2022, 13.2% of White non-Hispanic women reported smoking before pregnancy as compared to 9.5% of Black non-Hispanic women. Similarly, in 2012, 17.7% of White non-Hispanic women reported smoking during the last three months of pregnancy as compared to 10.2% of Black non-Hispanic women. However, in 2022, 7.5% of White non-Hispanic women reported smoking during the last three months of pregnancy as compared to 8.3% of Black non-Hispanic women.
- **Medical Home.** As per the NSCH 2020-21 data, 44.7% of Delaware children received coordinated, ongoing, comprehensive care within a medical home as compared to 45.3% in the U.S. However, there were notable disparities with regards to children with medical home. For instance, in Delaware, 35.1% of Black non-Hispanic children (36.7% in the U.S.), 28.9% of Hispanic children (33.2% in the U.S.), 42.9% other non-Hispanic children (44.6% in the U.S.), and 56.7% of White non-Hispanic children (54.6% in the U.S.) indicated having a medical home. Further, there were differences due to special health care needs (CSHCN) status. For instance, 35.8% of children in Delaware with special health care needs indicating having a medical home as compared to 39.3% in the U.S.

It is clear from these examples that disparities exist across racial and ethnic groups, across ages, and across geographical boundaries. We know that many of these inequities are a result of differing social factors. Focus groups conducted for our needs assessment confirmed that our population experiences challenges with access to transportation to medical visits, access to healthy foods, and safe places to be active. There are language barriers and issues of cultural competency that prevent our Spanish-speaking citizens from being able to benefit from the programs

and services that are available. And access to specialists and quality care is often limited by the county in which one lives.

The Division of Public Health operates under the authority of Title 16 of the Delaware Administrative Code, which governs health and safety regulations across the state. Within this framework, several key programs related to Family Health are outlined.
Title 16 includes regulations for both the Birth Defect Surveillance and Registry Program and the Autism Surveillance and Registry Program, which are partially funded through Title V. The Delaware Healthy Mother and Infant Consortium (DHMIC) is also established under this code. DHMIC is responsible for coordinating statewide efforts to prevent infant mortality and to improve the health of women of childbearing age and their infants.
In July 2020, the Delaware Perinatal Quality Collaborative (DPQC) was formally established in state code and announced during a virtual press conference hosted by the Governor. The DPQC focuses on using data collection and analysis to improve maternal and infant health outcomes across Delaware. Its core objectives include:

- Sharing up-to-date data for benchmarking and quality assurance/quality improvement (QA/QI),
- Identifying best practices and care protocols,
- Realigning service providers and systems,
- Supporting ongoing professional education,
- Raising public awareness about the importance of perinatal care.

Our Title V Program works in close partnership with DHMIC to align strategic priorities and initiatives.
Additionally, Title 16 includes regulations for School-Based Health Centers, codified in 2012 and updated in 2017. While the Newborn Hearing and Metabolic Screening Programs are not primarily funded by Title V, they are also established under Title 16 and closely coordinate with Title V activities. Both of these screening programs have mandated service provisions and are overseen by Governor-appointed boards.

As of July 1, 2025, DPH was charging the birth facilities and midwives $165.00 per newborn for the newborn metabolic screening including lab and follow up services. The DPH contracts with Nemours Children's Hospital to administer the statewide program which includes both the program and laboratory services. Nemours Children's Hospital currently sub-contracts with Revitty to provide the laboratory services. The Delaware Newborn Screening Advisory Committee meets at least three times a year and is a governor appointed body. The Advisory Committee members, DPH and Nemours spent quite a bit of time discussing the last few years discussing and voting on necessary changes including the elimination of the mandated second screen, how long blood spots should be stored and expanding the newborn screening panel. All these items, eliminating the second screen, timeline for specimen collection and the length of time bloodspot cards are stored were approved by the Advisory Committee and all birthing facilities were included in the process. The Advisory Committee voted on and provided a recommendation to the DPH Division Director to add four additional conditions, Pompe Disease, Muccopolysaccharidosis Type I (MPS I), X-Linked Adrenoleukodystrophy (X-ALD) and Spinal Muscular Atrophy (SMA) to Delaware's screening panel. With the DPH Director's approval, the additional conditions were added to the panel January 1, 2020. Most recently, MPSII and GAMT were approved and screening for those two additional disorders was added to the panel on July 1, 2024.

III.B.2. State Title V Program

III.B.2.a. Purpose and Design

The focus of our Title V program is to support and improve the health of women, infants, children, adolescents, including children and youth with special health care needs, and families in Delaware. To accomplish this, Delaware is tasked with identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes. Delaware's Title V MCH team works to collaborate with MCH partners at all levels throughout the year, so that all programs serving these populations can be strategically aligned statewide. This strategic alignment is imperative for utilizing resources efficiently and effectively assuring the greatest impact.

Delaware's Division of Public Health (DPH) is the largest division within the Department of Health & Social Services (DHSS). The Title V Team is part of the Bureau of Maternal & Child Health (MCH), which is situated within the Family Health Systems (FHS) unit. Title V is responsible for the planning, programming, development, administration, and evaluation of maternal and child health programs statewide. Within DPH, the Family Health Systems section has direct oversight of Title V, as well as a number of other MCH programs including Children and Youth with Special Health Care Needs (CYSHCN), the Early Childhood Comprehensive Systems (ECCS) initiative, Newborn Screening

(Metabolic and Hearing), Birth Defects Registry, State Systems Development Initiative (SSDI), Adolescent Health, School Based Health Centers, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Infant Mortality Elimination program, Family Health and Epidemiology, Title X/Family Planning, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, as well as others that require partnerships, coalition building and leadership.

The Life Course Perspective continues to be the lens through which we view our MCH work. Delaware's Title V MCH work focuses on ways to increase these protective factors and decrease risk factors. The Life Course Perspective suggests that a complex interaction of protective factors and risk factors contributes to health outcomes across the span of a person's life, or developmental trajectory.[1] These protective factors and risk factors include disease status, health care status, nutrition, socioeconomic status, and stress. Protective factors increase the developmental trajectory of a person while risk factors decrease the developmental trajectory of a person. Some key examples of protective factors:

- Data driven decision making
- Access to care
- Education and prevention
- Supporting coordinated, comprehensive and family-centered systems of care
- Title V as a leader and convener

Serving as a convener, collaborator, and partner in addressing MCH issues, including supporting partnerships to address community health factors.

Partnerships are a unique and a fantastic asset in Delaware and our Title V MCH is a leader and convener of a broad spectrum of partners to address the needs of women, infants, children, adolescents, and children with special health care needs. Delaware prides itself in building and maintaining partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. In working to improve the lives of women, children and families, leadership is an essential role for maternal and child health programs. Leaders must have a vision, take initiative, influence people, solve problems, and take responsibility in order to make change happen.

On April 14th, the DHMIC held its 19th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial, ethnic and geographical disparities that are present in high-risk zip code zones to reduce poor health outcomes in mothers and their infants. This year's theme was Our Vision. Our Voices. Elevating Community Voices to Transform Maternal and Child Health.

The event drew in many healthcare professionals, policymakers, community influencers, community partners, stakeholders, and citizens who were interested in learning ways on how to provide access to proper care for all Delaware mothers, before, during, and after pregnancy, their babies, and families no matter their socioeconomic, racial, or ethnic status.

DHMIC Chair, Priscilla Mpasi, MD, Lt. Governor Kyle Evans Gay, and DHMIC Vice-Chair, Tiffany Chalk, CMP, who was the emcee for the event, provided opening remarks on the importance of why we should continue the work to address maternal and infant mortality and morbidity in Delaware. State dignitaries including Speaker of the House and State Representative Melissa Minor-Brown and Senator Marie Pinkney, a DHMIC appointed member, presented the Black Maternal Health Awareness Resolution in the morning. U.S. Senator Lisa Blunt Rochester also shared inspirational words on how she plans to continue providing services for the MCH population.

There was a total of 24 speakers throughout the day, which was made up dignitaries, DHMIC leadership, two keynote speakers, and four different breakout sessions. The presentations ranged from topics on adverse childhood experiences, patient centered care, how men could impact maternal health outcomes, an interactive session for a

maternal and child health hub blueprint, guaranteed basic income (GBI), and more.

News of the 19th DHMIC annual Summit and its purpose were shared on six local and regional news media placements which was secured on three media outlets such as NBC10, 6ABC, and Delaware Public Media, where the DHMIC Chair, Priscilla Mpasi, MD, was interviewed.

In addition, regardless of your title and level in the organization, everyone at every level on the DPH Title V MCH team is engaged in the process of leadership. We conduct our work and our interactions with others using the 10 Principles of Leadership (LeadQuest) and these values as guideposts for our personal behavior, professional practice, and public health decisions. DPH has been focused on creating a culture of leadership for over 11 years, using this framework. Title V MCH has a proven track record of creating unity, building trusting relationships to help achieve success by working with others rather than stepping on or over people. We work on bringing people together, to establish a common vision and set of values along with programmatic systems and operations, such as planning, goal setting, communications and quality improvement.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. We have utilized a variety of training platforms for professional development including the MCH Navigator, Franklin Covey, DE TRAIN, and our internal DPH training office.

Through the power of partnerships, we continue to integrate our programs where it makes sense, find the connections to make sure we are not duplicating work, focus on doing things right. Public Health success will depend on health leaders working closely with both the private and public sectors, and over the next year, we are making a concerted effort to tap new and non-traditional partners (i.e., business community, transportation, housing, planning, including faith-based organizations, etc.), particularly as we address social context issues impacting the health of women, infants, and children.

Supporting coordinated, comprehensive and family-centered systems of services at state and local levels.

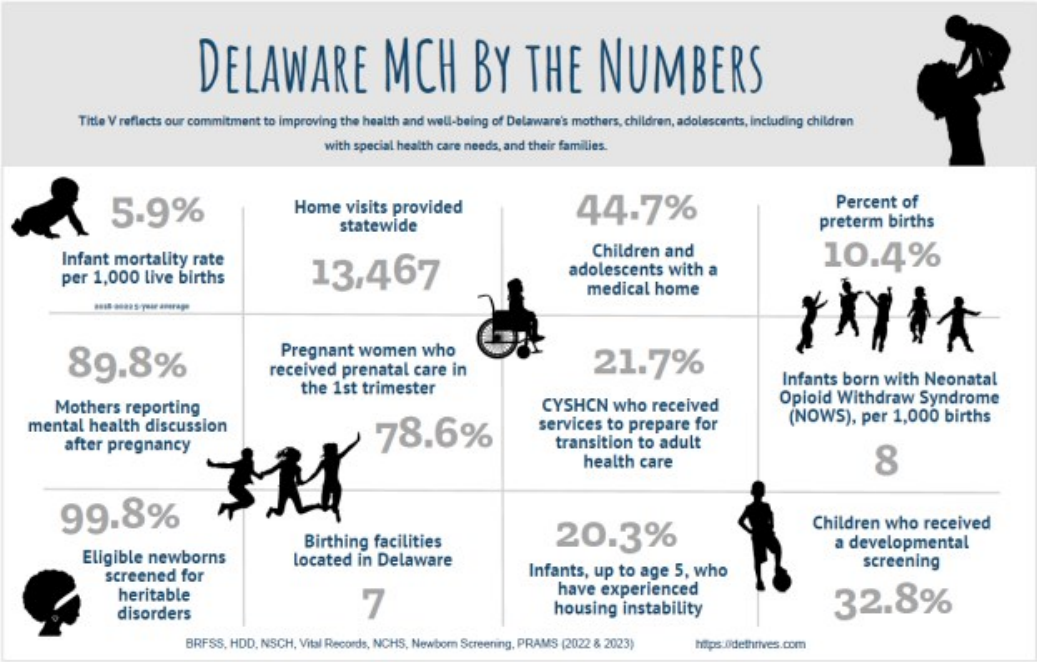
DPH believes everyone has the right to a standard of living adequate for health and necessary social services. In recent years, DPH has strived to improve community health factors with the help of many community leaders, non-profit organizations, state agencies, and stakeholders. One example is improving prenatal education and care to reduce the infant mortality rate. Another is educating parents and guardians how to protect children with asthma to keep them in school and out of the hospital.

Thanks to the collaborative efforts from the Department of Health, the Delaware Maternal and Child Death Review Commission (MCDRC), the Delaware Perinatal Quality Collaborative (DPQC), and the Delaware Healthy Mother & Infant Consortium (DHMIC), a toolkit was previously created and is used by Providers to share patient materials to promote and educate women and their families on the Urgent Maternal Health Warnings Signs. The toolkit included flyers, posters, double-sided tear off prescription pads, and a Provider Letter. These items can be ordered and delivered for free or can be downloaded from the DEThrives site in English, Spanish, or Haitian Creole.

With a long-term goal of progression toward universal developmental surveillance and screening, Delaware's early childhood community emphasizes a coordinated, comprehensive, and holistic approach. This entails focusing on the integration of a host of multi-sector programs in the health and early learning and education settings. To this end, the developmental screening effort places emphasis on collective impact with a goal toward shared measurement and agenda, in addition to the use of continuous quality improvement methods to address the gaps identified within the system.

DPH contracts with the Parent Information Center (PIC) to execute the Family SHADE project with a revitalized and programmatic approach, which will include family and professional partnerships at all levels of decision making, to best serve our children and youth with special health care needs (CYSHCN). PIC utilized the Family Leadership

Network (FLN) in collaboration with all mini-grantees to promote and receive feedback on where there are gaps in service delivery for CYSHCN population. The FLN network membership is a member network which offers trainings, quarterly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. They serve as a learning network and resource for the community agencies serving CYSHCN. For another year, PIC succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of competitive mini-grant opportunities that were innovative and aligned with our MCH NPMs.



On January 23rd, DPH hosted an all-day, in-person event, titled *Let's Thrive: A Home Visiting Workforce Symposium*. The event emphasized collaboration among partners, featuring a lecture-style format in the morning and interactive sessions in the afternoon, including skits and role-playing. The goal was to clarify the roles of Home Visiting professionals and Community Health Workers (CHWs), highlighting the referral chain through real-life scenarios.

The event showcased nine speakers who presented topics on Early Childhood Mental Health (IECMH) Consultation, the Delaware Family Support Hub (the Home Visiting App), and Social Determinants of Health Data. Participants also had a chance at some hands-on role-playing skits of how Family Support Specialists (commonly referred to as a Home Visitor), CHWs, IECMH consultants, and supervisors could assist and compliment one another's work when serving the same family by assisting one another with different resource outlets. The symposium was recorded and these training videos will serve current and future FSS hires to become familiar with the different faces and roles that exist within the Delaware Home Visiting realm.

Developing and utilizing innovative and evidence-based or -informed approaches to address cross-cutting issues that impact the health status of specific MCH populations and sub-populations, such as community health factors; and

Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core public health functions and address specific health priorities. Title V MCH plays a very important role in the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) process. It requires that our MCH partners across the state be engaged in the process, in order to access data, provide various perspectives in the analysis of data, and make a determination of contributing factors that impact health outcomes, particularly as it relates to women, infants and children. Assets and resources must also be identified and addressed

as well learning directly from the community about attitudes about health behavior, socioeconomic and environmental factors, and community health factors. The Title V priorities and State Action Plan build off the priorities identified through the SHA and SHIP process, as well as the DPH Strategic Planning priorities and Health People 2030.

Mentioned throughout the application, the Healthy Women, Healthy Babies program promotes access to care, by providing an evidence-based framework to improve women's health, mental health, and nutrition before, during & after pregnancy. The framework uses a Life Course perspective model that conceptualizes birth outcomes as the end product of the entire life course of the mother leading up to the pregnancy - not simply only the nine months of pregnancy. The goal is to provide assistive services to encourage the woman to maintain a healthy weight, nutritious diet, receive appropriate amounts of folic acid, manage chronic disease, address environmental risk factors such as smoking, substance abuse or other stress-inducing circumstances, as well as the development of a personalized reproductive life plan (for all women and men). The model is a value/performance-based approach focused on meeting or exceeding six benchmark indicators, with an emphasis on addressing community health factors and incorporates the role of community health workers to further support outcomes.

DPH has implemented 11 Healthy Women Healthy Baby (HWHB) Zones community-informed strategies that aim to increase awareness, educate, better serve women of reproductive age and amplify the voice of black maternal health grass roots organizations. The primary focus is innovation and to spread evidence-based programs and place-based strategies to improve health in maternal and infant health outcomes, as a complement to our medical intervention, HWHBs 2.0. The first-ever mini grants support the shared initiative to narrow the wide variance in birth outcomes between black women and white women by building state and local capacity and testing small-scale innovative strategies.

DPH worked with a contractor to develop a mini-grant process to fund local communities/organizations to implement interventions to address social determinants of health in priority communities throughout Delaware. While the specific services and activities provided by the CBOs vary greatly, each CBO's work taps into a strategy or set of strategies that has been shown to be supportive of this long-term goal. The CBOs that were funded through the four funding cycles (between 2019 and 2024) of the HWHB Initiative included: Black Mothers in Power; Breastfeeding Coalition of Delaware; Christina Cultural Arts Center; Delaware Adolescent Program, Inc.; Delaware Coalition Against Domestic Violence; Delaware Multicultural and Civic Organization; Hispanic American Association of Delaware; Impact Life; Parent Information Center; REACH Riverside (Kingswood); and Rose Hill Community Center.

Over the five years of the initiative, mini-grantees provided services to 4,129 individuals, primarily to women of color. Services provided by organizations were designed to meet the needs of pregnant and parenting women, many of whom were experiencing challenges with physical and mental health in addition to food and/or housing insecurity, social isolation, lack of childcare, and having significant challenges accessing medical care.

One key component of the HWHB Zones initiative is the provision of coaching and technical assistance (TA) to the mini-grantees throughout the life of the initiative to build capacity and ensure sustainability of the interventions, as well as focus on continuous quality improvement. In Grant Cycle 1, 2, 3, and 4 the TA consisted of two learning collaborative meetings as well as individual coaching and TA.

Implementing the core public health functions of assessment, assurance, and policy development through program efforts that are supported by the MCH Block Grant.

"Delaware Thrives" (DEThrives) is the branding theme and umbrella for all maternal and child health social marketing programming, developed in partnership with the Delaware Healthy Mother and Infant Consortium (DHMIC), which the state funds along with other federal funding sources, such as Title V, and DPH Family Health System staff support. DEThrives has purposefully become more robust with social media posts, messaging, programs, and partnerships. DEThrives utilizes Facebook, X, Instagram, and blog posts to educate, inform, and provide resources, services and

links to the Delaware maternal and child health population and our partners. MCH is using this strategy to engage and inform our population with up-to-date information pertaining to various needs and topics.

Several pending legislation updates are available for reporting, which aim to improve maternal and infant healthcare in Delaware. The goal of these bills were to break down barriers and remove other obstacles some mothers and families have faced when receiving healthcare treatment in Delaware.

- SS 1 for SB 106: An act to amend Title 16 of the Delaware Code relating to maternal mental health. This act modernizes and expands the concept of maternal mental health by replacing the definition of maternal depression with the more encompassing definition of perinatal mood and anxiety disorder. This Act contemplates treatment for any caregiver who may be affected by perinatal mood and anxiety disorder.
- SS 1 for SB 301: An act to amend Title 14 of the Delaware Code relating to providing medication abortion prescription drugs and emergency contraception. This Act requires public universities in this state to provide access to medication for the termination of pregnancy and emergency contraception. The medication and contraception must be provided on-site, but consultation to provide them may be performed by a provider at the student health center or by a provider who is associated with a university-contracted external agency.
- HB 362: An act to amend Title 18 of the Delaware Code relating to coverage for doula services. In 2023, the General Assembly passed House Bill 80, which required the coverage of doula services under the State's Medicaid plan beginning in 2024. This Act would require similar coverage under private health insurance plans.
- SS 1 for SB 5: An act proposing an amendment to Article I of the Delaware Constitution relating to the right to reproductive freedom. This Act clarifies: (1) That an individual has a fundamental right to reproductive freedom relating to that individual's pregnancy. (2) That the standard of medical judgment is a "good-faith medical judgment" rather than a "professional judgment". (3) That the health care professional making the good-faith medical judgment is the "treating attending health care professional" rather than the "attending health care professional".
- HB 223: An Act to amend Title 16 of the Delaware Code relating to informational materials concerning menstrual disorders. This Act requires DHSS, in conjunction with DOE, to develop or obtain informational materials concerning menstrual disorders to be provided upon request to school districts for purposes of educating students about menstrual disorders and their symptoms, and to ensure at least every 2 years the effectiveness of the information, that the information is up-to-date, and that any electronic links provided remain valid.
- HB 157: An Act to amend Title 16 of the Delaware Code relating to the Hearing Aid Loan Bank (HALB) Program. This Act repeals the HALB Program, as it is no longer operational. The Program was created for the purpose of lending hearing aids on a temporary basis to children under 3 years. Loans were initially for 6 months with possible 3-month extensions. The need for the HALB Program has steadily decreased over time and the Program is now obsolete.
- HB 149: An Act to amend Title 18 of the Delaware Code relating to SBHCs. This Act gives DPH the authority to approve supervised clinical training rotations for mental health providers at school-based health centers.
- HB 3: An Act to amend Title 11 of the Delaware Code relating to breastfeeding. This Act creates a breastfeeding and lactation program within the DOC to provide lactation support to women in DOC custody. Among other things, it permits women to collect breast milk for later retrieval and delivery to an infant or toddler by an approved person.
- SJR 6: Directing the Division of Medicaid & Medical Assistance (DMMA) to explore Children's Health Insurance Program (CHIP) initiatives. This directs DMMA to explore amending our Delaware Medicaid State Plan to allow for the adoption of CHIP From-Conception-to-End-of-Pregnancy option and the creation of a Health Services Initiative that will allow our State to use federal funding to partially cover prenatal and postpartum care for individuals otherwise ineligible for free or low-cost health-care coverage due to immigration status.

In January 2021, the State of Delaware began implementing a Guaranteed Basic Income (GBI) Demonstration for pregnant women. The GBI Demonstration was created with input and support from DHSS, the DHMIC, and the SDOH Subcommittee of the DHMIC. Community partners included Rose Hill Community Center, the DE Coalition Against Domestic Violence, and Stand by Me, all of which provided services and support to the participants.

The GBI Demonstration provided $1,000 a month in the form of a debit card for 2 years to women who enrolled during their 1st or 2nd trimester of pregnancy. Women had to have incomes below 185% of the federal poverty line to enrolled. Participants also received linkages to and guidance on prenatal care and post-partum care, financial coaching, and referrals for primary health care, mental health, and personal health and wellness. GBI was part of Delaware's HWHB Mini-Grant Initiative, which provided free services to pregnant women at risk of poor maternal and infant health outcomes.

The GBI Demonstration was designed to reduce stress, improve the physical and mental health of participants and their children, and improve maternal and infant birth outcomes. Additionally, the Demonstration was designed to reduce utilization of emergency departments and decrease hospitalizations, and to increase financial stability, housing stability, and employment stability.

Evaluation data demonstrate that the program achieved its intended goals. Over the course of the GBI Demonstration, participants spent their stipend on basic necessities: food, household items, transportation, rent, Internet and phone, clothing, utilities, insurance, childcare, and personal hygiene. Across the enrollees, nearly 1/3 of the stipends were used for food. Participants' physical and mental health improved throughout their participation. They could make ends meet and felt they were a better provider for all their children. Some women found new jobs, bought homes, paid off debts, and improved their credit scores. The GBI program in Delaware was a smart investment with a very sizeable, positive return for participants, the state, and the local economy. It also connected the women to important social and economic benefits including employment, food security, and safe and affordable housing. GBI also helped participants achieve financial self-sufficiency and reduce stress and anxiety. The ROI study of the GBI Demonstration showed that the investment in that part of the program paid for itself more than three times over and provided both immediate and lasting benefits to participants and their families.

DPH is pleased to be recognized by the Office of Disease Prevention and Health Promotion (ODPHP) within the U.S. Department of Health and Human Services as a Healthy People 2030 Champion for its commitment to furthering health and well-being. As a Healthy People 2030 Champion, DPH has demonstrated a commitment to helping achieve the Healthy People 2030 vision of a society in which all people can achieve their full potential for health and well-being across their lifespan. ODPHP recognized Delaware's DPH as part of a growing network of organizations partnering with it to improve health and well-being at the local, state, and tribal levels.

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[1] Lu, M. and Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: a life course perspective. *Maternal Child Health Journal*, 7(1), 13-30.

III.B.2.b. Organizational Structure

Delaware's Department of Health and Social Services (DHSS) is part of the executive branch and is responsible for promoting health, safety, and well-being among Delaware residents. It provides a wide range of services to individuals and families, especially those who are vulnerable or underserved. Core functions of DHSS, Public Health Services, Medicaid & Medical Assistance, Social Services, Substance Abuse & Mental Health, and Services for Seniors and People with Disabilities. DHSS is led by Secretary Josette Manning who was appointed by Governor Matthew Meyer in 2025.
Public health services are administered through the Division of Public Health (DPH).

The DPH is one of 12 Divisions in the DHSS. Core functions of the DPH include managing disease prevention, vaccinations, health education, emergency preparedness, and environmental health programs, addressing issues like, tobacco use, maternal/child health, and chronic disease prevention. DPH administers all health-related programs at the state level as there are no local health departments. DPH does however operate local health clinics across the state delivering services such as family planning, immunizations, WIC, STD screening and treatment.

The Division of Public Health has approximately 700 employees across four areas Community Health Promotion, Clinical Sciences, Administrative Operations and Office of the State Medical Director.

The Community Health Promotion area houses the following sections:

- Health Promotion & Disease Prevention (Chronic Diseases, Cancer Prevention & Control, WIC)

- Family Health Systems (Adolescent Health, Family Health Research & Epi, MCH)
- Performance Management
- Animal Welfare
- Public Health Resources (Health & Vital Statistics, Informatics

Clinical Sciences
- Infectious Disease Prevention & Control
- Public Health Nursing
- Community Health Services (public health clinics)
- Public Health Laboratory

Administrative/Operations
- EMS & Preparedness
- Health Systems Protection (Environmental, Drinking Water, Radon, Lead)
- Chief of Admin/Support Services (Budget & Finance)
- Contracts & Grant Management
- Early Intervention

Office of the State Medical Director
- Oral Health & Dental Services
- State Epidemiologist

The Title V Block grant program is managed by the Family Health Systems (FHS) section within the Division of Public Health and his led by the Title V MCH Director. The MCH Bureau is one of three Bureaus within the FHS section along with the Adolescent Health Bureau and the Center for Family Health Research and Epidemiology. The MCH Deputy Director leads the MCH Bureau, the CYSHCN Director, Title V MCH Coordinator sit within the MCH Bureau. Other programs within the MCH Bureau include Newborn Screening, Early Childhood Systems, Home Visiting and SSDI. There are initiatives and programs being implemented in all three Bureaus that are supported by either Title V grant funds or the Title V MOE funds. These include infant mortality initiatives, home visiting, newborn screening, school-based health centers, developmental screening, early intervention and more.

The MCH Bureau is responsible for administering the award made to the state under Title V. The programs administer the budget and allocate resources in accordance with the grant requirements. Additionally, state MOE dollars are used to advance related programs and services, such as home visiting and newborn screening. MCH coordinates closely with the fiscal and grants team to ensure we administer the funds in compliance with Title V while meeting our strategy and program needs. Over 50 FTEs are supported by the Title V Block grant and State MOE funds across the Division. About 13.5 FTEs are funded by the federal grant portion and although not all of them report directly to the Title V Director, we do have influence in ensuring that job duties align with the current Title V priorities. For the current application, the state is allocating over $13M in state funds to the MOE agreement. The total includes salaries from state general funds and state appropriated special funds, program income from the Newborn Screening Program; state funds budgeted for Infant Mortality initiatives, developmental screening, and Home Visiting. The Newborn Screening, Developmental Screening and Home Visiting are administered within the FHS, MCH Bureau. All of our infant mortality initiatives are administered within the FHS, Family Health Research & Epidemiology Bureau.

Organizational charts depicting the descriptions above are included as attachments.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

Population Served

Delaware Maternal and Child Health (MCH) serves all MCH populations, which are generally described in the next paragraph. About 1 in 2 (51.6%) Delaware women are of reproductive age (15-44 years). Delaware's average births from 2009 to 2023 were 10,500, with fairly stable annual totals. Children under 19 represent 20.5% of Delaware's population. At a population of about 1,051,900, that equates to around 215,600 children under 19.

There are also an estimated 396,000 families in Delaware. It is also important to note that 13,726 grandparents live with their grandchildren (under 18). Almost half of these Delaware grandparents (43%) are the main caregivers for their grandchildren, meaning they provide for their everyday needs. This is a higher percentage than the national average, where 33% of grandparents living with their grandchildren are the primary caregivers.

Delaware MCH works with partners such as Medicaid, CHIP, hospitals, federally qualified health centers, primary care and specialty providers, early intervention providers, home visiting, community health workers, and Family Voices to assure MCH populations have access to health insurance; primary care providers or, ideally, a certified medical home; specialty care services; support for transitioning to adult healthcare settings; and other supports and services based on identified family needs.

Health Services Infrastructure and Integration of Services

Overall, Delaware's health services infrastructure can present challenges in meeting the needs of mothers, children, and families. Delaware healthcare provider shortages are well-documented, particularly in the Western Sussex County and Kent County. The entire state is considered a mental healthcare shortage area, while two out of 3 counties have primary care shortages, as well as dental care shortages (HPSA Find, n.d.) and most recently OBGYN shortages.

Maternal Care

Delaware has one Level III birthing hospital, Christiana Care Health Services. This means patients who need higher levels of care must be transferred up north to New Castle County or seek care in bordering states, such as MD or PA. One hospital in the southern part of the state TidalHealth made significant changes to its obstetrics department, which occurred around January 2022. After a merger in 2020 that expanded the organization, TidalHealth began facing OB-GYN shortages in Sussex County due to financial stress and workforce deficits. Hospital leadership warned that they would shutter the obstetrics department at TidalHealth Nanticoke (Seaford, DE) if its financial performance didn't improve within a year. The hospital did not shut down maternity services. Instead, it temporarily relocated the OB unit multiple times during a renovation (April 2024 through early 2025), but maternity care continued with limitations. The Title V MCH Director, DHSS leadership did facilitate some conversations between some of the local providers and Tidal Health and two other birthing hospitals to help with some patients who had difficulty accessing maternal care. Hospitals often cite costs and/or staffing constraints in their decision to discontinue the service, and this had a ripple effect on pregnant women seeking maternal care in this area, which often served the uninsured and migrant population. Sussex County is officially designated a "high-priority shortage area" for women's health care, marked by frequent clinic and OB-GYN closures due to provider shortages and operational challenges. Women often wait many months for appointments—some were delayed 4 to 17 months after referral spotlightdelaware.org, as a long-standing lack of local specialists continues to impact access.

Pediatric (including Adolescent) Care

Delaware has 172.4 pediatricians per 100,000 children aged 0–21, ranking 3rd in the nation as of September 2023. The national average is 113.2 per 100,000. According to a 2021 Division of Public Health, Delaware Department of Health and Social Services workforce capacity report, southern Kent County and southern Sussex County contain areas with no practicing pediatricians or a youth-to-pediatrician ratio markedly higher than neighboring regions. Families in these areas must travel significant distances for pediatric services.

Delaware is home to Nemours Children's Hospital – Delaware, a freestanding pediatric hospital in Wilmington with 195 beds, the only Level IV NICU in the state, and Delaware's sole Level I pediatric trauma center. Christiana Hospital (Newark) in the northern part of the state operates the state's only Level III NICU with 60 bassinets. All eight acute care hospitals in Delaware participate in the state's Pediatric Emergency Care Facility Recognition Program, encompassing Levels I–III. Facility breakdown includes:

- Level I: Nemours Children's Hospital (comprehensive pediatric care)

- Level II: Christiana Hospital (stabilization & transfer)
- Level III (6 hospitals): Bayhealth Kent, Bayhealth Milford, Beebe Healthcare, Nanticoke Memorial, St. Francis, Wilmington Hospital

Delaware also supports pediatric acute care via school-based health centers in various districts across the state.

Delaware's statewide Immunization Information System (IIS) has operated and been in place since 1983, containing nearly 500,000 resident immunization records, including those for children 0–17 years old. Providers and facilities access DelVAX public portal via secure interfaces and can leverage tools for forecasting, reminder/recall, and coverage assessment to support school entry and appointment planning. About 93% of adolescents (11–17) have ≥2 immunizations recorded—which is above the national average of 90%. In addition, there is a 104% reporting rate for children under 6 (reflecting multiple doses or overreporting due to moving children)—well over the national target of 98%. Delaware law requires verified immunizations for school entry: Kindergarteners need doses of DTaP, polio, Hepatitis B, MMR, and varicella; secondary students must show Tdap and meningococcal doses. Delaware's Vaccine for Children's Program works in tandem with Delaware's broader immunization infrastructure, including DelVAX, quality improvement efforts, and public health campaigns. With recent funding cuts at the federal level, a ripple effect has trickled down to the state level, whereby the Delaware Division of Public Health required going through restructuring process and the DPH Immunizations team will be moving organizationally to the DPH Family Health Systems Section, where Title V MCH is administered.

Mental Health Care

Delaware meets only ~12% of its mental health care needs, with over 289,000 Delawareans living in mental health professional shortage areas—more than a quarter of residents. Delaware struggles with mental health provider shortages, delays in care, and bottlenecks affecting children and families. While school-based mental health programs exist in the city of Wilmington and other areas, reports suggest difficulties in access, mismanagement, and inconsistent quality.

Significant child mental health shortages persist—particularly in rural Sussex and Kent—limiting access to child psychiatrists and consistent school-based services. Delaware faces a critical shortage of child psychiatrists:
- New Castle County: 19 providers for ~157,805 children
- Kent County: 3 for ~50,830
- Sussex County: just 1 for ~47,032 children

Medicaid reimburses postpartum mental health screening, and the state funds programs such as:
- A postpartum depression hotline
- Medicaid depression care management pilot
- Home visiting, Healthy Start, and Perinatal Behavioral Health Initiative marchofdimes.orgstateregstoday.com.

The Delaware Division of Public Health's Healthy Women Healthy Babies program, in collaboration with the Delaware Healthy Mother and Infant Consortium initiatives fund a performance driven model including community-based mental health support, particularly in high-risk zones, addressing stress, anxiety, and social isolation among pregnant/postpartum women.

Delaware's system of care for pregnant and parenting women with Substance Use Disorder (SUD)

Delaware is slowly building a SUD care system for pregnant and parenting women, from inpatient centers that keep moms with children, to continuity supports around housing and daily needs, backed by state-coordinated initiatives, quality improvement, and Medicaid-funded incentive programs (i.e. Waiver-funded nutritious support + coordinated case management). In 2016, Delaware was selected for Substance-Exposed Infants Technical Assistance, enhancing screening, Plan of Safe Care protocols, linkage to treatment and home visiting, and strategies to reduce stigma.

Claymont Center for Pregnant & Parenting Women, operated by Gaudenzia in partnership with DSAMH, opened July 2022 as Delaware's only inpatient/SUD treatment facility where women can bring up to two children under 10 during their stay. The residential program offers two levels of care (high & low intensity), along with medication-assisted treatment (MAT), individual/group counseling and trauma-informed services. Since opening, it has served over 55 mothers and their children, helping women avoid custody loss while receiving critical care.

In April 2024, Gaudenzia launched a two-year housing support pilot for women completing treatment, offering full rental assistance during Year 1 and sliding-scale help in Year 2. It supports 7 families per cohort, aiming to promote recovery and family retention.

The Addiction Treatment Resource Center (ATRC) operated by DSAMH/SAMHSA serves as a centralized hub offering provider training, best practices, peer support, and links to Crisis services available 24/7 across the state.

Centers of Excellence launched in 2018 have improved SUD evaluation and treatment for pregnant women, including MAT, counseling, case management, housing referrals, and co-managed behavioral-health-&-medical teams news.delaware.gov.

Brandywine Counseling & Community Services (BCCS) runs a perinatal outreach program delivering care strategies for women with opioid use disorder and their infants, in partnership with major hospitals.

The Delaware Division of Medicaid and Medical Assistance implemented a CMS-approved 1115 Waiver (May 2024) supports diapers & meals for postpartum moms (first 12 weeks) and adds Contingency Management Services—low-barrier incentive tools to encourage engagement in outpatient treatment & sustained recovery (24 weeks for stimulants; 64 weeks for opioids). Through the Delaware Perinatal Quality Collaborative, perinatal SUD and neonatal abstinence syndrome are prioritized, promoting family-centered, evidence-based care standards across hospitals and public health agencies.

Title V Role in Addressing Key MCH Issues

Delaware MCH plays a vital role in addressing key issues for MCH populations. Representative examples include:

Delaware MCH implemented the Help Me Grow system, which creates a central home for parents with young children and pregnant women seeking information on services, including a free telephone access point through United Way 2-1-1 and an online developmental screening tool, for young children. This multi-faceted initiative involves 1) limiting barriers to access by providing a validated developmental screening tool, PEDS, freely to providers and 2) addressing practice challenges such as billing/reimbursement, adapting workflow and training and technical assistance on what to do when the screening results suggest additional assessment is required 3) promote Help Me Grow 211/United Way centralized telephone access point to providers and families as a referral pathway. Physicians and other health care agencies can refer families to a centralized call center, Delaware 2-1-1, which is part of United Way of Delaware. Families are linked with appropriate community resources and services to support children's on-time development.

Delaware MCH implemented the Medical Legal Partnership evidence-based program. Medical conditions can be aggravated by legal or social problems, and the Medical Legal Partnership, a partnership between DPH and Community Legal Aid Society, is designed to improve the health of low-income women and their families address these stressors in an integrated way and improve health outcomes for women and babies. Unmet housing needs, lack of access to quality healthcare, financial insecurity, immigration status and family stability are just some of the social determinants of health affecting pregnant women. Many of these stressful situations require legal aid. This program assists with these unmet legal needs.

Delaware MCH works very closely with Medicaid and other partners to identify and address access to quality

services, such as home visiting for pregnant women, children and families, prenatal and postpartum care and interventions to improve maternal health outcomes, and most recently the pediatric mental health care access grant (PMHCA).

Delaware MCH also plays a leadership role in supporting Delaware's maternal mortality review process, and ensures coordination and collaboration with two Governor appointed bodies, the Delaware Healthy Mother and Infant Consortium and the Delaware Perinatal Quality Collaborative, to share data to inform interventions.

Delaware MCH provides staff support and infrastructure to the Delaware Healthy Mother Infant Consortium (DHMIC). Beginning in the 1990s, Delaware's infant mortality rate was increasing while the national trend was decreasing. This trend prompted the Governor's Administration, at the time, to convene an Infant Mortality Task Force in June 2004. In May 2005 the Task Force's final report put forth a three-year plan with 20 recommendations to reduce the high infant mortality rate in Delaware. Through the collaborative Delaware Healthy Mother Infant Consortium, strategies focus on the women's health, her family, her health care provider and her community. Aligned with the State of Delaware Title V Maternal and Child Health Title V Five Year Needs Assessment, the Consortium focused on:

- The social context in which people live, learn, work and play and how that affects their health.
- Preconception and Postpartum Care that is patient centered
- Optimal health for all and how differential access to health-enhancing resources and/or exposure to health compromising factors result in unfavorable outcomes, understanding the Black-White disparity in infant and maternal mortality and morbidity rates.
- Safe Infant Sleeping practices and social factors in the home, and how sleeping arrangements can endanger the lives of infants; develop recommendations for preventing infant sleep related deaths
- Breastfeeding and strategies for encouraging providers and families to support breastfeeding
- Financial and social implications of fatherhood and the role of the male partner in pregnancy outcomes and the importance of improving male partner responsibility in birth control and family planning.

Delaware MCH provides staff support and infrastructure to the Delaware Perinatal Quality Collaborative. Perinatal cooperatives have been established in our state as a quality assurance mechanism that enhances the communication and collaboration across birth hospitals. This structure, with buy-in from organization leadership, has the potential to impact the delivery of care and provider practices through quality improvement initiatives and data sharing. The Perinatal Cooperative Advisory Board is composed of representatives from birth hospitals.

Delaware MCH implemented a state funded performance-based model of care, Healthy Women Healthy Babies. By contract, seven health providers are providing Healthy Women Healthy Babies services at 20 locations across the state. The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial care for women at the highest risk of poor birth outcomes.

Delaware MCH operates the Title X Family Planning Program and Delaware Contraceptive Access Now. DE CAN was launched in 2014–2015 as a public-private partnership between Upstream USA and Delaware's DPH, Delaware Division of Medicaid and Medical Assistance and other key MCH stakeholders. DelCAN aims to reduce unintended pregnancies by ensuring same-day access to the full range of contraceptives, particularly long-acting reversible contraceptives (LARCs) like IUDs and implants. It operates and builds upon the fabric of the Title X clinics and other recruited providers, offering education, free or low-cost contraceptives, technical assistance, and achieved for Medicaid policy and payment reform.

Delaware MCH has trained and deployed community health workers, which have been documented as a method to enhance health education and promotion with high-risk, hard-to-engage, and underserved populations. As a complementary strategy to home visitation, promotors serve as health ambassadors in the largely rural and Hispanic areas of southern Delaware while cultural brokers serve as connectors in the urban communities in the City of Wilmington. The community health workers aim to accomplish the following:

1. Build social capital, social cohesion, within communities to identify respected members and elders who are

influential. These respected members will help identify social networks that can be leveraged to promote health and prevent disease.
2. Increase access to medical/ social services, early learning and development programs and enhance self-sufficiency.
3. Build community support and acceptability to home visiting to retain home visiting clients through the duration of the program.
4. Use innovative, creative and culturally sensitive strategies to engage community member and promote individual, family and community wellness.

Delaware MCH is the entity responsible for administering newborn screening. The program is mandated under Delaware Code Title 16, Chapter 8C, which requires all newborns to be screened 24–48 hours after birth and undergo critical congenital heart defect (CCHD) screening before discharge. The Division of Public Health (DPH), through administrative rules and oversight, manages the program through a contractual relationship with Nemours. Since Jan 2018, Nemours has managed the program in collaboration with PerkinElmer, an external lab partner, enhancing genetic testing capabilities and accelerating result turnaround—down from weeks to 1–2 days. A state Governor appointed Newborn Screening Advisory Committee, including clinicians, ethicists, and family representatives, advises the DPH Director on screening goals and disorders.

Delaware MCH Epidemiology is at a critical turning point, with the most recent reductions in workforce and the elimination of several branches at the CDC and specifically the CDC MCH Epidemiologist assignee program with a termination effective date of June 2nd, 2025. This deficit in expertise will largely be felt by the Title V DE MCH team. DPH MCH also suffered another hit regarding contractual services ending that supported MCH epidemiology staff capacity. MCH Epidemiology plays a critical role in monitoring health status, morbidity, and mortality among MCH populations, establishing data and system linkages, and supporting Delaware MCH in evaluating programs and services.

Financing of Services

Medicaid and CHIP together cover approximately 39% of all children in Delaware. Coverage for children with special health care needs (CSHCN) mirrors the national rate, which is around 15–18% of all Delaware children are enrolled under Medicaid/CHIP. Delaware does not provide CHIP coverage for pregnant women; however, a resolution was passed this legislative session in 2025, to explore this coverage and cost estimates.

Delaware offers coverage up to 212% of FPL for infants, older children, and pregnant women. The current eligibility requirements for Delaware Medicaid and CHIP are as follows:

Population	**Eligibility (%) of FPL**
Children 0–1	212% (Medicaid)
Children 1–5	142% (Medicaid)
Children 6–18	138% (Medicaid) + CHIP to 212%
CHIP additional children	Up to 212% of FPL
Pregnant women	212% (Medicaid, incl. postpartum)
Parents/caretakers	87% (MAGI Medicaid)
Adults (expansion)	138% (Medicaid Expansion)

Delaware's Medicaid program provides comprehensive coverage for children, primarily through the Delaware Healthy Children Program (DHCP) under Medicaid/CHIP, with several essential services and innovative payment structures. The program offers low-cost insurance for uninsured children (aged 0–19) up to 200% of Federal Poverty Level (FPL). Children on Medicaid are enrolled in one of three Managed Care Organizations (MCOs): AmeriHealth Caritas, Delaware First Health, or Highmark Health Options. Most services—e.g. doctor visits, prescription drugs, hospital care, lab work, mental health—are covered through these MCOs. Non-emergency medical transportation and pharmacy services are billed fee-for-service directly by Medicaid. Families pay modest premiums under DHCP ($10–25/month) with no additional co-pays for nearly all services.

Under Medicaid, until age 21, Delaware enforces Early and Periodic Screening, Diagnosis, and Treatment (EPSDT**)**, the broadest children's benefit package. It mandates coverage of medically necessary services like therapies and assistive devices not typically covered by standard Medicaid. School districts are reimbursed to support in-school health services as well as School Based Health Center providers, which reduces barriers for children needing care during the school day.
In January 2025, Delaware partnered with Nemours Children's Health on the first pediatric global budget model in the nation:

- Aligns incentives toward preventive care and addressing social determinants of health
- Providers are rewarded for keeping kids healthy rather than for delivering more treatments or procedures

Delaware has extended postpartum Medicaid coverage, with federal approval, with a minimum 60 days to 12 months, effective July 1, 2022, through a State Plan Amendment. This coverage enhances access to necessary postpartum care, preventive services, and support without the worry of losing insurance during the first year after childbirth.

For individuals and families who are not eligible for Medicaid or do not have access to insurance through an employer plan, Delaware helps them navigate and find marketplace plans that meet their needs, called Choose Health Delaware. The navigation program offers online information and tools to help residents review and compare Marketplace plans before redirecting users to HealthCare.gov for enrollment. In-person enrollment assistance is available year-round through Navigator organizations:

- Westside Family Healthcare (statewide): trained, certified staff assist English, Spanish, and Haitian Creole speakers
- Quality Insights: covers New Castle, Kent, and Sussex counties; bilingual services in English and Spanish

They help with eligibility, plan selection, performing enrollment, and post-enrollment support (e.g., appeals, subsidy reconciliation). Navigators offer in-person assistance in clinics and nonprofits, provide phone and email support, and serve underserved populations.

III.B.3.b. System of Services for CSHCN

CYSHCN Health Services

a. Population Served:

According to the 2022 National Survey of Children's Health (NSCH), the estimated number of CYSHCN between birth and age 17 years is 33,202. Of these CYSHCN 66.9 percent were adequately insured in comparison to 61.3 percent nationwide. In Delaware, 71.5 non-CYSHCN were adequately insured in comparison to 68.2 percent of non-CYSHCN nationwide.

According to the 2022-2023 National Survey of Children's Health (NSCH), the estimated number of Children and Youth with Special Health Care Needs (CYSHCN) between birth and age 17 years in Delaware is 61,253. Of these CYSHCN, 35.8 percent (n = 21,932) have a medical home in comparison to the nationwide average of 39.3 percent. Conversely, 64.2 percent (n = 39,321) of Delaware CYSHCN do not have a medical home as compared to 60.7 percent of CYSHCN nationwide.

The 2022-2023 National Survey of Children's Health (NSCH), the estimated number of Children and Youth with Special Health Care Needs (CYSHCN) between 12-17 years of age who were prepared for transition to adult health care, in Delaware is 26,596. Of these CYSHCN, 21.7 percent (n=5,771) received services to prepare for transition to an adult health care system in comparison to the nationwide average of 21.8 percent. On the other hand, 78.3 percent (n=2,082) of Delaware CYSHCN did not receive services to prepare for transition as compared to 78.2 percent nationwide.

b. Infrastructure:

Through the Maternal Child Health Title V Block Grant, Delaware continues to actively work with partnering state, hospitals and community contracted agencies to assure that all Children and Youth with Special Health Care Needs (CYSHCN) have both a medical home concept of care and adequate insurance through statewide initiatives with grantees that serve CYSHCN. The success of our approach to serve CYSHCN is a result of Delaware being a small state and our ability to develop long lasting rapports. According to calendar year 2022, Delaware's Vital Records reports that there were 11,218 occurrent births. Most recently, Delaware's Vital Records reports that there were 10,774 occurrent births in calendar year 2023.

The state of Delaware has 8 birthing facilities: Bayhealth Hospital Sussex Campus, Bayhealth Hospital, Kent Campus, Beebe Hospital, Tidal Hospital, Christiana Care Health Services, St. Francis Hospital, Birth Facility, and Nemours Children's Hospital which serves high-risk pregnant women who have been identified as having a high-risk delivery. Nemours Children's Hospital is the sole children's hospital in the state of Delaware. They also serve as our diagnostic facility for children that are Deaf or Hard of Hearing. Nemours Children's Hospital is contracted with the Division of Public Health to manage and follow up on newborn metabolic screening.

Part C Birth to Three

The Delaware Department of Health and Social Services (DHSS) served as the lead department for the Division of Public Health (DPH). The Part C of Individuals with Disabilities Education Act (IDEA) program and the Family Health Systems program falls under the Division of Public Health (DPH). Birth to Three Early Intervention program, has held the responsibility for assuring and implementing all components of the statewide system in compliance with policies under Part C IDEA. The Family Health System is where the Maternal Child Health Title V program and the Early Hearing Detection and Intervention (EHDI) Program resides. Family Health System's EHDI program and Birth to Three program have worked closely together in serving infants ages 0-3 years of age providing statewide, comprehensive, coordinated, multidisciplinary, interagency system of care that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families.

Our EHDI program referred infants and toddlers' birth to three years of age who received a diagnosis of Deaf or Hard of Hearing (D/HH) to the Birth to Three program once diagnosed with hearing loss at our Nemours Children's Hospital sole diagnostic audiology department in the state of Delaware. Our EHDI Coordinator, EHDI Follow-Up Coordinator and Children and Youth with/Special Health Care Needs (CYSHCN) Director have worked closely with Birth to Three Early Intervention and Nemours Children's Hospital. The EHDI team has referred infants' ages 0-3 years of age to the Birth to Three program, once their diagnosed. The process consisted of the Nemours Audiology team informing the family that the state of Delaware Division of Public Health EHDI program will be made aware of the diagnosis and the EHDI program will make a referral to the Birth to Three Part C program so that the family can make an informed decision on the option of receiving services for their newly diagnosed child. The family is also made aware that a referral will be sent to the Hands and Voices Guide by Your side Program and to the Statewide Programs for the Deaf/Hard of Hearing (D/HH), and Deaf-Blind Mentorship program. The EHDI Coordinator received quarterly excel reports from the Birth to Three coordinator for each county throughout the year which provided data on the families that accepted the early intervention services and the number of families that completed a signed Individualized Family Service Plan (IFSP) from the Birth to Three Program. The most current data gathered is as follows:

In 2022 of the 11,218 total occurrent births, 11,113 infants were screened. Of those screened there were 10,821infants that passed and a total of 292 did not pass. Of those that did not pass there were a total of 235 with no hearing loss and a total of 11 with Permanent hearing loss. Of the 11 with permanent hearing loss, 1 infant expired/passed away before being referred; therefore, of the 10 infants referred to Part C Birth to Three, 2 were enrolled into the Part C Birth to Three Early Intervention program. Also, there were 2 families that signed their Individualized Family Service Plan (IFSP) after 6 months of age. These 10 families were referred to Hands & Voices Guide by Your Side where 8 out of the 10 D/HH diagnosed 0-3 infants accepted services. These 10 families were also referred to the Statewide Programs for the Deaf, Harf of Hearing, and Deaf-Blind Mentorship.

The Department of Health and Social Services (DHSS), Division of Public Health (DPH) ensures compliance with the federal requirements of the Individuals with Disabilities Education Act (IDEA), which provides funding to help support the system. Children and their families receive early intervention supports and services by Birth to Three within the Division of Public Health, with staff drawn from the Division of Public Health and the Division of Developmental Disabilities Services (DDDS). Some major external partners, through interagency agreements and contracts, are Department of Education IDEA Part B; Division for the Visually Impaired (DVI), Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Nemours Children's Hospital, and community providers. The Birth to Three program also works with DVI and provides service coordination for children with visual impairments or who are blind.

Family Support Healthcare Alliance Delaware (SHADE) Project

In FY 2024-2025 the Maternal Child Health Title V Block Grant funded the Parent Information Center (PIC) to implement the Family Support Healthcare Alliance Delaware (SHADE) programmatic approach. The Director of CYSHCN served as the program manager, providing technical assistance to PIC's team. Family SHADE extended family and professional partnerships at all levels of decision making, to best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resource for community organizations serving CYSHCN. Families are included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems of change to best serve families of CYSHCN. PIC oversees the Family Leadership Network (FLN) members and meets with them monthly. PIC also serves as the fiduciary lead in funding mini-grantees that serve CYSHCN. Over the past 3 years they have funded community agencies to increase their capacity and extend their reach in serving CYSHCN. These agencies have impacted all 3 counties (New Castle, Kent, and Sussex) across the state of Delaware. These mini-grantees have focused on the following National Performance Measures (NPM):

- Performance Measure (Developmental Screening)
  Percent of children, ages 9 through 35 months, who received developmentally appropriate services in a well-coordinated early childhood system.
- Performance Measure (Access to Medical Home)
  Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
- Performance Measure (Transition into Adult Healthcare)
  Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.
- Performance Measure (Adequate Insurance) Percent of children, ages 0 through 17, who are continuously and adequately insured.

Managed Care Organization (MCO) Calls:

Maternal Child Health (MCH) supported the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish and English as these calls have continued to be a wanted resource. Parent Information Center (PIC) overseen the Family Voices program, and they scheduled these forums where parents/caregivers asked questions and discussed issues they were having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). The Zip codes of the anonymous families that attended the MCO Calls were: 19317, 19968 19977, 19720, 19904. Common Issues discussed included: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations helped problem solve.

Family members can meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help.

c. Integration of Services:

Children with Medical Complexity Advisory Committee (CMCAC)
Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity is to perform an in-depth analysis of the full continuum of care for children with medical complexity. The data needed to perform a quantitative analysis is very detailed and complex. Therefore, the first recommendation made as a result of the Plan development, was for the Division of Medicaid and Medical Assistance (DMMA) to continue working with stakeholders to address the needs of this vulnerable population. As a result, the Children with Medical Complexity Advisory Committee (CMCAC) serves as a resource. This group meets quarterly to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ultimately ensure that every child with medical complexity can receive the adequate and appropriate health care services they need and deserve.

Department of Services for Children, Youth, and Their Families (DSCYF)
Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the Division of Public Health (DPH). Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and aftercare. The Department of Services for Children, Youth, and Their Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training, and support to many daycare providers throughout the state and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

The Division of Public Health (DPH) has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP).
The AAP, Medicaid, and the Family Health Systems have participated on the vaccine committee, Early and Periodic Screening Diagnostic, and Treatment (EPSDT) implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality. The Interagency Coordinating Council (ICC) has been active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide. The ICC advises and assists the Department of Health and Social Services with implementation of the Birth to Three Early Intervention system and other federal infants and toddlers' programs. Council members include parents, state agency personnel, private providers, insurance providers, legislators and professionals involved in personnel preparation. The ICC has welcomed parents of children birth to three to share their stories with the council. These partners have worked on addressing the unmet needs in early childhood special education and early intervention programs for children with disabilities by assisting in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

The Sussex County Health Coalition
Parent Information Center (PIC) implemented the Family Support Health Care DE Alliance (Family SHADE) project. Through the execution of the project, there is representation for Children and Youth w/Special Health Care Needs (CYSHCN) from the Family SHADE project who attends and serves as a member of the Sussex County Health Coalition. Through the Family SHADE project, PIC has established partnerships with organizations serving CYSHCN at the Sussex County Health Coalition. The Sussex County Health Coalition exists to engage the entire community in collaborative family-focused effort to improve the health of all children, youth and families in Sussex County, Delaware. They envision a community in which Delaware citizens and institutions (public, private, and not-for-profit) are actively engaged in community health promotion as a shared community good, and working together to create an environment which supports healthy lifestyles for our children and their families. Parent Information Center -

Family SHADE project partners with Help Me Grow to identify ways to partner on early childhood, health and wellness, family outreach and community engagement activities.

Delaware's Developmental Disabilities Council

The DDC is a federally funded state agency that works to ensure individuals with developmental disabilities and their families have access to culturally competent supports and services. They also advocate for the rights and opportunities of people with developmental disabilities within their communities. The CYSHCN director served as a personnel committee member and as an instrumental contributor to the Delaware Developmental Disabilities Council's 5 Year Strategic Plan 2022-2026. The Administration for Community Living (ACL) under the US Department of Health and Social Services approved our 5 Year Strategic Plan. The Goal of the Council is to foster an environment that empowers and supports all Delawareans with developmental disabilities to lead self-directed lives. Areas of emphasis for the next 5 years is Education, Early Intervention, Housing, and Health/Healthcare. Aligning service delivery through Delaware's Title V priorities and strategic plans for the coming year targeting families of CYSHCN assures that we are meeting the needs through a congruent and collaborative initiative addressing NPM Medical home, transition to an adult healthcare system for CYSHCN and adequate insurance.

d. Financing of Services

DHSS Emergency Medical Services for Children (EMSC) program

The EMSC program has served as a national initiative designed to reduce morbidity and mortality in children due to life-threatening illness and injuries. In 1984, Senator Daniel Inouye and Senator Orrin Hatch developed initial legislation to support the EMSC program. In 1984 this federal legislation (Public Law 98.555) was enacted to fund EMSC programs in the states to address the emergency care of children. The Health Resources and Services Administration (HRSA) provides EMSC grant funding to help states develop existing hospital and Emergency Medical Services (EMS) systems to be better able to provide excellent care for critically ill and injured children. This is the only federal program that focuses specifically on the quality of children's emergency care. EMSC program are projects that provided specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for childcare agencies; and ensure that all state trauma/disaster plans address pediatric needs. The Delaware EMSC Advisory Committee meets quarterly and is chaired by a pediatrician who also represents the EMSC program on the Delaware Emergency Medical Services Oversight Council (DEMSOC). Title 16, Chapter 97 of the Delaware Code was revised in 2012 to officially establish the Emergency Medical Services for Children (EMSC) Program within the Office of Emergency Medical Services, EMS and Preparedness Section, Division of Public Health. The EMSC Act of 2012 also defines the membership of the EMSC Advisory Committee and enables development of a Pediatric System Quality Program.

Medicaid and Medical Assistance

Medicaid furnishes medical assistance to eligible low-income families and to eligible aged, blind and/or disabled people whose income is insufficient to meet the cost of necessary medical services. Medicaid pays for: doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, mental health and substance abuse services. The majority of people receiving Medicaid must choose a managed care organization (MCO) which will provide or arrange for all preventative care and medical needs.

Delaware's Division of Developmental Disabilities Services (DDDS)

The Division of Developmental Disabilities Services (DDDS) provides services and supports for children and adults with intellectual and developmental disabilities to support them in their home and community. DDDS uses a person-centered approach to assist individuals with identifying services, supports, and resources to support the family's vision and goals. DDDS supports individuals with intellectual and developmental disabilities to live their good lives by accessing services they need to thrive in their community. DDDS works to identify and support the unique needs of eligible service recipients by offering access to an extensive network of providers including employment and pre-vocational services; support coordination and community navigation: assistive technologies; respite; a variety of day and residential programs; and options for supported living.

Diamond State Health Plan (DSHP)
Through an amendment approved by CMS in 2012, Delaware was authorized to create the (DSHP-Plus), which is Delaware's managed long-term services and supports (MLTSS) program. Additional state plan populations to receive services through MCOs, including:
(1) individuals receiving care at nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR)
(2) children in pediatric nursing facilities
(3) individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and
(4) workers with disabilities who buy-in for coverage.

This amendment added eligibility for the following new populations:
(1) individuals who would previously have been enrolled through the 1915(c) home and community based services (HCBS) waiver program for the Elderly and Disabled. This included those receiving services under the Money Follows the Person demonstration
(2) individuals who would previously have been enrolled though the 1915(c) HCBS waiver for Individuals with Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) Related Diseases
(3) individuals residing in NFs who no longer meet the current medical necessity criteria for NF services; and
(4) adults and children with incomes below 250 percent of the Supplemental Security Income Federal Benefit Rate who are at risk for institutionalization.

Additionally, this amendment expanded HCBS to include:
(1) cost-effective and medically necessary home modifications
(2) chore services; and
(3) home-delivered meals

The DSHP demonstration includes five distinct components: 1) The DSHP Medicaid managed care program provides Medicaid state plan benefits through a comprehensive managed care delivery system to most recipients eligible under the state plan; 2) The DSHP Plus program provides long-term care services and supports (LTSS) to certain individuals under the State Plan, and to certain demonstration populations; 3) The PROMISE program provides enhanced behavioral health services fee-for-service (FFS) to Medicaid beneficiaries with a higher level of behavioral health needs and functional limitations who need Home and Community Based Services (HCBS) to live and work in integrated settings; 4) Coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18, were enrolled in Medicaid at that time, and are now residents in Delaware applying for Medicaid; and 5) Coverage for high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs).

Key Strategies to strengthen the integration of health care delivery systems

The Maternal Child Health Title V Children and Youth with Special Health Care Needs (CYSHCN) system of care is intentional in the alignment of a crosswalk of MCH Block Grant's domains and national performance measures with the 6 core indicators serving CYSHCN which are:

1. Children and youth are screened early and continuously
2. Receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing
3. Community -based services are organized so families can use them easily
4. CYSHCN receive services necessary to make transitions to adult life including healthcare
5. Families have adequate insurance and funding to pay for services they need
6. Families of CYSHCN are partners in decision-making at all levels of care from direct care to the organizations that serve them

Through the utilization of the 6 core indicators, we will address 4 key areas in partnership with those that serve CYSHCN.

1. Optimum Health for All: All CYSHCN have a fair and just opportunity to be as healthy as possible and thrive throughout their lives.
2. Quality of Life and Well-being: The service system prioritizes quality of life, well-being, and supports flourishing for CYSHCN and their families
3. Access to services: Health care and other related services are accessible, affordable, comprehensive, and continuous; they prioritize the well-being of CYSHCN and families.
4. Financing of services: CYSHCN and their families have timely access to integrated, easy-to-navigate, high-quality health care and supports they need.

This framework will strengthen the integration of health care delivery systems that serve CYSHCN, key partners, alignment of resources, and shared programmatic goals across our state.

III.B.3.c. Relationship with Medicaid

The Delaware Title V program has an active MOU in place with our Division of Medicaid and Medical Assistance (DMMA) program however, it is outdated, signed in 2018. We are currently drafting a new MOU together that is reflective of our collaborative partnership to serve the maternal and child health population including children with special healthcare needs. This MOU was entered into for the purpose of improving the maternal and child health service delivery and public health outcomes for underserved populations throughout the State of Delaware. In particular, the implementation of this MOU seeks to:

- Provide coordination between DMMA and the Division of Public Health (DPH) for programs impacting women, infants and children.
- Provide coordination in the administration of programs that are designed to improve the health of children particularly Children with Special Health Care Needs and families in the State of Delaware.
- Maintain a process that allows for joint access to critical data elimination duplication of effort.

The Centers for Medicare & Medicaid Services (CMS) approved Delaware's request to extend its Diamond State Health Plan (DSHP) Section 1115 demonstration for five more years, from January 1, 2024, to December 31, 2028. This extension allowed Delaware to maintain longstanding Medicaid policies and implement new initiatives aimed at improving health coverage and access to care for Medicaid beneficiaries.

Key Components impacting the MCH population:

1. Ongoing Coverage:
    - Continued Medicaid services for disabled children with incomes up to 250% of SSI, even if they don't meet updated institutional level-of-care criteria.
2. Contingency Management Services to support evidence-based outpatient treatment for individuals with stimulant or opioid use disorders:
    - Adults (18+) with stimulant use disorders are eligible for a 24-week program.
    - Pregnant or postpartum individuals (up to 12 months) with opioid use disorders—age 18 or older and medically cleared for outpatient care through an ASAM assessment—are eligible for a 64-week program.
3. New or Expanded Benefits:
    - Respite Care: For caregivers of children and young adults (up to age 21) not already receiving respite services through the PROMISE and Lifespan 1915 waiver
    - Self-directed Personal Care: For children under the home health benefit.
    - Evidence-Based Home Visiting: Services through Nurse Family Partnership (up to age 2) and Healthy Families Delaware (up to age 3).
    - Postpartum Nutrition Support: For 12 weeks after childbirth, including:
        - Up to 2 meals/day
        - Up to 80 diapers/week
        - One pack of baby wipes/week

Other recent approved policies impacting the MCH population receiving Medicaid, the Delaware Department of Health and Social Services' Division of Medicaid and Medical Assistance announced in 2023 that Medicaid postpartum health care coverage has been extended from 60 days to 12 months following the end of a pregnancy.

Medicaid recipients are now eligible for 12 months of continuous postpartum coverage, starting from the date the pregnancy ends—regardless of the pregnancy outcome—and continuing through the end of the month in which the 12-month period concludes. Importantly, individuals will remain eligible for this extended postpartum care even if their income, household size, or other eligibility factors change during the coverage period.

Effective January 1, 2023, the Medicaid program, began providing coverage of a self-directed option for parents on behalf of children receiving personal care services as well as respite services for children. The self-directed option gives families the flexibility to hire, for example, a neighbor, friend, or family member, including a legally responsible family member as the service provider.

As of January 2024, Medicaid now covers Doula services as a benefit for eligible participants. Doulas are nonmedical birth companions who provide emotional, physical, and informational support during labor and delivery, as well as throughout the prenatal and postpartum periods. Their presence can help reduce stress and anxiety related to childbirth and breastfeeding, boosting confidence in the birthing process. Doulas have also been shown to play a valuable role in addressing maternal and infant health.

Covered Doula Services Include:

- At least one prenatal visit (required)
- Up to three prenatal visits
- Attendance at labor and birth
- Up to three postpartum visits (in-person or virtual, 90 minutes each)
- Post-loss support: Up to three postpartum visits may also be provided after a pregnancy loss, but only if at least one prenatal doula visit was completed.

Delaware's Children with Medical Complexity Advisory Committee was developed to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ultimately ensure that every child with medical complexity has the opportunity to receive the adequate and appropriate health care services they need and deserve. Membership includes up to six advocates of a child with medical complexity and representative from several other state agencies including the Division of Public Health, Division of Developmental Disability Services, Delaware, Department of Children, Youth & their Families, Department of Education, all three Managed Care Organizations, community partners and medical providers. The representative for the Division of Public Health is the Title V CYSHCN Director and/or the Title V Deputy Director. Through this collaborative planning process, a series of recommendations were developed that ultimately formed Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity (the Plan), was published in 2018. This group continues to meet quarterly to work on the recommendations outline in the plan. Recent accomplishments of this committee include the development and completion of private duty nursing Nurse Educator Survey; began the process to develop a PSA to highlight the experience of a CMC family and the rewards and benefits of home care positions for nurses; development of a Complex Care Support Needs Assessment Methodology to further define the CMC population requiring home care; developed and published a brochure titled "What to Expect When Your Child's Medical Equipment or Supplies Change." and Delaware First Health provided Durable Medical Equipment/Supply Care Coordination training. The details of these achievements and future plans can be found in CMC year end summary report.

In true collaboration, not only is the Title V program providing input and support with policy recommendations, but Title V also assists with outreach and dissemination of these programs initiatives to our network of collaborators including provider, community partners and most importantly the families we serve. Through programs like Help Me Grow, Family SHADE and home visiting, we assist families with enrollment into Medicaid when necessary. The Title V program also hosts a monthly call with DMMA and families with a child with special healthcare needs to ask questions and get direct support.

In 2022, Medicaid covered 42.8% of births in Delaware, according to data from the Vital Statistics office. Medicaid covers a higher percentage of births from mothers of younger ages – 77.3% from those 20-years-old or younger, and 62.5% those ages 20-24.

III.B.4. MCH Emergency Planning and Preparedness

The Delaware DPH supports every section within the Division to develop a Continuity of Operations Plan Standard Operating Guidelines (COOP SOG). This COOP SOG is a recovery plan that works as a companion plan with the

Delaware Emergency Operations Plan (DEOP) and other Division of Public Health (DPH) preparedness plans and provides a framework to minimize potential impact and allow for rapid recovery from an incident that disrupts operations. This plan encompasses the magnitude of operations and services performed by the section and is tailored to the section's unique operations and mission essential functions.

The document has been tailored for the use of the Family Health Systems (FHS) section using *the Federal Emergency Management Agency (FEMA) Continuity of Operations (COOP) Plan Template, State of Alaska Division of Homeland Security and Emergency Management and Virginia Department of Emergency Management COOP SOG.*
This COOP SOG was prepared by the Section Chief of FHS/Title V Director, to develop, implement and maintain a viable COOP capability. This plan complies with applicable internal Department of Technology & Information (DTI) policy, Executive Order 38 and supports recommendations provided in FEMA's Continuity Guidance Circular 1 (CGC 1) and Continuity Guidance Circular 2 (CGC 2). This COOP SOG has been distributed internally to appropriate personnel within DPH and with external organizations that might be affected by its implementation.

The purpose of a well-designed COOP SOG is to minimize interruption of FHS' operation if an internal or external disruptive event were to occur. By having an effective COOP SOG in place, FHS can resume its core activities within an acceptable period following such an incident. The COOP SOG allows FHS to shift efficiently from its normal structure and organization to one that facilitates rapid recovery and continuation of services. The ability to make this shift immediately is critical for FHS to continue as a viable and stable entity during a crisis. The objectives of the COOP SOG are to:

• Establish policies and procedures to assure continuous performance of FHS's operations
• Identify and pre-arrange constitution of an alternate facility
• Assure safety of all FHS personnel
• Provide communication and direction to stakeholders
• Minimize the loss of assets, resources, critical records and data
• Build infrastructure to support a timely recovery
• Manage the immediate response to an emergency effectively
• Provide information and training for employees regarding roles and responsibilities during an emergency; and
• Maintain, exercise and audit the COOP SOG at least annually

This plan includes guidance for FHS staff that may respond to a significant outage or disruption of a business process due to a natural or manmade event. Section staff would be responsible for reestablishing critical tasks (services to the general population and for internal purposes) immediately following an event. This document shall provide guidance for directing and controlling all key tasks disrupted by an event.

The DHSS/DPH has also developed the State Health Operations Center (SHOC) which provides command and control for all public health and medical response and recovery functions, Emergency Support Function (ESF) 8, in a statewide or local emergency or disaster. The SHOC oversees and coordinates health and medical response operations including the operation of Points of Dispensing (PODs), Alternate Care Sites, Shelter Medical Stations, and hospital coordination. Organizational Structure: The organization and structure of the SHOC follows the Incident Command System (ICS) and is National Incident Management System (NIMS) compliant. The State Health Officer (SHO) serves as the Incident Commander (IC) for whom the members of the Command staff work to provide legal and policy support as well as maintain communications with the media and the public. Four Section Chiefs report to the IC during a SHOC: The Finance & Administration Section handles human resources, procurement, and other administrative services. Planning Section gathers and analyzes information and helps to formulate the Incident Action Plan (IAP). Operations Section implements the IAP and manages the SHOC's tactical response to the event. Logistics Section maintains all supply, transportation, communications, and other such support to SHOC operations. SHOC can be activated at one of three levels, depending on the type and complexity of the event. The DPH Director or their designee determines the level of SHOC activation.

- SHOC Level 1 activation indicates heightened assessment and is used for events such as a mass public gathering requiring the deployment of DPH resources, or the presentation of a suspicious substance associated with a credible threat.
- SHOC Level 2 activation is the result of a localized event with a potential statewide impact, such as a severe weather warning, or a confirmed regional or Delaware case of a disease with potentially urgent public health implications and/or widespread impact.
- SHOC Level 3 is activated during a statewide emergency, such as a pandemic disease or illness or a credible threat of or an actual terrorist attack in the state or region

Every Performance Plan for staff members in the Family Health Systems section includes the following statement:

As an essential employee in the Division of Public Health, you will be available or reachable through electronic means 24 hours per day, 7 days per week except when on annual leave. You may be called upon to perform functions pertinent to any emergency including coming to the work site (or an alternate work site) when other state offices are closed to perform emergency work functions at the request of the supervisor, section chief, Associate Deputy Director, Senior Deputy Director or Director.

In response to the Emergency Planning and Community Right-to-Know Act (EPCRA). Delaware created the State Emergency Response Commission (SERC) which is responsible for implementing and overseeing other requirements of the Act. The DPH Director, Steven Blessing is a member of the SERC along with various other state agency Directors, County representations and Community Partners such as the Delaware Volunteer Firefighter's Association. Once established, each SERC designated emergency planning districts and appointed Local Emergency Planning Committee (LEPC) for each district. Each LEPC has specific duties to fulfill, and the SERC supervises and coordinates those activities. The SERC also receives various reports from businesses that use or store hazardous chemicals, or that experience an emergency release of a hazardous substance and must establish procedures for receiving and processing requests for information from the public.
In Delaware, an existing state organization, the Commission on Hazardous Materials, was reorganized to form the Delaware State Emergency Response Commission. Each of the three counties (New Castle, Kent and Sussex) and the City of Wilmington have been identified as emergency planning districts, and LEPCs have been appointed.

The SERC website and the most recent SERC report.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

The State of Delaware Division of Public Health (DPH) and its Title V stakeholders made use of both the HRSA guidance[1] and AMCHP's CAST-5 framework[2] to inform the Needs Assessment process. These sources helped the DPH team in carrying out a comprehensive assessment of its priority issues and stakeholder needs beyond what could be discerned solely from a data-driven needs assessment. Moreover, the framework proposed by these sources allowed DPH to clearly define a leadership structure for the Needs Assessment, secure and engage stakeholders representing communities and families that are directly involved with Title V-supported programmatic activities, set forth a process to determine priorities for current and future Title V efforts, and ensure collaborative planning, implementation, evaluation, and continuous quality improvement for the Title V program.

The following summarizes the objectives and methods that were implemented as part of the Needs Assessment process:

- **Preparation (December 2023 - February 2024)**
  - Review Title V Maternal and Child Health (MCH) Services Block Grant guidance.
  - Develop a timeline and work plan.
  - Convene a Needs and Capacity Assessment Steering Committee.
  - Identify guiding principles/frameworks and core values.
  - Request access to national, state, and local data sources.
  - Establish a plan for community engagement and identify opportunities to raise awareness and share information about the assessment with partners.

- **Assess Health Status of MCH Populations and State Program Capacity (March 2024 - May 2024)**
  - Conduct environmental scan of MCH initiatives and data.
  - Assess infrastructure of MCH programs.
  - Assess partnerships/engagement within MCH programs.
  - Assess MCH workforce capacity.

- **Carry Out Needs and Capacity Assessment (June 2024 - October 2024)**
  - Identify an initial list of potential priorities based on takeaways from the health and program capacity assessments.
  - Criteria-based ranking of the initial list of priorities by the Needs and Capacity Assessment Steering Committee using core values.
  - Identification of narrowed list of potential priorities for ranking by families and partners.
  - Prioritization events with partners, families and community members, providers, and other state agencies.

- **Analyze (October 2024 - December 2024)**
  - Tabulation of rankings from prioritization events and survey.
    Review and approval of final list of priorities by Department of Health leadership.
  - Analysis of identified priority health issues, identification of evidence-based strategies, and opportunity to seek input from the public and potential service populations on strategy acceptability and implementation recommendations.

- **Act (January 2025 - July 2025)**
  - Development of Title V 2025 Action Plan and submission to HRSA by July 2025.

Various stakeholders – comprising of community-based organizations, families, and individuals – were thoroughly engaged as part of the needs assessment and priority needs selection processes. In particular, the DPH carried out three initiatives to gain insights from MCH-related stakeholders: stakeholder survey, key informant interviews, and focus groups. A summary of how each of these initiatives was designed to solicit and integrate stakeholder feedback is as follows:

- **Stakeholder Survey**. Staff from the DPH Title V Maternal and Child Health Program created a survey to broadly ascertain stakeholder feedback, which is located on our DEThrives website. The survey that was distributed during the previous Title V needs assessment was used as a guide with additional input provided by staff at Forward Consultants, LLC, which served as the contracted vendor to conduct the survey. The target audience was the Title V stakeholder email contact list maintained by the Title V program. The survey was emailed to 571 stakeholders, of

which, 62 (10.9 percent) completed the survey.

Despite the limited number of stakeholders who completed the survey, the respondents comprised a variety of organizations and roles (Tables 1 and 2, respectively). Moreover, the respondents represented the five population health domains evenly (Figure 1) and were proportionally representative of each region of the state with many respondents reportedly working at the statewide level (Figure 2).

Table 1. Respondents' Self-Reported Organizations Represented.

Organizations	*n* = 62
Department of Health and Social Service or Department of Health	17 (27.4%)
Human services nonprofit	9 (14.5%)
Hospital or medical center	7 (11.3%)
Education	5 (8.1%)
School based wellness center	5 (8.1%)
Child advocacy (e.g., child abuse prevention)	2 (3.2%)
Community health center (e.g., federally qualified health center)	2 (3.2%)
Parent-child center	2 (3.2%)
Other	13 (21.0%)

Table 2. Respondents' Self-Reported Role Within Organization.

Role	*n* = 62
Public health professional (e.g., health educator, community worker)	22 (35.5%)
Healthcare provider (e.g., physician, nurse, dentist)	13 (21.0%)
Social service provider (e.g., social worker, mental health counselor)	8 (12.9%)
Community advocate	6 (9.7%)
Hospital or health system administrator	5 (8.1%)
City/county administrator	2 (3.2%)
Childcare provider/early education teacher	2 (3.2%)
Academic researcher	1 (1.6%)
Other	20 (32.3%)

Figure 1. Population Health Domains Reported by Respondents.

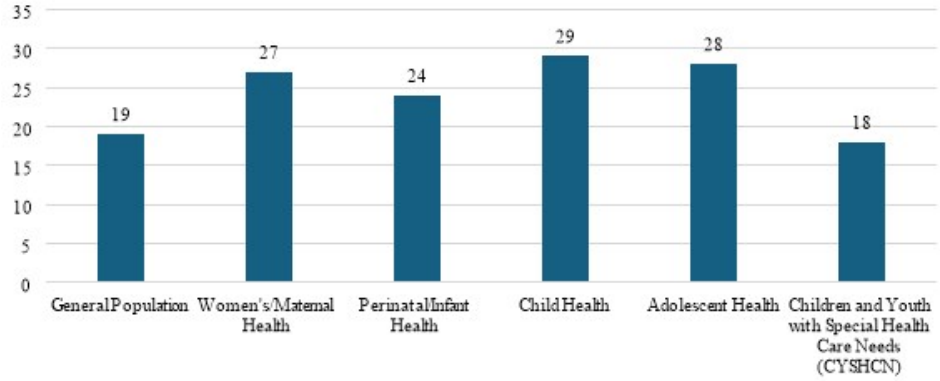
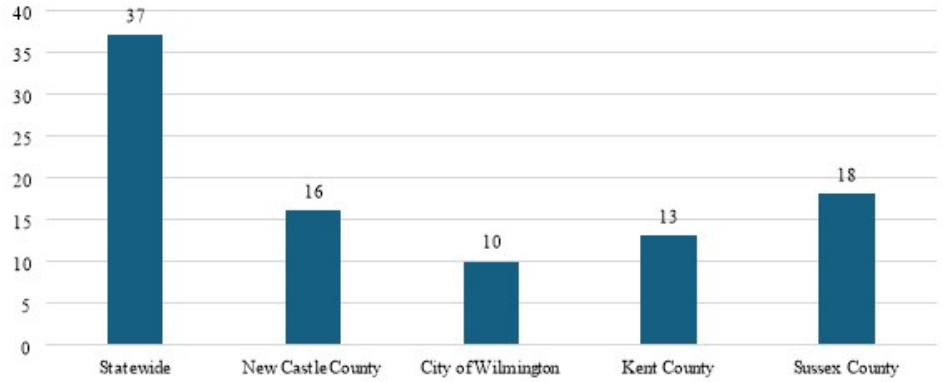


Figure 2. Geographic Area of the Population Served.



The respondents were asked which of the MCH population domain(s) best describe(s) the target audience for their program/organization. Each MCH population health domain comprises of multiple NPMs with specific NPMs being represented across more than one MCH population health domains (e.g., the Medical Health NPM is situated under the children and youth special health care needs (CYSHCN), child health, and adolescent health domains). Table 3 lists the count of respondents by NPM. As some NPMs are situated under multiple MCH population health domains, certain NPMs have a larger number of respondents as compared to other NPMs that may have fewer respondents (e.g., 57 respondents (91.9 percent of the total) were asked to speak to the Preventive Dental Visit NPM while 38 respondents (61.3 percent of the total) were asked to speak to the Safe Sleep NPM.

Table 3. Count of Respondents by NPM.

NPM	MCH Population Health Domain	*n* = 62
Preventive Dental Visit	Women/Maternal, Child, Adolescent	57 (91.9%)
Medical Home	CYSHCN, Child, Adolescent	52 (83.9%)
Housing Instability	Perinatal/Infant, Women/Maternal, Child	50 (80.6%)
Perinatal Discrimination	Women/Maternal, Perinatal/Infant	46 (74.2%)
Transition	CYSHCN, Adolescent	46 (74.2%)
Bullying	CYSHCN, Adolescent	46 (74.2%)
Developmental Screening	Child	39 (62.9%)
Childhood Vaccination	Child	39 (62.9%)
Physical Activity	Child	39 (62.9%)
Food Sufficiency	Child	39 (62.9%)
Adolescent Well-Visit	Adolescent	39 (62.9%)
Mental Health Treatment	Adolescent	39 (62.9%)
Tobacco Use	Adolescent	39 (62.9%)
Adult Mentor	Adolescent	39 (62.9%)
Postpartum Visit	Women/Maternal	38 (61.3%)
Postpartum Mental Health	Women/Maternal	38 (61.3%)
Postpartum Contraception	Women/Maternal	38 (61.3%)
Risk-Appropriate Perinatal	Perinatal/Infant	38 (61.3%)
Breastfeeding	Perinatal/Infant	38 (61.3%)
Safe Sleep	Perinatal/Infant	38 (61.3%)

- **Key Informant Interviews**. Staff from both the DPH Title V Maternal and Child Health Program and Forward Consultants developed a set of key informant interview questions. Seventeen (17) key informants who extensively work within one or more of the five maternal and child health population domains (i.e., Women's/Maternal Health; Perinatal/Infant Health; Child Health; Adolescent Health; and Children and Youth with Special Health Care Needs (CYSHCN)) were contacted for an interview, which is also located on our DEThrives website. The key informants were selected by the Internal Steering Committee for Title V Needs Assessment, which comprises of nine staff members from the Delaware Division of Public Health who serve in varying roles in statewide maternal and child health programming. The key informants have varying levels of educational attainment and professional experience; they also represented agencies and organizations that generally operate statewide. All key informants were asked the questions listed below. Based on the conversation flow, note that not all questions were asked of the key informants and the questions were not necessarily asked in this order:
  - We'd like you to think about [population domain] and all the priority areas that are identified by the federal Bureau of Maternal of Child Health. Thinking of both the Population Domains and the National Performance Measures, which does your organization play a role in addressing?
    - Can you tell me about some things your organization is working on in relation to the Population Domains and/or National Performance Measures?
    - What have been some of the strengths of this program?
    - What have been some gains in this area for Delaware?
    - What have been some challenges your organization has observed?
  - Thinking about Delaware's [population domain], within this domain where do you see the greatest disparities?

  - In what ways do you believe these disparities can best be addressed?
  - What do you see as key strategies for addressing these disparities?
  - What are some potential solutions?
  - What resources would be needed?
- What do you feel are the greatest strengths of [population domain]?
  - Are these strengths sustainable?
  - Do you know of ways to improve these strengths?
- Do you know of any emerging issues pertaining to the [population domain]?
  - What are some leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?
  - What would be some challenges encountered?
- Thinking of maternal, child and family health in general, are there important or emerging needs in your community that are missing from our list?

Of the 17 key informants, 14 (82.4 percent) ultimately completed an interview by Forward Consultants staff via Zoom between May 28, 2024, and June 12, 2024. For reporting purposes, the names of the key informants were omitted and each of them was assigned a number. Table 4 on the following page lists the key informants by the maternal and child health population domain on which they are considered to have experience and expertise. Note that 12 of the 14 key informants interviewed were able to share insights on more than one domain and each population health domain is represented by five or more key informants.

Table 4. Key Informant Expertise and Experience by Maternal and Child Health Population Domain.

Key Informant	Women/ Maternal	Perinatal/ Infant	Child	Adolescent	CYSHCN
1			X	X	X
2	X			X	
3	X	X	X	X	
4	X	X	X		
5	X	X			
6	X	X	X	X	X
7	X	X			
8			X	X	X
9	X				
10			X		X
11	X			X	
12	X		X		X
13		X			
14	X	X	X		

- **Focus Groups**. DPH and AB&C the contracted social marketing vendor, engaged Goeins-Williams Associates, Inc. (GWA) to plan and conduct a total of 14 focus groups statewide to meet the Title V needs assessment requirements related to the DPH Maternal and Child Health program. GWA ended up conducting fifteen statewide focus groups to meet the specifications of DPH. The focus groups included teens, fathers/partners, mothers of children and youth with special health needs, black women without children, and women with children. Three focus groups were conducted in Spanish. Five groups were canceled and rescheduled because of the inability to recruit enough participants or failure of enough participants to attend once recruited. Two sessions were rescheduled as Zoom sessions to address challenges of participants in finding day care or transportation. Table 5 summarizes the details for the focus groups and the required specifications:

Table 5. Summary of Focus Groups Conducted.

Group Description	Group Makeup	County	Respondents

Women's General Health	Spanish speaking women with children, ages 18 to 44 who meet Federal income guidelines and reside in specified zip codes.	New Castle	11
Teens General Health	Adolescent girls, ages 13 to 17 who reside in specified zip codes in the county	New Castle	11
Children and Youth with Special Health Needs	Spanish speaking mothers of special needs children with physical and behavioral health diagnoses, ages birth to 18 who reside in the county.	New Castle	8
Fathers/Partners General Health	Fathers/Partners, ages 18 to 44 with children ages birth to 8 who reside in specified zip codes in the county.	New Castle	8
Teens General Health	Adolescent boys, ages 13 to 17 who reside in specified zip codes in the county	Sussex	9
Women's General Health	Women with children, ages 18 to 44 who meet Federal income guidelines and reside in specified zip codes.	Kent	8
Children and Youth with Special Health Needs	Mothers of special needs children with physical and behavioral health diagnoses, ages birth to 18 who reside in the county	New Castle	7
Preconception	Black women ages 18 to 44, not pregnant, without children, who meet Federal income guidelines, have certain health conditions, and reside in the county	Kent/Sussex	3
Women's General Health	Women with children, ages 18 to 44 who meet Federal income guidelines and reside in specified zip codes in the county.	New Castle	13
Children and Youth with Special Health Needs	Mothers of special needs children with physical and behavioral health diagnoses, ages birth to 18 who reside in the county.	Kent/Sussex	9
Children and Youth with Special Health Needs	Spanish speaking mothers of special needs children with physical and behavioral health diagnoses, ages birth to 18 who reside in the county.	Sussex	8
Preconception	Black women ages 18 to 44, not pregnant, without children, who meet Federal income guidelines, have certain health conditions, and reside in the county.	New Castle	8
Fathers/Partners General Health	Fathers/Partners, ages 18 to 44 with children ages birth to 8 who reside in specified zip codes in the counties.	Kent/Sussex	10

Group Description	Group Makeup	County	Respondents
Women's General Health (Rescheduled as a Zoom meeting)	Women with children, ages 18 to 44 who meet Federal income guidelines and reside in specified zip codes in the county.	Sussex	9
Preconception (Zoom make-up session)	Black women ages 18 to 44, not pregnant, without children, who meet Federal income guidelines, have certain health conditions, and reside in the county.	Kent/Sussex	7

One hundred thirty-six (136) participants/respondents were recruited and confirmed by GWA through community networks and screened to verify their eligibility to participate in each of the focus groups. One hundred and twenty-nine (129) individuals participated as respondents in the focus groups with a goal of having ten respondents participating in each group. GWA prepared comprehensive discussion guides for each of the focus group categories which were approved by the client. A survey questionnaire was included in each discussion guide. The focus group discussion guides and questionnaires were translated into Spanish after approval. The focus group guide topics included: Introduction, Healthy Behaviors, Experiences of Fathers During and After Pregnancy, Relationships, Resources in the Community, Mental Health, Transition to Adult Care, Mentoring, Bullying, Social Determinants of Health, and Wrap-up. The topics and questions for the discussion guides varied based on the categories. The Focus Group Analysis can be found on our DEThrives website.

The following quantitative and qualitative methods were carried out to ascertain the status of the MCH population in each population health domain:

- **Quantitative Methods.** Quantitative methods were carried out on the stakeholder survey results and available population health data. The stakeholder survey involved the use of Likert scales, which facilitated the use of quantitative analyses. Population health data was gathered via documentation of the incidence and prevalence of various population health indicators and sources relevant to each population health domain (e.g., Pregnancy Risk Assessment Monitoring System (PRAMS) data for postpartum visit for the women/maternal health domain, National Survey of Children's Health (NSCH) data for medical home-related data for the child and CYSHCN health domains). Where applicable, data at the state level was compared to data at the national level and Healthy People 2030 goals to determine on which NPMs the State of Delaware were lagging; accordingly, these NPMs would be emphasized for improvement by Title V stakeholders.

- **Qualitative Methods.** Qualitative methods were conducted on the key informant interviews and focus groups to determine the strengths and limitations of the MCH population in each population health domains. The qualitative data was transcribed, and themes were analyzed by both Forward Consultants, LLC (for the key informant interviews) and Goeins-Williams Associates, Inc (for the focus groups).

Table 6 lists the data sources that were used to inform each of the National Performance Measures (NPMs) data sheets that were developed for MCH stakeholders. These data sheets were used in conjunction with the stakeholder survey, key informant interview, and focus group results to holistically assist MCH stakeholders in their determination of what NPMs within each population health domains would be emphasized for future Title V MCH programmatic efforts.

Table 6. Data Source(s) Used for Each NPM.

NPM	Data Source(s)
Postpartum Visit	Pregnancy Risk Assessment Monitoring System (2021)
Postpartum Mental Health	Pregnancy Risk Assessment Monitoring System (2021)
Postpartum Contraceptive Use	Pregnancy Risk Assessment Monitoring System (2021)
Perinatal Care Discrimination	Surgo Health Maternity Vulnerability Index (2023)
Risk-Appropriate Perinatal Care	Delaware Health Statistics Center (2021-2023)
Breastfeeding	National Survey of Children's Health (2021-2022), Pregnancy Risk Assessment Monitoring System (2021)
Safe Sleep	Pregnancy Risk Assessment Monitoring System (2021)
Housing Instability	National Survey of Children's Health (2021-2022), Surgo Health Maternity Vulnerability Index (2023), Pregnancy Risk Assessment Monitoring System (2021)
Developmental Screening	National Survey of Children's Health (2021-2022)
Childhood Vaccination	CDC Coverage with Selected Vaccines and Exemption from School Vaccine Requirements Among Children in Kindergarten — United States (2022–2023)
Preventive Dental Visit	Pregnancy Risk Assessment Monitoring System (2021)
Physical Activity	National Survey of Children's Health (2021-2022)
Food Sufficiency	National Survey of Children's Health (2021-2022)
Adolescent Well-Visit	National Survey of Children's Health (2021-2022)
Mental Health Treatment	National Survey of Children's Health (2021-2022)
Tobacco Use	Youth Risk Behavior Survey (2021)
Adult Mentor	National Survey of Children's Health (2021-2022)
Medical Home	National Survey of Children's Health (2021-2022)
Transition	National Survey of Children's Health (2021-2022)
Bullying	National Survey of Children's Health (2021-2022)

To help determine and finalize the state's Title V priority needs, Forward Consultants staff aggregated the data sheets used to inform the NPMs, stakeholder survey results, key informant interview findings, and focus group results and segmented these materials into five workbooks, one for each population health domain.

Finally, the chosen priority NPM(s) for each population health domain were then provided to the relevant DPH stakeholder, who then made use of the MCH Evidence Strategy Planning Tool designed by Georgetown University[3] and a state action plan template to help build out the NPM(s) for the state action plan.

[1] HRSA Guidance. Retrieved from: https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=BlockGrantGuidance.pdf&isForDownload=False

[2] AMCHP CAST-5. Retrieved from: https://amchp.org/resources/capacity-assessment-for-state-title-v-cast-5/

[3] MCH Evidence Strategic Planning Tool. Retrieved from: https://www.mchevidence.org/documents/MCH-Evidence-Planning-Tool.pdf

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

The following information present key findings of Delaware's MCH population health and well-being, including CYSHCN. As previously mentioned, MCH created Data Sheets for each of the 20 National Performance Measures (NPM). Each Health Data Sheet provides a snapshot of Delaware's pulse regarding the various health indicators. These Data Sheets can be found on our DEThrives website:

Stakeholder Survey. The stakeholder survey helped determine which NPMs were considered the most important as well as the perception of the stakeholders' awareness, progress, and desire of the need to address the NPM. The stakeholders completing the survey also listed the pressing needs of the MCH population.

Most Important NPMs. Respondents provided assorted responses on which NPM they each considered to be the most important within each domain (Table 1). With that said, the respondents disproportionately chose postpartum mental health screening and housing instability (women/maternal health domain); housing instability and risk-appropriate perinatal care (perinatal/infant health domain); housing instability, food sufficiency, developmental screening (child health domain); mental health treatment and adolescent well-visit (adolescent health domain), and medical home and transition (CYSHCN domain) as key NPMs to be addressed.

Table 1. For Each Domain, NPM Selected as Most Important to be Addressed.

Women's/Maternal Health	***n* = 38 (%)**
Postpartum Mental Health Screening	14 (36.8%)
Housing Instability	10 (26.3%)
Perinatal Care Discrimination	8 (21.1%)
Postpartum Visit	5 (13.2%)
Preventive Dental Visit	1 (2.6%)
Postpartum Contraception	0 (0.0%)
Perinatal/Infant Health	***n* = 38 (%)**
Housing Instability	14 (36.8%)
Risk-Appropriate Perinatal Care	9 (23.7%)
Perinatal Care Discrimination	6 (15.8%)
Safe Sleep	6 (15.8%)
Breastfeeding	3 (7.9%)
Child Health	***n* = 39 (%)**
Housing Instability	11 (28.2%)
Food Sufficiency	10 (25.6%)
Developmental Screening	9 (23.1%)
Medical Home	6 (15.4%)
Preventive Dental Visit	2 (5.1%)
Physical Activity	1 (2.6%)
Childhood Vaccination	0 (0.0%)
Adolescent Health	***n* = 39 (%)**
Mental Health Treatment	16 (41.0%)
Adolescent Well-Visit	8 (20.5%)
Medical Home	5 (12.8%)
Adult Mentor	5 (12.8%)
Transition	2 (5.1%)
Bullying	1 (2.6%)
Tobacco Use	1 (2.6%)
Preventive Dental Visit	1 (2.6%)
Children and Youth with Special Health Care Needs	***n* = 31 (%)**
Medical Home	17 (54.8%)
Transition	13 (41.9%)
Bullying	1 (3.2%)

Needs. When asked "What are the *top three important things* that women, children, and families need to live their fullest lives?", the top five most frequently stated themes by percentage of comments reported were:

- Housing (26.0%);
- Access to healthcare (16.0%);
- Mental health (10.7%);
- Food (8.7%); and
- Financial stability (7.3%).

In addition, when asked "What are the *top three biggest unmet needs* of women, children, and families in your community?", the top five most commonly listed themes by percentage of comments reported were:

- Housing (29.1%);
- Access to healthcare (15.8%);
- Food security (13.3%);
- Mental health (6.1%); and
- Ability to have a living wage (5.5%).

A word cloud of themes is provided in Figures 1 and 2.

Figure 1. Top Three Important Things Women, Children, and Families Need to Live Their Fullest Lives.

Figure 2. Top Three Biggest Unmet Needs of Women, Children, and Families in Community.

Focus Groups. The following are the strengths and needs identified across the focus groups by population health domain (note that children and adolescents were aggregated with one another).

- ***Women/Maternal Health.*** The discussion on women's general health covered a range of topics, including access to healthcare, family situations, and community impact on health. The participants shared their experiences and insights on the qualities they seek in healthcare providers, barriers to accessing healthcare, comfort level in discussing personal questions or concerns with their healthcare providers, prenatal and postpartum care, child development and healthcare, postpartum visits and breastfeeding experiences, community conditions affecting children's health, health and nutrition concerns, improving access to childhood vaccinations, community resources, and everyday worries and concerns of mothers.

  The discussion highlighted the importance of effective communication and education to address vaccine hesitancy and improve access to essential vaccinations for children, as well as the need for community resources and support for parents to enhance their children's learning and development. It also revealed that everyone does not have family support or someone to talk to about their concerns and issues which is important to relieving stress and anxiety.

  The groups explored the potential impact of community conditions on children's health, focusing on housing situations, access to healthy food choices and the difficulties of accessing affordable healthy food in their communities, and transportation issues.

- ***Preconception.*** Respondents expressed the lack of awareness and promotion of available services, emphasizing the need to make these resources more accessible and understandable for low-income people and engaging with the community through hands-on activities and demonstrations to share health information more effectively.

  The women expressed frustration with the complexities of health insurance, the high cost of healthcare, and the lack of support for medication expenses. The discussion on healthcare providers emphasized the importance of respectful and helpful treatment from healthcare providers and the impact it has on individuals' overall healthcare experiences. Participants expresses dissatisfaction with their providers due to instances of rudeness and

language barriers.

The conversation also touched on the ideal healthcare experience, emphasizing the significance of respectful and welcoming healthcare environments, efficient time management, and the convenience of accessing comprehensive information through an app. The discussion reflected a focus on patient-centered care and the importance of addressing barriers to healthcare access and the need for more representation of black doctors and nurses in the community.

Participants have anxieties about health, financial stability, and the unknown future. The discussion touched on the stress of managing expenses, the desire for financial security, and the fear of the unknown.

- ***Children/Adolescents.*** Both boys and girls have support to stay healthy and are influenced by family members, coaches, and other adults who role model healthy behaviors. The greatest influence on staying healthy for boys appears to be sports, which is also one of their biggest outlets. Girls appear to have higher levels of mental health issues, are depressed, stressed, and have less people to talk to about their issues. Unhappiness for boys appears to be tied to finances and they worry about money. Girls also have fewer resources and are less aware of what is available to them. Girls more than boys are less comfortable discussing mental health issues with their health care providers.

  The biggest issues for the teens are their mental health and lack of access to free, safe recreation, or people they can confide in. Some of the teens feel there is a stigma associated with seeking help for mental health issues and males and Black girls are stereotyped and judged.

  Teens recognize that mentors can be a source of support and provide them with someone to talk to, most of the teens do not have mentors.

  For the most part, teens are not aware of what is needed to transition to adult healthcare. This is an area where healthcare providers do more to engage with teens and their parents.

  The teens worry about their future, and their safety, and staying away from the wrong crowd and drugs. The boys expressed a greater need to have more access to free recreation facilities. The girls need greater access to and more awareness of the resources that are available to help them with their depression and high levels of stress. The teens could benefit from having group discussions that focus on their future where they learn about finances, opportunities for college, and life skills.

- ***CYSHCN.*** Participants shared their experiences and challenges in caring for children and youth with special health needs. The survey questionnaire and the discussions highlight the various experiences and health concerns of the participants, fostering an understanding of the range of child health issues within the groups. The participants discussed the challenges of finding a good physician and the importance of family-centered care in healthcare. They also shared their personal struggles and challenges as parents of children with special needs, discussing difficulties with healthcare providers, work-life balance, and accessing necessary services and support. Several participants openly shared their experiences as parents of children with special needs, including the emotional and practical challenges they face, as well as the importance of mutual support between parents in similar situations.

  Participants shared personal experiences with the healthcare system, highlighting the lack of care and support for their children with special needs. The participants also face issues with records, misdiagnosis, and delayed treatment. They emphasized the need for parents to advocate for their children and trust their instincts, sharing their own experiences of having to fight for proper care. They want to build rapport with healthcare providers and consistent care coordinators, and seek out the best possible care for children, even if it means going out of state. The Spanish speaking participants face obstacles because of language barriers, lack of understanding and support from some doctors, and what they believe is discrimination from health care providers.

  Participants shared their experiences and challenges in accessing therapy and healthcare services for their children, including difficulties finding good therapists and navigating the referral process. Additionally, they discussed the lack of information on state and community resources from healthcare providers and the disparities in available resources in different regions citing community resources are less available downstate.

Table 2 summarizes both the quantitative analyses using varied sources (e.g., PRAMS, NSCH) as well as commentary given by the key informants into a “modified” SWOT analysis (i.e., Strengths, Challenges/Weaknesses,

Opportunities/Solutions, and Emerging Concerns/Threats) by maternal and child health population domain.

Table 2. Strengths, Challenges/Weaknesses, Opportunities/Solutions, and Emerging Concerns/Threats (Modified SWOT).

	Strengths	Challenges/ Weaknesses	Opportunities/ Solutions	Emerging Concerns/ Threats
Women/ Maternal Health	– Indicators on par with national figures – DE-Thrives Website – DHMIC Partners and Meetings	– Housing Instability – Increasing rates of obstetric hemorrhage – Limited Workforce, especially downstate – Mental Health Services – Racism – Health Communicatio n Accessibility – Transportation Issues	– EHR Integration – Guaranteed Basic Income – Medicaid Utilization – Medical Home – Mental Health Teams – Social Determinants of Health – Telehealth Services	– Food Insecurity – Limited Access to Haitian Creole Translators – Substance Misuse Issues – Syphilis – Telehealth Services as Substitute for In-Person Services
Perinatal/ Infant Health	– Reduction in adverse birth outcomes (e.g., infant mortality) Addressing SDOH – DE-Thrives Website – Decrease in Statewide Perinatal Mortality – Kicks Count Initiative	– Housing Instability – Ongoing disparities in indicators when segmented by race/ethnicity and health care coverage – Mental Health Services – Persistent Racial Disparities in Perinatal Mortality – Transportation	– Doulas/ Home Health Visiting Program – EHR Integration – Medicaid Utilization – Medical Home – Telehealth Services	– Substance Misuse Issues

	Strengths	Challenges/ Weaknesses	Opportunities/ Solutions	Emerging Concerns/ Threats
Child Health	– Indicators (i.e., physical activity, food sufficiency, child vaccination) – Care Coordination (SBHCs)	– Housing Instability – Ongoing disparities in indicators when segmented by race/ethnicity and health care coverage Lead Exposure – Limited Access to Oral Health Care – Mental Health Services – Limited Care Coordination – Vaccinations	– Conscious Discipline Training – Database Integration – Guaranteed Basic Income – House Bill 202	– Access to Childcare – Vaping
Adolescent Health	– Indicators (i.e., adult mentor, medical home, mental health treatment, tobacco use) generally on par with national figures – Care Coordination (SBHCs) – Support for Sex Education	– Ongoing disparities in indicators when segmented by race/ethnicity and health care coverage – Lack of Immunizations – Limited Access to Oral Health Care – Mental Health Services – Limited Access to Vision Screenings	– Care Mapping Training	– Vaping

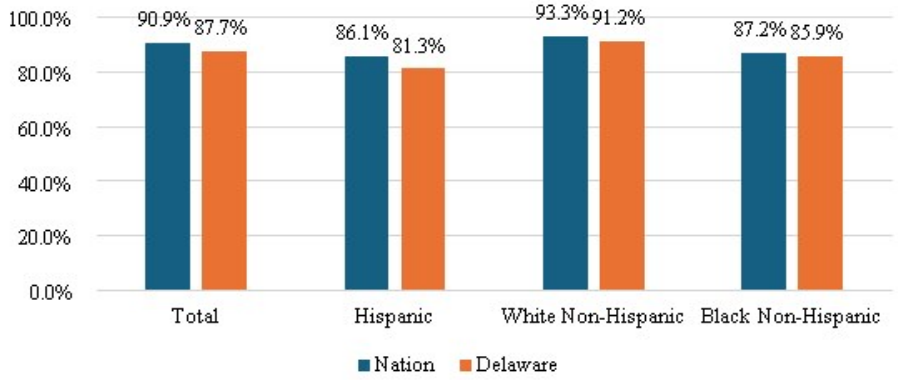
	Strengths	Challenges/ Weaknesses	Opportunities/ Solutions	Emerging Concerns/ Threats
CYSHCN	– Indicators (i.e., medical home, bullying, transition) generally on par with national figures – Care Coordination	– Ongoing disparities in indicators when segmented by race/ethnicity and health care coverage – Transition to Adulthood	– Care Mapping Training – House Bill 202	– Access to Childcare – Assessing Mental Health

The population health analyses by population health domain are given below.

- **Women/Maternal Health.** Data from both PRAMS and the NSCH were used to inform many of the NPMs comprising the women/maternal health domain. Other sources, such as data collected by Delaware-based initiatives (e.g., Delaware Perinatal Quality Collaborative), were also used. Where applicable, data on the NPMs were segmented by race/ethnicity to better understand the extent to which disparities exist with the NPMs.

  - ***Postpartum Visit*** As given in Figure 3, the estimated percentage of postpartum women in Delaware with a postpartum visit was slightly lower than the corresponding nationwide percentage. Moreover, the percentages of Hispanic and Black non-Hispanic postpartum women with a postpartum visit were lower than that of White non-Hispanic postpartum women.

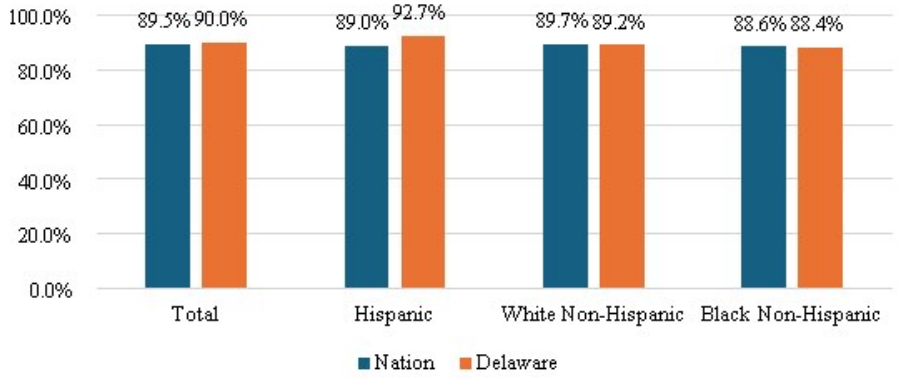
    Figure 3. Estimated Percentage of Postpartum Women with a Postpartum Visit, by Selected Race/Ethnicities.



    Source: PRAMS 2021.

  - ***Postpartum Mental Health Screening.*** The estimated percentage of postpartum women in Delaware with a postpartum mental health screening was roughly the same as the corresponding nationwide percentage as given in Figure 4. The percentages were also comparable across race/ethnicities.

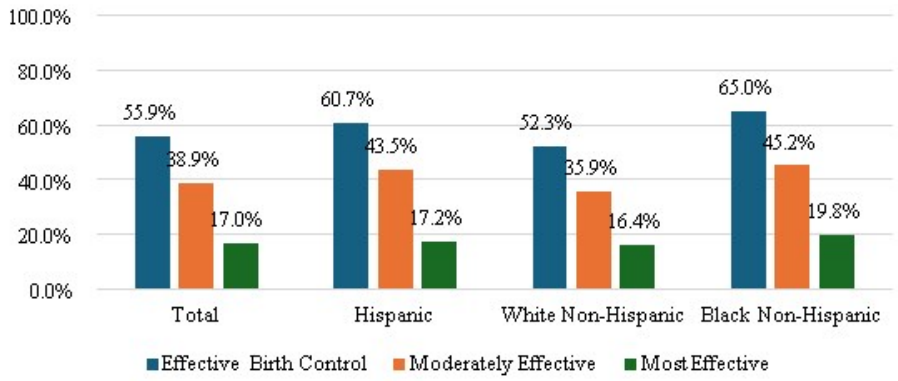
    Figure 4. Estimated Percentage of Postpartum Women with a Postpartum Mental Health Screening, by Selected Race/Ethnicities.



    Source: PRAMS 2021.

  - ***Postpartum Contraception Use.*** Figure 5 provides the estimated percentage of postpartum women reportedly using a “moderately effective” form of contraception (pill, patch, shot, ring, or condoms), a “most effective” form of contraception (IUD, implant), or both (“effective birth control”) by race/ethnicity and health care coverage, respectively. Note that the estimated percentages of White non-Hispanic postpartum women using effective birth control was lower than the percentages among the other race/ethnicities.

    Figure 5. Estimated Percentage of Postpartum Women with Postpartum Contraception Use, by Selected Race/Ethnicities.



Source: PRAMS 2021.

- ***Risk-Appropriate Perinatal Care.*** Table 3 lists the number of VLBW infants that meet the criteria for the above-listed numerator and denominator. As evidenced by this table, the percentage of VLBW infants born at the single Level III birthing hospital in Delaware has increased from 69.4 percent to 90.0 percent from 2021 to 2023.

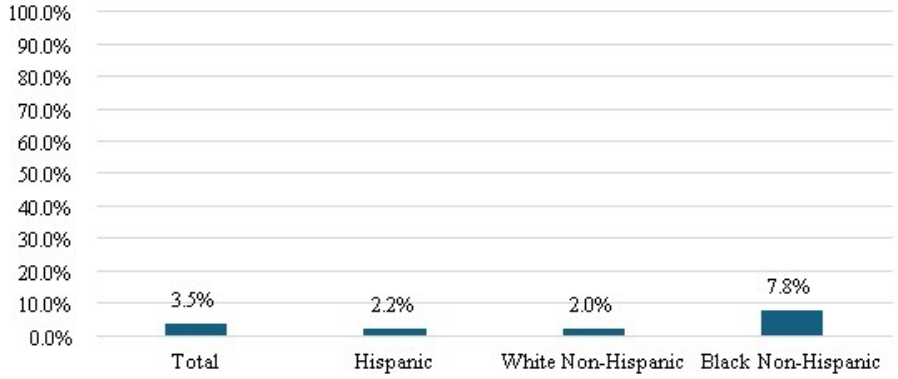
Table 3. Number and Percentage of VLBW Infants Born at Level III Birthing Hospital.

Year	Numerator	Denominator	Percentage
2021	34	49	69.4%
2022	97	112	86.6%
2023	108	120	90.0%

Source: Delaware Health Statistics Center.

- ***Housing Instability.*** The estimated percentage of women who stated that they were homeless in the 12 months before their baby was born was highest among Black non-Hispanic women as compared to the other race/ethnicities examined (Figure 6).

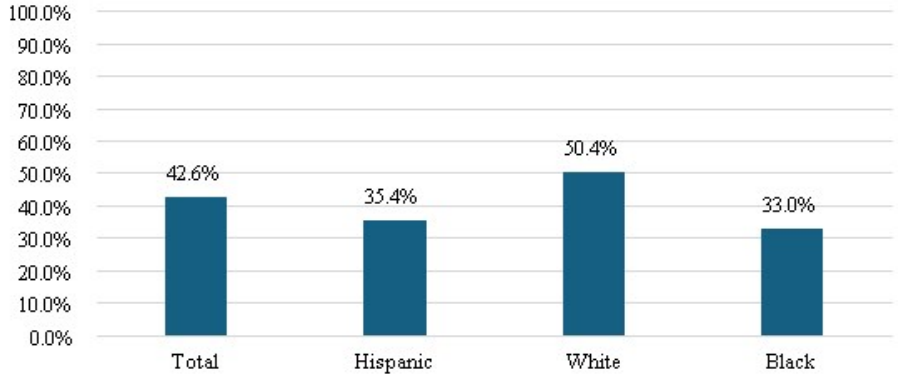
Figure 6. Percentage of Women Who Stated They Were Homeless in the 12 Months Before Their Baby Was Born, by Selected Race/Ethnicities.



Source: PRAMS 2021.

- ***Preventive Dental Visit.*** As given in Figure 7, the percentages of Hispanic and Black non-Hispanic postpartum women with a dental cleaning during their pregnancy were lower than that of White non-Hispanic postpartum women.

Figure 7. Percentage of Postpartum Who Had Dental Cleaning During Recent Pregnancy, by Selected Race/Ethnicities. [Delaware Only]

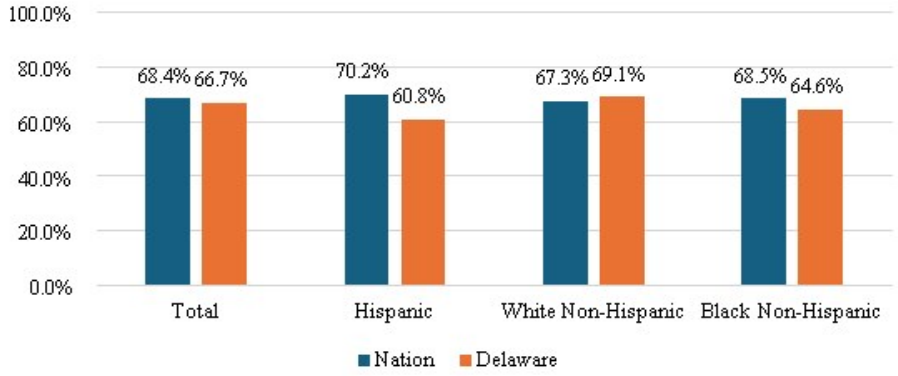


Source: PRAMS 2021.

- **Infant/Perinatal Health.** The PRAMS data set was used to help ascertain the status of the NPMs underlying the infant/perinatal health domain. Other sources, such as substance exposed infant data collected by Delaware-based programs, were also used. Where applicable, data on the NPMs were segmented by race/ethnicity to better understand the extent to which disparities exist with the NPMs.

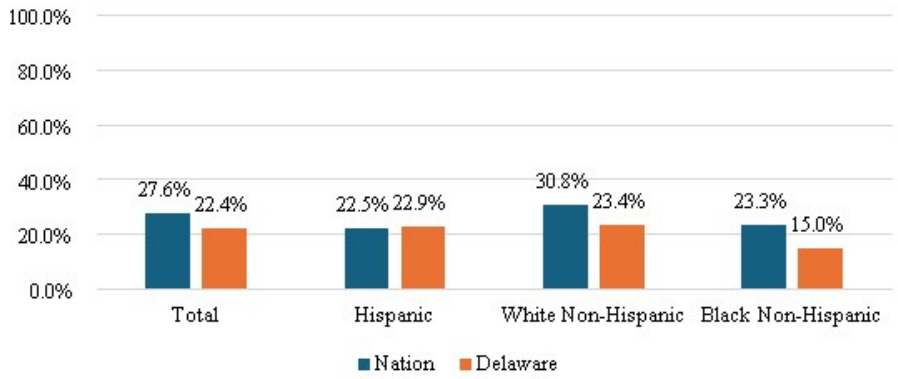
  - ***Breastfeeding.*** The estimated percentage of infants in Delaware who were reportedly breastfed at one month was approximately the same as the corresponding nationwide percentage as given in the figures. These percentages were also comparable across race/ethnicities, health care coverage, and age of the mother. However, among infants and children in Delaware ages six months to two years who were breastfed exclusively for six months, the reported percentages among Black non-Hispanic infants and children were lower than the other race/ethnicity categories as shown in Figures 8 and 9.

Figure 8. Estimated Percentage of Infants Breastfeeding at One Month, by Selected Race/Ethnicities.



Source: PRAMS 2021.

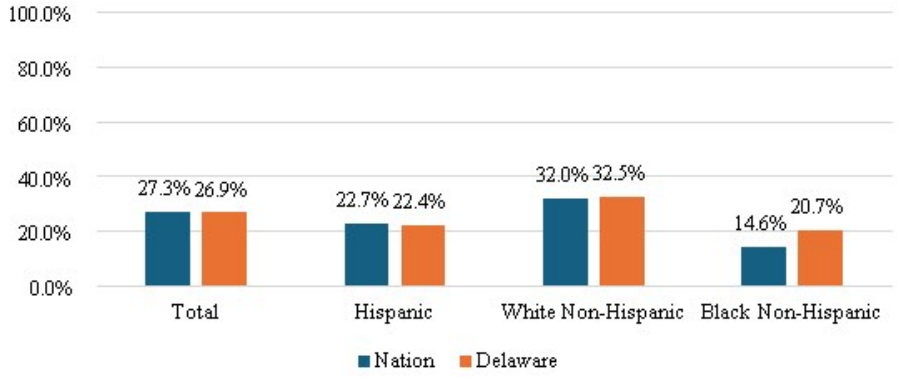
Figure 9. Estimated Percentage of Infants and Children Six Months to 2 Years of Age Who Were Breastfed Exclusively for Six Months, by Race/Ethnicity.



Source: NSCH 2021-2022.

- ***Safe Sleep.*** The estimated percentage of infants in Delaware who reportedly engaged in safe sleep behaviors was lower among Black non-Hispanic infants as compared to White non-Hispanic infants, and to a lower extent, Hispanic infants (Figure 10).

Figure 10. Estimated Percentage of Infants Reportedly Engaged in Proper Safe Sleep Behaviors, by Selected Race/Ethnicities.

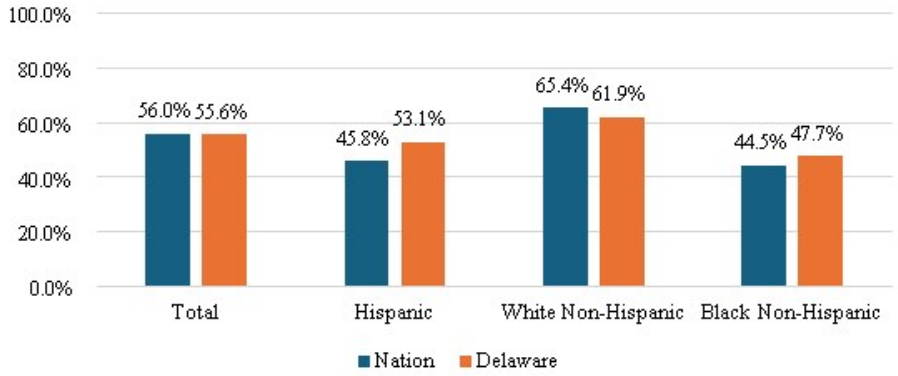


Source: PRAMS 2021.

- **Child Health.** The NSCH data set was used to inform the NPMs for the child health domain. As in the other domains, where applicable, data on the NPMs were segmented by race/ethnicity to better understand the extent to which disparities exist with the NPMs.

  - ***Housing Instability***. In Delaware, the percentage of Black non-Hispanic children residing in supportive neighborhoods was lower than the corresponding percentages of White non-Hispanic and Hispanic children (Figure 11).

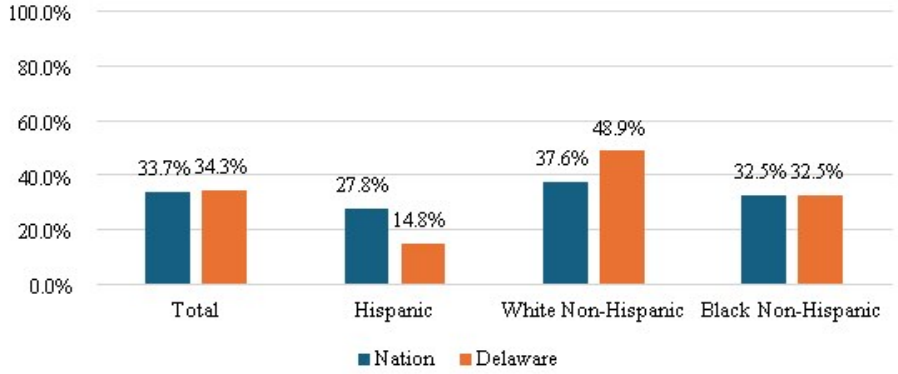
Figure 11. Percentage of Children Residing in Supportive Neighborhoods, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Developmental Screening.*** In Delaware, the percentage of White non-Hispanic children who received a developmental screening tool was higher than that of Black non-Hispanic children, which in turn, was higher than that of Hispanic children (Figure 12).

Figure 12. Percentage of Children Ages 9-35 Months Who Received a Developmental Screening Tool, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Childhood Vaccination.*** Table 4 lists the estimated immunization coverage with measles, mumps, and rubella (MMR); diphtheria, tetanus, and acellular pertussis (DTaP); poliovirus (Polio); and varicella vaccines (VAR) among kindergartners nationwide and in Delaware and nationwide. As shown here, the percentages across each vaccination category are comparable between the state and nation.

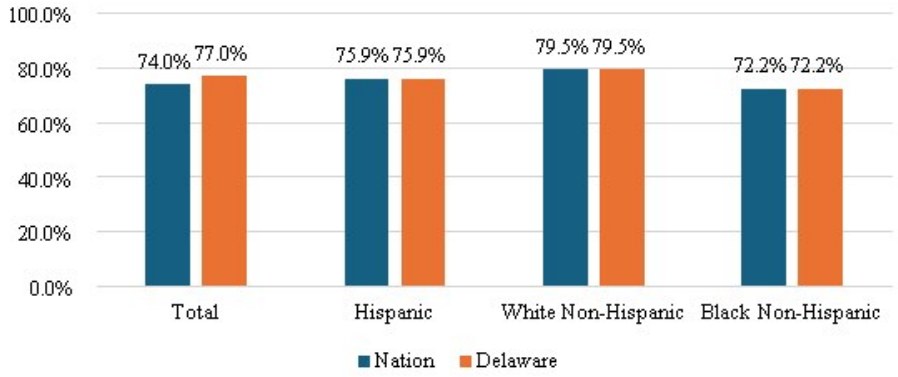
Table 4. Vaccination Percentages Among Kindergartners, 2022-2023 School Year.

	2 Doses of MMR	5 Doses of DTaP	4 Doses of Polio	2 Doses of VAR
Nation	93.1%	92.7%	93.1%	92.9%
Delaware	95.1%	93.8%	94.0%	94.0%

In addition, in 2021, the percentage of Delaware children who received by age 24 months all recommended doses of the combined seven-vaccine series is 76.6 percent, which places Delaware as having the 10th highest vaccination rate nationwide. The nationwide percentage is 70.0 percent. Note that the seven-vaccine series is as follows: diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; measles, mumps and rubella (MMR) vaccine; poliovirus vaccine; Haemophilus influenzae type b (Hib) vaccine; hepatitis B (HepB) vaccine; varicella vaccine; and pneumococcal conjugate vaccine (PCV).

- ***Preventive Dental Visit.*** The percentage of children who have seen a dentist in the past year for a preventive dental care visit was slightly lower among Black non-Hispanic children as compared to White non-Hispanic and Hispanic children as given in Figure 13. In addition. Medicaid-enrolled children also reportedly had a slightly lower percentage of children with a preventive dental visit as compared to children covered by private insurance.

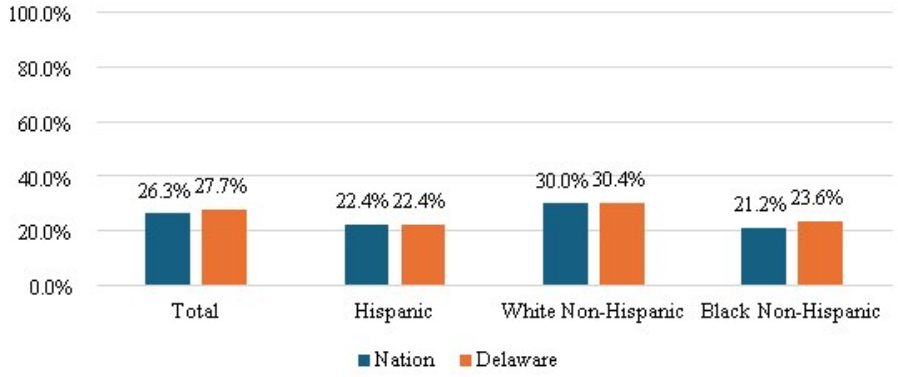
Figure 13. Percentage of Children Who Have Seen Dentist in Past Year for Preventive Dental Care, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Physical Activity.*** The percentages of Hispanic and Black non-Hispanic children who were reportedly physically active were lower than that of White non-Hispanic children (Figure 14).

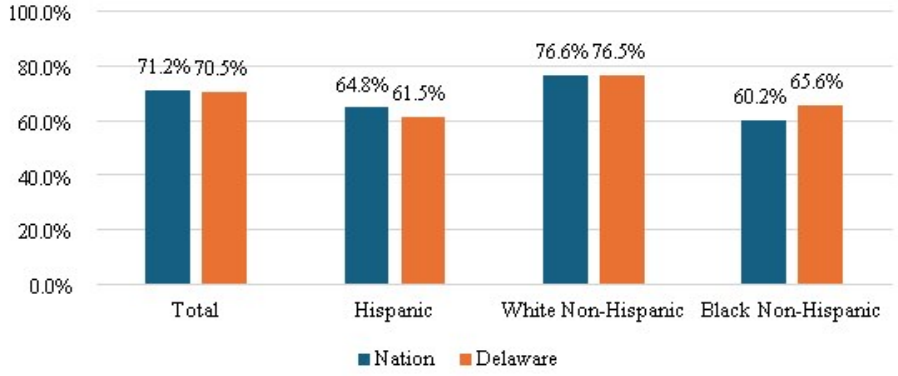
Figure 14. Percentage of Children Who Are Reportedly Physically Active, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Food Sufficiency.*** Figure 15 indicates that the percentages of Black non-Hispanic and Hispanic children residing in households that were food sufficient were lower than the corresponding percentage for White non-Hispanic children, both nationally and in Delaware.

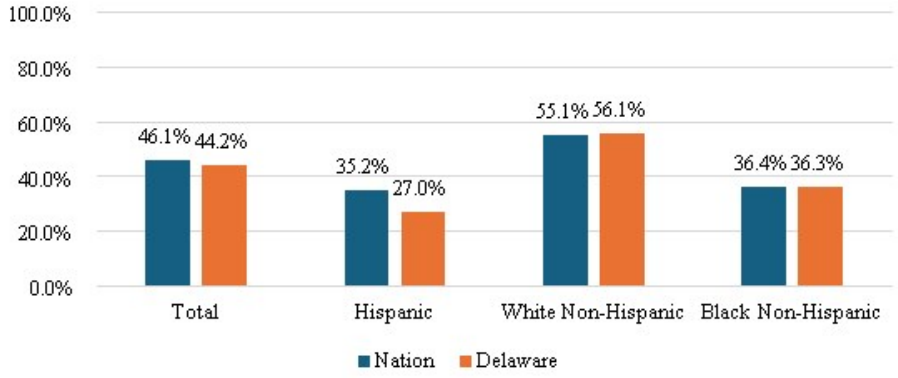
Figure 15. Percentage of Children Aged 0-11 Years Whose Households Were Food Sufficient, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Medical Home.*** Generally speaking, across all categories assessed (i.e., personal doctor or nurse; usual source of sick care; family centered care, referrals, care coordination, and medical home), the Delaware percentages are more favorable (i.e., higher) than the corresponding national percentages (data available on request). Note that the percentage of White non-Hispanic children who have a medical home are disproportionately higher than both Hispanic and Black non-Hispanic children (Figure 16).

  Figure 16. Percentage of Children Ages 0-17 Years Who Have a Medical Home by Selected Race/Ethnicities.

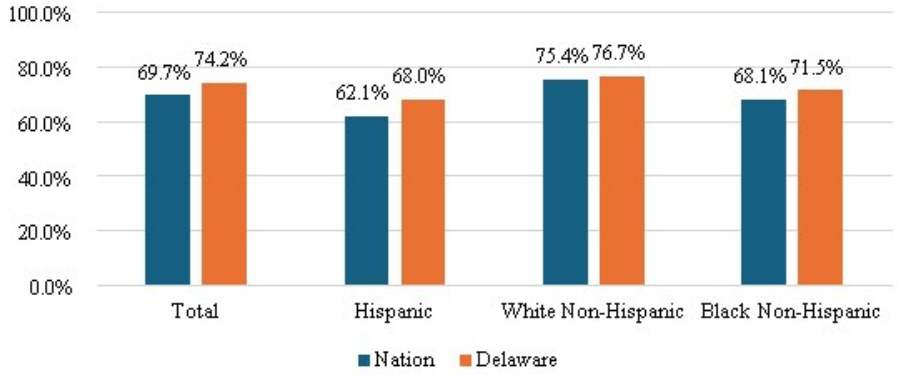


  Source: NSCH 2021-2022.

- **Adolescent Health.** As in the child health domain, the NSCH data set was used to inform the NPMs for the adolescent health domain. In addition, the Youth Risk Behavior Survey (YRBS) was employed as a source for specific NPMs. Moreover, as in the other domains, where applicable, data on the NPMs were segmented by race/ethnicity to better understand the extent to which disparities exist with the NPMs.

  - ***Adolescent Well Visit.*** Figure 17 indicates that the percentages of Hispanic adolescents with a well visit were slightly lower than the corresponding percentages for Black non-Hispanic adolescents, which in turn, were lower than the percentages reported for White non-Hispanic adolescents at both the state and national level.

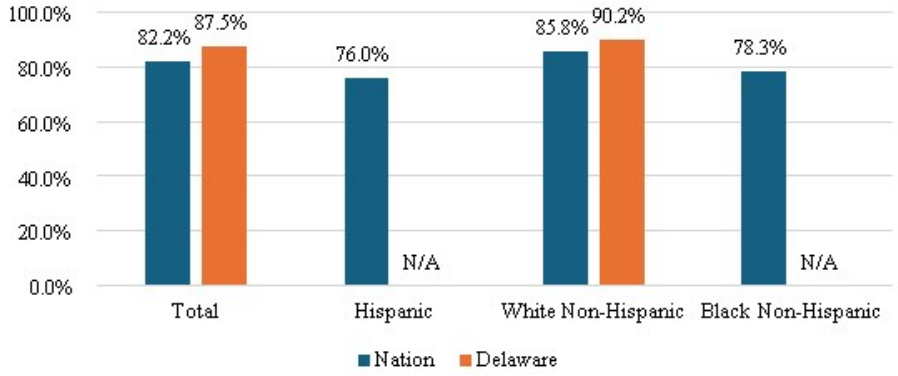
    Figure 17. Percentage of Adolescents with A Well Visit, by Selected Race/Ethnicities.



    Source: NSCH 2021-2022.

  - ***Mental Health Treatment.*** Figure 18 indicates that the percentages of Black non-Hispanic and Hispanic adolescents who receive needed mental health treatment or counseling were slightly lower than the corresponding percentage for White non-Hispanic adolescents at the national level (state-level was not available for these two race/ethnicities).

Figure 18. Percentage of Adolescents Receiving Needed Mental Health Treatment, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Tobacco Use.*** As shown in Table 5, the percentage of high school age adolescents reportedly using tobacco products was similar across the nation and Delaware in each category assessed.

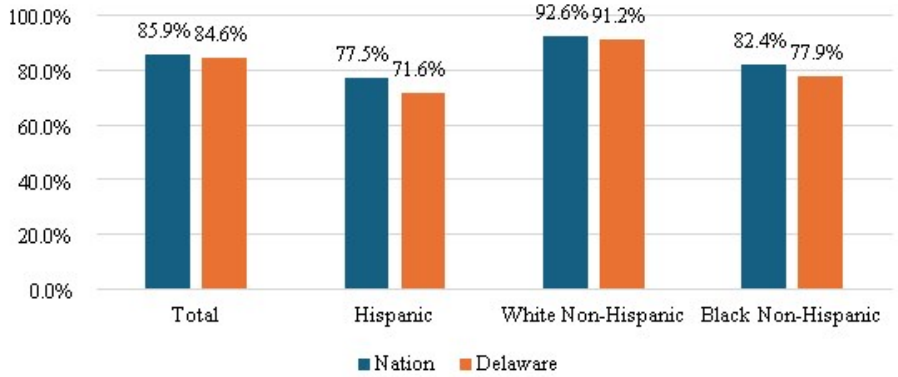
Table 5. Percentage of Adolescents Grades 9-12 Who Report Using Tobacco Products by Selected Race/Ethnicities.

	Nation	Delaware
High school students who currently smoked cigarettes or cigars or used tobacco or electronic vapor products.	18.7%	18.3%
High school students who currently smoked cigarettes.	3.8%	2.7%
High school students who currently used electronic vapor products.	18.1%	17.9%
High school students who currently used smokeless tobacco.	2.5%	1.6%

Source: YRBS 2021.

- ***Adult Mentor.*** The percentages of Hispanic and Black non-Hispanic adolescents who reportedly have an adult mentor (i.e., one or more adults outside the home who they can rely on for advice or guidance) were lower than that of White non-Hispanic adolescents (Figure 19).

Figure 19. Percentage of Adolescents Ages 12-17 Years Who Have a Mentor, by Selected Race/Ethnicities.

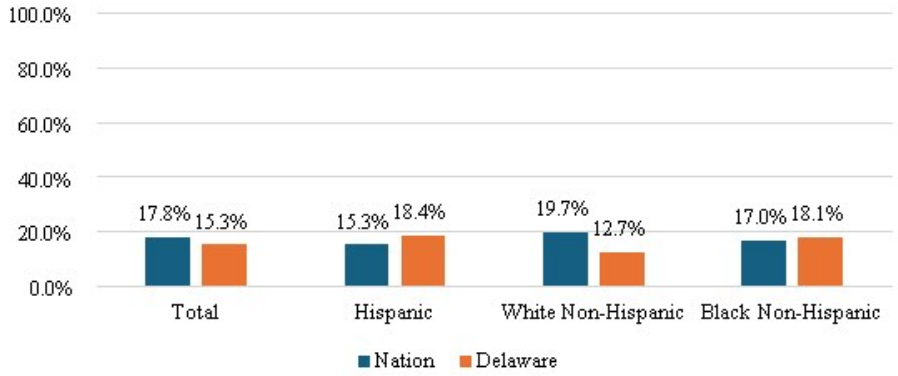


Source: NSCH 2021-2022.

- ***Transition to Adult Health Care.*** As shown in Figure 20, in Delaware, the percentages of Hispanic and Black non-Hispanic adolescents who reportedly have a transition plan to adult health care was higher than that of White

non-Hispanic adolescents.

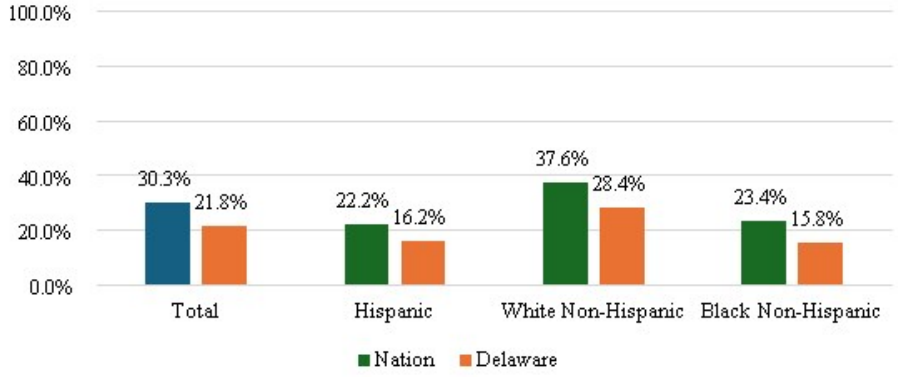
Figure 20. Percentage of Adolescents Who Received Services to Prepare for Transition to Adult Health Care, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Bullying.*** The percentage of adolescents who are reportedly bullied was slightly lower among Delaware adolescents as compared to the nation (Figure 21). The percentages of Black non-Hispanic and Hispanic adolescents who reported being bullied is also lower than that of White non-Hispanic adolescents (Figure 21).

Figure 21. Percentage of Adolescents Who Are Bullied, by Selected Race/Ethnicities.

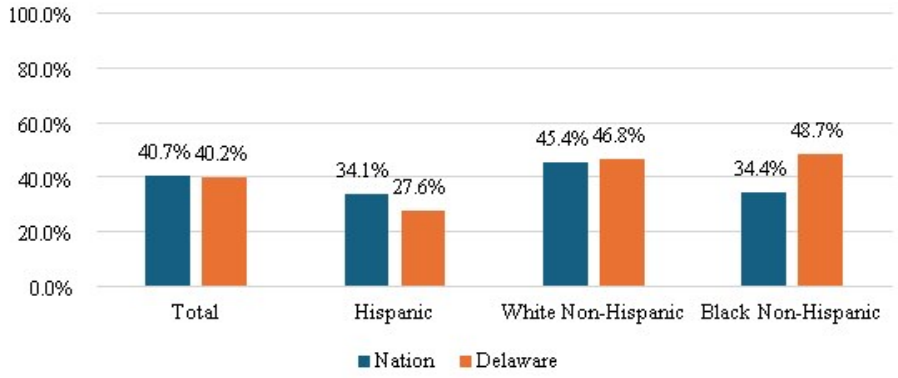


Source: NSCH 2021-2022.

- **CYSHCN Health.** The NSCH data set was used to inform the NPMs for the CYSHCN health domain. As in the other domains, where applicable, data on the NPMs were segmented by race/ethnicity to better understand the extent to which disparities exist with the NPMs.

  - ***Medical Home.*** Generally speaking, across all categories assessed (i.e., personal doctor or nurse; usual source of sick care; family centered care, referrals, care coordination, and medical home), the Delaware percentages and national percentages were fairly comparable. The percentage of Hispanic CYSHCN who have a medical home is disproportionately lower than both Black non-Hispanic and White non-Hispanic CYSHCN (Figure 22).

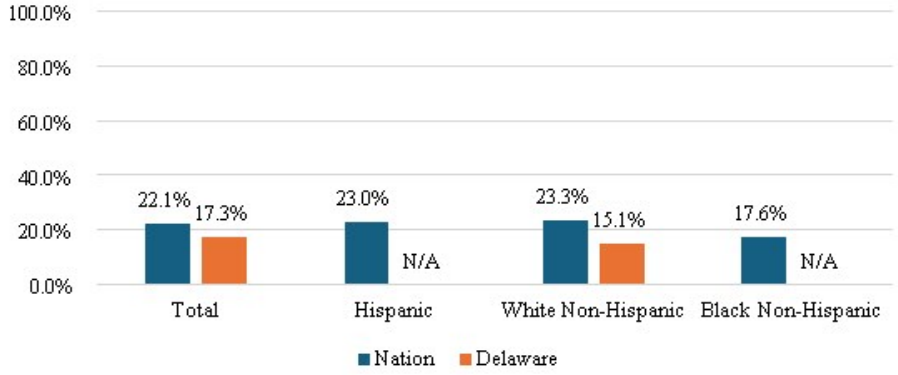
Figure 22. Percentage of CYSHCN Ages 0-17 Years Who Have a Medical Home, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Transition to Adult Health Care.*** Figure 23 shows the percentage of CYSHCN adolescents who reportedly received services to prepare for transition to adult health care by race/ethnicity.

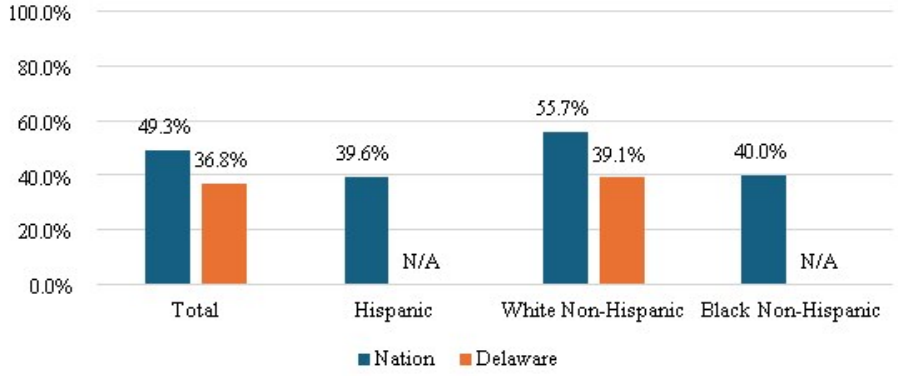
Figure 23. Percentage of CYSHCN Adolescents Who Received Services to Prepare for Transition to Adult Health Care, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

- ***Bullying.*** The percentage of CYSHCN adolescents who reportedly were bullied are given by race/ethnicity in Figure 24.

Figure 24. Percentage of CYSHCN Adolescents Who Are Bullied, by Selected Race/Ethnicities.



Source: NSCH 2021-2022.

Key Informant Interviews. Overall, for each SWOT category, the following are substantive themes given by the key informants across multiple domains:

- ***Strengths***: sound collaboration among partners, especially the DHMIC; and availability of resources via the DE-Thrives website;

- ***Challenges/Weaknesses***: housing instability; limited workforce; transportation issues; mental health issues; racial disparities; and limited access to oral care;
- ***Opportunities/Solutions***: telehealth services; guaranteed basic income; potential to integrate or share electronic health records (EHRs) across platforms; House Bill 202 (i.e., the requirement of childcare providers to carry out developmental screening in order to attain or maintain licensure); and various types of training modules; and
- ***Emerging Concerns/Threats***: food insecurity; limited access to Haitian Creole translators; substance misuse; and vaping.

The following serve as current initiatives to improve MCH population health:

Delaware Perinatal Quality Collaborative. The Delaware Perinatal Quality Collaborative (DPQC) is a state network of birthing institutions working to improve the quality of care for mothers and babies in Delaware. The DPQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible. The DPQC has carried out numerous following initiatives to improve perinatal health, including:

- Addressing persistent severe hypertension (SHTN) among Delaware's pregnant women.
- Integration of the Eat, Sleep, and Console (ESC) protocol for infants identified with neonatal opioid withdrawal syndrome (NOWS).
- Determining the effects of low-dose aspirin (LDA) administration on reducing severe preeclampsia (PEC) among Delaware's pregnant women.
- Initiating state maternal health innovation (SMHI) focused on perinatal women with substance use disorder (SUD).
- Implementing a fourth trimester of care model.

Maternal and Child Death Review Commission's (MCDRC). The MCDRC's mission of public health surveillance is to identify opportunities to improve the care of women, children and families is carried out through the work of its three fatality review programs. The longest-running program is Child Death Review (CDR) which was expanded in 2014 with support from the Centers for Disease Control and Prevention (CDC) to add Sudden Death in the Young (SDY) reviews. To mitigate the risk of unsafe sleep-related deaths, the Commission continued to oversee the Cribs for Kids program. In 2022, MCDRC staff distributed 224 cribs and reached over 320 people through safe sleep trainings. CDR/SDY findings also inform the Child Protection Accountability Commission (CPAC)-MCDRC Joint Action Plan to coordinate state agency efforts and standardize practices relating to child death investigations and family risk assessment.

Healthy Women, Healthy Babies Program. The DHMIC developed the Healthy Women, Healthy Babies program, which provides preconception and prenatal care services to women at-risk for poor birth outcomes. These services are offered at seven participating clinics statewide, all of which are located in communities that serve the program's target population of women who are African American and/or have a low socioeconomic status. Given the relatively high number of prenatal women enrolled in the program, the Healthy Women, Healthy Babies program serves as a primary source for effecting improvements in perinatal outcomes statewide.

Evidence-Based Home Visiting (MIECHV and State-Supported Services). In the State of Delaware, evidence-based home visiting is a voluntary free service for pregnant women and families with children under the age of five years. A Family Support Specialist will get to know eligible individuals and their families so that they can offer tailored support services to meet the individual/family's needs. Four evidence-based home visiting programs operate statewide in Delaware: Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers.

Family Support and Healthcare Alliance Delaware (Family SHADE). The aim of Family SHADE, as part of the Title V CYSHCN work in Delaware, is to build state and local capacity, and test small scale innovative strategies to improve the overall systems of care for children and youth with special health care needs and their families. The primary focus is innovation and strategies to improve the Title V National Performance Measures and/or support the implementation of the standards for systems of care for CYSHCN through measurable outcomes.

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

In Delaware, the executive branch of state government is headed by Governor Matt Meyer who took office as Delaware's 76th Governor in January 2025. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency and is led by Secretary Josette D. Manning, Esq. The Delaware Department of Health and Social Services is the largest state agency employing more than 4,000 individuals in a wide range of public service jobs and in one way or another affects almost every citizen in our great state. The

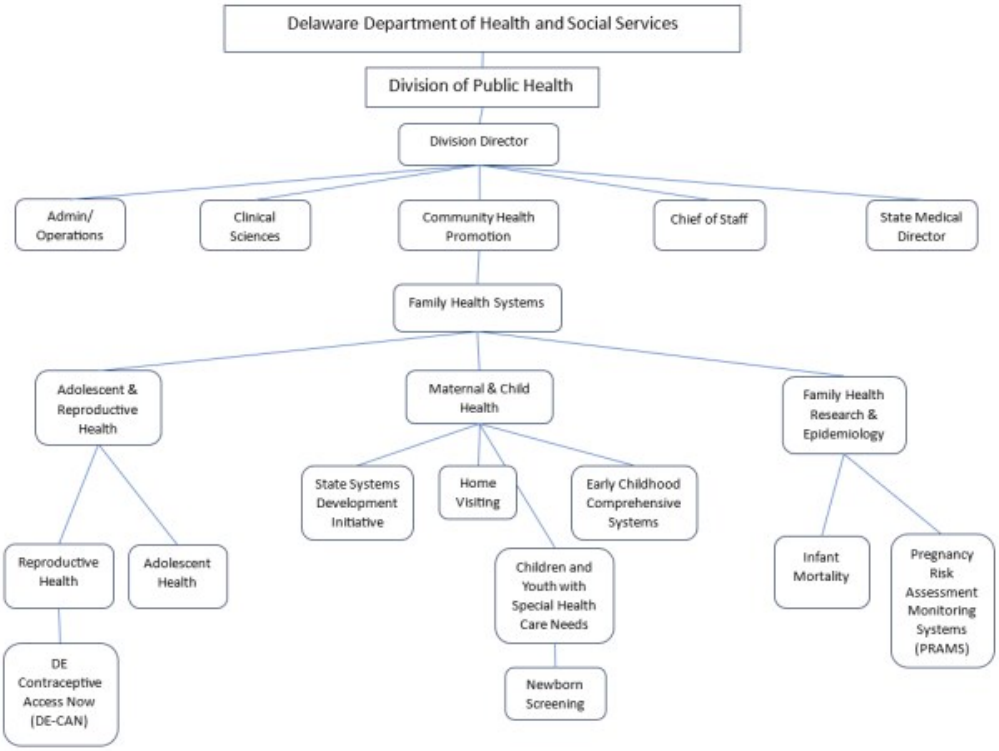
Department consists of 11 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

The divisions are united by an overarching mission, which is simple yet profound: to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.

The Division of Public Health (DPH) is one of the largest divisions within DHSS, serves as the Title V agency in Delaware. Under the direction of Steve Blessing, the mission of DPH is to protect and promote the health of all people in Delaware. DPH's vision is healthy people in healthy communities.

Because Delaware does not have county or local health departments, DPH administers both state and local public health programs. DPH is structured into five main strands: Administration/Operations, Clinical Sciences, Community Health Promotion, Chief of Staff, and State Medical Director. Each strand is comprised of a multitude of sections. Community Health Promotion is led by Tracey Johnson, and the Family Health Systems (FHS) section falls within Community Health Promotion. The Section Chief of FHS is Leah Jones, MPA. The Title V Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs are part of FHS, within the Community Health strand.

The Family Health Systems Section is the home of many of the programs funded by Delaware's Title V federal-state partnership. As such, the section chief for FHS, Leah Jones, MPA, also serves as the state Title V MCH Director. The section is comprised of three units. The Bureau of Maternal & Child Health is led by the MCH Deputy Director, Crystal Sherman, BS. The MCH Bureau is responsible for direct administration of the Title V Block Grant, and includes the following programs: Children and Youth with Special Health Care Needs; Newborn Screening (metabolic and hearing) ; Birth Defects Registry; Early Childhood Comprehensive Systems Impact; State Systems Development Initiative; and Home Visiting (MIECHV and state funded). The Bureau of Adolescent and Reproductive Health, led by Michelle Mathew, B.S., includes the Adolescent Health Program (School-Based Health Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Center for Family Health Research and Epidemiology, led by Dr. Naa Dede Hesse, PhD, MPH, includes the Infant Mortality Elimination Program, the Healthy Women, Healthy Babies Program, and the Pregnancy Risk Assessment Monitoring System.



MCH advertises Delaware's Title V Block Grant with our partners, stakeholders, families and community members. We encourage everyone to learn more about the Title V Block Grant in Delaware, which is committed to Maternal and Child Health. Together, we can work toward enhancing the health and well-being of mothers, children, and families, including children with special health care needs.

Delaware convened our Title V Needs Assessment team early 2023 to begin the two-year Needs Assessment process where we assessed the health needs of our population, Title V's program capacity, as well as Delaware's partnerships and ability to collaborate and coordinate efforts. Our team has met in person throughout each year to review the most recent state and national data that was specific to Delaware's MCH populations. Our team used the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); and Delaware Health Statistics (birth records, death records, hospital discharge data).

Delaware's Title V team continued to meet to prepare for the upcoming 2025-2030 Five-Year Needs Assessment. We identified the core members of our Internal Steering Committee, defined the roles and responsibilities of the team, and set expectations for each member. We are using the services of our epidemiology, research, and evaluation (ERE), Forward Consultants, for most of our Needs Assessment data needs. We approached our activities with an aggressive timeline, to ensure enough time was allotted for compiling the feedback and writing the Title V 2025 State Action Plan, along with the Title V 2026 Application Year/2024 Annual Report Block Grant.

Our SSDI Director along with our MCH Deputy Director have met to develop the plan for our public input process. MCH aims to have several methods used to gather public input, including regular email updates to stakeholders, surveys, community forums/listening sessions, key informant interviews and focus groups. Qualitative data such as focus groups and key informant interviews can be considered the stories behind the data. The timing and sequence

of gathering public input will be iterative with each activity laying the groundwork for subsequent activities. Division staff plan to attend coalitions, programs, and special initiative meetings across the state to discuss the Needs Assessment process and solicit input.

MCH has conducted Focus Groups regarding several MCH issues related health care and their community. Our goal is to have maternal health groups focused on questions related to women's health, groups focused on mothers and children and youth with special health care needs, father/partner groups, and preconception groups with African American women without children. In addition, Delaware added a new domain to our focus groups, adolescents, for this needs assessment cycle. MCH is conducting a Professional Stakeholder Survey that was distributed to our stakeholders of MCH service agencies, organizations, coalitions, and programs for input on MCH population needs, system gaps and leverage points.

MCH has determined that Key Informant Interviews will also be conducted to learn more about system strengths and needs and to better understand the landscape of services and supports. MCH has identified stakeholders to participate in key informant interviews with partners representing every population domain. MCH has also added an additional interview with a mental health worker in a high-risk School Based Health Center. The results and findings from all gathered data will inform our decision-making efforts to select our NPMs, SPMs, and ESMs.

MCH has reached out to our partners during our Needs Assessment process to request their assistance with our public input, stakeholder input and awareness. We then reached out again thanking our partners for their continued support through the process. Our partnership with the community is very valuable to MCH. We explained our work is done to identify the strengths and weaknesses of our public health system and to improve maternal, child, family, and community health outcomes. We informed our community partners with information, such as:

- Data Sheets were developed for each National Performance Measure.
- Focus Groups of individuals and families with lived experience have been conducted statewide.
- Our Stakeholder Survey was distributed to partners across Delaware to provide their feedback about MCH health.
- Key Informant Interviews were conducted and different perspectives related to MCH were discussed.
- We are amid a Workforce Capacity survey to identify Title V capacity, structure, and capability.
- Check DEThrives for the Data Sheets, updated Needs Assessment information, survey analysis, and more!

As the Title V agency, DPH operates a comprehensive array of programs and services to promote and protect the health of Delaware's mothers and children, including children and youth with special health care needs. Within DPH, the Family Health Systems section houses many of these programs, as described within the application. However, the capacity to support the MCH population extends throughout all sections of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers and supports for healthy

lifestyles (physical activity, nutrition, tobacco cessation), to name a few. An overview of DPH's partnerships, collaborations and coordination surrounding our programs and services for the MCH population is summarized throughout this block grant application.

The Delaware Title V MCH program can meet the needs of women, mothers, infants, children, CYSHCN and adolescents through partnerships, collaboration, and coordination with other entities. Delaware benefits from the commitment and engagement of its stakeholder community. Delaware has many advisory boards, councils, and coalitions that our MCH program works with to extend the reach of Title V, guide our work and expand on the overall capacity to support mothers, children and families. One of the largest groups of partners coming together around MCH issues in Delaware is the DHMIC.

MCH's finest collaboration is the Delaware Healthy Mother & Infant Consortium (DHMIC). The DHMIC pursues the health of women, infants and families through a life course approach. The DHMIC approach includes planning with the community, thinking holistically about women's health and addressing inter-generational health. The DHMIC supports a continuum of services promoting optimal health from birth throughout the lifespan, from one generation to the next. Formed as a statewide vehicle to address infant mortality, the consortium includes approximately 20 Executive Committee members, including two representatives from the House of Representatives, two representatives of the Delaware State Senate (one selected by each caucus), a representative from the Governor's office, a representative from the Department of Services for Children, Youth and their Families (DSCYF), the Secretary of the Department of Health and Social Services, and 15 additional members approved by the Governor who represents the medical, social service and professional communities as well as the general public. These additional representatives come from the State Senate, DPH, hospital systems, universities, faith-based communities, and more. The DHMIC invites over 150 partners and stakeholders to the quarterly meetings.

The DHMIC focuses on creating optimal health for women, infants, and families through a life course approach. Life course is a way of thinking and doing. It looks back across an individual's or community's life experiences and across generations for clues to current patterns of health. Our approach includes thinking holistically about women's health and planning with the community. We support a continuum of services promoting health from birth throughout the lifespan, from one generation to the next.

The DHMIC represents one of the largest groups of partners coming together around MCH issues, but there are many other advisory boards, councils, and coalitions that our MCH program works with to extend the reach of Title V, guide our work, and expand the overall capacity to support mothers, children, and families. Some other current initiatives that MCH is involved with to serve and improve the MCH population health are: Family SHADE, MIECHV, HWHB Program, Maternal and Child Death Review Commission, and Delaware's Perinatal Quality Collaborative. As outlined in our organizational structure, our Title V program is intimately connected with federal investments, such as the State Systems Development Initiative (SSDI), Maternal and Infant Early Childhood Home Visiting (MIECHV), Early Childhood Comprehensive Systems (ECCS), and Personal Responsibility Education Program (PREP) Partners by virtue of the location of these grant programs within the same section - Family Health Systems. In addition, we previously partnered with Project LAUNCH and the Division of Substance Abuse and Mental Health in combating the opioid epidemic.

III.C.1.b.ii.b. Impact of Agency Capacity

As the Title V agency, DPH operates a comprehensive array of programs and services to promote and protect the health of Delaware's mothers, children, and adolescents, including children and youth with special health care needs. Within, DPH, the Family Health Systems Section houses many of these programs. However, the capacity to support the MCH population extends throughout all sections of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers and supports for healthy lifestyles (physical activity, nutrition, tobacco cessation), to name a few. An overview of DPH's programs and services for the MCH population is summarized all throughout this block grant application and below by the Title V MCH population domains.

Women/Maternal Health

Programs, services and information are available to women in broad categories - general health, sexual and reproductive health, and maternal health.

In the category of general health, DPH's Office of Women's Health (OWA) offers education to the public regarding a variety of women's health issues via outreach. The OWH addresses women's health issues across their lifespan through forums, programs, and initiatives designed to educate the public regarding women's health and healthy lifestyles. The OWH serves as a resource for information regarding women's health data, strategies, services, and programs to include concerns relating to adolescent, reproductive, menopausal, and postmenopausal phases of a woman's life. In the area of sexual and reproductive health, the Title X program offers family planning counseling and education, testing and treatment for sexually transmitted diseases, birth control supplies, pap smears, breast exams, HIV testing and counselling, and more. Finally, to support maternal health, DPH operates the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program which provides evidence-based home visiting for pregnant women, statewide. The WIC program is also available to low-income pregnant women and provides nutritious foods to supplement diets, information on healthy eating, and referrals to other services.

In Delaware, many programs, campaigns and services in the area of maternal health stem from the work of the Delaware Healthy Mother and Infant Consortium (DHMIC). The mission of the DHMIC is to provide statewide leadership and coordination of efforts to prevent infant mortality and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The Family Health Systems Section of DPH is responsible for the DHMIC and administration of related programs and initiatives. One such program is the Healthy Women, Healthy Babies program, which is about total care before, during, and after pregnancy. From well-woman visits to community programs, the services provide care for the whole woman. These services include weight and stress management, depression treatment, prenatal care, birth control/contraception, and more. The DHMIC also develops educational materials and tools to promote reproductive life planning, breastfeeding and the dangers of urgent maternal warning signs.

Perinatal/Infant Health

Much of our capacity to promote maternal health extends to the support of perinatal and infant health. For example, Delaware's Perinatal Quality Cooperative (DPQC) falls under the DHMIC umbrella and works to enhance communication and collaboration across birth hospitals to improve delivery of care. Related to infant health and the prevention of infant mortality, the DHMIC develops educational messages to promote important practices like breastfeeding and safe sleep environments. Similarly, WIC and the MIECHV reinforce these messages. With state funding, we have been able to contract with outside agencies to expand evidence-based home visiting, giving Delaware a continuum with the ability to serve families prenatally through a child's fifth birthday.

Birth Defect Surveillance and Registry Program was established and is a surveillance system to gather information on the prevalence and type of birth defects in the children of Delaware with the goal of identifying previously unrecognized health and environmental hazards, preventing certain birth defects, ensuring that appropriate services are available to children with birth defects, and ultimately decreasing the infant mortality rate. DPH partners with Christiana Care Services, Inc. works collectively to have a constant eye to process improvement and refinement with data integrity and quality always being the driver of change.

DPH's Newborn Screening program offers both metabolic and hearing screening for every infant born in Delaware. The program also provides follow-up case management of positive screens to ensure identified infants, and their families are linked to appropriate treatment services. Delaware screens for all the disorders recommended by the Uniform Screening Panel.

DPH also offers lead testing, physicals, and immunizations through child health clinics at state service centers across the state.

Child Health

To support healthy growth and development in both infants and children, Delaware continues to implement the Help Me Grow (HMG) model to improve early identification of developmental issues and timely connection to services. The HMG system is a framework that brings together child-serving partners to improve early childhood services. Help Me Grow 2-1-1 is a one-stop-shop that offers programs, services, and helpful information for parents-to-be and families. HMG 2-1-1 assists families looking for housing, diapers, help in the winter, and concerns about a child's early development. Help me Grown 2-1-1 can help with these issues, and much more.

Help Me Grow Delaware is part of a larger coalition of over 30 states that are related to the Help Me Grow National Center to promote early childhood systems to improve and provide innovative services for families with young children nationwide. Delaware's program begins prenatally (before birth) and continues through age eight (8).

HMG focuses on supporting young children's healthy development by connecting families with community resources. It is not a stand-alone program but rather a system model that utilizes and builds on existing resources to develop and enhance a comprehensive approach to early childhood systems-building in any given community. Through comprehensive physician and community outreach and centralized information and referral centers, families are linked with needed programs and services.

Help Me Grow is a partnership of many organizations throughout the state and has four key areas of activity: Centralized Access Point (CAP), Health Provider Outreach, Family and Community Engagement, and Data Collection and Analysis. Help Me Grow call specialists provide families with connections to existing resources statewide as well as providing a developmental screening utilized the validate tool, ASQ.

A component of our effort to increase developmental screening is providing physicians with online access to the Parents' Evaluation of Developmental Status (PEDS) validated screening tool. Delaware's Early Childhood Comprehensive Systems program (ECCS) shares the vision of the State's early childhood community to support a coordinated, comprehensive and sustainable early childhood framework. For that reason, the ECCS program collaborates with its place-based community partners and stakeholders to improve outcomes in population-based children's developmental health and family well-being. This approach entails closer relationship and integration of early childhood and education settings and health sector.

Delaware has four evidence-based Home Visiting Programs. These programs are the Nurse-Family Partnership, Healthy Families Delaware, Parents and Caregivers as Teachers, and Early Head Start. Westside Family Healthcare and Christiana Care Health Systems have a Home Visiting Community Health Program that can offer support for Delaware families. The Home Visiting Community Health Workers have the ability to connect families with resources and have various educational sessions and events that the family may find helpful. In addition, a Community Health Worker (CHW) through Quality Insights Delaware helps women to get and stay healthy by linking them to key resources to meet specific needs related to the Social Determinants of Health. CHWs complement a woman's healthcare team by addressing food insecurity, transportation, housing needs, and much more.

In 2024, there were over 13,000 home visits provided in Delaware, statewide. This includes 3,000 virtual visits. A Family Support Specialist can help families determine
eligibility and assist them in registering with state agencies to obtain services, such as Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) benefits. A Family Support Specialist supports breastfeeding newborns and can connect families with a lactation consultant. Recognizing developmental milestones can help parents and caregivers ensure that their child is on track. A Family Support Specialist can educate parents and caregivers about those milestones and help detect any delays or disabilities.

Adolescent Health

School Based Health Centers (SBHCs) are core to our capacity to support adolescent health. For the past 30 years, Delaware School Based Health Centers, located in 38 public high schools and middle schools and 24 in elementary schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to

support women's overall physical and mental health. SBHCs provide at-risk assessments, diagnosis and treatment of minor illness/injury, mental health counseling, nutrition/health counseling, diagnosis and treatment of STDs, HIV testing and counseling and reproductive health services with school district approval as well as health education. In addition, Delaware's SBHCs provide important access to mental health services and help eliminate barriers to accessing mental health care among adolescents.

Delaware's Personal Responsibility Education Program (PREP) focuses on building capacity of teachers and volunteers to implement evidence-based pregnancy prevention and risk-reduction programs delivered at middle and high schools in addition to community sites throughout the state. Many SBHCs have expanded their use of telehealth and strengthened referral systems, improving access and responsiveness to student needs. The Department of Public Health (DPH) collaborates closely with other state agencies to provide additional resources and support to SBHC providers, ensuring that students receive the mental and behavioral health services they require.

Delaware is actively promoting and encouraging SBHCs and school districts to educate and raise awareness about developing healthier behaviors and reducing risk-taking behaviors. Once SBHCs are fully staffed, our goal is to reestablish partnerships with the Department of Education and school districts to launch a health messaging campaign addressing mental health treatment.

Children and Youth with Special Health Care Needs Health

The state of Delaware's capacity to serve Children and Youth with Special Health Care Needs (CYSHCN) and their families has grown in a small scale during the last 5 years (2020 to 2025). The capacity to grow was a result of the Family SHADE mini-grantee project that impacted all 3 counties (New Castle, Kent and Sussex County) in the state of Delaware serving CYSHCN. This capacity grew as a result of the partnerships that were developed with the following agencies: Jay's House, Tomaro's CHANGE, Teach Zen, Down Syndrome Association of Delaware, and Children's Beach House. The partnerships that were developed over the last 5 years have assisted in addressing National Performance Measure (NPM) Adequate Insurance, and Medical Home. As we transition into the next 5 years (2025 to 2030) we will utilize the response we received in our statewide needs assessment from families of CYSHCN and the subject matter experts that provide services to CYSHCN. We will address Transition to Adult Health Care NPM, adolescents with special health care needs, age 12-17 and NPM Medical Home.
Delaware's Maternal Child Health Care system of service will be intentional in the implementation of a crosswalk through our MCH Title V Block Grant 6 domains and develop an alignment with the 7 measures for CYSHCN which are:

1. Well-Functioning System of Care
2. Family-Centered Care
3. Medical Home (0-17)
4. Early and Continuous Screening
5. Adequate & Continuous Insurance
6. Access to Community-based Services
7. Health Care Transition to adult health care, adolescents with special health care needs, age 12-17

Our foundation of our work will include the 6 Core CYSHCN indicators which are:

1. Children and Youth are screened early and continuously
2. A medical home model of care that is patient-centered coordinated, comprehensive, and ongoing
3. Community-based services are organized so families can use them easily
4. CYSHCN receive services necessary to make transitions to adult life, including healthcare
5. Families have adequate insurance and funding to pay for services they need
6. Families of CYSHCN Are partners in decision making at all levels of care from direct care to the organizations that serve them

Delaware will continue to use this framework and these guiding principles in the delivery of service for children and youth with special health care needs and their families. Throughout the crosswalk of service delivery, we will keep these core indicators in the forefront when executing services delivered through the Maternal Child Health Title V Block Grant.

1. Optimum Health for all
2. Quality of life and well-being
3. Access to services
4. Financing of service

Aligning the CYSHCN 6 core indicators with these 4 core indicators will serve as a framework in meeting the needs of CYSHCN and their families served by the MCH Title V Block Grant.

The CYSHCN program is currently going through a Request for Proposal (RFP) for the Family SHADE Project due to the current vendor's contract ending on November 30, 2025. We are projecting to execute the project with a selected vendor in December of 2025.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

In Delaware, the majority of Title V block grant funding is used to support approximately 13.50 positions (FTEs) across the division that are involved with MCH programs and services, including Birth to Three, adolescent and child health, health education, and primary care. In this way, Title V funding has historically been leveraged to bolster the capacity of many DPH programs that serve mothers, children, adolescents, children and youth with special health care needs, and families. Most of these positions do not report directly to the Title V program, but rather to the Administrator of the specific program or clinic that they work within. As we consider our recent Five-Year Needs Assessment findings and develop our 5-year State Action Plan, we will also work with the Program Managers of these positions to assess job responsibilities and ensure alignment with our new Title V priorities.

The MCH leadership team has a significant amount of professional experience, and all staff have been in their roles for at least five years.

- *Family Health Systems Section Chief*: Leah Woodall, MPA, was appointed as the Section Chief of the Family Health Systems Section in 2013 and serves as the state's Title V Director. Leah has worked for DPH since April 2010, first serving as the Title V/MCH Bureau Chief and Deputy Director.
- *Maternal and Child Health Bureau Chief/Title V MCH Deputy Director*: Crystal Sherman, BS, has served in the role of MCH Bureau Chief and Deputy Director since October 2015. Before this promotion, Crystal was also in the MCH unit and served as the Home Visiting Program Administrator.
- *Director of Children & Youth with Special Health Care Needs*: Isabel Rivera-Green, MSW, has been serving as the Director of Children & Youth with Special Health Care Needs since September 2018. Before this role, Isabel served as the Early Hearing Detection Intervention (EHDI) Coordinator from October 2015 until she was hired as the CYSHCN Director.
- *Title V Block Grant Coordinator/Needs Assessment Coordinator, Project Director of State Systems Development Initiative (SSDI):* Elizabeth Orndorff has been serving since August 2018 as the Title V Coordinator and the SSDI Director. She is also responsible for coordinating the 2025 Title V Five-Year Needs Assessment.
- *Maternal and Child Health Epidemiologist, Centers for Disease Control and Prevention Assignee*: Katie Labgold, PhD, MPH, began with MCH in October 2024 and unfortunately was only with us through April 2025. In addition to her routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, Dr. Labgold provided scientific and technical assistance to Division staff and stakeholders in the areas of maternal and child health outcomes.

Having a well-prepared work force is critical to meet the maternal and child health needs of the people of Delaware. The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. However, professional development is an ongoing process to ensure staff have the tools needed to perform all job functions with the highest level of execution. We have utilized a variety of training platforms for professional development including the MCH Navigator, Franklin Covey and our internal DPH training office.

Upon hire, all MCH staff are encouraged to utilize the MCH Self-Assessment tool as a guide to identify their

strengths and learning needs as well as match their learning needs to appropriate trainings. Supervisors are tasked with reviewing and coaching staff on the development of their goals and ensuring time is allotted for professional development. Leadership has met to discuss strengths of staff to ensure we continue to recruit team members that have the skills that are needed as well as complement the section.

Having a committed, empowered workforce, with a wide-range of expertise, is necessary to create a resilience oriented, trauma-informed system of care. As part of our Five-Year Needs Assessment, MCH conducted a Workforce Capacity Analysis where the objective was to identify Delaware's Title V program capacity. The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work; however, the dedicated team recognizes the need for continuous professional development. They recognize a need to learn how: to balance the needs of stakeholders, to find evidence, to learn quality improvement methods, and to understand community health factors. DPH offers internal training opportunities to support staff. In addition, DPH offers training opportunities through a collaborative agreement with the University of Pittsburgh Mid-Atlantic Regional Public Health Training Center. In addition, all DPH employees are signed up for a State Health Operations (SHOC) role. SHOC is a critical component in DPH response operations during any event or incident that may affect the public health of Delaware's residents and guests. Each employee's participation ensures Delaware's preparedness for emergencies.

In September 2022, many staff members from administrative to leadership roles, participated in a two-day training workshop by Franklin Covey. These workshops were focused on developing and implementing strategic plans and were geared towards programmatic and planning team members. This was a great opportunity for our team to create a shared vision, set clear goals and achieve desired results. These trainings were selected as we were kicking off strategic planning for the Family Health Systems sections and the Bureaus within the Section and we wanted all team members to be active participants in both processes.

- *Create a Shared Vision and Strategy*. Part of the Franklin Covey Leadership Series. Participants engaged in a transformational leadership journey that gave us the powerful framework, skills, and tools to be a more visionary and strategic leader. In this module, we learned the importance of thinking BIG for our team, drafted a team vision statement, and created a relevant team strategy, and crafted and practiced our strategic narrative.
- *Execute Your Team's Strategy and Goals*. Part of the Franklin Covey Leadership Series. Participants engaged in a transformational leadership journey that gave us the powerful framework, skills, and tools to be a disciplined and focused leader. In this module, we explored the key leadership principle of alignment, assessed six core systems, created a plan to align them to our team's strategy, and learned how to implement the powerful 4 Disciplines of the Execution® goal-achieving system.
- *Clifton Strengths/Strength Finder*. We each participated in a series of insightful questions to uncover the one true you. We learned that it takes commitment to become the best you. The assessment measured our unique talents, our natural pattern of thinking, feeling and behaving - and categorized them into the 34 Clifton Strengths themes. Taking the Clifton Strengths assessment unlocked the personalized report and resources we needed to maximize each of our potentials.

Our workforce gained hands on experience, applying timeless principles that yielded greater productivity, improved communication, strengthened relationships, increased influence, and laser-like focus on critical priorities. The trainings were very interactive and involved role playing so participants could put what they were learning into practice.

All MCH have access to an All-Access Pass to the entire Franklin Covey Library which provides a refresher of all the trainings along with several other topics important to leadership. The All-Access Pass was designed to help organizations achieve strategic initiatives, develop leaders, and build skills and capabilities across the organization in a completely nimble and flexible way that helps them overcome those challenges - all at the very best value. With access to Franklin Covey courses, assessments, videos, tools, and digital assets, we can utilize the content in a wide variety of ways and across multiple delivery modalities to best meet the needs of our organization. The All-Access Pass includes courses such as: The 4 Essential Roles of Leadership; Managing Millennials; Presentation

Advantage; Find Out WHY: The Key to Successful Innovation, and more. All courses are offered in formats that are convenient to participants and on a schedule that is most convenient to them.

Later this year at our annual retreat, we will be offering training around leading teams, *6 Critical Practices of Leading Teams*. This full-day training is designed to equip leaders with essential tools to lead effectively and support high-performing teams. This training is a special collection of relevant, practical resources that provide leaders with the mindsets, skillsets and toolsets needed to excel in their critical roles of leading others effectively.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.

Additionally, internal DPH workforce development opportunities include our Office of Performance Management, which has created a comprehensive workforce development plan outlining DPH training goals and objectives, as well as resources, roles and responsibilities related to the plan's implementation.

As part of the Governor's Trauma-Informed Care initiative, DHSS required every employee complete the online course titled: DHSS Trauma Informed Awareness Training. This training is also part of the new employee/supervisor curricula for future new hires. DHSS Trauma Informed Awareness Training examines the pervasive effects trauma has on individuals, families and organizations. Many DPH programs are considered trauma informed, some sections have no idea about the impacts of trauma on our clients, patients and co-workers, therefore, the Governor's initiative is that we all become trauma aware.

DPH staff are also afforded the opportunity to advance their skills through the DE TRAIN Learning Network. DE TRAIN is an affiliate of the TRAIN national learning network that provides quality-training opportunities for professionals who protect and improve Delaware's public health. This is a free service funded by Delaware Public Health's Emergency Medical Services and Preparedness Section (EMSPS) in partnership with the Public Health Foundation Training.

Delaware's MCH program does not include parents or family members who fill staff positions in our department, and we no longer have a dedicated staff member to focus on evaluation, data-analysis, or epidemiology. To fill this gap, we have a contractual relationship Forward Consultants to provide this level of support. With the help of our ERE, MCH just recently finished our Title V Block Grant Five-Year Needs Assessment process. This was a two-year endeavor, where one phase of the process, we conducted a Workforce Capacity Analysis.

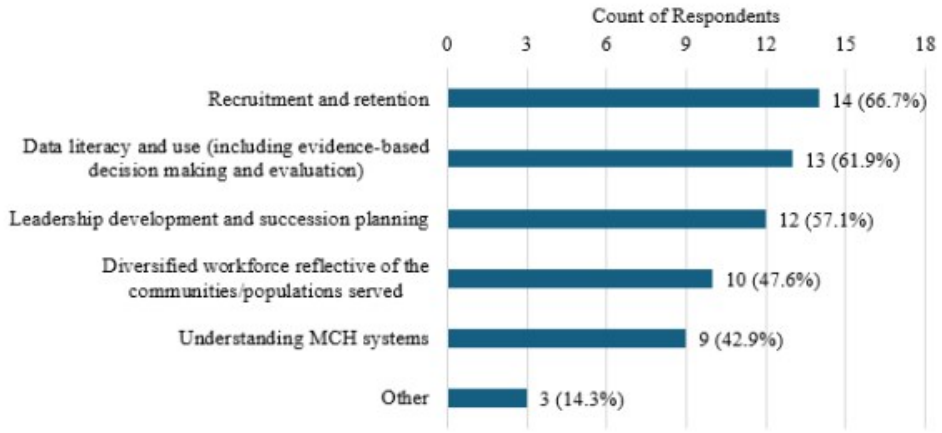
Table 1 lists the count and percentage of respondents who stated that they need either formal or On The Job (OTJ) training to each program area listed. As evidenced by this table, the most common program areas selected for training needs involved health disparities, use of culturally and linguistically appropriate MCH education and outreach efforts, and use a systems approach to explain the interactions among individuals, groups, organizations, and communities.

Table 1. Program Areas by Reported Training Needs (Formal and OTJ Training).

	n (%)
Health disparities.	16 (76.2%)
Use of culturally and linguistically appropriate MCH education and outreach efforts.	16 (76.2%)
Use a systems approach to explain the interactions among individuals, groups, organizations, and communities.	15 (71.4%)
Use data to identify issues related to the health status of a particular MCH population group, design programs, and/or formulate policy.	14 (66.7%)
Modify programs or activities based on evaluation data or stakeholder feedback.	14 (66.7%)
Formulate strategies to balance the interests of diverse stakeholders, consistent with desired policy change.	14 (66.7%)
Understand the roles and relationships of groups involved in public policy development and the implementation process.	13 (61.9%)
Collaborations including family professional partnerships.	13 (61.9%)
Strategies to conduct quality improvement in primary care, women's health, and specialty services.	12 (57.1%)
Recognize and create learning opportunities for others (e.g., mentorship).	12 (57.1%)
Communicate clearly through effective presentations and written scholarships about MCH populations, issues, and/or services.	12 (57.1%)
Knowledge of evidence-based programs and best practices.	12 (57.1%)
Collaborate with researchers to develop high-quality evaluations of programs and policies.	11 (52.4%)
Knowledge of where to find research evidence on the success of programs and services.	11 (52.4%)
Services and supports necessary to transition to adulthood for all children and youth and their families.	11 (52.4%)
Community inclusion for Children and Youth with Special Health Care Needs.	11 (52.4%)
MCH safety programming.	11 (52.4%)
Medical Home model.	10 (47.6%)
Identify researchers with appropriate skill sets for research and evaluation assistance.	9 (42.9%)
Manage a project effectively and efficiently, including planning, implementing, delegating, and sharing responsibility, staffing, and evaluation.	9 (42.9%)
Family-centered, coordinated care.	9 (42.9%)
Services and supports necessary to transition to adulthood for Children and Youth with Special Health Care Needs.	9 (42.9%)
Formulate a focused and important practice, research, or policy question.	7 (33.3%)

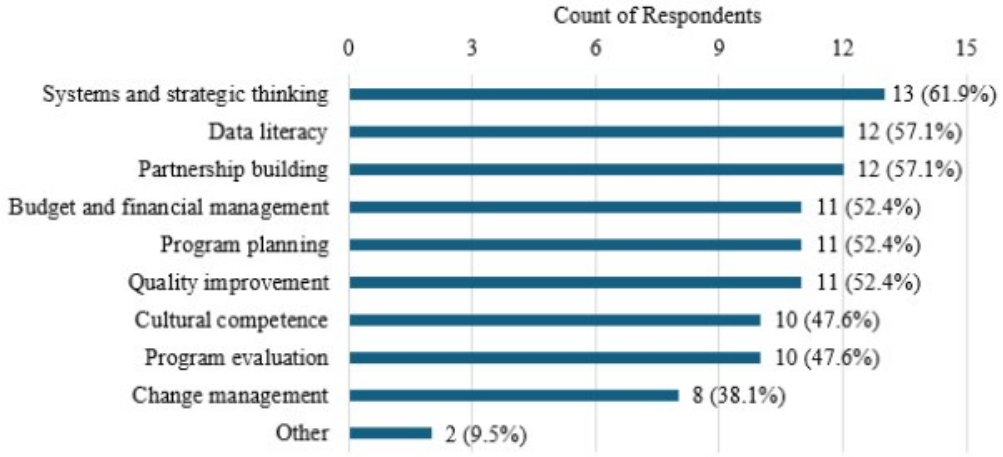
As indicated in Figure 1, the top needs reported by respondents for the current and future MCH public health workforce are recruitment and retention (66.7%) followed by data literacy (61.9%) and leadership development and succession planning (57.1%).

Figure 1. "What Do You See as the Top Needs Among the Current and Future MCH Public Health Workforce?"



As shown in Figure 2, the most chosen critical workforce skill to address public health challenges now and in the future is systems and strategic thinking (61.9%). Most of the respondents selected each workforce skill listed with the exception of cultural competency and program evaluation (both at 47.6%) and change management (38.1%).

Figure 2. "What Do You See as the Most Critical Workforce Skills to Address Public Health Challenges Now and in the Future?"



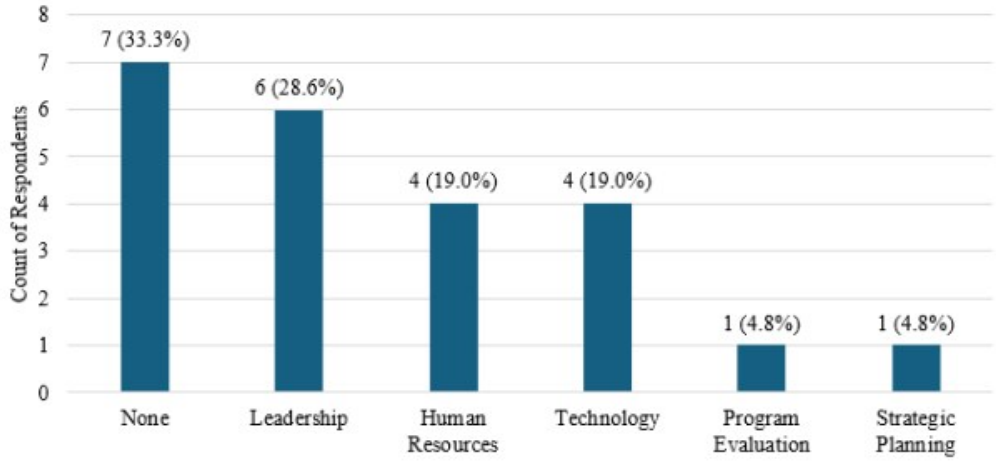
Most respondents stated social determinants of health (61.9%) as a workforce area that is the most important for Delaware's Title V MCH Program to address in the coming years. Note that the other workforce areas were generally selected at similar counts (Table 2).

Table 2. "Which of the Following Areas of Workforce Development Are the Most Important for Delaware's Title V MCH Program to Address in the Coming Years?"

	n (%)
Social Determinants of Health	13 (61.9%)
Community engagement	10 (47.6%)
Health equity	10 (47.6%)
Health disparities	9 (42.9%)
Partnership building	9 (42.9%)
Communication	8 (38.1%)
Data literacy	8 (38.1%)
Systems thinking	8 (38.1%)
Working with communities and systems	8 (38.1%)
Critical thinking	7 (33.3%)
Developing others through teaching, mentoring	7 (33.3%)
Cultural competency	6 (28.6%)
Trauma informed care	6 (28.6%)
Policy	4 (19.0%)
Public Health/Title V knowledge base	4 (19.0%)
Self-reflection	4 (19.0%)
Ethics and professionalism	3 (14.3%)
Family centered care	3 (14.3%)
Interdisciplinary team building	3 (14.3%)

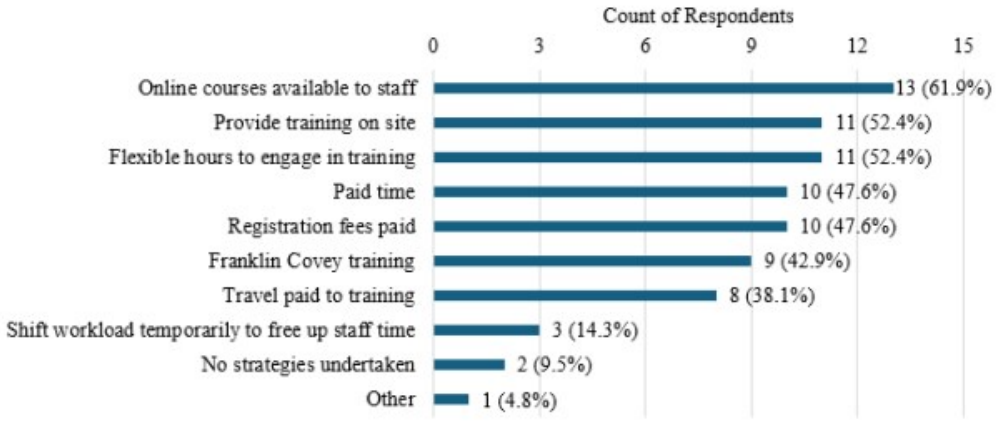
In the Workforce Capacity Survey, when asked on what content areas the respondents personally think would be beneficial to them for a training session, one-third of respondents did not have a specific area and a little of a quarter (28.6 percent) stated leadership (Figure 3).

Figure 3. "On What Content Areas (e.g., Leadership, Technology) Do You Personally Think Would be Beneficial to You for A Training Session(s)?"



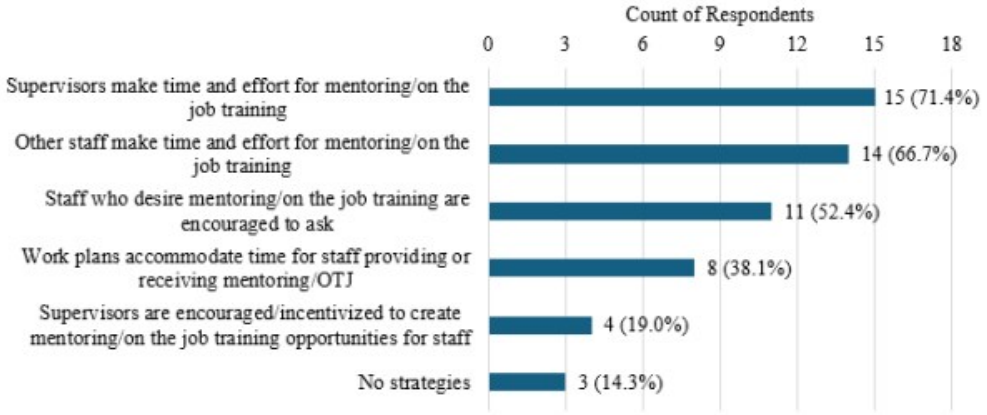
As shown in Figure 4, most respondents said that online courses (61.9%), onsite training (52.4%), and flexible hours to engage in training (52.4%) serve as strategies their organizations uses to provide formal training/continuing education opportunities for state level program staff. Trainings involving travel or paid time/courses tended to not be reported as frequently.

Figure 4. "Which of the Following Strategies Does Your Organization Use to Provide Formal Training/Continuing Education Opportunities for State Level Program Staff?"



For informal trainings, respondents tended to report that supervisors and other staff make time and effort for mentoring/on the job training (71.4% and 66.7%, respectively). However, few respondents said that supervisors are encouraged/incentivized to create mentoring/on the job training opportunities for staff (Figure 5).

Figure 5. "Which of the Following Strategies Does Your Organization Use to Provide Informal Trainings for State Level Program Staff?"



When respondents were asked to provide examples of how they feel training could be improved, many of them would like to see a more formal training and onboarding process.

Multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future. As such, our MCH Title V Workgroup selected a State Performance Measure focused on Workforce Development. We aim to strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities. Further Workforce Development activities and plans are discussed in detail within the III.E.3. Cross Cutting/Systems Building Application Year Narrative section.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The State Systems Development Initiative's (SSDI) primary focus is to enhance the data capacities of the Maternal and Child Health (MCH) Program. The SSDI grant is also a key component of our Title V program and compliments

the MCH Block Grant by funding data infrastructure. The primary activities are preparing data for and performing data linkages on databases, reporting data for the MCH Block Grant and other MCH projects, increasing the number and quality of databases available for linkage and analysis, and producing the Five-Year MCH Needs Assessment. SSDI was launched to complement the Title V MCH Block Grant Program and to combine the efforts of State MCH and Children and Youth with Special Health Care Needs Agencies. In addition, SSDI is intended to assist state agency MCH programs with flexibility to address MCH data capacity needs during an emergency and as emerging issues or threats arise. SSDI also aids in the building of state and community infrastructure that results in comprehensive, community-based systems of care for all children and their families.

The Delaware SSDI grant is crucial to our Title V program and compliments the MCH Block Grant by allocating funds for the purpose of developing, enhancing, and expanding state and jurisdictional Title V MCH data capacity. Our intent is to improve the availability, timeliness, and quality of MCH data in Delaware. The program's initiatives ensure the MCH programs have access to relevant information and data. Utilization of these data is central to state and jurisdictional reporting on our Title V program assessment, planning, implementation, and evaluation efforts, along with related investment, in the yearly MCH Block Grant Application/Annual Report. Our SSDI grant enhances our ability to respond to our performance measure reporting requirements in the Block Grant. This heightened data capacity is intended to enable us to engage in informed decision making and resource allocation that supports effective, efficient, and quality programming.

The Delaware Division of Public Health (DPH) recognizes that a structured surveillance system to enable analysis of risk factors, behaviors, practices, and experiences before, during and after pregnancy would provide valuable statistics to support existing MCH programs and a basis for applications for new MCH funding allocations for new intervention programs. DPH promotes interoperability within our data systems and encourages enhancing current systems versus building new ones.

The SSDI program has historically been instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee. Additional contractual dollars are allocated to working with Forward Consultants to support projects that provide evaluation services such as the Title V Needs Assessment Survey, Key Informant Interviews, Workforce Capacity, our Boot Camp, and all related analysis. In addition, the SSDI program partially funds our Birth Defects Active Surveillance Registry. Our Birth Defects Registry (BDR) identifies and records reportable birth defects diagnoses. The BDR is responsible for conducting case findings and ascertainment, medical record abstraction, and provides DPH with pertinent information and case review with the Birth Defect Medical Genetics Director. A detailed Birth Defects summary is provided as an attachment to this Application.
Upon the departure of Dr. Khaleel Hussaini in 09/23, our MCH Director began the search for another CDC Epidemiologist Assignee. Our Director spoke during the 2023 Title V Federal State Partnership Meeting and expressed how important the CDC and HRSA MCHB relationship is to ensure that our state MCH epi capacity needs are addressed, and that Delaware's epi assignee had recently left. HRSA MCHB immediately connected us with the CDC MCH Epidemiology Program. Together, we were supported through an assignment of a senior CDC maternal and child health epidemiologist.

Delaware was seeking direct assistance from the CDC for MCH epidemiologic support:

- Support data driven decision making
- Build epidemiologic capacity at the state and local level
- Support applied research to ensure that MCH initiatives in DE are based on tested applications of the most recent trends and emerging science
- Disseminate information and strengthen the evidence base in MCH

Some proposed research projects the CDC MCVH Epi Assignee would be responsible for, included:

- Healthy Women healthy Babies 3.0
- Title V MCH Five-Year Needs Assessment and Annual Application
- Infant Mortality Report and Data Briefs
- Women of Childbearing Age Report
- School Based Health Centers

As a result of the excellent partnership, we selected Dr. Katie Labgold as our MCH CDC Epi Assignee. We were extremely excited to enhance our Title V workforce capacity with Dr. Labgold. She brought a wealth of skills and experience in:

- Maternal and child health and chronic health outcomes
- Applied epidemiology and fieldwork
- Statistical software and data management programs
- Spatial epidemiology and associated analytic software
- Working with large data sets and data linkage methods
- Primary data collection
- Vital statistics, hospital discharge records, and weighted population surveys
- Surveillance
- Evaluation
- Qualitative data collection and analysis
- Oral and written communication to a variety of audiences (e.g., scientific, community-based)
- Collaboration with a variety of partners (e.g., federal, state/territorial, tribal, local, non-government including healthcare providers, community groups

Delaware hosted a site visit on May 17, 2024, which was an opportunity for the CDC MCH Epi candidate to onboard and meet internal and external partners. In October 2024, Delaware transitioned to our new MCH Epidemiologist. In addition to her routine analyses of quantitative and qualitative population health data available to support the MCH Block Grant, and other program initiatives and evaluation, she provided scientific and technical assistance to DPH staff and stakeholders in the areas of maternal and child health outcomes, development of surveillance databases, and integration of technologies.

As the CDC Senior Maternal and Child Health (MCH) Epidemiology Assignee to Delaware DPH, Family Health Systems (FHS) from October 2024 to June 2025, Dr. Labgold supported a range of MCH epidemiologic capacity building activities. Specific to Title V, Dr. Labgold provided invaluable technical assistance for the selection of NPMs and measurement of ESMs. She also provided early feedback on an updated Medicaid DUA to better meet Title V activity needs.

In addition to direct Title V support, Dr. Labgold provided technical and scientific advice on data collection and analysis for various internal and external partners. This included analytic support for Delaware's School Based Health Center performance measures and database development/management with the goal of preparing the 2023-2024 annual report. Dr. Labgold also provided technical and scientific advice to Delaware Healthy Mother and Infant Consortium (DHMIC) and Delaware Perinatal Quality Collaborative (DPQC) projects and grants. Support included the study design and data request preparation of two analyses (1. Vital Statistics data request for quality improvement analysis of severe hypertension treatment during pregnancy; 2. Medicaid data request for tracking postpartum visits). Dr. Labgold also provided expert epidemiologic input for two DPQC grants, supported the preparation of DPQC's 1st annual report, and providing feedback on DPQC analyses and conference presentations/abstracts.

During her tenure, Dr. Labgold designed four surveillance analyses related to infant, child, and maternal health in Delaware. These included updated surveillance of maternal substance use disorder and neonatal abstinence syndrome, identification of the drivers of preterm birth and preterm birth disparities, updated feto-infant mortality perinatal periods of risk analysis, and surveillance of adverse and positive childhood experiences (ACES & PCES). She also supported the analytic design for a program evaluation of the Healthy Women Healthy Babies program. A critical need of FHS is more timely data, for which Dr. Labgold prepared a data brief highlighting the need for real-time access to critical maternal and child health data.

Beyond these core functions, Dr. Labgold provided ongoing support for enhanced epidemiologic and public health capacity efforts by serving as a member of the Delaware DPH Privacy board ensuring appropriate analysis and storage of personal health information (PHI), mentoring early career staff in MCH data analysis projects, and

providing technical and topical expertise on a number of workgroups (e.g., Maternal Care Target Areas project, maternal and feto-infant mortality reviews, congenital syphilis, and birth defects registry data updates).

Unfortunately, in April 2025, MCH was notified that Dr. Labgold's position was affected by the Department of Health and Human Services' reduction in force (RIF) action. Therefore, effective June 1st, 2025, we would no longer have benefit of the CDC MCH Epidemiology Program, and Dr. Labgold would no longer be able to provide technical and epidemiology capacity building support for Delaware. This is a huge loss for Delaware. While we will be able to work with Forward Consultants to support our data needs and project support, the vacancy is a negative impact for Delaware. In the short time we worked with Dr. Labgold, her guidance and assistance were immeasurable, and the void is felt by all of us in FHS.

With the addition of our new CDC Assignee, we aimed to incorporate Delaware's Strategic Priorities by continuing to address infant and maternal mortality rates and racial, ethnic, and geographic health disparities. The primary focus of the IMTF/HWHB funding has been to reduce the number of Delaware babies who die before their first birthday. The strategy has been to identify women at the highest risk of poor birth outcomes and to address any underlying medical conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk.

Delaware's MCH epidemiologists have consistent, electronic, and timely access to:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Delaware Birth Defects Registry
- Delaware School Survey (DSS)
- Evidence-Based Home Visiting
- Fetal Infant Mortality Review
- High School Youth Risk Behavior Surveillance (YRBS)
- Hospital Discharge Data (HDD)
- Maternal Mortality Review
- Medicaid claims data
- Middle School Youth Risk Behavior Surveillance (YRBS)
- Syndromic Surveillance Data (ESSENCE)
- Vital Records Birth
- Vital Records Birth-Death Linked
- Vital Records Death
- FHS program-specific data
  - HWHB*
  - FPAR TITLE X Family Planning data*
  - Newborn Bloodspot Screening*
  - Newborn Hearing Screening*
  - School-based health centers data*
  - Pregnancy Risk Assessment Monitoring System (PRAMS)*
  - Neonatal Abstinence Syndrome Surveillance (Based on HDD)*
  - Delaware Perinatal Quality Collaborative (DPQC) (specific to quality indicators) *

**FHS oversight*

Delaware's MCH and epidemiological staff work in multiple capacities within the Division of Public Health. Our epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as reproductive and women's health, SSDI, home visiting, chronic disease prevention and health promotion, newborn screening, and children and youth with special healthcare needs. Additional data analysis support is provided through several collaborative relationships.

These activities provide clear and concise evidence of epidemiological and data enhancement activities that support the Title V Block Grant and performance measure reporting and are being utilized in an integrated manner to provide us with a vast array of information to inform our Title V strategies and activities.

Delaware’s geographic size requires us to rely heavily on partnerships and collaborative projects to succeed and, while some states would consider this a barrier, we have come to understand the value in collaborative projects with our cross-state agencies and partners. Some examples of collaborative projects supported by SSDI include providing funding support for technical advice to the Child Death Review Commission, Maternal Mortality Review Commission, Perinatal Quality Collaborative, Non-medically Indicated Deliveries (NMIDs), and more.

Goal 1. Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.
Objectives
1.2. Assist Title V MCH Block Grant programs with development, selection, refinement, and/or tracking of data and National Performance Measures that are associated with the Title V MCH Block Grant performance measure framework.

Progress Update: Resources deployed by the SSDI program include not only financial, but also project management and epidemiological resources. Funds deployed to support evaluation and analysis of MCH data allows us to ensure that data relevant to Title V programs and priorities is made available in a timely manner. The SSDI program is instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee to Delaware, Dr. Katie Labgold.

Additional contractual dollars were also allocated to working with Forward Consultants, LLC to support projects that provided evaluation services for the Title V Stakeholder surveys. The Title V Team worked with Forward Consultants the past two years to guide us through our comprehensive Needs Assessment, to ascertain our needs, desired outcomes, and system capacity for Delaware's MCH population. The results of the assessment are then used to establish the priorities that will guide our Title V program for the next five year.

The State of Delaware's needs assessment process involves collecting information from stakeholders, MCH leaders, family members and representatives, as well as the women, parents, and adolescents of Delaware. This information is collected in a variety of ways, including gauging MCH workforce capacity, conducting focus groups with community members, carrying out a survey of stakeholders, and interviewing key MCH partners. Each source provides important perspectives, context, and data to help the Title V program identify priorities.

Delaware created Data Sheets for our Needs Assessment process. A detailed and specialized Health Infographic for each of the 20 National Performance Measures, along with an additional Data Sheet for CYSHCN Medical Home. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it related to each measure. Information such as Delaware's goals and objectives, Delaware's baseline data, how Delaware compares to our neighboring states as well as nationally, and more were included on each Health Infographic.

Delaware's SSDI Project Director led our MCH Needs Assessment Internal Steering Committee, which regularly met for the purpose of reviewing the proposed assessment methodology, monitoring assessment progress, and reviewing draft primary data collection tools, and topic briefs. The MCH Title V team carefully selected and assembled fellow DPH peers to be members of our Boot Camp Committee where an intense review and scrutiny was conducted on our Five-Year Needs Assessment data collection. The Boot Camp Committee reviewed each data sheet, the Focus Group Study, our Stakeholder Survey Report, as well as the Key Informant Interview Analysis. Because our group was varied with field expertise, a robust discussion developed after each National Performance Measure was presented.

In order to assess the needs of our MCH population, we tasked our Internal Steering Committee members to prioritize and rank each health issue based on:

- Size of the Health Issue
- Seriousness of the Health Issue
- Disparities in Outcomes
- Current Level of Intervention
- Community Support
- Political Will
- Importance to Consumer
- Alignment with National and State Goals

Goal 2. Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.

Objectives

2.1 Collaborate with the office of Epidemiology, Health Data & Informatics to ensure consistent data access and/or data linkage across the 5-year funding cycle.

Progress Update: The SSDI Program Director has researched to specify which elements would be needed to support our Title V National and State Performance Measure progress reporting. To date, there have been no instances where we could not obtain data to support this reporting. This objective will serve as an on-going exercise for our Title V efforts as changes are provided by MCHB. As a standard practice, we will monitor and continuously evaluate our ability to access the data points. Our team will plan accordingly to utilize guided information as we work through the various data linkages and capture information related to our Title V priorities. It is our intention to use MCHB updated guidance's as a framework for organizing our data efforts.

Statewide, Delaware is working towards reducing the number of babies born exposed to opioids and other harmful substances. Previously having the expertise of our CDC MCH Assignee provided us with significant advantages in our efforts to establish data linkages with hospital discharge data. Our CDC MCH Assignee, as well as our contracted epidemiology assistance, have researched and produced findings in this area that have informed our strategies and measures to continue our work in reducing the number of children diagnosed with Neonatal Abstinence Syndrome (NAS). This linkage allows us to not only determine if mothers received prenatal care, but also the risk factors in predicting whether an infant is diagnosed with NAS or not.

As reported in our FY26 Title V MCH Block Grant application, the SSDI is a key component of our Title V program. The purpose of the SSDI program has always focused on access to data and data linkages of key data elements to support the Title V program. Delaware's SSDI program has made tremendous progress towards gaining access to Middle and High School Surveys, Vital Statistics, Newborn Screening, Oral Health and Medicaid data, as well as, executing data linkages as needed. The SSDI program will continue to support and improve access to data by expanding or enhancing current data systems. The SSDI program supports the continued work on projects that increase our ability to receive more "real time" data. By promoting MCH data infrastructure, our community stakeholders and partners have MCH data collection and analysis capacity. They are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. This in turn facilitates the creation of effective programs, which leads to health improvements in the MCH population.

The data from Birth Defects Registry Data, PRAMS data, Medicaid data, program specific data such as Healthy Women Healthy Babies, School-Based Health Centers, Title X Family Planning data are matched as needed for program evaluation and monitoring purposes. While Medicaid claims data are routinely linked to vital statistics birth certificate data by the Delaware Health Statistics Center are not under Title V purview, Medicaid data are also being linked where feasible to HDD, and other Title V program data. As noted previously, there has been a significant knowledge gap with regards to the impact of COVID-19 on the Title V MCH population as these data are not easily accessible for surveillance purposes and/or linkage to enhance the epidemiological knowledge base.

2.3. Collaborate with the state office that oversees vital statistics to assure continued access to vital statistics MCH data in a timely manner.

Progress Update: Currently, Medicaid data are available only as specific use case for developing reports specific to conduct the School Based Health Centers evaluations. Linking with birth certificate data are currently prohibited as only Vital Statistics can complete that, as per their MOU.

As part of the work done to support the Title V/Title XIX MOU, the SSDI Director will work with our epidemiology support to improve the timeliness of shared Medicaid claims data that is related to MCH programs and services. While historically the CDC Assignee maintained limited access to the Medicaid claims data, their work with our Vital Statistics office will seek to enhance the scope of that access. That could result in increased access to additional data sets or it could result in a mutually agreed upon reporting structure that is provided to MCH on a regularly scheduled basis. Continued discussions are ongoing, and details will continue to be worked out. Unfortunately, with the loss of our CDC MCH Assignee, this effort has not progressed.

Delaware has also had recent progress with emphasis on the contributions of the SSDI grant in building and supporting accessible, timely and linked MCH data systems. Vital statistics data (i.e., birth and death) data are routinely matched to Hospital Discharge Data (HDD) to monitor trends like Neonatal Abstinence Syndrome (NAS), for example.

Goal 3. Enhance the development, integration, and tracking of community factors to inform Title V programming.

Objectives

3.1. Develop and track performance measures that can be used to assess the progress of Title V programs, policies, or initiatives in achieving favorable outcomes in community health factors.

Progress Update: Through our Focus Groups, Stakeholder Survey, Key Informant Interviews, and Workforce Capacity Analysis, Delaware's objective was to learn from these methods each study's various subgroups about the general healthcare and reproductive health needs and concerns of women in our state, to improve service delivery and the health outcomes of women, children, and their families. Every effort was made to select locations and populations within our community that represented our state.

Our Boot Camp Committee assessed the health status of MCH populations and state program capacity. In addition, we conducted an environmental scan of MCH initiatives and data and assessed the infrastructure of MCH programs. Lastly, our team also assessed the partnerships/engagement within MCH programs and assessed the MCH workforce capacity. Once all data from our Title V Five-Year Needs Assessment was reviewed by our Internal Steering Committee, our members selected our state's health Priority Needs in each of the health domains. From that point, our SSDI Director met with each health domain lead to review the results of the Needs Assessment and begin the process of selecting their measures.

Our domain leads invited their community partners to the table when working through the State Action Plan - developing Strategies, Objectives, and Evidence-Based or Informed Strategy Measures (ESMs). Also at each meeting, were our CDC MCH Assignee, as well as our epidemiology, research, and evaluation (ERE) contractor. This process would not have been possible without them. Together, they guided each domain lead and community partner members through MCH Needs Assessment Toolkit page, using their Strategy Planning Tool. This document helped each domain lead to set their five-year targets, which are the performance objectives, for the NPMs selected. Each domain lead and community partners also selected ESMs that correspond with their Priority Need. We anticipate the results of this selection to directly relate to community priorities and establish a level of accountability for achieving measurable progress.

During our meetings, our goal was to set evidence-based, outcome-driven performance objectives that were based on:

- Data-Driven Objective Setting
- Partner Involvement
- SMART Objectives
- Health Outcomes Consideration
- Evidence-Based Decision-Making
- Continuous Review and Adaptation

3.2 Work with community-based organizations to understand local data capacity, infrastructure, and needs for assessing progress in reducing community health factors.

Progress Update: Our FHS team routinely and purposefully meets with many community-based organizations and health partners to ensure access to quality health care and needed services for our maternal and child health populations. We have been successful at leveraging partnerships and resources to maximize services available to the MCH population.

Throughout our 2025 Five-Year Needs Assessment process, MCH periodically met with various community-based organizations to increase data capacity efforts. We want to ensure our program managers, epidemiologists, partners, and stakeholders have MCH data collection and analysis capacity. They are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. We believe that access to MCH data allows for population assessment, program development, and progress monitoring of the MCH Block Grant State Action Plan. This in turn, facilitates the creation of effective programs, which leads to health improvements in the MCH population.

The MCH program relies on our partners and epidemiologists, who assist in developing process and outcome measures to gauge the impact of the Action Plan on the health of the MCH population. Progress is monitored on each measure by MCH program staff and other stakeholders periodically throughout the year and during our Steering Committee meetings. Based on measurement performance, MCH program staff and stakeholders revise our strategies, objectives, and our evidence-based -informed practices, as needed, to improve health impact. MCH program staff and epidemiologists completed our Five-Year Needs Assessment review, which provided data on the MCH population. MCH staff, stakeholders and our Steering Committee then used this data to select priorities for the upcoming grant cycle. Once the priorities were chosen an action plan was developed to impact each priority.

Access to MCH data allows for program development and progress monitoring of the MCH Block grant Action Plan. Our Title V team met throughout the year to assess the health needs of our population, Title V's program capacity, as well as Delaware's partnerships and ability to collaborate and coordinate efforts. We met to review the most recent state and national data that was specific to Delaware's MCH populations. Our team used the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); and Delaware Health Statistics (birth records, death records, hospital discharge data) to gauge Delaware's health population.

It is the intention of MCH to integrate data and epidemiology into research and evaluation of programs and activities. MCH is committed to contracting consistent, high-quality support in research, epidemiology and program evaluation for our section and its associated programs.

Goal 4. Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.

Objectives

4.3. Participate in analysis and/or reporting of data.

Progress Update: We will continue to provide support for ongoing data collection needs. MCH will also continue to work to monitor for timely MCH data collection that support not only our Title V national health priorities, but also programs within our section that provide education and services related to preconception and interconception care. Currently, Medicaid data are available only as specific use case for developing reports specific to conduct the SBHCs evaluations. Linking with birth certificate data are currently prohibited as only Vital Statistics can complete that, as per their MOU.

With the help of the CDC Assignee, the SSDI Project Director has gathered local/state/national data that is used to support the Title V MCH Block Grant program activities just as has been done in previous years. This data contributes to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation. This information supported our on-going work associated with the Five-Year Needs Assessment and our FY26 Block Grant application.

As stated throughout our application, the SSDI program is solely focused on providing the MCH Block Grant not only the data but the analysis and the evaluation capacity that is needed to ensure the program understands what and where the needs in our state are. Funds used to support evaluation and analysis of MCH data allows us to ensure that data relevant to Title V programs and priorities is made available in a timely manner. Throughout the 5-year SSDI grant cycle, the SSDI Program Manager has and will continue to provide valuable support to the on-going Needs Assessment to track progress and identify persistent gaps and barriers.

During Fiscal Year 2025, a portion of the SSDI grant has been used to support the SSDI Project Director to attend the 2025 Federal/State Partnership Meeting as well as the 2025 Association of Maternal and Child Health Programs (AMCHP) Annual Conference, both in Washington D.C. As the Title V MCH Needs Assessment Coordinator and SSDI Project Director, this role's responsibilities include leading the Title V Needs Assessment planning process and managing the SSDI grant. This role was responsible for representing the Title V program population domains of Child and Adolescent Health. The focus of this effort was addressing oral health for children, increase adolescent physical activity, and adolescent well visits (National Performance Measures).

III.C.1.b.ii.e. Other Data Capacity

Delaware's Title V data capacity efforts are funded by other sources other than the State Systems Development Initiative (SSDI), which supports up-to-date maternal and child Health (MCH) data and information systems. Delaware's MCH Block Grant is complimented by other funding sources within the Family Health Systems (FHS) that increase our data capacity efforts, which support up to date MCH data and information systems. This ensures our program managers, epidemiologists, partners, and stakeholders have MCH data collection and analysis capacity. They are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. For example, access to MCH data allows for population assessment, program development, and progress monitoring of the MCH Block Grant State Action Plan. This in turn, facilitates the creation of effective programs, which leads to health improvements in the MCH population.

FHS's vision is to nurture an environment that inspires everyone to contribute solutions, innovate and support the goal of a healthier Delaware. Our mission is to improve the health of families and provide leadership to communities in the development of health systems. The accomplishment of our mission will facilitate the Division in realizing its vision of creating an environment in which people in Delaware can reach their full potential for a healthy life. The Division of Public Health (DPH) Family Health Systems (FHS) section solicits services in the area of maternal, child, adolescent, children and youth with special health care needs, health epidemiology, research, and evaluation. It is the intention of FHS to integrate data and epidemiology into research and evaluation of programs and activities.

In addition to our SSDI grant, other key components of our MCH epidemiological and data enhancement activities support our Title V program and activities. FHS is committed to contracting consistent, high-quality support in research, epidemiology and program evaluation for our section and its associated programs. Forward Consultants is our epidemiology, research, and evaluation (ERE) contractor and FHS is confident they have the experience and

capacity to carry out all required activities with assistance and guidance from the DPH, FHS section. Our ERE contracting services maintain and improve existing methods of information collection for FHS MCH statistical analysis. Examples include linked infant birth and death records, poor birth outcomes registry, and birth certificate data analysis.

The contract covers the maintenance and improvement of existing methods of information collection for FHS Management statistical analysis. Our ERE contract also covers developing new methods to collect key information for decision-making and research. This can include merging existing sources of information (e.g., population-based information, surveillance systems, survey information and program/service utilization information). Project examples include data collection methods to assess the impact of nurse home visiting, assess the impact of preconception care and enhanced prenatal care services, literature review of provider cultural competence, and home visiting needs assessment.

Our ERE contracting services also aims to improve access to and use of information in addition to translating information into an easily understandable form to inform the public and key stakeholders. Project examples include data analysis and presentation of data for the annual Delaware Healthy Mother & Infant Consortium (DHMIC) report, birth defects registry analysis, and social distal factors report. Forward Consultants also designs and implements research studies to assess program impact. This includes natural experiments, prospective studies, case control studies, or cross-sectional studies. Research studies may rely on quantitative methods, qualitative methods, or a mix of the two. Some project examples include a research study proposed by the Data/Science Committee of the DHMIC, and a study to assess the impact of nurse home visiting.

The FHS contracted services with Forward Consultants designs and implements program evaluation to measure whether program goals are met, and activities are effective. This may include process evaluation but should primarily focus on outcome and impact evaluation. Efficiency should be measured through cost analysis. Some project examples may include evaluation of preconception and enhanced prenatal care programs (should include cost evaluation), evaluation plan and two surveys funded through the federal Pregnancy Risk Education Prevention (PREP) Grant, Healthy Women, Healthy Babies (HWHB) Program, community health program, and Children & Youth with Special Health Care Needs (CYSHCN) activities.

Forward Consultants continues to work with the CHADIS team to develop the dashboard that will capture developmental screening and referral data for both pediatricians and early intervention programs. This project has had a number of iterations. This grant period, Forward Consultants has partnered with KIDS COUNT in Delaware to determine how to integrate Help Me Grow system data within KIDS COUNT local and national data system. In addition, our ERE continues to work with HMG Delaware's core team to bridge gaps within the four components that underlie the Help Me Grow system through continuous quality improvement measures. Forward Consultants also leads the Data and Surveillance sub-committee of the Help Me Grow Advisory committee to track, analyze HMG/2-1-1 data and recommend improvement. Lastly, our ERE continued providing input for the data tracking and analysis action plan for Delaware Help Me Grow system's strategic plan.

In addition, the ERE contracted services provide expertise with respect to all phases of statistical interpretation related to family health epidemiologic topics. This includes interpreting infant birth certificate data, newborn screening, birth defects surveillance data, hospital discharge data, Pregnancy Risk Assessment Monitoring System (PRAMS), and other national data sets to answer MCH questions posed by consumers and/or stakeholders.

Lastly, our contracted services also require Forward Consultants to analyze and prepare reports in order to communicate research and surveillance trends to various audiences. This also requires prepared ad-hoc reports and data summaries, as requested by DPH and DHMIC.

The following are examples of programs that require ERE services:

- Healthy Women, Healthy Babies
  - This is composed of: preconception care, prenatal care, interconception care services, and infant

care (home visiting)
- Adolescent health services through school-based wellness centers
- Children with special health care needs (traumatic brain injury, birth defects and newborn screening)
- Violence and injury preventions services
- Pregnancy Risk Assessment Monitoring (PRAMS) system
- Fetal Infant Mortality Review (FIMR)
- Reproductive health
- Women's health
- Men's health
- Community health
- Title V Five-Year Needs Assessment

The MCH program relies on our epidemiologists, who assist in developing process and outcome measures to gauge the impact of the Action Plan on the health of the MCH population. Progress is monitored on each measure by MCH program staff and other stakeholders periodically throughout the year and during our Steering Committee meetings. Based on measurement performance, MCH program staff and stakeholders revise our strategies, objectives, and our evidence-based -informed practices, as needed, to improve health impact. MCH program staff and epidemiologists completed our Five-Year Needs Assessment review, which provided data on the MCH population. MCH staff, stakeholders and our Steering Committee then used this data to select priorities for the upcoming grant cycle. Once the priorities were chosen an action plan was developed to impact each priority.

When it comes to women's and maternal health, we continue to focus on increasing the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies. As in the past, our key priority is to find ways to reduce the infant mortality rate in Delaware and we understand the importance of preconception care and quality prenatal care for our mothers. To continue making progress in providing "whole health" care to our women and mothers, we continue to bolster and nurture our community partnerships by working together, leveraging talents and resources, and striving to find new ways to provide services.

DPH launched a data portal allowing Delawareans to assess the overall health of their communities. The My Healthy Community data portal delivers neighborhood-focused population health, and environmental data to the public. The innovative technological showpiece allows users to navigate the data at the smallest geographical area available, to understand and explore data about the factors that influence health. Just recently for National Environmental Public Health Tracking Awareness Week (7/8/24-7/12/24), DPH invited the public to explore the My Healthy Community portal. DPH is dedicated to empowering communities to use health data to make informed decisions on policy and community improvement. This is a perfect example of how Delaware is making data more transparent, accessible, and easy to understand. Sharing community-level statistics and data allows Delawareans to understand what is occurring in their neighborhoods, make informed decisions about their health, and take steps to continue improving our quality of life.

Delaware residents are able to explore a variety of data indicators in the following categories: environment, climate and health, chronic disease, mental health & substance abuse, healthy lifestyles, community safety, maternal & child health, health services utilization and infectious disease. Air quality data, asthma incidence data, public and private drinking water results, drug overdose and death data, education, socioeconomic influencers, lead poisoning, and suicide and homicide are all currently available. DPH believes that our health and the environment in which we live are inherently connected and the My Healthy Community portal will allow communities, governments and stakeholders to better understand the issues that impact our health, determine priorities and track progress. Communities can use the data to initiate community-based approaches, support and facilitate discussions that describe and define population health priorities and educate residents about their community's health and the environment in which they live.

The Division of Public Health is convinced that access to data is a key factor in making progress toward a stronger and healthier Delaware. The ability to easily access such crucial information like substance use and overdose data by zip code enables Delawareans to compare it to larger areas and examine trends. For the first time, Emergency

Department non-fatal drug overdose data from DPH, and Prescription Monitoring Program (PMP) data will be available thanks to a partnership with the Division of Professional Regulation. Addiction, air quality, chronic disease and drinking water quality impact every one of us and when communities become aware of the level at which these issues are occurring in their neighborhoods, it can spur action that can improve the quality of life for current and future generations.

Additional substance use disorder (SUD) data and additional health indicators were also built to highlight Delaware's progress in meeting health care benchmarks (obesity, tobacco use, preventable Emergency Department visits, etc.) as part of DHSS's ongoing efforts to bring transparency to health care spending and to set targets for improving the health of Delawareans. Future funding has been secured for data on vulnerable populations and climate change, and for violent death data and internal sharing of timely SUD data.

Over the last three decades, scientific evidence has clearly demonstrated how personal behaviors affect development of diseases. Smoking, physical inactivity, poor eating habits, obesity, alcohol abuse, and other risk factors can lead to a variety of chronic health problems-like heart disease, cancer, type 2 diabetes, or lung diseases. Lifestyle behaviors increase the risk of communicable diseases such as AIDS, sexually transmitted diseases, and vaccine-preventable diseases. Injuries from violence and accidents also may be caused by behavioral risks. As a result of this evidence, public health professionals are focusing on ways to help people change their behaviors to reduce risks and prevent illness or premature death.

These data are gathered through the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual survey of Delaware's adult population about behaviors which increase the risk of disease, premature death, and disability. BRFSS is a cooperative effort of the Delaware Division of Public Health and the CDC and is primarily funded by CDC. Delaware has been collecting behavioral risk factor data continuously since 1990. Interviewing is conducted every month of every year, and data are analyzed on a calendar-year basis. The BRFSS made methodological improvements in 2011 to address social and technical changes in telephone usage. The annual sample in Delaware is about 4,000 adults aged 18 and older. The random-sample telephone survey is conducted for DPH by Abt Associates, Inc. Data from the survey are used by both public and private health providers to plan health programs and to track progress toward the state's health goals.

As MCH-related data is transmitted across various stakeholders (e.g., individuals/families, DPH MCHB, and contractors who analyze and report on data), privacy has been a longstanding concern and priority for Title V-supported projects. Given this, DPH MCHB makes as certain as possible that data is shared through secure files and/or website portal logins and with contractors that have the documented capacity to maintain data privacy (this is documented via business associates' agreements). Moreover, when data is analyzed, identifying information is always immediately omitted. Finally, when reporting and presenting, no personal identifying data is shown.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Partnerships and collaborations are essential to strengthening our ability to serve the maternal and child health (MCH) population, including children and youth with special health care needs (CYSHCN), and to advance our Title V priorities. We work closely with other MCHB programs to amplify the impact of our grant investments. The Family Health Systems Section in the DPH is responsible for administering the Title V MCH Block grant along with several other HRSA MCH investments including the following programs:

- The Pediatric Mental Care Access Grant (PMHCA) grant in to address pediatric mental health care access in primary care. The Delaware Child Psychiatry Access Program (DCPAP) goals are:
    - Increase the availability and accessibility of child and adolescent psychiatric and mental health to pediatric primary care practitioners caring for children and adolescents with behavioral disorders.
    - Conduct training and provide technical assistance to primary care providers to enable them to conduct early identification, diagnosis, and treatment for mothers and children with behavioral health conditions.
    - Provide evidence-based methods such as web-based education and training sessions to pediatric and maternal providers on detection, assessment, treatment, and referral of patients with behavioral health disorders.
    - Improve access through telehealth to treatment and referral services for pediatric patients with

identified behavioral health disorders, especially those living in rural and other underserved areas.

Delaware has a shortage of child psychiatrists. The shortage is critically severe in the south. In northernmost New Castle County, there are 19 child psychiatrists for an under-18 population of 157,805. For Kent County, the shortage is worse with only 3 child psychiatrists for 50,830 children. Meanwhile, in Sussex County there is 1 child psychiatrist for a population of 47,032. Delaware neither has enough psychiatrists to cover its population, nor a medical school to provide more of them.

- The HRSA Newborn Hearing grant is also administered by the Family Health Section in the MCH Bureau and strives to ensure that families of babies and children who are deaf or hard of hearing receive appropriate and timely services. These services include hearing screening, diagnosis, and early intervention, as well as parent-to-parent support provided through coordinated systems of care. This program partners with the Parent Information Center to provide learning community opportunities as well as parent support. Title V partners with this program to coordinate activities with the Newborn Screening program as well as conducting outreach and providing education to providers and families. The CYSHCN Director is an active member of both the Newborn Screening Advisory Board and the EHDI Board.

- The Project Director of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant also serves as the Title V Deputy Director, allowing for natural alignment of key activities such as needs assessments and program coordination. MCH and MIECHV home visiting programs are closely coordinated to ensure the needs of Delaware's most vulnerable families are effectively met. The Help Me Grow (HMG) call center functions as the centralized intake hub for all home visiting programs in the state, where families are triaged and referred to the program best suited to address their specific needs. HMG is jointly supported by both Title V and MIECHV funding.

- State Maternal Health Innovation Grant (SMHI) is administered by the FHS section in DPH and partnering with the Delaware Perinatal Quality Collaborative (DPQC) to achieve the established goals. The DPQC is well-situated to carry out a State Maternal Health Innovation initiative to improve the health of perinatal women, with particular emphasis on enhancing care coordination and wraparound services for perinatal women with substance use disorder. It is anticipated that this multi-faceted approach will help the DPQC and the State of Delaware overall achieve the following goals:
    - Improved access to care that is comprehensive, high-quality, appropriate, and on-going throughout the preconception, prenatal, labor and delivery, and postpartum periods;
    - Enhanced state maternal health surveillance and data capacity; and
    - Identification and implementation of innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and SMM.

- The Parent Information Center (PIC) of Delaware is a non-profit organization, comprised mostly of parents who have shared similar journeys, that houses the Family-to-Family Health Information Center formally known as Delaware Family Voices. And although, this program is not administered by Title V, we do currently provide funding to implement the Family SHADE program which provides opportunities for collaborations of smaller community agencies serving the CYSHCN population, provides professional development to parents wanting to become family leaders and it also provides mini grant awards to support local community innovative initiatives that will Title V meet priority needs for this vulnerable population.

Other Federal Investments

- The Women, Infants, and Children (WIC) program is administered by the DPH under the Health Promotion and Disease Prevention section. MCH maintains a strong partnership with the WIC program, working collaboratively on a variety of initiatives that support family health and well-being. These joint efforts include promoting breastfeeding initiation and duration, increasing referrals to WIC services, and improving access to nutritious food for pregnant individuals, infants, and young children. WIC staff are consistently engaged in MCH-led efforts and are active participants in key meetings and workgroups, including the Delaware Healthy Mother and Infant Consortium (DHMIC), Home Visiting programs, Help Me Grow (HMG), and the Delaware Breastfeeding Coalition. Their involvement ensures alignment across programs and strengthens a coordinated approach to maternal and child health services.

- Delaware has been committed to conducting maternal mortality review (MMR) in alignment with national standards and best practices since 2011. The Delaware MMR program became a statutory function of the Child Death Review Commission (CDRC) in 2008. The CDRC oversees other child fatality reviews and so it is best positioned to oversee MMR in partnership with DPH MCH. The CDRC's authority allows for

subpoena power to obtain case records and immunity protection from discoverability for the MMRC, its members and records. In 2019 Delaware was awarded the Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees grant from the Centers for Disease Control and Prevention (CDC). This grant funded the position of Delaware's first dedicated MMR Coordinator. In 2022, the CDRC collaborated with Delaware state legislators to amend Title 31 of the Delaware Code relating to Maternal and Child Mortality. The guiding principle was that improving the quality of maternal health care and ensuring full access to it improves health outcomes and reduces preventable pregnancy related deaths. Included in this legislation was changing the Commission's name to the Maternal and Child Death Review Commission (MCDRC) to better reflect the work being done by the Commission.
Findings and recommendations from the Delaware MMRC inform the discussion and consideration of women's health issues in the state. Delaware MMRC findings are reported annually to the Governor, General Assembly and to the public, which has helped engage more stakeholders and provide timely information on emerging issues affecting the health and well-being of women in the state. Specifically, in Delaware the MCDRC works closely with the Office of Vital Statistics in DPH, the Delaware Perinatal Quality Collaborative, the Delaware Healthy Mother and Infant Consortium, the Division of Forensic Sciences-Medical Examiner, Delaware Medicaid and Medical Assistance, all birthing hospitals and numerous community and clinical partners within the context of all its fatality review programs and the Community Action Team.

- The Delaware Division of Public Health (DPH) administered the funding opportunity "The Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry". The SUID/SDY registry is a resource designed to increase understanding of the causes and risk factors for sudden death in the young. It supports a standardized approach to case investigation and review that can inform community-directed prevention strategies. A registry participant since 2014, DPH has close working relationships with the Maternal and Child Death Review Commission (MCDRC), the Division of Forensic Sciences Office of the Medical Examiner (DFS-ME), the Office of the Child Advocate (OCA), and the Division of Family Services (DFS) to do this work. The most recent grant supports Delaware's continuing efforts to strengthen collaborative, high-quality multidisciplinary reviews and implement community-led interventions to reduce sleep-related deaths.

- The Adolescent Health Bureau, within the Family Health Services (FHS) section of the Department of Public Health (DPH), provides funding to a community-based organization to implement evidence-based reproductive health education for youth ages 12 to 18. This initiative is supported through the federally funded Personal Responsibility Education Program (PREP) grant, which aims to equip adolescents with knowledge and skills to make informed decisions about their sexual health and reduce risk behaviors.

Local MCH Programs and Organizations

- All hospitals in Delaware are active members of the Delaware Perinatal Quality Collaborative (DPQC), reflecting a strong, statewide commitment to improving maternal and child health outcomes. In addition, the majority of these hospitals are also engaged participants in the Delaware Healthy Mother and Infant Consortium (DHMIC), underscoring their dedication to coordinated perinatal care. Notably, the current chair of the DHMIC is a faculty member affiliated with Delaware's largest hospital, further strengthening the connection between clinical leadership and public health strategy.

- Delaware's MCH programs maintain a wide array of formal partnerships and contracts with hospitals and Federally Qualified Health Centers (FQHCs) across the state. These collaborations support the delivery of critical services such as community health worker initiatives, Healthy Women, Healthy Babies (HWHB) programs, and school-based health centers (SBHCs). Together, these integrated efforts form a robust network aimed at improving access to care for families throughout Delaware.

- In recent years, the DE CYSHCN program has established more community-centered funding opportunities to address Title V priorities for this population. These funding opportunities support partnering directly with organizations at a local level that are working to improve outcomes. We expect to continue local funding opportunities and recently published another RFP for a backbone agency to coordinate these local funding awards.

- Children & Families First (CFF), the largest nonprofit organization in Delaware, is a cornerstone partner in many of the state's Maternal and Child Health (MCH) initiatives. With a long-standing commitment to strengthening families and supporting child development, CFF serves as the sole implementer of two evidence-based home visiting programs in Delaware: Nurse-Family Partnership and Healthy Families

America.
In addition to their home visiting services, CFF is also a provider under the Healthy Women, Healthy Babies (HWHB) program and an active member of the Delaware Healthy Mother and Infant Consortium (DHMIC). Their deep community roots, wide-reaching service network, and commitment to positive outcomes for families make CFF a committed partner in advancing the health and well-being of women, children, and families across the state.

- The United Way plays a vital role in supporting families across Delaware through its administration of the 2-1-1 Helpline and its operation of the Help Me Grow (HMG) call center. As the contracted provider for these services, United Way serves as a critical connection point, linking families, especially those in crisis or with urgent needs, to essential community resources and support systems. In addition, through funding from Delaware's Part C Birth to Three program, United Way conducts developmental screenings, provides caregiver education, and facilitates appropriate referrals to early intervention services. This multi-faceted role makes United Way a key partner in promoting early childhood development and family well-being statewide.

Other State Agencies and Programs

- Our MCH program maintains a strong and ongoing partnership with the state Medicaid agency through regular monthly meetings. These meetings serve as a platform for aligning priorities, coordinating services, and advancing shared goals to improve outcomes for the MCH populations. In recent years, this collaboration has produced important progress, including efforts to secure Medicaid reimbursement for evidence-based home visiting programs such as NFP and HFA, as well as expanding coverage for doula services.

  In addition to this Medicaid partnership, MCH also works closely with Family Voices of Delaware to ensure that the voices of families with CYSHCN are heard. Together, we co-host monthly virtual forums that bring families and MCOs to the table to discuss key issues, share resources, and address questions. These sessions foster transparency, trust, and ongoing dialogue, ensuring that families remain central to the design and delivery of the care they receive.

- The Department of Education (DOE) is a highly valued partner in our Maternal and Child Health (MCH) efforts, particularly in programs that support early childhood and adolescent health. Our collaboration spans several critical initiatives, including developmental screening, early intervention services, evidence-based home visiting, and school-based health centers. One of the cornerstone programs in this partnership is the Parents as Teachers home visiting initiative. The DOE receives state general funds to support the implementation of this evidence-based program, which is also bolstered by federal support through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.
  Through strategic coordination, we have successfully braided multiple funding sources—including Title V, MIECHV, and the Preschool Development Grant (PDG)—to maximize our collective impact. This integrated funding approach, made possible by close collaboration between the DPH and DOE, enables us to expand reach and enhance services for the children and adolescents we serve across the state.

III.C.1.b.iv. Family and Community Partnerships

One of the most impressive examples of family and community collaboration is the Delaware Healthy Mothers and Infants Consortium (DHMIC). Formed in 2005 as a statewide vehicle to address infant mortality, the consortium includes approximately 150 members, including representatives from DPH, hospital systems, universities, the legislature and community members. The current co-chair is a community member with lived experience. The Delaware Perinatal Quality Collaborative (DPQC) was initially established in 2011 as a subcommittee of the Delaware Healthy Mother and Infant Consortium (DHMIC). In 2019 the DPQC was memorialized in state code as a freestanding organization. The DPQC is now constituted as an independent public instrumentality. All seven birthing institutions in Delaware are members of the DPQC. The Collaborative is comprised of voting members appointed by member organizations. Each member organization has one representative. Family Health Systems MCH staff these committees and support the partners in advancing shared work. Collectively, the DHMIC follows a life course model. (For more information, visit www.dethrives.com)

In the domain of CYSHCN, a key partnership is the Parent Information Center who contractually oversees Family SHADE (Support and Healthcare Alliance Delaware), a collaborative alliance of family partners and organizations dedicated to supporting families of children with disabilities and chronic medical conditions, Delaware Family Voices is a part of the Parent information Center along with the Family to Family Information Center. The Parent Information Center (PIC) offers

several ways for parents to be engaged including educational opportunities for parents to learn, engage with each other as well community providers. PIC implements the Family Leadership Network for parents/guardians of children birth to 26 that have a suspected or diagnosed disability. The network membership includes trainings, monthly learning community sessions, and support with Individualized Education Plans, and referrals. Participants will receive monthly stipends for attendance and participation. Parents as Collaborative Leaders is used and includes training topics such as Defining Parent Leadership, Listening & Asking Clarifying Questions, Critical Elements of Collaboration and Tips for Leading Meetings. PIC's workforce includes parents, and this brings a wealth of knowledge and expertise to the table to better engage families.

The Family SHADE program has evolved over few years and focuses on awarding mini-grants and providing the necessary technical assistance for the awardees to be successful. Learning communities are also being offered to community organizations serving this population to give organizations an opportunity to learn and support each other as well. Topics have included newborn screening, fetal alcohol syndrome and data and evaluation. Family SHADE has also held Symposiums that included presentations on transition and developmental screening.

A very important activity for partnering with families is the Managed Care Organization Health calls facilitated by Delaware Family Voices, with the phone line provided by DPH. These regularly scheduled calls give family members an opportunity to ask a question or discuss an issue. On the call are representatives from various agencies and organizations to listen and help problem solve. These calls give families a non-adversarial venue discuss to share their concerns, and as a result many families get a better understanding of how the system works and the providers and policymakers hear how a family is impacted by rules and regulations.

The Interagency Coordinating Council (ICC) is a Governor appointed body tasked with advising and assisting Delaware's Birth to Three Early Intervention Program. The ICC supports the implementation of our state's Birth to Three Early Intervention program as required by IDEA Part C. This council is comprised of parent representatives, providers, state legislators, and other stakeholders who advise and assist the program through quarterly meetings and various committees. The purpose of the council is to:

- Advise and assist the Lead Agency (DHSS) in the implementation of Part C of the IDEA
- Advise and assist the State educational agency regarding the transition of toddlers with disabilities to preschool and other appropriate services
- Advise with respect to the integration of services for infants and toddlers with disabilities and at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services in the State.

The DHMIC, Family SHADE, Delaware Early Childhood Council, and the Interagency Coordinating Council represent four of the largest groups of partners that include consumers/families coming together around MCH issues, but there are many other advisory boards, councils, and coalitions that our MCH program works with to extend the reach of Title V, guide our work, and expand the overall capacity to support mothers, children, and families. Other committees include, the Help Me Grow Advisory Committee, convened by DPH, consists of representatives from organizations across the state. Similarly, the Home Visiting Community Advisory Board pulls together home visiting and partnering programs from across the state to ensure a coordinated continuum of home visiting services. In addition, the Governor's appointed Early Hearing Detection and Intervention (EHDI) Board was created by legislation passed in 2012. The Newborn Screening Advisory Council, formed in 2000, helps the Division determine best practices for the program including the addition of new conditions to the Delaware screening panel. Additional key partnerships and collaborations include the Developmental Disabilities Council, the Sussex County Health Coalition, and the Breastfeeding Coalition of Delaware.

In the spirit of Title V, we are committed to continuing these efforts to collaborate with families and consumers of our programs and services to ensure that our efforts and resources are aligned with the priority needs of Delaware's mothers, children, and children and youth with special health care needs.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Delaware's 2025 Title V needs assessment and priority selection process benefited from the commitment and engagement of its committed and engaged stakeholder (including families) community. In addition to relying upon data to drive the assessment and prioritization process, the Steering Committee employed multiple methods to engage partners and consumers, valuing their unique perspectives, contributions and assessment of the state of MCH in Delaware. The goals of the prioritization process were to 1.) Use a data-informed method to identify and prioritize Delaware's top health issues related to the health of women, infants, children and youth, including children and youth with special health care needs; and, 2.) Incorporate stakeholder and public input into finalizing the priority areas by population domain for action planning. The Needs Assessment Steering Committee was responsible for

reviewing and understanding the data, and then assigning scores for each of the 20 national health areas in order to rank them.

In November 2024, five workbooks (one for each population health domain) were given to 25 MCH stakeholders. At an in-person prioritization boot camp, each of the National Performance Measures (NPM) was systematically discussed among the MCH stakeholders who were then tasked to appraise each of the NPMs based on both the content presented within each of the workbooks and their own experience and expertise. For each NPM, the MCH stakeholders complete a ranking worksheet that asked the stakeholders to rate each NPM on eight different criteria:

- **Size of the Health Issue** (Percent of population with health issue; the percentage of the population with the problem, with an emphasis on the percentage of the population at risk for the problem.)
- **Seriousness of the Health Issue** (Degree to which there is an urgency for intervention as data is available: Trends: Is the problem growing? Mortality/Morbidity: Disproportionate death/disability)
- **Disparities in Outcomes** (Disparities: Are some groups (by race, ethnicity, socioeconomic status (SES)) affected more than others?)
- **Current Level of Intervention** (The degree to which an intervention is in place to address the health issue. Information from census of services - are there adequate programs/services to meet the need? Are these programs accessible?)
- **Community Support** (Is there community support for this issue to be addressed? (Stakeholder Survey and Key Informant Interviews))
- **Political Will** (Is there political will (political costs and benefits) for this issue to be addressed)?)
- **Importance to Consumer** (Is this issue important to the public? How is it seen considering other priority areas by consumers? (Focus Groups))
- **Alignment with National and State Goals** (Part of National or State goals, ex.: Healthy People 2030, DPH Strategic Plan, Delaware SHIP, etc.)

Each of these criteria were scored on a Likert scale of 1 (lowest) to 5 (highest) based on each MCH stakeholder's discretion. A "Not Sure" option, which was scored as a 0, was also provided but MCH stakeholders were instructed to use this option sparingly. Note that one criterion – **Disparities in Outcomes** – was weighted twice (i.e., scores were multiplied twice) and three criteria – **Seriousness of the Health Issue**, **Current Level of Intervention**, and **Political Will** – were weighted 1.5 times as these four criteria were considered to be of greater importance, consequence, and management (i.e., ability to have an effect) by Title V stakeholders. Each score was multiplied by its weight (either by one, 1.5, or two), added to generate a total for each criterion across each NPM, and then divided by the number of stakeholders responding with a non-zero score to determine an average score for each criterion across each NPM. These average scores by criterion across each NPM are below.

Average Score of Ranking Criteria for Each NPM (Orange Highlight = Highest Score, Yellow Highlight = Lowest Score).

Description	A. Size of the Health Issue	B. Seriousness Health Issue	C. Disparities in Outcomes	D. Current Level of Intervention	E. Community Support	F. Political Will	G. Importance to Consumer	H. Aligns w/National State Goals
Housing Instability	4.3	6.8	9.2	4.1	4.2	5.3	4.6	4.4
Developmental Screening	4.0	5.9	9.3	5.8	3.5	5.7	3.3	4.0
Perinatal Care Discrimination	4.3	7.0	9.8	3.7	3.8	4.7	4.3	3.5
Mental Health Treatment	4.2	6.8	7.6	4.7	3.9	5.3	4.2	4.1
Postpartum Visit	3.8	6.0	8.9	4.4	3.5	5.1	3.3	4.1
Postpartum Mental Health Screening	4.0	6.7	7.4	4.4	3.6	5.4	3.6	4.2
Food Sufficiency	3.9	5.9	8.4	4.8	3.6	4.6	3.7	4.1
Safe Sleep	3.3	5.6	8.3	5.3	3.5	4.5	3.2	4.0
Preventive Dental Visit	4.1	6.0	8.5	4.1	3.0	4.5	3.3	3.7
Medical Home	3.7	5.5	8.3	4.6	3.4	4.3	3.4	3.8
Tobacco Use	3.5	6.0	6.7	4.7	3.4	4.8	3.4	4.0
Physical Activity	4.3	5.9	7.8	4.8	3.0	3.8	3.0	3.9
Childhood Vaccination	3.6	5.7	6.6	5.7	3.1	4.3	3.4	3.8
Breastfeeding	3.6	5.0	7.4	5.5	3.2	4.2	3.1	4.0
Postpartum Contraceptive Use	3.7	5.2	7.4	4.7	2.9	4.6	2.9	3.6
Adolescent Well Visit	3.5	4.9	6.9	5.3	3.0	4.1	3.2	3.6
Transition	3.9	5.3	7.3	4.0	3.0	3.6	3.6	3.7
Bullying	3.3	5.3	7.0	3.7	3.0	4.0	3.5	3.3
Risk Appropriate Perinatal Care	2.4	5.2	6.4	4.8	2.8	4.5	3.2	3.1
Adult Mentor	3.0	4.4	6.5	3.4	2.4	3.3	2.7	3.2

Three NPMs – Housing Instability, Developmental Screening, and Perinatal Care Discrimination – featured the highest scores across the criteria (given in orange highlight) whereas two NPMs – Risk Appropriate Perinatal Care and Adult Mentor – consistently comprised the two lowest criteria scores (given in yellow highlight).

The scores were then added across the criteria to generate a composite total for each NPM. The table below lists the NPMs and their corresponding totals in descending order.

NPMs by Composite Score of Ranking Criteria (Descending Order).

Description	Total
Housing Instability	42.8
Developmental Screening	41.5
Perinatal Care Discrimination	41.1
Mental Health Treatment	40.8
Postpartum Visit	39.2
Postpartum Mental Health Screening	39.2
Food Sufficiency	39.0
Safe Sleep	37.8
Preventive Dental Visit	37.2
Medical Home	37.0
Tobacco Use	36.5
Physical Activity	36.4
Childhood Vaccination	36.1
Breastfeeding	36.1
Postpartum Contraceptive Use	34.9
Adolescent Well Visit	34.5
Transition	34.4
Bullying	33.0
Risk Appropriate Perinatal Care	32.4
Adult Mentor	28.8

The key informant interviews uncovered emerging issues and themes that were either not directly linked or were subtlety related to the final list of priority needs chosen. These included:

- **Perinatal Outcomes versus Racial Disparities in Perinatal Outcomes.** Although decreases in adverse perinatal outcomes (e.g., infant mortality) statewide was considered a strength, the key informants noted that racial disparities in such outcomes still persist. This distinction helped increase the recognition and corresponding scoring of the perinatal care discrimination NPM.

- **Telehealth Services.** Key informants also generally viewed telehealth services as an opportunity/solution for improving access to healthcare, especially in rural regions downstate. However, key informants emphasized that the widespread use of telehealth services since the COVID-19 pandemic cannot appropriately serve as a complete substitute for in-person visits.

- **Guaranteed Basic Income.** Guaranteed basic income was cited by three key informants to be a promising opportunity to help alleviate or mitigate rising housing and food expenses. However, the key informants also recognized the challenges of sustaining this effort.

- **Limited Access to Transportation**. Many stakeholders in both the key informant interviews and focus groups shared that limited access to transportation, particularly in Kent and Sussex Counties directly impacts the ability for individuals and families to access MCH-related services. This cross-cutting issue is not classified as a priority need given sustainability concerns. With that said, improving adequate access to transportation will continue to be an issue Title V stakeholders will keep in mind for other grants and partnership opportunities (e.g., working with rural-based non-profits, Delaware Department of Transportation) within the state.

One noteworthy factor that impacted the state's priority needs since the prior reporting cycle involved the increase in inadequate housing within the state. As evidenced in the feedback given in the stakeholder survey, key informant

interviews, and focus groups, housing instability has increasingly become a perversive issue referenced by multiple stakeholders.

Our Internal Steering Committee wanted to ensure that each of the five Title V population domains (plus the Cross-Cutting/Systems Building domain) was represented in the priority health area selection, and that all rules outlined in the Title V Guidance had been considered. In addition to selecting priorities that aligned with the National Performance Measures, the Steering committee also took in to account additional suggestions from the stakeholders for priorities that were outside of the scope outlined in the Guidance. Some of those health issues highlighted were infant mortality, community health factors, and mental health. Where possible, the Committee incorporated those suggestions as a feed to the National Performance Measures to ensure that the objectives and strategies focused not only on the stated measure, but also an additional perspective of the measure that was closely related.

In December 2024, both the average scores of ranking criteria for each NPM and NPMs by composite score of ranking criteria were provided to the Title V stakeholders once more. The participating stakeholders were asked to use these scores, discussion among the participating stakeholders, and insights provided by participating stakeholders with expertise and experience in the respective population health domains to score what NPMs would be prioritized for each population health domain. Using Retroboard, stakeholders were able to score the NPMs; the NPMs with the highest scores are listed in Figure 49. For ease, these were as follows by population health domain:

- **Women/Maternal Health**
  - Perinatal Care Discrimination
  - Postpartum Visit
- **Perinatal/Infant Health**
  - Housing Instability
- **Child Health**
  - Developmental Screening
  - Medical Home
- **Adolescent Health**
  - Medical Home
- **CYSHCN Health**
  - Medical Home
  - Transition

Figure 49. Highest Priority NPMs via Retroboard.

Finally, the chosen priority NPM(s) for each population health domain were then provided to the relevant DPH domain leader, who then made use of the MCH Evidence Strategy Planning Tool designed by Georgetown University and a state action plan template to help build out the NPM(s) for the state action plan. Each domain leader

scheduled meetings with stakeholders, family members, community partners, and other public health professionals to review the results of the Needs Assessment and identify the priority needs of each population health domain. These are the identified priority needs of Delaware for the next five-year grant cycle:

Women's Health:

- Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.
- Women have access to safe and supportive patient centered care, where their concerns are listened to, and they are included as partners in health decision making.

Perinatal/Infant Health:

- Ensure women and their families facing housing instability are connected to essential resources and services that can improve their housing outcomes.

Child Health:

- Children receive developmentally appropriate services in a well-coordinated early childhood system.
- Families know what a medical home is and have access to a medical home for their children.

Adolescent Health:

- Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening(s).

Children and Youth with Special Health Care Needs:

- All children, with and without special health care needs, have access to a medical home model of care.
- All CYSHCN receive the necessary organized services to make the transition to adult health care.

Cross-Cutting/Systems Building:

- Multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future.

Our Internal Steering Committee will continue to meet periodically through the upcoming year to ensure we are on track with our Priority Needs. We will continually assess the health needs of our population, Title V's program capacity, as well as Delaware's partnerships and ability to collaborate and coordinate efforts. We will continue to review up to date state and national data specific to our MCH populations. We will continue to use the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); and Delaware Health Statistics (birth records, death records, hospital discharge data).

Our team understands that we will need to periodically review our State Action Plan, including all previously selected Strategies, Objectives, and ESMs for each of our Priority Needs. Collectively, we will need to determine if any Strategies and/or ESMs have been successfully completed. In addition, our team may possibly need to identify new ESMs that could be incorporated into our State Action Plan moving forward. These new ESMs would then be added to the Plan to continue to strengthen Delaware's maternal and child health population.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,042,781	$2,073,458	$2,067,298	$2,126,787
State Funds	$9,957,273	$9,957,273	$9,783,792	$9,783,792
Local Funds	$0	$0	$0	$0
Other Funds	$0	$2,053,906	$0	$0
Program Funds	$2,053,906	$0	$2,580,255	$2,580,255
SubTotal	$14,053,960	$14,084,637	$14,431,345	$14,490,834
Other Federal Funds	$9,974,592	$9,974,592	$8,200,541	$5,849,820
Total	$24,028,552	$24,059,229	$22,631,886	$20,340,654

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,073,458	$2,123,731	$2,126,787	
State Funds	$10,016,039	$10,008,609	$10,148,719	
Local Funds	$0	$0	$0	
Other Funds	$2,659,797	$2,659,797	$0	
Program Funds	$0	$0	$2,761,872	
SubTotal	$14,749,294	$14,792,137	$15,037,378	
Other Federal Funds	$7,166,969	$6,064,837	$5,879,035	
Total	$21,916,263	$20,856,974	$20,916,413	

	2026	
	Budgeted	Expended
Federal Allocation	$2,123,731	
State Funds	$10,425,098	
Local Funds	$0	
Other Funds	$3,456,508	
Program Funds	$0	
SubTotal	$16,005,337	
Other Federal Funds	$7,166,969	
Total	$23,172,306	

Expenditures

The Delaware Division of Public Health (DPH) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. The Division of Public Health's financial policies and procedures are based on the requirements of the State of Delaware Budget and Accounting Policy Manual. As stated in the manual, it is "an essential element used to achieve the State's goals to gather data and to produce reports with the financial information needed to effectively plan activities and control operations for the services provided to the citizens of Delaware."

Procedures are in place to ensure that there is proper authorization for transactions, supporting documentation of all financial documents, and proper segregation of duties. In addition, DPH adheres to the guidance and memoranda of the Office of Management and Budget, the Department of Finance, the Division of Accounting, the State Treasurer's office federal rules and regulations, and Delaware Department of Health and Social Services/ Division of Public Health policies and procedures. DPH also adheres to the State of Delaware and Department of Health & Social Services (DHSS) policies and procedures regarding the use of state and department contracts.

DPH's record retention schedule is retained and approved by the Division of Public Archives. All records retention and destruction must first be approved by Archives, in accordance with the approved records retention schedule.

DPH and all associated programs are subject to periodic audits to ensure compliance with state and federal law, regulatory requirements, and agency policies.

Federal Block Grant and non-federal MCH Partnership expenditures are reported separately on Forms 2 and 3. Any significant variations from previous years' reporting are described in the field-level notes on those forms.

It should be noted that, per the definition of "direct service" in the Title V Block Grant guidance, Delaware funds minimal direct services with the federal Block Grant funds. We do, however, use state funds appropriated for infant mortality initiatives to pay for direct services provided by Healthy Women, Healthy Babies program providers.

Budget

Federal Block Grant and non-federal MCH Partnership budgets are reported separately on Forms 2 and 3. The total budget for our federal-state MCH partnership is $16,005,337
which includes our block grant award and state Maintenance of Effort funds, as indicated on Form 2.

When additional federal grants are included, the state MCH budget totals $22,348,453 Form 2 provides more detail on these other federal funds, which include the following grants: State Systems Development Initiative (SSDI); Early Hearing Detection and Intervention (EHDI); Maternal, Infant, and Early Childhood Home Visiting (MIECHV); (ECCS); Pregnancy Risk Assessment and Monitoring System (PRAMS); and Title X.

FY25 Budget – Federal Title V Funds

Personnel Costs **$1,540,942**

Salary, fringe, health insurance, indirect

Title V Maternal and Child Health Block Grant Funding has historically funded staff positions within the Division of Public Health's MCH services and programs, including the Smart Start/Healthy Families America home visiting program, Birth to Three, Adolescent Health, and Reproductive Health. As a result, most of the federal allocation of each year's MCH Block Grant award is budgeted for staff salaries, other employment costs (OEC), and indirect costs.

Contractual $567,789

All contractual funding will support the activities described in our action plan. Based on activities described in our 5-year action plan narrative, the following are budgeted amounts for each domain. The largest amount of funds will be used to support the Family SHADE mini grant project. Please note that we will also be working to align the work and responsibilities of the staff funded by the Block Grant with the activities laid out in the action plan.

Travel $10,000

To support key staff attending the federal/state partnership meeting as well as AMCHP.

Supplies $5,000

We are budgeting funds to support supply needs of our staff.

FY 25 TOTAL BUDGET $2,123,731

Spending Requirements

Maintenance of Effort
In FY89, the Delaware Division of Public Health allocated $5,679,728 in general fund dollars to Maternal and Child Health, including programs for Children with Special Health Care Needs. This figure serves as the base for determining our required maintenance of effort. For the current application, the state is allocating $13,881,606 in state funds to the Maintenance of Effort agreement. This includes support for 38 FTEs from state general funds and 5.6 FTEs from state appropriated special funds, as well as the appropriated special funds for infant mortality initiatives, developmental screening, and Nurse Family Partnership home visiting.

CYSHCN

The budget planned for FY 2025 meets the 30% requirement for CYSHCN. This requirement will be met through the following:

- funding for staff who serve CYSHCN and their families
- implementation of the Family SHADE contract
- operation of the birth defects registry
- support for the newborn metabolic and hearing screening programs

Preventive and Primary Care for Children

The budget planned for FY 2025 meets the 30% requirement for preventive and primary care for children. This requirement will be met through the following:

- funding for staff that provide services to infants and children 1-22
- programs supporting developmental screening such as Books, Balls and Blocks, QT 30
- promotion of availability of oral health services
- support for the implementation of the HMG program serving as the central intake for some of our early childhood programs as well assisting and referring families with children ages 0-8.

Administration

Less than 10% of our FY2025 budget is allocated for administrative costs. This category primarily includes funding for staff (salaries, indirects) who work to administer the Title V Block Grant (fiscal analyst, administrative assistant, etc), as opposed to staff who are implementing programs or delivering services. Small amounts for travel and supplies are also included.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Delaware

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

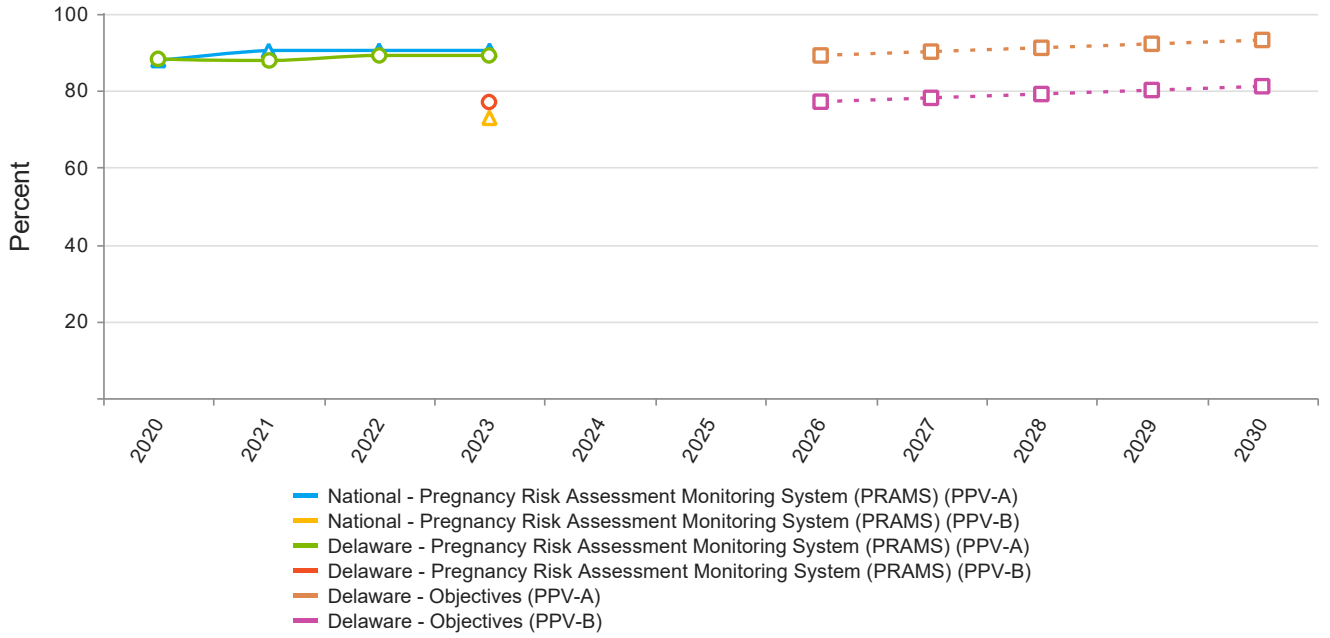
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	89.0	88.9
Numerator	8,744	8,290
Denominator	9,828	9,324
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	89.0	90.0	91.0	92.0	93.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	81.5	76.8
Numerator	7,046	6,240
Denominator	8,649	8,125
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	77.0	78.0	79.0	80.0	81.0

Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - 80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	70.0	75.0	80.0

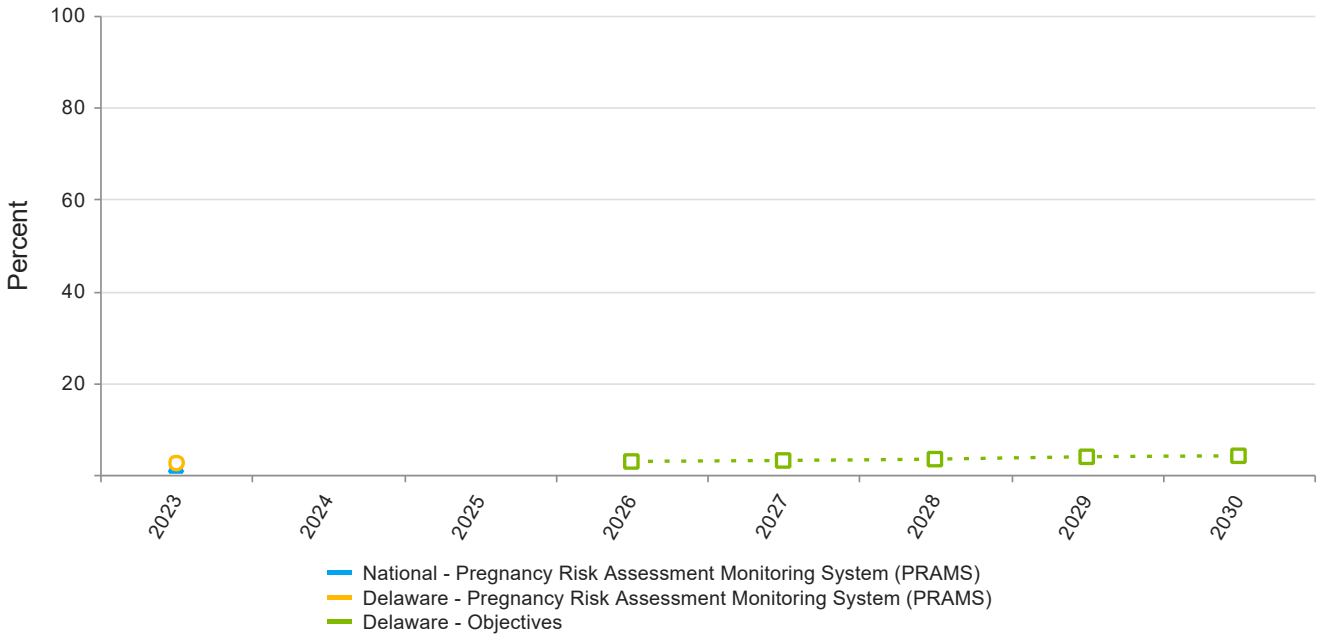
ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	70.7
Numerator	29
Denominator	41
Data Source	MIECHV Program Data
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

NPM - Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR
Indicators and Annual Objectives



NPM - Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR - Women/Maternal Health

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	2.8
Numerator	262
Denominator	9,283
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	3.0	3.2	3.5	4.0	4.2

Evidence-Based or –Informed Strategy Measures

ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	15.0	20.0	30.0	35.0	40.0

State Action Plan Table

State Action Plan Table (Delaware) - Women/Maternal Health - Entry 1

Priority Need

Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.

NPM

NPM - Postpartum Visit

Five-Year Objectives

Increase the percent of women participating in a MCH program (HWHB, Home Visiting) who have a postpartum visit within 12 weeks after giving birth.

Strategies

HWHBs Community Health Workers will serve as a liaison between patients and health care providers to improve access to postpartum care. Ensure that they are recruited, trained, and deployed to support postpartum care access and coordination.
HWHB programs will improve their data collection and reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are meticulously documented.
Train CHWs and track core competencies in perinatal health, postpartum care, and community engagement.
Evidence-based home visiting programs will support and assist women who have recently given birth in completing a postpartum visit within 12 weeks.
Build community awareness and the availability of doula services and that this services are now covered by Medicaid including 3 visits during the postpartum period.

ESMs	Status
ESM PPV.1 - 80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are	Active
ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.	Active

NOMs

Maternal Mortality
Neonatal Abstinence Syndrome
Women's Health Status
Postpartum Depression
Postpartum Anxiety

State Action Plan Table (Delaware) - Women/Maternal Health - Entry 2

Priority Need

Women have access to safe and supportive patient centered care, where their concerns are listened to, and they are included as partners in health decision making.

NPM

NPM - Perinatal Care Discrimination

Five-Year Objectives

Develop dissemination plan for Her Story 2.0 series to ensure broad and targeted reach, including community providers (e.g., DPQC, Ob/Gyn, Primary Care providers (MDs and Nurses), doulas, influencers) by December 2026.

Strategies

Develop Her Story 2.0 by engaging community partners, providers and women in uplifting information, patient navigation resources and expertise that can enhance maternal health initiatives and messaging. A series of videos will recognize the complex interaction of social context issues (i.e. implicit bias within the health system, reduced access to perinatal and postpartum care, food insecurity, lack of housing, SUD, etc.) in the lives of pregnant and postpartum women of minority status, and specifically Black women, which contribute to an increase in poor health outcomes.

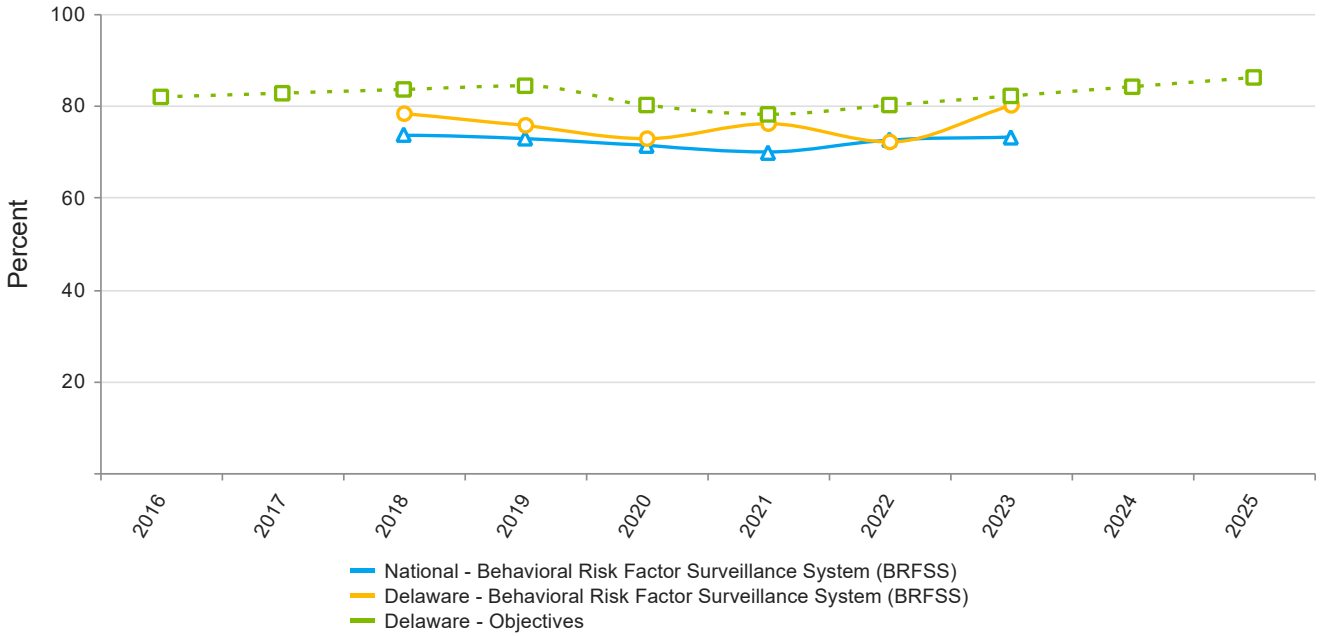
ESMs	Status
ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i	Active

NOMs

Severe Maternal Morbidity
Maternal Mortality
Low Birth Weight
Preterm Birth
Stillbirth
Perinatal Mortality
Infant Mortality
Neonatal Mortality
Preterm-Related Mortality
Postpartum Depression
Postpartum Anxiety

2021-2025: National Performance Measures

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80	78	80.0	82	84
Annual Indicator	75.6	72.8	75.9	71.9	80.1
Numerator	124,769	117,625	125,530	116,483	135,447
Denominator	165,041	161,675	165,284	161,938	169,192
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	17,000	17,250	8,500	9,000	9,500
Annual Indicator	8,488	8,015	8,109	9,937	10,618
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	86	88	90
Annual Indicator	88	84.2	86.1	89	92.4
Numerator			6,335	5,920	8,848
Denominator			7,354	6,655	9,574
Data Source	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Final	Final

2021-2025: ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		63	60	65	70
Annual Indicator	62	53.1	58.6	58.6	65.9
Numerator					2,618
Denominator					3,971
Data Source	Medicaid Claims Data	PRAMS data	PRAMS data	PRAMS data	PRAMS data
Data Source Year	2019	2020	2021	2021	2022
Provisional or Final ?	Final	Final	Final	Provisional	Final

2021-2025: State Performance Measures

2021-2025: SPM 1 - Percent of Delaware women with a recent live birth who indicated that their pregnancy was unintended.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	28	27	26	25
Annual Indicator	45.8	45	42.8	42.8	38.9
Numerator					3,890
Denominator					9,999
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2019	2020	2021	2021	2022
Provisional or Final ?	Final	Final	Final	Provisional	Final

2021-2025: SPM 2 - Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.

Measure Status:	Inactive - We are not continuing with this measure going forward. This data is not available as we have lost MCH Epidemiology capacity as well as timely access.

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5	5	5	5
Annual Indicator	4.6	21.1	21.1	21.1	21.1
Numerator		4	4	4	4
Denominator		19	19	19	19
Data Source	HWHB Program Data and Vital Statistics Data	HWHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data
Data Source Year	2019	2020	2021	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Women/Maternal Health - Annual Report

In the domain of Maternal/Women's Health, we continue to focus on increasing the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies. As in the past, our key priority is to find ways to reduce the maternal and infant mortality rate in Delaware and we understand the importance of preconception care, quality prenatal and postpartum care for our mothers. In order to continue making progress in providing "whole health" care to our women and mothers, we continue to bolster and nurture our community partnerships by working together focused on addressing the community risk factors, leveraging talents and resources, and striving to find new ways to provide services.

Over the last year, the Delaware DPH team work through the DHMIC committee infrastructure to develop one year action plans, to assist with implementation of the Five Year Delaware Healthy Mothers and Infants Consortium's (DHMIC) strategic plan. The MCH Director was involved in the strategic planning process, as well as several other MCH stakeholders that were involved in the Title V MCH Needs Assessment process and selection of priorities, which helped with alignment of goals and strategies. The DHMIC Five Year Strategic Plan is available on Dethrives.com and is driving our DHMIC Chair and Vice Chair who are two years into their leadership roles, and have a considerable task of onboarding and membership engagement activities. With the newly elected Governor Matt Meyer in January 2025, coordination and DHMIC governance and membership are at the center of discussions as well as elevating our strategic priorities. The DHMIC appointed members remain focused on the following aspirational goals:

1. The elimination of disparities between White, Black, and Hispanic infant and maternal mortality.
2. The reduction of pre-term birthrate from 11% to less than 7% to be the lowest in the country.
3. The development of an innovative model of care that addresses both the health disparities and the reduction in pre-term births.

The DHMIC leadership is still settling into their roles, responsibilities, with continued planning, preparation and reviewing historical documents to guide the new vision and direction. Dr. Priscilla Mpasi completed her second year as Chair of the DHMIC along with Tiffany Chalk, who served as Vice Chair. To help re engage members and revisit strategic priorities, the DHMIC had a retreat on December 16, 2024, whereby 11 out of 16 DHMIC appointed members gathered for an in-person meeting held at the Hilton Garden Inn in Dover, DE. A virtual session took place on February 21st via Zoom for the members who were unavailable to attend the in-person meeting. The meeting was facilitated by Liddy Garcia-Bunnel, Principal of Health Management Associates (HMA), several members from the Division of Public Health (DPH) were present for support, and the Vice-Chair of the Well Woman/Black Maternal Health (WW/BMH) Committee, Mona Liza Hamlin, was invited to the meeting space as well. The purpose of the meeting was for the members to review a list of DHMIC related items which included going through the DHMIC By Laws, mission, vision, strategic plan, an overview of the budget and state investment appropriated to DPH to support DHMIC and the DHMIC committee infrastructure was reviewed as well. The last 45 minutes of the retreat concluded with a private meeting strictly reserved for all DHMIC members to go over membership accountability and opened the floor for members to discuss the establishment of the DHMIC Executive Committee.

Staff in the Division of Public Health's Family Health Systems Section largely provide staff support to the committees, in addition to contractual staff support and help carry out and execute strategies to support the DHMIC's strategic plan. The current Committees and workgroups include:

- Well Woman/Black Maternal Health Committee - The focus of this committee is on a comprehensive, evidence-based approach to reproductive health and the health of women before, during, and after pregnancy - one that is woman-centered and clinician-engaged. The group functions to meet the often complex needs of reproductive-age women, particularly from more vulnerable populations, and works to foster leadership and information sharing, solicit voices of the consumer, encourage innovation, build awareness, and promote reproductive life planning. The purpose of the BMHW is to address the disproportionately high and unacceptable disparity rates of maternal mortality and morbidity in Delaware. Partners continue to be engaged around the theme to ensure all women of reproductive age in Delaware will be healthy and have access to safe, respectful, culturally appropriate maternal care before, during and beyond pregnancy.

  The Committee has been working on a blueprint to develop Her Story 2.0. The original vision of the Her Story

initiative was to elevate women's voices and develop women-centered messaging in different stages of life. The people initially involved were strategically selected to represent a group of women at various stages of their lives.

We now have an opportunity to reimagine Her Story with a stronger, dual call to action:

- Empowering women through the sharing of their stories
- Encouraging providers to gain a better and more accurate understanding of women's experiences.

By pursuing the goal of motivating women to talk about their stories, the initiative will create a platform for providers to hear directly from the women they treat. The target audience for Her Story 2.0 will be

- **Primary**: Women of reproductive age, focused on Black women and women with behavioral health challenges (SUD and mental health), across the life course (includes either prenatal or postpartum in Delaware)
- **Secondary**: Health care providers, including OBGYN's, primary care providers, and nurse practitioners who treat the primary audience

The goal is to support women and give them additional capacity to navigate the perinatal system of care. Another focused aspect is reaching clinicians and supportive staff with messaging, and increase awareness of resources provided on DE Thrives to treat patients with dignity and respect and provide quality care to all. Some topics and themes discussed include:

- Raise awareness of perinatal discrimination that occurs for populations disproportionately impacted by maternal and infant mortality
- Educate target populations on the importance of the fourth trimester and postpartum visit within 12 weeks after giving birth
- Empower/educate women to be advocates for their own health; educate them on what they need to know and ask
- Behavioral Health (SUD/Mental Health/Depression/Anxiety); Trauma-informed care,
- Maternal Health Warning Signs (i.e. complications such as infection and bleeding, pain and discomfort, high blood pressure, etc.)
- Acknowledging men's role in health outcomes for moms and babies
- Access and barriers to reproductive health care, perinatal and postpartum care (i.e. low socioeconomic status, racial discrimination, lack of social support, lack of adequate health insurance, etc.

Additionally, the workgroup members discussed potential outreach methods, metrics, community partners, potential challenges, and how to leverage Her Story 1.0 in our work moving forward.

2) One of the DHMIC Committees which seeks to understand where people live, work, play and pray can help create actionable engagement strategies to improve health outcomes by addressing social context factors. This group works to collaborate with the community, offer space for shared learning with providers, review policies and programs to identify opportunities for change, evaluate best practices, identify health needs, and engage the faith-based community. The Committee is focused focus on housing stability for pregnant and parenting women. The Delaware Healthy Maternal Infant Consortium, experienced a change in leadership and Representative Minor-Brown stepped into the role of Speaker of the House, thus, relinquishing her role as Co-Chair. Ray Fitzgerald, Executive Director of the Wilmington Housing Authority serves as Co-Chair, with newly designated Dr. Julius Mullen, with extensive background and expertise in non profit leadership, trauma informed care, brain science, mental health and youth development.

3) Data Committee – Over the last year, this committee has been redefined its purpose and re energized membership and has a new Chair, Dr. Alethea Miller and Vice Chair, Dr. Linsey Ashkenase. The mission of the Data Committee of the Delaware Healthy Mothers and Infants Consortium is to leverage timely and relevant data to effectively communicate and enhance maternal and infant health outcomes across Delaware. The vision is to be a

leading force in maternal and infant health, where data-driven insights lead to innovative solutions, equitable healthcare, and improved outcomes.

Education and prevention are a cornerstone of the DHMIC work, utilizing the latest social media platforms, particularly when it comes to increasing awareness of the importance of well woman care. In partnership with a social marketing firm, Aloysius Butler and Clark (AB&C), the Division of Public Health and several Maternal and Child Health (MCH) partners we continued to develop, update and launch messaging through the use of social media. We continue to post messages via short videos or reels, short animated posts to showcase interviews about our MCH work, blogs, Twitter, Facebook, YouTube, Instagram, and in the near future planning to maximize our reach by using LinkedIn, in which all MCH programs and initiatives and professionals participate and are showcased as a post and/or story so our messaging can be shown broadly on different social media platforms to reach different audiences , demographic, or general interests based on our user's life's stage. The branding tagline, Delaware Thrives, evolves around the theme that "Health Begins Where You Live, Learn, Work & Play to help encourage all to make healthier choices and to take action in their community." On April 14th, the DHMIC held its 19th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial, ethnic and geographical disparities that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. This year's theme was *Our Vision. Our Voices. Elevating Community Voices to Transform Maternal and Child Health.*

The summit sold out with 419 Eventbrite registrations, with nearly 380 in-person attendees (the venue's maximum capacity is 360), which included about 17 walk-ins. The event drew in many healthcare professionals, policymakers, community influencers, community partners, stakeholders, and citizens such as nursing students who were interested in learning ways on how to provide access to proper care for all Delaware mothers, before, during, and after pregnancy, their babies, and families no matter their socioeconomic, racial, or ethnic status.

DHMIC Chair, Priscilla Mpasi, MD, Lt. Governor Kyle Evans Gay, and DHMIC Vice-Chair, Tiffany Chalk, CMP, who was the emcee for the event, provided opening remarks on the importance of why we should continue the work to address maternal and infant mortality and morbidity in Delaware. State dignitaries including Speaker of the House and State Representative Melissa Minor-Brown (a former DHMIC appointed member) and Senator Marie Pinkney, a DHMIC appointed member, presented the Black Maternal Health Awareness Resolution in the morning. U.S. Senator Lisa Blunt Rochester also made an appearance in the afternoon sharing inspirational words on how she plans to continue providing services for the MCH population.

There was a total of 24 speakers throughout the day, which was made up dignitaries, DHMIC leadership, two keynote speakers, and four different breakout sessions. The presentations presented throughout the day ranged from topics on adverse childhood experiences (ACEs), patient centered care, how men could impact maternal health outcomes, an interactive session for a maternal and child health (MCH) hub blueprint, guaranteed basic income (GBI), and more.

Many information sharing strategies were available during the Summit such as a surprise poetry ready by the Poet Laureate of Delaware to kick off the Summit inspired by the voices and experiences of women during the postpartum period, a passport themed activity was offered to attendees to encourage group discussions and education with the innovation stations, also known as vendor tables, attendees were encouraged to submit family photos to be shared at the beginning of the summit to show Delaware families thriving, an interactive photobooth was offered, and attendees were given the opportunity to submit inspirational words shared on a projector screen during the event to go along with the *Our Vision. Our Voices* theme.

For the first time, DEThrives offered community organizations to submit a rate of proposal form to share what work they are doing in the community, which ultimately led most organizations an invitation to be one of the eighteen innovation stations at the event. The innovation stations were placed in a separate room which allowed attendees to learn about community services available throughout the state. A resource table was placed in the hallway where attendees had to pass to arrive in the main ballroom and in the separate breakout room where the innovation

stations were for supplemental hardcopy materials relating to the materials that were presented throughout the day. Bridget Buckaloo, a DHMIC appointed member, presented the annual Kitty Esterly, MD, Champion Award which recognizes a person and an organization who puts in the extra effort to address and change the root causes of infant mortality by improving the overall health and well-being of mothers and the community. The Delaware Healthy Mother and Infant Consortium (DHMIC) established the Champion award to recognize exemplary individuals or groups and organizations in the community that have made a significant impact in moving their communities along the process of increase positive health outcomes and promoting culturally competent healthcare workforce and environment. The award is named for the beloved Dr. Katherine L Esterly, a member of the DHMIC from its inception until her death. Dr. Esterly who was the first neonatologist in the state of Delaware worked tirelessly for the cause of infants, particularly the disadvantaged. Shawnisha Thomas, LPCMH, Thomas Clinical Consultation Services, received the outstanding individual award. The organization award was awarded to the Delaware Adolescent Program, Inc. (DAPI). The announcement of these awards on social media was a top post earning 299 engagements on DEThrives' social media accounts in April which earned almost 1K impressions for that post alone.

News of the 19th DHMIC annual Summit and its purpose were shared on six local and regional news media placements which was secured on three media outlets such as NBC10 (news of the summit was shared 3x from this outlet on April 14th), 6ABC (news of the summit was played 2x from this outlet on April 14th), and Delaware Public Media (the interview was published on May 2nd), where the DHMIC Chair, Priscilla Mpasi, MD, was interviewed. This resulted in an estimated of 460K+ impressions (number of times a post has been displayed).

During the 19th annual Delaware Healthy Mother & Infant Consortium (DHMIC) Summit, Delaware State Representative Melissa Minor-Brown and State Senator Marie Pinkney, who are also DHMIC members, presented the *Black Maternal Health Awareness Week Resolution.* The DPH/Family Health Systems team drafted the resolution to elevate this important week. The resolution states evidence-based data of Delaware's 5-year (2018-2022) infant mortality rate which is 6.1 deaths per 1,000 live births, which is above the 5-year national average of 5.5. For reference, Delaware ranks 34th in the nation for the highest prevalence of infant morality. Based on infant mortality data for the state of Delaware, there are 11.3 infant deaths per 1,000 live births, the 5-year Delaware Black (non-Hispanic) infant mortality rate is 3.3 times the 5-year White (non-Hispanic) infant mortality rate of 3.4 infant deaths per 1,000 live births. Statistics such as the above were shared throughout the week of BMHAW and the resolution was also read during the DHMIC Annual Summit.

In celebration of the Black Maternal Health Awareness Week (BMHAW) observance (April 11th – 17th), community voices and leaders read the BMHAW Concurrent Resolution on April 8th at Delaware's Legislative Hall. Community voices such as the DHMIC Chair Dr. Priscilla Mpasi, Vice-Chair Tiffany Chalk, Speaker of the House and State Representative Melissa Minor-Brown (a former DHMIC appointed member), Senator Marie Pinkney (a DHMIC appointed member), April Lyons-Alls the Director of MPA Program with Delaware State University, Mona Liza Hamlin Vice-Chair of the WW/BMH Committee, LaToya Brathwaite who is the Founder and Lead Practitioner of her business Mother, Baby, & Beyond LLC, and others were present to read and share the BMHAW Resolution. This resolution brings awareness to the unfortunate disparities that are present in Black (non-Hispanic) mothers compared to White (non-Hispanic) mothers.

Summit speaker presentations and photos and reels are repurposed on https://dethrives.com/summit and social media channels, including Facebook and Twitter.

Delaware has made a significant investment of resources to focus on addressing maternal mortality and morbidity and specifically, implemented many programs and interventions to reduce our racial disparity in infant mortality. According to the March of Dimes, women in Delaware are overall at moderate vulnerability to adverse outcomes based on their availability of reproductive health services with a clear increase in vulnerability across the southern parts of the state. Access to prenatal care varies based on race/ethnicity and poverty with almost half of Hispanic women living in higher poverty areas experiencing inadequate prenatal care (43%). Black non-Hispanic women in Delaware experience higher rates of preterm birth compared to other groups, thus putting their infants at risk for complications and death. Our work to address maternal and infant mortality and morbidity is spearheaded by the Center

for Family Health Research and Epidemiology, which is housed within the Family Health Systems Section, led by our Title V/MCH Director. These efforts are very much a part of our Title V federal state partnership and continue to be supported by $4.2M in state funding allocated to DPH for prevention of infant mortality. The DHMIC has undertaken an aggressive initiative to examine the health of women by taking a Life Course approach to both understanding and addressing the disparities that have led to the rise in black maternal and infant mortality in Delaware. DHMIC and its partners continue to engage the community at large, health care providers, policymakers, faith-based organizations, and African American influencers in understanding the impact of race-related constructs such as perceived discrimination on black women and their families.

The Title V MCH team works very closely with the Maternal and Child Health Review Commission, which currently sits in the Administrative Courts, and the data supports our prevention and education work to improve the health of women before, during and between pregnancies. By continuing to study the circumstances surrounding maternal and child deaths, we can strengthen support systems, address unfair and uneven conditions that can complicate pregnancies and births, and ensure that every child and family gets a strong, healthy start. Review teams that carefully consider each death are made up of dedicated partners in medicine, nursing, behavioral health, public health, insurers, social work, education, child welfare, forensics, law enforcement, and community advocacy. The Commission's Community Action Team (CAT) was also established over the last year and engages more public and community partners to interpret and act on recommendations from the review teams. The Delaware Healthy Mother and Infant Consortium (DHMIC) and the Delaware Perinatal Quality Collaborative (DPQC) do important work and collaborate to improve community-based and clinical care for women and infants. DPH works in partnership with the Maternal and Child Death Review Commission and co-leads two federal grants to support high-quality reviews of sudden child deaths, which includes funding from the Centers for Disease Control and Prevention (CDC) to participate in the Sudden Unexplained Infant Death (SUID) and Sudden Death in the Young (SDY) case registry. CDC support through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE-MM) grant funds dedicated staff to review maternal deaths and funds all initiatives and activities of the CAT to implement recommendations for improving maternal and infant health. Based on our current Delaware data, women who experience stillbirths and infant deaths, particularly when prematurity is present, often have multiple pregnancy-related, behavioral health and social issues that impact their overall health. Many women (40%) have a history of mental health conditions going into their pregnancy, and about one-third have symptoms of postpartum mental health issues after the loss. In addition, multiple life stressors, history of abuse—including domestic violence—social chaos and financial concerns are not uncommon, adding to the mother's overall stress and ability to cope.

The Maternal Mortality Review (MMR) Committee sits under the Maternal and Child Death Review Commission and reviewed 9 maternal deaths, also known as pregnancy associated deaths.in 2024. Noteworthy findings from these reviews include:

- Overdose continues to be the most common cause of death reviewed by the MMR team. Many women who were struggling with substance use disorder (SUD) also had a serious mental illness and social risk factors such as unstable housing, domestic violence or traumatic experiences.
- Most maternal deaths could be prevented. The Delaware MMR team votes on whether or not they think the death could have been prevented, and in the majority of cases they said yes.
- The late postpartum period, months after delivery, is when deaths are occurring. In the group of cases reviewed, all of the deaths occurred in the late postpartum period. This is contrary to what people may think is the riskiest period: it is not on the day of delivery but months later. Especially for women dealing with SUD and social stressors, the postpartum period can be a time when it is harder for them to get the support they need.

The MMR Committee members identified the following recommendations based on the 2024 cases:
1. To address the multiple kinds of stressors affecting women at risk, it is recommended that healthcare providers make more referrals to offer them the services of a care coordinator who can help women navigate the system to get the care they want.
2. To connect women at the time of delivery so they are set up for postpartum follow up, embed care coordinators, including nurse navigators, in delivery hospitals.
3. To reduce the occurrence of overdose deaths, it was recognized that it is important that providers have

discussions with women about harm reduction approaches to mitigate their risk of death—such as through the use of naloxone—even in the midst of living with SUD.

Due to the collaborative efforts from the Department of Health, the Delaware Maternal and Child Death Review Commission (MCDRC), the Delaware Perinatal Quality Collaborative (DPQC), and the Delaware Healthy Mother & Infant Consortium (DHMIC), a new toolkit was created for Providers to share patient materials to promote and educate women and their families on the Urgent Maternal Health Warnings Signs. The toolkit includes flyers, posters, double-sided tear off prescription pads, and a Provider Letter. These items can be ordered and delivered for free or can be downloaded here from the DEThrives.com site in English, Spanish, or Haitian Creole.

DPH is proud to share accomplishments resulting from implementing 11 Healthy Women Healthy Baby (HWHB) Zones community-informed strategies that aim to increase awareness, educate, better serve women of reproductive age and amplify the voice of black maternal health grass roots organizations. Since early 2020, 11 community-based organizations (CBOs) throughout Delaware have been funded and supported by this initiative to provide services, support, and community resources to women of color (and their partners and children). The CBOs want to help them live healthier, happier lives – with a long-term goal of reducing disparities in maternal and infant health outcomes. The primary focus over a five year cycle was innovation and to spread evidence-based programs and place-based strategies to improve the social factors of health, as a complement to our medical intervention, HWHBs 2.0. The first-ever mini grants supported the shared initiative to narrow the wide variance in birth outcomes between black women and white women by building state and local capacity and testing small-scale innovative strategies.

DPH worked with Health Management Associates (HMA), as the lead backbone entity, to develop a mini-grant process to fund local communities/organizations to implement interventions to address social factorsstr of health in priority high risk communities throughout Delaware. While the specific services and activities provided by the CBOs vary greatly, each CBO's work taps into a strategy or set of strategies that has been shown to be supportive of this long-term goal. The CBOs that were funded through the four funding cycles (between 2019 and 2024) of the HWHB Initiative included:

1. Black Mothers in Power
2. Breastfeeding Coalition of Delaware
3. Christina Cultural Arts Center
4. Delaware Adolescent Program, Inc.
5. Delaware Coalition Against Domestic Violence
6. Delaware Multicultural and Civic Organization
7. Hispanic American Association of Delaware
8. Impact Life
9. Parent Information Center
10. REACH Riverside (Kingswood)
11. Rose Hill Community Center.

Over the five years of the initiative, mini-grantees provided services to 4,129 individuals[1], primarily to women of color. Services provided by organizations were designed to meet the needs of pregnant and parenting women, many of whom were experiencing challenges with physical and mental health in addition to food and/or housing insecurity, social isolation, lack of childcare, and having significant challenges accessing medical care. Services provided include:

- Breastfeeding education and support.
- Career and professional development training.
- Case management and referrals to other services.
- Doula training and certification; education to providers about doulas.
- Education and social support to build healthy relationships and life skills.
- Fitness classes, self-improvement classes, wellness classes.
- Health access funds to help meet basic needs.
- Nutrition counseling, meal planning and recipes.
- Parenting education and support.
- Pop-up cashless grocery stores.

- Training to other providers.

Table 1. Healthy Women, Healthy Babies Mini-Grantees, Areas of Impact and Details about Impacts, Delaware, 2019-2024

Mini-Grantee	Key Areas of Impact	Details about Impacts
Black Mothers in Power	Increase the number of Black doulas in Delaware.	29 new doulas trained.
Breastfeeding Coalition of Delaware	Increase the rate and duration of breastfeeding.	79% of participants reported they were still breastfeeding at the end of seven months.
Christina Cultural Arts Center	Increase skills in self-care and parenting, sense of support and community, knowledge of child's development, and confidence in parenting and parents' well-being.	83% of parents report strong protective beliefs and behaviors.
Delaware Adolescent Program, Inc.	Increase healthy relationships among youth; empower youth to make decisions about the reproductive health and their future.	85% of participants completed a life plan and of those, 99% said they intend to use it; increases in beliefs of control over when they become pregnant, in using contraception or abstaining, and in setting and achieving goals.
Delaware Coalition Against Domestic Violence	Reduce financial stress and increase hopefulness of participants; provide counseling and referrals to needed health and economic supports; increase health care provider support; screening and referral of survivors for domestic violence services.	96% of participants reported feeling more hopeful. 82% of participants reported that receiving the flex funds reduced their financial stress.
Delaware Multicultural and Civic Organization	Increase healthy life skills and improved economic status; improve professional skills and job readiness.	100% of participants applied for at least one job after using the career counselor, and two-thirds discovered new career paths, developed new skills, and became more committed to their continued education.
Hispanic American Association of Delaware	Reduce participant stress, anxiety, and depression.	Participants had statistically significant reductions in stress.
Impact Life	Reduce food insecurity and improve access to healthy food options and nutritional education; improve physical health.	Participants highly value the program; receiving food has made a significant positive difference in their lives.
Parent Information Center	Increase the number of doulas, particularly women of color, in Delaware; increase awareness about doulas.	118 doulas trained and 109 women served by doulas, with high rates of satisfaction. There were statistically significant gains in knowledge
Riverside	skills; improve access to basic need items.	about being a good father.
Rose Hill Community Center	Increase participation in physical activities; knowledge, attitudes, intentions towards nutritional food options; and physical and mental wellness. Reduced stress.	Reduced stress, reduced weight, and improved health among participants.

Source: HWHB Mini Grantee administrative data, 2019-2024

One key component of the HWHB Zones initiative is the provision of coaching and technical assistance (TA) to the mini-grantees (and one unfunded organization) throughout the life of the initiative to build capacity and ensure

sustainability of the interventions, as well as focus on continuous quality improvement. In Grant Cycle 1, 2, 3, and 4 the TA consisted of two learning collaborative meetings as well as individual coaching and TA. Each mini grantee has a coach from HMA with whom they meet regularly. The frequency and length of coaching and TA calls and meetings over the last year were developed by each coach and mini grantee in collaboration.

In January 2021, as an expansion of the HWHB Babies Mini-Grant Initiative, the State of Delaware began implementing a Guaranteed Basic Income (GBI) Demonstration for pregnant women. The GBI Demonstration was created with input and support from DHSS, the DHMIC. Community partners included Rose Hill Community Center, the Delaware Coalition Against Domestic Violence, and Stand by Me, all of which provided services and support to the participants.

The GBI Demonstration provided $1,000 a month in the form of a debit card for two years to women who enrolled during their first or second trimester of pregnancy. Women had to have incomes below 185% of the federal poverty line to enrolled. Forty women enrolled in the Demonstration. Participants also received linkages to and guidance on prenatal care and post-partum care, financial coaching, and referrals for primary health care, mental health, and personal health and wellness. GBI was part of Delaware's HWHB Mini-Grant Initiative, which provided free services to pregnant women at risk of poor maternal and infant health outcomes.

The GBI Demonstration was designed to reduce stress, improve the physical and mental health of participants and their children, and improve maternal and infant birth outcomes. Additionally, the Demonstration was designed to reduce utilization of emergency departments and decrease hospitalizations, and to increase financial stability, housing stability, and employment stability.

As the HWHB Initiative ended its fifth and final year of implementation, evaluation data demonstrate that the program achieved its intended goals. Over the course of the GBI Demonstration, participants spent their stipend on basic necessities: food, household items, transportation, rent, Internet and phone, clothing, utilities, insurance, childcare, and personal hygiene. Across the 40 enrollees, nearly one-third of the stipends (between 27% and 30%) were used for food. Participants' physical and mental health improved throughout their participation in the Demonstration. Participants could make ends meet and felt they were a better provider for all their children. Participants appreciated the close relationships they built with their case managers and were closer to meeting their personal and financial goals. Some women found new jobs, bought homes, paid off debts, and improved their credit scores. The GBI program in Delaware was a smart investment with a very sizeable, positive return for participants, the state, and the local economy. This program, which combined monthly cash grants of $1,000 plus a cluster of important wrap-around services, improved the health of pregnant women, new mothers, and their babies. It also connected the women to important social and economic benefits including employment, food security, and safe and affordable housing. GBI also helped participants achieve financial self-sufficiency and reduce stress and anxiety. The ROI study of the GBI Demonstration showed that the investment in that part of the program paid for itself more than three times over and provided both immediate and lasting benefits to participants and their families.

Recognizing the potential of doulas to improve outcomes for our most vulnerable women and babies, the State of Delaware is exploring ways to improve access to doula care for this population, including Medicaid reimbursement. DPH and the Division of Medicaid and Medical Assistance (DMMA) under the auspices of the DHMIC have facilitated conversations with community stakeholders (including birthing hospitals) about the support doulas can provide to women prenatally, during labor and delivery and postpartum and what would be needed to move towards credentialing and Medicaid reimbursement. The DHMIC established a Doula Adhoc Committee, which was led by DHMIC member and legislator, Representative Mimi Minor Brown, addressed doula policy and reimbursement opportunities. While many of the services provided by doulas are nonmedical, there is evidence of the benefits of doulas to address health disparities and improve maternal and infant outcomes. This past year, the committee released a short issue brief summarizing its accomplishments and will likely sunset, as the DHMIC explores broader maternal health workforce challenges.

In 2023, DPH engaged doulas across the State of Delaware to gather their insights on issues related to training and

certification to inform the development of a statewide infrastructure to increase access to high quality doula are for women most at risk of poor birth outcomes in the state. The stakeholder engagement study aimed to gain an in-depth understanding of community-based doulas' knowledge, attitudes, feelings, beliefs and experiences in relation to training and certification, as well as other perceived needs in the state. Our specific research questions included the following: How do doulas perceive training and certification requirements for their practice? Assuming certification is required for Medicaid reimbursement, what core competencies do doulas believe should be included in approved training programs in order to meet the needs of low-income women and women of color? What supports do doulas believe are needed to better serve the Medicaid population in Delaware? Three focus groups were conducted in September and November 2022 for a total of 11 participants. A brief summary of findings:

- Training and Core Competencies – Any training required for Medicaid reimbursement should include full spectrum of care, from prenatal to postpartum. Cultural competency training is essential component. Need-based financial assistance for training should be provided to support access to doula care.
- Certification – Provide flexibility in training requirements and include a pathway for experienced doulas to waive training requirements.
- Education of Health Care Providers – positive working relationships between licensed providers and doulas is critical for the delivery of high quality, integrated care. Raise awareness about doulas' scope of services and the value they offer to birthing people.
- Doula Representation – Representation of doulas in policy making, from planning to implementation is essential.
- Professional Development & Networking/Mentorship Opportunities - the State or health care organizations should develop training, TA and support systems for navigating the Medicaid reimbursement process.

DMMA, per HB 343, passed in 2022 by the Delaware General Assembly, finalized a doula care services benefits package under Medicaid. Additionally, building off of HB 80, which required coverage of doula services under the State's Medicaid plan beginning in 2024, HB 362 broadened access to doula services and improve maternal healthcare outcomes for more individuals by extending similar coverage to private health insurance plans. As this evolves, it will be important to monitor access and maternal health outcomes, as there has been a very slow uptake. Additionally, DMMA explored Medicaid doula benefit designs in other states, including meeting with Medicaid leaders in California and Virginia on their benefit design and development. Building on lessons learned from Virginia, DMMA connected with their Certification Board to learn more about certifying doulas for Medicaid reimbursement. The selected Certification Board has worked with Virginia and Rhode Island to develop their approach to their Medicaid Doula certification process. In January 2024, Medicaid designed and launched the benefits package and reimbursement structure and process for Doulas seeking Medicaid reimbursement. There are minimum requirements for certification & training, reasonable reimbursement rates for both Doulas and Medicaid, and billing coverage if doulas enroll as independent providers. As of this writing, there are 14 Doulas enrolled in Medicaid as a provider. Our first birth with a doula certified by Medicaid took place in April 2024. This past year, Delaware amended our State Plan Amendment to allow for Medicaid doulas to receive 5 additional postpartum visits with the recommendation from a licensed clinician. Also, because many doulas see themselves as rooted in their communities and not necessarily the formal healthcare system, there is currently no single national doula network or standard of practice and we do not know how many doulas there are in the state/people interested in offering doula services, other than the data compiled from our two HWHBs mini grantees that trained Doulas in the State of Delaware.

Healthy Women Healthy Babies (HWHB) program 3.0, was implemented over the last year and will be monitored in the coming year using a framework focused on performance-based outcomes. DPH contracts with seven health providers to deliver the HWHB services at 20 locations across the state. The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial care for women at the highest risk of poor birth outcomes. DPH worked tirelessly in collaboration with the DHMIC and several MCH partners to review a recent release of a comprehensive evaluation of the program and specific birth outcomes to help inform plans for improving program quality. There was an important focus on incorporating a strong behavioral health component and emphasis on the postpartum period in the 3.0 model.

The HWHBs 3.0 program will continue to use an outcomes-orientation and learning collaborative approach throughout the contracting process and ongoing service delivery relationship. By focusing on outcomes, the program takes an approach that deepens funder-provider-participant mutual accountability in designing and delivering services focused on reaching a core set and minimum of 6 benchmark indicators (i.e. screening for pregnancy intention; increase women who have a well woman visit; screen for substance misuse; increase the proportion of HWHB participants that abstain from tobacco use; depression screening and referral; postpartum visit, etc.). Another important component to the program, providers are required to coordinate and collaborate with a Community Health Worker (CHW), Health Ambassador, Lay Health Advisor (LHA), or Promotora, defined as an individual who is indigenous to his or her community and consents to be a link between community members and the service delivery system, to further enhance outcomes for women and babies.

This year, we continued to support braiding funding streams to support community health worker expansion into high risk zones. The HWHB community health workers conduct community outreach in the high risk zones via a systematic approach in partnership with community based organizations to address well woman care aspects of health and social factors such as housing, transportation, food insecurity, and access to mental health services. In order to measure the impact of hiring, training and deploying community health workers to engage women of reproductive age and provide linkages to services and resources in the community, DPH developed a dashboard for the client referrals and goals documented by the community health workers (CHW) from from October 2020 to March 2025. In this time frame, 304 unduplicated clients were documented as having referrals and goals set with CHWs. In turn, 1,102 referrals and goals were reported among these 304 clients, which represents between three and four referrals (and goals) on average per client. We also monitor the number of clients by referral category as well as the number of times the clients were referred to the respective categories. For example, Food-related referrals were the most reported referral category by count of referrals (n = 241; 21.9 percent) followed by Baby Supplies-related referrals (n = 147; 13.3 percent), and Housing-related referrals (n = 137; 12.4 percent). These three categories represented almost half (47.6 percent) of all referrals reported.

There is strong evidence that home visiting supports good maternal and women's health outcomes. Since 2010, Delaware has competitively applied for and has been awarded the Maternal Infant Early Childhood Home Visiting Grant (MIECHV) funding through the Affordable Care Act. Funding is used to support evidence-based home visiting programs through increased enrollment and retention of families served in high risk communities. Delaware grant funds are also used to sustain and build upon the existing home visiting continuum within Delaware, which includes three programs including Healthy Families America (known programmatically as Smart Start) Nurse Family Partnership, and Parents as Teachers. The Maternal and Child Death Review Commission was very focused in their annual report and recommends that evidence based home visiting program referrals are essential to support pregnant women and supports the Delaware Division of Medicaid and Medical Assistance's (DMMA) efforts to reimburse for evidence-based home visiting services such as Nurse Family Partnership, Healthy Families Delaware and Parents as Teachers.

Delaware Division of Medicaid and Medical Assistance (DMMA) launched Medicaid reimbursement for evidence-based home visiting programs, and over the last year, while it has been painfully slow, the MCOs are finally making progress on negotiating a rate with the lead community based organization and partner, Children and Families First, which operates and delivers home visiting services (i.e. Nurse Family Partnership and Healthy Families Delaware) to women and families. While we have learned that there are a variety of approaches and mechanisms for reimbursement through Medicaid, movement on solidifying reimbursement for home visiting services is finally getting some traction.

School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public school setting and also contribute to better outcomes related to NPM 1 Well Woman Care. There is a growing interest for expansion to elementary, middle and additional high schools. School Based Health Centers are going through a paradigm shift, and there is a lot of stakeholder interest and commitment to understand national and in state innovations in practices and policies, and explore options moving forward to enhance SBHCs in Delaware within the local healthcare, education, and community landscape. Delaware currently defines SBHCs as health centers, located in or near a school, which use a holistic approach to address a broad range of health and health-

related needs of students. Services may also include preventative care, behavioral healthcare, sexual and reproductive healthcare, nutritional health services, screenings and referrals, health promotion and education, and supportive services. SBHCs are operated by multi-disciplinary health professionals, which includes a nurse practitioner overseen by a primary care physician, licensed behavioral health provider, licensed nutritionist, and or dental hygienist. SBHCs are separate from, but interact with, other school health professionals, including school nurses and school psychologists and counselors. SBHCs also operate alongside and interact with outside health care professionals and systems.

The Delaware Division of Public Health (DPH), in collaboration with several key stakeholders, completed a year long process to create a Delaware School-Based Health Center (SBHC) Strategic Plan, released in 2021. The planning helped DE develop a model for expansion of SBHCs that is both financially sustainable and anchored in best practices. The DPH Adolescent and Reproductive Health Bureau team is working on aligning staff to support implementation of the strategic plan, provide technical assistance to our medical sponsors and support expansion. A key strategy is to work closely with the Delaware School Based Health Center Alliance to assist with implementation, policy and best practices for delivering physical and behavioral health services to students.

Delaware's SBHCs provide important access to mental health services and help eliminate barriers to accessing mental health care among adolescents (i.e. women). Over the last five years, school district school boards voted and approved to add Nexplanon as a birth control method and offered at the school-based health center sites and as of this writing total 14 sites). This is a major accomplishment being that each school district's elected school board members vote on and approve what services can be offered at each SBHC site. Offering the most effective birth control methods as an option, gives more young women informed choices so that they can decide when/if to get pregnant and ultimately reduce unplanned pregnancies. DPH Title V MCH was awarded the three year Pediatric Mental Health Care Access grant in the amount of approximately $850,000 annually, and plans to include exploring collaborative strategies with schools and School-based Health Centers to expand and increase access to pediatric mental health care services, as well as build provider capacity and support.

Unplanned pregnancies are expensive and cost women, families, government, and society. Extensive data show that unplanned pregnancies have been linked to increased health problems in women and their infants, lower educational attainment, higher poverty rates, and increased health care and societal costs. And, unplanned pregnancies significantly increase Medicaid expenses. By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.

Launched in 2016, DE CAN (www.upstream.org/delawarecan/) improves access for all women to the full range of contraceptive methods, including the most effective, IUDs and implants. By implementing Upstream USA's whole healthcare practice transformation approach, DE CAN created a long-term system change for contraceptive access across Delaware. It includes three critical components to help break down barriers for all women accessing contraceptive care. First, it enabled health centers to make reproductive care a routine part of primary care by implementing a Pregnancy Intention Screening Question (PISQ) – a variation of the question, "do you want to become pregnant in the next year?" – at every healthcare appointment. Second, if the patient did not desire to become pregnant, DE CAN trained health centers to counsel patients on the full range of contraceptives available to them from most to moderate effective. DE CAN enabled health centers to be able to provide patients with their choice of contraception at that visit – the same day – by training administrative staff on business processes such as billing, coding and stocking devices. Third, DE CAN created consumer demand for contraception by developing consumer-marketing campaigns to educate women about their options for care and local provider clinics.

Delaware CAN included health centers that serve nearly 80% of women of reproductive age in the state. Nearly 2,000 women in Delaware took advantage of an "All Methods Free" program during the intensive intervention. Upstream hosted 130 trainings, trained nearly 3000 clinicians and staff from 41 partners representing 185 sites across DE. A key component of the model included quality improvement and implementation coaching that followed each training. During the quality improvement phase of the initiative, Upstream and health centers worked together

to remove barriers, implement patient centered contraceptive counseling, integrate pregnancy intention screening into the EHR and set up data collection to assess impact. The 41 partners served nearly 125,000 women of Delaware's approximately 190,000 women of reproductive age. The Division of Public Health's team, along with Upstream, USA worked closely with Medicaid and several MCH stakeholders to ensure that there were no policy barriers to all women getting same-day access to all methods of birth control, at low or no cost. The Delaware Division of Medicaid and Medical Assistance (DMMA) revised its reimbursement policy for hospitals providing labor and delivery services, so that they can offer their patients placement of IUDs and implants immediately post-delivery if patients request them. This change in policy promotes optimal birth spacing and increases access to this birth control method.
DPH has successfully integrated the nationally recognized Delaware Contraceptive Access Now (DECAN) initiative into the Family Planning Program, which sits in the Family Health Systems Section in DPH, where Title V MCH also resides organizationally. Since FY20, the program receives a consistent state GF investment in the amount of $1.5M and furthers the DPH's priority to sustain providing low cost access of all methods of birth control, including the most effective LARCS to low income women across the state. This initiative continues to improve public health by empowering women to become pregnant only if and when they want to by training staff on best practices in patient-centered care and shared decision-making, that will increases their knowledge of all contraceptive methods including mechanism of action, efficacy, risks, side effects and benefits.

In February 2024, DPH in collaboration with many partners and stakeholders were successful in promulgating regulations authorizing Pharmacists to dispense and administer contraceptives. With the regulations finalized, DPH is working on the implementation phase including facilitated small and large group discussions that result in clear action steps needed for the various components of this program, including training, resources, and payment for pharmacists as well as consumer support and awareness methods. The Adolescent and Reproductive Health Bureau team will support facilitation of the small group discussions as well as implementation.

The Division of Public Health's team, is working with five of the six Delaware birthing hospitals to ensure that all patients can receive the contraceptive method of their choice immediately after giving birth, including immediate post-partum LARCS. This change in policy promotes healthy birth spacing and give women more access to all methods of birth control. Currently the largest hospital system in the state, Christiana Health Systems offers these services, as well as Nanticoke Health Systems and Bayhealth Medical Centers. Beebe Medical Center has trained their providers and have implemented this service in the past year. The Division of Public Health continues to work with all hospitals statewide on training and technical assistance with these new processes and procedures.
Furthermore, Delaware's Division of Medicaid and Medical Assistance also implemented a reimbursement policy change approved by the Centers for Medicare and Medicaid Services (CMS) allowing the cost of long acting reversible contraception (LARC) to be carved out of the federally qualified health center (FQHC) prospective payment system (PPS) rate.

DPH has developed a Contraceptive Counseling training based on Upstream, USA's team approach patient-centered contraceptive counseling model and continues to provide support to Sub-Recipient Sites on sustainability of this initiative. This training is offered on a quarterly basis to all Title X Family Planning sites as well as Delaware Social Service Organizations to provide patient-centered contraceptive counseling for their clients experiencing challenges including substance use disorder, mental health issues, homelessness and domestic violence. A partner resource page has been developed by Upstream, USA so that tool kits and documentation are available to providers to support and sustain the project.
In 2024 the Delaware Family Planning program completed four full in-person DECAN training sessions across the state on February 21, 2024, May 21, 2024, September 24, 2024, and November 21, 2024. On July 10, 2024 a requested on-site DECAN training was given at Beebe Health the need of Beebe specific providers needing to be trained and certified in Nexplanon insertions and removals. These trainings included interactive conversations and games that cover topics such as the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and hands-on clinical Nexplanon and IUD training for clinicians. As of today, for 2025, we have completed one DECAN training session which was held on March 12, 2025. The DECAN program will have three additional trainings in 2025 on June 17, 2024, September 24,

2025 and November 20, 2025.

There was a total of 23 staff members in 2024 whom were trained on the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and cultural competency. There was 23 clinicians trained in Nexplanon insertions/removals and 20 clinicians trained on IUD insertion/removals. A total of 7 provider sites took part in the 2024 DECAN trainings including support staff and providers from Delaware Division of Public Health, Westside Family Healthcare, Beebe Healthcare, Tidal Health, LaRed Health Center, Coras, and The Rosa Health Center. So far in 2025 there has been 5 staff trained in the non-clinical portion of the DECAN training as well as 3 clinicians trained in Nexplanon insertion/removals and 3 clinicians trained in IUD insertion/removals.

To assess DE CAN's long-term impact, the University of Maryland in partnership with the University of Delaware, conducted a rigorous and independent evaluation of the intervention. The evaluation includes both a process and impact study and assesses outcomes such as contraceptive use, LARC utilization, Medicaid costs, and unplanned pregnancies resulting in unplanned births. The evaluation explored implementation and identifying key lessons learned to document, contextualize and deepen understanding of the impact of DE CAN. The evaluation involves eight distinct data collection activities and runs from 2016-2022. In September 2023, a final evaluation presentation was shared with key stakeholders. Data collection activities included: Title X patient survey, Delaware Primary Care Physician survey, interviews with women, male partner interviews, sustainability survey and stakeholder interviews and surveys. Some findings were shared:

- We find increases in LARC use for Title X adult patients
- We find increases in postpartum LARC use for Medicaid and non-Medicaid women
- We find increases in LARC insertion for teens enrolled in Medicaid, age 15-18.We do not find statistically significant results for LARC insertion for adult non-postpartum women in Medicaid, age 19-44.

[1] Total counts of individuals served by cycle of the initiative are higher because some individuals were served in one program in one cycle and then returned again later for different programming. In this report, unique individuals are counted only once. Additionally, one mini-grantee (Impact Life) could not count unduplicated clients served, so their number (1,333) likely is a duplicated count.

In May 2005, the Infant Mortality Task Force at the time issued a report that included 20 recommendations to reduce the number of Delaware babies who die before their first birthday (rate of infant mortality) and to eliminate the racial disparity in the rate at which these babies die. The infant mortality rate is generally regarded as proxy for the overall health of a community. Maternal age, chronic illness (asthma, hypertension, diabetes), nutrition, infection (STI, HIV), stress, unwanted pregnancy, smoking, and other drug use and lack of prenatal care are all factors that increase the risk of adverse pregnancy outcomes and maternal complications.

In 2005-2006, the Division of Public Health (DPH) and key stakeholders developed the infrastructure required to implement the Infant Mortality Task Force recommendations. To this day, DPH partners with Medicaid to develop policy and wraparound services supplementing direct care services for preconception, prenatal, and postnatal care. The Delaware Healthy Mother and Infant Consortium (DHMIC) was established by Governor appointment to monitor and evaluate implemented programs and services and adopts by-laws necessary for efficient functioning, election officers, appointments of members and meets on quarterly basis. Additionally, the DPH's Center Family Health and Epidemiology was established to provide scientific expertise and technical support to DPH and the DHMIC. The goal of the DPH staff are to help measure the impact of all programs that provide services in MCH, provide expertise in application for federal and other supplemental funding opportunities, and facilitate evaluation of all MCH-related programs. In addition, the CDC-assigned State MCH Epidemiologist was an essential team member and with the most recent federal RIFs, this leaves a very big gap in epidemiology support,research and data projects within the Center, and scientific technical assistance for all MCH-related projects. In the coming year, DHMIC and DPH and stakeholders will review our current interventions and framework for addressing well woman care, postpartum care as a key period of risk, and housing stability for pregnant women.

The nearly two-decade downward trend of the infant mortality rate in Delaware continues but there are still too many Delaware women with poor health outcomes during labor and delivery and postpartum as well as families that do not see their babies celebrate a first birthday. The Black infant mortality rate,11 infant deaths per 1000 live births, is still more than three times the White infant mortality rate of 3.4 infant deaths per 1000 live births.

It is noteworthy that the last five years also saw a more robust engagement of the working directly with communities to support women living in concentrated disadvantaged areas of Delaware. This effort has increased the footprint of health engagement beyond what Medical Legal Partnership and Home Visiting services were already providing in the focus population.

DPH led a comprehensive strategic planning process to develop a five-year plan for the DHMIC, which led to another huge paradigm shift, largely related to a change in leadership, whereby the Chair and Vice Chair with more than two decades of experience leading the DHMIC, both stepped down at the same time in the Spring of 2023. Over the next year, DPH and the DHMIC will continue to be focused on orienting new leadership, new members due to some recent vacancies and address themes captured during the DHMIC strategic planning process expressed by members and stakeholders: a desire for revisiting the committee structure and membership engagement, improved communications and transparency, and accountability strategies such as data dashboards to measure and report on success. In addition, with the gubernatorial election in January 2025, there is much education on maternal and infant health priorities to Governor Matt Myer's new established administration, the Title V team is preparing issue briefs and a summary of recent accomplishments of the DHMIC. Topics include the history, purpose, Title V MCH priorities, Delaware Code codifying DHMIC as well as the importance of the Governor appointed DHMIC in supporting statewide comprehensive initiatives to improve the health of women before, during and between pregnancies, address health disparities and improve birth outcomes in the State.

The DHMIC established the Healthy Women Healthy Babies (HWHBs) program in July 2009. A significant amount of state funds, approximately $4.2M, is invested in several infant mortality reduction initiatives as well as improved health outcomes for women and babies. The primary focus of the IMTF/HWHB funding has been to reduce the number of Delaware babies who die before their first birthday, and improve the health of women before, during and beyond pregnancy. The strategy has been to identify women at the highest risk of poor birth outcomes and to address any underlying medical conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk. The success of this effort lies in the fact that since its inception, our infant mortality rate had dropped almost 36% over the last decade of intense efforts and evidence-based program interventions. In the past few years, substantial funding has been directed at addressing the social determinants of health which are the major drivers behind the racial disparity. In in the coming year, DPH will continue to allocate state General Funds $1.5 million and will remain a priority. In addition, the DHMIC will continue to address housing instability and preventing pregnant women from homelessness aimed at improving maternal and infant health outcomes.

Delaware was recently awarded the State Maternal Health Innovation grant award, and DPH established a Maternal

Health Task Force. As part of the HRSA State Maternal Health Innovation Grant Requirements, the state established a Maternal Health Task Force to serve as a multidisciplinary advisory and coordination body. The Task Force was officially launched on March 31, 2025, and held its third meeting on May 16, 2025. Its primary focus over the coming year, is to reduce substance use disorder (SUD)-related deaths among pregnant and postpartum individual in Delaware. The Task Force brings together key stakeholders, including healthcare providers, public health professionals, behavioral health experts, community-based organizations, and individuals with lived experience, to identify system gaps, promote evidence-based practices, and guide the implementation of targeted interventions aimed at improving maternal health outcomes and preventing SUD-related morbidity and mortality.

To ensure continuous progress between meetings, committees have been formed and are actively advancing the strategic priorities. On April 29, 2025, the Task Force held listening sessions with 20 women living with SUD and 9 staff members from maternal and behavioral health programs. These sessions provided valuable insights to inform the design and delivery of services over the next year.

One major initiative underway that will evolve over the coming year, involves formalizing a Memorandum of Understanding (MOU) with a peer-led recovery support services nonprofit in Delaware, working with Impact Life, through the backbone organization, HMA. This partnership will enable the hiring, training, and certification of Peer Support Specialists as doulas, with the goal of deploying a workforce that is representative of and embedded within the communities it serves. The MOU is in development and execution is anticipated shortly, with hiring and training activities expected to begin soon thereafter.

Over the next year we plan to work collaboratively with the Delaware Division of Medicaid, who has a few initiatives focused on the post-partum period of risk. Dr. Alethea Miller, the MCH Clinical lead with DMMA is spearheading the following projects focused on pregnant women with mental health and substance use disorder. The projects they are doing right now are based on three goals:

1. Evidence-based practice that serve pregnant post partum women
2. Perinatal care and resources they need to address mental health or substance use disorder as well as non-medical needs.
3. Remove barriers to accessing and engaging in MH/SUD treatment and services.
4. Continue a program on evidence-based practices for breastfeeding. .

The HWHBs program aims to reduce the occurrence of adverse birth outcomes, infant mortality and low birth weight babies by providing support and services to high risk women during preconception and prenatal care for women who are at risk for poor outcomes. The goal is to provide assistive services to encourage the woman to maintain a healthy weight, nutritious diet, receive appropriate amounts of folic acid, manage chronic disease, address environmental risk factors such as smoking, substance abuse or other stress-inducing circumstances, as well as the development of a personalized reproductive life plan (for all women and men). The HWHB program has been nationally recognized by the National Association of Maternal and Child Health Programs for providing evidence-based preventive services beyond the scope of routine prenatal care.

The HWHB program is housed under the Division of Public Health in the Family Health Systems Section and has completed five years of the new refreshed model to improve preconception, prenatal, postpartum and birth outcomes of Delaware women, particularly those at increased risk. The new model, transformed in 2019, is a value/performance-based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health and incorporates the role of community health workers to further support outcomes. The Division of Medicaid and Medical Assistance (DMMA) was an essential partner in the transformation of the HWHBs 3.0 model and continues to play a role in the program's enhanced model and performance-based redesign. In the next year, we plan to continue to review benchmark data indicators and demographic data as well as explore data linkages of HWHBs 3.0 patient data with Medicaid claims data to monitor benchmarks and outcomes. The DPH team will evaluate whether the new model is moving the needle on producing evidence on improving health outcomes for women and birth outcomes.

The collaboration between DPH and the Division of Medicaid and Medical Assistance to improve maternal health outcomes is imperative and continues. Three years ago, Medicaid created a new position and hired a MCH Quality Assurance Administrator or clinical lead who is a Nurse Practitioner, and this position was vacant in November 2022 during a transition in leadership and was filled in the Spring of 2023. DPH reconvened monthly meetings with this position and will continue this relationship and partnership. The DPH Title V MCH team meets with Dr. Alethea Miller, who is currently in this position, to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies. In addition, Dr. Alethea Miller represents the Division of Medicaid and Medical Assistance as the designee on the Delaware Healthy Mother and Infant Consortium as an appointed member, serves on the DHMIC Annual Summit planning committee, and Co-Chairs the DHMIC Data Committee. Over the

next year, we plan to continue meeting on a monthly basis to discuss policy, programming and interventions impacting the maternal and child health population.

Over the next year, DPH in collaboration with DHMIC partners plan to address some of the underlying environmental, economic and social structures that impact resources needed for health, such as poverty, lack of stable housing, access to healthy foods, , medical legal partnership, financial literacy, etc. The plan for the coming year, is to discuss the findings with new DHMIC leadership, Committees and prepare recommendations that take into account the ROI, costs and sustainability, and explore alternative evidence based models, such as Family Connects, an evidence based home visiting program.

The Title V MCH team will be exploring the implementation of the Family Connects evidence-based home visiting model over the next year. Family Connects is an *evidence-based, universal nurse home visiting program* designed to support all families with newborns during the critical postpartum period. Through in-home assessments, education, and coordinated referrals, Family Connects strengthens families and aligns community resources for better health outcomes. The specific results and outcomes that Delaware would like to achieve, which this program has reported in Evidence-Based Trials:

- 50% reduction in infant ER visits & hospitalizations
- 28% drop in maternal postpartum anxiety symptoms
- 42% boost in community connections (highest among Hispanic and Black families)
- $3 savings per $1 invested, from reduced emergency care

In the coming year, Health Management Associates (HMA) will continue working closely with DPH and DHMIC to serve as a backbone agency (BBO) as part of the maternal and infant mortality reduction work to build state and local capacity and assist with identifying innovative strategies to shift the impact of social context factors tied to root causes related to infant and maternal mortality and morbidity. The primary focus is innovation and to spread evidence-based programs and strategies to eliminate the disparities in maternal and infant health outcomes. In addition, HMA will work with DPH and DHMIC to staff and facilitate the Social Determinants of Health Housing Workgroup, staff and facilitate a Governance and Membership Committee, the Well Woman/Black Maternal Health Committee and provide, and create shared dashboard reports and tools for quality improvement and overall evaluation. The identified HWHB high-risk zones continue to experience extensive and complex hardships that are driving poor maternal and infant mortality and morbidity rates. In partnership with DPH, HMA, DHMIC and maternal and child health stakeholders will use our local connections to identify possible new and/or current interventions to provide services, such as Family Connects, to needed communities in high-risk zones. DPH, working in partnership with HMA, remains committed to engaging nontraditional, community-based nonprofits in this work.

Implementation of the Delaware Healthy Mother and Infant Consortium (DHMIC) Five Year Strategic Plan will continue to be a priority in the upcoming year. Plans are underway to support the Governor appointed DHMIC Chair, Vice Chair, and new members and orient them to the current infrastructure, roles and responsibilities, programs and interventions, state/federal funding investments in maternal and infant mortality and morbidity and strategic priorities.

The Delaware Perinatal Quality Collaborative (DPQC) was established in February 2011 as an action arm and under the umbrella of the DHMIC and now functions as its own board and is charged to collaborate closely with DHMIC. The DPQC works to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through continuous quality improvement. Data collection and analysis is crucial to the DPQC's efforts to improve the care and outcomes of Delaware's women and their babies. The foundation of the collaborative is to share current data to use for benchmarking and quality assurance/improvement, identify best standards of care/protocols, realignment of service providers and service systems, continuing education of professionals and increasing public awareness of the importance of perinatal care. Member organizations (i.e. hospitals) agree to collect and report specific data elements relevant to the clinical priorities selected by the DPQC. The confidence that the quality improvement data that members share will not be released to the public. The quality improvement focus of the Collaborative requires that member-birthing institutions be able to share their quality data freely without concern that unauthorized persons may have access to information.

The DPQC is composed of representatives from birth hospitals and the Birth Center in Delaware. The collaborative benefits from the leadership of neonatologists, primatologists, nursing directors, hospital administrators and advocates. A Medical Director, who serves as a long standing DHMIC member, is a well-respected perinatologist and is also the Chair of the Maternal and Child Death Review Commission. The Medical Director and the Perinatal Nurse Specialist are tasked with oversight, education and technical assistance on workflow and process issues that will support changes in practice. The Perinatal Nurse Specialist effectuates changes in practices using academic detailing to explain and implement standards, enhancing access to information and resources, and assessing the program's impact on a continuous basis. The DPH, Center for Family Health Research and Epidemiology, receives and compiles data for quality improvement purposes and provides the cooperative with access to data and resources. In 2020, the DPQC was formally established

in Delaware Code and signed by the Governor during a virtual press conference. It was not until June 2023, that formal Governor appointments were first solidified, due to staff turnover, but in the coming year, DPH will be working on filling some additional vacancies. DPH did not have a role in identifying any of the representatives of the hospitals/birthing institutions. Those selections were coordinated by the Delaware Healthcare Association reaching out to the institutions and asking them for their representative. The plan is to update and set up structures to organize the work of the DPQC and process of filling vacancies for consideration by the new Governor's administration. The Bylaws were finally approved and adopted by the DPQC in 2024.

Data collection and analysis is crucial to the DPQC's efforts to improve the care and outcomes of DE's women and their babies. The foundation of the collaborative is to share current data to use for benchmarking and QA/QI, identify best standards of care/protocols, realignment of service providers and service systems, continuing education of professionals and increasing public awareness of the importance of perinatal care. Establishing the Collaborative in Code gives them the ability to:

- Enter binding memoranda of understanding among member institutions to hold each other accountable for sharing quality improvement data and for following the protocols for securely handling the shared data.
- Enter into agreements with data storage and or transmission companies to provide their services to the Collaborative to enable it to do its work.
- Apply for funding to support the work of the quality collaborative.
- The confidence that the quality improvement data that members share will not be released to the public. The quality improvement focus of the Collaborative requires that member-birthing institutions be able to share their quality data freely without concern that unauthorized persons may have access to information. The legislation would enable the collaborative to close some of its meetings to the public. Placing the DPQC in statute will allow for sharing of more confidential data and cases that could potentially be a violation of state data laws but are important for continuous quality improvement and learning among providers/ birthing institutions. (i.e. patient data protection including HIPPA). For example, even a medical chart review of 10 patients should not be shared publicly, but this is how the birthing hospitals/institutions learn from each other. The same applies to case reviews.
- Continue to function in cooperation with the DHMIC.

Achievements of the DPQC to date include the establishment of a maternal transport protocol, Neonatal Abstinence Syndrome (NAS) standards of care for mothers and babies, reductions in deliveries before 39 weeks when it is not medically indicated, quality improvement efforts to address obstetrical hemorrhaging, which is the major cause of maternal mortality, most recently develop a comprehensive State Maternal Health Strategic Plan as a result of a new U.S. Health Resources and Services Administration (HRSA) federal grant, State Maternal Health Innovation grant.

The following are DPQC goals and expectations for the coming year:

- ***Continuing Work on Addressing Persistent Severe Hypertension (SHTN) Among Delaware's Pregnant Women.*** To improve the provision of antihypertensive treatment for SHTN among pregnant women, the DPQC has incorporated the Society for Maternal-Fetal Medicine (SMFM) quality metric on timely initiation for the treatment of SHTN in obstetric patients. In August 2023, the DPQC leadership shared the SMFM quality metric ("Time to Treat") among its constituent six birthing hospitals. Between January 2024 and October 2024, the statewide percentage of obstetrical patients that reportedly had timely initiation for the treatment of SHTN increased from 54.5% (95% CI: 42.5%-66.5%) to 80.8% (95% CI: 74.5%-87.1%). Through this collaborative learning process, the number of obstetric patients identified with persistent new-onset SHTN has more than doubled in this time frame. These findings suggest that the DPQC and its six birthing hospitals have made considerable strides on both the identification of persistent new-onset SHTN among obstetric patients as well as appropriate implementation of the "Time to Treat" metric. These findings will be presented at a national conference in February 2025 and the efforts undertaken on this project will continue through this year.
- ***Determining the Effects of Low-Dose Aspirin (LDA) Administration on Reducing Severe Preeclampsia (PEC) Among Delaware's Pregnant Women.*** As a longstanding initiative, the DPQC and the six birthing hospitals have been conducting chart audits to ascertain whether pregnant women who are at risk for PEC were reportedly administered LDA prophylaxis. In 2025, the DPQC will be investigating the extent to which the incidence of PEC has been affected through the provision of LDA to at-risk patients.
- ***Integration of the Eat, Sleep, and Console (ESC) Protocol for Infants Identified with Neonatal Opioid Withdrawal Syndrome (NOWS).*** ESC protocol is a non-pharmacological approach for assessing and treating infants with NOWS. In 2024, all six birthing hospitals completed ESC training. As of Fall 2024, all six birthing hospitals are implementing the ESC module. In 2025, the DPQC will be assessing the impact of the ESC protocol on reducing (1) the length of hospital stay and (2) postnatal opioid treatment of infants with NOWS.
- ***Implementing a Fourth Trimester of Care Model.*** In 2024, DPQC assessed birthing hospital's postpartum care practices to inform a statewide fourth trimester care model. In the coming year, DPQC and the six birthing hospitals will implement a plan that ensures that all pregnant women have a postpartum visit

scheduled within two weeks of delivery. This model seeks to standardize information provided to pregnant women at hospital discharge, educate providers on the benefits of early postpartum visit, and identify/report on early postpartum warning signs. This model is also intended to help educate postpartum women on the importance of birth spacing and family planning, as well as linking postpartum women to resources needed to ensure the safety and wellbeing of themselves and their infant(s).

- ***Initiating State Maternal Health Innovation (SMHI) Focused on Perinatal Women with Substance Use Disorder (SUD).*** During 2025, DPQC will be carrying out the SMHI initiative to improve the health of perinatal women, with particular emphasis on enhancing care coordination and wraparound services for perinatal women with SUD. It is anticipated that this multi-faceted approach will help DPQC and other state partners achieve the following goals:
    - Improve access to care that is comprehensive, high-quality, appropriate, and on-going throughout the preconception, prenatal, labor and delivery, and postpartum periods.
    - Enhance state maternal health surveillance and data capacity.
    - Identify and implement innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and severe maternal morbidity (SMM).
- ***Continuing Other Initiatives.*** DPQC will continue hospital-based surveillance of SMM and obstetrical hemorrhage. This involves data sharing with federal partners such as the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Agency (HRSA) and working with the Delaware Maternal and Child Death Review Commission (MCDRC) to advance the shared mission to improve the overall health and wellbeing of perinatal women and their families.

Over the next year, DPH will also revisit the staffing infrastructure and support to the DPQC as well as implement a peer support doula specialists that support pregnant women with SUD, in light of the new State Maternal Health Innovation award.

Over the next year, we will continue incorporating preconception health education into the clinic-based setting, mainly through our family planning sites as well as our Healthy Women Healthy Babies provider sites. This is an excellent opportunity that will align and enhance Delaware's efforts to transform the HWHBs 3.0 program. Milestones include working with providers on implementing small tests of change in asking the Pregnancy Intention Screening Question at the practice site level and gathering data to report on this benchmark indicator, implementing preconception health education in practice based setting, development of education materials and social marketing messaging via DEThrives Facebook, Twitter, and blogs for patients, practice workflow, and prioritizing preconception screening of patients.

DE CAN Sustainability. DE CAN has paved the way for improving access to all methods of contraception, including LARCs. The statewide initiative has improved clinical counseling techniques based on best practices, increased same day access to birth control, increased number of patients screened for pregnancy intention, improved training of staff and clinicians, and increased patient awareness of family planning services. Several outpatient private providers in addition to our Federally Qualified Health Centers serving our most at risk women, are DE CAN provider sites. Many of these providers are already receiving funds (state and federal) through the Delaware Division of Public Health, as Title X/family planning providers or Healthy Women Healthy Babies providers. Essentially, the DE CAN initiative is now sustained building on the fabric of our family planning and reproductive health service provider network.

DPH is very pleased to share that there continues to be a sustained funding investment, since FY21, through State General Funds in the amount of $1.5M to support the sustainability and ongoing programmatic costs of Delaware Contraceptive Access Now (DE CAN). DPH in-kind support will continue through DPH and DMMA, a contractual MCH Epidemiologist (.15 FTE) as well as the State Pharmacy as a mechanism to track, store and distribute LARC devices to participating Title X network providers to support the ongoing sustainability, infrastructure and ongoing operational costs. In addition, DPH gained two (2) new state funded full-time FTEs to sustain limited program operations. At a minimum, the continuity of DE CAN ensures that health care providers (through the Title X network) who serve low-income uninsured women, are equipped to provide the most effective long acting reversible contraceptive methods. Furthermore, DPH continues to sustain limited training and technical assistance as designed by Upstream, in consultation with the Delaware DPH, to support the 39 community health centers[1] through attrition and staff turnover who serve the majority of low-income women.

The DECAN training plan for the upcoming year includes five in-person trainings which include both non-clinical and clinical portions. Each training session varies in number of attendees and audiences depending on the needs of providers/clinics but the preparation is usually geared towards 10-15 people. DECAN non-clinical trainings can now be requested for site specific locations or opt for a virtual training. The Family Planning team is currently working with the TAPP Network to build and develop a virtual training platform for the DECAN non-clinical training which will allow staff to register and participate in the training fitting into their schedule. The Family Planning Program will monitor participants and track completion through the new Learning Management System.

In addition, the Family Planning team is working with stakeholders to implement regulations that support a bill passed in 2021 that authorizes and permits pharmacists to dispense and administer hormonal birth control. The regulations help Delaware comply with the law and help establish a protocol to implement the law into practice. Over the next year, the Family Planning team will facilitate a forum of stakeholders planning todevelop a training curriculum for pharmacists as well as increasing awareness of the new regulation. The training will build off of the DE CAN training tailored to pharmacists. This will require research, planning, coordinating with the Board of Pharmacy, other stakeholders as needed and leveraging national technical assistance, and assembling a team to assist with developing a training curriculum.

In addition, DE CAN funding will continue to support a stock of LARCs for those birthing hospitals that provide LARCS immediate postpartum so that access continues for uninsured women. These funds will ensure that a system is in place to sustain access to the most effective methods of contraception, LARCs (IUDs and implants), to Delaware's uninsured and under-insured women of reproductive age.

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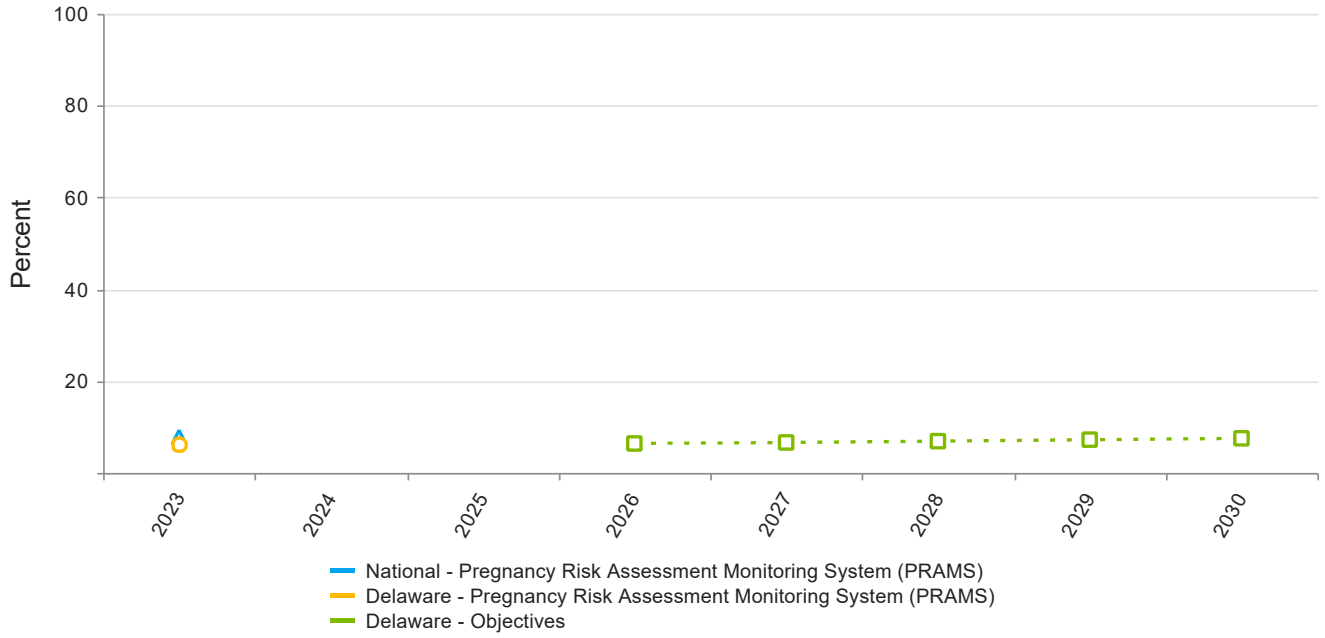
[1] In CY2024, Title X had a total number of 39 provider sites, including SBHCs that provide reproductive health services.

Perinatal/Infant Health

National Performance Measures

NPM - Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth - HI-Pregnancy
Indicators and Annual Objectives



NPM - Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth - HI-Pregnancy - Perinatal/Infant Health

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	6.1
Numerator	581
Denominator	9,474
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	6.5	6.7	7.0	7.3	7.6

Evidence-Based or –Informed Strategy Measures

ESM HI-Pregnancy.1 - Decrease the number of pregnant women facing housing instability.

Measure Status:	Active

Baseline data was not available/provided.

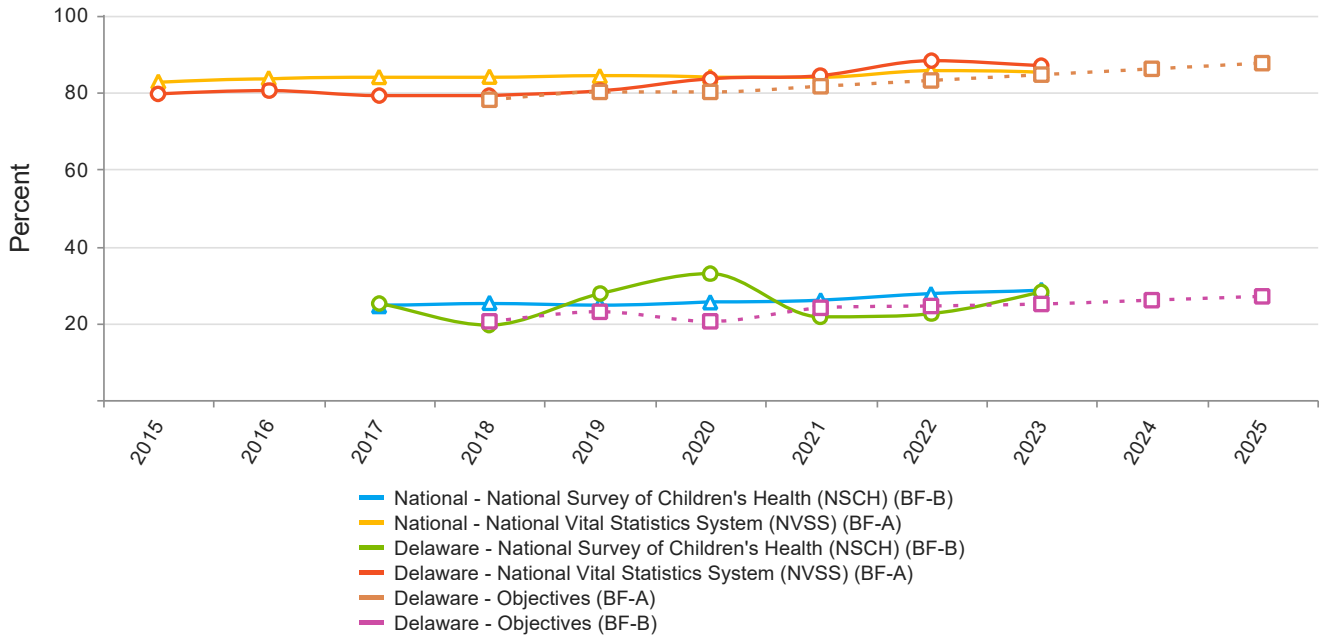
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	75.0	85.0	95.0

State Action Plan Table

State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 1	
Priority Need	
Pregnant and parenting women have stable housing and are connected to essential resources and services that can improve their outcomes.	
NPM	
NPM - Housing Instability - Pregnancy	
Five-Year Objectives	
By 2030, decrease the number of pregnant women facing housing instability.	
Strategies	
Partner with Community Legal Aid to prioritize services for pregnant women.	
Continue to partner with the DHMIC SODH Committee to implement the core set recommendations that have been developed to address housing instability for pregnant and parenting women.	
CHWs will screen the women they are serving for SODH related needs including housing and connecting them to appropriate resources.	
ESMs	**Status**
ESM HI-Pregnancy.1 - Decrease the number of pregnant women facing housing instability.	Active
NOMs	
Severe Maternal Morbidity	
Maternal Mortality	
Low Birth Weight	
Preterm Birth	
Stillbirth	
Perinatal Mortality	
Infant Mortality	
SUID Mortality	
Neonatal Abstinence Syndrome	
Postpartum Depression	
Postpartum Anxiety	

2021-2025: National Performance Measures

2021-2025: NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF Indicators



2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	84.5	86
Annual Indicator	88.1	86.9
Numerator	9,316	8,893
Denominator	10,573	10,234
Data Source	NVSS	NVSS
Data Source Year	2022	2023

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	25	26
Annual Indicator	22.4	28.0
Numerator	6,100	7,724
Denominator	27,226	27,596
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	58	60	62	64	66
Annual Indicator	47.9	57	55.3	48.2	48.2
Numerator				27	27
Denominator				56	56
Data Source	MIECHV program data	MIECHV program daa	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 2 - Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.

Measure Status:	**Inactive - We are not continuing with this measure going forward. This data is not available as we have lost MCH Epidemiology capacity as well as timely access.**

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5	5	5	5
Annual Indicator	4.6	21.1	21.1	21.1	21.1
Numerator		4	4	4	4
Denominator		19	19	19	19
Data Source	HWHB Program Data and Vital Statistics Data	HWHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data
Data Source Year	2019	2020	2021	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

According to the 2022 CDC Breastfeeding Report Card, 83.6 % of babies born in Delaware in 2019 were “ever breastfed or fed breast milk” ; equal to the national estimate of 83.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding initiation are lowest for Black, non-Hispanic infants, as well as infants in low-income households. These disparities are mirrored in the data for longer-term breastfeeding, with the overall rate dropping to just 25% of infants who are breastfed exclusively for 6 months; equal to the national average of 24.9%.

According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2021 data, the percentage of women who ever breastfed increased by 12% from 79.2% in 2012 to 88.6% in 2021 and currently breastfeeding (i.e., at the time of survey) increased by 23% from 48.8% in 2012 to 60.1% in 2021 among women with a recent live birth. There were differences in breastfeeding rates by race and ethnicity. For instance, based on PRAMS data, the 2021 prevalence of ever breastfed among Black non-Hispanics was 85.0% as compared to 88.0% among White non-Hispanics, 91.4% among Hispanics, and 96.7% among other races non-Hispanic. Similarly, the 2021 prevalence of currently breastfeeding (or at the time of survey) among Black non-Hispanics was 48.1% as compared with 64.4% among White non-Hispanics and 57.7% % among Hispanics, and 71.9% among other races non-Hispanic.

Delaware scored a 93 again this past year on the 2024 mPINC is CDC’s national survey of Maternity Practices in Infant Nutrition and Care with several indications receiving 100.

The Delaware WIC Program has sustained breastfeeding community partnerships for more than eighteen years. These partnerships include Christiana Health Care Systems (the largest birthing hospital in the State), The Latin American Community Center, Westside Family Healthcare, Nemours Childrens Hospital, and the Food Bank of Delaware. Because of these partnerships, WIC continues to take breastfeeding support to the heart of the community. Other partnerships include: The Breastfeeding Coalition of Delaware, The Delaware Healthy Mother and Infant Consortium, and the Perdue Chicken Plants of Milford and Georgetown Delaware. In concert with these partnerships the Delaware WIC Program has been able to reach approximately 80% of its eligible population.

The DE WIC program is awaiting FY 2025 participant breastfeeding survey findings from the Gibbous Group. These finding will be used to assess current program successes and opportunities to improve program operations. According to the Gibbious findings in the First and Second Quarter Report and the WIC WOW Data System:

- Breastfeeding initiation at increased by 4% in the last two quarters
- Breastfeeding Initiation rates in the WIC population has increased by 2% from the 1st to the 2nd quarter
- Exclusivity increased by 3% from the 1st to the 2nd quarter
- 12-month Duration remained level during the 1st and 2nd quarter

WIC programs offer peer counselors. “Peer” means that the counselor has breastfeed their own baby and can help other mothers breastfeed. According to Gibbious findings of the second quarter, a participant contacted by a peer counselor is 95% more likely to be breastfeeding at 3 months and 81% more likely to be breastfeeding at 6 months.

Delaware WIC offices offer remote and in person visits for breastfeeding moms. DE WIC also offers virtual breastfeeding classes. These classes have been successful and will continue to be offered. Classes are offered in English, Spanish and Haitian-Creole. Currently, classes are offered the first and third Wednesday of each month at 11am and 5pm, as well as a third breastfeeding class on the third Saturday of each month starting at 11am.

Delaware created and launched a website to capture nutrition education, with extensive information on breastfeeding that was once only offered to participants in the form of physical literature. They now will have this vital education wherever they are from their mobile device. This site can be accessed here: https://delaware.wicresources.org/breastfeeding/.

The DE WIC program is pleased to share the findings of the most recent participant survey launched Spring 2024. The survey revealed a 97% Satisfaction Rate with WIC services, based on willingness to refer the WIC program to a friend or colleague.
The survey was successfully sent out via the WIC program’s texting service used to communicate events, helpful suggestions, and appointment reminders. Of the 220 Participants who answered the survey, 85% found the texting service was useful with others giving suggestions to further refine the program’s messages and timing. When asked about their experiences with WIC clinics, 87% were happy with the quality of services, 82% were satisfied or very satisfied with WIC staff, and 81% found appointments were easy to schedule.
Participants shared that the majority of those responding had talked with a Breastfeeding Peer Counselor and 96% felt the experience was good to excellent. Participants sought help from peer counselors on topics such as breastfeeding goals, latching techniques, pumping, and emotional support. All findings will help inform future improvement efforts while also providing an opportunity to thank staff for the great results!

DE WIC built a cross-functional team that includes WIC program staff, local clinic staff, birthing hospital leadership, and community peer counselors to meet quarterly to review the latest breastfeeding rates and develop big and small strategies to enhance the peer counselor role and breastfeeding supports across the state. In coordination with the team, the WIC program does an annual survey of participants to identify issues and inform participant-driven strategies. Some initiatives that the Delaware program has successfully implemented include a major push to inform moms of their breastfeeding rights, increased breastfeeding awareness by state employees in co-located facilities and integrating the peer counselors into the WIC clinics to support groups and foster one-on-one interactions. The team has recently begun looking at service patterns and seeing where targeted intervention can improve supports. The WIC team is also exploring the use of telehealth with our WIC Breastfeeding Peer Counselors in providing virtual breastfeeding classes to our WIC moms.

On August 18th, 2023, DEThrives in conjunction with the Delaware Healthy Mother Infant Consortium (DHMIC) published an Op-Ed on DelawareOnline/The News Journal to encourage the community to understand the WHY of breastfeeding. Charmain Sampson, International board-certified lactation consultant (IBCLC), a Health Program Coordinator of the Delaware WIC Program, authored the piece.

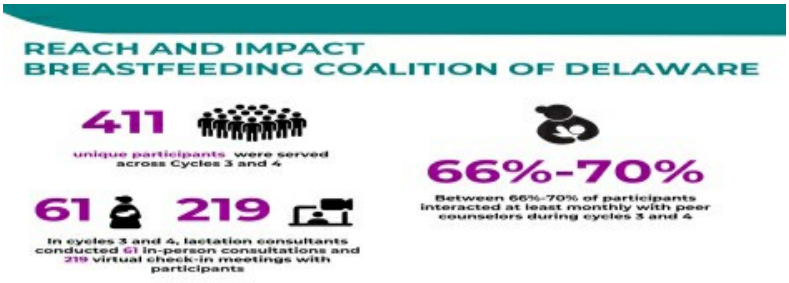
Between August 24th – September 7th, DEThrives ran a short animated video about the benefits of breastfeeding for mom and baby. The ad targeted those who were pregnant and parents of children aged 0-2 years old. This August promotional post (linked back to the DEThrives breastfeeding blog) earned the most engagement (likes, comments, shares on the post) during the quarter, garnished over 18K video plays, reached over 12K people, gained over 22K impressions (number of times a post has been displayed), had 56 link clicks (# of times a user clicked on the ad), and had a frequency (number of times a user is exposed to an ad during the ad run dates) of 1.88 (2.76 was the average frequency for this quarter – July through September 2023).

The Breastfeeding Coalition of Delaware was one of the awarded community-based organizations through the DHMIC Healthy Women Healthy Babies Zone project for Cycles 3 and 4 (January 2021-June 2024). The Delaware Breastfeeding Village is an incentive based breastfeeding program that brings families together who may be at high risk for breastfeeding barriers. Black mothers, mothers from low-income families, mothers experiencing housing instability, and non-English speaking mothers are at high risk and are offered text support and monthly breastfeeding education and groups. The program consists of two, 6-month cohorts. In each 6-month cohort, there is a monthly 1-hour breastfeeding education session. Additionally, participants are offered ongoing support and engagement with peer counselors. In Cycle 3, it is intended that there will be 75 mothers per cohort for a total of 150 mothers at the end of 12 months. Process Data Demographic information from the mothers is captured during their initial application and attendance at the breastfeeding education sessions is tracked. Additionally, peer counselors and the IBCLC log their encounters with mothers and the supplies distributed and staff complete timesheets each month to track hours spent supporting the mothers.
Intended outcomes of the program include:
1. Increased breastfeeding duration
2. Identification of most important breastfeeding barriers among new mothers.
3. Identification of the most important supplies used to overcome breastfeeding barriers 4. Increased awareness of the level of staff engagement required to improve breastfeeding behaviors
5. Increased satisfaction with the breastfeeding program Beginning with Cohort 2, participants are completing periodic surveys after breastfeeding education sessions.

These surveys ask mothers about their current feeding methods, breastfeeding exclusivity and duration, any breastfeeding difficulties, overall experience with breastfeeding, what they have learned in the program and any impacts of participating in the program. These data will be available in the next Cycle 3 report.

Pay for Performance Data measures for BCD include the following:
• Process Measure: Peer counselors will have least 1 touch per mother for each month of the 6- month cohort.
• Outcome Measure: At least 50% of the mothers will report offering at least some breast milk to their baby at 6 months.

In Cohort 1, peer counselors have at least one touch per month per month with 72% of the mothers. To meet their P4P measure, BCD will need to increase their touches with mothers. In terms of their P4P outcome measure, as of the end of the first cohort in Cycle 3, 85% of mothers report that they are offering their baby breastmilk. BCD's evaluation has not changed since its initial implementation at the beginning of Cycle 3 however, coaches are beginning conversations with BCD about incorporation of national benchmarks into future evaluation work.



After conducting our required MIECHV benchmark evaluation this past, we were slightly above the national threshold of 43.3% with 48.8%. The percentage of infants aged 6 to 12 months who were enrolled in home visiting for at least 6 months and were documented to be breastfed for any amount at 6 months of age was almost 50 percent which although higher than national, it's still low and something we will continue to focus improvement efforts on. Breastfeeding initiation has been an ongoing state priority for the DHMIC as well as for Title V, so it makes sense for MIECHV to align with our priorities.

We have accomplished much in the last years around breastfeeding and although breastfeeding did not rank as the number one priority for our Title V program to address in the perinatal/infant domain, we will continue with various activity.

We will continue to utilize social marketing techniques to influence women's decisions around infant feeding. Promoting messages and materials through our DE Thrives website is one strategy. The Delaware Division of Public Health (DPH) and the Delaware Healthy Mother & Infant Consortium (DHMIC) are dedicated to awarding mini grants to support local organizations whose results-driven work strives to reduce infant and mother mortality as well as morbidity among high-risk women in Delaware.

Finally, we will continue to support our home visiting program to ensure that home visitors have the expertise and supplies they need to support women in breastfeeding. This will include helping a core set of staff, spread geographically across the state, to earn and maintain the IBCLC credential when requested. We are hoping to have home visitors with IBCLC certification within all of our evidence-based home visiting models (Nurse Family Partnership, Healthy Families America and Parents as Teachers).

Perinatal/Infant Health - Application Year

Following the 2025 Needs Assessment process, a new priority was identified within the Perinatal Health Domain: reducing the percentage of pregnant women and children experiencing housing instability. This priority aligns with Healthy People 2030 Objective 4, which aims to decrease the proportion of families spending more than 30% of their income on housing (baseline of 34.6% in 2017 to a target of 25.5%).

Safe and secure housing is a fundamental social determinant health. Housing instability can include a variety of challenges, such as difficulty making housing payments, overcrowding, moving frequently, eviction, and homelessness.[1] In pregnancy, housing instability is associated with inadequate prenatal care and adverse birth outcomes, including low birthweight and preterm birth.[2] Housing instability, particularly in early childhood, is linked to poor health and development.[1,3] Homelessness is the most extreme form of housing instability. The highest risk period for sheltered homelessness is the first year of life and families with children comprise a third of all sheltered homeless people.[4] Housing instability disproportionately burdens those with lower income and Black and Hispanic populations.[1,2,3,4]

The Maternity Vulnerability Index (MVI)[5] serves as a tool to understand where birthing people in each state may be more likely to have poor outcomes, including preterm birth and maternal death, due to clinical risk factors and other social, contextual, and environmental factors. The index ranges from 0 (least vulnerable) to 100 (most vulnerable). One of the MVI themes – Physical Environment – measures environmental factors that influence maternal health outcomes including crime rates, housing, pollution, and access to transportation.

As given in Table 1, Delaware's overall MVI (62) classifies it as having a high maternal vulnerability index, which contrasts with its neighboring states of Maryland (48; Moderate), New Jersey (38; Low), and Pennsylvania (58; Moderate). Delaware's physical environment theme score (68; High) is also high and similar to that of its neighboring states.

Table 1. Physical Environment Domain and MVI for Delaware, Delaware Counties, and Neighboring States (Surgo Health, Maternal Vulnerability Index, 2023).

	Delaware	Kent County	New Castle County	Sussex County	Maryland	New Jersey	Pennsylvania
Physical Environment	68 High	76 High	65 High	57 Moderate	74 High	68 High	64 High
Overall MVI	62 High	69 High	46 Moderate	55 Moderate	48 Moderate	38 Low	58 Moderate

In addition, note that Housing & Shelter was the most reported request by 2-1-1. Between January 1, 2022 and December 31, 2023, there were **33,810 Housing & Shelter requests** to 2-1-1, which corresponds to **32.5 percent of all 2-1-1 requests.**

The estimated percentage of women who stated that they were homeless in the 12 months before their baby was born was highest among Black non-Hispanic women as compared to the other race/ethnicities examined (Figure 1). In addition, in Delaware, the percentage of Black non-Hispanic children residing in supportive neighborhoods was lower than the corresponding percentages of White non-Hispanic and Hispanic children (Figure 3).

The Social Determinant of Health Committee of the Delaware Healthy Mother Infant Consortium (DHMIC) which seeks to understand where people live, work, play and pray can help create actionable engagement strategies to improve health outcomes by addressing social context factors. This group works to collaborate with the community, offer space for shared learning with providers, review policies and programs to identify opportunities for change, evaluate best practices, identify health needs, and engage the faith-based community. The SDOH Committee is

focused on housing stability for pregnant and parenting women. The Committee experienced a change in leadership when Representative Minor-Brown stepped into the role of Speaker of the House, thus, relinquishing her role as Co-Chair. Ray Fitzgerald, Executive Director of the Wilmington Housing Authority serves as Co-Chair, with newly designated Dr. Julius Mullen, with extensive background and expertise in non-profit leadership, trauma informed care, brain science, mental health and youth development.

Homelessness and housing instability increases the risk of pregnancy complications and worse health for mothers and babies. Over the last year, the housing workgroup was established under the DHMIC SDOH Committee, and is comprised of housing authorities, housing alliance, managed care entities, Delaware Coalition Against Domestic Violence, University of Delaware, Governor's Office, and two Sections within the Division of Public Health, and developed a set of core recommendations:

1. As part of Delaware's **central intake waiting list**, indicate and prioritize high-risk pregnant women who are unstably housed for HUD's Housing Choice Vouchers.
2. Utilize **TANF Surplus dollars** to create a pilot program with the Division of Public Health as the referring entity to obtain state rental assistance program, SRAP, vouchers for high-risk unstably housed pregnant women.
3. Support multiple **safe and secure options along the continuum**, including maternity villages or homes, voucher assistance, and permanent supportive housing.
4. Advocate to remove **restrictive zoning** to increase the affordable housing stock in Delaware, and support expansion of **home ownership** programs operated by housing authorities.

Health Management Associates (HMA) was hired contractually by the Division of Public Health to analyze conditions in Delaware that would inform the work of these two committees, including housing stability, enrollment size and criteria, funding availability, and evaluation needs. As part of this, HMA will support the DHMIC to reengage key stakeholders in a discussion on housing insecure pregnant women, and the Housing Workgroup, which was established in June 2024 to help identify new policy, program and opportunities to improve the system. In addition, the DHMIC will continue to address housing instability and preventing pregnant women from homelessness aimed at improving maternal and infant health outcomes.

Over the next year, DPH in collaboration with DHMIC partners plan to address some of the underlying environmental, economic and social structures that impact resources needed for health, such as poverty, lack of stable housing, access to healthy foods, , medical legal partnership, financial literacy, etc. The plan for the coming year, is to discuss the findings with new DHMIC leadership, Committees and prepare recommendations that take into account the ROI, costs and sustainability, and explore alternative evidence-based models, such as Family Connects, an evidence-based home visiting program.

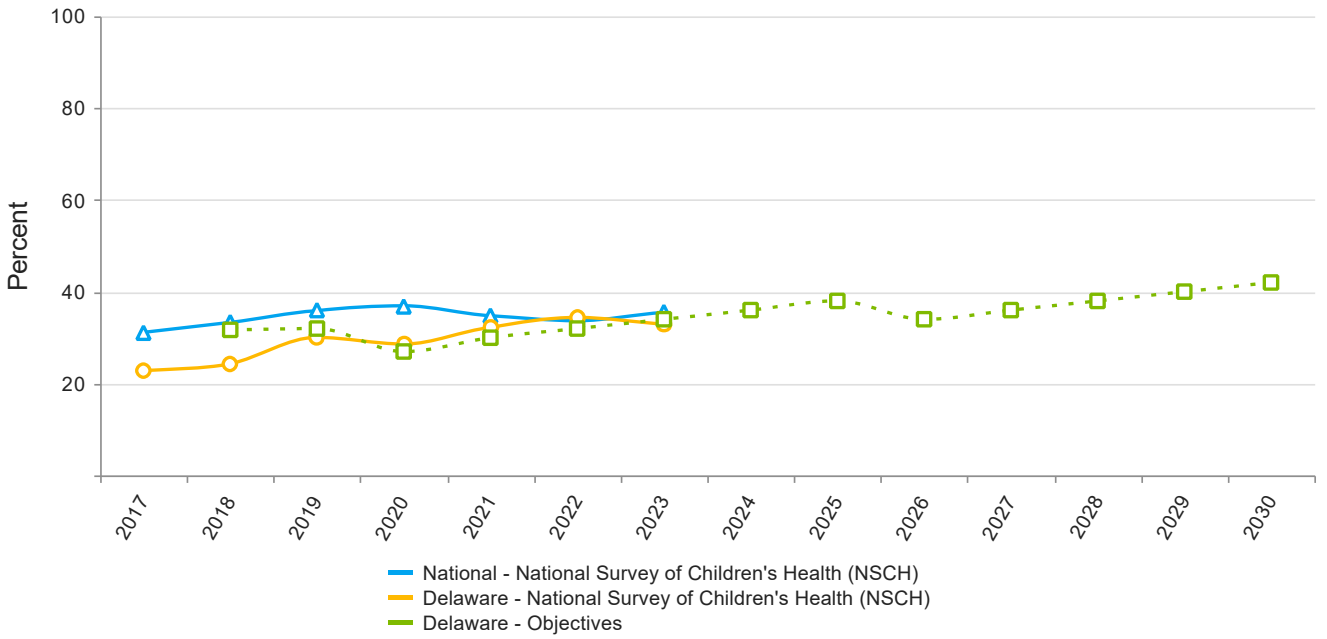
Health Management Associates (HMA) will continue working closely with DPH and DHMIC to serve as a backbone agency (BBO) as part of the maternal and infant mortality reduction work to build state and local capacity and assist with identifying innovative strategies to shift the impact of social context factors tied to root causes related to infant and maternal mortality and morbidity. The primary focus is innovation and to spread evidence-based programs and strategies to eliminate the disparities in maternal and infant health outcomes. In addition, HMA will work with DPH and DHMIC to staff and facilitate the Social Determinants of Health Housing Workgroup, staff and facilitate a Governance and Membership Committee, the Well Woman/Black Maternal Health Committee and provide, and create shared dashboard reports and tools for quality improvement and overall evaluation. The identified HWHB high-risk zones continue to experience extensive and complex hardships that are driving poor maternal and infant mortality and morbidity rates. In partnership with DPH, HMA, DHMIC and maternal and child health stakeholders will use our local connections to identify possible new and/or current interventions to provide services, such as Family Connects, to needed communities in high-risk zones. DPH, working in partnership with HMA, remains committed to engaging nontraditional, community-based nonprofits in this work.

In the coming year, DHMIC and DPH and stakeholders will review our current interventions and framework for addressing well woman care, postpartum care as a key period of risk, and housing stability for pregnant women.

[1] Healthy People 2030. Housing instability.
[2] DiTosto JD, Holder K, Soyemi E, Beestrum M, Yee LM. Housing instability and adverse perinatal outcomes: a systematic review. Am J Obstet Gynecol MFM. 2021;3(6):100477. doi:10.1016/j.ajogmf.2021.100477.
[3] Bess KD, Miller AL, Mehdipanah R. The effects of housing insecurity on children's health: a scoping review [published online ahead of print, 2022 Feb 4]. Health Promot Int. 2022;daac006. doi:10.1093/heapro/daac006
[4] U.S. Department of Housing and Urban Development. The 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of Homelessness in the United States.
[5] The US Maternal Vulnerability Index (MVI).

National Performance Measures

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	27	30.0	32.0	34	36
Annual Indicator	30.3	29.1	32.1	34.3	32.8
Numerator	6,522	6,073	7,257	8,614	8,638
Denominator	21,559	20,867	22,604	25,117	26,363
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	34.0	36.0	38.0	40.0	42.0

Evidence-Based or –Informed Strategy Measures

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		92	94	96	98
Annual Indicator	83.3	82.2	81	77	76
Numerator	398	412	439	412	419
Denominator	478	501	542	535	551
Data Source	MIECHV program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	80.0	82.0	84.0	86.0	88.0

ESM DS.2 - Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.

Measure Status:	Active

State Provided Data			
	2022	2023	2024
Annual Objective			75
Annual Indicator		31.3	38.1
Numerator		45	86
Denominator		144	226
Data Source		MIECHV ASQ and OEL ASQ	CHADIS Pilot Project Data
Data Source Year		2023	2024
Provisional or Final ?		Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	54.0	56.0	58.0	60.0	62.0

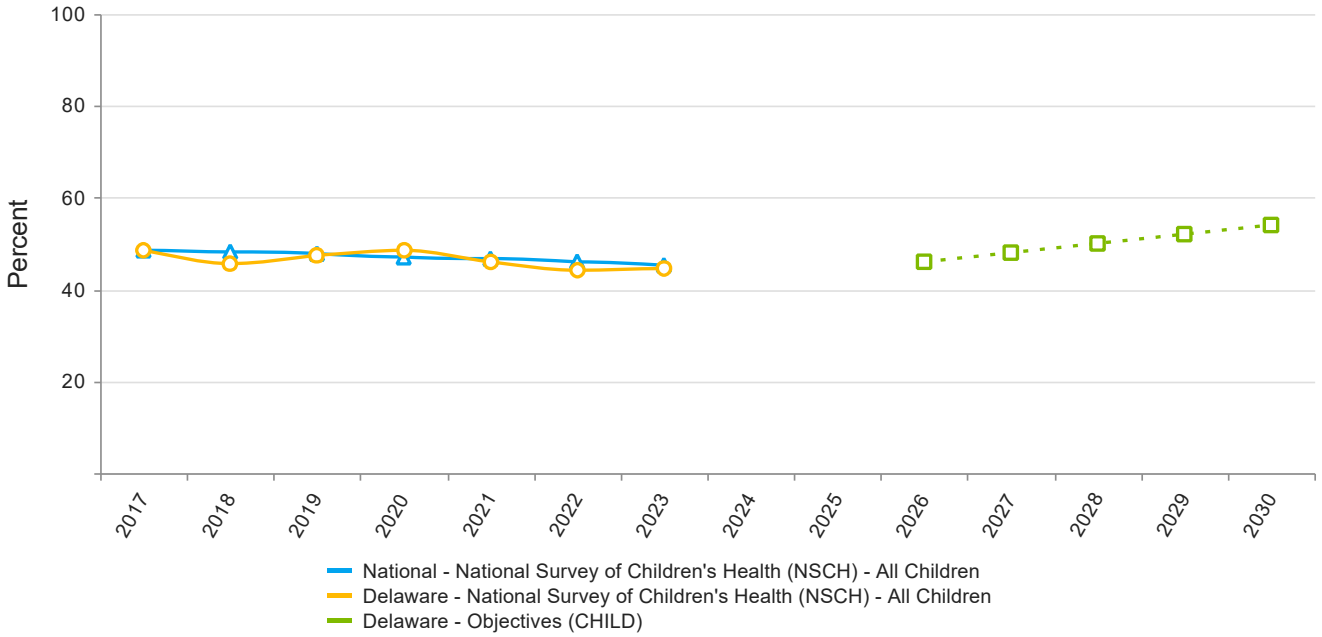
ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	30.0	25.0	20.0	15.0	10.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	44.2	44.7
Numerator	91,124	92,739
Denominator	206,169	207,631
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	48.0	50.0	52.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	72.9
Numerator	462
Denominator	634
Data Source	MIECHV Program Data
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	77.0	80.0	85.0	90.0

State Action Plan Table

State Action Plan Table (Delaware) - Child Health - Entry 1
Priority Need
Children receive developmentally appropriate services in a well-coordinated early childhood system.
NPM
NPM - Developmental Screening
Five-Year Objectives
By July 2030, increase the percentage of children, ages 9 through 71 months, receiving a developmental screening using a validated parent-completed screening tool.
By July 2030, increase the percentage of pediatric clinics and childcare programs that are using evidence-based screening tools.
By July 2030, reduce the disparity in developmental screening outcomes between children, ages 36 through 47 months residing in higher risk geographic regions as compared to children ages 36 through 47 months residing in lower risk geographic regions.
Strategies
Continue to train medical and childcare providers on developmental screening.
Utilize Home Visiting/MIECHV programs to assist families in completing the Ages and Stages Developmental Screening tool to clients but also providing education/resources on milestones and referrals to early intervention when needed.
Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention.
Promote parent and caregiver awareness of developmental screening.
Continue to host Books, Balls and Blocks events to educate families on developmental milestones, age-appropriate activities, and provide an opportunity for children to receive developmental screening.
Continue to build out the CHADIS platform with pediatric practices.
Provide System Coordination of developmental screenings with partners and providers. This includes HMG, childcare, home visiting programs, and primary care providers to assess for gaps, assure access and reduce duplication.

ESMs	Status
ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.	Active
ESM DS.2 - Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.	Active
ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.	Active

NOMs

School Readiness

Children's Health Status

State Action Plan Table (Delaware) - Child Health - Entry 2

Priority Need

All children, with and without special health care needs, have access to a medical home model of care.

NPM

NPM - Medical Home

Five-Year Objectives

Increase the number of children who report having a medical home.

Strategies

Partner with HMG and home visiting programs to identify families who have children without a medical home and provide resources and referrals.

Develop educational materials on what a medical home is and disseminate.

Offer ongoing professional development opportunities for providers to support family-centered care with a medical home.

ESMs	Status
ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.	Active

NOMs

Children's Health Status

CSHCN Systems of Care

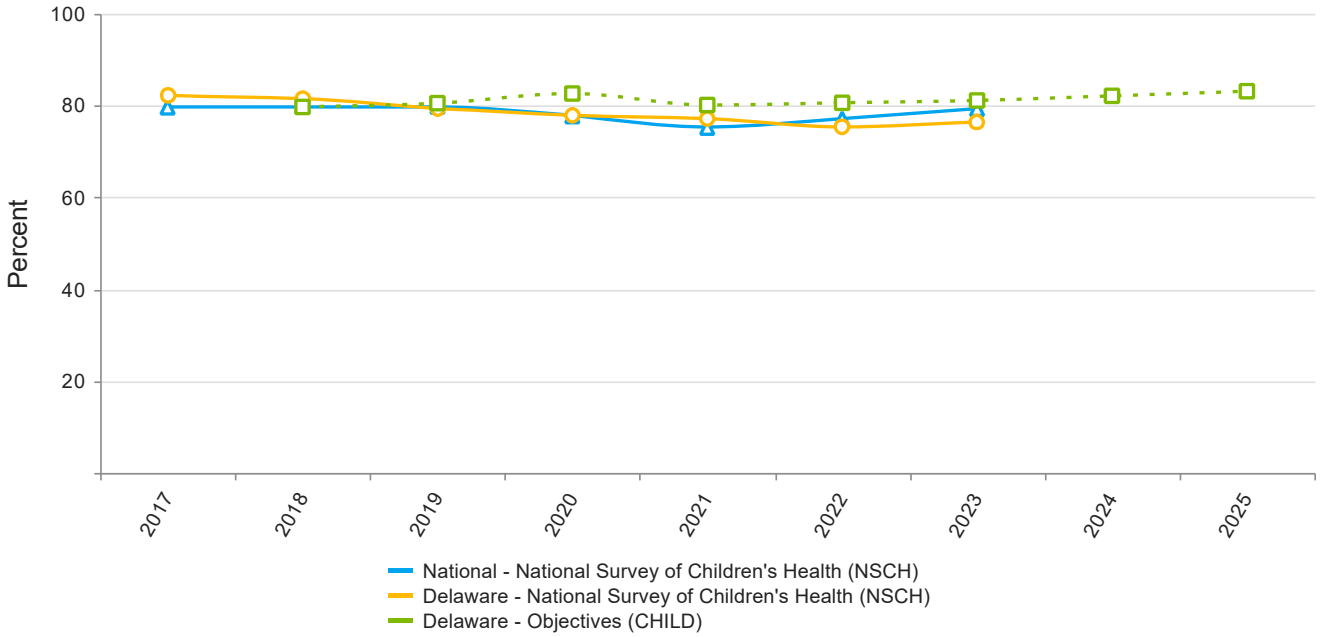
Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child Indicators



2021-2025: 2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.5	80	80.5	81	82
Annual Indicator	79.7	77.4	77.3	75.4	76.2
Numerator	149,645	148,645	149,188	147,612	152,458
Denominator	187,697	192,077	193,050	195,852	200,007
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		81	82	83	84
Annual Indicator	78.8	73.6	77.3	75.4	76.2
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019-2020	2020-2021	2021-2022	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			725
Annual Indicator	683	1,000	788
Numerator			
Denominator			
Data Source	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Developmental Screening

During Delaware's 2020 MCH Title V Five-Year Needs Assessment process, the MCH team, along with various stakeholders, identified Developmental Screening as the main priority for the children's health domain. Developmental delays and disabilities such as autism, behavioral disorders, speech, and language challenges are frequently missed until the child reaches school age - which is too late. Research shows the earlier the detection, the better the chances for a child with developmental delays to improve. Developmental screening is therefore critical to ensuring a child's school readiness and social emotional health. The American Academy of Pediatrics recommends a system of developmental monitoring and screening in order to identify conditions or delays impacting children's development over the long and short term. The Academy recommends the promotion of early detection and intervention for developmental disorders to improve the well-being of children and families.

Delaware has approximately 65,000 children aged 5 and under. According to America's Health Rankings, in 2024, Delaware's developmental screening rates for children 9-35 months was 32.8% which falls short of the national rate of 34.8%. The report indicates an overall for decrease for the nation and the state. Since 2009, Delaware has acted to improve the state of developmental screening, early detection and intervention and referrals, first, with the enactment of legislation requiring private health insurance coverage for developmental screenings for children at specific ages, including the appropriation of funds to the Maternal Child Health Bureau to promote developmental screening and surveillance within pediatrics.

The recent legislation in 2023, HB202, requiring all licensed childcare centers to provide annual developmental and social emotional screening to children under the age of five not enrolled in kindergarten is further indication of Delaware's intent to expand access so that all children who need additional support can benefit from early detection and intervention. Despite the state's investments, developmental screening rates have ebbed and flowed in the state, with demand exceeding service capacity in some areas.

The Early Childhood Comprehensive Systems (ECCS) program uses the Help Me Grow (HMG) model to determine its goals and objectives. The four components of the HMG model are founded on the socio-ecological framework which addresses how multiple factors could impact child/family physical, mental health and social well-being. The ECCS program therefore assesses their goals/activities on the effectiveness of performance in Health Provider Outreach, Family and Community Engagement, Centralized Access Point and Data Collection and Analysis. These components guide the ECCS strategic plans, theories of change and outcomes.

Twelve years after Delaware embarked on the promotion of developmental screening and surveillance through legislation, the Maternal Child Health Bureau (MCHB), through the Early Childhood Comprehensive program has dedicated time and effort to address subsequent challenges in streamlining the referral and care coordination process. Through implementing the Child Health and Development Interactive System (CHADIS) pilot project, the ECCS program focused its efforts, this fiscal year, on continuous quality improvement (CQI) efforts to mitigate the challenges and gaps encountered because of the CHADIS pilot project.

The Delaware CHADIS pilot was officially launched in November 2022 and gave participating practices access to the customized referral platform as well as 600+ questionnaires and screening tools. Developmental screening questionnaires available in CHADIS include the Ages and Stages Questionnaires (ASQ), Parents Evaluation of Developmental Status (PEDS Online), Modified Checklist for Autism in Toddlers (MCHAT) and The Survey of Well-being of Young Children (SWYC). In addition to developmental screening, pilot practices have also been utilizing screeners for lead, as well as, anxiety and depression – Patient Health Questionnaire -2 and -9 (PHQ-2/-9), Edinburgh Postnatal Depression Scale (EPDS), Generalized Anxiety Disorder (GAD) and Screen for Child Anxiety Related Disorders (SCARED) and social determinants of health - Adverse Childhood Experiences (ACE) and Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE).

The purpose of this project is to address care coordination of the developmental screening process and referral to early intervention services with the goal of improving gaps that exist in the system. Specifically, the pilot is intended to: improve communication between early intervention services and pediatric practices; close the feedback loop of patient outcomes between early intervention services and pediatric practices; track referrals to early intervention and status of referrals at all stages; collect data for analysis through a CHADIS dashboard; and leverage HMG at 211 (HMG@211) services as a support for referrals for social determinants of health and for those children currently ineligible for early intervention services. To accomplish the goals of this project, a Delaware referral platform was designed and built within the CHADIS system with feedback from Birth to Three (B23 - previously Child Developmental Watch), Early Childhood Special Education (ECSE- Child Find) and HMG@211.

As is expected with any pilot project, there have been some setbacks and challenges. The ECCS program and its partners, the Delaware American Academy of Pediatrics, the Early Childhood Special Education program (ECSE); Birth to Three (B23), Help Me Grow at 211 (HMG@211) and Total Child Health (TCH), who manages CHADIS, including four (4) pediatric practices worked during this period to address the challenges with early intervention accessing and processing referrals on the CHADIS referral platform and completing the feedback loop to referring physicians.

Since its inception in 2022 and more especially, this fiscal year, the CHADIS pilot project led to multiple training sessions for CHADIS users such as pediatric practice staff; early intervention programs (ECSE and B23) and HMG@211. The training focused on access and use of the CHADIS platform and the newly built referral system. The most recent in-person CHADIS training for Early Childhood Special Education staff was held in May 2024. Through the CHADIS project, pediatric practices can send developmental screening questionnaires (PEDS, ASQ and SWYC) out in advance of well-child visits, for parents to complete, or to have them complete questionnaires at the time of the appointment, electronically.

Pediatric practices can use the online referral platform to make referrals directly to B23, ECSE and HMG@211 programs. The pilot project also enabled the early intervention programs to access and process referrals from the pediatric practices via the online referral system. A key feature of the referral system is that practices and early intervention programs are currently able to communicate for follow up including closing the feedback loop. This fiscal period, after surveying users, improvements were made to the feedback feature to ensure that it is clearly understood and more visible to users.

In addition to the CHADIS pilot project, the Early Childhood Comprehensive System program also tracks pediatric practices that have been implementing the Parents' Evaluation of Developmental Status (PEDS) since 2012. The state of Delaware provides pediatric practices the use of PEDS online free of charge. Out of these practices, four (4) opted to join the CHADIS pilot project in 2022. For this fiscal year, the total screens of this combined group (PEDS Online practices and CHADIS practices) were 13,160; of which 70% were unduplicated cases (N = 9,214). Of the 9,214 unduplicated cases, 70% (N = 6,456) were 35 months of age or younger. Of the 30% of patients screened more than once, 90% were 35 months of age or less - meaning that providers tend to comply with the AAP Bright Futures recommendations - screening at 9, 18 and 24- or 30- months, but are less attentive to AAP recommendations to continue screening at subsequent well-visits.

To respond to training needs, the CHADIS team provided six trainings (virtual and in-person) for over 45 early intervention and Help Me Grow@211 staff. The training covered the use of CHADIS and the referral platform. A major challenge in this journey has been recruitment of pediatric practices to sign up to utilize the PEDS online developmental screener. At the inception of the state's PEDS online platform in 2012, close to 30 pediatric practices signed up to use the screener. Over subsequent years the number has dwindled to about 20 practices. The ECCS program and its partners have brainstormed ways to gin up interest; ranging from one-on-one visits to non-active practices; transitioning active practices to use the CHADIS platform; reaching out to other pediatric practices not doing developmental screens, to updating the developmental screening webpage on the Division of Public Health's website, among others.

Through surveys and anecdotal reports from pilot pediatric practices, we learn they are satisfied with using CHADIS system and the referral platform. They like the fact that parents can complete the developmental screener ahead of their well-visits; they have access to about 600 other screening tools at their disposal; that the information is integrated with their Electronic Health Records (EHR). The challenges they raise is in relation to the early intervention program, specifically the Early Childhood Special Education program (Part B). Although the ECCS program and its partner (DEAAP) consulted with and had a ECSE representative at the table throughout the building of the CHADIS referral platform, we have received feedback questioning the purpose of the pilot, including raising concerns about confidentiality, parental consent; the design of the referral platform and duplicating their administrative efforts related to their workflow. For these reasons, the ECSE team are not consistent to provide the feedback physicians are seeking on referred patients. A CQI task force, made up of the CHADIS users and ECSE staff, has been proposed to train and identify solutions to improve the platform and workflow integration, as well as other challenges and setbacks. The following are other challenges of the pilot project:

DEThrives advertised a social media post during the month of May 2025 to support developmental screening. DPH aimed to have families see why developmental screenings are so important and learn about the different types, like the Ages & Stages Questionnaire (ASQ). With the Home Visiting Program and Help Me Grow program at Delaware 2-1-1, you'll have all the support you need to access the right services.

Delaware is poised to transition the Birth to Three (Part C) program, which is currently under the Division of Public Health, to the Department of Education. The transition is planned to occur by the end of 2027. Surveys and anecdotal reports from pediatricians indicate a better alignment and understanding of Part C process as compared to Part B. The CHADIS pilot practices indicate they are satisfied with the services received from Part C. There's uncertainty as to the impact the move to Department of Education will have on the Part C "culture", especially in dealing with infants and children not yet in the school system, and their current approach to early intervention, such as privacy and confidentiality, parent authentication and the feedback loop, which seems to work for pediatric practices.

Continuous quality improvement is an on-going process deployed within the pilot project. In 2024 and currently, time and effort was spent following up with physicians and early intervention programs to remind them to use the feedback loop feature on the platform to improve/increase communications. The high turnover of the early intervention professionals, especially the Early Childhood Special Education staff (Part B) means continual training to educate staff on the use of the platform, updating referral status and closing the feedback loop.

Since the pilot has only 4 pediatric practices, the spread in the use of the platform is limited, therefore the referrals stemming from CHADIS is minimal compared the universe of referrals the early intervention programs receive at any given time. For these reasons, it poses difficulties for early intervention to incorporate CHADIS into their daily workflow. The scale up and spread of CHADIS to other pediatric practices should make referrals from CHADIS more prevalent in their workflow.

As mentioned earlier, Child Find (ECSE/Part B) concerns regarding confidentiality and consent of the referral platform as it relates to Family Educational Rights and Privacy Act (FERPA) has also been an issue we've had to contend with. We're in the process of changing the consent form on the CHADIS platform to reflect third party referrals and parent authentication. Additionally, we've had challenges getting the health providers to make referrals related to socio economic needs to Help Me Grow, the centralized access point (HMG@211). The plan is to focus on HMG@211 promotion through virtual or in-person trainings targeting practice staff and physicians.

As with any pilot project, checking in with users is very essential. In the last quarter of 2024, we sent out surveys to our pilot practices, early intervention programs and parents regarding their experiences with CHADIS and whether it achieved its outlined goals. The results indicated that physician practices were satisfied with CHADIS and the referral platform as whole but had issues with feedback loop from early intervention, including some concerns with auto-population of patient demographic information. Early intervention professionals were concerned about confidentiality, parent authentication and compliance to FERPA rules (though CHADIS is FERPA compliant). Though the number of parents who responded to the survey were few, those who responded were concerned about the nature of the social determinants of health screener, which is a recommendation for using CHADIS for the pilot project. Some of the parents expressed the fact that some questions were too private. The ECCS/MCH team worked with the CHADIS team, following the feedback to make the necessary changes and improve the platform.

The next phase of the pilot is scaling up and spread of the project to the broader pediatric community. This phase includes transitioning pediatric practices that are currently implementing the Parent Evaluation of Developmental Status (PEDS online) instrument and utilizing the state's free PEDS online platform, on a frequent basis, to the CHADIS platform. This phase will then be followed by targeting currently in-active pediatric practices that signed up to implement the PEDS tool. We expect to have difficulties with the transition since it will involve a change in workflow and behavior, which could be seen as an added burden. In 2024, Bay Health Pediatrics in the southern part of the state signed up to use the CHADIS system. We also started discussions with a Federally Qualified Health

Center (FQHC) but that is yet to be completed.

In May 2025, during the National Developmental Disabilities Awareness Month DPH DEThrives promoted a social media post around the importance of developmental screenings. Developmental delays and disabilities like autism, behavioral disorders, etc. can be missed without a screening. Research shows the earlier the detection, the better the chances for a child with developmental delays to improve. DPH encouraged parents to visit HMG at Delaware 2-2-1 or our DEThrives website.

The Early Childhood Comprehensive Systems (ECCS) program collaborates with and financially supports the Delaware American Academy of Pediatrics (DEAAP) through a contractual agreement to promote within the pediatric community. The agreement also includes DEAAP's early literacy partners to grow and expand efforts to promote developmental milestones, surveillance and screening and early childhood health through literacy via the Reach Out and Read (ROR) evidence-based, national pediatric literacy program. The DEAAP Early Literacy Committee (ELC) meets regularly to explore ways to engage and support Delaware's primary care pediatricians to promote early literacy from birth to five (5) years. They are focused on building engagement and awareness of ROR as well as sustainability of the program so that all interested practices can participate in ROR.

The Reach Out and Read program gives young children a foundation for success by incorporating books into pediatric care and encouraging families to read aloud together. Using the ROR model of early childhood literacy promotion, primary care clinicians advise parents on the critical importance of reading aloud daily and distribute free, developmentally appropriate books to children from birth through five (5) years of age at each routine well-child visit. This evidence-based intervention model promotes developmental screening and milestones and addresses important social determinants of health and is considered the standard of care as recommended by the American Academy of Pediatrics in support of early brain development.

A matching grant of $250,000 from the Longwood Foundation in 2023 to Delaware's ROR project created a strong foundation for the program to thrive in the state to becoming an ROR affiliate. Delaware now has 30 active ROR practices in the state with 6 additional practices approved, pending training. The program has been prioritizing federally qualified health centers (FQHCs), practices that care for the underserved population and major health care systems in the state.

The ECCS program has been working with the DEAAP to leverage the synergies that exist between early childhood development and health, and early literacy. The observation over the years, has been that engaging early childhood partners and stakeholders to support Reach Out and Read in primary care and pediatric practices, tends to enhance the opportunity to promote literacy, developmental screening, child health and well-being. This approach could help in the resistance encountered when promoting developmental screening to pediatric practices. Specifically, DEAAP has been working to recruit partners to provide books and early childhood health resources for ROR practices for each of the 13 well-child visits. These partnerships provide valuable information and resources to families while also supporting the ROR program and its sustainability in pediatric practices in Delaware.

To support the ROR program, partnerships have been fostered with programs to donate children's books on specific child health topics. Programs such as Delaware libraries; Food Bank; Women Infant and Children; Division of Public Health's Office of Healthy Environments, Lead Program and Bureau of Oral Health and Dental Services including the Delaware Readiness Teams have donated children's books related to their subject matter.

Following pediatric practices visits made by the (Health Provider Outreach) HPO team, we were informed by the pediatrician of a pediatric clinic affiliated with a major hospital in southern Delaware about mental health referrals not being honored for their enrolled families. Though this was anecdotal, we know Delaware families have had long wait times to receive mental health services. We reached out to staff at Delaware Child Psychiatry Access Program (DCPAP); the program provides pediatric primary care professionals with free child psychiatry consultation and behavioral health support. We also reached out to staff who manages the Early Childhood Mental Health Consultation to brainstorm ways we could leverage the resources of Help Me Grow@211 to assist parents with their referrals and determine ways to engage them while waiting for their appointment with the experts. After a series of meetings, the issue of funding became a challenge that could not be resolved. This issue remains a challenge, and we continue to figure out ways this gap could be resolved. Child mental health services continue to be an emerging issue and a gap the state must deal with, especially services for families while they are on the wait list to see a mental health provider.

The success of the state's developmental screening initiative can't be complete without engaging the community and

families to increase their knowledge about developmental screening, behavioral health and the importance of parental monitoring of children's milestones. The ECCS program's family and community engagement efforts via the Books Balls and Blocks (BBB) activity is an approach to improve health outcomes across all domains for families.

Through BBB, parents with young children and caregivers learn to play with their children to increase relational health and learn ways to stimulate a child's development. While playing with their child, parents who have not completed the Ages and Stages Questionnaire developmental screener (ASQ) can do so. A recent legislation requires childcare centers to administer annual developmental screens using the ASQ. BBB efforts target this gap and invites parents and childcare centers into a partnership to ensure that parents have completed their annual ASQ screens. Books Balls and Block events can be in-person or virtual. In person events could be a partnership with another program or a stand-alone activity organized by the ECCS program. During in-person events, families are exposed to interactive stations representing developmental milestones or domains for a child's growth. Parents completing the ASQ can use the interactive stations to assess their child's growth in certain areas. The interactive stations also help to enhance children's brain and physical development.

Online BBB activities provide the chance for children to explore and practice specific skills, such as fine and gross motor, communication and problem solving. Using zoom as a medium, parents gather with their children (12-23 months) and (36-48 months) - typically on Saturdays to learn and play for about 45 minutes. Each session targets specific age groups and is limited to not more than 15 families – items for the curriculum are mailed ahead of the event to families. The virtual BBB was Delaware's response to the pandemic.

An informed and knowledgeable constituency increases family resilience improving the trajectory of children's health outcomes. Through technical assistance from the Help Me Grow national center in 2023, the BBB program now provides parents with protective factors information so they can help themselves, families, and communities.

In 2024, the BBB program participated in over 10 events across the state in partnership with other early childhood programs, or in some cases, initiated by the BBB program. The partners included childcare centers; libraries; University of Delaware and non-profits such as United Way and Winterthur. The activities ranged from community health fairs to informational tables. Through these activities, BBB staff had 118 interactions with families and assisted them to complete 49 ASQ screens.

Through the BBB virtual sessions, emerged parent meetings - parents who participated in the virtual sessions with their children would linger after each session to ask questions related to their child's growth. Due to this need, the coordinators organized half hour sessions to engage interested parents. The topics included potty training; child development and behavior; navigating and linking resources/services and the promotion of the 5 protective factors - an informed strategy known to improve the health and well-being of families. A year into the parent meetings, the challenge has been consistency in parent participation. The same challenge is seen in the virtual sessions.

To resolve such challenges, we have brainstormed partnerships with programs that have a "built-in" parent base – where families congregate on a regular basis, are easy to reach and participate in activities. We have had discussions with some libraries to facilitate parts of their "Toddler Time" sessions. This approach will guarantee parent attendance and participation. Other programs under consideration have been community centers in parts of Wilmington such as Kingswood, Rose Hill, and the YWCA which have activities that draw families. Providing incentives is a way to increase attendance but sustaining it financially is not possible.

These educational sessions will increase parental or community knowledge on the importance of developmental screening, who administers screens in the state, and developmental milestones including how to access resources and services. The intended outcomes of such strategies are that individuals or communities that increase their knowledge on developmental screening, increase their confidence in utilizing the services and benefit from improved health outcomes for the child and family.

Educating families to have a better understanding of developmental screens and milestones or encouraging providers to implement developmental screens should not be done in a vacuum. Such activities should have built-in supports where services and resources are easily accessible and navigable with timely linkages. The ECCS program's partnership with Delaware 211, under the guidance of United Way, is the centralized access point, Help Me Grow@211. The service provides care coordination, referral, linkage and follow-up for families pre-natal to age 8. Child Development Specialists support early childhood providers in developmental screening and referrals to

early intervention services. To assure the accuracy of resources and services, the centralized access point maintains its directory in real-time and offers follow-up services with the caller's consent. HMG@211 increases access to a continuum of early childhood family supports and services including socio-economic needs.

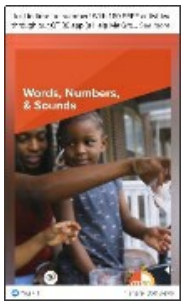
The centralized access point increased the number of calls received in 2024 by 25%; from 3,970 calls in 2023 to 4,957. Follow-up calls to ascertain satisfaction with the referrals provided, indicated that 75% of those contacted responded that their needs had been met. Similarly, 75% indicated they were able to link to the referrals provided them.

Help Me Grow at 211 does hundred percent follow-up with caller consent, however they end up not being able to contact a significant proportion of callers who leave their contact information. This could be because families in crisis tend to be temporarily homeless so phone numbers provided could change over time. This is a prevailing issue that eludes our efforts.

Three hundred and thirty-four (334) of the 2024 calls (N=4,957) were referred to the Birth to Three program (B23) (Part C) which provides early intervention services to children birth to three. Home visiting programs such as Parents as Teachers (PAT); Early Head Start; Healthy Family Delaware; Children and Families First and Nurse Family partnerships received a combined 298 referrals. Most of the referrals for the home visiting programs came from Managed Care Organizations and Christiana Care, (Delaware's main health system). This was made possible because of the close collaboration between home visiting programs and HMG@211. The cooperation over the years, led to establishing processes in place with the overarching goal of engaging families and community partnerships to improve health and well-being across all domains.

The partnership between the Women Infants and Children program (WIC) continues with a dedicated staff from WIC referring clients to HMG@211 . WIC referrals are sent each week to HMG staff. Some of the requests range from utilities, housing to food. A little over a year into its inception, approximately 200 families have been served by the HMG@211 staff.

DEThrives advertised a Quality Time 30 (QT-30) social media post. The post aimed to target parents/guardians and caregivers of children aged 0-8 years old in Delaware to generate awareness of the QT30 app and increase the number of app downloads. Dedicating 30 minutes a day to a child can lead to better health for the child, better chances to be ready to go to school, and a better life overall.



Help Me Grow staff collaborates with the Department of Education's Office of Early Childhood Intervention by supporting the needed follow-up after an ASQ has been completed by childcares. Staff follows up when the screens suggest a possible delay in milestones, contacting the parent to discuss the results and subsequent referral to Birth to Three program. In 2024, staff supported with 5,070 Ages and Stages Questionnaire screens.

In 2023, the ECCS/HMG program decided to begin tracking families who receive public assistance as way to provide a snapshot of family's income. This is information needed for Help Me Grow fidelity assessment. Delaware's HMG@211 does not inquire about individual income. Public assistance was used as a proxy to determine the number of families/households, that call the service, who are either on or below 100% to 200% federal poverty level. Callers to the helpline were asked if they received the following benefits: Medicaid, WIC, SNAP/EBT; purchase of care and TANF. A year after tracking this data, 922 of callers were on Medicaid, 630 received WIC while 345 were on SNAP/EBT. POC and TANF were very minimal. It's important to note that most of these counts are duplicated counts; the count represents individuals who indicated they received one or more of the benefits. In the future this information could be used to assure fair distribution of resources while considering the economic needs of vulnerable families and build staff capacity in servicing different populations.

HMG data analysis also indicates a reduction on "Student Help", which was initiated during the Covid lockdown. The number of calls requesting assistance with laptops and other educational materials was 1012 in 2023 as compared to five hundred eight (508) in 2024. This activity provided another opportunity to assist individuals who were interested in applying for public assistance. Overall, staff linked callers to apply for public assistance in 274 occurrences.

The Maternal Child Health Bureau values the importance of social media marketing to increase visibility of MCH programs; directly communicate with families and providers while enabling users' easy access to reach out with inquiries and concerns. The creation of www.Delawarethrives.com accomplishes these goals and has increased the reach of MCH programs across the board.

The website houses all MCH programs. Developmental screening, Books, Balls and Blocks (BBB- representing family engagement) and Help Me Grow@211 are some of the child health web pages on the DEThrives website. In 2024, the Help Me Grow page drew about 3,057 pageviews (the frequency at which the users' browser loaded the webpage including instance of reloading, refreshing and using the back button) with about 4000 users. The engagement rate for that year was approximately 62% - the rate reflects the degree to which visitors actively interact with and stick around the site.

The Data Collection and Analysis (DCA) team is responsible to tracking and analyzing all the data in the child health domain. MCH contracts with Forward Consultants, an external epidemiologist who has worked with the program over the past decade. Help Me Grow at 211 data is sent to the Forward Consultants for analysis and a quarterly report is shared with the Help Me Grow Advisory committee. The committee is represented by child-serving providers who provide guidance and advise for the HMG system.

Similarly, PEDS online and ASQ data is also shared with the committee at the same frequency. The ASQ data is tracked by the Office of Early Intervention and shared with the ECCS program under a Memorandum of Understanding (MOU) between the ECCS program and Office of Early Learning. In 2024, the DCA partnered with KIDS COUNT, a national and state-by-state initiative, a hub tracking and analyzing state and national childhood to impact policies to grow safe, healthy strong communities. KIDS COUNT is part of the Center for Community Research & Service at the University of Delaware. The partnership led to a KIDS COUNT representative sitting on the HMG Advisory committee. As part of the HMG strategic plan is the integration of the HMG system data with the KIDS COUNT data. There are also plans to develop an annual HMG report that will be shared with a broader group of stakeholders, including coming up with a system which makes HMG data more accessible to stakeholders.

The BBB page had about 983 page views with 377 users. The engagement rate for the third quarter was 70% - the rates for the other three quarters were not available. Pageviews for the developmental screening page was 1,430 with an engagement rate of 75% in the second quarter – the other quarter rates were also not available. The site also has a page where providers and other individuals can order (free of charge) collateral materials to promote child health in their communities. There are brochures, one pagers and other materials on BBB, QT:30 (Quality Time:30 – a brochure which encourages parents to spend at least 30 minutes in play with their child), home visiting, safe sleep, developmental screening and HMG@211. The site is managed by a communications vendor, Aloysius, Butler and Clark (AB&C). They consult with MCH leadership on content, messaging, trends to track, etc. For FY 24, AB&C posted 3 blogs on children's growth and nutrition. "Crawl Baby Crawl" and "What's in Your Lunch Box" were two of those blogs.

During the month of October 2024, DPH DEThrives promoted the Quality Time (QT30) app by incorporating Halloween into the post. Make Halloween safe, memorable, and fun. Help your child get their costume on, examine your child's candy, count candy together, and more. For more activities, DPH encouraged parents to download our free QT30 app.

During the 4th quarter, AB&C worked with the MCH Social Media Liaison on an HMG themed promoted post (funds were put towards it to increase the chances for users to view the content). The post shared how HMG@211 services could assist families during the holiday season, listing that they could connect the user to emergency shelters, warm clothing, diapers, mental health resources, assistance to heat their home, and more. The ads ran from 12/19/24 – 12/31/24 and was posted on Facebook's and Instagram's in-feed. It targeted adults, leaning more towards female than males aged 18 and above. HMG at Delaware 211 was tagged in the post. The ad earned over 481K impressions, earning the most impressions out of the three promoted posts that quarter. There were 24 link clicks and 5 post reactions. Most impressions came from women aged 35-44 years old.

Dental Visit

According to the 2022/2023 National Survey of Children's Health (NSCH), 76.2% of Delaware children, ages 1 through 17, have had a preventive dental visit in the past year. Delaware is slightly below the national average of 79.2% of children with a preventive medical visit. The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders. Our stakeholders recognize that dental health equals overall health and the Title V team has identified that MCH is able to align our collaborations and resources to make an impact on this population.

The passing of HB83 requires all public and charter schools to provide a mandatory dental screening for all kindergarten students. In collaboration with the Department of Education, the Bureau of Oral Health and Dental Services (BOHDS) has committed to administer and provide dental screenings and resources for this program. Students were screened by a licensed dental professional from BOHDS in 105 schools. Each student screened received a dental report card documenting the results of the dental screening. A toothbrush, toothpaste, dental resource guide, and brushing instructions was provided to each student. It is estimated approximately 8,000 students were screened.

- 84% have no visible signs of dental problems
- 16% show visible signs of dental problems
- 1.6% show visible signs or symptoms or a serious dental problem

1. Dental Resource Guide 2024.pdf

How to Brush for kids English and Spanish F

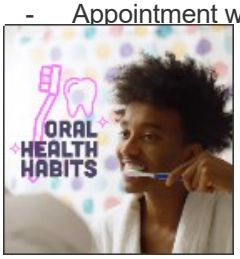
The Delaware Smile Check Program is a school-based preventive oral health and case management program serving grades pre-kindergarten through 12th grade. The program offers dental screenings, fluoride varnish application, patient education, case management to assist families with removing barriers that prevent their child from receiving dental treatment, and finding a dental home. The program implemented an online only registration process that directs families to the registration page of our new electronic dental software. Families register their child for the program by clicking the link to our registration form or using a QR code and all the information is loaded into the portal of our electronic dental software. The forms are available in over 20 languages.

The school-based Smile Check program screened 844 children from 07/01/2024 -06/23/2025 and administered 800 fluoride varnish treatments to children in PreK through 12th grade. We learned that out new registration process requires additional outreach and education for families and school professionals.

- 100% students needed a dental home and have not seen a dentist in the past 7 months
- 39% have suspected dental caries
- 6.5% had an urgent dental need (pain or swelling)

All 844 received case management to connect them to a dental home and assist with removing barriers preventing the child or their family from receiving dental care. Our new dental software allows case managers to select text messages and emails that provide resources and patient education. All families received either a text message, email and/or phone call in English, Spanish, Haitian, and Arabic.

- 9.9% of patients completed dental treatment in full
- 2.1% successfully secured dental insurance
- 30% were unable to be verified due to no insurance and contact information changing
- Patients seen in the last 3 months have not been verified
- Appointment waiting times of 6 months or more



In February 2025, DPH DEThrives promoted National Children's Dental Health Month by posting dental resources and information for children and adolescents with two different posts. This National Children's Dental Health Month let's practice healthier oral habits 😊. The Delaware Smile Check Program offers free dental screenings, fluoride treatments, a toothbrush, educational resources, and more.

Did you know your oral health impacts your overall health and is especially important in your adolescent years? You may have many concerns, from vaping and tobacco use to nutrition. Here are several healthy habits you can start today.

A dental wellness center was opened at Warner Elementary School. Students can receive a dental examination, cleaning, fluoride, fluoride varnish or dental sealants at school if they do not have a dental home. Only students that are uninsured have Medicaid or DCHIP can receive these services. Ten students received a dental examination, six received a fluoride and dental cleaning and 20 dental sealants were completed. Eight students received silver diamine fluoride to arrest decay until they were connected to a dentist to complete any restorative work needed.

The Division of Public Health coordinates with partners to release information through DEThrives, Facebook, and X monthly. Social media content is released two times a month or more and content coincides with the National Wellness Calendar. The content is intended to improve oral health literacy, early intervention, routine dental care, and total health wellness. Twenty-four social media messages were sent from July 2025 to May of 2025, in addition to one Newsletter.

July 2024
- Zero HIV Stigma Day
- International Self Care Day

August
- Back to School Dental Check-Up
- Breastfeeding Infant Oral Health National Breastfeeding Month

September
- Dental Story Time for National Library Card Month
- Smile Check Advert/ Access to Care

October
- Halloween Tips Healthy Choices and Brush and Floss
- Breast Cancer and Oral Health
- Advertising Ordering Free Oral Health Education First Smile Delaware

November
- Diabetes and Oral Health
- Dental Career Development

December
- Oral Health and Mental Health
- Seasonal Depression Impact on Oral Health
- Taking Care of Your Teeth During the Holidays

January
- MLK Jr.
- Flu and Cold Season
- Is It Safe to Go To The Dentist (Pregnancy)

February
- Children's Dental Health Month
- Heart and Oral Health

March
- World Down Syndrome Day (Oral Health and Special Needs)
- World Health Day (Routine Dental Care)

April
- Oral Cancer Month (Oral Cancer Screening)

May
- Women's Health Month (Oral Health)
- Mental Health Month (Don't forget Your Teeth)

Impressions Newsletter:
https://dhss.delaware.gov/wp-content/uploads/sites/10/dph/pdf/impressions_summer24_.pdf

During the month of November, 2024 DEThrives ran a social media post for the oral health-related topic. The description, "Healthy smiles ! Through DPH's Kindergarten Oral Health Screening Program, Delaware students can receive access to no-cost dental care . Learn about the Delaware Smile Check Program by visiting the Healthy Smiles page on DEThrives.

Dental Hygienists from the Bureau of Oral Health and Dental Services hosted four educational programs following the "I CAN KEEP SMILING" curriculum at Delaware Public Libraries for Storytime in Sussex and New Castle Counties. Adults attended with their children. Each session was 1 - 2 hours long. Children are read a book about oral health, shown demonstrations on brushing and flossing are provided with a puppet and families are given an oral health activity. Assistance is provided to families after story time to see if they need help with finding a dentist, securing dental insurance or have dental questions.

I Can Keep Smiling 4-8 Lesson Plan.docx

Start Smiling flyer is a reminder for families that their children should have a visit to the dentist on a routine basis. The flyer, which is in English and Spanish, was distributed by 32 schools with school registration packets. In addition, the flyers were distributed to pediatric medical offices who distributed the information during a well child

check, community organizations and community grocery stores in areas that have access to care challenges. A total of 4,100 flyers were distributed.

Back to School Oral Health.pdf

Informational flyers were developed specifically to target children aged 4 who have Medicaid or DCHIP dental insurance. The flyers are intended to provide families with information about their new managed care dental coverage. Children with Medicaid now have an option of choosing one of three Managed Care dental carriers. Flyers were developed for each of the Managed Care Options and the information specific to the child's MCO was mailed to them with a new flyer created to encourage them to schedule an appointment. A total of 3,782 families received this information. The intended goal is to remind parents to schedule a dental visit for their child prior to entering kindergarten and allow adequate time for them to complete any outstanding dental work needed prior to starting school.

Dental Trifolds BOHDS 42025 DE First

Dental Trifolds BOHDS 42025 Amerih

Dental Trifolds BOHDS 42025 Highm

Age 4 Mailer OCOMMS Approved.

Educational programs were designed and developed to improve oral health literacy, improve oral health outcomes, increase access to dental care, and promote routine oral health care and dental homes. The approximate number of people who received education either in person or virtually was around 870. The programs targeted early childhood and Medical Dental Integration.

- Preschool: Family Night Oral Health Education, Resources and Smile Check Promotion
- Preschool: Whole Child Health Night, Oral Health Education, Resources and Smile Check Promotion
- 2 Pre-K classes: "I can Keep Smiling" Sorting good and bad foods, read books, practice brushing
- Boys and Girls Club: "I can Keep Smiling" Sorting good and bad foods, read books, practice brushing
- Early Learning Center: "I can Keep Smiling" Sorting good and bad foods, read books, practice brushing
- Education Presentation: Maternal Child Health Community Health Workers: Dental Care Strategies for Pregnant Patients
- Bay Health Internal Medicine Lunch and Learn: Oral Health and Systemic Disease How to Promote Oral Health
- OBGYN Providers: How to promote oral health, prevent encounter, maintain good oral health during pregnancy
- Delaware First Health Baby Shower: Oral health promotion and resources
- YMCA Healthy Kids Day: Oral health promotion, oral health games and resources
- Community Health Fair: Families dental wellness center, oral health literacy, and promotion
- Office of Women's Health: Oral Health Promotion
- St. Francis 3rd Year Medical Residents: Integrating Oral Health into Primary Care
- Christiana Care Medical Residents: Integrating Oral Health into Primary Care

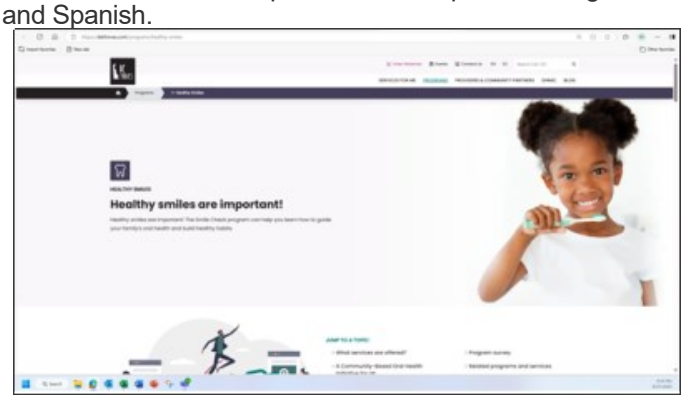
On March 20 2025, DPH DEThrives incorporated World Oral Health Day into our social media schedule. DEThrives informed families of the benefits our the Health Smiles program.

Reach out and Read is an early literacy program collaboration that incorporates oral health education. The Bureau of Oral Health purchased 1,000 English books and 700 Spanish "Brush, Brush, Brush" books for pediatric medical providers enrolled in the program. Our dental hygienists received orders for the books and made the deliveries. They offer oral health education and supplies for the pediatricians and fluoride varnish training to staff. 575 English 'Brush, Brush, Brush" books and 175 Spanish books were delivered to pediatric dental offices, and 285 child toothbrushes with oral health education and 250 adult toothbrushes were delivered to be distributed by medical staff when discussing oral health.

AAP OVER VIEW REACH OUT AND REA

A dental helpline was set up to assist the public with finding a dental provider, for medical providers to contact and speak with a dental hygienist about and oral health problem or asking questions about a dental screening form that was sent home with the child. 475 phone calls were received from the public who needed assistance with finding a dentist and scheduling and appointment.

An oral health landing page (https://dethrives.com/smile-check) is on our DEThrives.com website. The term “Healthy Smiles” is where general oral health information is placed on the DEThrives site in collaboration with the Bureau of Oral Health and Dental Services (BOHDS). The term “Smile Check” is the name of the dental program by the BOHDS, known as the “Delaware Smile Check Program”. The “Smile Check” landing page easily allows the public to enroll their child for virtual or in-person school dental services. Organizations and schools are also encouraged to participate in this program and to receive “Smile Check” services by signing up. Items such as the “Dental Resource Guide”, dental tips for children with special needs, a prescreening checklist, on-site and virtual forms are available in both English and Spanish.



DEThrives displays an online sign-up form for the Delaware Smile Check Program. During this reporting cycle, 616 English student consent forms were completed, 172 Spanish consent forms were completed, and 217 school/organizational consent forms were completed using the DE Thrives website.

MCH assists with marketing oral health activities, events, education through DEThrives Facebook, X and sharing with other Title V partners. The Bureau of Oral Health and Dental Services coordinates with MCH to release information through DEThrives at a minimum monthly on Facebook and Twitter. This includes preventive education and oral health events available to the public to support children and their families to maintain good oral health and improve oral health literacy.

During National Dental Care Month, May 2025, DPH DEThrives ran a post for dental health. The add description, “This is National Dental Care Month, make oral health a priority and build healthier habits! Through the Smile Check program, receive a FREE dental screening and educational info as well as a toothbrush, toothpaste, and floss.”

DEThrives advertised the Smile Check for the Healthy Smiles Program in July 2025. This was a promotional post because the Healthy Smiles program page continues to rank in the top 3-5 most visited program pages on the DEThrives site, so we wanted to see if the metric numbers would increase drastically if there were some paid dollars behind a dental related post. The add ran from 7/11/25 through 7/25/25 on Facebook and Instagram in-feed and in reels, where it will target adults aged 18-45 years old who are parents of children under the age of 18. The purpose of this post was to increase awareness of the services the Healthy Smiles program offers. The description was, “Don't forget about your oral health! With the Smile Check program, you can get a dental screening for FREE, but receive all the essentials for great oral health, plus a toothbrush, toothpaste, floss, and helpful resources.”

MCH has also helped build a lasting connection and relationship between CYSHCN and BOHDS. Information has been shared to assist families with finding a dental provider. The Delaware Smile Check Program has targeted schools that have many children with disabilities and collaborated with dental specialist that can meet the needs of the families for treatment. The Delaware Smile Check Program is designed to provide parents, dental personnel, and medical providers with the tools needed to improve our state’s oral and overall health.

The Family SHADE website continues to promote the Bureau of Oral Health and Dental Services (BOHDS) to expand their reach to the CYSHCN population by putting the BOHDS information on their Family SHADE website. This continues to afford families easy access to dentists that are able to serve their CYSHCN. Having the BOHDS information on the Family SHADE website continues to make it more convenient for families to access the dentists

that will best serve their CYSHCN and eliminate them calling each dentist to ask if they can serve their child.

Child Health - Application Year

For fiscal year 2026, Delaware's child health National Performance Measure (NPM) will focus on increasing the "percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year." The developmental screening map across the state is complex and has evolved over the last 20 years when health providers began paying close attention to issue.

Starting in 2005, MCH records show a group of physicians gathering to raise concerns and advocate for private insurance coverage for developmental screening. This advocacy led to HB 199 mandating private health insurers to cover developmental screenings for infants and toddlers in 2009. This legislation was further triggered by the 2007 National Survey of Children's Health report which ranked Delaware 49th in the country of children 10 to 36 months having completed a developmental screen. Delaware's screening rate in 2007 was 10.9% but improved significantly (30.8% in 2011-2015) following the legislation, with the implementation of strategies such as state funding appropriations for the Early Childhood Comprehensive Systems (Division of Public Health) program to promote developmental screening within the pediatric community.

The funding enabled the purchase of the Parents Evaluation of Developmental Status screener (PEDS Online). The validated screening tool was made available free of charge to pediatric and Family practices in 2012. This was a joint effort with Nemours Children's Hospital. The award of the ECCS COIIN grant in 2016 further expanded the effort to include the partnership with early childcare and education. Early care and education, prior to the ECCS COIIN grant utilized a child development screener that generated individual data as opposed to aggregate data and was expensive to administer as it required hired hands. Though the Ages and Stages Questionnaire was used in some childcare settings, it was not used across the board. As beneficiaries of the ECCS COIIN grant, staff at the Colonial School district's early learning program cited the return on investments in utilizing the ASQ within school districts. House Bill 202, now Title 14, is the outcome of such advocacy; the bill, as mentioned earlier in this report, mandates licensed childcares to administer annual developmental screens using the ASQ, and has been in effect since 2023.

This historical narrative paints the complex backdrop of Delaware's journey towards an effective and efficient developmental screening and surveillance system. It's noteworthy to point out that home visiting programs also administer developmental screens using the ASQ. Nemours continues to administer screens but changed from PEDS online to the SWYC – (Survey of Well-being of Young Children).

With this as a backdrop, the ECCS program's overarching goal for the coming application year is to continue the path of integration. Over the years, the ECCS program has placed efforts in developing a shared data system, starting with developmental screening. The program developed and has always had access to PEDS online and Help Me Grow@211 data. We will renew the data sharing agreement with the Office of Early Intervention to continue receiving aggregate ASQ data monthly. Access to home visiting ASQ data is also available through the MIECHV program.

For the application year, we plan to reach out to Nemours to reactivate the data sharing agreement that existed prior to the organization switching from PEDS online to SWYC. Having such a centralized database for developmental screening will provide a comprehensive picture of the scope of Delaware's developmental screening initiatives. It will begin the path to developmental screening integration. There will be an improvement of community and state knowledge, while increasing awareness of the data, infrastructure, opportunities, challenges and available data sources.

As pediatric practices close, providers retire and new physicians are hired, the need to continue promoting developmental screens and the use of PEDS Online is essential. As mentioned earlier, the number of practices currently utilizing the instrument has decreased. For this coming year and beyond, we plan to visit active and inactive PEDS online practices to understand any gaps, share trends and the transition to the CHADIS system. This activity will be coupled with educating practice staff and physicians on PEDS Online, developmental surveillance and screening, referrals to early intervention/social services and the CHADIS referral platform. Through this engagement,

barriers to implementation/referrals will be identified which will aid in employing targeted quality improvement processes to address those barriers.

Unforeseen challenges experienced with the CHADIS project has delayed the scaling up and spread. That said, the proposed visits to practices, mentioned in the earlier paragraph, will be done in tandem the promotion of CHADIS, to introduce active and non-active practices already utilizing PEDS online to the platform. The first phase will be to target “low hanging fruit” practices that will require less resources and encouragement. The second phase will target non-active PEDS online partners. These practices initially signed up to implement the PEDS tool but have ceased utilizing it for one reason or the other. The third phase will be reaching out to practices that are not implementing any developmental screening instrument to sway them to consider the benefits of implementing screens. The ECCS program and its partners (DE AAP and CHADIS Inc) are aware this will not be an easy feat but see it as a critical activity to strengthen our developmental screening initiative. We will rely on several strategies to move this effort forward, such as publishing a whitepaper; using peers to encourage implementation including enabling access to outcomes information on families referred to early intervention.

For the past 3 years, the ECCS program has partnered with and supported the Delaware Chapter of the American Academy of Pediatrics (DEAAP) in its quest to support and promote developmental screening through early literacy and the Reach out and Read program. Over the years, of promoting developmental screening, it became evident that leveraging the ROR program tended to encourage pediatricians to implement developmental screening. We will continue pursuing this approach to encourage practices that are interested in the ROR program to include developmental screening this application year. There are currently about 30 pediatric practices that have signed up to implement ROR program.

Work on the CHADIS project is on-going, so we will continue to work closely with CHADIS staff to ensure the dashboard captures pertinent data, is accessible to individuals who need to have access, is robust and user-friendly.

We will also continue tracking and monitoring the documentation of children at CHADIS pilot pediatric practices or existing PEDS practices that transition to the CHADIS system that refer to early intervention due to the children having a higher risk developmental screen. This will provide the data we will need for ESM:6.2.

The CHADIS referral platform enables pediatric practices to refer to early intervention programs (Parts B and C) when screen results indicate a risk for delays. Referrals for families who indicate a socio-economic need is passed through the HMG@211 helpline. CHADIS data reports show that the 4 pilot practices are not referring to the helpline. The plan for this application year is to promote the helpline among pediatricians and their staffs. We will hold short trainings to introduce them to HMG services that could help providers as well as families.

Additionally, we will target early intervention programs (Parts B and C) to offer, through continuous quality improvement efforts, to improve and increase communications with pediatric practices; improve early intervention processing of referrals through the referral platform and assure a closed feedback loop.

Our efforts to develop and maintain engagement with child-serving providers and families will continue through the Books, Balls and Blocks initiative. The virtual sessions will continue; however, we’ll focus on holding an in-person event in Kent and Sussex counties, targeting high risk zones. We will continue the partnerships with school districts, childcare centers, libraries and other non-profits to coordinate BBB events or participate in events they initiate. We plan to follow up with a library that was interested in collaborating with BBB to organize sessions during one of their established programs “Toddler Time”. This will test our theory that partnering with a program that has a core parental participation could increase the BBB reach.

To address the disparity outcomes that exists between children residing in high-risk zip zones as opposed to those in non-high-risk zones, the BBB program will target childcare centers in those high-risk zones and offer education on milestones including opportunity for parents to complete an ASQ screen. This will help in achieving the child health

ESM 6.2 goal by 2030. Similarly, the HMG@211 staff will target individuals that call from the high-risk zip zones and offer to administer a screen over the phone or provide developmental screening information to them via text messages.

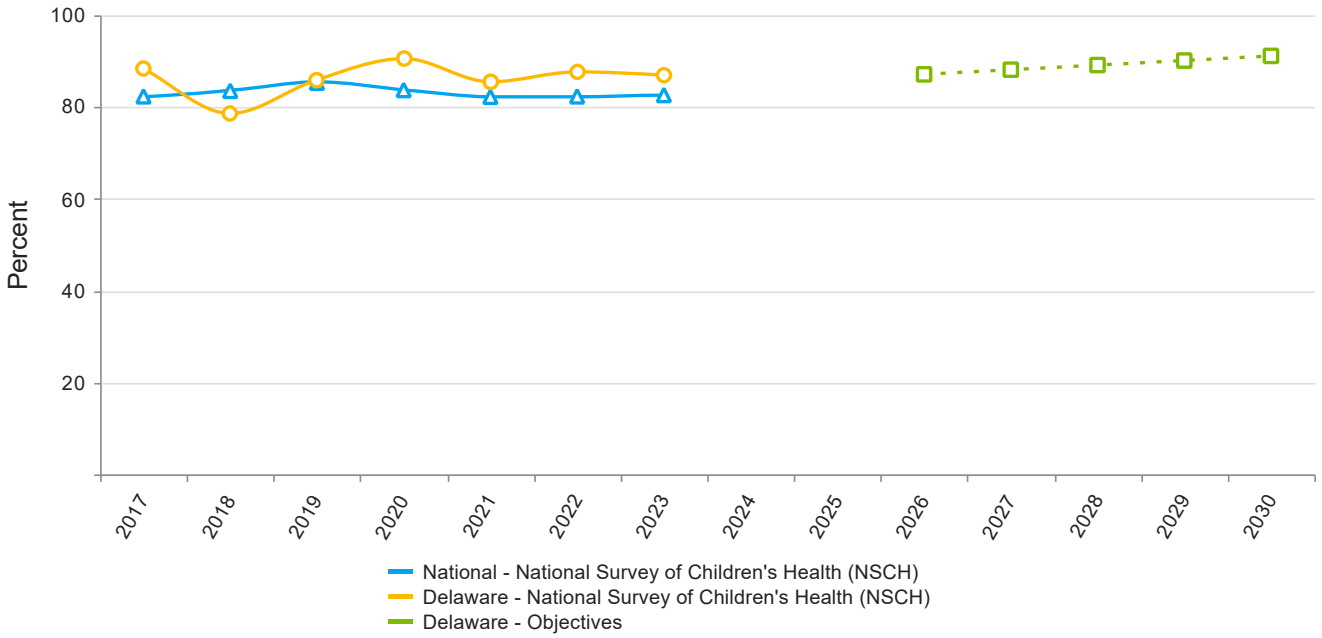
The Help Me Grow at 211 helpline was launched in 2012, despite marketing efforts to promote its services, processes and resources, providers and families appear not to know about it or understand the service. It's our goal for this application year, to use several strategies to promote HMG awareness. In addition to the traditional approaches to promote programs such as distribution of collateral materials, using social marketing or face-to-face presentations, the ECCS program will use a simulation approach to engage participants, so they have an interactive experience with the HMG system services. The idea is that adult learners learn by doing, and by doing they it will change their knowledge, attitudes and behavior about the HMG system. We will target child-serving providers so they can share the information they learn with the families they serve.

A simulation event was held in the first quarter of this year and was very successful, so for the coming application year we will organize another event in southern Delaware, where we can target providers serving vulnerable populations who could be better served with HMG services. This event will be organized in tandem with a networking event which will provide the space for providers and programs to connect with one another while introducing HMG as a one-stop-shop for referrals to community services and resources for women and children to strengthen the early childhood community.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	86.8
Numerator	13,797
Denominator	15,887
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	87.0	88.0	89.0	90.0	91.0

Evidence-Based or –Informed Strategy Measures

ESM MHT.1 - Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	70.0	75.0	80.0

ESM MHT.2 - Percentage of high school students enrolled in Delaware SBHCs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	45.0	50.0	55.0	60.0	65.0

ESM MHT.3 - Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services (PHQ and GAD-7 are usually components of a risk assessment).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

State Action Plan Table

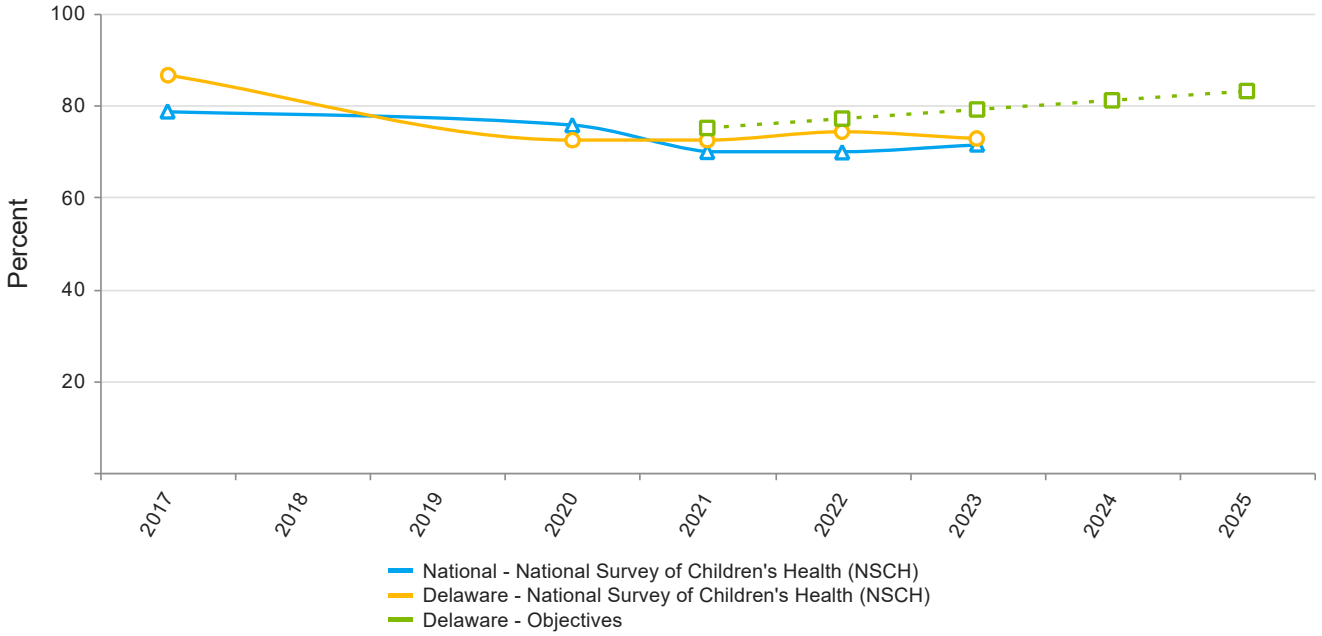
State Action Plan Table (Delaware) - Adolescent Health - Entry 1	
Priority Need	
Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening	
NPM	
NPM - Mental Health Treatment	
Five-Year Objectives	
Expand the number of qualified providers through strategic partnership with the DSCYF DCPAP Pediatric Mental Health Grant.	
Increase the percentage of high school students enrolled in Delaware SBHCs.	
Increase the percentage of students enrolled in Delaware SBHCs who are screened for behavioral and mental health services.	
Strategies	
Enhance the capacity of behavioral and mental health providers both working in and referred by Delaware SBHCs through partnership with DSCYF Delaware Child Psychiatry Access Program – Pediatric Mental Health Grant.	
Improve the outreach of Delaware SBHCs in enrolling and screening high school students for behavioral and mental health services.	
ESMs	**Status**
ESM MHT.1 - Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.	Active
ESM MHT.2 - Percentage of high school students enrolled in Delaware SBHCs.	Active
ESM MHT.3 - Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services (PHQ and GAD-7 are usually components of a risk assessment).	Active

NOMs

Adolescent Mortality
Adolescent Suicide
Adolescent Firearm Death
Adolescent Injury Hospitalization
Children's Health Status
Adolescent Depression/Anxiety
CSHCN Systems of Care
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	77	79	81
Annual Indicator	75.7	71.9	71.8	74.2	72.6
Numerator	47,654	48,388	51,420	53,987	52,895
Denominator	62,974	67,333	71,653	72,759	72,862
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	75	75	80
Annual Indicator	29.2	76.2	74.2	66.7	82
Numerator	883	4,902	4,958	4,420	6,028
Denominator	3,027	6,429	6,678	6,631	7,352
Data Source	SBHC Program Data	SBHC Porgram Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

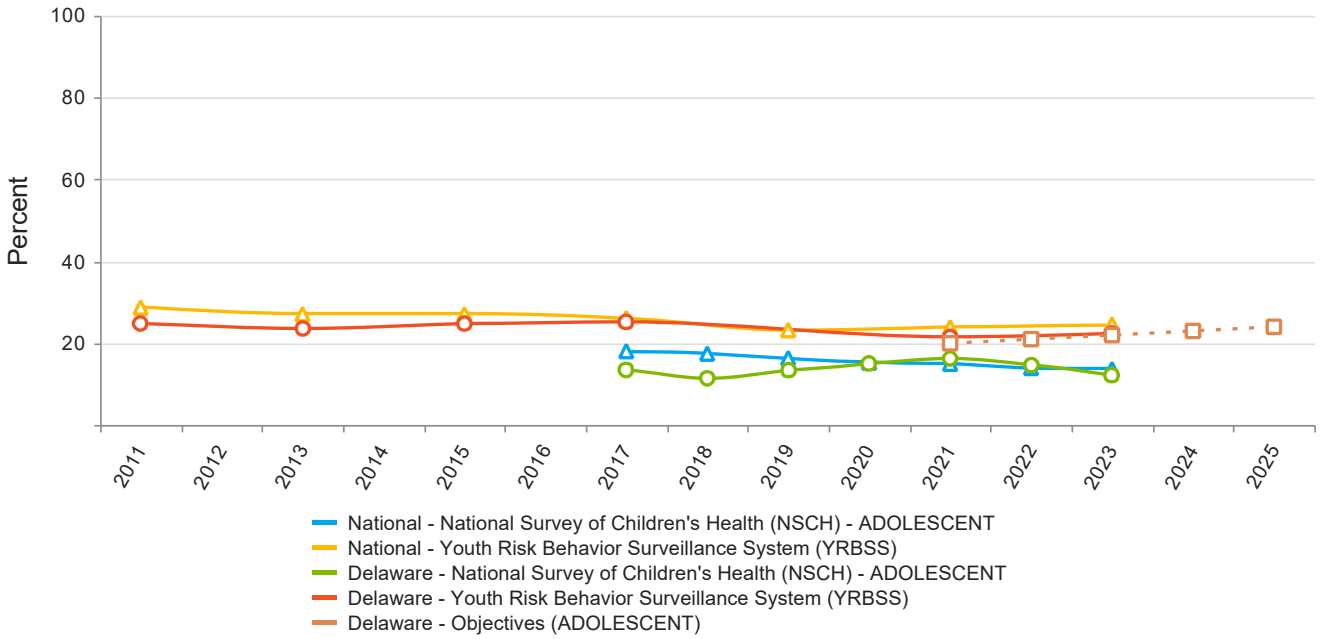
2021-2025: ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			55
Annual Indicator	48.2	53.6	52
Numerator	4,530	3,413	5,262
Denominator	9,407	6,367	10,121
Data Source	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Provisional	Final

2021-2025: ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			0.2
Annual Indicator	0.1	0.2	0
Numerator	99	337	53
Denominator	140,263	141,729	142,495
Data Source	DOE Program Data	DOE Program Data	DOE Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

2021-2025: NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - PA-Adolescent
Indicators



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	22	22	23
Annual Indicator	25.1	25.1	21.6	21.6	22.4
Numerator	9,329	9,329	8,529	8,529	9,237
Denominator	37,230	37,230	39,459	39,459	41,212
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2021	2021	2023

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	21.0	22	23
Annual Indicator	13.0	14.9	16.0	14.8	12.1
Numerator	8,196	9,878	11,362	10,707	8,813
Denominator	62,967	66,257	70,996	72,524	72,721
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:		**Active**	
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			12
Annual Indicator	14.3	21.4	21.4
Numerator	6	9	9
Denominator	42	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Adolescent Health - Annual Report

Adolescence is an important time for promoting good health and preventing disease. Unfortunately, this important time is one that is sometimes overlooked. Adolescent health includes the physical, social, emotional, cognitive, and intellectual domains. It is important to understand the factors that can affect adolescent health so that organizations and individuals who work with youth can support the health and healthy development of all adolescents.

Puberty is a unique life cycle that offers people particular challenges and opportunities. Adolescence is considered a crucial phase in human life that requires extreme parental care, guidance, and empathy. Only with caution, we can ensure that our youth grow into healthy adults who can help improve our society and become their leaders for a bright and prosperous future. Therefore, the goal of effective youth care requires systematic steps to prevent, detect and treat physical and mental disorders in young people.

Adolescent Well-Visit

According to the 2022/2023 National Survey for Children's Health (NSCH), the percent of Delaware adolescents (ages 12 through 17) who have had a preventive medical visit in the past year is 72.6%, which is only slightly above the national average of 71.4%. We are holding steady with our numbers, but still have much work to be done. During Delaware's 2020 Needs Assessment, our stakeholders identified the adolescent well visit as the number two priority for this population domain and was ranked 7th important, overall.

According to the 2022/2023 NSCH, 19.1% of Delaware's children, ages 0 through 17, have experiences two or more adverse childhood experiences (ACEs). During the same time frame, the national average of children experiencing two or more ACEs was 17.2%.

In partnership with a community agency, training is offered for staff at School Based Health Centers (SBHCs) each year. Attendees range from School of the Deaf, Detention and Treatment Centers from within the Department of Services for Children Youth and Their Families (DSCYF), Delaware Adolescent Program Inc. (DAPI), SBHCs, middle schools, high schools as well as community agencies, partners and parents. In addition, mental health and medical providers participate in trainings provided throughout the year. The following list represents trainings provided thus far this year.

Teacher Training: Best Practices in Facilitating Evidence-Based Sex Education	In person	October 2024
Teen Dating Violence workshop at the Fall Provider Meeting	In person	October 2024
Crash Course in Best Practices for Teaching Sex Ed at Delcastle HS for the district's health teachers	In person	November 2024
Curriculum Booster Training for Champion Teachers	In person	November 2024
STI Updates, Supporting Youth, and Relationships / Sexting / SEM	In person	December 2024
Parent information session for Child Inc	In person	November 2024
Facilitated parent workshop at Academia Antonia Alonso Charter	In person	February 2025
Professional Training Opportunity: Supporting Teens	In person	March 2025

COVID-19 impacted School Based Health Centers across the state of Delaware. Many SBHC's implemented telehealth at the onset of COVID-19 which is still in place to ensure are students have access to treatment when needed. Upon availability of the vaccine to adolescents 12 and older, SBHC's have coordinated efforts for the vaccine with medical vendors in the latter months of the school year. The demand for mental health services has surged significantly since the onset of COVID-19. SBHC providers continue to deliver essential mental health services, aiming to decrease mental health and psychosocial issues among adolescents.

COVID 19 efforts to promote education, testing, vaccines, and awareness are still being promoted in various ways throughout the state. Using methods such as:

- Social Media
- Radio Stations
- Bulletin Boards
- School Staff
- SBHC Staff
- Flyers/Posters
- Medical Provider Websites

During the 2023/2024 school year, the School Based Health Centers in Delaware schools administered 1,066 depression screenings, 1,043 STD screenings, 14,996 Emotional (Mental Health) evaluations, and 2,573 risk assessments. These numbers have increased from the previous school year.

During the month of May, DEThrives ran a promotion during National Teen Pregnancy Prevention Month. DPH bolstered the services that SBHCs offer teens in the state of Delaware. These services include diagnosis and treatment of STDs/STIs, reproductive health services, and more.

The SBHC Operational meeting this year was held in conjunction with Title X Family planning on October 23, 2024, and May 6, 2025. It comprised of mental health and medical providers from SBHC's, providers and administrative representatives from DPH Clinics, Federally Qualified Health Care Centers, Community Health Care Centers, as well as DPH/FHS staff. The Adolescent and Reproductive Health Department attended an Annual Summit with DHMIC on April 14, 2025, 'Our Vision. Our Voice Elevating Community Voices to Transform Maternal and Child Health'. This year's training sessions covered a broad and impactful range of topics centered around cultural humility, teen violence, and mental health. The Delaware Healthy Mother and Infant Consortium (DHMIC) Summit emphasized the critical importance of community voices in shaping maternal and child health outcomes. Participants heard from both local and national experts who shared innovative care models and strategies for improving the health for mothers and babies in our communities.

Key Training and Summit Topics Included:

- Teen Dating Violence
  Presented by J. Green (10/23/24)
- *Danielle Johnson, RN, BSN and Brian Wharton, MSN, RN, CPEN (10/23/24)*
- The Mental Game of Winners: How to Get Unstuck, Out of Your Head, and Thrive
  Charles Clark (10/23/24)
- Applying the Science of ACEs and Toxic Stress to Improve Outcomes for Mothers and Children
  Keynote Speaker: Nadine Burke Harris, MD, MPH, FAAP (04/17/25)
- Putting the "C" in Community: Community-Driven Approaches to Patient-Centered Care (04/17/25)
  Presented by:
  - LaToya Brathwaite, MSN, APRN, FNP-BC
  - Gina Hamilton, BA, BSN, RN
  - Kim Blanch, BSN, RN
  - Amanda Watson, DNP, CNM, APRN
- How Men Can Impact Maternal Health Outcomes (04/17/25)
  Speakers:
  - Jared Jenkins
  - Wade G. Jones, LPCMH, LCDP, CAADC, CCS
  - Gregory Whilby
  - Doris L.P. Griffin, Ed.D.
- From Surviving to Thriving: How Guaranteed Basic Income Empowers Children and Families (04/17/25)
  Speakers:
  - Leah Jones, MPA

    - Logan Herring, Sr., BA (CEO, WRK Group, DHMIC Appointed Member)
    - Alonna Berry
- The Case for Investing in Mothers and Children (04/17/25)
  Janet Currie, PhD

In addition to the above training, the Adolescent and Reproductive Health Unit participated in an in-person training session on "Community Engagement: Building Support Through Community and Youth Engagement" from November 6-8, 2024, in Phoenix Az, in with the Family & Youth Services Bureau. To provide program managers and project staff with skills-based training on effectively developing and maintaining community partnerships, with a focus on building community and youth engagement to support PREP (Personal Responsibility Education Program) programming.

On August 29, September 10, and September 23, 2024, we attended the virtual conference "Program Management: How to Maximize Impact in PREP Programming." This event provided valuable guidance and resources to help grantees strengthen how they manage their programs. The training focused on ensuring programs comply with PREP rules and requirements, and offered practical tips for planning, implementing, and improving program performance. Key focus areas included:

- Assessing whether programs meet PREP requirements
- Applying strategies to improve program management
- Identifying at least two areas for program improvement

This training equipped participants with tools and action steps to optimize their program operations and increase overall impact. The conference featured multiple speakers, interactive workshop sessions, and numerous networking opportunities, enabling DPH to engage with an array of professionals and stakeholders.

Legislation was submitted and approved; House bill No. 129; awarding $170,000 to two high needs elementary schools per year until all high needs elementary schools are in compliance. There are currently 20 high need elementary schools in the state of Delaware. August 31, 2022, Baltz Elementary and January 24, 2023 Frederick Douglass Elementary became a State Recognized School-Based Health Center Provider. As a SBHC, they have applied for and are eligible to provide medical, mental health care treatment and health education to promote a healthy lifestyle. These centers will serve children allowing access to services such as sports physicals, and mental health counseling.

Delaware's DPH, DEThrives partnered with the Department of Education to promote School Based Health Centers during the month of February 2025. DEThrives and DOE promoted the importance of an annual well visit/yearly check in with a doctor. Students who feel better, live healthier lives, are involved in fewer school discipline cases, and do better in school. This post was one of the top performing Tweets (based on engagement) on X during this grant cycle.

Mental and behavioral health services remain critical areas of growth within School-Based Health Centers (SBHCs). While many SBHCs face ongoing challenges—such as staffing shortages and high turnover—others have successfully met or exceeded their goals in delivering these essential services. Despite these achievements, the overall demand for mental health support among students continues to outpace capacity.

To help address this growing need, many SBHCs have expanded their use of telehealth and strengthened referral systems, improving access and responsiveness to student needs. DPH collaborates closely with other state agencies to provide additional resources and support to SBHC providers, ensuring that students receive the mental and behavioral health services they require.

The Strategic Plan that was developed by the Division of Public Health/ Family Health Systems/Adolescent Health was an intense, virtual, strategic planning process in which 13 goals was established to produce a synchronized organization of SBHC's across the state of Delaware. The plan is currently being implemented in all stages throughout the state with continued coordinated efforts with stakeholders such as the department of education,

medical vendors, Delaware School-based health Alliance, etc. https://dethrives.com/sbhc. As we continue to implement the plan, SBHC continues to evolve and develop allowing students to utilize services needed such as mental health, reproductive health, and well visits.

Programs implemented during the school day focus on reducing risk-taking behaviors, developing healthy behaviors, and emphasizing the importance of ongoing healthcare. Adolescents grappling with unhealthy mental health behaviors may struggle with academic performance, decision-making, and overall health. Unfortunately, due to the COVID-19 pandemic, we were unable to fully partner with our SBHC and Delaware school districts during the school year. As we continue to move forward past the pandemic, we are working to reestablish relationships with school districts and DOE to improve healthy behaviors and reduce risk-taking behaviors.

We are actively promoting and encouraging SBHCs and school districts to educate and raise awareness about developing healthier behaviors and reducing risk-taking behaviors. Once SBHCs are fully staffed, our goal is to reestablish partnerships with the Department of Education and school districts to launch a health messaging campaign addressing mental health treatment.

Towards the end of the 2024/2025 school year, DEThrives shared additional information for adolescents during National Adolescent Health Month. Every day, SBHCs across the state help teens with early detection of health issues to mental health support. SBHCs offer four types of services: physical health, mental health, health education, and nutritional consultation.

As of 2024, Delaware has 38 recognized School-Based Health Centers (SBHCs) operating in high schools and middle schools, and 24 in elementary schools. All public high schools in the state are equipped with an SBHC. In 2024, three elementary schools and one middle school established new SBHCs to expand access to essential health services for students. These participating schools are listed on the sitemap.

Looking ahead to the upcoming fiscal year, Delaware anticipates the recognition of additional elementary and middle school SBHCs, further strengthening the delivery of critical health services within school communities.

Between November 5th, 2024, through November 15th, 2024, DEThrives ran a 12 second reel (short animated video clip on Facebook and Instagram about Tobacco, Alcohol, and Drug Cessation. This post was run on reels and on stories to aim for a younger audience) to educate users on the importance to not consume alcohol, smoke, or use illegal drugs while pregnant. The ad targeted women over the age of 18 years old with a goal of increasing the reach (total number of unique people who saw your ad at least once) for the ad. The ad earned over 244K impressions (number of times a post has been displayed), a reach of over 225K, a frequency of 1.08 (number of times a user is exposed to an ad over a certain time frame), had 125 link clicks, 82 post reactions, and 2 post shares.

The Take Care Delaware Implementation Team, comprised of law enforcement, educators and mental health providers, spent 2018-2019 working together to create guidelines for implementation. In July 2019, Governor John Carney signed Delaware House Bill 74 (Take Care Delaware program), enabling a partnership between law enforcement and schools to adopt a trauma-informed approach to children who have been identified at the scene of a traumatic event. With that, we had what we needed to address the needs of children traumatized by violence in their homes, schools and communities.

DPH worked with members of the Delaware State Police (DSP), DOE, and the Department of Services for Youth, Children, and their Families (DSCYF) to explore implementation of a program called Take Care Delaware. This program is modeled closely to the Handle with Care Model that was implemented in West Virginia, Maryland, and Tennessee. This program provides a statewide trauma informed response to child maltreatment and children's exposure to violence. The model states that "If a law enforcement officer encounters a child during a call, that child's

information is forwarded to the school before the school bell rings the next day. The school implements individual, class and whole school trauma-sensitive curricula so that traumatized children are “Handled With Care". If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school.”

Delaware began the 2024/2025 school year with 21 school districts and 24 law enforcement departments and ended the school year with 25 school districts and 27 police departments in the program. This year’s program began during the 2024/2025 school year (8/25/24 – 6/13/25). The data shows there has been 3,049 incidents generated, which equals to 4,798 notices. Take Care Delaware will begin the process again of scheduling meetings with additional New Castle County Vo-Tech and Charter Schools, to continue the progress.

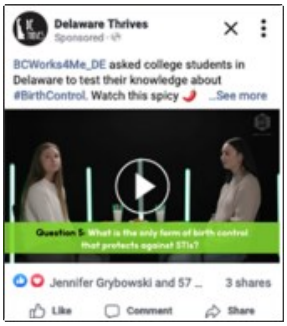
During the month of June 2025 DPH promoted a social media post during Men’s Health Month. DEThrives educated adolescent boys about developing healthier eating habits, prioritizing their physical, sexual, and emotional health, as well as providing some quizzes about Young Men’s Health.

For the last year of this five-year reporting cycle, our selected priority of increasing the number of adolescents receiving a preventive well-visit annually to support their social, emotional and physical well-being, we have continued to focus on access and availability of mental health resources.

DEThrives promoted mental health again during the month of December 2024. How can we better prioritize child and adolescent health and help shape their future? It's not just about physical growth, but how children evolve mentally and socially. Learn about improving access to quality services, strengthening maternal and child health (MCH), and more. Resource link: https://mchb.hrsa.gov/programs-impact/focus-areas/child-adolescent-health

We partner with our School Based Health Centers to address increasing the number adolescents who receive an annual preventive medical visit. Our School Based Health Centers offer mental health support and counseling so even though bullying was not selected during this past Needs Assessment, we still plan to support the emotional well-being of adolescents. MCH also understands that bullying behavior can be triggered at much earlier ages. With this in mind, our Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and our Early Childhood Comprehensive System (ECCS) programs have a focus on social and emotional wellness and provide materials and education to the families and communities they serve. School Based Health Centers have also expanded into elementary schools in Delaware as well.

Poor mental health in adolescence is more than feeling blue. It can impact many areas of a teen’s life. Youth with poor mental health may struggle with school, grades, decision making, and their health. Mental and behavioral health services remain areas of significant growth and development. SBHCs continue to face challenges in providing services to students due to staffing shortages and high turnover rates. Conversely, other SBHCs are successfully meeting and exceeding their projected goals for delivering mental and behavioral health services. Despite these successes, SBHCs continue to grapple with the high demand for mental health services. To address this, telehealth and referral services have been implemented in many SBHCs to help meet the demand and accommodate student needs effectively.



From July 15, 2024, through August 6, 2024, DEThrives ran a 4-minute reel (short video) on Facebook and Instagram regarding Sexual Health and Birth Control. The aim was to increase reach of the post's messaging which was about birth control and reproductive health for the teen and young adult population. Since ads cannot be targeted to users under the age of 18 years old relating to anything about sexual health, the target audience was set to adults aged 18-22 years old. Since the video was a 4 minute long one (which is too long of a video to post on social due to users' short attention span), the goal of the post was to increase the reach (total number of unique people who saw the ad at least once). The post earned over 110K impressions (number of times a post has been displayed), 89 link clicks (how many times users clicked on the resource link of the post), the reach was over 169K, the frequency (number of times a user is exposed to an ad over a certain time frame) was 1.36, earned 59 post reactions (an example of this is when a user likes the post), and earned 5 post shares. This promoted post earned the most social engagement during quarter 3 (July – Sept 2024) where most clicks came from women.

In 2020, the Delaware Department of Education (DOE) developed and launched Project THRIVE, which helps children receive trauma-informed support from their schools, communities and caregivers. Project THRIVE provides free mental health services to eligible Delaware students. Services are available to students, grades pre-k through 12th grade, attending Delaware public, private, parochial and home schools.

Project THRIVE services help students who are struggling with traumatic situations, such as physical or emotional abuse, community violence, bullying, serious illness or death in the family, and more. Trauma can harm mental and physical health, and limit school success. Project THRIVE offers access to a local network of professional mental health providers, youth centered strategies aimed at recovery and healing, tools for self-regulating emotions and behaviors as well as strategies to improve a student's engagement in school. Project THRIVE services help students:

- Process and understand traumatic situations
- Attend school regularly
- Better control emotions and behaviors
- Develop coping skills for managing stress at home and school

Children and youth thrive in the presence of thriving caregivers. Project THRIVE is committed to supporting caregiver agency and helping them become good consumers of mental health care on behalf of their children. The mental health provider of choice will be supported in delivering trauma-specific mental health services.

MCH partnered with the DOE to expand advertisement of Project THRIVE. The need for self-identification of trauma has become a critical component to the success of Project THRIVE. MCH is committed to the success of this program and MCH worked to continue with a developed advertisement campaign to reach youth to increase self-identification and subsequently, utilization of Project THRIVE's services. The advertisement campaign was focused on building awareness of Project THRIVE to adolescents.

In lieu of continuing with paid media, MCH has pursued sharing the Project THRIVE content organically (free) with the help of DPH and the DOE. Through our paid communications vendor, DPH contracted to create various posts and stories. DPH is now organically posting and tagging the DOE on social media (Facebook, X, and Instagram) so the content can be reshared by the DOE and other partners to help broaden the message.

The call to action is to visit the anchor link "de.gov/projectthrive" (brings you to the part of the DOE webpage that is more consumer friendly rather than reading about background info on the services first that may cater more to

professionals) to learn more info and to dial 2-1-1, or text your zip code to 898-211 to learn more info or enroll in the services.

For National Bullying Prevention Month, DEThrives posted an Instagram story on Project THRIVE. The video advertised the free mental health services that are available to all Delaware students. The video informed the audience to call 2-1-1 to begin the process.

Unfortunately, MCH was notified during this last grant cycle that Project THRIVE's 5-year grant ended on September 30th, 2024. They have been granted a one-year contract extension to wrap up existing services. MCH will continue to advertise Project THRIVE's services until the grant has ended. During Project THRIVE's grant, a total of 546 school aged children and adolescents were able to receive mental health services from the provider of their choice. These children and adolescents received services in all three of Delaware's counties. All students or parents on the students' behalf reported observable improvements in their wellbeing since services were initiated. Moreover, all students or parents on the student's behalf report satisfaction with the Project THRIVE mental health providers and services, reporting they felt included in the treatment planning for their loved ones.

Through our social media platforms, DEThrives website, Instagram, You Tube, X, and Facebook, the Adolescent Health program works with the Social Media Coordinator to post messages on the importance of healthy choices for adolescents, which will empower them to adopt healthy behaviors.

Physical Activity (ages 12-17)

According to the 2022 National Survey of Children's Health (NSCH), only 12.5% of male children, ages 12 through 17 in Delaware are physically active at least 60 minutes per day, compared to 11.9% of male children nationally. Comparably, only 16.9% of female children, ages 12 through 17 in Delaware are physically active at least 60 minutes per day, compared to 20.4% of female children nationally. In addition, according to the NSCH, 20.2% of Delaware's children, ages 6 through 17 are obese, compared to a national average of 17.0%. During our 2020 Needs Assessment, our stakeholders selected increasing physical activity among the adolescent population as the number one priority for this population domain and was ranked 5th overall.

The Physical Activity, Nutrition, and Obesity prevention (PANO) program in the Health Promotion Disease Section of the Division of Public Health (DPH) facilitates collaborative work efforts and interventions that address increased physical for Delaware families including children and adolescents. MCH has partnered with the PANO office to increase physical activity for adolescents, ages 12-17. PANO program's long-term goal is to reduce the prevalence of adult and childhood obesity and other chronic diseases by promoting healthy lifestyles and improving health outcomes for Delawareans. Objectives encompass the development and implementation of evidence-based policy, system, and environmental (PSE) strategies that will help Delawareans engage in regular physical activity, better nutrition, and make intentional lifestyle changes, lowering the risk of developing heart disease, cancer, chronic lower respiratory disease, diabetes, and other chronic diseases.

PANO provides support to the Delaware Cancer Consortium, Cancer Risk Reduction Committee, Healthy Lifestyles Subcommittee (HLSC). The HLSC developed health and wellness policy recommendations to the Office of the Governor, many of which impact the health and wellness of adolescents. To help implement some of these policy recommendations, PANO launched the Advancing Healthy Lifestyles (AHL): Preventing Obesity to Reduce Chronic Disease Initiative.

During the month of January 2025 DEThrives promoted an adolescent physical activity post. Healthier choices start now! As a young adult, the choices you make today can impact your future. Make sure you're doing one hour or more of moderate to vigorous physical activity (light jogging, brisk walking, jumping rope, yoga, etc.) every day and visit your health care provider every year. For more tips, visit: https://dethrives.com/services-for-me/teens

AHL foundational pillars include Coordinated School Health and Wellness, Community Capacity Building, and Workplace and Employee Wellness. Each component provides opportunities to implement evidence-based practices and programs that reach broad populations across the lifespan, with a cross-cutting approach that overlaps and interrelates with one another. Each component is designed to engage and support specific objectives of the AHL initiative which will help develop a HLSC Action Plan, while connecting to partners in schools, the community, and the workplace.

In August 2024, PANO shifted its AHL school-based efforts from implementation of the Triple Play program in partnership with the Boys and Girls Clubs of Delaware, to a more targeted approach to engaging Delaware schools and early childcare education (ECE) settings. During the 24/25 school year, the Advancing Healthy Lifestyles Healthy Schools Recognition and Mini-Grant Programs was launched. The Healthy Schools Recognition Program aims to recognize Delaware schools that are implementing policy, systems, and environmental (PSE) change strategies and programs to improve the health and well-being of their students, with a focus on improved nutrition and increased physical activity. For the 24/25 pilot year, nine schools were awarded Healthy Schools Pioneer Awards. In conjunction with the Healthy Schools Recognition Program, a pilot Healthy Schools and Healthy ECEs Mini-Grant Program was also launched, which provides funding for Delaware K-12 schools and early childcare centers to implement pilot healthy lifestyle interventions and PSE change strategies. The goal of the mini-grant program is to support schools and early childcare centers in implementing pilot programs that facilitate and build a healthy school environment. For the '25 pilot year, three schools were awarded a Healthy Schools mini-grant, and six early childcare centers were awarded a Healthy ECE mini-grant.

During the month of May 2025, DPH advertised a physical activity post via DEThrives in recognition of National Physical fitness and sports Month. Are you moving at least one hour a day? National Physical Fitness and Sports Month is the perfect time to develop a healthier routine to keep your heart healthy, build muscles, and strengthen bones. From biking to swimming, here's a guide from the CDC.

For community-based work, the 24/25 Advancing Healthy Lifestyles mini-grant program offered funding and technical assistance to 10 community-based organizations implementing policy, system, and environmental changes to support healthy eating and physical activity in communities throughout Delaware. These efforts enable community-based organizations to achieve long-term and sustainable outcomes around health and wellness initiatives that support young Delawareans and the communities that care for them. See table below for program summaries for October 24 to May 25:

- Boys and Girls Clubs of Delaware focused on tackling food-access issues and food insecurity through a mini-farm project, community events, a mobile produce stand, and improved youth education in agriculture and nutrition.
- Christiana Care introduced a culinary medicine and nutrition education program for health care providers, enhancing their ability to advise patients on healthy eating.
- Delaware Breast Cancer Coalition funded their hybrid health education program, “Yes2Health,” for individuals at risk for certain chronic diseases to increase physical activity and nutritional knowledge.
- Delaware State University (DSU) implemented programming focused on physical activity and nutrition for DSU students, delivering educational resources that empower students to make informed and healthy lifestyle choices.
- Delaware State University (DSU) launched a Lunch and Learn series in partnership with the Roads to Success Program, to support students transitioning into adulthood, focused on portion control, food safety, and healthy food choices through engaging discussions and activities.
- Inner City Cultural League sustained its current initiative to reduce obesity and chronic diseases by offering physical activity classes, maintaining a robotic garden, and actively engaging participants in nutrition and agriculture education.
- Lutheran Community Services supported its Food Farmacy program, which addresses food insecurity and lack of consistent access to affordable foods that promote health and well-being.
- La Red Health Center enhanced their existing Produce Prescription program by distributing healthy food and promoting physical activity to combat food insecurity for both patients and staff through CSA produce shares, nutrition classes, and a walking club.
- Mid-County Center implemented a Healthy Lifestyles program for seniors, with a focus on nutrition and physical activity to help seniors increase physical activity, consume more fruits and vegetables, and manage their weight.
- W.B. Simpson Elementary School expanded its Family Health Night program, hosting afterschool events designed to tackle public health challenges for students and their families to promote children’s health, active lifestyles, nutrition, wellness, and physical activity.

AHL’s third annual conference serves as an annual convening that provides a platform for cross sectional sharing on national, regional, and local best practices, challenges, opportunities, and success stories. The goal of the conference is to strengthen efforts to reduce obesity and other chronic diseases amongst Delawareans. The 2025 theme was Eat Well, Move Well, Live Well, and sessions focused on strategies to address food insecurity, increase physical activity, and improve healthy lifestyles to reduce chronic disease. Nearly 350 individuals representing multiple sectors including state and local government, nonprofit, healthcare, higher education, and K-12 education, registered for the event. The annual conference served as an opportunity to close gaps in health inequities, assess progress, and further strengthen the work of community stakeholders.

Visit the Advancing Healthy Lifestyles webpage for more information on AHL activities.

DPH partners with the Sussex County Health Coalition (SCHC) to implement the Let’s Get Healthy Sussex Initiative to increase healthy eating and beverage consumption, and physical activity in high need communities in Delaware. SCHC’s Let’s Get Healthy Sussex Campaign included an awareness campaign, mini-grant program, and community-based partnerships to reach populations with healthy eating, lifestyle messaging and access to education through classes. The awareness campaign included curated PSAs through social media, radio stations, and news stations in Sussex County. The campaign generated 148,879 impressions and 539 engagements, highlighting its impact on community awareness and interaction with health-related content. Mini-grants were awarded to 7 organizations who were able to reach over 1,500 high-risk community members with health education, physical activities, and healthy cooking classes through programming such as Yoga at the Library, Parent Movement Clubs, Yoga Story Time, and Kickboxing for Kids. SCHC also provided six months of one-hour long “Lunch and Learn” sessions in partnership with the University of Delaware Cooperative Extension focused on nutritional education and practical guidance on preparing meals using local sourced ingredients.

DPH’s PANO collaborates with the Delaware Department of Education (DOE) on coordinated school health and wellness initiatives. To support DOE physical education regulations on annual physical fitness assessment, reporting and compliance standards, PANO supports the utilization and implementation of WELNET® a physical fitness education and assessment tool, from Focused Fitness. PANO collaborates with DOE and Focused Fitness to provide physical education and physical activity resources to Delawareans. Technical assistance is provided for WELNET® implementation, professional development, and training opportunities for Delaware educators, and

provides online resources. During the 2023/2024 school year, 242 schools were provided access to the software. There was a 100% overall response rate for school districts and an 87% overall response rate for charter schools. The DOE has been working diligently to increase compliance rates and ensure schools across Delaware are implementing and reporting on the required physical fitness assessments.

In observance of National Exercise Day and Move More Month, DPH's DEThrives promoted a social media post durin the month of April 2025. Is your teen or pre-teen getting at least 60 minutes of physical activity each day? This National Exercise Day and every day, encourage movement to prevent heart disease, reduce stress, and so much more. Learn about the benefits of fitness and how to make it a routine via the Healthy Children website.

PANO provides technical assistance and resources to Delaware's professional Society of Health and Physical Educators (SHAPE DE), which makes up the professional workforce of health, physical activity, and physical education teachers throughout Delaware. SHAPE DE annual convention was designed to provide SHAPE members and health education professionals the opportunity to share instructional ideas with each other and learn from local and national subject matter experts. Over 375 educators were pre-registered for the event. This year, an additional 15 physical education teachers were supported to attend the SHAPE America National Convention. Attendees were able to interact and network with hundreds of teachers from across the nation to share best practices and hear from subject matter experts in the field. Each attendee is submitting a call for proposal and will be presenting at the SHAPE Delaware Convention.

In 2024, PANO expanded obesity prevention efforts in Early Childhood Education (ECE) settings. PANO partnered with the Delaware Institute for Excellence in Early Childhood (DIEEC) to provide technical assistance and support to early childcare providers in implementing evidence-based healthy living and obesity prevention initiatives. The DIEEC is conducting a series of listening sessions aimed at identifying barriers to promoting physical activity and healthy eating within ECE settings. They also hosted two learning sessions focused on best and effective practices for physical activity in ECE settings. Additionally, DIEEC staff participated in professional development to strengthen their expertise in the area of nutrition, physical activity, and obesity prevention in ECE settings.

Nutrition Counseling

New Castle County Community Health Services continues to expand nutrition services. This past year, the Registered Dietitian Nutritionist (RDN) received referrals resulting in 130 clients having nutrition consultations. The referrals come from multiple sources, including APRNs from sexual and reproductive health clinics, child health and adult health clinics, Child Development Watch and Community Mobile Health Units which focus on chronic health screenings.

Within the Division of Public Health, programs such as Family Planning, Child Health, Sexual Reproductive Health, Adult Health, Child Development Watch, our Community Mobile Health Units (which focus on chronic disease screening and prevention), along with our Tuberculosis Clinic can refer to an RDN for nutrition counseling. Additional public health programs such as the Lead Poisoning Prevention Program, and the Women Infants and Children (WIC) Program have also established parameters for nutrition referrals. Children with elevated blood lead levels are referred to the Nutritionist for nutrition-focused lead poisoning prevention guidance, with emphasis on managing or reducing the amount of lead in the blood by consuming nutrients that compete with lead for absorption by the body. The WIC Program refers to the Nutritionist for concerning nutrition conditions such as selective eating, food allergies and intolerances, elevated blood lead levels, and low hemoglobin levels for infants and children aged 1-5 years.

Other state programs, such as Birth to Three Child Development Watch (CDW), which focuses on children with developmental delays and/or disabilities have an established referral process for nutrition consults. This provides opportunity for the Nutrition Program to reach infants and children in the community and guide families through feeding challenges that often accompany children in the CDW program such as restrictive eating behaviors, food progression delays and food aversions which can lead to weight concerns. By partnering with children and their

caregivers at an early age, concerning eating habits can be addressed with the goal to manage or resolve potentially harmful food-focused behaviors.

Nutrition consultations are conducted either over the telephone or in person based on patient/parent preference and accommodations, and this year we are expanding to Telehealth virtual visits. Consultations focus on the identified nutritional concern(s) and distributing knowledge and resources to help minimize obstacles along the path towards resolution or management of concerns. Common nutrition concerns seen by the Nutritionist include obtaining and maintaining healthy weight, encouraging the introduction of new foods, increasing the consumption of a broader variety of healthy foods, and the ability for participants to make more informed food choices to live a healthy lifestyle. Along with these common concerns, recognition and navigation of food preferences, allergies, intolerances, and sensitivities as well as digestive disorders, developmental disabilities, and chronic health conditions is critical. This past year we have seen increased clientele for health conditions such as diabetes, heart disease, obesity, high blood pressure, cholesterol reading concerns, as well as Celiacs Disease and Autism Spectrum Disorder, among others. With many influencing factors, individualized food plans are key to accomplishing nutrition and health goals. With the goal to inspire healthy lifestyles, healthy eating guidelines, recommended daily intakes, and portion sizes of foods are discussed with the client and are personalized based on the needs and preferences of the individual. Integrating client involvement and making them a partner in their health journey helps inspire positive choices and attainable goals on the way to managing and minimizing detrimental health outcomes. Combining client input and their health concern(s), food plans and recipes guided by USDA's MyPlate and the Dietary Guidelines for Americans 2020-2025 are provided and are tailored to the certain preferences and dietary needs of each client.

In addition to nutrition consulting, continuing education is a critical part of the career of an RDN to maintain registration and licensure, in addition to exploring research and staying up to date on current health and nutrition news and topics. Trainings I have completed this year include *Nutrition for the Neurologically Impaired Child, Decoding the Nutrition Facts Label, Strengthening Health Outcomes in the Community Population Part 1: Recognizing Patients at Nutritional Risk, Strengthening Health Outcomes in the Community Population Part 2: Incorporating Nutrition into Practice, and Protein Metabolism and Aging*. Completion of these trainings included the curriculum to obtain the Certificate in Community Training from Abbott Nutrition Health Institute.

During the month of March 2025, DEThrives promoted a health-related post in recognition of National Nutrition Month. The post was aimed at parents of children or adolescents. This National Nutrition Month, fuel your child with healthier choices. Limit recreational screen time to two hours each day. Ensure they get one or more hours of physical activity each day. Limit sugar-sweetened beverages.

Being engaged in community health events and conferences throughout the state has broadened my awareness of resources and networks to utilize in expanding nutrition services.

On June 5, 2025, the Division of Public Health's Physical Activity, Nutrition, and Obesity Prevention (PANO) Program hosted the third annual Advancing Healthy Lifestyles (AHL) Conference: Eat Well, Move Well, Live Well. AHL Conference initiatives include reducing obesity and chronic conditions, achieving positive health outcomes by coordinating school health and wellness along with workplace wellness, and fostering connections between youth-serving organizations and schools to support the health and well-being on youth across the state. The AHL conference provides an opportunity to engage in panel discussions and network with colleagues as well as other health professionals and those in careers which promote healthy living.

The PANO Program's Advancing Healthy Lifestyles Coalition has opened opportunities to build relationships amongst colleagues, healthcare professionals, and community members. Together, with the goal to reduce adult and childhood obesity, along with other chronic conditions, to achieve long-term positive health outcomes for schools,

communities and workplaces throughout Delaware, I plan to further their vision to uplift the wellbeing of all Delawareans and break down barriers to achieve healthy lifestyles.

I plan to participate in the annual HIV Awareness/Testing Event on Friday June 27, 2025, in Newark, hosted by the Hudson State Service Center, provides on-site HIV screenings for all ages along with information and resources. HIV related nutrition information and resources including healthy food choices and food safety are provided along with the Nutritionist on site to answer questions and provide nutrition material tailored to those affected by HIV/AIDS in the community.

Additional webinars attended:

- August 3, 2023 - Delaware Annual WIC World Breastfeeding Celebration
- December 6, 2023 - KIDS COUNT in Delaware Focus on Childhood Nutrition webinar.
    - Description: Nutrition plays a foundational role in determining a child's future health outcomes. Yet, in Delaware, over 30,000 children experience food insecurity. Led by Miranda Perez-Rivera- a research assistant with KIDS COUNT in Delaware and student in the Biden School for Public Policy and Administration. The Childhood Nutrition Webinar explored resources available to supplement food quantity and assist families with providing adequate nutrition to their children. Representatives from Women, Infants, and Children (WIC), HMG@211, The Food Bank of Delaware, and the School Nutrition AgriCulture Program (SNAC) shared how they are helping Delaware children succeed through their resources. It is our responsibility as a community to ensure no child is hungry and they have the resources they need to thrive.
- January 11, 2024 - Key Trends in Food, Nutrition & Health 2024 hosted by General Mills Bell Institute of Health & Nutrition. Understand current global food and health trends and how they shape the nutrition landscape and learn how to advise your clients on how to best navigate new products in the market.

Adolescent Health - Application Year

During Delaware's 2025 MCH Title V Five-Year Needs Assessment process, the MCH team along with various stakeholders, identified a specific priority pertaining to adolescents. Delaware selected Mental LB Treatment, which is the percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling. As a result of our Needs Assessment process, Delaware identified a priority need for adolescents. We aim to increase the percentage of high school, School Based Health Centers (SBHC) enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening(s). We plan to leverage our School Based Health Centers in the state to address priorities like mental health.

Adolescent Mental Health

According to the 2022/2023 National Survey of Children's Health (NSCH), 86.8% of Delaware adolescents have received needed treatment or counseling in the past year. This is slightly above the national average of 82.5% of adolescents. We are aware the COVID-19 pandemic had an effect on adolescents receiving mental health services; however, we will continue to make this a priority for Delaware.

Delaware's School-Based Health Centers (SBHCs) play a vital role in providing prevention-oriented, multidisciplinary health care to students directly within public school settings. These centers are an essential component of the state's strategy to improve adolescent health outcomes and support national performance measures, including well-woman care, reproductive health, physical activity, mental health, and adolescent well visits.

SBHCs use a holistic model of care, offering a broad spectrum of services such as preventive care, behavioral and mental health services, reproductive and sexual health care, nutritional counseling, screenings and referrals, health promotion, and supportive services. Each SBHC is staffed by a team of licensed professionals, including a nurse practitioner (under physician oversight), a behavioral health provider, and a licensed nutritionist. These teams work collaboratively with school nurses, counselors, psychologists, and external healthcare professionals to ensure coordinated and responsive care for students.

Following the COVID-19 pandemic, SBHC enrollment and utilization have significantly increased. The growing demand for services has prompted widespread interest in expanding SBHCs to more elementary, middle, and high schools across the state. Currently, Delaware operates SBHCs in 38 public high schools and 24 public elementary schools. In elementary schools, SBHCs provide services such as sports physicals, immunizations, mental health counseling, and health education to children in grades K–5. At the middle and high school levels, services are more comprehensive and include diagnosis and treatment of minor illnesses, STI testing and treatment, reproductive health counseling, and mental health support.

A major advancement in reproductive health services occurred when school boards across 20 SBHC sites approved the addition of Nexplanon, a long-acting contraceptive option. This decision marks a critical step in giving adolescents greater access to effective birth control and helping reduce unintended pregnancies. Because each SBHC's services must be approved by its local school board, this approval reflects strong community support for comprehensive health services in schools.

In June 2021, Delaware released the Implementation Plan for the Strategic Expansion of SBHCs, setting forth 13 ambitious goals to guide development through 2025. The plan emphasizes a data-informed, community-driven approach to expanding and strengthening SBHC services. Priorities include creating new SBHC sites where the need is greatest, introducing a hub-and-spoke service model, expanding referral systems, increasing telehealth capacity, and enhancing culturally and linguistically appropriate services. The plan also focuses on building sustainable funding streams, improving data infrastructure, and fostering public-private partnerships. Governance of the plan will be overseen by an independent body representing both sectors, ensuring transparency, accountability, and sustained impact.

Behavioral and mental health services remain a core focus of SBHC programming. As the demand for these

services grows, Delaware SBHCs have increased their use of telehealth and strengthened referral networks to connect students with appropriate care. A critical partnership with the Delaware Child Psychiatry Access Program (DCPAP), supported by the Pediatric Mental Health Care Access Grant, has expanded provider capacity by offering consultation, training, and support for both SBHC-based and referral-based mental health providers.

To support students' emotional well-being, Delaware continues to invest in mental health outreach, screening, and early intervention. Efforts are underway to increase the percentage of SBHC-enrolled adolescents who are screened for behavioral health concerns and to ensure that those identified as at-risk receive timely, appropriate treatment. SBHCs do not replace primary care providers but serve as accessible points of entry for adolescents who may otherwise face barriers to care. Community Health Workers (CHWs) further support these efforts by assisting with Medicaid transitions, connecting students to primary care, and acting as health educators and advocates in their communities.

Training and professional development are essential to maintaining high-quality care. Annual trainings are provided to SBHC staff, as well as to educators, community partners, and agencies serving youth. Topics include reproductive health, program management, mental health awareness, and culturally responsive care. These trainings also extend to specialized populations, pregnant and parenting teens, and adolescents involved in the juvenile justice system.

Partnering with a community agency, we have conducted several trainings to equip educators, behavioral health specialists, and medical professionals with the knowledge and tools to provide inclusive, affirming care. These efforts are part of a broader movement across schools and communities to ensure safe, respectful, and supportive environments for all students.

Community engagement remains central to the SBHC model. Delaware continues to explore a variety of methods of outreach to connect with adolescents and families. Strategies include social media campaigns, school-based events, community summits, flyers, radio broadcasts, and student-led activities. These outreach efforts aim to increase awareness of SBHC services, encourage enrollment, and promote positive health behaviors.

Looking ahead, Delaware remains committed to increasing the number of adolescents receiving annual preventive well visits. These visits are critical for identifying physical, emotional, and social health needs early and ensuring access to appropriate care and resources. SBHCs are instrumental in achieving this goal, offering a trusted, accessible, and youth-centered approach to care.

Delaware's SBHCs have been a cornerstone of adolescent health for over 30 years, and their role is more vital than ever. With strong stakeholder commitment, innovative partnerships, and a clear strategic vision, SBHCs are poised to expand their impact and continue improving the health and well-being of Delaware's youth well into the future.

We will continue to partner with the Department of Education and participating school districts to advertise and promote mental health services. We will continue to share information with our partners so they can easily access and share content, as well. In addition, we plan to continue our working relationship with the various school districts to advertise adolescent health as well as School Based Health Center messaging in each middle and high schools.

DPH will continue to facilitate collaborative work efforts and interventions that address increased physical activity, mental health awareness, improved nutrition, healthier lifestyles, and information and resources for Delaware children and adolescents. MCH will continue to utilize DEThrives to engage and inform our adolescent population with up-to-date information pertaining to various needs and topics via social media posts, Facebook Instagram and X. Subjects pertaining to Adolescents, such as My Life My Plan Teen, Addiction, Mindfulness, COVID-19, School Based Health Centers, Anxiety and Depression, Mental Illness, Exercise, and more have been posted. In working with our partners, MCH will continue to use social media to promote adolescent health comprehensively. Social media messages will be developed around the importance of mental health, preventative well visits, healthy lifestyles, and emotional wellbeing. DEThrives contains a "Services for Me" page, where content is organized by the user's life stage. These life stages include a "Teens" category. Additional maternal and child health messaging can be found

on the different audience pages, which are organized by the different life stages an individual will be in. All web pages, either a program or audience page, have a “Related Programs and Services” section at the bottom of the webpage that will list other pages or program pages that relate to the page the user is currently on. This is another way for the user to learn more information about related services DEThrives has.

Nutrition Counseling

The New Castle County Community Health Services has expanded nutrition services over the past year. During Fiscal Year 25, the Nutrition Program’s Registered Dietitian Nutritionist (RDN) served over 130 clients.

Clients may be referred to a nutritionist after accessing any of our New Castle County Community Health Services (NCC CHS). Referrals may commonly come from Child Health and Immunizations, Sexual Reproductive Health and Family Planning, Tuberculosis, Birth to Three, Health 2 Go Mobile Health Clinic, the Woman Infants and Children Supplemental Nutrition Program (WIC), and the Lead Program, to name a few. Furthermore, our mobile clinic implements a device referred to as Cholestech, a screening tool used to assess cholesterol, blood pressure, and blood glucose levels. At each mobile unit, on-site screenings for both adults and adolescents and referrals to the Nutritionist are made based on screening results or at the patient’s request.

Nutrition consultations are offered either by telephone or in person, depending on the preferences and needs of the patient or parent. In the upcoming months, telehealth visits will also be an option using DPH’s electronic medical record system, Patagonia Health. These sessions focus on addressing identified nutritional concerns and providing education and resources to help reduce barriers, manage, or resolve nutrition related issues. Common concerns that are addressed include achieving and maintaining a healthy weight, managing elevated blood pressure, improving knowledge of affordable nutrient dense foods, encouraging the introduction to new foods, and empowering participants to make informed food choices to support a healthy lifestyle. While addressing these concerns, recognition and navigation of food preferences, allergies, intolerances, digestive disorders, developmental disabilities, and chronic health conditions is critical. Furthermore, community health factors, specifically economic stability and living situations, are taken into consideration when providing counseling and education.

Based on the clients input and specific health concerns, education is tailored to meet the individuals’ unique needs and preferences. This includes customized food plans, meal planning and grocery shopping guidance, suggested daily intakes and portion sizes, energy calculations and nutrient recommendations, disease friendly recipes, goal setting, and education regarding specific health topics. Nutritional plans, recipes, and education are guided by the USDA’s MyPlate framework, the Dietary Guidelines for Americans, 2020-2025, and the Academy of Nutrition and Dietetics, in addition to well renown, disease specific organizations, including the American Heart Association and Diabetes Association. Clients are actively involved in this process and empowered as partners in their health journey, promoting positive decision-making and supports the achievement of realistic, sustainable goals.

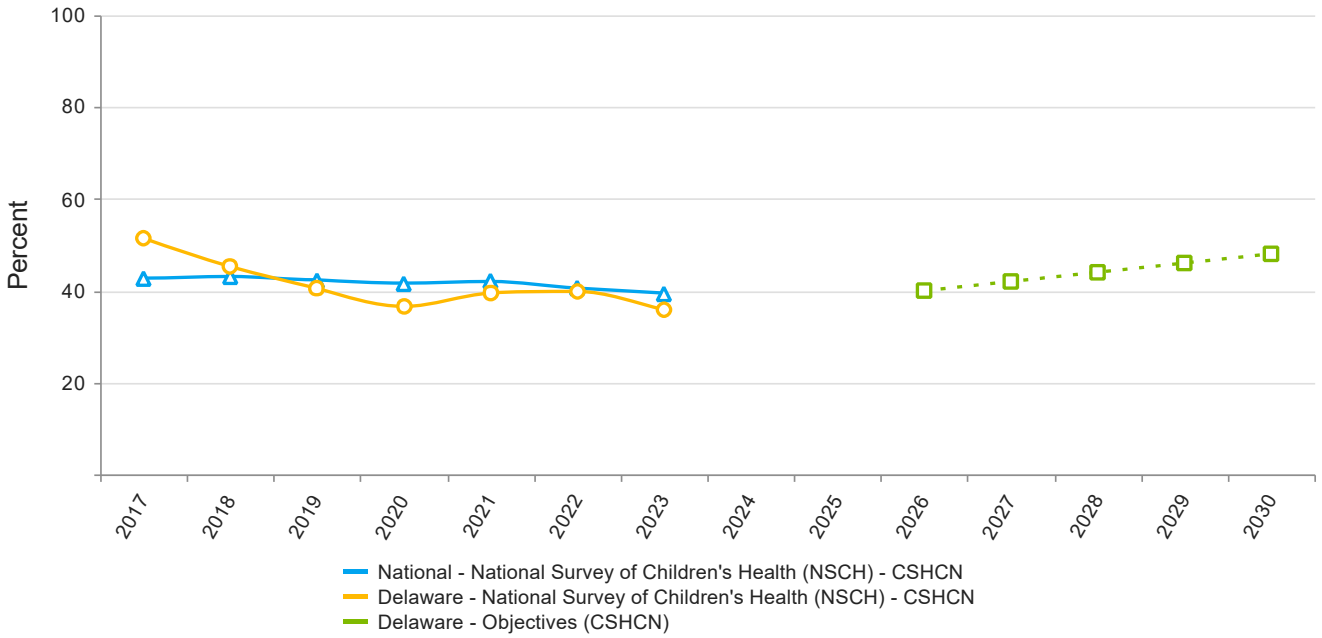
In addition to providing nutrition consultations, continuing education is a vital aspect of a Registered Dietitians career to maintain registration and licensure, as well as to stay informed on current research, health trends, and nutrition-related topics. Already, I have attended two statewide conferences, including the Division of Public Health (DPH) and the Physical Activity, Nutrition, and Obesity Prevention (PANO) Program’s Advancing Healthy Lifestyles (AHL) Coalition, and the Delaware Academy of Nutrition and Dietetics (DAND) annual conference. In the coming year, I will continue to attend conferences, health and nutrition trainings and webinars to complete Continuing Professional Education Units (CPEUs) and further expand my knowledge and resources.

Furthermore, I am a member of DPH and PANO’s Program’s Advancing Healthy Lifestyles (AHL) Coalition. This coalition supports a shared vision to enhance the well-being of all Delawareans by breaking down barriers to healthy living. Additionally, I am a part of the Delaware Academy of Nutrition and Dietetics (DAND), an organization that is committed to improving and protecting the nutritional health of citizens in addition to advocating for the profession of dietetics.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	40.2	35.8
Numerator	18,442	21,932
Denominator	45,845	61,253
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	40.0	42.0	44.0	46.0	48.0

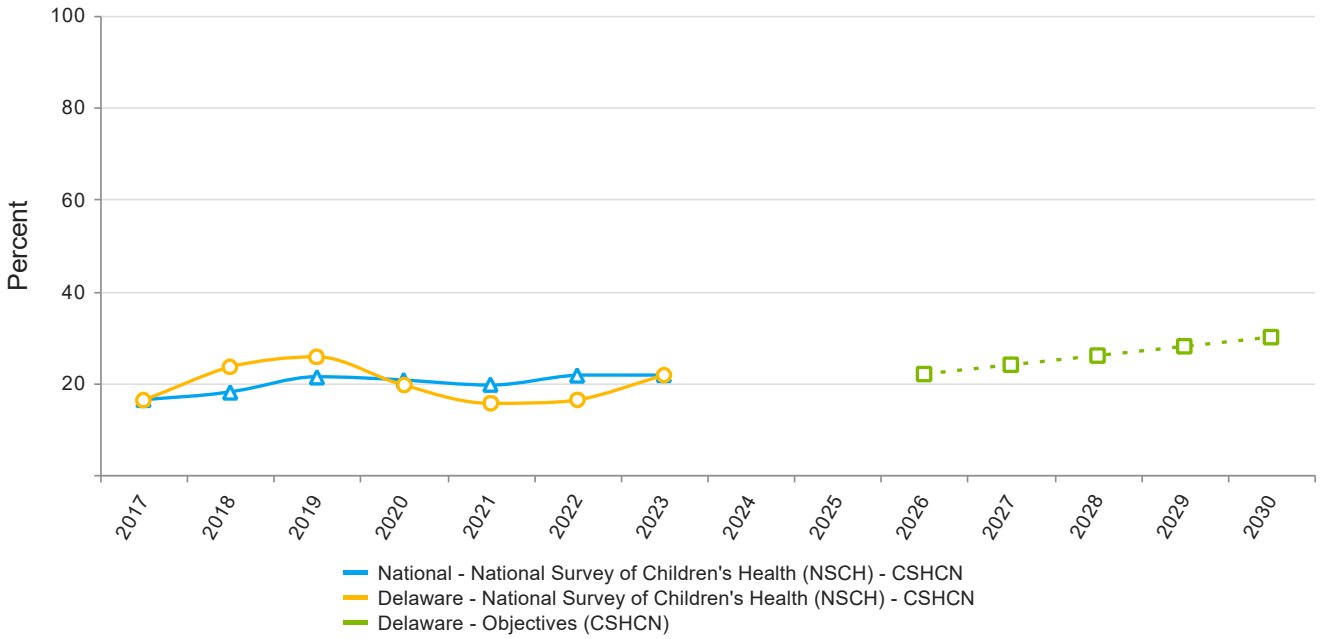
Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.

Measure Status:	Active
State Provided Data	
	2024
Annual Objective	
Annual Indicator	72.9
Numerator	462
Denominator	634
Data Source	MIECHV Program Data
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	75.0	77.0	80.0	85.0	90.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC
Indicators and Annual Objectives



NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	21.7
Numerator	5,781
Denominator	26,596
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	22.0	24.0	26.0	28.0	30.0

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12-17.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

State Action Plan Table

State Action Plan Table (Delaware) - Children with Special Health Care Needs - Entry 1

Priority Need

All children, with and without special health care needs, have access to a medical home model of care.

NPM

NPM - Medical Home

Five-Year Objectives

By 2030, increase the percent of parents of CYSHCN who feel that are a part of a medical home model of care.

Strategies

Utilize universal practices to promote all children and CYSHCN have access to care that meets the medical home model of care criteria, which includes comprehensive care, patient-centered, coordinated care, accessible services, quality and safety.

Develop a survey which will be utilized by mini-grantees who are awarded by Family SHADE, which captures the families that are served and have access to care which meets the medical home model of care criteria.

Family SHADE will collaborate with Family to Family to educate health care providers and build partnerships by providing educational sessions on medical home model of care.

Develop and disseminate a variety of culturally relevant educational messages and resources on the medical home model of care.

Assist families with Medicaid enrollment.

ESMs	Status
ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.	Active

NOMs

Children's Health Status

CSHCN Systems of Care

Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

State Action Plan Table (Delaware) - Children with Special Health Care Needs - Entry 2

Priority Need

All CYSHCN receive the necessary organized services to make the transition to adult health care.

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

By 2030, increase the percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Strategies

Mini-grantees will survey adolescents, ages 12 through 17, with special health care needs to assess their knowledge and awareness on the importance of an organized transition process and if they feel they have the necessary support to develop a plan.

Partner with the Family Leadership Network (FLN) will customize a transition plan tool kit to assist families on things to consider, questions to ask their doctors as their child with a special health care need transitions to adult health care.

Mini-grantees will educate adolescents and families they serve with special health care needs, ages 12 through 17, on how to prepare for transition to adult health care plan.

Work with current partners (Parent Information Center, Family Voices) and mini-grantees to provide education and skill-building opportunities for youth and families on navigating insurance; making appointments; self-management.

Explore adolescents and their family's needs to help with transition to adult healthcare, insurance, employment, education and housing.

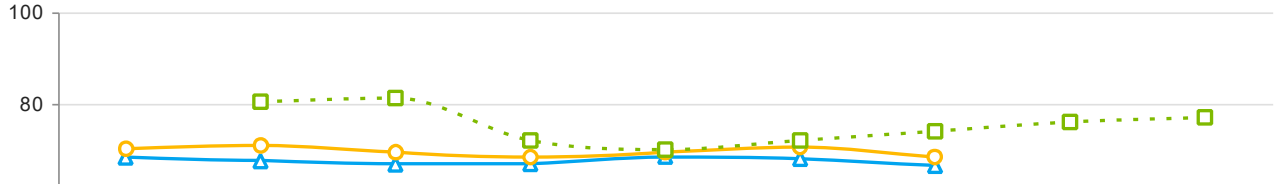
ESMs	Status
ESM TAHC.1 - Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12-17.	Active

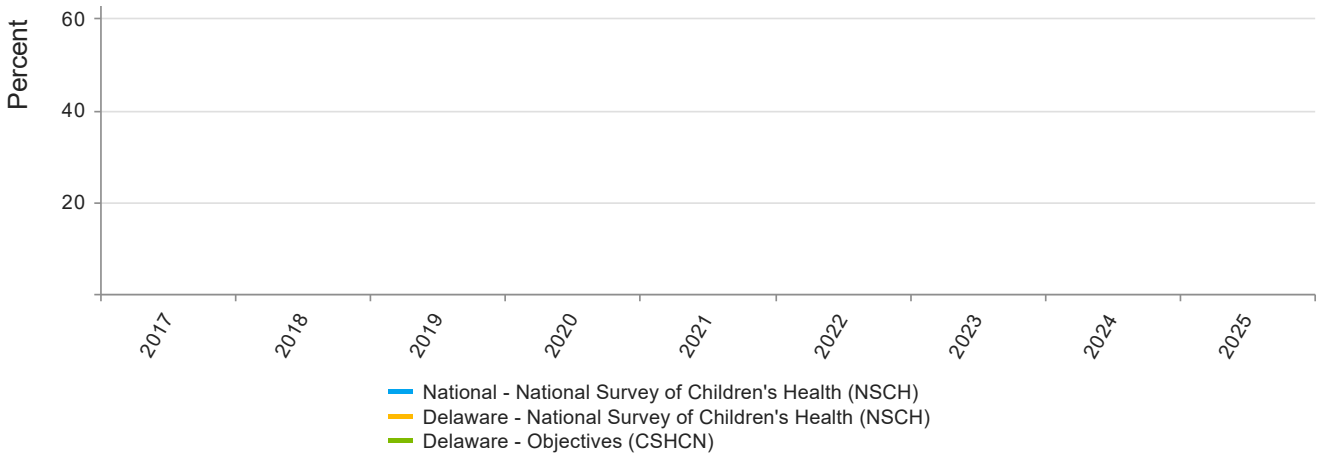
NOMs

CSHCN Systems of Care

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI Indicators





2021-2025: 2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	70.0	72.0	74	76
Annual Indicator	68.6	67.2	68.8	70.7	68.5
Numerator	138,831	136,015	140,169	145,366	141,609
Denominator	202,281	202,319	203,715	205,678	206,831
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	92	94	96
Annual Indicator	90	89.1	91.5	90.6	93.8
Numerator	564	595	644	598	656
Denominator	627	668	704	660	699
Data Source	MIECHV Program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			80
Annual Indicator	73.3	73.3	60
Numerator	11	11	9
Denominator	15	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

2021-2025: ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:		Active	
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			75
Annual Indicator		100	100
Numerator		609	554
Denominator		609	554
Data Source		CYSHCN Mini Grantee data	CYSHCN Mini Grantee data
Data Source Year		2023	2024
Provisional or Final ?		Final	Final

According to the 2022 National Survey of Children's Health (NSCH), the estimated number of CYSHCN between birth and age 17 years is 33,202. Of these CYSHCN 66.9 percent were adequately insured in comparison to 61.3 percent nationwide. In Delaware, 71.5 non-CYSHCN were adequately insured in comparison to 68.2 percent of non-CYSHCN nationwide.

According to the 2022-2023 National Survey of Children's Health (NSCH), the estimated number of Children and Youth with Special Health Care Needs (CYSHCN) between birth and age 17 years in Delaware is 61,253. Of these CYSHCN, 35.8 percent (n = 21,932) have a medical home in comparison to the nationwide average of 39.3 percent. Conversely, 64.2 percent (n = 39,321) of Delaware CYSHCN do not have a medical home as compared to 60.7 percent of CYSHCN nationwide.

Through the Maternal Child Health Title V Block Grant, Delaware continues to actively work with partnering state and community contracted agencies to assure that all CYSHCN have both a medical home concept of care and adequate insurance through statewide initiatives with grantees that serve CYSHCN.

Family SHADE

In FY 2024-2025 Delaware continued to utilize Parent Information Center (PIC) to implement the Family Support Healthcare Alliance Delaware (SHADE) programmatic approach. Family SHADE extended family and professional partnerships at all levels of decision making, to best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resource for community organizations serving CYSHCN. Families included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems of change to best serve families of CYSHCN. In 2024 PIC began the planning phase of implementing the third cohort of funding through a competitive RFP mini-grant process. We received 4 applicants and awarded 3 of the four. Parent Information Center (PIC) captured data from the mini-grantees impact on the CYSHCN and their families to measure outcomes on medical home and CYSHCN adequately insured through the services rendered in the third cohort. PIC worked toward growing their Family Leadership Network (FLN) memberships. PIC has grown the Family Leadership Network (FLN) to 11 FLN members but recently decreased back to 9 FLN members due to family commitments. The FLN members have consisted of parents/guardians of children birth to 26 that have a special health care need. The network membership included trainings, quarterly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals for services. FLN members received monthly stipends for attendance and participation. The Family SHADE quarterly Learning Communities provided families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. PIC prioritized aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identified needs that impacted families of CYSHCN. Through these initiatives, the Family SHADE project contributed to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations focused on innovative strategies and improving the Title V national performance measures and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

The Family SHADE Early Hearing Detection and Intervention (EHDI) Learning Communities funded through the HRSA - Universal Newborn Hearing Screening and Intervention Grant provided families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. The Parent Information Center took the lessons learned from the second year of the mini-grant program and enhanced the program in year 3 (2024-2025) by monitoring the mini-grantees closely and created a data collection tool that was administered with all the mini-grantees to assure that data collection was seamlessly aligned with the National Performance Measures (NPM) Medical Home. There was a planned approach which engaged family and community partnerships while executing overall efforts in making our children healthy every step of the way through the process of serving CYSHCN. Delaware will work in alignment with our Early Hearing

Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health Title V programs infusing CYSHCN and their families. The Parent Information Center (PIC) team will monitor and evaluate through every phase of the projects the impact that is being made on CYSHCN and their families. The PIC team continues to provide technical support to the mini-grantees along with regularly scheduled monthly site visits by the project manager/consultant and the research/evaluator. Also, through monthly regularly scheduled programmatic meetings with the PIC team members executing the Family SHADE project, the CYSHCN Director, will review the NPMs below and align their data collection tools and their projects to mirror their projects initiatives with the Maternal Child Health Title V NPMs listed below:

- Performance Measure (Developmental Screening)
  Percent of children, ages 9 through 35 months, who received developmentally appropriate services in a well-coordinated early childhood system.
- Performance Measure (Access to Medical Home)
  Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
- Performance Measure (Shift into Adult Healthcare)
  Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transfer to adult health care.
- Performance Measure (Adequate Insurance) Percent of children, ages 0 through 17, who are continuously and adequately insured.

There were 24 Learning Communities offered to CYSHCN Families in Yr. 2024. Of those 24 Learning Communities, 24 parents attended each time a Learning Community was offered. PIC continued to prioritize aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identified needs that were impacting families of CYSHCN. PIC in partnership with community organizations, and a coalition located in one of our 3 counties (Sussex County), focused on innovative strategies in improving the Title V national performance measures and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. On October 3, 2024, Family SHADE coordinated their Annual Summit at the Delaware Modern Maturity Center. There was prior registration in place to attend but the attendance was low in numbers. For the families and vendors that attended, they found the event to be beneficial. PIC continued to routinely take surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

Crosswalk of Maternal Child Health Block Grant with the 6 Core Indicators serving Children and Youth with Special Health Care Needs

The Director of CYSHCN along with the Parent Information Center -Family SHADE project team strategized with our MCH Title V team to make sure that they were touching on all 6 core indicators and aligning with: optimum health for all, quality of life and well-being, access to services, and financing of services. We aligned the current work and priorities that we are doing to serve CYSHCN and their families and improved the system of care adhering to the results identified in the needs assessment. This approach has allowed us in measuring how well the state of Delaware's CYSHCN system of care is functioning based on the state data that we have received and how we compared to the national data. This approach assisted and guided our Title V programs in aligning the work and priorities and guiding principles for a system of services for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. This table below illustrates the starting point for 2024-2025 of our state and on how we identified where the state was and where we want to go in improving the system of services for CYSHCN. This approach allowed us to do a crosswalk in the Title V needs assessment and assisted in reporting future Block Grant application related to the 6 core CYSHCN indicators.

The Maternal Child Health (MCH) Title V Block Grant, Title V Delaware data and population in comparison to the national data and nationwide population is outlined in the table below. This information guided us with a baseline and a starting point as we began to move forward to develop our task and activities to implement our work, priorities,

in alignment with the 6 core CYSHCN indicators within the Crosswalk of Maternal Child Health Block grant 6 core Indicators. This foundation has allowed us to see where we are now in serving CYSHCN and where we want to move toward making a change across all domains within Delaware's Maternal Child Health Title V delivery of service. Information below from: National Survey of Children's Health - Data Resource Center for Child and Adolescent Health (childhealthdata.org)

Measure	Delaware Data	Delaware Pop. Est.	National Data	Nationwide Pop. Est.
Well - Functioning System of Care	53.1% of CSHCN who received needed care coordination. 46.9% CSHCN Who did not receive needed care coordination.	47574	54.1%CSHCN who received needed care coordination. 45.9% CSHCN who did not receive needed care coordination.	13,805,035
Family-centered care	81.2%CSHCN who receive family centered care 18.8% CSHCN who do not have family centered care	55,602	81.2 CSHCN Who have family centered care. 18.8% CSHCN who do not have family centered care	16,985,492
Medical Home (0-17)	35.8% Have a medical home 64.2% Do not have a medical home	61,253	39.3% Have a medical home 60.7% Do not have a medical home	31,823
Early and Continuous Screening	32.8% of children ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year. 67.2% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	26,363	35.6% of children ages 9 through 35 months, who received a developmental screening using a parent -completed screening tool in the past year. 64.4% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	8,034,058
Adequate & Continuous Insurance in 2022	66.9% CYSHCN Current insurance is adequate for child's health needs. 71.5% Non-CYSHCN Current insurance is adequate for child's health needs.	145,862	61.3% CYSHCN - Current insurance is adequate for child's health needs. 68.2% Non-CYSHCN Current insurance is adequate for child's health needs. r	48,591,549
Access to Community-Based Services	Data on access to community -based services was not captured on the NSCH Interactive Data Query 2022-present -Data Resource Center for Child and Adolescent Health. Delaware will begin to collect this data in calendar year 2025-2026.			
Health Care Transition to adult health care, adolescents with special health care needs, age 12-17	21.7% of CYSHCN Received services to prepare for transition 78.3% of CYSHCN did not receive services to prepare for transition	26,596	CYSHCN who received services to prepare for transition 21.8% CYSHCN who did not receive services to prepare for transition 78.2%	8,719,418

Delaware implemented the development of a crosswalk through our MCH Title V Block Grant and developed an alignment with the 7 measures for CYSHCN. The 6 Core CYSHCN indicators continue to be implemented throughout the domains and national performance measures in the delivery of service for our CYSHCN population. Delaware will continue to use guiding principles for a system of service for children and youth with special health care needs.

	CORE INDICATOR#1 Children and youth are screened early and continuously	CORE INDICATOR#2 receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing	CORE INDICATOR#3 Community-based services are organized so families can use them easily	CORE INDICATOR#4 CYSHCN receive services necessary to make transitions to adult life, including healthcare	CORE INDICATOR#5 Families have adequate insurance and funding to pay for services they need	CORE INDICATOR#6 Families of CYSHCN Are partners in decision-making at all levels of care from direct care to the organizations that serve them
Optimum Health for All	Healthy People 2030 define optimal health for all as "The attainment of the highest level of health for all people. Achieving A Healthy America requires valuing everyone with a focus on improving health and well-being. Addressing poverty, damaging living conditions, and access to health and social services will mitigate adverse health effects. The principles and strategies will seamlessly acknowledge that poverty, discrimination, and their downstream consequences cause barriers for optimal health for all. Delaware will continue to implement a crosswalk across our national performance measures which are: Well-women visit, Breastfeeding, Developmental Screening, Dental Visit (child/adolescent), physical activity (ages 12-17), Adolescent Well-visit, Adequate insurance, and workforce development.					
Quality of life & well-being	Historically, health care does not include a proactive focus on patient and family well-being and quality of life. Yet, studies have shown that parents and families of CYSHCN often experience disruptions to family life, social isolation, and chronic stress, and have significant and various psychosocial support needs. Data reveals that "CYSHCN and their families are at risk for adverse outcomes in economic, academic, and social emotional domains, in addition to physical health. Moreover, access to opportunities and supports exacerbate the ability to access services for CYSHCN and their families' experiences. Historically, the health system focused on measuring health outcomes, not necessarily metrics meaningful to families. These metrics should be developed in partnership with Families and can include the wellbeing and quality of life of the child from birth through adulthood, wellbeing of the family unit, and the ability to achieve dignity, autonomy and independence.					
Access to services	Access to services and supports is defined broadly and includes the 4 components of access to health care: coverage, services; timeliness; and a capable, qualified, and a competent workforce. This concept includes all social services necessary for CYSHCN and families to have full, thriving lives, including but not limited to education, early intervention, child welfare, foster care, health, and community-based supports. This critical area recognizes the educational system as an entry point and major deliverer of services for children and families. The ideal system is integrated across all sectors and anticipates families' needs. It aligns the delivery, payment, and administration of services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.					
Financing of service	Addressing health optimal health for all, well-being, quality of life, and access to care requires an adequately financed system of services. This includes both the overall systems of financing, including insurance design and organization of programs, as well as specific models and mechanisms for payment and eligibility. It supports models that improve quality and value, and recognizes outcomes meaningful to stakeholders, including families, providers, and payers. Although the following principles and strategies focus on health care and related services, including care coordination, which is necessary in a system that is not fully integrated, CYSHCN also may require an array of additional social services and educational supports.					

Family SHADE (Support and Healthcare Alliance Delaware) Family Leadership Network (FLN)

PIC set out with the goal to grow the Family Leadership Network to 15 FLN members. However, they successfully

grew the membership to 11 FLN members but, toward the end of Yr. 2024 the FLN membership decreased to 9 FLN members, due to family commitments. The FLN members have consisted of parents/guardians of children birth to 26 that have a special health care need. The network membership included trainings, quarterly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals for services. The FLN members met virtually and in person on August 14,2024, November 14, 2024, September 10, 2024, and November 20th, 2024. The FLN invited keynote speakers to address topics that the FLN members requested knowledge on so that they could be best informed on topics addressing their CYSHCN. Some of the topics the parents asked for presentations on were: Mental Health Respite, Understanding Medicaid, ADHD/Conduct Disorder/Pros/Cons of medications and interactions, and Support for siblings of children with mental health/complex medical needs (Sibshop Trainings). FLN members received monthly stipends for attendance and participation. The Family SHADE quarterly Learning Communities provided families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. PIC prioritized aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identified needs that impacted families of CYSHCN. Through these initiatives, the Family SHADE project contributed to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations focused on innovative strategies and improved the Title V national performance measures and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities. The FLN members represented members from area codes 19701, 19702, 19904, 19707, 19938, 19709, 19702 and 19707 which represented Kent County and New Castle County. The FLN members attended Family SHADE Learning Communities and served as a resource, support, and mentor through their knowledge gained for other families that were navigating the system of care for CYSHCN. The FLN members shared their experiences with other families in navigating and understanding the Medical Home Model of Care through their Pediatrician/Primary Care Physician and other specialists. FLN members received a monthly stipend for attendance and participation as long as Parent Information Center (PIC) had the monetary resources available for this network. Unfortunately, the FLN members were not able to recruit representation from Sussex County which is our Southern geographic area of Delaware. The FLN members consisted of 4 of the members where white (not Hispanic) and 1 was White (Hispanic) 6 where Black or African American (not Hispanic), and 1 Black or African American (Hispanic). The ages of the FLN member's children were 9 years old, 22 years old and 18 years old. Below are some of the Learning Communities that were available to the FLN members and families of CYSHCN. Some of these events were virtual and in person. Below are some of the flyers which were circulated amongst state and community partners through email distribution list, and https://DEthrives.com Family SHADE web page.

Although they were not able to recruit 15 FLN members as they set out to do, they had several Learning Communities for FLN members and families of CYSHCN to attend. In calendar year 2024, Family Leadership Network (FLN), focused on the Evidence Based Strategies (ESMs) below.

- Evidence-Based Strategy Measures (ESM) #1 Increase the % of CYSHCN 0-17 that are served by the mini grantees.
- ESM #2 Increase the % of families enrolled as a member in the Family Leadership Network (FLN)

- ESM #3 Increase the % of families served through the Family Voices Managed Care Organization (MCO) Calls/Zoom meetings.

Parent Information Center (PIC) Family SHADE Annual Summit October 3, 2024

The Annual Summit meeting for the Family SHADE project took place at the Modern Maturity Center in Dover, Delaware on October 3, 2024. The presenters covered topics on:

- Medical Home and Comprehensive Care- Dr. Charmaine Wright - Description: The medical home as an approach to the delivery of primary care that is: Accessible - Family-centered – Continuous – Comprehensive – Coordinated – Compassionate – Optimal Effective Health for All: This session discussed the components of medical home and how a medical home can strengthen relationships between families and professionals to improve outcomes for CYSHCN.
- Care notebook – Christina Andrews -Description: The care notebook was discussed with the participants as a valuable tool in achieving medical home/family centered care. This record keeping system allowed participants to have all pertinent information about their child and his/her needs in one place. The presenter educated families on the importance on why the care notebook should follow their child to all appointments, tests, therapies, IEPs, etc. This book helps in the coordination of care as they heard from the interactions by other professionals involved in their child's care.
- Long Term Services & Supports (LTSS) & Division of Developmental Disabilities Services (DDDS) Respite Services (Jenn Tozer) – or Care Mapping for Families
- Mini-grantee presentations from Teach Zen, Down Syndrome Association, and Children's Beach House on their services provided. These presentations were conducted during a working lunch.
- Presentation from the Division of Public Health Maternal Child Health Title V -Isabel Rivera-Green, MSW, CYSHCN Director -A high level overview of the MCH Title V Block Grant with a focus on CYSHCN.
- Panel discussion from Family Leadership Network members and other parents of CYSHCN.

There were 64 or more attendees, but only 46 completed the online evaluation and 6 others completed a paper evaluation for a total of 52 evaluation forms. Attendance was much better than for the previous year's conference. Still, it was disappointing that there were a large number of no-shows compared to the numbers preregistering. And the no-shows were particularly among parents of children with special health care needs. It appears that changes and additional encouragements need to be made to increase the ability and willingness of parents to attend. Post meeting planning by the PIC/ SHADE team identified the principal problem being the provision of childcare during attendance, a particularly important need for CYSHCN parents. The difficulty in providing childcare has become more difficult in recent years with fewer providers of temporary care available and the increased cost of providing for care with appropriate liability protection. For the special needs parents, this is a particularly telling issue that needs additional planning and resources in the future. Other considerations for the future will be partnering with other organizations such as the Department of Education; consideration of timing including moving the summit to a weekend time; more follow up with the CYSHCN parents before the meeting with reminders and other incentives; and possibly looking for means to provide more transportation help. There is a need for plans to make the meeting not only informative for parents, but also a respite for them to encourage attendance and to make attendance really rewarding for parents.

Among those who filled out evaluations, 15 identified as vendors, 19 as healthcare or other professionals, 12 as parents, and 6 as educators. These are primary identifications, although some identified in more than one category. Nine attendees reported explicitly that they were a parent/guardian of a child with special health care needs. Of the 52 respondents, 44 (85%) reported the sessions and content were "absolutely" useful, 7 reported there were "for the most part" useful, and one did not answer. Even higher percentages reported the information presented was "high quality" and that the presenters were "very" knowledgeable. The Vendor Tour period was very positively received, garnering an overall score of 4.8 out of 5. And the Modern Maturity Center itself (the facility, the food, and the logistics) was also positively received with a score of 4.8 out of 5. The only concerns were a couple who thought the sound equipment needed to be louder, and one participant thought the room was too cold. An unexpurgated list of the volunteered feedback comments is provided below.

One thing to note among the responses was the overwhelmingly positive responses to the Summit content, among all of parents, professionals, educators, and vendors. The overall response was among the most positive conference reviews we have seen. Credit for planning, logistics and staffing should be given to Chevonne Boyd and her support team. Finally, and though not an original goal of the conference, it is significant to note the positive interactions among the vendors themselves. There was a lot of networking, and vendors themselves said they learned much from interaction with the other vendors during the vendor showcase session and at other times.

All the volunteered comments

Thank you for the amazing work that you do!, Everything was amazing and the facility was very nice, Everything was well organized! We must bring back Dr. Charmaine Wright, First time here. Great event! Thank you for the invitation!, Excellent event!, Thx for this conference, The event was very organized., More attentive to microphones and sound quality in the rooms. Hard to hear in the back of some rooms, Loved it! Needs more vendor time please, At times had hard time hearing speaker. Was very cold. Information was great and useful., I LOVE ❤ 😍 THE VENDORS. I WAS ABLR TO COLLEXT SEVERAL IMPORTANT INFORMATION FROM THEM. You must have them again!! The Staff looked sharp. Very nice, and friendly, while being helpful. I like their black shirts.., None!!, There was an emergency with our Keynote Speaker and the staff were calm and professional. They were able to adjust without missing a beat!!, Great networking and learning opportunity, thank you for hosting this event. It was both informative and well-presented., Great event, DPH presentation also strong and informative, Great and informative event, very good.

Family SHADE Mini-Grant Project Timeline

Delaware implemented the Family SHADE mini-grantee Project in the 1st Cohort, Calendar Yr. 2021-2022. There were 2 mini-grantees that were awarded, Jay's House and Tomaro's CHANGE. Jay's House served children with Autism and did not have a data baseline at the time they began to serve this population. However, Jay's House sustained their program and became a full-time daycare serving children on the spectrum because of networking with agencies and providers through the exposure made possible by the Family SHADE project. After Yr. 1 Jay's House decided to not reapply because Jay's House was fully functioning and had the support of community providers. Tomaro's CHANGE never got their project off the ground and was not awarded funding in Yr. 1. Cohort 1 focused on National Performance Measure (NPM) Medical Home for CYSHCN. This 1st Cohort was a slow start, however through data collection, assessments, evaluations, and lessons learned we were able to re-evaluate the implementation of the Family SHADE Mini-grantee approach. Parent Information Center (PIC) provided technical assistance to both mini-grantees and Jay's House benefited long term from the mini-grant experience. Tomaro's CHANGE did reapply in the 2nd Cohort Yr. 2023-2024 and was able to impact CYSHCN through a small group approach providing holistic therapeutic care directly to youth and adolescents and indirectly to families, particularly those at risk or with special health care needs. Tomaro's CHANGE focused on National Performance Measure Medical Home. PIC grew and expanded the outreach for new mini-grantees to apply through a competitive mini-grant process. In the 2nd Cohort, PIC hired a new Parent Information Center (PIC) Program Consultant -Yvonne Bunch and a new Evaluator Steven Martin. Both had expertise on the state and community sector working with families and children. Their established connections assisted in expanding PIC's reach to gain the interest of new mini-grantee applicants. The new mini-grantees that were awarded were, Teach Zen, Down Syndrome Association of Delaware (DSADE) and Children's Beach House (CBH) as well as Tomaro's CHANGE who returned for Cohort 2. Teach Zen focused on NPM Developmental Screening. Teach Zen impacted at-risk children of low-income families who were enrolled in early childcare program who received 50% funding from Purchase of Care assistance. The program succeeded in exposing young children with special health care needs between the ages of 3 to 5 who were enrolled in a childcare program to Social Emotional Learning and self-regulation techniques to improve their overall emotional wellbeing. Through our Family SHADE mini-grantee project, Delaware was able to impact lives of CYSHCN and their families by making the services the mini-grantees had to offer accessible to CYSHCN and their families. They addressed NPM Medical Home, Adequate Insurance and Developmental Screening. The mini-grantees from Cohort 2 with the exception of Tomaro's CHANGE, received an amendment to their current Memorandum of Understanding (MOU) and transitioned into the 3rd and 4th Cohort Yr. 2024 to 2025. Tomaro's CHANGE was not able to secure a facility to provide her services and decided she would not be able to pursue the project. The mini-grantees (Teach Zen, CBH, and DSADE) have continued to grow the delivery of service for

CYSHCN with the guidance of Parent Information Center (PIC). Below is a table showing the growth of a piloted project which began in Yr. 2021 and the growth over a 3-year timeline as a result of the Family SHADE mini-grantee project serving CYSHCN and their families.

PIC-FAMILY SHADE YR. 1 COHORT Contract Year 10/1/2021 to 9/30/2022

Reporting Data below is for 1/01/2022 to 12/31/2022

PROJECTS	YR. 1 BASELINE # OF UNDUPLICATED CYSHCN PARENTS SERVED	# INCLUDES DUPLICATIVE PARTICIPANTS	CYSHCN & THEIR FAMILIES IMPACTED	CONVERT INTO % OF CYSHCN IMPACTED
Jay's House	0	0	21	100%
Tomaro's CHANGE	0	0	0	0%
Family Leadership Network (FLN) Meetings	0	0	89	100%
Total	0	0	110	200%

PIC-FAMILY SHADE YR. 2 COHORT Contract Year 12/01/2023 to 11/30/2024

Reporting Data below is for 1/01/2023 to 12/31/2023

PROJECTS	YR. 2 BASELINE # OF CYSHCN CAN BE SERVED/ PROJECTED TO BE SERVED	# INCLUDES DUPLICATIVE PARTICIPANTS	# OF CYSHCN SERVED BY MINI-GRANTEES (ACTUAL # SERVED)	CONVERT INTO % OF CYSHCN IMPACTED
Tomaro's CHANGE	20	0	50	2.5%
Teach Zen (we will report this data in the comments but not in the total number provided)	A baseline was not identified.	0	Of the 156 kids served, only 20% were CYSHCN (30 CYSHCN)	100%
Down Syndrome Association of Delaware (DSADE)	501	0	539	1.08% (1.075)
Children's Beach House (CBH)	20	0	20	100%
Total	541	0	609	113% (this is 609/541 = 1.125)

PIC-FAMILY SHADE YR. 3 COHORT Contract Year 12/01/2024 to 11/30/2025

Reporting Data below is for 1/01/2024 to 12/31/2024

MINI-GRANTEE PROJECTS	YR. 3 BASELINE # OF CYSHCN CLIENTS CONTINUING	# INCLUDES DUPLICATIVE PARTICIPANTS	# OF NEW CYSHCN CLIENTS SERVED BY MINI-GRANTEES	CONVERT INTO % OF CYSHCN IMPACTED
Tomaro's CHANGE	Tomaro's CHANGE was not awarded a cohort in Yr. 2024			
Teach Zen	0 continuing clients from Yrs. 1–2	0	143 children were served, and of those non-CYSHCN, 50 (35% of the 143) were CYSHCN	35% (of those served)
Down Syndrome Association of Delaware (DSADE)	404 *eligible clients from Yrs. 1–2 continuing to be served	0	444 total, 40 new	100%
Children's Beach House (CBH)	20 *eligible clients from Yr. 2 continuing to be served	0	60 CYSHCN were served, and of those CYSHCN, 40 were new CYSHCN in Cohort 3	80%
Total	424 *clients continue to receive services until age 18	0	554	84% of CYSHCN were impacted by the mini-grantees

From Yr. 1 through Yr. 3, the mini-grantees addressed:
National Performance Measure (NPM): Percentage of children ages 0 through 17 who are continuously and adequately insured; ESM #1 Evidence-Based Strategy Measures: Number of CYSHCN population served by the mini-grantees

The hard work and passion these organizations have for the population they serve goes recognized by local and federal partners. For example, during our MCH Title V Federal Site review, Children's Beach House was recognized for their Youth Development Program. The Director, of CBH -Ms. Jacqueline, Donaldson Youth Development Program was asked to be interviewed to get a closer understanding of the impact the program makes on CYSHCN and their families. The Delaware CYSHCN Director coordinated the virtual interview with the federal partners and as a result, Children's Beach House (CBH) was noted as a potential submission to the Maternal Child Health Innovations Hub MCH Innovations Database. The Program Associate, Family Leadership Initiatives Representative Ms. Ruth Mulugeta and their team saw the CBH Youth Development Program as a great fit for the database. They

also felt that the work with family engagement would be a great resource to be featured in the database for other Maternal Child Health professionals to learn from. This recognition was one of the many highlights of the success of the Family SHADE mini-grantee project.

Family SHADE Mini-Grant program

In 2024 Parent Information Center (PIC) began the planning phase of implementing the third year of funding through a competitive RFP process. We received 4 applicants and awarded 3 of the four. The mini-grantees that were awarded were Children's Beach House, Teach Zen and Down Syndrome Association. A rigorous scoring matrix was used by 3 reviewers to determine the selection of the mini-grantees. These organizations served CYSHCN across the state of Delaware's three counties: New Castle, Kent, and Sussex County. A memorandum of understanding (MOU) was executed with each mini-grantee for one year in the amount of 50,000.00 for each mini-grantee.

Parent Information Center (PIC) aligned the work with Children and Youth with Special Health Care Needs (CYSHCN) and with the Maternal Child Health Title V National Performance Measures (NPMs) so that there was a seamless approach in the delivery of service for families of CYSHCN. The mini-grantees with the support of the Parent Information Center (PIC) Program Manager Consultant -Yvonne Bunch and Researcher/Evaluator -Steve Martin, facilitated support on lessons learned and enhanced the delivery of service as well as developed data collection tools to collect progress made in Yr. 2024. Below is the chart that demonstrates services provided in FY 2024 and the beginning of February 2025.

PIC–FAMILY SHADE YR. 4 COHORT

Contract Year 12/01/2024 to 11/30/2025

(Reporting Data below is for 1/01/2024 to 2/28/2025)

MINI-GRANTEE PROJECTS	YR. 3 BASELINE # OF CYSHCN CLIENTS CONTINUING	# INCLUDES DUPLICATIVE PARTICIPANTS	# OF NEW CYSHCN CLIENTS SERVED BY MINI-GRANTEES	CONVERT INTO % OF CYSHCN IMPACTED
Teach Zen	0 continuing clients from Yrs. 1-2	0	143 children served, and of those non-CYSHCN, 50 (35% of the 143) were CYSHCN	35% of those served
Down Syndrome Association of Delaware (DSADE)	435 *eligible clients from Yrs. 1-2 continuing to be served	0	452 total, 17 new	100%
Children's Beach House (CBH)	37 of 40 continued clients from Yr. 2 was served. 3 moved out of state. *eligible clients from Yr. 2 continuing to be served	0	37 CYSHCN were served, of those CYSHCN 50, were new CYSHCN in Cohort 4	80%
Total	424 *clients continue to receive services until age 18	0	589	84% of CYSHCN were impacted by the mini-grantees

From Yr. 1 through Yr. 3, the mini-grantees addressed:
National Performance Measure (NPM): Percentage of children ages 0 through 17 who are continuously and adequately insured
ESM #1 Evidence-Based Strategy Measure: Number of CYSHCN population served by the mini-grantees

Under the guidance of the PIC program manager/consultant and researcher/evaluator, there were three agencies that participated in the Family Support and Healthcare Alliance Delaware (SHADE) mini-grant program in FY 2024: Children's Beach House (CBH), Down Syndrome Association (DSA), and Teach Zen Inc. (TZ). All three had participated in the Family SHADE project in Cohort 2, FY2023, and all three were able to provide continuity of service to children and families meeting the criteria for children and youth with special health care needs. In 2024, both Children's Beach House and Down Syndrome Association used funding to recruit new

1. **Children's Beach House** (CBH) implemented their Third year of a Youth Development Program described as "giving kids what all kids need." CBH assisted in establishing and meeting the needs kids had such as relationships with friends, positive adult role models, the safety and security to try new things and develop natural skills and talents, and access to community resources to help them thrive. Through a rigorous case management program provided by the programs team of Family Engagement Coordinators (FEC). These FECs continued to work with each child and family to identify each child's unique interests and talents and to weave together a network of services and relationships that helped them to thrive. This project pursued their second year in collaboration with the children's schools and learning specialists, as well as a wide variety of partnering government agencies and community-based nonprofits. The CBH program's objectives were as follows:
    - increase parents' understanding of their child's individual needs.
    - increase the ability to access resources and services to meet the needs of their child and family unit.
    - Children will increase their sense of belonging, in school at Children's Beach House and in the community.

    This project aligned with NPM -Access to a medical Home. CBH served 40 CYSHCN and their families as well as provided related services to another 22 siblings of their clients who were also CYSHCN. CBH clients do a good job of approximating the race/ethnic distribution in Delaware: 35% Caucasian, 21% African-American, 19% Hispanic, 3% Native American, and 20% Mixed. In terms of National Performance Measures, approximately 20% of their clients were put in contact with a primary Medical Home practice where one had not existed previously, with expanded ancillary services, primarily dental services and family counseling. All clients also received Developmental Screening assessments and referrals both with their in-house professional staff and with referrals. Their involvement with health practitioners and with school advisors provided several individual interventions and many instances of facilitating health care connections.

    A key strength of the CBH efforts is the youths' involvement in the Beach house week, which gave the CBH staff the opportunity to observe and work with CYSHCN closely providing physical and personal screenings and assessments and observations that directed CBH continued involvement and work with the families after the youths' camp involvement. CBH expanded their work from the previous year by adding parent workshops, expanding health and dental services, and increasing mental health support working with schools.

    In January, CBH identified the planned cohort of 50 new clients for SHADE services. The youth range in age from 8 to 17 with most 10-15. Most participants are from Sussex County and that is reflected in the increased Hispanic youth in the new Cohort: 32% Caucasian, 20% African-American, 30% Hispanic, 2% Native American, and 16% Mixed. The youth had previous contact with CBH, but they had not been part of the intensive SHADE services or been beach house participants. In preliminary assessment of their needs, the primary needs identified related to dental and mental health. Others related needs seen are helping families find a more stable medical home and established health insurance coverage. These are being addressed by CBH staff. CBH begun moving ahead with expanding parental involvement beyond the parent workshops established in FY2024. CBH stated its main goal of this cohort is "to empower parents and guardians by increasing their understanding of their child's special health care needs." By building strong relationships, they aim to improve access to essential services for families with children requiring specialized care.

    In February, CBH took first steps to establish a Parent Advisory Board (PAB) for parents and caregivers of children with special healthcare needs. The goal is to provide a platform where caregivers can share experiences, collaborate on initiatives, learn about other resources, and actively participate in planning efforts to better support their children. Directly to support the Advisory Board and more generally for all its clients, CBH is identifying and fostering collaboration and resource-sharing with organizations that share a similar mission,

ensuring that families receive the comprehensive support they need.

CBH continued to use a Likert scale, ranging from 1 to 4 to gauge outcomes. During the assessment analysis, participants supplied qualitative data explaining the lower scores on the sense of belonging scale. The participants highlighted the challenge of facing isolation within educational and community settings due to their disabilities. Furthermore, participants conveyed that they did not frequently perceive themselves as integral to the group or community. Nevertheless, they emphasized the development of their social aptitude and self-confidence through their engagement in the camp program. Parent guardians, moreover, emphasized the valuable insights they had gained regarding their children's needs and the resources available to support them, because of the diligent efforts of the family engagement coordinators.

2. **Down Syndrome Association (DSA)** continued to implement their unique partnership between their agency and the established Down Syndrome Program at Nemours Children's Health System to ensure families left the clinic feeling supported, with multiple contacts helping them address medical and non-medical concerns and care for their child, mentally, physically, and emotionally. In this 3rd cohort, Their Multi-Specialty Approach provided a coordinated, multi-specialty approach to address every child's medical, developmental, and social needs helping them reach their full health and developmental potential. It is essential that families be able to access these resources on location, reducing barriers to these services by increasing convenience and providing innovative holistic support for the entire family. This project aligned with National Performance Measure (NPM) Medical Home concept of care. DSA provided services on a continual basis throughout the year of the FY2024 Family SHADE award's ongoing efforts. In looking over their previous data, new clients were most likely to be recruited in September, December and January, outside of the 6-month time frame for funding in FY2024. This is demonstrated by the 31 clients recruited in FY2024 (13 of those in September) with the 17 clients recruited so far in the first four months of FY2025. It is important to note that DSA activities are more about continuing client support than new clients recruited. Over 400 DSA CYSHCN continuing clients were provided services under the DSA SHADE award through the community liaisons and outreach workers. All the DSA clients necessarily meet the definition of CYSHCN, and given the outreach through health care, schools, and Family Services, Down Syndrome families in Delaware received services through DSA. In terms of National Performance Measures, although some of the CYSHCN clients had previous medical services in the community, virtually all became linked to a comprehensive Medical Home through the linkage with DSA, initiated by their outreach workers directly or through referral from community providers aware of the DSA/Nemours services. All new DSA clients also received initial and then ongoing Developmental Screening assessments which had not been available to them previously. DSA continued to receive technical assistance from the Parent Information Center Evaluator/Steve Martin by utilizing a Likert scale, ranging from 1 to 4, to gauge the outcomes. The program activities focused on addressing the social-emotional developmental goals of participants by providing exposure and experience in a variety of confidence-building activities, including arts and crafts, swimming, boating, theater, and physical activities. Utilizing an asset-based framework, we enhanced the protective factors for both the participants and their families. This was achieved through partnerships with primary care providers, collaboration with schools, and other community organizations. These collaborations allowed us to establish coordinated care plans for those in greatest need.

   The move to allow FY2025 Maternal Child Health Title V CYSHCN funds to be expended for CYSHCN Services over a 12 month period beginning with the end of FY2024 funding has been particularly helpful to Down Syndrome Association (DSA). DSA has done a good job of demonstrating how a mini-grant can be used in conjunction with other funding and support to provide for increased linking of at-risk clients with a medical home. The increased expansion of DSA efforts into the southern part of Delaware known as Sussex County, with its new facility and added facility at the Nemours Sussex locations has allowed DSA to leverage the limited mini-grant funds to increasingly target recruiting at-risk, primarily Hispanic clients. Using the Family SHADE mini-grant funding for outreach and recruiting has identified Down Syndrome clients in areas not previously reached or been able to bring them into the umbrella of the medical home concept of services offered by DSA's partnership with Nemours' clinic. Clients recruited sustained in services based on the ongoing relationship with Nemours. DSA has collaborated with Nemours to develop a survey of parents and caregivers about their interaction with the DSA Advocacy Team of parent-advocates and self-advocates. The Family SHADE program manager/consultant and researcher/evaluator are actively working with DSA and Nemours on this survey.

3. **Teach Zen** implemented the One Love, One Heart Curriculum with at-risk children of low-income families who were enrolled in an early childcare program for a second year. TZ provided services at five-day care centers in the city of Wilmington, New Castle County area in FY2024 in zip code areas 19801 and 4 in zip code 19805. The first three centers (Leap of Faith, MoC Jackson Street, and MoC Guardian Angels) were involved in the TZ mini-grant opportunity in Cohort 2-FY2023, and in Cohort 3-FY2024 they received 6 Booster sessions in each of three classrooms. The two new centers, both YMCA programs received 12 sessions in each classroom with 4 classrooms at the Central Y and 2 classrooms at the Walnut Street Y in the New Castle County, City of Wilmington, Delaware. The program was12 weeks in length and covered the following topic areas below along with the links that provide a description on the services rendered.
    - Kindness and Compassion
    - Discovering the Benefits of using our Breathing to calm Ourselves (link below of activities) Meet Kyma — Teach Zen
    - Handling Emotions/Various Self-Regulation Techniques
    - Positive Self Image
    - Sharing/Social Engagement (Games)
    - Cultural songs and community drumming (link below with illustration) https://www.youtube.com/watch?v=fMFyRuhfVkE

All sessions were completed in each classroom by the beginning of November 2024. There were 148 unique student participants. The TZ program is different than both CBH and DSA in several major ways. Teach Zen's work at the Centers did not involve contact with families, so the only interactions were with CYSHCN students. The TZ sessions were part of the Day Care curriculum, and parents were not present. Beyond the direct work with the students, there was a potentially more important and long-lasting element of the TZ program: teaching the teachers. Also, in the TZ program, youth clients in FY2024 were all Purchase of Care eligible, but only about 25% could be identified as CYSHCN.

The more important and long-term impact for Teach Zen is the training and examples provided to day care teachers. TZ implemented a questionnaire for staff that was scheduled to be completed in November and December 2024. Some of the survey results have just been provided to the evaluators. When fully available, the results will be used to see if staff training has led to a longer-term impact beyond Teach Zen's direct contact in this limited mini-grant, particularly comparing teachers at sites with repeated contact with TZ compared to those with only one contact. We will also compare results from this year 2024 and last year 2023 for the three Centers who received repeated services in 2024: getting repeated services. This will speak to sustainability and support for new efforts to introduce the program at other day care centers. TZ has started a repeated series of one-on-one sessions with teachers in classrooms at each of the twos, threes, and fours (shorthand for each of increasing older classrooms). Sessions have been held with teachers in each of December, January, and February. Sessions have focused on seeing what teachers have learned, what they hope to gain, and problem-solving sessions for dealing with student issues with which teachers are currently managing.

Managed Care Organization (MCO) Calls:

Maternal Child Health (MCH) supported the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish and English as these calls have continued to be a wanted resource. Parent Information Center (PIC) overseen the Family Voices program, and they scheduled these forums where parents/caregivers asked questions and discussed issues they were having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). The Zip codes of the anonymous families that attended the MCO Calls were: 19317, 19968 19977, 19720, 19904. Common Issues discussed included: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations helped problem solve. These calls were beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they had for their children. Also, any organization, provider or state agency with questions could listen and learn. Family members can meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help.

Data on CYSHCN Families and State and community organizations attending the Zoom MCO Calls in calendar year 2024:

January 9, 2024: There were 3 parents of CYSHCN. There were 27 professionals participating to answer the questions of families. There was representation by PIC, Highmark, AmeriHealth, Nemours Health Services, Easter Seals, Autism Delaware, Delaware Family Voices, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

February 13, 2024: There were 5 parents of CYSHCN. There were 27professionals participating to answer the questions of the CYSHCN Families. There was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

March 12, 2024: There were 5 CYSHCN parents that attended the MCO call. Besides family participants, there were 11 representatives from PIC, Highmark, AmeriHealth, Autism Delaware, Delaware Family Voices, Legal Aid, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

April 9, 2024: There were 5 CYSHCN parents that attended the MCO call. Besides family participants, there were 16 representatives in total from PIC, Highmark, AmeriHealth, Autism Delaware, Delaware Family Voices, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

May 14, 2024: There were 6 CYSHCN parents that attended the MCO call. Besides family participants, there were 34 representatives in total from PIC, Highmark, Ameri-Health, Delaware First Health, Legal Aid, Sunny Days, Division of Medicaid and Medical Assistance.

June 11, 2024: There were 12 parents of CYSHCN that attended the MCO call. Besides family participants, there were 10 representatives from PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, Delaware Early Learning, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

August 13, 2024: There were 3 CYSHCN Parents that attended the MCO call. There were 24 representatives in attendance from PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, Autism Delaware, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

September 10, 2024: There were 3 named participants and 3 identifiable just by a phone contact. There were 2 representatives in total from organizations that were able to answer the CYSHCN parents. The representatives were from PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, JEVS Human Services, Autism Delaware, Children's Charity, Center for Disability Studies, Division of Medicaid and Medical

Assistance, Division of Developmental Disability Services.

October 8, 2024: There were 3 CYSHCN parents in attendance. There were 2 representatives from PIC. There were no representatives from Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, JEVS Human Services, Children's Charity, A Better Chance for Our Children, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

November 12, 2024: There were 17 CYSHCN parents. There were 7 representatives in total from PIC, Highmark, AmeriHealth, Delaware Family Voices, JEVS Human Services, Autism Delaware, Delaware First Health, Maternal and Child Health Bureau, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

To participate in the Managed Care Organization (MCO) calls/zoom meetings, registration can be done through the PIC website at www.picofdel.org/events or call the office at 302-999-7394.

Part C Birth to Three

The Delaware Department of Health and Social Services (DHSS) served as the lead department for the Division of Public Health (DPH). The Part C of Individuals with Disabilities Education Act (IDEA) program and the Family Health Systems program falls under the Division of Public Health (DPH). Birth to Three Early Intervention program, has held the responsibility for assuring and implementing all components of the statewide system in compliance with policies under Part C IDEA. The Family Health System is where the Maternal Child Health Title V program and the Early Hearing Detection and Intervention (EHDI) Program resides. Family Health System's EHDI program and Birth to Three program have worked closely together in serving infants ages 0-3 years of age providing statewide, comprehensive, coordinated, multidisciplinary, interagency system of care that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. Our EHDI program referred infants and toddlers' birth to three years of age who received a diagnosis of Deaf or Hard of Hearing (D/HH) to the Birth to Three program once diagnosed with hearing loss at our Nemours Children's Hospital sole diagnostic audiology department in the state of Delaware. Our EHDI Coordinator, EHDI Follow-Up Coordinator and Children and Youth with/Special Health Care Needs (CYSHCN) Director have worked closely with Birth to Three Early Intervention and Nemours Children's Hospital. The EHDI team has referred infants' ages 0-3 years of age to the Birth to Three program, once their diagnosed. The process consisted of the Nemours Audiology team informing the family that the state of Delaware Division of Public Health EHDI program will be made aware of the diagnosis and the EHDI program will make a referral to the Birth to Three Part C program so that the family can make an informed decision on the option of receiving services for their newly diagnosed child. The family is also made aware that a referral will be sent to the Hands and Voices Guide by Your side Program and to the Statewide Programs for the Deaf/Hard of Hearing (D/HH), and Deaf-Blind Mentorship program. The EHDI Coordinator received quarterly excel reports from the Birth to Three coordinator for each county throughout the year which provided data on the families that accepted the early intervention services and the number of families that completed a signed Individualized Family Service Plan (IFSP) from the Birth to Three Program. Our EHDI Coordinator compiled the data and reported this data annually to the Centers for Disease Control (CDC) and Prevention, Hearing Screening & Follow-up Survey (HSFS). The most current data gathered is as follows:

In 2022 of the 11,218 total occurrent births, 11,113 infants were screened. Of those screened there were 10,821infants that passed and a total of 292 did not pass. Of those that did not pass there were a total of 235 with no hearing loss and a total of 11 with Permanent hearing loss. Of the 11 with permanent hearing loss, 1 infant expired/passed away before being referred; therefore, of the 10 infants referred to Part C Birth to Three, 2 were enrolled into the Part C Birth to Three Early Intervention program. Also, there were 2 families that signed their Individualized Family Service Plan (IFSP) after 6 months of age. These 10 families were referred to Hands & Voices Guide by Your Side where 8 out of the 10 D/HH diagnosed 0-3 infants accepted services. These 10 families were also referred to the Statewide Programs for the Deaf, Harf of Hearing, and Deaf-Blind Mentorship program. Of the 10 diagnosed infants 5 families accepted services from the mentorship program.

The mission of Delaware's Birth to Three Early Intervention Program continues to enhance the development of

infants and toddlers with disabilities and/or developmental delays, and to enhance the capacity of their families to meet the special needs of these young children. This mission has been adopted by both the Interagency Coordinating Council (ICC) and DHSS. Guiding principles include:

- Family-centered focus - Delaware is committed to strengthening and supporting families, sensitivity to the family's right to privacy, and respect for optimal health for all preferences. As the primary influence in the child's life, and the most valuable source of information about the needs of the child and family, family members are key participants in each step of early intervention design and delivery. A critical function of early intervention service providers should be to enhance and build the confidence and competency of the family so that the family can support their child's development throughout the day as natural learning opportunities occur.
- Integration of services - The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services and supports should be planned, using a collaborative, multidisciplinary, interagency approach. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.
- Universal application - Families of infants and toddlers with disabilities in all areas of the state should receive comprehensive, multidisciplinary assessments of their young children, ages birth through two years, and have access to all necessary early intervention services and supports.
- Cost effectiveness - The system maximizes the use of third-party payment and avoids duplication of effort. Initial evaluation for eligibility and service coordination are provided at no cost to the family. Delaware has instituted a System of Payments policy to ensure financial sustainability of the program.
- High quality services - Service should be provided at the highest standards of quality with early intervention service providers being required to meet appropriate licensing and credentialing guidelines.

The Department of Health and Social Services (DHSS), Division of Public Health (DPH) ensured compliance with the federal requirements of the Individuals with Disabilities Education Act (IDEA), which provided funding to help support the system. Children and their families received early intervention supports and services by Birth to Three within the Division of Public Health, with staff drawn from the Division of Public Health and the Division of Developmental Disabilities Services (DDDS). Some major external partners, through interagency agreements and contracts, are Department of Education IDEA Part B; Division for the Visually Impaired (DVI), Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Nemours Children's Hospital, and community providers. The Birth to Three program worked with DVI and provided service coordination for children with visual impairments or who blind.

DHSS Emergency Medical Services for Children (EMSC) program

The EMSC program has served as a national initiative designed to reduce morbidity and mortality in children due to life-threatening illness and injuries. In 1984, Senator Daniel Inouye and Senator Orrin Hatch developed initial legislation to support the EMSC program. In 1984 this federal legislation (Public Law 98.555) was enacted to fund EMSC programs in the states to address the emergency care of children. The Health Resources and Services Administration (HRSA) provides EMSC grant funding to help states develop existing hospital and Emergency Medical Services (EMS) systems to be better able to provide excellent care for critically ill and injured children. This is the only federal program that focuses specifically on the quality of children's emergency care. EMSC program are projects that provided specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for childcare agencies; and ensure that all state trauma/disaster plans address pediatric needs. The Delaware EMSC Advisory Committee meets quarterly and is chaired by a pediatrician who also represents the EMSC program on the Delaware Emergency Medical Services Oversight Council (DEMSOC). Title 16, Chapter 97 of the Delaware Code was revised in 2012 to officially establish the Emergency Medical Services for Children (EMSC) Program within the Office of Emergency Medical Services, EMS and Preparedness Section, Division of Public Health. The EMSC Act of 2012 also defines the membership of the EMSC Advisory Committee and enables development of a Pediatric System Quality Program.

Department of Services for Children, Youth, and Their Families (DSCYF)
Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the Division of Public Health (DPH). Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and aftercare. The Department of Services for Children, Youth, and Their Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training, and support to many daycare providers throughout the state and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

The Division of Public Health (DPH) has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Systems have participated on the vaccine committee, Early and Periodic Screening Diagnostic, and Treatment (EPSDT) implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality. The Interagency Coordinating Council (ICC) has been active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide. The ICC advises and assists the Department of Health and Social Services with implementation of the Birth to Three Early Intervention system and other federal infants and toddlers' programs. Council members include parents, state agency personnel, private providers, insurance providers, legislators and professionals involved in personnel preparation. The ICC has welcomed parents of children birth to three to share their stories with the council. These partners have worked on addressing the unmet needs in early childhood special education and early intervention programs for children with disabilities by assisting in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

The Sussex County Health Coalition
Parent Information Center (PIC) implemented the Family Support Health Care DE Alliance (Family SHADE) project. Through the execution of the project, there is representation for Children and Youth w/Special Health Care Needs (CYSHCN) from the Family SHADE project who attends and serves as a member of the Sussex County Health Coalition. Through the Family SHADE project, PIC has established partnerships with organizations serving CYSHCN at the Sussex County Health Coalition. The Sussex County Health Coalition exists to engage the entire community in collaborative family-focused effort to improve the health of all children, youth and families in Sussex County, Delaware. They envision a community in which Delaware citizens and institutions (public, private, and not-for-profit) are actively engaged in community health promotion as a shared community good, and working together to create an environment which supports healthy lifestyles for our children and their families. Parent Information Center - Family SHADE project partners with Help Me Grow to identify ways to partner on early childhood, health and wellness, family outreach and community engagement activities.

Bureau of Oral Health and Dental Services and Family SHADE project
Family SHADE promoted the Bureau of Oral Health and Dental Services (BOHDS) and expanded their reach to the CYSHCN population by putting the BOHDS information on the Division of Public Health Family SHADE website www.DEthrives.org. This continues to afford families easy access to Dentist that were able to serve CYSHCN. Having the BOHDS information on the Family SHADE website made it more convenient for families to access the dentist that best served CYSHCN and eliminated them from calling each dentist to ask if they can serve their child. It improved access to Dental Care for Delawareans with Disabilities and helped the dental workforce provide more

effective and optimal health for all patients with disabilities. Through outreach, information dissemination, and education made available to pediatricians and dental practitioners, this collaborative educated practitioners on best practices on serving the CYSHCN population. A Tool Kit is still an idea that we are working toward implementing through this collaborative initiative. Family SHADE Project will revisit the idea of a Tool Kit for Delaware's Dental Workforce pending the capacity to execute the project. The implementation of a Toolkit for practitioners which would include a Tool Kit of resources such as an assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

COVID Response and Support Funds Ended for the CYSHCN Family SHADE Project

In November 2024, Family SHADE project funding ended and a reallocation of the Maternal Child Health Title V funds for CYSHCN Family SHADE Project was implemented to pay for the contractual full-time project coordinator (FTE) to support community-based organizations/mini grantees with technical assistance and to continue to support and build community resiliency and the development in a variety of areas. The project coordinator-Yvonne Bunch made sure that the mini-grantees included in their COVID response plans education and planning in the event of another pandemic. Ms. Bunch is a retired merit state of Delaware employee from the Department of Services for Children, Youth, and their Families (DSCYF) with specialty of working with vendors serving youth throughout the state of Delaware. Her expertise has made her a good match in providing oversight to the awardees of the mini-grants. She has provided on going education and technical assistance to the grantees. As we move forward, the 3 mini-grantees which are awarded funding through the Family SHADE project, have a COVID response plan and COVID support in congruency with their implementation plan and their evaluation plan.

In collaboration with the National Family to Family Network, Parent Information Center joined an alliance of Family-to-Family Health Information Centers to provide outreach, education and support to children and youth with special healthcare needs and their families. The Parent Information Center -Family SHADE project continues to implement the COVID Outreach Project. The project provides information, education, and support about COVID vaccines to youth ages 12-15 and their families. The Covid Vaccine Outreach project can be accessed by contacting Ms. Jennifer Aaron, Outreach Coordinator, at 302-999-7394 or jaaron@picofdel.org.

Children and Youth with Special Health Care Needs (CYSHCN) Technical Assistance (TA)

The Title V CYSHCN Director -Isabel Rivera-Green, SSDI Director Elizabeth Orndorff and the Center for Disease Control (CDC) and Prevention -Katie Labgold, Epidemiology Expert, Parent Information Center (PIC) Family SHADE Project Team members, Delaware Family Voices -Family to Family Team members, and the University of Delaware Center for Disabilities Studies -Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program Team members met for Technical Assistance on January 27, 2025. We provided a background summary on the Needs Assessment Results for Children and Youth with Special Health Care Needs (CYSHCN). We also reviewed what the new National Performance Measures (NPM) for CYSHCN in Delaware will be focusing on in the next 5 years 2025-2030. Delaware will focus on the NPM related to transferring to the adult system of health care. Delaware will also focus on Medical Home across all sectors of the Maternal Child Health Title V programs with a universal approach. Educating those funded by the MCH Title V Grant on the Medical Home concept of care. Katie Labgold CDC Epidemiology Expert facilitated the discussion on developing a Strategy Plan address populations and performance. We utilized the Fishbone Diagram which we adopted from the MCH Evidence Georgetown University www.mchevidence.org. Our outcomes were the following:

Goal NPM: All children and CYSHCN have access to care that meets the medical home model of care.

NPM/SPM: Increase access and awareness to care that meets medical home model of care.

Goal NPM: All CYSHCN receive the necessary organized services to make the transfer to adult system of healthcare.

NPM/SPM: Having individualized services, which are responsive to the needs of each family to support the shift into adult system of healthcare.

Strategies to implement the action plan:

- Education through social media, information dissemination through sheets/pamphlets, and providing availability to information dissemination through our Home Visiting Program and School Based Health Centers.

- Partnerships with Medicaid, Visiting Nurses Program, Parent Information Center, Family Voices, and other agencies that serve CYSHCN.

This Technical Assistance Training was beneficial for our partners and our state team. It aligned a seamless state and community organization plan to serve CYSHCN and their families moving forward in the next 5 years 2025 to 2030.

AMCHP Maternal Child Health (MCH) Emergency Preparedness Response (EPR) Leadership Academy

In calendar Yr. 2024 Delaware's CYSHCN Director-Isabel Rivera-Green applied for the opportunity to participate in the AMCHP MCH Leadership Academy. The reviewers were impressed with the passion, demonstrated and desired commitment to the critical intersection of MCH and EPR, and clear goals and objectives sought to accomplish by the participation in the Academy. The MCH EPR Leadership Academy strives to increase national resilience by focusing on individual leadership development, increasing knowledge of maternal and child health emergency preparedness and response considerations, and developing skills associated with challenging and changing systems. The MCH EPR Leadership Academy requires a total 25 – 30-hour commitment over a six (6) month period, beginning in February 2025 and extending through August 2025. This was a competitive application process with 52 applications for only 10 spots. Delaware's CYSHCN Director has had the opportunity to do the following:

- Attend the MCH EPR Leadership Academy Orientation
- Participate in DiSC Workplace Training
- Attend a forum at the 2025 AMCHP Conference

As a result of the academy, an abstract has been developed for a capstone project that will be completed in August of 2025. The CYSHCN Director has met with the Executive Director -Kristin Harvey of the Governor Appointed Delaware Developmental Disabilities Council in pursuit to implement this capstone. Below is the abstract of the capstone project:

In pursuit of developing a statewide centralized online site for families of children, youth, and adults with special health care needs and medical complexities, to access emergency preparedness resources. I will focus my efforts on working with the governor appointed Developmental Disabilities Council (DDC), state, and local partners who have had prior experience addressing the COVID pandemic. These activities will include aligning in a centralized location emergency preparedness checklist tool, website hyperlinks, and contact numbers of providers who have access to emergency preparedness resources. This initiative aligns with my values and concerns for all individuals' abilities to adequately access emergency preparedness resources without barriers or limitations that are experienced by individuals having a special health care need or medical complexity. Through the established resources existing in Delaware, and with my appointed role on the DDC, I will be able to build upon the existing strengths of this initiative to support families in finding the information they need to best aid their children, youth and adult family members in the event of an unforeseen emergency.

Family Voices continues to execute the Delaware Family to Family Health Information Center (F2F HIC) initiative throughout calendar year 2024.

The F2F HIC initiative, supported by the Maternal and Child Health Bureau (MCHB), has offered information, training, and support to families of children and youth with special health care needs (CYSHCN) to improve their health and well-being. Delaware's F2F HIC focused on involving families in healthcare decisions and policy. Some relevant events that took place in Delaware in 2024 included:

- A virtual town hall on March 6, 2024, hosted by the Delaware Health and Social Services, Division of Medicaid and Medical Assistance (DMMA), discussing Medicaid benefits for children.
- A DMMA event on June 28, 2024, aimed at fostering collaboration between nursing schools and home health agencies.
- A Primary Care Reform Collaborative meeting was scheduled in October 7, 2024.

Delaware's Family Delegate Ms. Meedra Surratte is leading this initiative in promoting optimal health for children and youth with special health care needs (CYSHCN) and access to an effective health delivery system that is family centered. Our Family Delegate is actively working with the National Family Voices Network of Family-to-Family

Health.

Delaware's Developmental Disabilities Council:
Delaware's Director of Children and Youth with Special Health Care Needs (CYSHCN) is a governor appointed member to the Delaware Developmental Disabilities Council (DDC). The CYSHCN director served as a personnel committee member and as an instrumental contributor to the Delaware Developmental Disabilities Council's 5 Year Strategic Plan 2022-2026. The Administration for Community Living (ACL) under the US Department of Health and Social Services approved our 5 Year Strategic Plan. The mission of the Delaware Developmental Disabilities Council (DDC) is to promote and empowerment. The DDC focuses on the following Goals and Objectives:

- Accessible Healthcare: The DDC aims to improve access to healthcare for Delawareans with disabilities.
- Empowerment through Advocacy: The DDC provides training and resources to help individuals with I/DD become effective advocates for their own health, with a focus on the African American community and those for whom English is not their first language.
- Improved Care Coordination: The DDC seeks to optimize programs and services for individuals with I/DD and their families by improving care coordination and healthcare access.
- Support: The DDC's overarching goal is to make Delaware a state where all people with developmental disabilities are included, valued, and supported.

The DDC will continue to work to do the following:

- Fund projects that promote systems change
- Facilitate access to culturally competent services
- Educate the public and policy makers
- Hold agencies accountable

The Goal of the Council is to foster an environment that empowers and supports all Delawareans with developmental disabilities to lead self-directed lives. Areas of emphasis for the next 5 years is Education, Early Intervention, Housing, and Health/Healthcare. Aligning service delivery through Delaware's Title V priorities and strategic plans for the coming year targeting families of CYSHCN assures that we are meeting the needs through a congruent and collaborative initiative addressing NPM Medical home, transfering to an adult healthcare system for CYSHCN and adequate insurance.

Children with Special Health Care Needs - Application Year

According to the 2022-2023 National Survey of Children's Health (NSCH), the estimated number of Children and Youth with Special Health Care Needs (CYSHCN) between birth and age 17 years in Delaware is 61,253. Of these CYSHCN, 35.8 percent (n = 21,932) have a medical home in comparison to the nationwide average of 39.3 percent. Conversely, 64.2 percent (n = 39,321) of Delaware CYSHCN do not have a medical home as compared to 60.7 percent of CYSHCN nationwide.

The 2022-2023 National Survey of Children's Health (NSCH), the estimated number of Children and Youth with Special Health Care Needs (CYSHCN) between 12-17 years of age who were prepared for transition to adult health care, in Delaware is 26,596. Of these CYSHCN, 21.7 percent (n=5,771) received services to prepare for transition to an adult health care system in comparison to the nationwide average of 21.8 percent. On the other hand, 78.3 percent (n=2,082) of Delaware CYSHCN did not receive services to prepare for transition as compared to 78.2 percent nationwide.

Through the Maternal Child Health Title V Block Grant and our statewide needs assessment, we have identified two national performance measures (NPMs) that were identified as emerging concerns by families of CYSHCN. One of the NPMs is to increase the percent of children with special health care needs who have a medical home. The second NPM is to prepare CYSHCN and their families to be prepared for transition to adult health care. These two NPMs were significant measures identified by families of CYSHCN and they will serve as a guide in serving CYSHCN over the next 5 Yrs. 2025-2030. Through our state action plan and working with partnering state and community contracted agencies, we will focus on these national performance measures.

Family Support Healthcare Alliance Delaware (SHADE) Request for Proposal (RFP)
Family Support Healthcare Alliance Delaware (SHADE) "Mini-Grant" project for Children with Special Health Care Needs Request for Proposal (RFP) was executed on May 12, 2025. The competitive process is open to our current vendor Parent Information Center (PIC) and new applicants to apply. The deadline for the RFP applicants was set for July 1, 2025 with an estimated notification of award on September 1, 2025, and an estimated project begin date on December 1, 2025. The scope of work will be to target the two national performance measures (NPM) that are specific to the CYSHCN population however, other Title V NPMs can be addressed to improve through a CYSHCN system of care. The two NPMs specific to CYSHCN are:

1) NPM - Medical Home - Percent of children with and without special health care needs, ages 0-17, who have a medical home. State 2021/2022 Result: 40.2% State 2022/2023 Results 35.0% Project Goal: Increase by 50%
2) NPM - Transition - To increase the percent of adolescent with and without special health care needs who have received the services necessary to make transitions to adult health care. State 2021/2022 Results: 15.3% State 2022/2023 Results 19.0% Project Goal: Increase by 50%

Delaware Data Source: The National Survey of Children's Health Data Resource Center (DRC)

Family SHADE will serve as an umbrella organization that serves as a fiduciary agent and convener. This format is one that has worked successfully for other MCH programs nationwide and this concept has now taken shape in Delaware as well. Family SHADE is the interconnecting hub of an alliance of organizations that serve families of Children and Youth with Special Health Care Needs (CYSHCN). Family SHADE has developed from a concept on paper to a dedicated network of organizations and families committed to addressing issues of concern to families of CYSHCN. A governance structure for Family SHADE has been adopted by the membership, for the Family SHADE Family Leadership Network (FLN) members. The Division of Public Health (DPH) intends to contract with a qualified organization to serve as a backbone agency to operate and manage the Family SHADE mini-grant project to address the two NPMs (Medical Home and Preparation for Transition to Adult System of Health Care) specific to CYSHCN. The backbone agency will serve as the coordinating body that will bring together a variety stakeholders and lead a synchronized effort to achieve a common goal. The Family SHADE project with the Family Leadership Network (FLN) members who are Families of CYSHCN in addition to these resources will decrease duplication in services, increase access to services, and address unmet needs to ensure the systems of care for CYSHCN is

meeting the needs of Delaware families. The aim of the Family SHADE RFP, as part of the Title V CYSHCN work in Delaware, is to continue the building of state and local capacity, and test small scale innovative strategies to improve the overall systems of care for children and youth with special health care needs and their families. The primary focus is innovation and strategies to improve the Title V national performance measures and/or support the implementation of the standards for systems of care for CYSHCN through measurable outcomes.

The Family SHADE programmatic approach will extend family and professional partnerships at all levels of decision making that will best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE will serve as a learning network and respected resource for community organizations serving CYSHCN. Families will be included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems change to best serve families of CYSHCN. The new contracted vendor will review the historical data from the prior 4 Cohorts and review the impact the mini-grantees have made in the lives of CYSHCN. The new vendor will continue to take prior lessons learn and continue to enhance the CYSHCN System of care by assuring that data will be captured from prospective mini-grantees to impact families of CYSHCN through measurable outcomes on medical home and CYSHCN transition to adult healthcare services. The new vendor will work toward growing the Family Leadership Network (FLN) membership. This network of parents/guardians of children birth to 26 that have a special health care need. The network membership will continue to attend trainings, monthly learning community sessions, and support families with Individual Educational Plans (IEPs), and referrals. The Family SHADE Learning Communities will provide families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. The new vendor executing the Family SHADE project will continue to prioritize aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identify needs that are impacting families of CYSHCN. Through these initiatives, the Family SHADE project will contribute to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. The new vendor will be introduced to the Sussex County Coalition to focus on innovative strategies and improving the Title V national performance measures and support the implementation of the standards for systems of care for CYSHCN through measurable outcomes. The new vendor will continue to routinely take surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

Crosswalk of Maternal Child Health Block Grant with the 6 Core Indicators serving Children and Youth with Special Health Care Needs

The Director of CYSHCN will provide technical assistance to the selected vendor in executing the Family SHADE project. The Family SHADE project will target the identified emerging issues that were identified in our statewide needs assessment. Families of CYSHCN identified the following National Performance Measures (NPM): Medical Home and Preparation of Transition to adult health care system for CYSHCN ages 12 -17. Families reported that these NPMs are emerging issues that CYSHCN and their families would benefit from improving in the CYSHCN System of Care. The Family SHADE project's mini-grantees and Family Leadership Network (FLN) will be instrumental in contributing and collaborating with our MCH Title V team to address these emerging issues and seamlessly touch on all 6 core CYSHCN indicators which are:

1. Children and youth are screened early and continuously
2. Receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing
3. Community-Based services are organized so families can use them easily
4. Receive services necessary to make transitions to adult life, and including healthcare
5. Families have adequate insurance and funding to pay for services they need
6. Are partners in decision-making at all levels of care from direct care to the organizations that serve them

Delaware will develop a crosswalk between our MCH Title V Block Grant domains and the 6 core CYSHCN indicators. We will be intentional in improving the lives of CYSHCN and their families, ensuring they can thrive in their communities from childhood through adulthood. We will focus on four key areas: 1. Optimal health for all 2. Family and child well-being and quality of life, 3. Access to services, and 4. Financing of services. We will utilize this framework to create a system where CYSHCN have access to the support they need to reach their full potential. We will align the current work and priorities that we are doing to serve CYSHCN and their families and improve the

system of care through adhering to the results identified in the needs assessment. This approach will allow us to identify the systems strengths, weakness and opportunities to enhance our CYSHCN system of care. We will measure the state of Delaware's CYSHCN system of care level of functioning based on the state data that we have received and how we compared to the national data. This approach will assist and guide our Title V programs in aligning the work and priorities and guiding principles for a system of services for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. This table below illustrates the starting point for 2025-2026 of our state and on how we identified where the state was and where we want to go in improving the system of services for CYSHCN. This approach allowed us to do a crosswalk in the Title V needs assessment and assisted in reporting future Block Grant application related to the 6 core CYSHCN indicators.

The Maternal Child Health (MCH) Title V Block Grant, Title V Delaware data and population in comparison to the national data and nationwide population is outlined in the table below. This information guided us with a baseline and a starting point as we began to move forward to develop our task and activities to implement our work, priorities, in alignment with the 6 core CYSHCN indicators within the Crosswalk of Maternal Child Health Block grant 6 core Indicators. This foundation has allowed us to see where we are now in serving CYSHCN and where we want to move toward making a change across all domains within Delaware's Maternal Child Health Title V delivery of service. Information below from: National Survey of Children's Health - Data Resource Center for Child and Adolescent Health (childhealthdata.org)

Measure	Delaware Data	Delaware Pop. Est.	National Data	Nationwide Pop. Est.
Well - Functioning System of Care	53.1% of CSHCN who received needed care coordination. 46.9% CSHCN Who did not receive needed care coordination.	47574	54.1%CSHCN who received needed care coordination. 45.9% CSHCN who did not receive needed care coordination.	13,805,035
Family-centered care	81.2%CSHCN who receive family centered care 18.8% CSHCN who do not have family centered care	55,602	81.2 CSHCN Who have family centered care. 18.8% CSHCN who do not have family centered care	16,985,492
Medical Home (0-17)	35.8% Have a medical home 64.2% Do not have a medical home	61,253	39.3% Have a medical home 60.7% Do not have a medical home	31,823
Early and Continuous Screening	32.8% of children ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year. 67.2% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	26,363	35.6% of children ages 9 through 35 months, who received a developmental screening using a parent -completed screening tool in the past year. 64.4% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	8,034,058
Adequate & Continuous Insurance in 2022	66.9% CYSHCN Current insurance is adequate for child's health needs. 71.5% Non-CYSHCN Current insurance is adequate for child's health needs.	145,862	61.3% CYSHCN - Current insurance is adequate for child's health needs. 68.2% Non-CYSHCN Current insurance is adequate for child's health needs. r	48,591,549
Access to Community-Based Services	Data on access to community -based services was not captured on the NSCH Interactive Data Query 2022-present -Data Resource Center for Child and Adolescent Health. Delaware will begin to collect this data in calendar year 2025-2026.			
Health Care Transition to adult health care, adolescents with special health care needs, age 12-17	21.7% of CYSHCN Received services to prepare for transition 78.3% of CYSHCN did not receive services to prepare for transition	26,596	CYSHCN who received services to prepare for transition 21.8% CYSHCN who did not receive services to prepare for transition 78.2%	8,719,418

Delaware will implement the development of a crosswalk through our MCH Title V Block Grant and developed an alignment with the 7 measures for CYSHCN. The 6 Core CYSHCN indicators continue to be implemented throughout the domains and national performance measures in the delivery of service for our CYSHCN population. Delaware will continue to use guiding principles for a system of service for children and youth with special health care needs.

	CORE INDICATOR#1 Children and youth are screened early and continuously	CORE INDICATOR#2 receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing	CORE INDICATOR#3 Community-based services are organized so families can use them easily	CORE INDICATOR#4 CYSHCN receive services necessary to make transitions to adult life, including healthcare	CORE INDICATOR#5 Families have adequate insurance and funding to pay for services they need	CORE INDICATOR#6 Families of CYSHCN Are partners in decision-making at all levels of care from direct care to the organizations that serve them
Optimum Health for All	Healthy People 2030 define optimal health for all as "The attainment of the highest level of health for all people. Achieving A Healthy America requires valuing everyone with a focus on improving health and well-being. Addressing poverty, damaging living conditions, and access to health and social services will mitigate adverse health effects. The principles and strategies will seamlessly acknowledge that poverty, discrimination, and their downstream consequences cause barriers for optimal health for all. Delaware will continue to implement a crosswalk across our national performance measures which are: Well-women visit, Breastfeeding, Developmental Screening, Dental Visit (child/adolescent), physical activity (ages 12-17), Adolescent Well-visit, Adequate insurance, and workforce development.					
Quality of life & well-being	Historically, health care does not include a proactive focus on patient and family well-being and quality of life. Yet, studies have shown that parents and families of CYSHCN often experience disruptions to family life, social isolation, and chronic stress, and have significant and various psychosocial support needs. Data reveals that "CYSHCN and their families are at risk for adverse outcomes in economic, academic, and social emotional domains, in addition to physical health. Moreover, access to opportunities and supports exacerbate the ability to access services for CYSHCN and their families' experiences. Historically, the health system focused on measuring health outcomes, not necessarily metrics meaningful to families. These metrics should be developed in partnership with Families and can include the wellbeing and quality of life of the child from birth through adulthood, wellbeing of the family unit, and the ability to achieve dignity, autonomy and independence.					
Access to services	Access to services and supports is defined broadly and includes the 4 components of access to health care: coverage, services; timeliness; and a capable, qualified, and a competent workforce. This concept includes all social services necessary for CYSHCN and families to have full, thriving lives, including but not limited to education, early intervention, child welfare, foster care, health, and community-based supports. This critical area recognizes the educational system as an entry point and major deliverer of services for children and families. The ideal system is integrated across all sectors and anticipates families' needs. It aligns the delivery, payment, and administration of services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.					
Financing of service	Addressing health optimal health for all, well-being, quality of life, and access to care requires an adequately financed system of services. This includes both the overall systems of financing, including insurance design and organization of programs, as well as specific models and mechanisms for payment and eligibility. It supports models that improve quality and value, and recognizes outcomes meaningful to stakeholders, including families, providers, and payers. Although the following principles and strategies focus on health care and related services, including care coordination, which is necessary in a system that is not fully integrated, CYSHCN also may require an array of additional social services and educational supports.					

Family SHADE Mini-Grant program

Parent Information Center (PIC) has served as the fiduciary for the mini-grantee project over the last 4 Cohorts. In 2025 we executed a new RFP for the Family SHADE Mini-Grant program because of procurement rules and

regulations. PIC will have the opportunity to apply and compete for the Family SHADE mini-grant project. The public notice went out on May 12, 2025, and the deadline for receipt of proposals for the Family SHADE project is July 1, 2025. We Estimate the project beginning with a new vendor or our current vendor PIC on December 1, 2025. PIC's current contract will end on November 30, 2025, and we are exploring plans to set up a warm hand off from PIC to the new vendor. The warm hand off will be beneficial to the Family Leadership Network (FLN) because they are instrumental in contributing their input to the CYSHCN system of care. We will also afford this same transition of vendors to the current mini-grantees which are Teach Zen, Children's Beach House, and Down Syndrome Association of Delaware. However, if PIC applies for the RFP and is awarded, there will not be a need to do a warm hand off. The CYSHCN will provide the vendor with the crosswalk of the National Performance Measures that we will focus on addressing for the next 5 years (Yr. 2025 to Yr. 2030). An overview of the mini-grant estimated timetable process will be determined once a vendor is selected through the RFP competitive process. Currently, PIC will continue to execute the Family SHADE Project and lead the current mini-grantees. Below are Learning Communities that are scheduled for the FLN members and meeting quarterly meetings.

Learning Communities:

- Children's Community Alternative Disability (CCADP) Program Information Session
- Emergency Preparedness
- Medical Transitions for adult health care overview
- How to Have Effective Individualized Health Care/Individualized Health Care Plan (IHP)
- Medical Home
- Social Security for Transition-Age Youth
- Care Notebook

Family Leadership Network Quarterly Meetings

- 9/10/2025 at 12:00pm -Navigating Individualized Educational Plans Meetings for Children and Youth with Special Health Care Needs
- 12/13/2025 at 10:00am Networking Brunch and Year-End Review

Transition Symposium Date to Be Determined

- Medical Transitions (Deeper Diver) -Guided by Learning Community
- Emergency Preparedness -My Emergency Readiness Plan
- Medical Home
- Mini-grant overview

Through year 4 of the Family SHADE mini-grant program, PIC will continue to collect the data on the 3 mini-grantees which are Teach Zen, Children's Beach House and Down Syndrome Association of Delaware. These mini-grantees will continue to implement the following services which align with the Maternal Child Health Title V National Performance Measures (NPMs) as well as align current work and priorities with the Guiding Principles for a System of Service for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. As we move forward into the next 5 years serving CYSHCN and their families, we will focus on National Performance Measures Medical Home and Transition into adult health care for CYSHCN ages 12-17. The current mini-grantees have received information on the priorities that the Maternal Child Health Title V program will focus on as a result of a statewide needs assessment that was conducted to determine the approach for the next 5 years. The needs assessment was completed by families of CYSHCN and subject matter experts that serve this population.

Once the new mini-grantees are awarded they will develop skills that will further sustain their projects after the funding has ended. These organizations will enhance their skills so that they can compete and apply for future grant opportunities to grow their efforts in serving CYSHCN. Below are tools that these organizations will develop while working with Family SHADE mini-grantee project serving CYSHCN:

- Logic Model
- Work Plan
- Evaluation Plan
- Evaluation Tool
- Sustainability proposal
- Emergency response plan

The new vendor will take the lessons learned from the 4 cohorts of the mini-grant program and enhance the program as they move forward into the next 5 years. They will review the prior data collected and learn from prior activities that worked and needed to be enhanced. The new vendor will become familiar with the scope of work for the Family SHADE project and create a data collection system that captures the service delivery of the CYSHCN system of care. Identifying gaps in service from lessons learned and reviewing prior activities so that we can enhance the work and address the identified National Performance Measures (NPM): Medical Home and Transition into the CYSHCN Adult System of Health Care for ages 12-17. Developing a data collection tool system will be necessary to track the impact on the CYSHCN System of care. The data collection tool will be administered to the awarded mini-grantees and the new vendor that serves as the fiduciary will monitor the mini-grantees closely and provide technical assistance to support the use of a data collection tool that will be administered with all the mini-grantees to assure that data collection will seamlessly align with the National Performance Measures (NPM) Medical Home and Health Care Transition to adult health care, adolescents with special health care needs, age 12-17. There will be an intentional approach to engage family and community partnerships while executing optimal health for all every step of the way through the process. Delaware will work in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health programs in the execution of the CYSHCN system of care with an intentional plan to touch each of the Maternal Child Health Title V Domains while addressing the CYSHCN 6 core indicators. The vendor will monitor and evaluate through every phase of the projects the impact that is being made on CYSHCN and their families. The team will provide technical support to the mini-grantees along with regularly scheduled monthly site visits by the project coordinator.

The CYSHCN Director will meet regularly through monthly scheduled programmatic meetings with the Family SHADE vendor executing the Family SHADE project. We will review the NPMs below and align their data collection tools and their projects to mirror their projects initiatives with the Maternal Child Health Title V NPMs listed below:

- Performance Measure Access to Medical Home
  Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
- Performance Measure Transition to Adult Healthcare
  Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.

The Family SHADE project will continue to enhance the data collection process for all of the mini-grantees as well as data collection for the other programs that serve CYSHCN and their families. Collecting reportable data that captures the impact made on CYSHCN and their families will be a priority. The development of a data collection tool will capture knowledge gained through Pre and Post-test provided to mini-grantee participants. The data collection will also capture the services provided, demographical information such as age, location, special health care need (SHCN), and the number of times attended and if parent/guardian was present.

The Family SHADE project will continue to utilize the Family Leadership Network (FLN) members in collaboration with all of the mini-grantees to receive feedback on where there are gaps in service delivery for CYSHCN population. Family SHADE will work toward recruiting 15 FLN members that will serve as collaborative leaders who contribute feedback on their experiences on service delivery to the project and to the mini-grantees which will serve CYSHCN and their families. This network will continue to consist of parents/guardians of children birth to age 26 that have a suspected or diagnosed disability. The FLN network membership includes trainings, monthly learning community sessions, support with Individual Education Plans (IEPs), and referrals. They will attend Family SHADE Learning Communities and serve as a resource, support, and mentor through their knowledge gained for other families that are navigating the system of care for CYSHCN. The FLN members will share their experiences with other families in navigating and understanding the Medical Home Model of Care through their Pediatrician/Primary Care Physician and other specialists. FLN members will receive a monthly stipend for attendance and participation as long as the monetary resources are available for this FLN network.

The quarterly FLN meetings, align in conjunction with Learning Community Forums. This will be done to have the

Learning Community sessions serve as a training mechanism for the FLN members. The Target for the calendar year 2026 is to recruit 15 active Family leaders from the community but to date they have only succeeded at recruiting 9 FLN members. The FLN members will transition to the new Family SHADE awarded vendor or remain with PIC, if they apply for the Family SHADE RFP. The FLN members will continue to meet quarterly throughout the calendar year.

Family SHADE Innovated Activities:
The Family SHADE Project will reevaluate the utilization of quarterly symposiums. Historically, the symposiums and the summits that were executed by Parent Information Center (PIC) were poorly attended by families of CYSHCN. The intent of the symposiums and the summits are to provide the CYSHCN community with the opportunity to engage in Maternal Child Health (MCH) Title V services provided to CYSHCN and their families. However, the attendance was low every year these events were held. Moving forward we will explore other opportunities for families of CYSHCN to take advantage of. The goal is for families of CYSHCN to be informed about the Medical Home Concept and Transition of health care for CYSHCN ages 12 – 17.

Managed Care Organization (MCO) Calls:
Maternal Child Health (MCH) will continue to support the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish and English as these calls have continued to be a wanted resource. Parent Information Center (PIC) overseen the Family Voices program and they schedule these forums where parents/caregivers ask questions and discuss issues they are having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). Common Issues discussed include: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations help problem solve. These calls are beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they have for their children. Also, any organization, provider or state agency with questions can listen and learn. Family members meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help. These meetings occur approximately monthly with some months not meeting when other large annual meetings and symposiums occur. These meetings will continue to be confidential therefore it is not possible to report on specific questions covered monthly. However, the range of service areas present monthly and the length of the meetings give some sense of the breath of areas covered and accessible to parents and families. Also, any organization, provider or state agency with questions or calling to listen and learn. To participate in the MCO calls, registration can be done through the PIC website at www.picofdel.org/events or call the office at 302-999-7394.

Part C Birth to Three
The Delaware Department of Health and Social Services (DHSS) serves as the lead department for the Division of Public Health (DPH). The Part C of Individuals with Disabilities Education Act (IDEA) program and the Family Health Systems program falls under the Division of Public Health (DPH). Birth to Three Early Intervention program, holds the responsibility for assuring and implementing all components of the statewide system in compliance with policies under Part C IDEA. The Family Health System is where the Maternal Child Health Title V program and the Early Hearing Detection and Intervention (EHDI) Program resides. Family Health System's EHDI program and Birth to Three program have worked closely together in serving infants ages 0-3 years of age providing statewide, comprehensive, coordinated, multidisciplinary, interagency system of care that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. Our EHDI program refers infants and toddlers' birth to three years of age who receive a diagnosis of Deaf or Hard of Hearing (D/HH) to the Birth to Three program once diagnosed with hearing loss at our Nemours Children's Hospital sole diagnostic audiology department in the state of Delaware. Our EHDI Coordinator, EHDI Follow-Up Coordinator and Children and Youth with/Special Health Care Needs (CYSHCN) Director will continue to work closely with Birth to Three Early Intervention and Nemours Children's Hospital. The EHDI team will continue to refer infants' ages 0-3 years of age to the Birth to Three program, once their diagnosed. The process will continue to consist of the Nemours Audiology team informing the family that the state of Delaware Division of Public Health EHDI program will be made aware of the diagnosis and the EHDI program will make referrals to the Birth to Three Part C program so

that the family can have the option of receiving services for their newly diagnosed child. The family will be made aware that a referral will be sent to the Hands and Voices Guide by Your side Program and to the Statewide Programs for the Deaf/Hard of Hearing (D/HH), and Deaf-Blind Mentorship program. The EHDI Coordinator will continue to receive quarterly excel reports from the Birth to Three coordinator for each county throughout the year which provides data on the families that accepted the early intervention services and the number of families that completed a signed Individualized Family Service Plan (IFSP) from the Birth to Three Program. Our EHDI Coordinator will continue to compile the data. With the changes in our federal leadership, our EHDI Coordinator will not be reporting this data annually to the Centers for Disease Control (CDC) and Prevention, Hearing Screening & Follow-up Survey (HSFS).

Delaware's formerly known Child Development Watch has changed their name to Birth to Three. The mission of Delaware's Birth to Three Early Intervention Program is to enhance the development of infants and toddlers with disabilities and/or developmental delays, and to enhance the capacity of their families to meet the special needs of these young children. This mission has been adopted by both the Interagency Coordinating Council (ICC) and DHSS. The guiding principles include:

- Family-centered focus - Delaware is committed to strengthening and supporting families, sensitivity to the family's right to privacy, and respect for multicultural preferences. As the primary influence in the child's life, and the most valuable source of information about the needs of the child and family, family members are key participants in each step of early intervention design and delivery. A critical function of early intervention service providers should be to enhance and build the confidence and competency of the family so that the family can support their child's development throughout the day as natural learning opportunities occur.
- Integration of services - The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services and supports should be planned, using a collaborative, multidisciplinary, interagency approach. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.
- Universal application - Families of infants and toddlers with disabilities in all areas of the state should receive comprehensive, multidisciplinary assessments of their young children, ages birth through two years and have access to all necessary early intervention services and supports.
- Cost effectiveness - The system maximizes the use of third-party payment and avoids duplication of effort. Initial evaluation for eligibility and service coordination are provided at no cost to the family. Delaware has instituted a System of Payments policy to ensure financial sustainability of the program.
- High quality services - Service should be provided at the highest standards of quality with early intervention service providers being required to meet appropriate licensing and credentialing guidelines.

The Department of Health and Social Services (DHSS), Division of Public Health (DPH) ensures compliance with the federal requirements of the Individuals with Disabilities Education Act (IDEA), which provided funding to help support the system. Children and their families received early intervention supports and services by Birth to Three within the Division of Public Health, with staff drawn from the Division of Public Health and the Division of Developmental Disabilities Services (DDDS). Some major external partners, through interagency agreements and contracts, are Department of Education IDEA Part B; Division for the Visually Impaired (DVI), Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Nemours Children's Hospital, and community providers. The Birth to Three program works with DVI and provides service coordination for children with visual impairments or who blind.

DHSS Emergency Medical Services for Children (EMSC) program

The EMSC program serves as a national initiative designed to reduce morbidity and mortality in children due to life-threatening illness and injuries. In 1984, Senator Daniel Inouye and Senator Orrin Hatch developed initial legislation to support the EMSC program. In 1984 this federal legislation (Public Law 98.555) was enacted to fund EMSC programs in the states to address the emergency care of children. The Health Resources and Services Administration (HRSA) provides EMSC grant funding to help states develop existing hospital and Emergency Medical Services (EMS) systems to be better able to provide excellent care for critically ill and injured children. This

is the only federal program that focuses specifically on the quality of children's emergency care. EMSC program are projects that continue to provide specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for childcare agencies; and ensure that all state trauma/disaster plans address pediatric needs. The Delaware EMSC Advisory Committee meets quarterly and is chaired by a pediatrician who also represents the EMSC program on the Delaware Emergency Medical Services Oversight Council (DEMSOC). Title 16, Chapter 97 of the Delaware Code was revised in 2012 to officially establish the Emergency Medical Services for Children (EMSC) Program within the Office of Emergency Medical Services, EMS and Preparedness Section, Division of Public Health. The EMSC Act of 2012 also defines the membership of the EMSC Advisory Committee and enables development of a Pediatric System Quality Program.

Department of Services for Children, Youth, and Their Families (DSCYF). Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the Division of Public Health (DPH). Its primary responsibility will continue to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and aftercare. The Department of Services for Children, Youth, and Their Family Services (DSCYFS). This department will continue to provide child oriented and family focused services. The Foster Care staff will continue to work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training, and support to many daycare providers throughout the state, and investigating complaints concerning day care facilities. The Division's Office of Children's Services also continues to assess families with problems and provides them with supportive services to empower them to protect and nurture their children.

The Division of Public Health (DPH) has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Systems have participated on the vaccine committee, Early and Periodic Screening Diagnostic, and Treatment (EPSDT) implementation committee, and lead poisoning prevention committee. The AAP continues to be involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality. The Interagency Coordinating Council (ICC) continues to be active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide. In calendar year 2025, the ICC will continue to advise and assist the Department of Health and Social Services with implementation of the Birth to Three Early Intervention system and other federal infants and toddlers' programs. Council members include parents, state agency personnel, private providers, insurance providers, legislators and professionals involved in personnel preparation. The ICC will continue to welcome parents of children birth to three to share their stories with the council. These partners will work on addressing the unmet needs in early childhood special education and early intervention programs for children with disabilities by assisting in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

Family SHADE partnership with Sussex County Health Coalition

Through the Family Support Health Care DE Alliance (Family SHADE) project, there will be on going representation of Children and Youth with Special Health Care Needs (CYSHCN) and their families within the Sussex County Health Coalition. Over the years, the Family SHADE project has developed an established relationship with the Sussex County Health Coalition. Through the Family SHADE project, there will be an on-going partnership with organizations serving CYSHCN at the Sussex County Health Coalition. The Sussex County Health Coalition exists to engage the entire community in collaborative family-focused effort to improve the health of all children, youth and families in Sussex County, Delaware. They envision a community in which Delaware citizens and institutions (public, private, and not-for-profit) are actively engaged in community health promotion as a shared community good, and

working together to create a cultural and physical environment which supports healthy lifestyles for our children and their families. The Family SHADE project partners with Help Me Grow to identify ways to partner on early childhood, health and wellness, family outreach and community engagement activities.

Bureau of Oral Health and Dental Services and the Family SHADE project:
Family SHADE promotes the Bureau of Oral Health and Dental Services (BOHDS) and will continue to expand their reach to the CYSHCN population by putting the BOHDS information on the Division of Public Health Family SHADE website www.DEthrives.org. This affords families easy access to Dentist that were able to serve CYSHCN. Having the BOHDS information on the Family SHADE website makes it more convenient for families to access the dentist that best serve CYSHCN and eliminates them from having to call each dentist to ask if they can serve their child with special needs. It will improve access to Dental Care for Delawareans with Disabilities and helped the dental workforce provide more effective and culturally competent care to patients with disabilities. Through outreach, information dissemination, and education made available to pediatricians and dental practitioners, this collaborative educated practitioners on best practices on serving the CYSHCN population. A Tool Kit is still an idea that we will work toward to implement through this collaborative initiative. Family SHADE Project will revisit the idea of a Tool Kit for Delaware's Dental Workforce. The implementation of a Toolkit for practitioners which would include a Tool Kit of resources such as an assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

Emergency Response and Support:
Family SHADE project will plan to continue to support community-based organizations/mini grantees with technical assistance and support to build community resiliency and support the development in a variety of areas which includes emergency response preparedness, plans, and education. The CYSHCN Director will assist in the pursuit of developing a statewide centralized online site for families of children, youth, and adults with special health care needs and medical complexities, to access emergency preparedness resources. There will be intentional efforts to work with the governor appointed Developmental Disabilities Council (DDC), state, and local partners who have had prior experience addressing the COVID pandemic. These activities will include aligning in a centralized location emergency preparedness checklist tool, website hyperlinks, and contact numbers of providers who have access to emergency preparedness resources. This initiative will align to adequately access emergency preparedness resources without barriers or limitations that are experienced by individuals having a special health care need or medical complexity. Through the established resources existing in Delaware, and with the CYSHCN Director being appointed as a member of the Delaware Developmental Disabilities Council (DDC), the Family SHADE project will be able to build upon the existing strengths of this initiative to support families in finding the information they need to best aid their children, youth and adult family members in the event of an unforeseen emergency.

In collaboration with the National Family to Family Network, Parent Information Center participates in an alliance of Family-to-Family Health Information Centers to provide outreach, education and support to children and youth with special healthcare needs and their families. Our Parent Information Center (PIC) community agency will continue to provide information, education, and support about COVID vaccines to youth ages 12-15 and their families. The Covid Vaccine Outreach project can be accessed by contacting Ms. Jennifer Aaron, Outreach Coordinator, at 302-999-7394 or jaaron@picofdel.org

The Title V CYSHCN Director will reconvene the work in collaboration with Delaware Family Voices in establishing a Collaborative Action Team Process: Family Engagement & Leadership. The State Collaborative Action Team Process included our Division of Public Health Maternal Child Health CYSHCN Director and Family Voices parent lead organization. We will continue to work together to develop a plan to enhance family engagement and family professional partnerships at the individual, program, and policy level. Through the technical support from the National Family Voices Leadership in Family and Professional Partnerships (LFPP) we will establish a draft Strategic Plan that included sustainability and the start of the collaborative. Family Voices has reconvened the Delaware Family to Family Health Information Center (F2F HIC) initiative. Delaware's Family Delegate Ms. Meedra Surratte is leading this initiative in promoting optimal health for children and youth with special health care needs (CYSHCN) and access to an effective health delivery system that is family centered. Our Family Delegate continues

to actively work with the National Family Voices Network of Family-to-Family Health.

Delaware's Developmental Disabilities Council:
Delaware's Director of Children and Youth with Special Health Care Needs (CYSHCN) is a governor appointed member to the Delaware Developmental Disabilities Council (DDC). The CYSHCN director will continue to serve as a personnel committee member and as an instrumental contributor to the Delaware Developmental Disabilities Council's 5 Year Strategic Plan 2021-2026. The Administration for Community Living (ACL) under the US Department of Health and Social Services approves our 5 Year Strategic Plan. The goal of the Delaware Developmental Disabilities Council (DDC) is to advocate to strengthen education policies and programs, as well as empower students and their families through education and resources.

The DDC will work to do the following:

- Fund projects that promote systems change
- Facilitate access to culturally competent services
- Educate the public and policy makers
- Hold agencies accountable

The Goal of the Council during Yr. 2021-2026 has been to foster an environment that empowers and supports all Delawareans with developmental disabilities to lead self-directed lives. Areas of emphasis for the strategic plan is Self-Advocacy, Education and Early Intervention, and Housing. Aligning service delivery through Delaware's Title V priorities and strategic plans for the coming year targeting families of CYSHCN assures that we are meeting the needs through a congruent and collaborative initiative addressing NPM -medical home, NPM - transition to adult health care for CYSHCN ages 12-17 The CYSHCN Director will discuss the priority CYSHCN NPMs, the Maternal Child Health Domains and the CYSHCN 6 core indicators. In the upcoming final year of the DDC strategic plan, will continue to address the following goals:

Goal 1. Self-Advocacy

Description: The Delaware Developmental Disabilities Council will foster an environment that empowers and supports Delawareans with developmental disabilities to lead self-directed lives.

Expected Goal Outcome: Delawareans with Intellectual and Developmental Disabilities I/DD will report increased confidence in advocating for themselves and others regarding legislation, self-direction, service provision, educational opportunities, recreational activities, HCBS/LTSS services, and independent living. As a result, a larger number of self-advocates will report satisfaction and happiness in their lives and will go on to achieve their goals such as higher education, obtaining competitive employment, having a healthy relationship, becoming parents, and more.

Objectives:

1. The Delaware Developmental Disabilities Council will support the development of a self-advocacy group in Delaware utilizing the existing framework of National Disability groups.
2. The Delaware Developmental Disabilities Council will provide opportunities for individuals with disabilities including families and allies to participate in capacity building activities through education, training, and access to resources
3. The Delaware Developmental Disabilities Council will make available training opportunities to professionals with regards to behavior and non-verbal signs (health care professional, educators).

Goal 2. Education and Early Intervention

Description: The Delaware Developmental Disabilities Council will advocate to strengthen education policies and programs, as well as empower students and their families through education and resources.

Expected Goal Outcome: More people with disabilities will participate and guide their Individualized Educational Plan (IEP) meetings. Parents will feel empowered to support their child's educational goals and to "set the bar high". More students with disabilities will think of what they want to do as a career, or if they would like to pursue higher education. Educators and the Department of Education (DOE) will hear from more individuals with disabilities and their families, which will help inform and improve policies and delivery of special education services.

Objectives:

1. The Delaware Developmental Disabilities Council will train and support parents and allies to become empowered to serve as advocates.
2. The Delaware Developmental Disabilities Council will support Delawareans with disabilities and their families/ caregivers by coordinating informal group meetings with speakers covering various topics, promote sharing of

mentorship and peer support opportunities.
3. The Delaware Developmental Disabilities Council will provide support and assistance to people with DD/ID and co-occurring serious and persistent mental illness.

Goal 3. Housing

Description: The Delaware Developmental Disabilities Council will support the development and distribution of training and resources that will improve access to affordable, accessible, and integrated housing in the community for Delawareans with developmental disabilities.

Expected Goal Outcome: There will be more disability representation on non-disability-related housing boards and commissions, to inform and shape policies and procedures. More materials regarding housing options will be available in plain language and in other languages. Individuals with disabilities and their families will feel more informed about housing options and empowered to advocate for the type of housing they prefer, which will help them to live fully integrated lives in the community.

Objectives:

1. The Delaware Developmental Disabilities Council will collaborate with strategic partners to develop a plain language digital resource library on legal rights and access to accessible, affordable, integrated housing for use by advocates and self-advocates.
2. The Delaware Developmental Disabilities Council will promote and support people with disabilities from a variety of backgrounds to be included at the table on all major Delaware housing committees.

Goal 4. Health/Healthcare

Description: The Delaware Developmental Disabilities Council will utilize its advocacy efforts to promote accessible healthcare among Delawareans with disabilities.

Expected Goal Outcome: People with disabilities will have the information, resources, and support that they need to become effective advocates for their health. Clinicians will be trained how to identify barriers experienced by people with disabilities seeking access to quality, informed medical care. They will also be trained on conscious and unconscious biases and how to identify and move past them. As a result, self-advocates and their families will experience better health care outcomes, including avoiding institutionalization.

Objectives:

1. The Delaware Developmental Disabilities Council will identify opportunities to eliminate institutional bias by changing default planning in transition services towards home and community-based settings.
2. The Delaware Developmental Disabilities Council will provide training and resources to assist individuals with Intellectual and Developmental Disabilities (I/DD) with a focus on the African American community or for whom English is not their first language, to become empowered, effective advocates for their own health. As a result, this group will experience better health care interactions and health outcomes.

The CYSHCN Director will continue to serve on the governor appointed Delaware Developmental Disabilities Council (DDC) and apply the 6 core CYSHCN indicators into the goals of the DDC Strategic plan so that there is a crosswalk between the Maternal Child Health Title V Strategic Plan and the DDC Strategic Plan as Delaware moves forward into the next 5 years.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	75	75	100
Annual Indicator	68	80	76	84	84
Numerator	17	20	19	21	21
Denominator	25	25	25	25	25
Data Source	FHS Data	FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	85.0	88.0	90.0	95.0	100.0

Evidence-Based or –Informed Strategy Measures

SPM ESM 1.1 - To increase the percentage of MCH staff that have completed at least one professional development opportunity.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	80
Numerator	20
Denominator	25
Data Source	MCH Program Data
Data Source Year	2024
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	90.0	93.0	95.0	98.0

State Action Plan Table

State Action Plan Table (Delaware) - Cross-Cutting/Systems Building - Entry 1	
SPM	
SPM 1 - Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.	
Five-Year Objectives	
Build MCH capacity and support the development of a trained and qualified workforce by providing professional development opportunities.	
Strategies	
Develop an Accountability Matrix, which provides specific workgroup, contact, and data information about each NPM to ensure no overlap and to track progress.	
Create ongoing learning resources and videos to internal employees as well as partners to address topics such as: onboarding, burnout, Title V resources, technical assistance opportunities, and more.	
Periodically survey and deliver to our internal and external partners the needed training opportunities that are requested to develop our workforce and address actual competency needs.	
ESMs	Status
SPM ESM 1.1 - To increase the percentage of MCH staff that have completed at least one professional development opportunity.	Active

Even though workforce development was not a formal priority, we have been focused on improvement and ensuring staff have the resources they need to feel confident in the job they are doing. However, we feel accountability is needed to ensure a more intentional approach as well as the ability devote resources and capacity to our community partners.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.
It's important to note that not all learning occurs in a classroom or on an electronic device. Learning can be as simple as a supervisor observing an employee performing a task and offering suggestions on how to improve that performance (i.e. on-the-job training). It can occur during staff, one-on-one, and, performance feedback meetings, or by reading an article in a professional periodical and putting the concepts to work on the job. Supervisors can also facilitate learning by adding a Professional Development section to employees' Performance Plans. Working together on this will help employees focus on his/her training goals and establish a more productive working relationship. To keep track of this, employees can use the DPH Personal/Professional Development Plan, as a tool to help them and their supervisors, develop goals and document uniquely tailored training needs and experiential learning exercises to expand their knowledge, skills and abilities to provide the best service possible to the citizens of Delaware.

We held our 2024 FHS Annual Employee Retreat this past Fall, "Come together, celebrate accomplishments, what we want to accomplish for the new year" and our theme was Revitalize and Restore. Our Retreat objectives were:

- Focus on DPH Strategic priorities: healthy lifestyles, population health and performance management.
- Revisit the FHS Vision, Mission, and Values that guide our work.
- Celebrate accomplishments, recognize team members, and develop new goals for FY25 that will be implemented in collaboration with management, program staff and community support.
- Achieve improvement in the way all staff engage with their colleagues, as well as view and do their work.
- Inspire action that sparks creativity and improves teamwork, the way our section operates, and the way our staff interacts and communicates.
- Healthy Lifestyles: complete physical activity event and allow staff to take a walk through the one-mile trail.

The speaker for our 2024 Retreat was from educere Institute. The workshop was on Self-Care & Wellness on Your Own Terms: Self-care is the art of nurturing and tending to the various dimensions of our existence - physical, mental, emotional, and spiritual. It's not a mere luxury; rather, it's an essential practice that contributes to our overall well-being. In this workshop, participants will explore practical strategies to prioritize well-being and nurture themselves amidst life's demands. Self-care is not indulgent; it is essential for maintaining balance and resilience. Participants will engage in opportunities to connect with colleagues and share ideas, tips, and tools.

All staff have access to an All Access Pass giving them the ability to utilize the entire *FranklinCovey* Library. The All Access Pass was designed to help organizations achieve strategic initiatives, develop leaders, and build skills and capabilities across the organization in a completely nimble and flexible way that helps them overcome those challenges - all at the very best value. With access to *FranklinCovey* courses, assessments, videos, tools, and digital assets, we can utilize the content in a wide variety of ways and across multiple delivery modalities to best meet the needs of our organization. MCH has begun to refamiliarize ourselves with the All Access Pass to the *FranklinCovey* Library as we start returning to the office. We feel that prompting our leaders with the trainings and videos that are available to us, will awaken the spirit of developing leaders and further build their skills. Because the courses are offered in formats that are convenient to participants and on a schedule that is most convenient to them, we feel the continued education will reenergize our leaders. Our Title V Deputy Director has spoken with the *FranklinCovey* expert assigned to Delaware to discuss the needs of our MCH staff and programming that might be beneficial.

Over the past year, staff have actively engaged in a range of professional development opportunities offered through the *FranklinCovey* platform. This ongoing commitment to growth has not only strengthened individual capabilities but also contributed to building a more collaborative, innovative, and resilient team. The training sessions provided staff with practical tools, strategies, and insights that support professional development and team effectiveness.
Among the wide variety of learning resources available, this past year, the top ten most frequently completed training topics reflected a strong alignment with the organization's values and leadership priorities. These included:

1. **Self-Awareness** – Empowering staff to better understand their own strengths, triggers, and development areas, fostering emotional intelligence and stronger interpersonal relationships.
2. **Developing & Retaining Talent** – Equipping leaders and managers with skills to nurture potential within their teams and reduce turnover through meaningful engagement.
3. **Giving Feedback** – Enhancing communication and performance by teaching staff how to deliver constructive, timely, and actionable feedback.
4. **Coaching** – Providing tools to support team members in reaching their goals through effective guidance, listening, and encouragement.
5. **Delegation** – Helping staff understand how to delegate tasks with clarity and confidence, ensuring accountability and team growth.
6. **Growth Mindset** – Encouraging continuous learning and adaptability by embracing challenges as opportunities for improvement.
7. **Listening** – Strengthening workplace relationships by promoting active listening and empathy in daily communication.
8. **Innovation & Creativity** – Inspiring employees to think outside the box, challenge assumptions, and explore new approaches to solving problems.
9. **Earning Trust** – Building stronger team dynamics by emphasizing reliability, transparency, and integrity in professional interactions.
10. **Setting Team Goals** – Aligning efforts by helping teams create clear, measurable, and shared objectives that drive performance and accountability.

By leveraging the FranklinCovey platform, staff are not only developing critical soft skills but are also contributing to a high-performance environment where growth, trust, and innovation succeed. These trainings are an essential part of our ongoing strategy to empower individuals, strengthen leadership capacity, and ultimately deliver better outcomes for those we serve.

Cross-Cutting/Systems Building - Application Year

The Delaware Division of Public Health (DPH) recognizes that a well-trained and well-prepared maternal and child health workforce is critical to meet the needs of the people of Delaware. Having a committed, empowered workforce, with a wide-range of expertise, is necessary to create a resilience-oriented, trauma-informed system of care. As part of our 2025 Five-Year Needs Assessment, MCH conducted a Workforce Capacity Analysis where we aimed to gain an accurate and complete picture of the strengths and weaknesses of our public health system, program capacity, including the organizational structure, agency capacity and MCH workforce capacity to ultimately improve maternal, child, family, and community health outcomes.

MCH partnered with Forward Consultants, LLC to create, facilitate, and analyze a survey, which was provided to staff and stakeholders involved with the MCH Bureau. A sampling frame consisting of leaders, from state government (primarily from the Delaware Division of Public Health) and other key organizations (non-profits, hospital, university, consulting firm) was created. The analysis addressed the following areas:

- Educational attainment
- Race/ethnicity
- Number of years working at agency
- Scope of work and responsibilities
- Representation within program areas
- Program capacity and training needs
- Assessing staff training needs and tools used
- Content areas for beneficial training requests
- Top needs among current and future MCH workforce
- Critical skills to address public health challenges
- Important areas for MCH workforce development
- Clear messaging from leadership
- Resilient-oriented trauma informed care
- Training received upon hire
- Formal, informal, and continuing education opportunities
- Stress/burnout

Delaware's MCH leaders have multiple complex responsibilities, yet they are also open to learning new skills, especially in the areas of leadership and knowledge of the practice. They recognize a need to learn how to balance the needs of multiple stakeholders, to find evidence, to learn quality improvement methods, and to understand the health needs of our maternal and child health population.

Particularly for the workforce, but also leaders themselves, recognize the need for continued formal trainings such as Systems Approach to Explain the Interactions Among Individuals, Groups, Organizations, and Communities. Our leaders are also interested in on-the-job (OTB) training, such as Using Data to Identify Issues Related to the Health Status of a Particular MCH Population Group, Design Programs, and/or Formulate Policy. The most requested skills to develop are Leadership, Analytic, Knowledge of Policy and Practices, and Knowledge of MCH Priority Areas. Content areas for training include Leadership, Human Resources, Technology, Program Evaluation, and Strategic Planning. Leaders recognize that workforce development, developing the current and future MCH public health workforce, and having a resilience oriented and trauma-informed, educated, and responsive workforce are all critical needs for the future. MCH leaders are also concerned with the feelings of burnout or being overly stressed, themselves as well as with their staff.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware DPH. Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities. Delaware's MCH staff have the ability to benefit from various professional development opportunities to build their capacity as part of the MCH workforce, more particularly our Family Health Systems (FHS) workforce. Our FHS staff have many strengths, including passion, dedication, and knowledge to ensure families receive high-quality services; strong interpersonal abilities required for partnership building,

collaboration, and integration; and the capability to manage multiple priorities.

Leaders need to be concerned with staff development and succession planning. We aim to prioritize workforce skills around program evaluation and data literacy. One goal is to prioritize systems thinking and change management, as well as cultural competence. The expectation is for multidisciplinary teams to have all these skills. In a team approach, it could be that staff with technical skills regarding evaluation and analysis are able to understand the context in which their results will be used, effectively collaborating with systems thinkers and leaders on the team. Similarly, systems thinkers and leaders will be able to use information and data to enact change and will be able to collaborate with the analytic thinkers on the team.

Delaware realizes that multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future. Therefore, to address specific training needs, our Workforce Development team has developed a few strategies to address the multiple needs of Delaware's MCH workforce. We are in the process of developing an Accountability Matrix, which provides specific workgroup, contact, and data information about each National Performance Measure to ensure no overlap exists and to track progress. The matrix will also cross reference each health domain to include all advisory boards and current focus. This will help the entire MCH community weed out duplication and determine if enough is being done within each health domain and NPM. We plan to include data sources, to aid our staff and partners with updated information. We hope this document will provide a 'birds eye' view of potential collaboration

In addition, our Workforce Development team determined that creating ongoing learning resources and videos would be imperative to the development of our workforce. We would advertise these resources and videos to our internal employees as well as partners to address topics such as: welcome information/onboarding/orientation, burnout, Title V resources, professional development opportunities, technical assistance opportunities, skill building, and more. We want our partners to know what Title V is, who we are, and how we can collaborate on future health projects.

Lastly, our FHS team will periodically survey and deliver to our internal and external partners the needed training opportunities that are requested to develop our workforce and address actual competency needs. This will be done to build our MCH capacity and support the development of a trained and qualified workforce by providing professional development opportunities. We plan to complete an environmental scan type review and provide approximately three trainings per year. Providing our Title V supports more broadly and disburse information more widely will raise up FHS staff, as well as our partners. We hope to build internal and external skills around storytelling by providing tools and resources to anyone who could benefit. A starting point for training comes from our Workforce Capacity Analysis where staff selected the topic areas of interest that would benefit their workforce development. Such trainings include:

- Data to Action (e.g., learning how to use data to identify issues related to the health status of a particular MCH population group and design/update programs accordingly)
- Human Resources (e.g., learning about issues and plans involving hiring and sustainability)
- Leadership Skills (e.g., learning about professional development opportunities to grow as a leader and visionary)
- Policy (e.g., learning about how MCH policy is designed and ultimately carried out)
- Program Evaluation (e.g., learning about how data is collected and utilized to assess the effectiveness of MCH programs)
- Strategic Planning (e.g., learning how to increase access and expand resources to assist MCH populations where it is needed the most)
- Technology (e.g., learning about current and new forms of technology to improve MCH efforts)

Figuring out ways to carve out time for both the trainer and trainee will be important; or perhaps new modes of training that hybridize formal and, on the job, methods could be developed. Finally, more work needs to be done to communicate and fully incorporate resilience oriented/trauma-informed care into leaders' and their staff's work. Other internal DPH workforce development opportunities include our Office of Performance Management, which has created a comprehensive workforce development plan outlining DPH training goals and objectives, as well as resources, roles and responsibilities related to the plan's implementation. In addition, DPH offers training

opportunities through a collaborative agreement with Johns Hopkins Bloomberg School of Public Health/Mid-Atlantic Public Health Training Center.

DPH staff are also afforded the opportunity to advance their skills through the DE TRAIN Learning Network. DE TRAIN is an affiliate of the TRAIN national learning network that provides quality-training opportunities for professionals who protect and improve Delaware's public health. This is a free service funded by Delaware Public Health's Emergency Medical Services and Preparedness Section (EMSPS) in partnership with the Public Health Foundation Training.

Performance Plans for all staff members in the MCH Bureau, include a professional development goal of completing a minimum of 15 hours of training annually. The Performance Plans specifically state to use either the *FranklinCovey* or MCH Navigator platforms. State Title V staff also have the ability to develop career aspirations and professional development goals that identify training opportunities to enhance needed knowledge and skills as part of their annual performance review process. Performance Plans are reviewed annually; however, supervisors have the ability to meet with staff 1:1 at any time to provide support, coaching and feedback related to performance.

FHS leadership will continue to work with staff internally to develop annual training plans and support staff in prioritizing professional development and identifying strengths and weaknesses. From our Workforce Capacity Analysis, on the job training was the preferred method to formal training; however, it is up to each supervisor on how to implement this for their team members. We will also be working with our key partners to determine when and what training and/or professional development they would like to see us offer this coming year.

We have secured an additional training to be provided by Franklin Covey, which is geared towards our leadership team in FHS, called 6 Critical Practices of Leading Teams. This full-day training is designed to equip leaders with essential tools to lead effectively and support high-performing teams. Leaders at every level make a significant impact on every metric within DPH: employee productivity and engagement, customer satisfaction and loyalty, innovation, and financial performance. Leaders are the "Difference-Makers" within DPH. The 6 Critical Practices for Leading a Team is a special collection of relevant, practical resources that provide leaders with the mindsets, skillsets and toolsets needed to excel in their critical roles of leading others effectively.

We are currently planning our 2025 FHS Annual Employee Retreat that will, like always, have a professional development component added. We are working with Franklin Covey to secure training that is focused on Change Management, especially around how to navigate all the uncertainty happening at the federal level. In addition, our FHS Retreat Planning Committee has scheduled a fun activity for each member of our team to engage in. Everyone attending the retreat has pre-selected a painting project design to complete the day of the event. When previously done, this activity has brought everyone together to laugh, socialize, and enjoy each other's company outside of the office setting. The final details for the day are still being finalized, however.

III.F. Public Input

The Delaware Title V Maternal and Child Health (MCH) team is committed to collecting input throughout the year and works in partnership with local agencies to assess and identify needs and priorities. Our MCH team attends webinars, is present at community meetings, joins advisory groups, attends conferences, presents at events, and more. This is to guarantee Title V obtains available data and to ensure that Title V is always at the table. The Title V team recognizes the need for Delaware to seek and obtain a broad spectrum of input and obtained many voices throughout the Title V application year – men, women, families, stakeholders, MCH workforce, partners, health experts, advisory boards, and more.

During this past grant cycle, MCH solicited input from professional partners, stakeholders, and the public by posting our Title V FY 2025 Application/FY 2023 Annual Report on our website, https://dethrives.com/title-v. Our DEThrives website is one that serves as the hub for information on many maternal and child health efforts in Delaware. The DEThrives website is available to everyone, including stakeholders, partners as well as the public.

As planned, MCH developed and delivered a series of comprehensive presentations highlighting our priorities. We have several advisory committees that meet regularly and provide ongoing input on MCH programs and priorities, including the Children with Medical Complexity Advisory Board, Help Me Grow and Home Visiting Advisory Board, the Birth Defects and Autism Registries Committee, Delaware Developmental Disabilities Council, Sussex County Health Coalition, and the Delaware Healthy Mothers and Infants Consortium (DHMIC). We have also attended meetings of Family SHADE, an alliance of organizations and families committed to working together to improve the quality of life for CYSHCN.

Our children and youth with special health care needs vendor, the Parent Information Center (PIC) implements our newly revitalized Family SHADE project. Delaware utilized Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making, to best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resource for community organizations serving CYSHCN. Families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems change to best serve families of CYSHCN.

The PIC implemented the third year of the new approach to Family SHADE project by executing another year of competitive mini-grant opportunities and awarding and implement Learning Communities to families and organizations that serve CYSHCN. PIC has grown the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The network membership included trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. FLN members received monthly stipends for attendance and participation. PIC in partnership with community organizations focused on innovative strategies and improving the Title V NPMs and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

There will be a planned approach to engage family and community partnerships every step of the way through the process. Delaware will work in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health community-based organizations serving underserved populations in soliciting recommendations from families and youth.

Beginning in the fall of 2023, Delaware's Title V team continued to meet to prepare for the upcoming 2025-2030 Five-Year Needs Assessment. We identified the core members of our Internal Steering Committee, defined the roles and responsibilities of the team, and set expectations for each member. We approached our activities with an aggressive timeline, to ensure enough time was allotted for compiling the feedback and writing the Title V 2025

State Action Plan, along with the Title V 2026 Application Year/2024 Annual Report Block Grant.

To prepare for the 2025 Needs Assessment, our Internal Steering Committee has reviewed the Title V MCH Services Block Grant Guidance and have developed a timeline and work plan. We have also convened our Needs Assessment Steering Committee periodically for status awareness and input. Our team has also identified our guiding principles/framework and core values in addition to requesting access to national, state, and local data sources. Lastly, our Title V Internal Steering Committee has established a plan for community engagement and identified opportunities to raise awareness and share information about the assessment with partners.

Through our 2025 Needs Assessment process, MCH has created detailed and specialized health data sheets for each of the newly identified NPMs. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it relates to each measure. Information such as Delaware's goals, the significance of each measure, definitions, Healthy People 2030 Objectives, Delaware's current health status, and Delaware specific data related to each measure. In addition, MCH assessed the process of the MCH populations health status and Delaware's State Program Capacity. Also, as a part of the Needs Assessment, we conducted an environmental scan of MCH initiatives and data, as well as assessed the infrastructure of MCH programs. MCH also assessed the partnerships and engagement within MCH programs, as well as assessing the MCH workforce capacity. We solicited the opinions of women, adolescents, and families in Delaware in addition to the input of local community-based organization.

Other stakeholders are contacted by MCH for input and feedback through various meetings, conferences, surveys, and other community activities. MCH periodically reaches out to the public for feedback or updates regarding the MCH community and our annual submission of the Title V Block Grant. Such areas throughout this year included questions regarding the 2025 Needs Assessment, our Block Grant Application, the introduction of our MCH Performance Measure health data sheets, DHMIC updates, and more. Our stakeholder involvement and input has been taken into consideration as our team was continuously involved with our 2025 Needs Assessment as well as the FY26 application. Our Domain Leads have made it a practice to keep in mind our Title V strategies as they take on new projects and activities with their partners, ensuring alignment where possible.

Throughout the two-year process of our Title V Five-Year Needs Assessment, DPH engaged with our partners, stakeholders, families and community members for input into the process. We encourage everyone to learn more about the Title V Block Grant in Delaware, which is committed to maternal and child health. Together, we can work towards enhancing the health and well-being of mothers, children, and families, including children with special health care needs.

Following the submission of the Title V 2025 Block Grant Application/2023 Annual Report, the Title V Coordinator emailed our partners and stakeholders statewide regarding our completed application and provided a public comment period. The nature of this year's comments pertained to our State Action Plan, Delaware's State Snapshot, requests to forward certain information to extended partners, and requests for copies of documents. The MCH Bureau usually receives comments, but rarely receives suggestions regarding changes to the Block Grant application.

All our Title V information is found in one central location, our DEThrives website. Here MCH has all the detailed Title V information, including our FY25 Block Grant Application, Delaware's Five-Year State Action Plan, data sheets on each of our NPMs, our State Action Plan Snapshot, the MCH Performance Measures data sheet, a framework of the Needs Assessment process, reports on our Focus Group studies, results of the Stakeholder Survey and more. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions.

Following the submission of our FY26 Block Grant application, we plan to post the application on our website. At that time, we will again solicit feedback and input into our Title V block grant application. Any major adjustments that

are suggested will be considered for research and update.

III.G. Technical Assistance

With a recent administration change in Delaware, key positions have changed including the Directors and Deputy Directors at the Division of Public Health, Division of Medicaid and Medicare Administration and current DHSS Secretary will be moving on in October 2025. The appointment of a new Secretary for DHSS has yet to be announced.
Without knowing the background of the of the new individual as well so many other new leaders, we would like to begin to prepare information to educate on the purpose and design of Title V. We would like access to any materials/resources that are already developed that we can “steal” that could help us provide insight on the important role Title V place to the MCH population.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Signed WIC_DPH_DSS_DMMA_2018.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - DE Birth Defects Registry_2025.07.10.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,123,731	
A. Preventive and Primary Care for Children	$ 644,011	(30.3%)
B. Children with Special Health Care Needs	$ 873,602	(41.1%)
C. Title V Administrative Costs	$ 187,084	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,704,697	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,425,098	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 3,456,508	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,881,606	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,005,337	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,166,969	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,172,306	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,684,909
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,892,092
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,238

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,073,458 (FY 24 Federal Award: $ 2,123,731)		$ 2,123,731	
A. Preventive and Primary Care for Children	$ 634,607	(30.6%)	$ 703,526	(33.1%)
B. Children with Special Health Care Needs	$ 812,645	(39.2%)	$ 822,980	(38.7%)
C. Title V Administrative Costs	$ 139,975	(6.8%)	$ 176,773	(8.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,587,227		$ 1,703,279	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,016,039		$ 10,008,609	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 2,659,797		$ 2,659,797	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,675,836		$ 12,668,406	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 14,749,294		$ 14,792,137	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 7,166,969		$ 6,064,837	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 21,916,263		$ 20,856,974	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,684,909	$ 3,684,909
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,892,092	$ 745,951
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 248,321
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730	$ 1,133,225
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,238	$ 152,431

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Delaware

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 419,034	$ 420,452
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 644,011	$ 703,526
4. CSHCN	$ 873,602	$ 822,980
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,936,647	$ 1,946,958

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 5,372,896	$ 5,270,344
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 4,051,562	$ 3,939,011
4. CSHCN	$ 1,000,640	$ 939,364
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 10,425,098	$ 10,148,719
Federal State MCH Block Grant Partnership Total	$ 12,361,745	$ 12,095,677

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Delaware

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 1,045,037	$ 1,417,738
3. Public Health Services and Systems	$ 1,078,694	$ 705,993
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,123,731	$ 2,123,731

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 1,334,912	$ 1,329,939
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,334,912	$ 1,329,939
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 6,005,128	$ 5,750,750
3. Public Health Services and Systems	$ 3,085,058	$ 3,022,489
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,133,640
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,527
Durable Medical Equipment and Supplies		$ 146,958
Laboratory Services		$ 0
Other		
HWHB Support Activities		$ 46,814
Direct Services Line 4 Expended Total		$ 1,329,939
Non-Federal Total	$ 10,425,098	$ 10,103,178

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Delaware

Total Births by Occurrence: 11,576 **Data Source Year: 2024**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,542 (99.7%)	1,037	34	34 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Delaware does not conduct long-term follow-up for newborn (blood spot) screening beyond ensuring the family is connected to recommended treatment services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2024**
	Column Name:	**Total Births by Occurrence Notes**

Field Note:

This data comes directly from our Newborn Screening Program and not Vital Statistics. And although they do receive files regularly from vital statistics to match newborns to ensure infants that were missed receiving follow-up services, this raw data and not likely to match exactly vital statistics data.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Delaware

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,056	55.0	0.0	37.0	1.0	7.0
2. Infants < 1 Year of Age	11,842	51.0	0.0	49.0	0.0	0.0
3. Children 1 through 21 Years of Age	13,128	60.0	0.0	0.0	0.0	40.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,281	58.0	0.0	41.0	0.0	1.0
4. Others	3,322	14.6	0.0	4.8	70.9	9.7
Total	31,348					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	10,427	Yes	10,427	100.0	10,427	3,056
2. Infants < 1 Year of Age	10,777	No	11,842	100.0	11,842	11,842
3. Children 1 through 21 Years of Age	252,626	Yes	252,626	100.0	252,626	13,128
3a. Children with Special Health Care Needs 0 through 21 years of age^	77,958	Yes	77,958	100.0	77,958	3,281
4. Others	768,519	Yes	768,519	100.0	768,519	3,322

^Represents a subset of all infants and children.

Form Notes for Form 5:

CHIP data is captured within Title XIX data.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	Field Note: 2,957 is the total number of pregnant women served by Healthy Women Healthy Babies (HWHB) Program Data; 99 pregnant women were received home visiting services.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note: 11,842 is the total number of newborns receiving a newborn screening.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: 3,720 referred to Birth to Three, of which 439 were ineligible for services and were referred to alternate MCH programs; for example, Help Me Grow.; 667 children between the ages of 1 and were served by home visiting; 12,022 received a developmental screening through the Office of Early Childhood/DOE ASQ portal, CHADIS or state PEDS.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: 3,281 is the number of children served in Birth to Three Program data.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note: 3,322 is the total number of individuals served by Family Planning Annual Report (FPAR) Program Data.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**
	Field Note: Difference in values is due to public health services affecting the entire population in Form 5b, while in Form 5a reflects direct services to women.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note:	

	Differences likely due to counting differences reflecting edits by Health Statistics Center reflecting in state, resident births, versus non resident births.	
3.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2024**
	Field Note: Number of infants receiving a newborn screening.	
4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Count value is population in Delaware, estimated by Census. All have some "touch" with DPH through programs, service centers, public campaigns that use Title V funds.	
5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: All have some "touch" with DPH through programs, education/public campaigns, services provided by DPH, Medicaid and contracted community organizations like PIC, that use Title V funds	
6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	Field Note: 100% includes all of the education and programming, which covers all genders and ages. This includes substance and tobacco use, healthy lifestyles, etc.	

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Delaware

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	10,915	4,996	2,875	2,273	43	633	15	0	80
Title V Served	10,915	4,996	2,875	2,273	43	633	15	0	80
Eligible for Title XIX	4,444	1,086	1,681	1,500	19	115	4	0	39
2. Total Infants in State	10,524	4,568	2,924	2,252	41	643	15	0	81
Title V Served	10,524	4,568	2,924	2,252	41	643	15	0	81
Eligible for Title XIX	4,439	1,060	1,702	1,498	21	113	4	0	41

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Delaware

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	13.50
1a. Total Number of FTEs (State Level)	13.50
1b. Total Number of FTEs (Local Level)	0
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	0
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	1
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	2
B. Training Needs (Optional)	
No training needs were reported by the state.	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Delaware

1. Title V Maternal and Child Health (MCH) Director	
Name	Leah Jones
Title	Chief, Family Health Systems
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5754
Extension	
Email	leah.woodall@delaware.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Isabel Rivera-Green
Title	CYSHCN Director
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5747
Extension	
Email	isabel.rivera-green@delaware.gov

3. State Family Leader (Optional)	
Name	Meedra Surratte, M.ED.
Title	Executive Director of Parent Information Center of Delaware/Delaware Family Voices
Address 1	404 Larch Circle
Address 2	
City/State/Zip	Wilmington / DE / 19804
Telephone	(302) 999-7394
Extension	
Email	msurratte@picofdel.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Elizabeth R Orndorff
Title	SSDI Director
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5744
Extension	
Email	elizabeth.orndorff@delaware.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 464-4357

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Delaware

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.	New
2.	Women have access to safe and supportive patient centered care, where their concerns are listened to, and they are included as partners in health decision making.	New
3.	Pregnant and parenting women have stable housing and are connected to essential resources and services that can improve their outcomes.	New
4.	Children receive developmentally appropriate services in a well-coordinated early childhood system.	Continued
5.	Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening	New
6.	All children, with and without special health care needs, have access to a medical home model of care.	New
7.	All CYSHCN receive the necessary organized services to make the transition to adult health care.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Delaware

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	111.1	10.4	115	10,353
2021	84.2	9.2	85	10,093
2020	82.8	9.1	83	10,021
2019	67.0	8.2	68	10,152
2018	68.8	8.2	71	10,326
2017	55.2	7.3	58	10,515
2016	63.1	7.7	67	10,621

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	NR	NR	NR	NR
2018_2022	NR	NR	NR	NR
2017_2021	18.9	6.0	10	52,912
2016_2020	NR	NR	NR	NR
2015_2019	NR	NR	NR	NR
2014_2018	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	13.5	0.6	444	33,000
2022	14.7	0.7	466	31,720
2021	13.5	0.7	425	31,410
2020	14.6	0.7	439	30,104
2019	14.9	0.7	444	29,792
2018	16.7	0.8	497	29,783
2017	18.5	0.8	552	29,906
2016	19.5	0.8	583	29,906
2015	18.1	0.8	540	29,829
2014	20.8	0.8	616	29,632
2013	24.4	0.9	728	29,860
2012	25.0	0.9	761	30,387
2011	29.0	1.0	900	31,023
2010	30.7	1.0	974	31,694
2009	33.5	1.0	1,081	32,283

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	9.2 %	0.3 %	954	10,426
2022	9.0 %	0.3 %	976	10,809
2021	9.1 %	0.3 %	952	10,478
2020	8.9 %	0.3 %	928	10,385
2019	9.4 %	0.3 %	995	10,552
2018	8.9 %	0.3 %	948	10,614
2017	9.0 %	0.3 %	981	10,853
2016	8.9 %	0.3 %	982	10,984
2015	9.3 %	0.3 %	1,036	11,162
2014	8.3 %	0.3 %	908	10,970
2013	8.3 %	0.3 %	900	10,827
2012	8.3 %	0.3 %	913	11,018
2011	8.4 %	0.3 %	942	11,253
2010	8.9 %	0.3 %	1,016	11,357
2009	8.6 %	0.3 %	994	11,556

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.4 %	0.3 %	1,088	10,424
2022	10.8 %	0.3 %	1,171	10,812
2021	11.0 %	0.3 %	1,151	10,480
2020	10.4 %	0.3 %	1,079	10,388
2019	10.7 %	0.3 %	1,130	10,560
2018	9.6 %	0.3 %	1,015	10,621
2017	10.2 %	0.3 %	1,108	10,846
2016	10.1 %	0.3 %	1,105	10,982
2015	9.9 %	0.3 %	1,101	11,153
2014	9.3 %	0.3 %	1,019	10,965
2013	9.4 %	0.3 %	1,022	10,818
2012	9.5 %	0.3 %	1,049	11,009
2011	9.3 %	0.3 %	1,051	11,247
2010	10.2 %	0.3 %	1,153	11,355
2009	10.0 %	0.3 %	1,160	11,543

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.2	0.7	56	10,872
2021	5.1	0.7	54	10,536
2020	5.5	0.7	57	10,449
2019	5.6	0.7	59	10,621
2018	5.6	0.7	60	10,681
2017	5.4	0.7	59	10,914
2016	5.0	0.7	55	11,047
2015	6.3	0.8	71	11,237
2014	5.3	0.7	59	11,031
2013	6.0	0.7	65	10,896
2012	6.0	0.7	67	11,090
2011	7.1	0.8	81	11,338
2010	5.9	0.7	68	11,432
2009	5.8	0.7	67	11,626

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.3	0.8	79	10,846
2021	4.6	0.7	48	10,502
2020	6.3	0.8	66	10,430
2019	7.2	0.8	76	10,600
2018	6.9	0.8	74	10,660
2017	6.4	0.8	70	10,888
2016	6.4	0.8	70	11,020
2015	9.2	0.9	103	11,202
2014	7.4	0.8	81	11,007
2013	6.8	0.8	74	10,863
2012	8.2	0.9	91	11,056
2011	8.8	0.9	99	11,291
2010	7.5	0.8	85	11,401
2009	6.6	0.8	77	11,584

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.5	0.8	81	10,816
2021	4.8	0.7	50	10,482
2020	5.1	0.7	53	10,392
2019	6.4	0.8	68	10,562
2018	5.9	0.8	63	10,621
2017	6.3	0.8	68	10,855
2016	7.8	0.9	86	10,992
2015	9.1	0.9	102	11,166
2014	6.7	0.8	74	10,972
2013	6.4	0.8	69	10,831
2012	7.6	0.8	84	11,023
2011	8.9	0.9	100	11,257
2010	7.5	0.8	85	11,364
2009	8.0	0.8	92	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.1	0.8	66	10,816
2021	3.0	0.5	31	10,482
2020	3.2	0.6	33	10,392
2019	4.4	0.6	46	10,562
2018	4.0	0.6	43	10,621
2017	4.1	0.6	45	10,855
2016	5.0	0.7	55	10,992
2015	7.2	0.8	80	11,166
2014	5.0	0.7	55	10,972
2013	4.4	0.6	48	10,831
2012	6.1	0.7	67	11,023
2011	6.5	0.8	73	11,257
2010	5.0	0.7	57	11,364
2009	5.8	0.7	67	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	1.4	0.4	15	10,816
2021	1.8	0.4	19	10,482
2020	1.9	0.4	20	10,392
2019	2.1	0.4	22	10,562
2018	1.9	0.4	20	10,621
2017	2.1	0.4	23	10,855
2016	2.8	0.5	31	10,992
2015	2.0	0.4	22	11,166
2014	1.7	0.4	19	10,972
2013	1.9	0.4	21	10,831
2012	1.5	0.4	17	11,023
2011	2.4	0.5	27	11,257
2010	2.5	0.5	28	11,364
2009	2.2	0.4	25	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	388.3	60.0	42	10,816
2021	181.3	41.6	19	10,482
2020	182.8	42.0	19	10,392
2019	284.0	51.9	30	10,562
2018	197.7	43.2	21	10,621
2017	230.3	46.1	25	10,855
2016	354.8	56.9	39	10,992
2015	456.7	64.1	51	11,166
2014	319.0	54.0	35	10,972
2013	295.4	52.3	32	10,831
2012	371.9	58.2	41	11,023
2011	426.4	61.7	48	11,257
2010	281.6	49.9	32	11,364
2009	346.1	54.8	40	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	104.1	31.4	11	10,562
2018	113.0	32.6	12	10,621
2017	101.3	30.6	11	10,855
2016	118.3	32.8	13	10,992
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	129.3	34.6	14	10,831
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	105.6	30.5	12	11,364
2009	121.1	32.4	14	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	11.9	1.1	124	10,439
2021	14.4	1.2	147	10,184
2020	20.9	1.5	212	10,126
2019	18.8	1.4	193	10,255
2018	23.3	1.5	242	10,392
2017	24.2	1.5	258	10,647
2016	26.8	1.6	288	10,731

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.5 %	4.3 %	19,986	34,141

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	10.8 %	1.2 %	21,586	200,226
2021_2022	12.1 %	1.1 %	23,764	196,434
2020_2021	12.6 %	1.2 %	24,323	193,742
2019_2020	13.6 %	1.4 %	26,333	193,228
2018_2019	13.2 %	1.5 %	24,874	188,379
2017_2018	10.6 %	1.4 %	19,918	187,802
2016_2017	10.8 %	1.3 %	20,487	189,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.5	4.9	25	101,918
2022	25.0	5.0	25	100,041
2021	13.9	3.7	14	100,513
2020	NR	NR	NR	NR
2019	24.9	5.0	25	100,413
2018	23.9	4.9	24	100,413
2017	14.9	3.9	15	100,707
2016	14.9	3.8	15	100,809
2015	15.8	4.0	16	101,233
2014	12.8	3.5	13	101,738
2013	18.6	4.3	19	101,932
2012	20.6	4.5	21	102,082
2011	18.8	4.3	19	100,869
2010	NR	NR	NR	NR
2009	16.8	4.1	17	101,227

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	25.3	4.5	32	126,239
2022	38.1	5.6	47	123,426
2021	49.4	6.3	61	123,453
2020	37.1	5.6	44	118,596
2019	32.2	5.2	38	117,881
2018	39.8	5.8	47	118,017
2017	30.5	5.1	36	118,145
2016	34.0	5.4	40	117,766
2015	27.3	4.8	32	117,211
2014	31.6	5.2	37	117,122
2013	32.5	5.3	38	116,766
2012	37.1	5.6	44	118,726
2011	31.9	5.2	38	119,280
2010	35.4	5.4	43	121,431
2009	39.4	5.7	48	121,966

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	19.8	3.2	38	191,534
2020_2022	20.4	3.3	38	186,472
2019_2021	15.8	2.9	29	183,513
2018_2020	13.3	2.7	24	181,058
2017_2019	11.0	2.5	20	181,122
2016_2018	9.4	2.3	17	181,393
2015_2017	8.8	2.2	16	181,147
2014_2016	9.4	2.3	17	180,556
2013_2015	12.2	2.6	22	179,785
2012_2014	11.6	2.5	21	181,255
2011_2013	10.9	2.4	20	183,456
2010_2012	11.2	2.4	21	188,321
2009_2011	13.0	2.6	25	191,829
2008_2010	13.9	2.7	27	194,904
2007_2009	15.4	2.8	30	194,529

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	5.4	1.2	20	373,118
2020_2022	5.5	1.2	20	365,475
2019_2021	5.3	1.2	19	359,930
2018_2020	4.8	1.2	17	354,494
2017_2019	5.1	1.2	18	354,043
2016_2018	5.4	1.2	19	353,928
2015_2017	5.1	1.2	18	353,122
2014_2016	4.3	1.1	15	352,099
2013_2015	4.3	1.1	15	351,099
2012_2014	6.0	1.3	21	352,614
2011_2013	7.9	1.5	28	354,772
2010_2012	8.1	1.5	29	359,437
2009_2011	5.2	1.2	19	362,677

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	9.4	1.6	35	373,118
2020_2022	11.5	1.8	42	365,475
2019_2021	11.7	1.8	42	359,930
2018_2020	10.2	1.7	36	354,494
2017_2019	9.6	1.7	34	354,043
2016_2018	9.6	1.7	34	353,928
2015_2017	9.3	1.6	33	353,122
2014_2016	6.5	1.4	23	352,099
2013_2015	6.6	1.4	23	351,099
2012_2014	6.5	1.4	23	352,614
2011_2013	7.6	1.5	27	354,772
2010_2012	7.5	1.5	27	359,437
2009_2011	7.2	1.4	26	362,677
2008_2010	7.9	1.5	29	365,649
2007_2009	7.1	1.4	26	365,850

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	129.0	10.8	143	110,826
2021	144.4	11.4	160	110,793
2020	131.2	10.9	146	111,260
2019	126.1	10.7	140	111,031
2018	128.8	10.8	143	111,058
2017	137.0	11.1	153	111,663
2016	150.5	11.6	168	111,626

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	218.8	13.3	270	123,426
2021	228.4	13.6	282	123,453
2020	204.1	13.1	242	118,596
2019	219.7	13.7	259	117,881
2018	190.7	12.7	225	118,017
2017	202.3	13.1	239	118,145
2016	228.4	13.9	269	117,766

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	46.4 %	2.9 %	80,986	174,522
2022	53.2 %	2.8 %	89,633	168,368
2021	56.3 %	2.9 %	94,170	167,152
2020	63.2 %	2.5 %	104,180	164,901
2019	55.0 %	2.9 %	90,922	165,462
2018	55.8 %	2.4 %	92,371	165,446
2017	52.4 %	2.8 %	86,253	164,630
2017	52.4 %	2.8 %	86,253	164,630
2016	57.7 %	2.7 %	95,478	165,472
2015	60.0 %	2.8 %	98,347	163,908
2014	57.7 %	2.6 %	94,165	163,136
2013	55.2 %	2.3 %	89,653	162,423
2012	59.4 %	2.2 %	95,703	160,987

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	89.8 %	1.3 %	186,594	207,756
2021_2022	89.8 %	1.2 %	184,943	206,060
2020_2021	89.4 %	1.2 %	182,163	203,709
2019_2020	88.9 %	1.4 %	179,718	202,058
2018_2019	89.6 %	1.4 %	181,112	202,227
2017_2018	90.0 %	1.4 %	183,076	203,376
2016_2017	90.5 %	1.2 %	183,956	203,320

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	18.5 %	0.6 %	855	4,610
2018	16.3 %	0.5 %	958	5,870
2016	16.2 %	0.4 %	1,116	6,906
2014	17.2 %	0.4 %	1,246	7,251
2012	16.9 %	0.4 %	1,292	7,642
2010	18.4 %	0.4 %	1,404	7,650
2008	17.3 %	0.5 %	1,097	6,328

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	20.2 %	1.9 %	26,469	131,192
2021_2022	20.5 %	1.8 %	26,702	130,352
2020_2021	20.5 %	1.9 %	26,344	128,410
2019_2020	19.3 %	2.0 %	25,001	129,302
2018_2019	18.8 %	2.0 %	23,965	127,511
2017_2018	19.1 %	2.1 %	24,077	126,291
2016_2017	19.2 %	2.0 %	23,507	122,553

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.6 %	1.1 %	986	9,326
2022	10.4 %	1.1 %	1,024	9,830
2021	9.7 %	1.2 %	929	9,535
2020	10.6 %	1.2 %	992	9,401
2019	10.4 %	1.1 %	1,005	9,672
2018	13.1 %	1.2 %	1,262	9,616
2017	11.7 %	1.1 %	1,157	9,893
2016	10.5 %	1.0 %	1,057	10,051
2015	13.9 %	1.2 %	1,429	10,264
2014	13.4 %	1.2 %	1,367	10,223
2013	13.0 %	1.1 %	1,296	9,981
2012	13.8 %	1.1 %	1,385	10,061

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	18.8 %	1.4 %	1,756	9,340

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	9.8 %	2.0 %	6,700	68,210
2021_2022	8.4 %	1.6 %	5,667	67,163
2020_2021	8.5 %	1.9 %	5,700	67,064
2019_2020	8.5 %	1.9 %	5,771	67,718
2018_2019	9.7 %	2.1 %	6,678	68,495
2017_2018	10.8 %	2.2 %	7,391	68,492
2016_2017	8.9 %	1.7 %	5,929	66,691

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	16.3 %	2.0 %	11,955	73,195
2021_2022	15.4 %	1.9 %	11,331	73,380
2020_2021	15.7 %	2.1 %	11,246	71,841
2019_2020	18.7 %	2.7 %	13,358	71,458
2018_2019	14.0 %	2.4 %	9,894	70,783
2017_2018	10.6 %	1.7 %	7,415	70,218
2016_2017	13.2 %	2.0 %	9,379	71,080

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	12.3 %	1.9 %	7,586	61,466
2021_2022	14.0 %	1.9 %	7,777	55,409
2020_2021	14.8 %	2.2 %	7,937	53,526
2019_2020	14.0 %	2.1 %	7,907	56,575
2018_2019	15.2 %	2.2 %	8,458	55,671
2017_2018	19.3 %	3.0 %	9,856	51,019
2016_2017	19.9 %	2.8 %	10,960	55,078

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	78.6 %	2.7 %	48,532	61,784
2021_2022	81.5 %	2.4 %	48,763	59,853
2020_2021	83.3 %	2.3 %	48,983	58,828
2019_2020	82.3 %	2.8 %	48,261	58,642
2018_2019	82.3 %	3.3 %	46,369	56,356

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	44.5 %	3.7 %	21,276	47,804
2021_2022	41.7 %	3.5 %	18,494	44,384
2020_2021	42.7 %	3.8 %	18,986	44,457
2019_2020	45.4 %	3.8 %	21,497	47,318
2018_2019	54.5 %	3.9 %	25,257	46,305

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	62.8 %	2.2 %	87,933	139,928
2021_2022	60.6 %	2.0 %	84,509	139,396
2020_2021	60.2 %	2.1 %	82,870	137,692
2019_2020	64.6 %	2.2 %	89,194	138,168
2018_2019	70.3 %	2.2 %	97,860	139,142

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.1 %	1.5 %	38,879	203,368
2021_2022	19.8 %	1.4 %	40,525	204,331
2020_2021	17.5 %	1.4 %	34,985	199,917
2019_2020	19.1 %	1.6 %	37,616	196,739
2018_2019	20.8 %	1.7 %	41,183	198,400
2017_2018	20.7 %	1.9 %	41,856	202,073
2016_2017	22.0 %	1.8 %	44,308	201,398

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Delaware

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	89.0	88.9
Numerator	8,744	8,290
Denominator	9,828	9,324
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	89.0	90.0	91.0	92.0	93.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	81.5	76.8
Numerator	7,046	6,240
Denominator	8,649	8,125
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	77.0	78.0	79.0	80.0	81.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR - Women/Maternal Health

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	2.8
Numerator	262
Denominator	9,283
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	3.0	3.2	3.5	4.0	4.2

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth - HI-Pregnancy - Perinatal/Infant Health

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	6.1
Numerator	581
Denominator	9,474
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	6.5	6.7	7.0	7.3	7.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	27	30.0	32.0	34	36
Annual Indicator	30.3	29.1	32.1	34.3	32.8
Numerator	6,522	6,073	7,257	8,614	8,638
Denominator	21,559	20,867	22,604	25,117	26,363
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	34.0	36.0	38.0	40.0	42.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	86.8
Numerator	13,797
Denominator	15,887
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	87.0	88.0	89.0	90.0	91.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	40.2	35.8
Numerator	18,442	21,932
Denominator	45,845	61,253
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	40.0	42.0	44.0	46.0	48.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	44.2	44.7
Numerator	91,124	92,739
Denominator	206,169	207,631
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	48.0	50.0	52.0	54.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	21.7
Numerator	5,781
Denominator	26,596
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	22.0	24.0	26.0	28.0	30.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Delaware

2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	84.5	86
Annual Indicator	88.1	86.9
Numerator	9,316	8,893
Denominator	10,573	10,234
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	25	26
Annual Indicator	22.4	28.0
Numerator	6,100	7,724
Denominator	27,226	27,596
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.5	80	80.5	81	82
Annual Indicator	79.7	77.4	77.3	75.4	76.2
Numerator	149,645	148,645	149,188	147,612	152,458
Denominator	187,697	192,077	193,050	195,852	200,007
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	77	79	81
Annual Indicator	75.7	71.9	71.8	74.2	72.6
Numerator	47,654	48,388	51,420	53,987	52,895
Denominator	62,974	67,333	71,653	72,759	72,862
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80	78	80.0	82	84
Annual Indicator	75.6	72.8	75.9	71.9	80.1
Numerator	124,769	117,625	125,530	116,483	135,447
Denominator	165,041	161,675	165,284	161,938	169,192
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - PA-Adolescent

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	22	22	23
Annual Indicator	25.1	25.1	21.6	21.6	22.4
Numerator	9,329	9,329	8,529	8,529	9,237
Denominator	37,230	37,230	39,459	39,459	41,212
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2021	2021	2023

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	21.0	22	23
Annual Indicator	13.0	14.9	16.0	14.8	12.1
Numerator	8,196	9,878	11,362	10,707	8,813
Denominator	62,967	66,257	70,996	72,524	72,721
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	70.0	72.0	74	76
Annual Indicator	68.6	67.2	68.8	70.7	68.5
Numerator	138,831	136,015	140,169	145,366	141,609
Denominator	202,281	202,319	203,715	205,678	206,831
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Delaware

SPM 1 - Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		50	75	75	100
Annual Indicator	68	80	76	84	84
Numerator	17	20	19	21	21
Denominator	25	25	25	25	25
Data Source	FHS Data	FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	88.0	90.0	95.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Counted if staff attended/participated in Franklin Covey 6 Principles or attended the FHS Retreat.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Counted staff that attended/participated in Franklin Covey Strategic Planning sessions and/or the Strength Finder as well as any staff that took courses through the All-Access Pass.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Counted staff that attended/participated in FHS Retreat and/or took courses through the All-Access Pass.	

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of Delaware women with a recent live birth who indicated that their pregnancy was unintended.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	28	27	26	25
Annual Indicator	45.8	45	42.8	42.8	38.9
Numerator					3,890
Denominator					9,999
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2019	2020	2021	2021	2022
Provisional or Final ?	Final	Final	Final	Provisional	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2016-2018 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined. Not sure is an option that was included with our "I didn't want to be pregnant....", however CDC does not want states to include that option in their numbers now. Even with this change, Delaware numbers have still been decreasing since 2012.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Unfortunately, we had a delay in receiving PRAMS 2022 data. Therefore, we don’t have updated data to report on SPM 1 on untended pregnancy.	

2021-2025: SPM 2 - Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.

Measure Status:	Inactive - We are not continuing with this measure going forward. This data is not available as we have lost MCH Epidemiology capacity as well as timely access.

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		5	5	5	5
Annual Indicator	4.6	21.1	21.1	21.1	21.1
Numerator		4	4	4	4
Denominator		19	19	19	19
Data Source	HWHB Program Data and Vital Statistics Data	HWHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data
Data Source Year	2019	2020	2021	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This is only represents 4 months of data. Disparity ratio = HWHB Black preterm/State White preterm = 9.48/9.49 = 1 i.e., same. Difference in HWHB Black preterm and State Black preterm = 9.48 - 14.07 = -4.59 lower!	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: HWHB black participants (i.e., 584) 4 experienced a death in comparison to of all non-HWHB black participants (i.e., 2337) 19 experienced a death, which would be 4/584 vs. 19/2337 or 0.68/0.81 = 0.84	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Unfortunately, we had to use 2020 data has a place holder as our 2021 vital statistics data is not yet available to us.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Unfortunately, we were not able to obtain provisional 2023 Vital Statistics data, and therefore, numbers are the same for this reporting year.	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note:	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Delaware

ESM PPV.1 - 80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	70.7
Numerator	29
Denominator	41
Data Source	MIECHV Program Data
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	15.0	20.0	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM HI-Pregnancy.1 - Decrease the number of pregnant women facing housing instability.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	75.0	85.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		92	94	96	98
Annual Indicator	83.3	82.2	81	77	76
Numerator	398	412	439	412	419
Denominator	478	501	542	535	551
Data Source	MIECHV program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.2 - Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.

Measure Status:	Active

State Provided Data			
	2022	2023	2024
Annual Objective			75
Annual Indicator		31.3	38.1
Numerator		45	86
Denominator		144	226
Data Source		MIECHV ASQ and OEL ASQ	CHADIS Pilot Project Data
Data Source Year		2023	2024
Provisional or Final ?		Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	54.0	56.0	58.0	60.0	62.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) ASQ and Office of Early Learning (OEL) ASQ data is used as it is a complete data set and is representative statewide.

ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	30.0	25.0	20.0	15.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM MHT.1 - Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM MHT.2 - Percentage of high school students enrolled in Delaware SBHCs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 ESMs:

None

ESM MHT.3 - Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services (PHQ and GAD-7 are usually components of a risk assessment).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	72.9
Numerator	462
Denominator	634
Data Source	MIECHV Program Data
Data Source Year	2024
Provisional or Final ?	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	77.0	80.0	85.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM TAHC.1 - Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12-17.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

None

SPM ESM 1.1 - To increase the percentage of MCH staff that have completed at least one professional development opportunity.

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	80
Numerator	20
Denominator	25
Data Source	MCH Program Data
Data Source Year	2024
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	90.0	93.0	95.0	98.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	58	60	62	64	66
Annual Indicator	47.9	57	55.3	48.2	48.2
Numerator				27	27
Denominator				56	56
Data Source	MIECHV program data	MIECHV program daa	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:
None

2021-2025: ESM PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		81	82	83	84
Annual Indicator	78.8	73.6	77.3	75.4	76.2
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019-2020	2020-2021	2021-2022	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data for just 2020 was not available.

2021-2025: ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			725
Annual Indicator	683	1,000	788
Numerator			
Denominator			
Data Source	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Referrals for English were 912. Referrals for Spanish were 88. Total of 1,000.

2021-2025: ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	75	75	80
Annual Indicator	29.2	76.2	74.2	66.7	82
Numerator	883	4,902	4,958	4,420	6,028
Denominator	3,027	6,429	6,678	6,631	7,352
Data Source	SBHC Program Data	SBHC Porgram Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 3,027 unique patients were seen and 883 risk assessments were completed in school year 2021 (8/2020-5/2021). This does not represent all of the SBHC in Delaware. However, it was our largest medical sponsor that submitted the data that represents 18 wellness centers.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 6,429 unique patients were seen and 4,902 risk assessments were completed in school year 2021 (8/2021-5/2022). This does not represent all of the SBHC in Delaware. However, it was our largest medical sponsor that submitted the data that represents 18 wellness centers.	

2021-2025: ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			55
Annual Indicator	48.2	53.6	52
Numerator	4,530	3,413	5,262
Denominator	9,407	6,367	10,121
Data Source	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Provisional	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
This represents data from the last half of CY2022 (July through December 2022).

2021-2025: ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			0.2
Annual Indicator	0.1	0.2	0
Numerator	99	337	53
Denominator	140,263	141,729	142,495
Data Source	DOE Program Data	DOE Program Data	DOE Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	17,000	17,250	8,500	9,000	9,500
Annual Indicator	8,488	8,015	8,109	9,937	10,618
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Actual number served was 16,672 but field would not allow us to go over 16,500.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 50% drop due to COVID.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: This data includes all family planning clinic provider sites that report data to DPH that receive federal Title X funds or state Delaware Contraceptive Access Now DE State General Fund dollars.	

2021-2025: ESM WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	86	88	90
Annual Indicator	88	84.2	86.1	89	92.4
Numerator			6,335	5,920	8,848
Denominator			7,354	6,655	9,574
Data Source	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		63	60	65	70
Annual Indicator	62	53.1	58.6	58.6	65.9
Numerator					2,618
Denominator					3,971
Data Source	Medicaid Claims Data	PRAMS data	PRAMS data	PRAMS data	PRAMS data
Data Source Year	2019	2020	2021	2021	2022
Provisional or Final ?	Final	Final	Final	Provisional	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
There was an issue with PRAMS data, and we are still awaiting this data.

2021-2025: ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			12
Annual Indicator	14.3	21.4	21.4
Numerator	6	9	9
Denominator	42	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: This program was unexpectedly discontinued in August 2024. The data below represents the same 2023/2024 school year program data.	

2021-2025: ESM AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		90	92	94	96
Annual Indicator	90	89.1	91.5	90.6	93.8
Numerator	564	595	644	598	656
Denominator	627	668	704	660	699
Data Source	MIECHV Program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 99% (533/537) of children had health insurance per the FY20 MIECHV program data.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 95% (558/587) of children had health insurance per the FY21 MIECHV program data.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 98% (602/615) of children had health insurance per the FY23 MIECHV program data.	

2021-2025: ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			80
Annual Indicator	73.3	73.3	60
Numerator	11	11	9
Denominator	15	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			75
Annual Indicator		100	100
Numerator		609	554
Denominator		609	554
Data Source		CYSHCN Mini Grantee data	CYSHCN Mini Grantee data
Data Source Year		2023	2024
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The number of children served by a Family SHADE mini-grantee was 609 (Numerator). The total children that can be served by a Family SHADE mini-grantee was 541 (Denominator). Our Annual Indicator was 113%, but this could not be entered into the EHB as it created an error. Also, Teach Zen did not identify a baseline of children to serve. Therefore, the number of children served by them was not factored into this count. For reference, Teach Zen saw 156 children but only 20% were CYSHCN which equals 30 CYSHCN served.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: The number of children served by a Family SHADE mini-grantee was 554 (Numerator). The total children that can be served by a Family SHADE mini-grantee was 424 (Denominator). Our Annual Indicator was 130.7%, but this could not be entered into the EHB as it created an error.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Delaware

SPM 1 - Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the number of well qualified MCH leaders in the field.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of MCH staff that have completed at least one professional development opportunity. **Denominator:** The number of MCH staff employed.
Data Sources and Data Issues:	MCH data
Significance:	Multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future. Workforce Development ensures all staff are properly prepared to deliver and produce high quality work. Workforce Development also helps prepare our MCH workforce in succession planning and decreased staff turnover.

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of Delaware women with a recent live birth who indicated that their pregnancy was unintended.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the number of live births that were the result of an unintended pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers who responded to the PRAMS survey that their pregnancy was wanted later or unwanted **Denominator:** Number of women who responded to PRAMS
Data Sources and Data Issues:	PRAMS
Significance:	Unplanned pregnancies are expensive and cost women, families, government, and society. Extensive data show that unplanned pregnancies have been linked to increased health problems in women and their infants, lower educational attainment, higher poverty rates, and increased health care and societal costs. And, unplanned pregnancies significantly increase Medicaid expenses. By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.

2021-2025: SPM 2 - Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Inactive - We are not continuing with this measure going forward. This data is not available as we have lost MCH Epidemiology capacity as well as timely access.
Goal:	By 2025, reduce and maintain the disparity ratio among enrolled and non-enrolled women by five percentage points.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of black/Hispanic women in HWHB/HV or mini grantee who experienced an infant death. **Denominator:** Denominator: Number of black/Hispanic women non-enrolled in HWHB/HV or mini grantee (i.e., Medicaid) who experienced an infant death.
Data Sources and Data Issues:	MCH Program Data , Medicaid and Vital Statistics
Significance:	While Delaware has made significant improvements in our infant mortality rates, the disparity has remained. We have recently switched gears and transformed our HWHB program as well implement community mini grants to address black infant mortality in our state.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Delaware

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Delaware

ESM PPV.1 - 80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Active
Goal:	To increase the percent of women participating in the HWHBs program who have a postpartum visit within 12 weeks after giving birth
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of women enrolled in HWHBs program who had a postpartum visit within 12 weeks after giving birth **Denominator:** Total number of women enrolled in HWHBs program who had a live birth
Data Sources and Data Issues:	HWHBs program data
Evidence-based/informed strategy:	80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are meticulously documented.)
Significance:	The postpartum period is an important time for maternal health and well-being. Based on research and evidence, untreated chronic conditions and pregnancy-related complications increase the risk of adverse health outcomes in the weeks and months following delivery. Data from Maternal Mortality Review Committees in 36 states suggest that more than half of pregnancy-related deaths occur from 7 to 365 days postpartum. Furthermore, Community Health Workers (CHWs) have a close understanding of the communities they serve, because they live, work, play and pray in the communities they serve. CHWs can help women communicate effectively with healthcare providers. They can improve access to perinatal health services, including postpartum checkups, and help link new mothers to community resources and support services.

ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Active
Goal:	By 2030, 90% of mothers enrolled in home visiting will receive a postpartum visit with a provider within 8 weeks of giving birth.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers who received a postpartum care visit within 8 weeks. **Denominator:** Number of mothers who had a live birth and were enrolled in the home visiting program at the time of delivery.
Data Sources and Data Issues:	MIECHV and MCH program data
Evidence-based/informed strategy:	Increase the percentage of mothers enrolled in home visiting who received a postpartum care visit with a healthcare provider within 8 weeks (56 days) of giving birth.
Significance:	To ensure that postpartum women receive necessary assessments and support for physical recovery from childbirth, mental health screening (e.g., postpartum depression), contraceptive counseling, breastfeeding support and chronic disease management if needed.

ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i
NPM – Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting healthcare during pregnancy, delivery, or at postpartum care - DSR

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To develop community-centered qualitative feedback for educational purposes, driven by and for women of color, which is essential to improve health disparities during pregnancy and birth. In addition, this is an educational strategy for health care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Total number of Her Story 2.0 campaign toolkits distributed and or ordered by providers and community based organizations</td></tr>
<tr><td>Denominator:</td><td>Total number of MCH partnerships recorded in a master spreadsheet</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>HWHBs program data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i.e. vignettes and videos of individuals with lived experience).</td></tr>
<tr><td>Significance:</td><td>The postpartum period is an important time for maternal health and well-being. Based on research and evidence, untreated chronic conditions and pregnancy-related complications increase the risk of adverse health outcomes in the weeks and months following delivery. Data from Maternal Mortality Review Committees in 36 states suggest that more than half of pregnancy-related deaths occur from 7 to 365 days postpartum. Furthermore, Community Health Workers (CHWs) have a close understanding of the communities they serve, because they live, work, play and pray in the communities they serve. CHWs can help women communicate effectively with healthcare providers. They can improve access to perinatal health services, including postpartum checkups, and help link new mothers to community resources and support services.</td></tr>
</table>

ESM HI-Pregnancy.1 - Decrease the number of pregnant women facing housing instability.
NPM – Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth - HI-Pregnancy

Measure Status:	Active
Goal:	By 2030, decrease the number of pregnant women who report being housing insecure in the 12 months before giving birth.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women with a positive housing outcome after CLASI services **Denominator:** Number of pregnant women who were served by CLASI
Data Sources and Data Issues:	Community Legal Aid Society, Inc. (CLASI) Program Reports
Evidence-based/informed strategy:	Increase the percentage of pregnant women served by CLASI as having a positive outcome after receiving legal services.
Significance:	Being housing secure while pregnant provides a safe, stable environment for both the pregnancy and the baby's development. Stable housing reduces stress, lowers the risk of complications like preterm birth, and improves long-term outcomes for both parent and child.

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	To ensure children enrolled in MIECHV programs benefit from early detection.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** MIECHV children who received a developmental screening. **Denominator:** Number of MIECHV children 9-71 months.
Data Sources and Data Issues:	MIECHV ASQ data.
Evidence-based/informed strategy:	Increase the percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.
Significance:	Children who miss developmental screens at the recommended frequencies miss developmental or behavioral delays being detected early. The earlier a delay is detected, the better outcomes for treatment.

ESM DS.2 - Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	Track and capture the number of children referred for early intervention following a high-risk developmental screen.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children with high-risk screens that were referred to early intervention. **Denominator:** Total number of children screened.
Data Sources and Data Issues:	PEDS online data (PEDS data doesn't represent all pediatric practices in the state. CHADIS Referral Data (Data represents 4 pediatric practices across the state that are involved in the CHADIS pilot project).
Evidence-based/informed strategy:	Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.
Significance:	Capturing referrals following developmental screens has been a gap across the state. Tracking this data will prevent families that fall between the cracks and miss the benefits of early detection, while also establishing a system within the state for developmental screening.

ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	Reduce disparities in children at risk for developmental delays.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children at risk for developmental delays residing in high-risk zones. **Denominator:** Total number of children screened residing in high-risk zones.
Data Sources and Data Issues:	Ages and Stages Questionnaire screening data in childcare and education.
Evidence-based/informed strategy:	Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.
Significance:	By reducing developmental screening disparities between children residing in high-risk and non-high-risk zones, we will be able to ensure as much as possible that all infants and toddlers (i.e., ages 0-23 months) ultimately have similar levels of school readiness (vis-à-vis the Ages and Stages Questionnaire) at ages 36-47 months.

ESM MHT.1 - Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	Enhance behavioral health care within SBHCs, supporting MH providers with resources. This will help improve the quality & timeliness of services, reduce gaps in care, and demonstrate progress toward improving access to timely treatment & counseling.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator represents the number of behavioral health providers working within SBHCs who are actively linked with PMHCA. **Denominator:** The denominator represents the total number of behavioral and mental health providers currently providing services within all of the high school SBHCs.
Data Sources and Data Issues:	Report data submitted by PMHCA.
Evidence-based/informed strategy:	Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.
Significance:	This measure is significant because it captures the implementation of an evidence-informed strategy aimed at increasing provider access to behavioral health services through PMHCA, which enhances the quality of mental health care in SBHCs. It directly measures the integration of support systems that strengthen provider capacity—an essential component of the goal to improve adolescent access to needed mental health treatment. Tracking this measure is important for demonstrating progress in building a much-needed mental health infrastructure within SBHCs.

ESM MHT.2 - Percentage of high school students enrolled in Delaware SBHCs.
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	By tracking this measure, the State aims to increase enrollment of SBHCs among high school students as a strategy to improve access to needed mental health treatment and counseling.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator represents the number of high school students whose parents have completed the required consent form to enroll in each SBHC. **Denominator:** The denominator represents the total number of high school students enrolled in each school.
Data Sources and Data Issues:	Report data submitted by medical providers who operate the contracted SBHCs.
Evidence-based/informed strategy:	Percentage of high school students enrolled in Delaware SBHCs.
Significance:	This measure directly reflects the effectiveness of Delaware's ESM to expand access to mental health services through school-based health centers (SBHCs). By increasing enrollment and utilization of SBHCs, the state can better identify and address the mental health needs of adolescents within a familiar and accessible setting. Measuring this allows the state to monitor progress toward ensuring more students receive timely mental health support, reduce barriers to care, and ultimately improve both health and educational outcomes.

ESM MHT.3 - Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services (PHQ and GAD-7 are usually components of a risk assessment).
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	% of students enrolled in SBHCs who receive routine behavioral & mental health screenings, as part of comprehensive risk assessments, to improve early identification of mental health needs & connect them with appropriate treatment and/or counseling.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator represents the number of high school students enrolled in SBHCs who have received a behavioral and mental health screening during a designated reporting period. **Denominator:** The denominator represents the total number of high school students enrolled in SBHCs during the designated reporting period.
Data Sources and Data Issues:	Report data submitted by medical providers who operate the contracted SBHCs.
Evidence-based/informed strategy:	Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services. Note: Patient Health Questionnaire (PHQ-9, which includes 9 questions) based on the diagnostic criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and Generalized Anxiety Disorder 7-item scale (GAD-7).
Significance:	This measure is significant because it evaluates the implementation of an evidence-based strategy to increase early identification of mental health needs through standardized screening tools like the PHQ-9 and GAD-7. It directly supports the goal of improving access to timely mental health treatment for adolescents by ensuring that behavioral health concerns are identified during routine SBHC visits. Measuring the percentage of students screened allows the State to assess how effectively SBHCs are serving as entry points for mental health care and demonstrates progress toward meeting the Title V National Performance Measure focused on adolescents receiving needed treatment or counseling.

ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	Increase the number of children receiving their recommended well child visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of enrolled children who received the expected number of well-child visits based on their age and the length of time they were enrolled in the program. **Denominator:** All children enrolled in the home visiting program for at least 6 months during the reporting period.
Data Sources and Data Issues:	MIECHV and MCH Program Data
Evidence-based/informed strategy:	Increase the percentage of children enrolled in home visiting services receiving their recommended well-child visits.
Significance:	To ensure children are connected to a medical home and receiving timely preventive care visits that include screenings, assessments, immunizations, and anticipatory guidance in line with AAP guidelines.

ESM TAHC.1 - Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12-17.
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Measure Status:	Active
Goal:	Increase the precent of adolescents with and without special healthcare needs, ages 12 through 17, who received services to prepare for the transition to adult health care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents with a special health care need with a transition plan **Denominator:** Number of adolescents with a special health care need served by a mini-grantee
Data Sources and Data Issues:	Family SHADE/MCH Program Data
Evidence-based/informed strategy:	Increase the percent of adolescents with special healthcare needs, ages 12 through 17, served by a mini grantee that have a transition plan.
Significance:	The transition of youth to adulthood, including the movement from a child to an adult model of healthcare, has become a priority issue nationwide as evidenced by the 2011 clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Poor health has the potential to negatively impact the youth and young adults' academic and adulthood but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions into adulthood.

ESM 1.1 - To increase the percentage of MCH staff that have completed at least one professional development opportunity.
SPM 1 – Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.

Measure Status:	Active
Goal:	To increase the number of well qualified MCH leaders in the field.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of MCH staff that have completed at least one professional development opportunity. **Denominator:** The number of MCH staff employed.
Data Sources and Data Issues:	MCH data.
Evidence-based/informed strategy:	To increase the percentage of MCH staff that have completed at least one professional development opportunity.
Significance:	Multiple workforce skills and identified needs are critically requisite to address public health challenges now and into the future. Workforce Development ensures all staff are properly prepared to deliver and produce high quality work. Workforce Development also helps prepare our MCH workforce in succession planning and decreased staff turnover.

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting
2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants enrolled in home visiting receiving breast milk at 6 months of age **Denominator:** Number of infants enrolled in home visiting at 6 months of age
Data Sources and Data Issues:	MCH/MIECHV program data
Significance:	Our home visiting programs enroll the most vulnerable families that are of lower socio-economic status. Mothers in this population have lower rates of initiating breastfeeding as well as difficulty continuing to breastfeed through 6 months of age.

2021-2025: ESM PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
2021-2025: NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Active
Goal:	Increase the percent of children enrolled in Medicaid, ages 1 through 17, who had a preventive dental visit in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children enrolled in Medicaid who received a preventative dental visit in the last year **Denominator:** Number of children who received a preventative dental visit in the last year
Data Sources and Data Issues:	National Survey for Children's Health
Significance:	Preventive dental visits ensures children have a bright and healthy smile. It also spares children the aches of tooth decay. We know the sooner families start regularizing their child’s dental visits, the better their oral health will be throughout their lives.

2021-2025: ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.
2021-2025: NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Active
Goal:	Increasing access for dental services.
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>1,000</td></tr><tr><td>**Numerator:**</td><td>the number of referrals received via DEThrives</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	MCH Program Data
Evidence-based/informed strategy:	Oral health is essential to overall health.
Significance:	Focused on improving access to oral health care and understanding the factors that contribute to improving oral health from a population health perspective.

2021-2025: ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed
2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	To increase the number of adolscents idenfitied in need of services (i.e. mental health; nutrition; reproduction health)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children receiving an assessment **Denominator:** # of unique children enrolled and receiving services at a SBHC
Data Sources and Data Issues:	SBHC program data
Significance:	Standardized assessment are important to ensure adolscents receive the services specific to their need.

2021-2025: ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.
2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	Ensure adolescents enrolled in SHBCs receive appropriate assessments and resources/services as needed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of mental health assessments completed within a SBHC **Denominator:** The number of students enrolled in a SBHC
Data Sources and Data Issues:	SBHC Program Data
Evidence-based/informed strategy:	Unfortunately, there is not much evidence behind School Based Wellness Centers based on the number of students enrolled and accessing services including mental health support, we know they are providing services that are needed for this population.
Significance:	Ensure adolescents receive services and treatment related to identified behavioral concerns that is accessible.

2021-2025: ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE
2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Measure Status:	Active
Goal:	Provide children enrolled in a Delaware school access to mental health services
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Raw # of unduplicated students receiving trauma specific mental health services from a provider chosen by student or parent.</td></tr><tr><td>**Denominator:**</td><td>Total # of students enrolled in DE schools.</td></tr></table>
Data Sources and Data Issues:	DOE Program Data
Evidence-based/informed strategy:	Project THRIVE provides free mental health services to eligible Delaware students. Services are available to students – grades pre-k through 12 – attending Delaware public schools, private schools, parochial schools and homeschools.
Significance:	Project THRIVE services help students who are struggling with traumatic situations, such as physical or emotional abuse, community violence, racism, bullying, and more. Trauma can harm mental and physical health, and limit school success. The Delaware Department of Education (DDOE) developed Project THRIVE to help children receive trauma-informed support from their schools, communities and caregivers. Project THRIVE services help students: Process and understand traumatic situations; Attend school regularly; Better control emotions and behaviors and Develop coping skills for managing stress at home and school

2021-2025: ESM WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	Increase the number of women of reproductive age receiving family planning services.
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>20,000</td></tr><tr><td>**Numerator:**</td><td>Total # of women of reproduction age that received family planning servicess</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	FPAR Title X/Family Planning Data
Significance:	Family planning visits not only help women to avoid unintended pregnancies, but also help a women prepare for healthy pregnancies by addressing important preventive care issues among women of reproductive age.

2021-2025: ESM WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	Increase # of women served by the HWHBs program that were screened for pregnancy intention
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women that were screening for pregnancy intention **Denominator:** # of women served
Data Sources and Data Issues:	HWHB Program Data
Significance:	Asking the pregnancy intention question gives women an opportunity to discuss their future and offers providers to further discuss contraception option that are best for her based on her answer.

2021-2025: ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce unintended pregnancies</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Medicaid women who use a most to moderately effective family planning birth control method</td></tr>
<tr><td>Denominator:</td><td>Medicaid women who use other types of family planning birth control</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Medicaid Claims Data</td></tr>
<tr><td>Significance:</td><td>By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.</td></tr>
</table>

2021-2025: ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.
2021-2025: NPM – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day - PA-Adolescent

Measure Status:	Active
Goal:	Goal of Triple Play
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of current DE school locations participating in the Triple Play Model</td></tr><tr><td>**Denominator:**</td><td>The total number of schools in DE</td></tr></table>
Data Sources and Data Issues:	PANO/MCH Data
Evidence-based/informed strategy:	Youth who participate in Triple Play have reported increases in physical activity, improved eating habits and improved relationships with their peers.
Significance:	Positive long-term health outcomes have been shown healthy lifestyle habits. The metrics are even more significant when considered how health behaviors during adolescence can impact health in adulthood. Partnerships between school and community organizations, including providers of out-of-school-time programs such as before-school, after-school, and summer programs, as a strategy to address health and educational inequities have a unique role in communities and often have additional flexibility that schools may not have.

2021-2025: ESM AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants
2021-2025: NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured - AI

Measure Status:	Active
Goal:	To increase the number of primary caregivers and children with health insurance
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of primary caregivers and children (families) with health insurance **Denominator:** # of families enrolled
Data Sources and Data Issues:	MIECHV program data
Significance:	Health insurance covers essential health benefits critical to maintaining generalhealth, preventive care, treating illness and accidents

2021-2025: ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.
2021-2025: NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured - AI

Measure Status:	Active
Goal:	Increase the number of families engaged in the Family Leadership Network.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of families enrolled in FLN</td></tr><tr><td>**Denominator:**</td><td>The number families identified as having a child with a special healthcare need.</td></tr></table>
Data Sources and Data Issues:	MCH Family SHADE data
Evidence-based/informed strategy:	Studies have shed light on the vital roles and functions that families of all backgrounds can perform to support their children's and youth's development and success.
Significance:	Research has shown that meaningful family engagement positively impacts youth outcomes across various domains. Family engagement with health care professionals improves care coordination and health outcomes at the individual, youth, and family level.

2021-2025: ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.
2021-2025: NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured - AI

Measure Status:	Active
Goal:	The goal is too serve as many families as each awardee has the capacity to serve.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children served by a Family SHADE mini-grantee **Denominator:** Total children that can be served by a Family SHADE mini-grantee.
Data Sources and Data Issues:	Family SHADE/MCH program data
Evidence-based/informed strategy:	Families and children with special healthcare needs have unique needs that requires additional support so by building capacity at the local level, we can increase the support available that is easily accessible to families and children.
Significance:	Building capacity at the local level to serve families with CYSHCN.

Form 11
Other State Data

State: Delaware

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Delaware

Annual Report Year 2024

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	Quarterly	12		
2) Vital Records Death	Yes	No	Quarterly	24	Yes	
3) Medicaid	Yes	Yes	More often than monthly	0	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	No	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	No	
7) Hospital Discharge	Yes	No	Annually	24	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	10	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Behavioral Risk Factor Surveillance System	Yes	No	Annually	12	No	
10) Youth Risk Behavior Surveillance System	Yes	No	Annually	12	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Delaware

Annual Report Year 2024

Form 12 Products And Publications