Maternal and Child Health Services Title V Block Grant

Delaware

FY 2027 Application/ FY 2025 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 13, 2026

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 2026 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 2026 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

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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, Immunizations & Adolescent Wellness Bureau, and the Maternal and Child Health Bureau. These sections implement programs that improve the health of women, infants, children, adolescents, CYSHCN, 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 the 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.

Delaware's Title V Program advances a life-course approach to improving the health of women, children, and families through strong partnerships with the Delaware Healthy Mother and Infant Consortium (DHMIC), Delaware Perinatal Quality Collaborative (DPQC), Delaware Division of Medicaid and Medical Assistance, healthcare providers, hospitals, community organizations, and individuals with lived experience.

Over the past five years, Delaware has implemented several innovative strategies and policy changes to improve maternal health, including expanded Medicaid postpartum coverage, Medicaid reimbursement for doula services, the 1115 Medicaid Demonstration Waiver providing postpartum nutrition supports, continued investment in home

visiting, Community Health Worker care coordination, implementation of the DPQC's Blue Band Initiative, and development of the Healthy Women Healthy Babies (HWHB) Housing Pilot to improve housing stability for pregnant women, and bolster and convene stakeholders through an Annual DHMIC Summit, engaging partners statewide, regionally and nationally. Delaware also continues to refine the HWHB 3.0 model, emphasizing value-based care, behavioral health integration, and care coordination.

DPH and DHMIC continue to elevate the voices of women and families through Her Story 2.0, a statewide storytelling initiative that informs policy, improves healthcare delivery, and increases public awareness of maternal health experiences. Delaware will continue strengthening maternal health through implementation of the DHMIC Strategic Plan, DPQC quality improvement initiatives, launch of the Maternal Health Resources Map, enhancement of Community Health Worker services, and continued evaluation of innovative programs, including HWHB 3.0, the HWHB Housing Pilot, the Medical-Legal Partnership, and exploration of the Family Connects home visiting model. DPH will also continue aligning Title V priorities with the HRSA State Maternal Health Innovation Grant, the Delaware Perinatal Quality Collaborative, and the Alliance for Innovation on Maternal Health (AIM) Postpartum Discharge Transition Bundle to improve postpartum care, maternal patient safety, quality improvement, and access to coordinated services.

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.

The Early Childhood Comprehensive System (ECCS) program utilizes the Help Me Grow model to address critical gaps in early identification by offering developmental and behavioral screenings, referrals, and follow-up services. Families are also empowered through the increased awareness of developmental milestones and available resources. The four components of the HMG model are: The Centralized Access Point; Child Health Provider Outreach; Family and Community Engagement and Data Collection and Analysis. The outcomes of a

recent strategic action plan process are a direction towards an increased effort to promote HMG with the community; inform and educate parents and caregivers; continued efforts to improve developmental and behavioral screening while tracking data trends to support advocacy a data-driven change.

We will continue with the promotion of the HMG centralized access point to increase community utilization. We plan to provide education to resident pediatricians to sensitize their hearts and minds on the importance of developmental screens, including being knowledgeable about community resources and services. We will seek to strengthen our partnerships to foster a shared approach to aligned and reinforce messaging around early childhood development and data collection and analysis.

The MCH Bureau partnered with evidence-based home visiting programs to ensure families are connected to a consistent medical home through program oversight, technical assistance, and continuous quality improvement. Home visitors receive ongoing training and support to promote well-child visits, developmental surveillance, and to help families overcome barriers to accessing healthcare. The Bureau will monitor MIECHV performance measures and collaborate with pediatric providers, Medicaid managed care organizations, Help Me Grow, Early Intervention, and other community partners to strengthen care coordination and referral pathways. These efforts will improve access to preventive healthcare, developmental screenings, immunizations, and other needed services, supporting positive maternal and child health outcomes. Additionally, the MCH Bureau will continue to use social media to educate families about the value of a medical home, increase awareness of preventive care, and connect families with healthcare and community resources.

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 MCH Program prioritizes adolescent health as part of its Five-Year State Action Plan, aligning with NPMs 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.

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 CYSHCN six core indicators throughout the 6 population domains of the MCH Title V guidance. The CYSHCN program will be intentional in developing a crosswalk across the 6 population domains. After a competitive request for proposal (RFP), Delaware contracted with the University of Delaware/Center for Disabilities Studies (UD/CDS). The UD/CDS will serve as the fiduciary of selected mini-grantees serving CYSHCN. The Mini-grantees and Family Leadership Network (FLN) members will address 2 NPMs, which are: Shift to Adult Health Care, and all children have access to a Medical Home model of care.

The CYSHCN program goals for Yr. 2025 -2030, is to increase the number of CYSHCN adolescents, served by mini-grantees with a transfer plan that prepares them for the adult health system of care. One of the strategies for addressing the transfer will be by the mini-grantees educating the CYSHCN adolescents they serve on the importance of a transfer plan. Focusing on children having access to a medical home will also be a priority for the next five years. One of the strategies for addressing medical home will be to utilize universal practices to promote all children enrolled in home visiting services, have access to care and receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule. 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. 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 included data collection and evaluation plans, as well as to report on key findings in funded programmatic contracts. 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The Delaware Healthy Mother & Infant Consortium (DHMIC) celebrated two decades of improving maternal and infant health during its annual summit in April 2026. The theme — “Learning from the past. Leading in the present. Shaping maternal and child health for the future” — highlighted past achievements while focusing on innovative strategies to drive continued progress.

More than 370 maternal and infant health advocates attended the full-day event, which included presentations by industry experts, question and answer sessions to engage attendees, networking opportunities, panel discussions, and group breakout sessions. Engagement activities throughout the Chase Center ballroom showcased key initiatives and accomplishments that have shaped maternal and child health in Delaware.
“Reaching our 20-year milestone is both a celebration and a call to action,” said DHMIC Chair Dr. Priscilla Mpasi. “Our progress proves what is possible when communities, health systems, and policymakers work together. As we look ahead, we remain deeply committed to ensuring every Delaware family has access to the care, support, and equitable opportunities they deserve.”

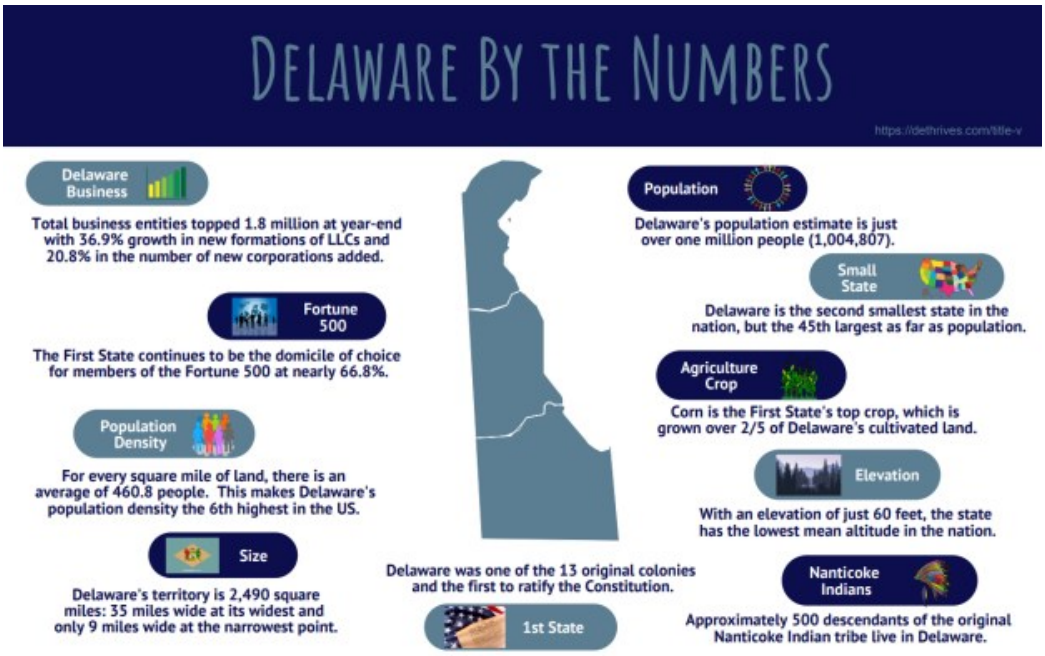
Multi-Emmy Award-winning and *NAACP* Image Award-winning director Emmai Alaquiva, served as the keynote speaker for the event. Alaquiva spoke about his award-winning film *The Ebony Canal*, showed clips from the film, and talked about the importance of getting out the stories of women who experience disparities in maternal health and infant outcomes, particularly in Black and Brown communities.

“The key takeaway today, for me, is bringing all of our partners together so we can learn from each other,” said Leah Jones, Division of Public Health (DPH) Section Chief of Family Health Systems. “While we celebrate the 20 years, we know there is still more work to be done. But when funding and data align, and we implement evidence-based strategies that we know will work, we can evaluate the progress and show a return on investment that will benefit not just mothers and their babies, but will allow all families to thrive.”

Since 2004, Delaware’s infant mortality rate dropped from the sixth highest among the states to the 22nd. According to the Division of Public Health, Pregnancy Risk Assessment Monitoring System (2012–2020), Delaware experienced a 36.2% drop in infant mortality and a 17% increase in pregnancy intention. Delaware reached a record-low infant mortality rate of 5.9 infant deaths per 1,000 live births in 2017-2021.
Through partnerships and innovative initiatives, DHMIC will continue its mission to prevent infant and maternal mortality and improve the health of women of childbearing age and infants in Delaware. For more information visit DEThrives.com/DHMIC.

III.B. Overview of the State

III.B.1. State Description (Last Modified: FY 2027 Application/FY 2025 Annual Report)



Delaware is a small but densely populated Mid-Atlantic state with a diverse, 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 determinants of health, 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 and health equity. Four strategic priorities were identified, of which the strategic plan is based: Promote Healthy Lifestyles; Improve Population Health and Reduce Health Care Costs; Achieve Health Equity. 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). One example is the *Delaware Contraception* Now program.

Health Equity

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 the social determinants of health. 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 Delaware Division of Public Health he Delaware Division of Public Health (DPH) is now providing health equity training through the Health Equity Institute of Delaware (HEIDE). Led by the Office of the Medical Director and Office of the Chief Health Equity Officer, HEIDE helps providers and public health workers approach their work from a health equity perspective. Participants participate in online, virtual, and in-person educational experiences led by local and national health equity experts. There are two learner tracks: a clinician track for those in clinical and patient care fields, and a professionals' track for those in non-clinical fields. College undergraduates and graduate students may also participate.
Learners will identify equity gaps and work to fill them through short- and long-term projects. The projects will cover areas such as climate change, sexual and reproductive health, mental health services, and dental care. Learners will also be involved in research that will help inform state action and contribute to national discourse.
HEIDE was launched in July 2024 with virtual sessions led by various speakers. The initiative includes Working4Equity, a lecture series for working clinicians, held monthly by HEIDE and the Medical Society of Delaware. The lectures may be helpful to scholars, practitioners involved in public health and health disparities work, and allies such as community members and for-profit businesses. High school students can receive training through a four-week summer internship program, HEIDE-STEPS, that focuses on the social factors affecting health. Applications for the summer 2025 HEIDE-STEPS program were accepted in January 2025.

The Delaware Healthy Mothers and Infants Consortium continues to emphasize health equity and the social determinants of health, through highlighting the topic at Annual MCH Summit agendas, bestowing health equity awards to individuals and organizations to recognize effort.

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 13th, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 20th anniversary annual summit to celebrate and share the successes of the work that has been done in the last twenty years addressing the infant and maternal mortality rates and how those rates can continue to improve in Delaware. The DHMIC focuses on understanding and addressing the health factors that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. This year's theme was *Learning from the Past. Leading in the Present. Shaping Maternal & Child Health for the Future*.

This year, the summit 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 status.

DHMIC Chair, Priscilla Mpasi, MD, FAAP, DHMIC Vice-Chair, Tiffany Chalk, CMP, and Lt. Governor Kyle Evans Gay provided opening remarks on the importance of why we should continue the work to address maternal and infant mortality and morbidity in Delaware. In the morning, state dignitaries including Speaker of the House and State Representative Melissa Minor-Brown, Senator Marie Pinkney, a DHMIC appointed member, and Representative Kamela Smith, a DHMIC appointed member, presented a tribute to the DHMIC in honor of their 20th Anniversary Summit.

There was a total of 25 speakers throughout the day, which were comprised of dignitaries, past and present DHMIC leadership, one keynote speaker, and two different breakout sessions, ranging from topics that included elevating patient voices in health care advocacy, innovations in Medicaid, the fourth trimester, hearing from the March of Dimes' Chief Medical and Health Officer who shared what the Maternal and Child Health Bureau Directors from neighboring states such as New Jersey, Virigina, Maryland, Pennsylvania, and West Viriginia are doing in their states around the MCH topic, and how the DHMIC's work has transformed over the past 20 years.

News of the 20th DHMIC annual Summit was shared on 28 local and regional news media placements which was secured on 6 different media outlets such as WDEL, 6ABC, WPVI, Delaware Public Media, and Delaware Live where the DHMIC Chair, Priscilla Mpasi, Leah A. Jones, Section Chief, Family Health Systems, DHSS, and Shané Darby, Black Mothers in Power Founder (also an appointed DHMIC member), were interviewed. This resulted in an estimated 1.9 million impressions with an advertising equivalency of $19.5K.

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 12 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, FranklinCovey, 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 on the importance of their child's growth and developmental milestones.

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 DHMIC, a toolkit was 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 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 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 has recently contracted with the University of Delaware (UD) 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). UD will utilize the Family Leadership Network (FLN) in collaboration with mini-grantees to promote and receive feedback on where there are gaps in service delivery for the CYSHCN population. The FLN network membership is a member network which has historically offered 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. The plan is for UD to succeed in the implementation of the revitalized Family SHADE project which will consist of the execution of competitive mini-grant opportunities that are innovative and aligned with our MCH NPMs.

The 2025 Home Visiting Retreat brought together 165 attendees from across Delaware's home visiting community - including Home Visitors, Family Support Specialists, DPH supervisors and leadership, and state leaders. This year's theme, "*Stronger Systems. Stronger Families*," focused on strengthening collaboration and supporting the well-being of the workforce.

The event featured remarks from Lieutenant Governor Kyle Evans Gay, who highlighted the impact of home visiting across the state. Attendees also heard a keynote presentation on building strong early childhood systems, and the role of trust in strengthening families and programs. In addition to learning and networking opportunities, participants enjoyed wellness and appreciation activities - including massages, professional headshots, a 360-degree photo booth, and multiple resource vendors offering tools and supports for day-to-day work. The retreat served as a meaningful opportunity for connection, reflection, and reenergizing the statewide effort to support Delaware families through high-quality home visiting services.

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

DHSS, through its DPH, collaborates with stakeholders, community members, and partners statewide to assess the health needs of Delawareans and to create and implement a State Health Improvement Plan (SHIP). A SHIP is considered a best practice for state health departments and is essential for accreditation by the Public Health Accreditation Board (PHAB).

The Delaware SHIP (2025-2028) is a significant step forward in our collective efforts to foster healthier communities across the state. The SHIP is a blueprint for enhancing our communities' and residents' health and well-being. This plan recognizes the significance of vital conditions and social influences on health. They help shape the environments in which individuals live, learn, work, and play and how communities contribute to thriving populations. The partnership with the SHIP shows the need for an ongoing collective approach to improving public health outcomes.

We recognize that issues with access to care, safe and affordable housing, and resources such as healthy food options notably change health outcomes. In addressing these issues, we aim to cut barriers that prevent individuals from reaching their best health. Different populations require varying levels of support to achieve positive health outcomes. By focusing on the unique challenges faced by vulnerable communities—such as low health literacy, food deserts, and limited access to health care—we can create targeted interventions that advance a supportive and healthy Delaware.

At the core of this plan lies a commitment to working across areas, understanding that everyone's access to health care and resources is crucial for all Delawareans and cannot be accomplished by one group. The DPH's priorities reflect this commitment, ensuring that the voices of all populations are at the forefront of our initiatives. Additionally, our partners are at the table making decisions with us. Through true collaboration, targeted interventions, the application of the framework of the vital conditions, and multisolving, we aim to create a health care landscape where everyone can thrive.

This plan is not just a roadmap for addressing current health challenges; it is a call to action for all stakeholders in Delaware to come together to build healthier, more thriving communities. By prioritizing the Vital Conditions for Health and Well-Being, we can cultivate environments where everyone can flourish. As we embark on this journey, we invite all Delawareans to join us in our pledge to promote health and ensure everyone has access to the resources they need for a healthy life. Together, we can make it happen. We can improve the overall health of our state and begin to realize the ambitious goals outlined in Healthy People 2030.

Mentioned throughout the application, the Healthy Women, Healthy Babies (HWHB) 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 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 is proud to share accomplishments resulting from implementing 11 HWHB Zones community-informed strategies that aim to increase awareness, educate, better serve women of reproductive age and amplify 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 (and their partners and children). The CBOs want to help them live healthier, happier lives. The primary focus over a five-year cycle was innovation and to spread evidence-based programs and place-based strategies to improve the factors of health, as a complement to our medical intervention, HWHBs 2.0. The first-ever mini grants supported building state and local capacity and testing small-scale innovative strategies.

DPH worked with a contractor as the lead backbone entity, to develop a mini-grant process to fund local communities/organizations to implement interventions to address health factors in 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.

Over the five years of the initiative, mini-grantees provided services to 4,129 individuals. 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.

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, 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 early 2026, DPH introduced our Division's Strategic Plan. This multi-year plan is a community-focused collective health approach, created by and for the people of our state. It represents the dedicated work of our many partners in health from across the state who have come together with single shared mission: to improve the health and well-being of every Delawarean. This Strategic Plan is more than a document; it's a blueprint for transformation. Rooted in data from the 2023 State Health Assessment and shaped by robust community input, the plan identifies five priority health outcomes: mental health, chronic disease, maternal and infant health, avoidable injuries, and premature death. To drive change in these areas, we've aligned them with the vital conditions that influence health: meaningful work, safe housing, reliable transportation, lifelong learning, and the basic needs of daily life.

To ensure both depth and collaboration, Coalition members representing a various group of local organizations, experts, and community voices were organized into four Vital Condition groups. Each group brought specialized insight to the development of goals, measurable objectives, and actionable strategies designed to create recommendations for meaningful, long-term improvements in public health. Whether through local engagement or statewide partnership, this plan reflects a shared commitment to building a healthier Delaware where everyone has the opportunity to thrive. Together, through shared purpose and coordinated action, we can work to ensure that all Delawareans, regardless of zip code, income, or background, have access to the resources and support they need to live full and healthy lives.

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.

[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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 Christen Linke Young 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 (Last Modified: FY 2026 Application/FY 2024 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Population Served

Delaware continues to strive toward reducing the gap between Delaware and the national average and connecting more children and families to coordinated, comprehensive healthcare services. According to the 2024 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 56,084. Of these CYSHCN, 44.4 percent (n = 24,905) have a medical home in comparison to the nationwide average of 40.5 percent. Therefore, Delaware CYSHCN had a medical home, exceeding the national average of 40.5% by 3.9percentage points. This represents a 9.6% higher rate of access to a medical home among Delaware CYSHCN compared to our peers nationwide. Conversely, 55.6 percent (n = 31,179) of Delaware CYSHCN do not have a medical home, compared to 59.5 percent of CYSHCN nationwide. Delaware's rate was 3.9 percentage points lower than the national average, representing a 6.6 percent better outcome compared to the nation in reducing the proportion of CYSHCN without access to a medical home. This improvement represents positive movement toward ensuring that more children receive comprehensive and coordinated healthcare services.

According to the 2024 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 28,258. Of these CYSHCN, 18.3 percent (n = 5,167) received services to prepare for the progression to adult health care in comparison to the nationwide average of 22.6 percent (n = 8,931,497). Conversely, 81.7 percent (n = 23,091) of Delaware CYSHCN did not receive services to prepare for progression to adult health care in comparison to 77.4 percent (n = 6,909,289) who did not receive services to prepare for the progression of CYSHCN nationwide. These findings highlight an opportunity to strengthen progression to adult health care for CYSHCN with a focus on planning and supporting service for CYSHCN as they progress into the adult health care systems.

Infrastructure

Through the MCH V Block Grant, Delaware is actively working 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 CYSHCN are prepared to progress into an adult health system of care for CYSHCN age 12-17 years. 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.

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 the statewide system in compliance with policies under Part C IDEA. 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 receives 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 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, family members are key participants in each step of early intervention design and delivery.

- 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 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 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 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 2025-2026 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. Up to November of 2025 PIC led the Family Leadership Network (FLN) members and met with them monthly. In calendar 2026, the University of Delaware became the new lead agency for the Family SHADE Project and they partnered with PIC which continued to work with the FLN members. The FLN receive monthly

stipends for attendance and participation. They serve as instrumental contributors on the decision making in serving our CYSHCN. The University of Delaware/Center for Disabilities Studies serves as the fiduciary lead in funding mini-grantees that serve CYSHCN. The Family SHADE Project has led opportunities for funding over the past 4 years. These opportunities afforded community agencies with the opportunity to increase their capacity and extend their reach in serving CYSHCN. The agencies that have served as awardees of the mini-grant opportunities over the past 4 years are: Jay's House, Tomaro's Change, Children's Beach House, Down Syndrome Association and Teach Zen. 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 (Progression into Adult Healthcare)
  Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the progression 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. 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.

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 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 Sussex County Health Coalition
Through the execution of the Family SHADE 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. 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.

III.B.3.c. Relationship with Medicaid (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 for Needs Assessment Update (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The State of Delaware Division of Public Health (DPH) and its Title V stakeholders made use of HRSA's Technical Assistance Resources, HRSA's Guidance and Forms[1], as well as AMCHP's CAST-5 framework[2] to inform the 2025 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.

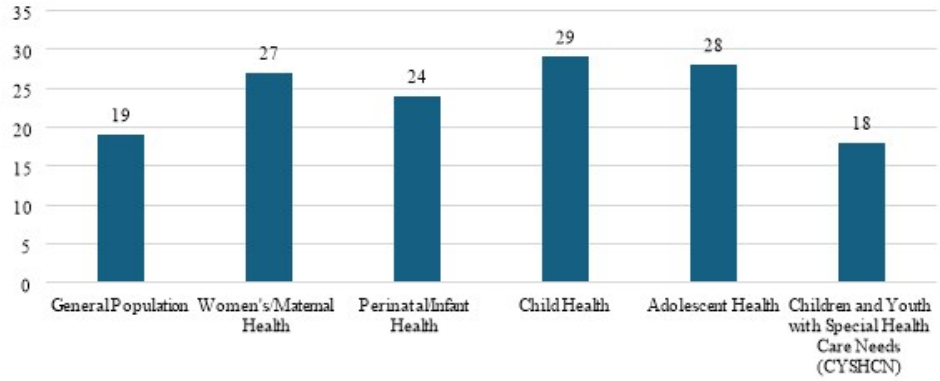
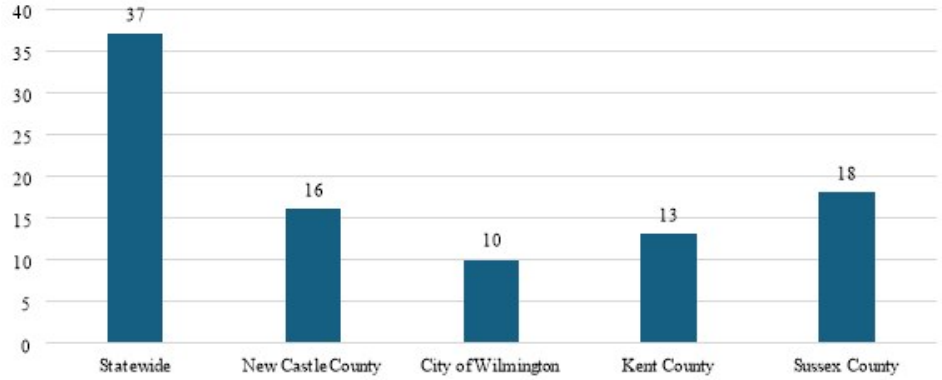


Figure 2. Geographic Area of the Population Served.



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.

During 2025 and 2026, Delaware reconvened our Title V Team 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. Our team has met to review the most recent state and national data that was specific to Delaware's MCH populations. Our team uses 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 has reviewed our State Action Plan; however, will not be making any updates to our selected NPMs, SPMs, or ESMs during this grant cycle. Each domain leader worked with our previous CDC Epidemiologist on ways to capture and report data for each selected ESM. Delaware did receive the MCH Evidence Center's annual ESM reports for the 2026 Application/2024 Annual Report in mid-May of 2026. This report will be a great conversation starter as we move forward with the review of our ESMs in the coming year. We hope to find ways to strengthen our ESMs by linking to more effective, science-based practices and to measure our progress in ways that tell how Title V is advancing each National Performance Measure.

With the loss of our CDC Epidemiologist Assignee, as well as the recent decision by leadership not to use contracted epidemiological services and only internal epi support, our ongoing needs assessment activities have suffered. With the

assistance of our previous epidemiology, research and evaluation (ERE) contractor, FHS planned to conduct another round of focus groups. We hoped to collect more data, opinions, and feedback from Delaware families, caregivers, mothers, fathers, and adolescents. We had planned to evaluate the current programs and assess our performance standards. Unfortunately, due to the lack of epidemiological support, FHS was not able to complete these intended activities. Once our epi support is trained and is familiar with MCH practices, we plan to resurrect these needs assessment data collection and program evaluation activities.

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 below.

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. Two of the largest groups of partners coming together around MCH issues in Delaware are the DHMIC and Family SHADE, which are frequently mentioned throughout our application.

The DHMIC and Family SHADE represent two 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. For example, the Help Me Grow Advisory Committee, convened by DPH, consists of representatives from organizations across the state. Similarly, the Home Visiting Community Advisory Board pull 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 and the Newborn Screening Advisory Council, help DPH to determine best practices for the program including the addition of new conditions to the Delaware panel. Additional key partnerships and collaborations include Delaware's Early Childhood Council (ECC), the Safe Kids Coalition, the Family Coordinating Council, the Sussex County Health Coalition, and the Breastfeeding Coalition of Delaware.

As in years past, Title V continues to support a very important activity, the Managed Care Organization (MCO) 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 questions or discuss an issue. On the call there are representatives from various agencies and organizations, such as Medicaid, private practitioners, Disability Law Program, and Health Management Organizations (HMO) representatives, to listen and help solve problems. These calls give families a non-adversarial venue discussion to share their concerns. These calls are offered in both English and Spanish. 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 the rules and regulations.

In the spirit of Title V, we are committed to continuing these efforts to partner with families and the 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.

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[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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The following information presents the 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

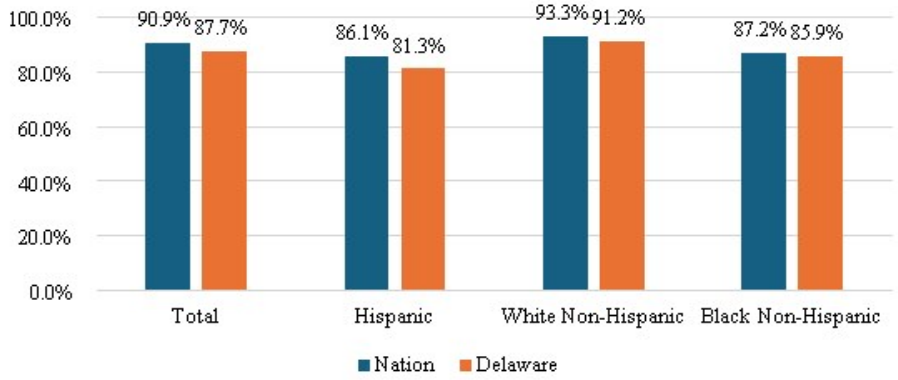
	Strengths	Challenges/ Weaknesses	Opportunities/ Solutions	Emerging Concerns/ Threats
CYSHCN	– Indicators (i.e., medical home, bullying, transition) generally on par with national figures – Care Coordination	– Ongoing disparities in indicators when segmented by race/ethnicity and health care coverage – 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.

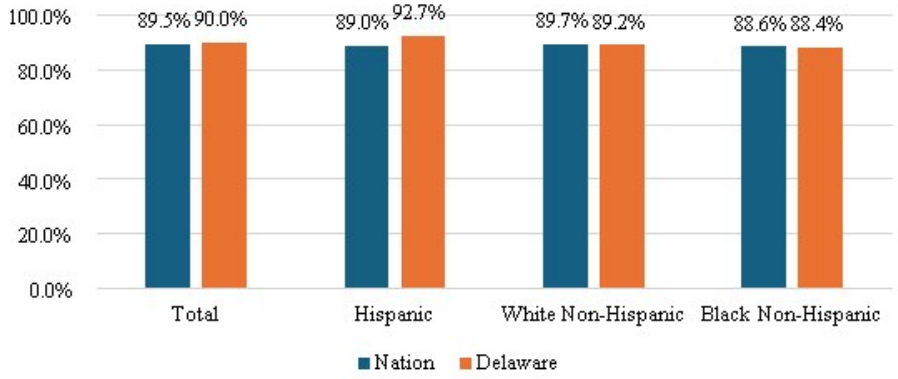
    Figure 3. Estimated Percentage of Postpartum Women with a Postpartum Visit, by Selected Race/Ethnicities.



    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.

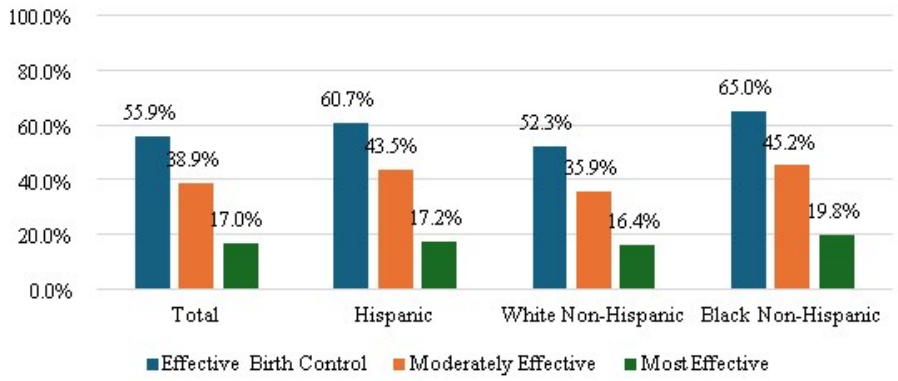
    Figure 4. Estimated Percentage of Postpartum Women with a Postpartum Mental Health Screening, by Selected Race/Ethnicities.



    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.

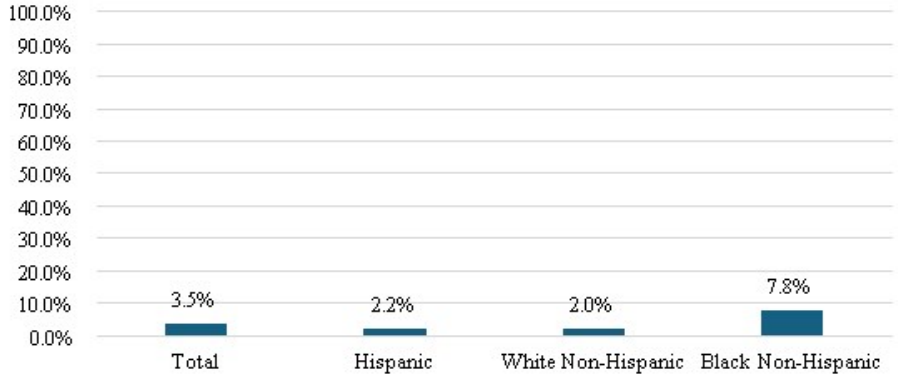
Table 3. Number and Percentage of VLBW Infants Born at Level III Birthing Hospital.

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).

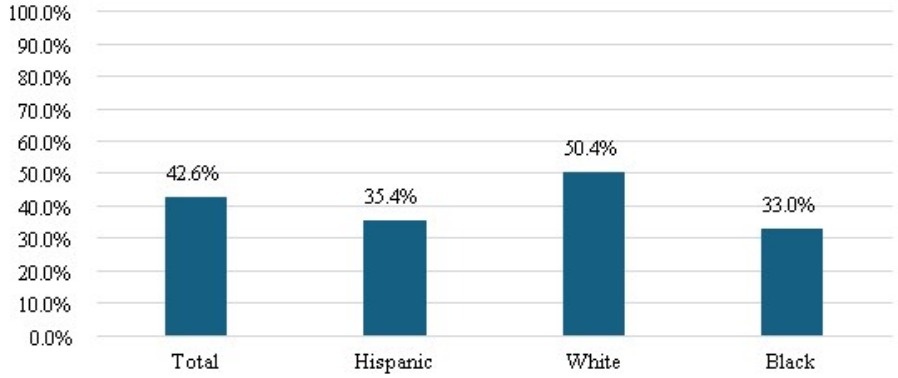
Figure 6. Percentage of Women Who Stated They Were Homeless in the 12 Months Before Their Baby Was Born, by Selected Race/Ethnicities.



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]

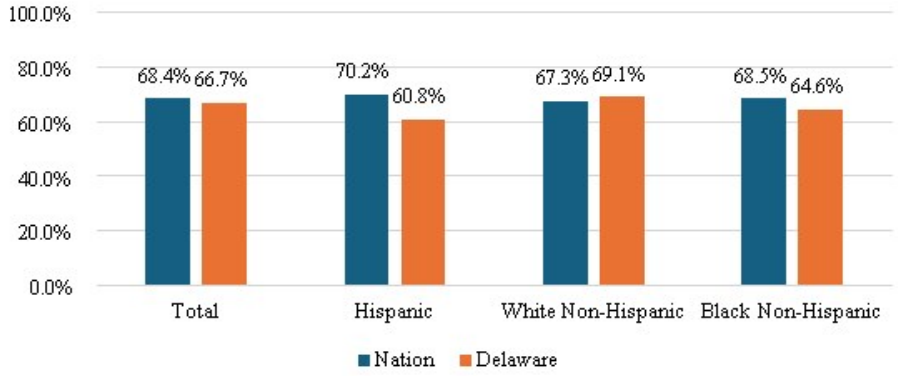


Source: PRAMS 2021.

- **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.

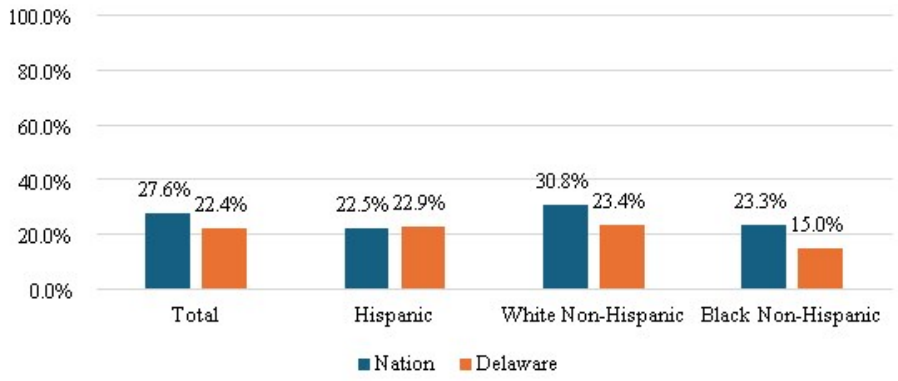
  - ***Breastfeeding.*** The estimated percentage of infants in Delaware who were reportedly breastfed at one month was approximately the same as the corresponding nationwide percentage as given in the figures. These percentages were also comparable across race/ethnicities, health care coverage, and age 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.

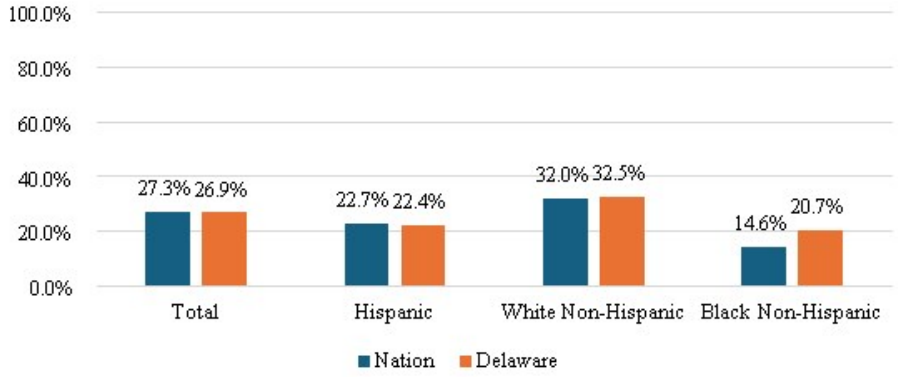
Figure 9. Estimated Percentage of Infants and Children Six Months to 2 Years of Age Who Were Breastfed Exclusively for Six Months, by Race/Ethnicity.



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.

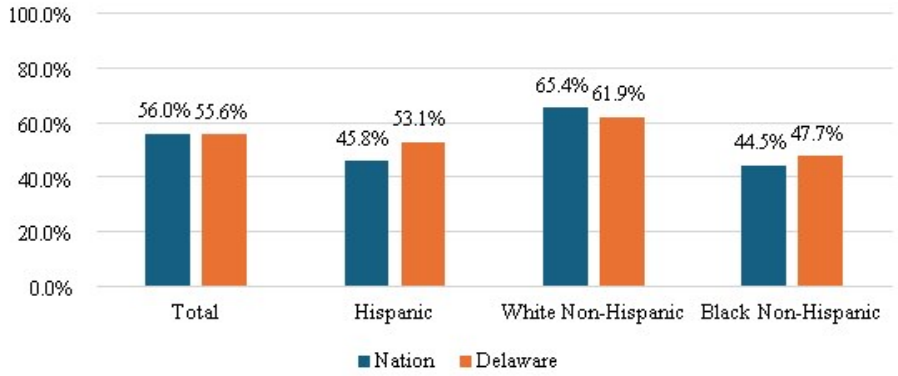


Source: PRAMS 2021.

- **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).

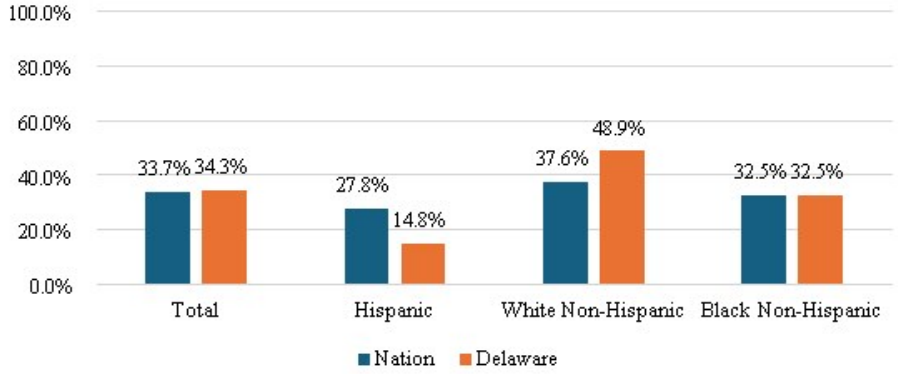
Figure 11. Percentage of Children Residing in Supportive Neighborhoods, by Selected Race/Ethnicities.



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.

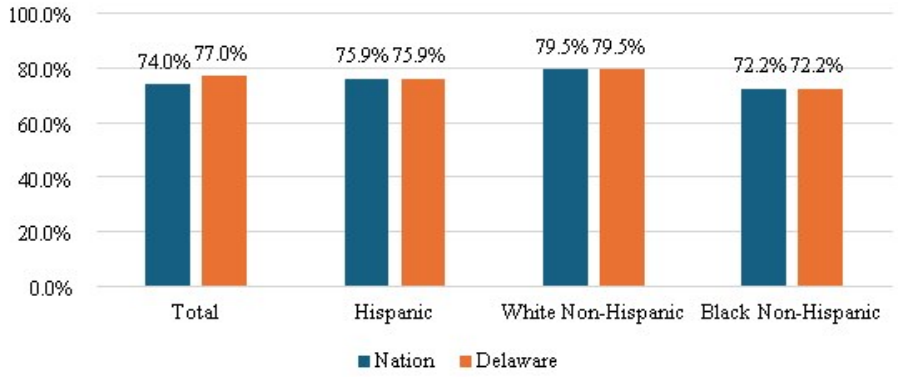
Table 4. Vaccination Percentages Among Kindergartners, 2022-2023 School Year.

	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.

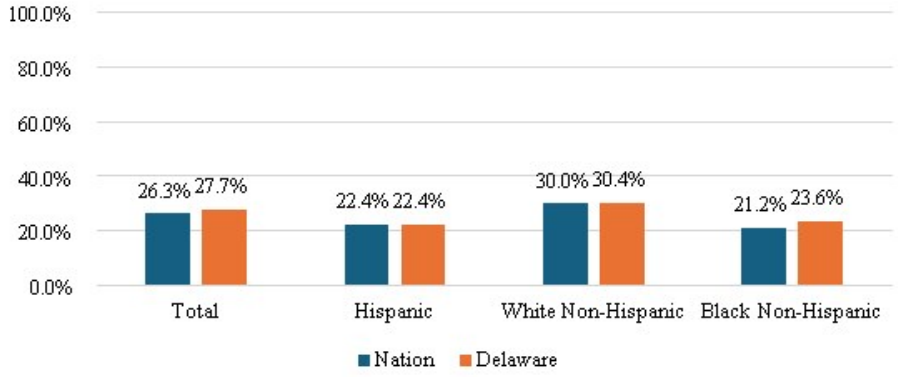
Figure 13. Percentage of Children Who Have Seen Dentist in Past Year for Preventive Dental Care, by Selected Race/Ethnicities.



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).

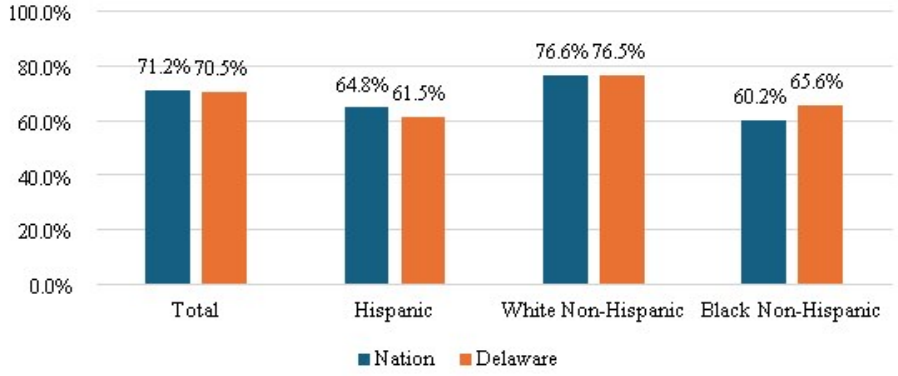
Figure 14. Percentage of Children Who Are Reportedly Physically Active, by Selected Race/Ethnicities.



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.

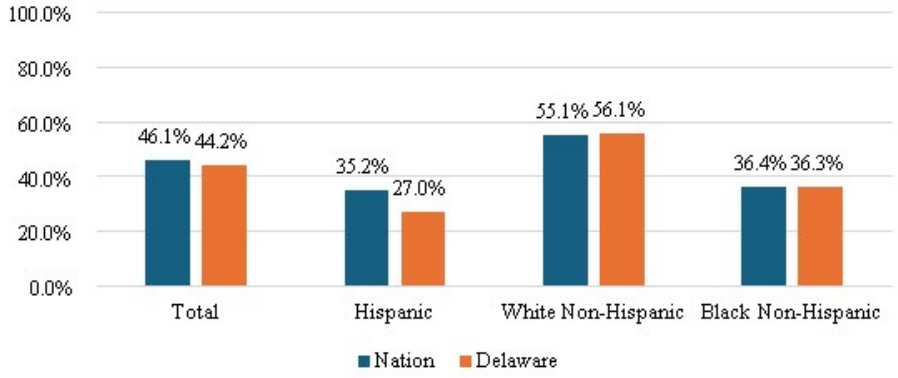
Figure 15. Percentage of Children Aged 0-11 Years Whose Households Were Food Sufficient, by Selected Race/Ethnicities.



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.

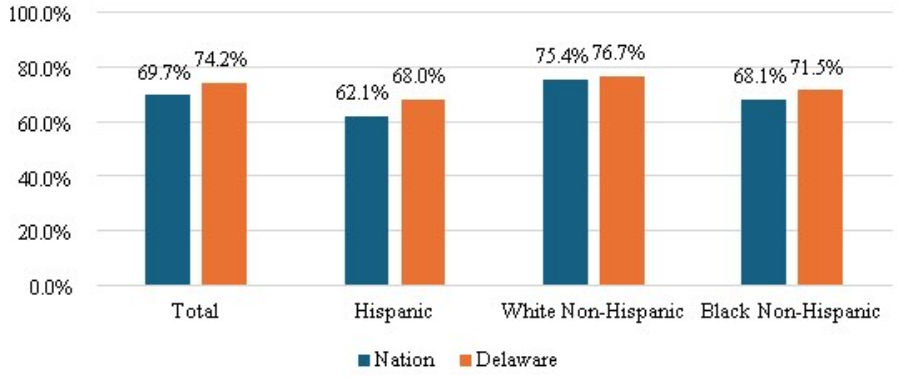


  Source: NSCH 2021-2022.

- **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.

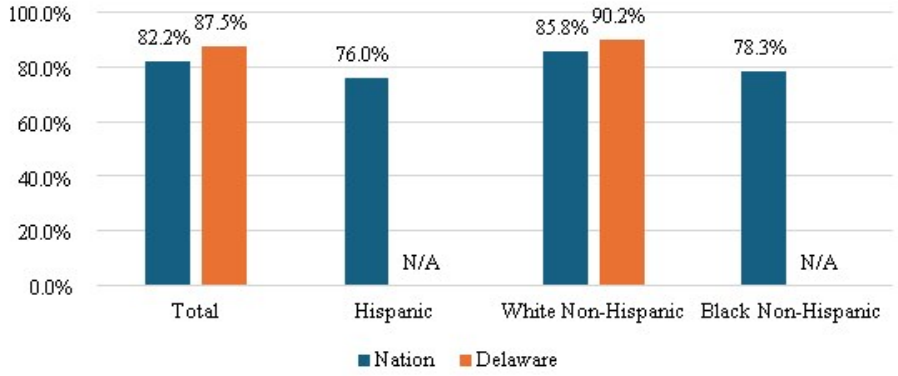
    Figure 17. Percentage of Adolescents with A Well Visit, by Selected Race/Ethnicities.



    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.

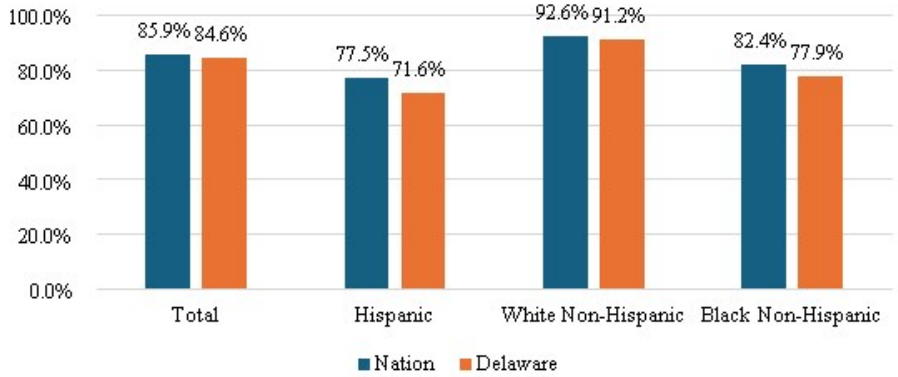
Table 5. Percentage of Adolescents Grades 9-12 Who Report Using Tobacco Products by Selected Race/Ethnicities.

	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.

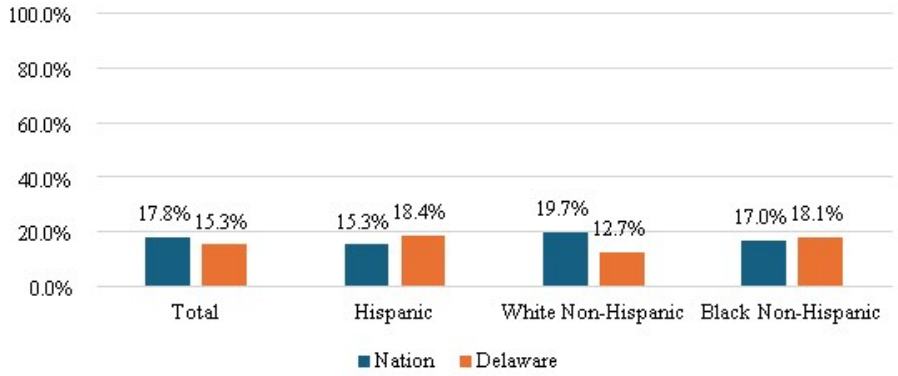


Source: NSCH 2021-2022.

- ***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.

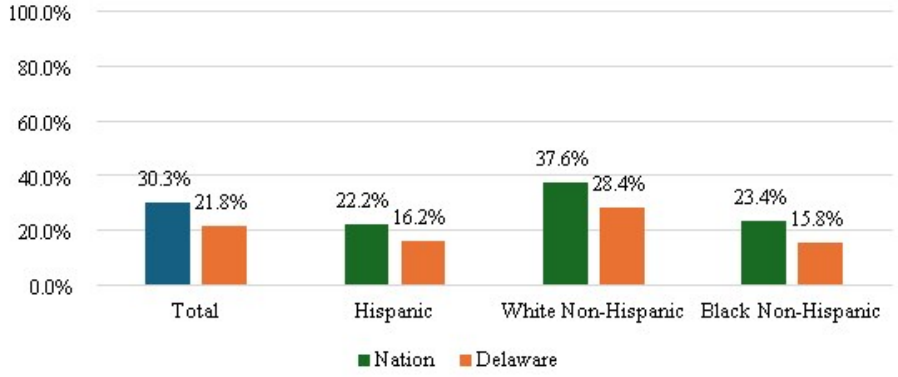
Figure 20. Percentage of Adolescents Who Received Services to Prepare for Transition to Adult Health Care, by Selected Race/Ethnicities.



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.

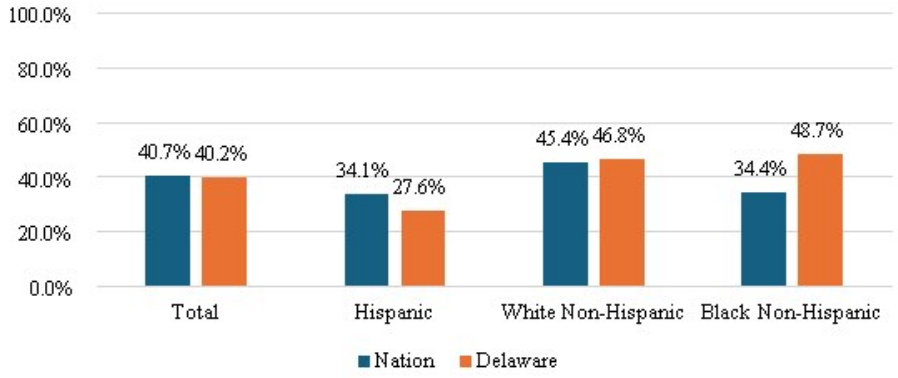


Source: NSCH 2021-2022.

- **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).

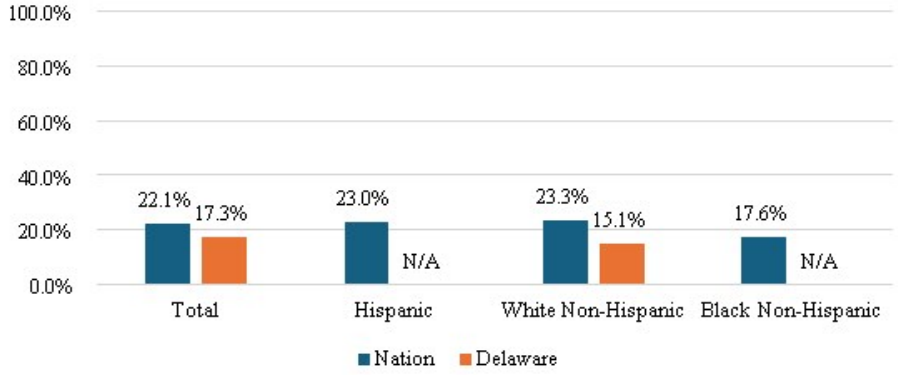
Figure 22. Percentage of CYSHCN Ages 0-17 Years Who Have a Medical Home, by Selected Race/Ethnicities.



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.

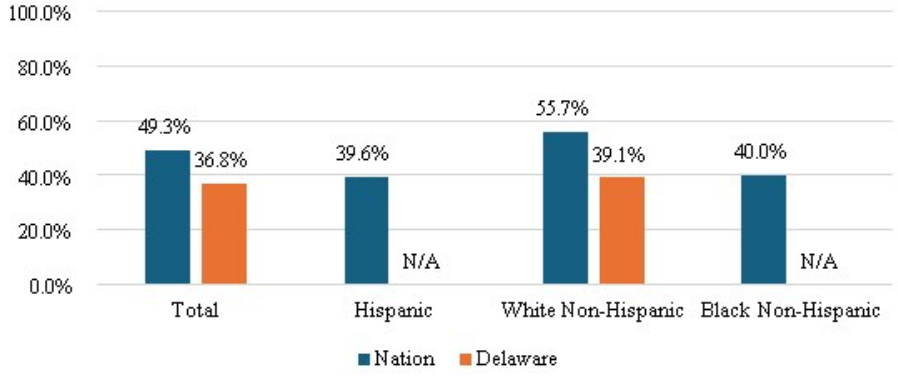
Figure 23. Percentage of CYSHCN Adolescents Who Received Services to Prepare for Transition to Adult Health Care, by Selected Race/Ethnicities.



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 Healthy Mother & Infant Consortium. The Delaware Healthy Mother & Infant Consortium (DHMIC) provides statewide leadership and coordination of efforts to prevent infant and maternal mortality and improve the health of women of childbearing age and infants throughout Delaware. In 2006, the DHMIC was established because Delaware's infant mortality rate was among the highest in the nation. Hidden within that mortality rate was a significant racial disparity, as African American infants were more than twice as likely to die before their first birthday than Caucasian infants. The solution is for women, to be in optimal health before pregnancy. When women enter pregnancy with tobacco use, uncontrolled chronic disease, or unmanaged stress, in many cases, prenatal care has limited impact on improving their outcomes. Helping women be healthy and change unhealthy behaviors is only one part of the solution. Infant mortality is an indicator of the health of the community, which can directly or indirectly affect each of us.

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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

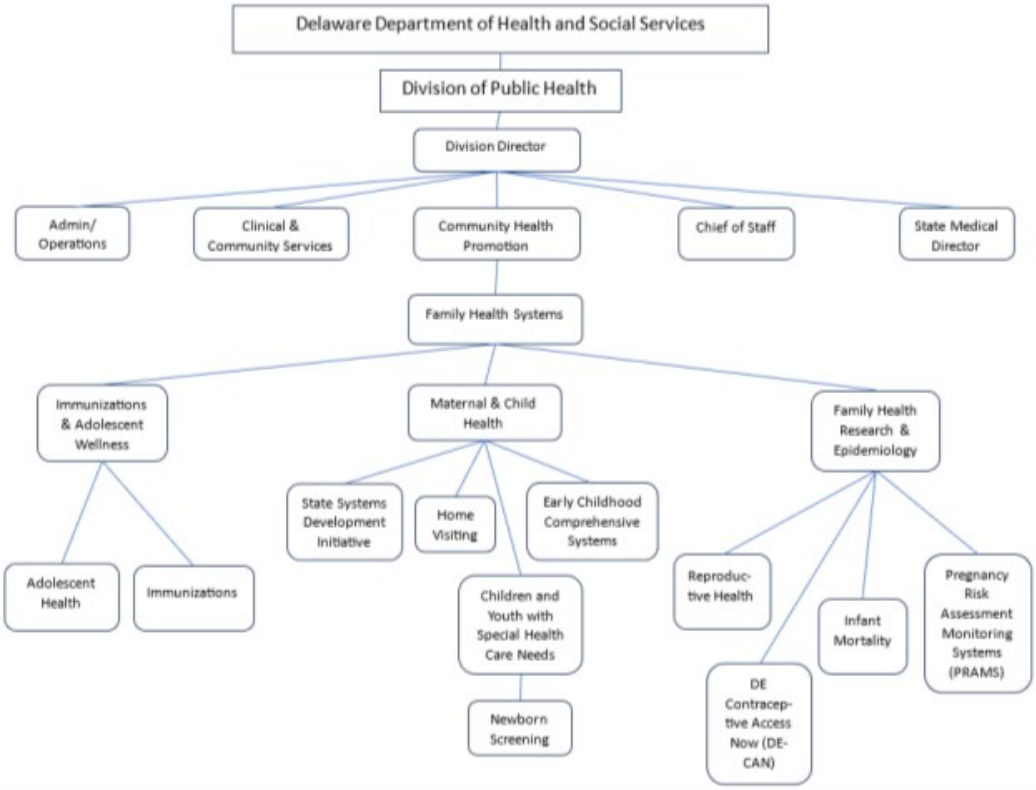
In Delaware, the executive branch of state government is headed by Governor Matt Meyer who took office as Delaware's 76th Governor in January 2025. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency and is led by Secretary Christen Linke Young. 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 10 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, health care quality, child support, developmental disabilities, visual impairment, aging and adults with physical disabilities, state service centers, 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 and 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 and Community Services, State Medical Director, Community Health Promotion, and Chief of Staff. Each strand is comprised of a multitude of sections. The Family Health Systems (FHS) section falls within the Community Health Promotion section. The Section Chief of FHS is Leah Jones, MPA. 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 Promotion 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, who is also the Title V Deputy Director. 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 Immunizations and Adolescent Wellness, led by Michelle Mathew, B.S., includes the Adolescent Health Program (School-Based Health Centers and Teen Pregnancy Prevention and the Immunizations 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, the Titel X Family Planning 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 used 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 met to develop the plan for our public input process. MCH aimed 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 was iterative with each activity laying the groundwork for subsequent activities. Division staff attended coalitions, programs, and special initiative meetings across the state to discuss the Needs Assessment

process and solicit input.

MCH conducted Focus Groups regarding several MCH issues related to health care and their community. Our goal was 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 determined that Key Informant Interviews would also be conducted to learn more about system strengths and needs and to better understand the landscape of services and supports. MCH identified stakeholders to participate in key informant interviews with partners representing every population domain. MCH had 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 informed our decision-making efforts to select our NPMs, SPMs, and ESMs.

MCH had 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, rural health, community mobile health units, oral health, 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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, oral health and dental services, 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.

The 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 2025, there were over 14,000 home visits provided in Delaware, statewide. This includes over 2,000 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

As part of Delaware's statewide needs assessment process in calendar year 2025, families and subject matter experts identified Transition to Adult Health Care for CYSHCN as a priority area and selected it as a new National Performance Measure (NPM) to replace Adequate Insurance. Transition to Adult Health Care for CYSHCN focuses on supporting youth (age 12-17) with special health care needs as they prepare to transition into adult health care systems and services. In addition, Delaware will continue to prioritize Medical Home as a longstanding National Performance Measure. The state has focused on improving access to medical homes for more than five years and remains committed to advancing coordinated, comprehensive, and family-centered care for CYSHCN through ongoing systems improvement efforts.

In Yr. 2025 The Family Support and Healthcare Alliance Delaware (SHADE) programmatic approach extended family and professional partnerships at all levels of decision making that best served our CYSHCN and their families. Family SHADE served as a learning network and respected resources for community organizations serving CYSHCN. Delaware's Parent Information Center (PIC) led the Family SHADE project in its 4th cohort. The Children's Beach House (CBH) and Down Syndrome Association (DSA) focused on NPM Medical Home and Adequate Insurance. Teach Zen (TZ) addressed NPM Developmental Milestones for CYSHCN. All 3 mini grantees served CYSHCN for 3 consecutive years. Each of the grantees had a different clientele and very different procedures for recruiting clients into their programs and providing services.

The Director of CYSHCN along with the University of Delaware/Center for Disabilities Studies (UD/CDS) -Family SHADE project team met and discussed with our MCH Title V team to make sure that we plan congruently with our domain leads, that we are 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. Our current work and priorities that we are addressing are to serve CYSHCN and their families and improve the system of care. This approach assisted and guided our Title V programs in aligning the work and priorities and guiding principles for a system of services for CYSHCN and their families. This information along with the 6 core CYSHCN guided us with identifying a baseline and a starting point as we began to move forward to developing our task and activities to implement our work, priorities, in alignment with the 6 core CYSHCN indicators within the Crosswalk of MCH 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 MCH Title V delivery of service.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 Jones, 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 2017. 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.
- *Deputy State Epidemiologist* for Family Health & Safety: Nang Ei Ei Khaing, PhD, was appointed as Deputy State Epidemiologist in December 2025 and currently leads the Office of Family Health & Safety Epidemiology (OFHSE). Prior to assuming this role, Nang served as the lead informatics epidemiologist in the Public Health Resources Section of DPH.

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.

Recently, 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.

During our 2025 Annual Retreat, we offered training around leading teams, *6 Critical Practices of Leading Teams*. This full-day training was designed to equip leaders with essential tools to lead effectively and support high-performing teams. This training was a special collection of relevant, practical resources that provided 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 our previous 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 with Children and Families First and Health Management Associates to provide this level of support. With the help of our ERE, MCH 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.

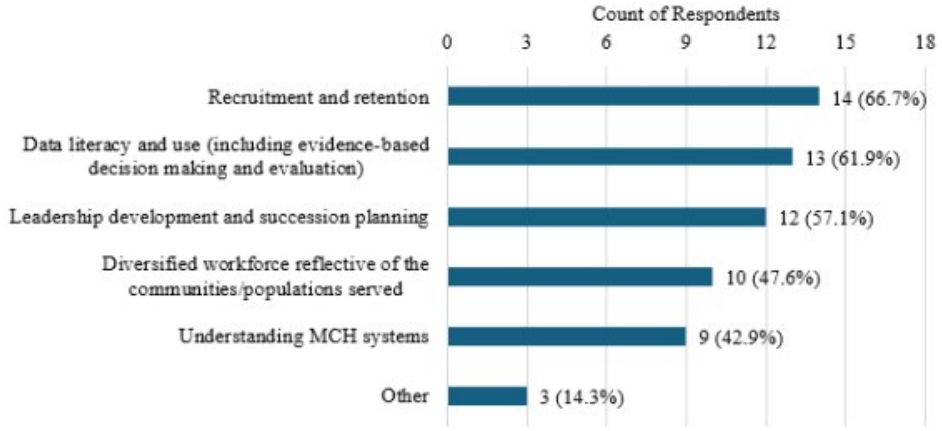
Table 1 lists the count and percentage of respondents who stated that they need either formal or On The Job (OTJ) training to each program area listed. As evidenced by this table, the most common program areas selected for training needs involved health disparities, use of culturally and linguistically 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%)

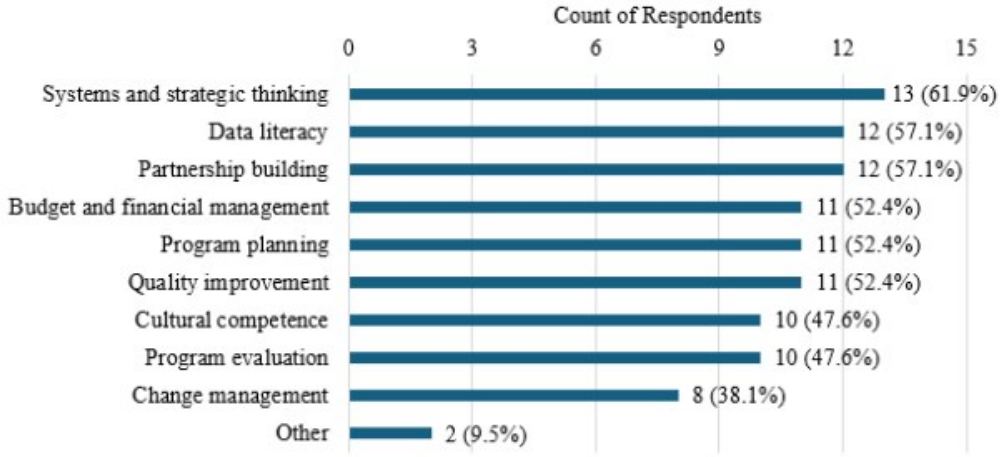
As indicated in Figure 1, the top needs reported by respondents for the current and future MCH public health workforce are recruitment and retention (66.7%) followed by data literacy (61.9%) and leadership development and succession planning (57.1%).

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?"



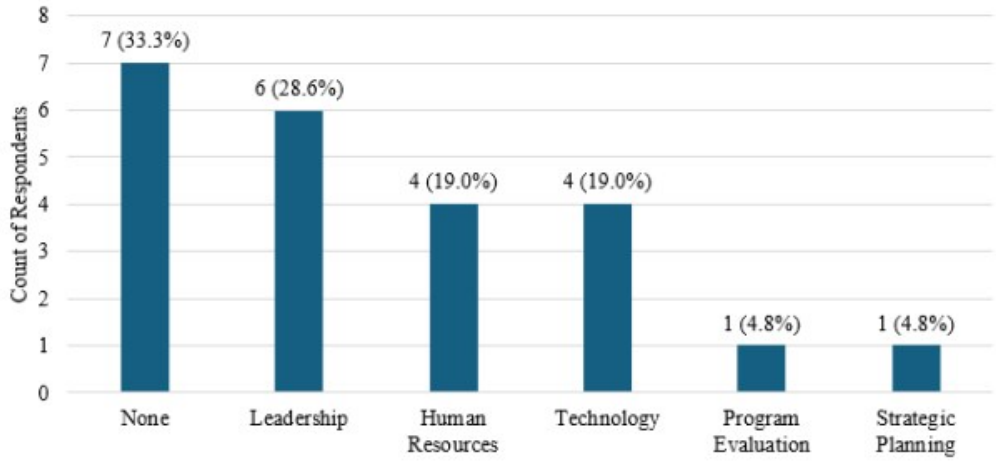
Most respondents stated social determinants of health (61.9%) as a workforce area that is the most important for Delaware's Title V MCH Program to address in the coming years. Note that the other workforce areas were generally selected at similar counts (Table 2).

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%)

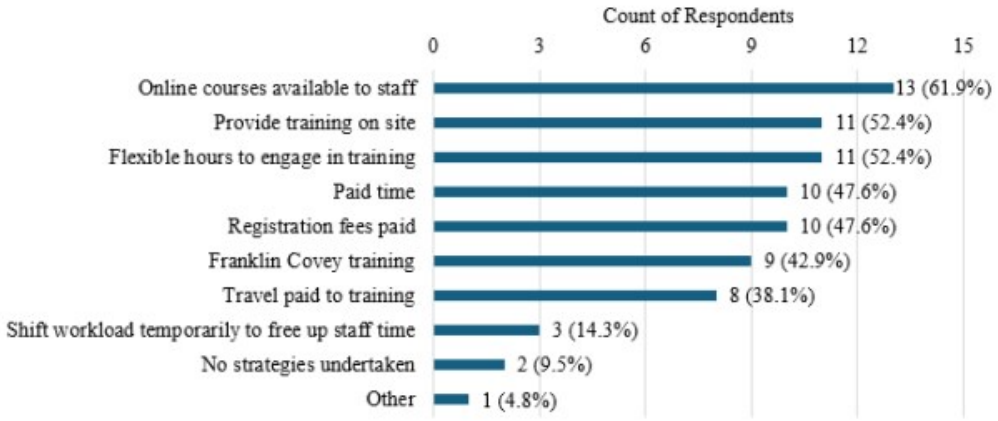
In the Workforce Capacity Survey, when asked on what content areas the respondents personally think would be beneficial to them for a training session, one-third of respondents did not have a specific area and a little of a quarter (28.6 percent) stated leadership (Figure 3).

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



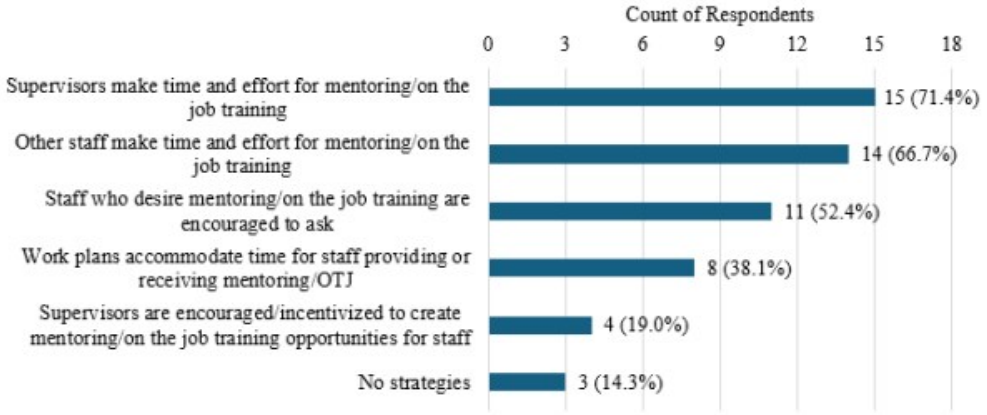
As shown in Figure 4, most respondents said that online courses (61.9%), onsite training (52.4%), and flexible hours to engage in training (52.4%) serve as strategies their organizations uses to provide formal training/continuing education opportunities for state level program staff. Trainings involving 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) (Last Modified: FY 2027 Application/FY 2025 Annual Report)

The primary focus of the State Systems Development Initiative's (SSDI) 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 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 contractual 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.

Our Title V Director began searching for another CDC Epidemiologist position towards the end of 2023. She 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.

As a result of the 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)

In October 2024, Dr. Labgold was welcomed to Family Health Systems (FHS). 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 MCH Epidemiology Assignee to 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 our National Performance Measures (NPMs) and measurement of Evidence- Based or -Informed Strategy Measures (ESMs). She also provided early feedback on an updated Medicaid Data Use Agreement 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; and 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 provided 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 Health Babies program.

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).

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. Dr. Labgold developed a report describing the delays due to the current data sharing policies and further identified how several states of similar population size were outpacing Delaware in the timeliness and data sharing standards of hospital discharge and vital statistics data. Additionally, conversations with other state MCH epidemiologists highlighted that many states do not require a data use agreement (DUA) and if necessary, there is a standing data use agreement for core surveillance and evaluation activities. In several states, MCH epidemiologists stated that they had direct access to either or both data sources through their state Office of Vital Statistics.

To address the data gap, FHS was requesting that the vital statistics data stewards work with the FHS epidemiologists in developing a standing DUA that would allow for the MCH epidemiologist to directly extract hospital discharge records and vital statistics records through at least a 6-month delay. This includes discussion about the mutually agreeable usage of provisional vs final data sets, as well as the frequency for which a standing data use agreement should be renewed. Ultimately, the current lack of timely data sharing directly hinders FHS's

ability to effectively serve the state's MCH population and best use state-resources to meet this goal. Enhanced data access is crucial for performing the essential epidemiologic tasks.

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 no longer had the 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 contracted services to support some of our data needs and project support, the vacancy is a detriment for Delaware. In the short time we worked with Dr. Labgold, her guidance and assistance were immeasurable, and the void is felt by all in FHS.

In addition to the loss of the CDC Assignee, our Division of Public Health moved in the direction of using epidemiology staff within the division over contracting out some of our historical epidemiology support. The Division was able to repurpose current epidemiology staff and assign them to MCH, however, there is a learning curve for those staff and we are still trying to adapt. Both setbacks have caused a void in the capacity needed in our section. FHS staff have been trying to build up our MCH epi support with the DPH assigned epidemiologist, but it is taking longer than expected. The hope is to build the support and capacity with the current epi staff we have assigned to FHS to assist in supporting Title V.

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 DPH. 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, developmental 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
1.3. Support data needs associated with the annual preparation of the Title V MCH Block Grant application/annual report.
Progress Update: Our Title V Internal Steering Committee met throughout this 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 reviewed 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 prepare for the 2027 Application/2025 Annual Report, our team has reviewed the Block Grant Guidance, developed a timeline and work plan, as well as convened our Needs and Capacity Assessment Steering Committee. Our members have already identified guiding principles/frameworks and core values, obtained access to national, state, and local data sources, in addition to establishing a plan for community engagement and identified opportunities to raise awareness and share information about the Block Grant Application with partners. Delaware created Data Sheets for our Needs Assessment process, which we continue to use for our current Block Grant Application. Each was 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 relates 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 in each Health Infographic.
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
2.4. Continue to foster the relationship with securing hospital discharge data (HDD) in a timely manner.

Progress Update: Hospital Discharge Data (HDD) is maintained by the Vital Records and Health Statistics Bureau, located within DPH. FHS does not have direct access to HDD, but is able to make requests as needed, via a data request. HDD is used by FHS for a variety of projects. There currently is a lag time for the availability of data because of the cleaning and request process. At the end of each year, Health Statistics must follow up on any discrepancies identified and unfortunately, with staffing issues, this process can take longer than anticipated.

FHS does not have direct access to the HDD database. When data is needed, a request is made and needs to be approved by DPH's Privacy Board. As noted, there is a delay in receiving data. Historically, the Health Statistics Bureau has been accommodating on requests, but the lag time still exists.

Any delayed access to hospital discharge and vital statistics data hinders FHS's ability to fulfill its core public health functions of real-time surveillance to guide MCH priorities, timely program evaluation, and rapid response to emerging maternal and child health threats.

FHS values the partnerships we have developed through the years with internal and external partners. FHS will continue to foster the working relationship we currently have with the Health Statistic Bureau to maintain the critical need of MCH epidemiologists to access timely population-based data to improve the health of all mothers, children, and women of reproductive age in Delaware.

2.5. Enhance information exchange systems and data interoperability across MCH partners and stakeholders.

Progress Update: 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, our 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 provide data 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.

Over the past year, our SSDI Director has convened a workgroup within FHS to review our Memorandum of Understanding between DPH/FHS and the Division of Medicaid and Medical Assistance (DMMA). Modifications were made to an outdated MOU to ensure it accurately reflects the current partnership, obligations, and expectations of both DPH and DMMA. It provided both DMMA and DPH an opportunity to clarify the terms of the agreement and define the roles within both divisions. Our goal was to specifically update the data sharing procedures. Both agencies agreed to annually review a data sharing plan that includes each division's responsibilities, in addition to what data is requested by each party, each year. Our expectation is to make the DPH/DMMA MOU a living foundation of our working relationship. Each modification to the MOU is a chance to align our goals, embrace change, and ensure the agreement accurately reflects the exciting possibilities ahead.

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

Objectives

3.4. Support coaches who train partners, mini-grantees, and/or community members to be responsive to the changing and emerging needs of the people served in Delaware as well as individuals and communities experiencing trauma.

Progress Update: FHS is committed to supporting our partners who serve our community. In April 2026, the Delaware Healthy Mother and Infant Consortium (DHMIC)

held its 20th annual summit, where the theme was “Learning from the Past. Leading in the Present. Shaping Maternal & Child Health for the Future.” Each annual summit is sponsored by the Division of Public Health (DPH). This was a landmark event celebrating 20 years of transforming maternal and child health – and each participant discovered new ways to support emerging maternal health needs and found ways to make meaningful change. It was an exciting day of connection, collaboration, and community. 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 background.

The 2025 Home Visiting Retreat brought together partners from across Delaware’s home visiting community - including Home Visitors, Family Support Specialists, DPH leadership, and state leaders. The theme, “Stronger Systems. Stronger Families,” focused on strengthening collaboration and supporting the well-being of the workforce.

The event featured remarks highlighting the impact of home visiting across the state. Attendees also heard keynote presentations on building strong early childhood systems, and the role of trust in strengthening families and programs. In addition to learning and networking opportunities, participants enjoyed wellness and appreciation activities - including massages, professional headshots, a 360-degree photo booth, and multiple resource vendors offering tools and supports for day-to-day work. This training retreat served as a meaningful opportunity for connection, reflection, and reenergizing the statewide effort to support Delaware families through high-quality home visiting services.

3.5. Develop products (e.g., data dashboards, fact sheets, infographics, journal articles, tool kits, websites, and white papers) that enhance state MCH data capacity and facilitate informed decision-making to drive improved MCH outcomes and achieve equity.

Progress Update: In an effort of continued involvement, DPH MCH Bureau is happy to report that we have recently revised the DEThrives Title V landing page with new content and updated materials. Title V supports mothers, children, and families during each stage of life, from infancy through adulthood, and we fund work that promotes family-centered, proven methods that improve a person's health. Title V supports doctors, nurses, behavioral health clinicians, public health professionals, Community Health Workers, Home Visitors, and others - working together to care for Delawareans. Our investments and partnerships contribute to building healthy people and communities.

The newly designed Title V landing page is simple to use and easy to navigate. Our reimagined site contains information on our recently submitted 2026 Application/2024 Annual Report, FY2026 Block Grant Application Quick Reference Guide, data sheets, as well as our 2025 Five-Year Needs Assessment process, findings, and reports.

In addition to the website update, the SSDI Director also led the development of two resource graphics for our partners. The first is our State Action Plan, which is a five-year plan to address our priority needs. Our Plan addresses nine priorities that span six reporting domains. These domains include all five MCH population domains, in addition to the sixth domain that addresses state-specific Cross-cutting/Systems Building needs. MCH services in Delaware are guided by this five-year State Action Plan (2026-2030), which reflects the input and needs of partners from across the state including state agencies, MCH providers, families and consumers, and members of the public. This five-year plan aligns with MCH legislation, mission and vision, and the performance measure framework.

The second resource is our State Action Plan Snapshot. This Snapshot offers a quick, public-facing summary of Delaware's five-year Title V State Action Plan. In addition to the MCH conceptual framework and public health essential services, the Title V program depends on many strengths, translated through core values and guiding principles, to promote a strong culture of continuous quality improvement, innovation and growth, and a sustained focus on what matters.

As a complement to our State Action Plan, this Snapshot offers an at-a-glance, high-level summary for the public, our partners, our stakeholders, and Delaware families to better understand our five-year plan. This snapshot identifies the priority needs within each of the six domains, the program objectives, key strategies, and relevant national and state performance measures for addressing each objective.

Delaware's *Thrive Quarterly: Home Visiting Highlights* newsletter and blog posts were recently created for our partners to stay connected and up to date on all the exciting things happening in the Home Visiting world. The newsletter highlights training opportunities, advisory board updates, outreach opportunities, MIECHV champions, legislative updates, upcoming events, and more.

Our SSDI Director also led the update of our *Healthier Eating Physical Activity Book*. This guide shares healthy eating and physical activities for children, ages 5-11 years old. It follows the 5-2-1-0 structure. The activities are broken down into four categories - social/emotional, language/communication, cognitive, and movement/ physical development - based on developmental milestone categories.

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

4.2. Provide support for ongoing data collection needs.

Progress Update: Over this past grant cycle, FHS has reviewed our available data and compared it to our current Strategies, SPMs, and selected ESMs. Our Title V team met with partners to review Delaware's State Action Plan. We have chosen not to modify any ESMs, as they are still being implemented and base line data is just being gathered.

With regard to providing support for ongoing data collection needs, we will 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. With the help of the previous 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 supports our on-going work associated with the MCH Title V Five-Year Needs Assessment and our Block Grant application.

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 in an effort to track progress and identify persistent gaps and barriers. The SSDI Program Manager led the Title V Five-Year Needs Assessment. Our Title V team used 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. Additionally, our team aimed to incorporate stakeholder and public input into finalizing our priority areas by population domain. The Needs Assessment Steering Committee was responsible for reviewing and understanding the data, canvassing and surveying our MCH team for emerging issues and concerns they are observing from the data, and identifying priority areas of concern from the national health areas.

The MCH Bureau and SSDI Director understands the value of relationships with our partners. We will continue to nurture the developed partnerships to ensure we continue to have the needed data for Delaware's ongoing data collection and needs assessment needs.

Over the next year, our SSDI Director plans to reconvene our Title V team to review our State Action Plan based on guidance received from the MCH Evidence Center. Delaware received their annual ESM report for the 2026 Application/2024 Annual Report. Based on the report, Delaware will begin conversations and plan to use the suggestions to find ways to strengthen our ESMs by linking them to effective, science-based practices and to measure our progress in ways that tell how Delaware Title V is advancing each NPM. Each Domain Leader will work to thoroughly review the current Strategies and selected ESMs to modify or update each, according to our identified Priority Needs and Objectives. We will also work with our assigned DPH epidemiologist on ways to capture and report data for each selected ESM. Our goal is to strengthen Delaware's State Action Plan, which will improve the health of mothers and children in Delaware.

Lastly, the SSDI program is instrumental in providing data support by funding a portion of the costs for our National Birth Defects Surveillance Registry contract.

During Fiscal Year 2026, a portion of the SSDI grant has been used to support the SSDI Project Director to attend the 2026 Association of Maternal and Child Health Programs (AMCHP) Annual Conference, 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. The SSDI Director's role is responsible for representing the Title V program population domain of Workforce Development, a State Performance Measure within the Cross-Cutting/Systems Building Health Domain.

III.C.1.b.ii.e. Other Data Capacity (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Delaware's Title V data capacity efforts have historically been funded by sources other than the State Systems Development Initiative (SSDI), which has supported up-to-date maternal and child Health (MCH) data and

information systems. Delaware's MCH Block Grant has been complimented by other funding sources within the Family Health Systems (FHS) section that has increased 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, innovation, and support the general 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) FHS section has historically solicited services in the area of maternal, child, adolescent, children and youth with special health care needs, epidemiology, research, and evaluation. It is the intention of FHS to integrate data and epidemiology into research and evaluation of programs and activities.

As of June 1st, 2025, FHS lost the support of the CDC Assigned MCH Epidemiologist, Katie Labgold, PhD, MPH, due to the Department of Health and Human Services reduction in force action. FHS lost the ability to provide technical and epidemiology capacity building support for Delaware. In addition to this loss, leadership within DPH moved in the direction of using local epidemiology capacity already employed in other sections of the division, instead of contracting any additional outside epidemiology support. Unfortunately, this has left an immeasurable void in our epi capacity. FHS leadership is attempting to build our MCH epi support with the assigned DPH epidemiologist, but the process is taking longer than anticipated.

Other key components of our MCH epidemiological and data enhancement activities support some of our Title V program and activities. FHS is committed to pursuing consistent, high-quality support in research, epidemiology and program evaluation for our section and its associated programs. Both Children and Families First (CFF) and Health Management Associates (HMA) serve as our epidemiology, research, and evaluation (ERE) contractors. 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 services also aim to improve access to and use of information in addition to translating information into an easily understandable format 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, and social distal factors report. HMA 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 services with CFF and HMA designs and implements program evaluation to measure whether program goals are met, and activities are effective. This may include process evaluation but primarily focuses 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, 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 CYSHCN activities.

The CFF team continues to work with the Child Health and Development Interactive System (CHADIS) team to develop a 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, CFF has partnered with KIDS COUNT in Delaware to determine how to integrate Help Me Grow (HMG) system data within KIDS COUNT local and national data. In addition, our ERE continues to work with HMG Delaware's core team to bridge gaps within the four components that underlie the HMG system through continuous quality improvement measures. CFF also leads the Data and Surveillance sub-committee of the HMG 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.

The ERE contracted services provide expertise with respect to all phases of statistical interpretation related to family health epidemiologic topics. This includes analyzing 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.

Moreover, HMA staff works intently with the Delaware Perinatal Quality Collaborative (DPQC) to conduct extensive epidemiological and quality improvement work to identify, monitor, and address factors contributing to maternal and infant morbidity and mortality across Delaware. Using statewide surveillance data, hospital-level clinical quality indicators, birth certificate records, fetal and infant mortality review findings, Medicaid data, and maternal health outcome measures, HMA and the DPQC have analyzed trends in severe maternal morbidity, obstetric hemorrhage, hypertensive disorders of pregnancy, substance use during pregnancy, neonatal abstinence syndrome, preterm birth, and infant mortality. Epidemiological analyses have been used to identify variations in care, assess adherence to evidence-based clinical practices, monitor maternal and infant health indicators, and guide implementation of targeted interventions such as AIM patient safety bundles, birth spacing initiatives, postpartum care improvement efforts, and strategies to reduce disparities in maternal and infant outcomes. These data-driven activities enable Delaware healthcare providers and policymakers to make informed decisions, prioritize resources, evaluate intervention effectiveness, and advance the overall quality of perinatal care throughout the state.

Lastly, our contracted services also require CFF and HMA to analyze and prepare reports to communicate research and surveillance trends to various audiences outside of DPH. 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)
- 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

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. 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.

Within My Healthy Community, 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.

DPH 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, such as 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.

Data on behaviors in Delaware are gathered through the Behavioral Risk Factor Surveillance System (BRFSS). 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 DPH 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. 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 are 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 information is shown.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 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 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 (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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)

Within the Children and Youth with Special Health Care Needs (CYSHCN) system, a key partner is the Center for Disabilities Studies (CDS) at the University of Delaware, which provides statewide family engagement, leadership development, and systems-building activities through its contract with the Delaware Division of Public Health. CDS serves as the administrative home for Family SHADE (Support and Healthcare Alliance Delaware), a statewide collaborative group of family leaders and organizations dedicated to improving support, services, and systems for children and youth with disabilities and chronic health conditions and their families. Family SHADE includes Delaware Family Voices and the Family-to-Family Health Information Center, ensuring families have access to peer support, education, navigation assistance, and opportunities to influence systems of care.

CDS offers multiple opportunities for parents and caregivers to engage as partners in improving programs and services for CYSHCN. Through the Family Leadership Network, parents and guardians of children and youth from birth through age 26 with suspected or diagnosed disabilities participate in leadership development training, monthly learning community sessions, peer networking, and receive support related to Individualized Education Programs (IEPs), service navigation, and referrals to community resources. Participants receive monthly stipends to recognize their time and contributions.

The Family Leadership Network utilizes the Parents as Collaborative Leaders curriculum to strengthen families' leadership skills and prepare them to serve as effective partners in systems improvement efforts. Training topics include defining parent leadership, effective communication, active listening, asking clarifying questions, the critical elements of collaboration, and strategies for leading productive meetings. CDS also employs staff with lived experience as parents and caregivers of children with disabilities and special health care needs, ensuring that family perspectives are embedded throughout program planning, implementation, and evaluation.
Family SHADE has evolved into a statewide initiative focused on strengthening organizations that serve CYSHCN and their families through competitive mini-grants, targeted technical assistance, and peer learning opportunities. Family SHADE convenes learning communities that bring together community organizations to share promising practices, build partnerships, and address emerging issues affecting families. Previous learning community topics have included newborn screening, fetal alcohol spectrum disorders, developmental screening, data and evaluation, and family engagement strategies. Family SHADE also hosts statewide symposiums and educational events that promote collaboration and provide training on topics such as transition planning, care coordination, and other priorities identified by families and community partners.

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 (Last Modified: FY 2026 Application/FY 2024 Annual Report)

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

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,067,298	$2,126,787	$2,073,458	$2,123,731
State Funds	$9,783,792	$9,783,792	$10,016,039	$10,008,609
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$2,659,797	$2,659,797
Program Funds	$2,580,255	$2,580,255	$0	$0
SubTotal	$14,431,345	$14,490,834	$14,749,294	$14,792,137
Other Federal Funds	$8,200,541	$5,849,820	$7,166,969	$6,064,837
Total	$22,631,886	$20,340,654	$21,916,263	$20,856,974

	2025		2026	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,126,787	$2,104,888	$2,123,731	
State Funds	$10,148,719	$10,425,098	$10,425,098	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$3,456,508	
Program Funds	$2,761,872	$2,761,872	$0	
SubTotal	$15,037,378	$15,291,858	$16,005,337	
Other Federal Funds	$5,879,035	$6,313,151	$7,166,969	
Total	$20,916,413	$21,605,009	$23,172,306	

	2027	
	Budgeted	Expended
Federal Allocation	$2,104,488	
State Funds	$9,912,592	
Local Funds	$0	
Other Funds	$3,954,663	
Program Funds	$0	
SubTotal	$15,971,743	
Other Federal Funds	$6,664,056	
Total	$22,635,799	

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.

III.D.2. Budget (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 $14,409,761
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.

FY27 Budget – Federal Title V Funds

Personnel Costs **$1,294,547**

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 $567,659

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 $10,000

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

FY 27 TOTAL BUDGET $2,104,488

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 $14,409,761 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 2027 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 2027 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 FY2027 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

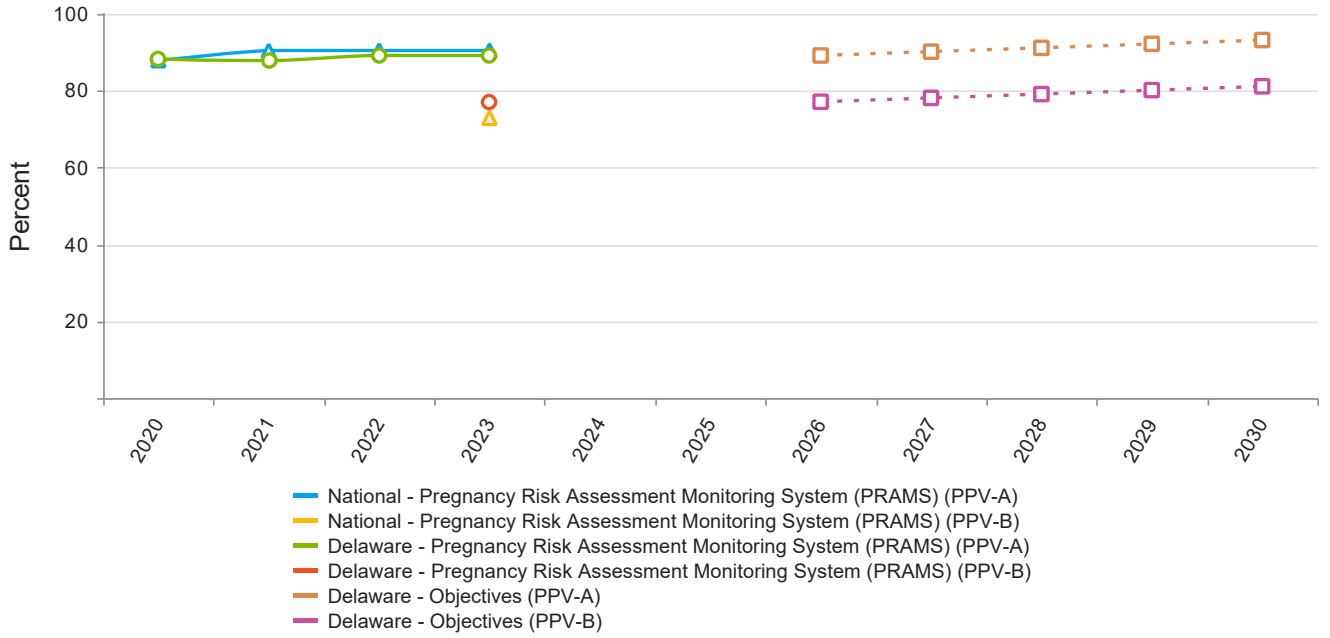
III.E.3 State Action Plan Narrative by Domain

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**	**2025**
Annual Objective			
Annual Indicator	89.0	88.9	88.9
Numerator	8,744	8,290	8,290
Denominator	9,828	9,324	9,324
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	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**	**2025**
Annual Objective			
Annual Indicator	81.5	76.8	76.8
Numerator	7,046	6,240	6,240
Denominator	8,649	8,125	8,125
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	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

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		97.1
Numerator		538
Denominator		554
Data Source		HWHB Program Data
Data Source Year		2025
Provisional or Final ?		Final

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

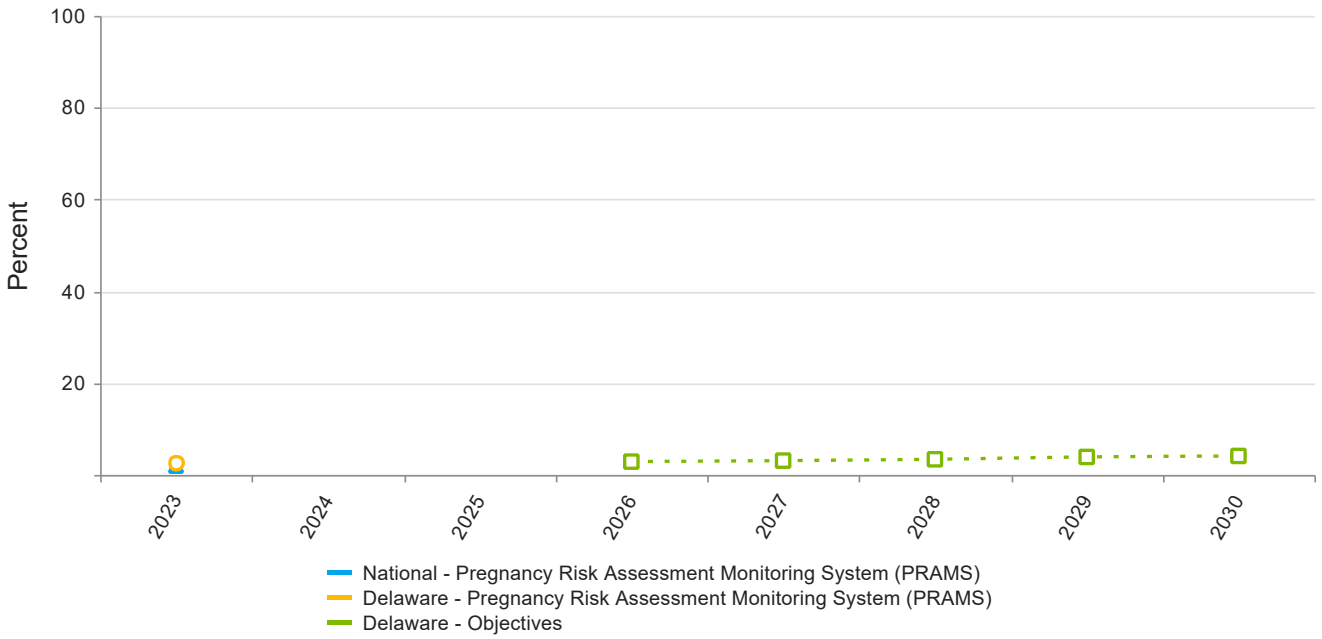
ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator	70.7	79.4
Numerator	29	50
Denominator	41	63
Data Source	MIECHV Program Data	MIECHV Program Data
Data Source Year	2024	2025
Provisional or Final ?	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	**2025**
Annual Objective		
Annual Indicator	2.8	2.8
Numerator	262	262
Denominator	9,283	9,283
Data Source	PRAMS	PRAMS
Data Source Year	2023	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.

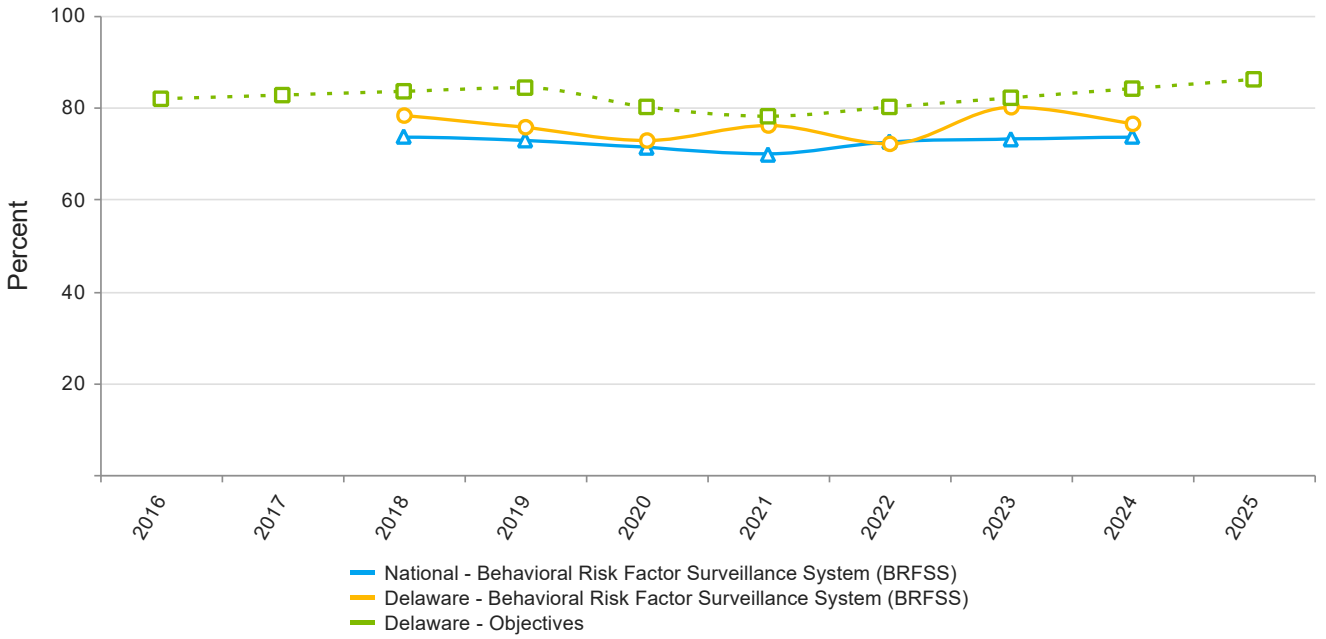
ESMs	Status
ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-delivered with women and communities most impacted by negative maternal healthcare outcomes. (i	Active

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	78	80.0	82	84	86
Annual Indicator	72.8	75.9	71.9	80.1	76.4
Numerator	117,625	125,530	116,483	135,447	132,056
Denominator	161,675	165,284	161,938	169,192	172,801
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2020	2021	2022	2023	2024

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	17,250	8,500	9,000	9,500	10,000
Annual Indicator	8,015	8,109	9,937	10,618	10,797
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning
Data Source Year	2021	2022	2023	2024	2025
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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	90	86	88	90	92
Annual Indicator	84.2	86.1	89	92.4	75.5
Numerator		6,335	5,920	8,848	9,500
Denominator		7,354	6,655	9,574	12,585
Data Source	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB PISQ Data
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Final	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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	63	60	65	70	75
Annual Indicator	53.1	58.6	58.6	65.9	42.7
Numerator				2,618	1,723
Denominator				3,971	4,035
Data Source	PRAMS data	PRAMS data	PRAMS data	PRAMS data	PRAMS Data
Data Source Year	2020	2021	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Final	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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	28	27	26	25	24
Annual Indicator	45	42.8	42.8	38.9	25.6
Numerator				3,890	2,472
Denominator				9,999	9,671
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	PRAMS Data
Data Source Year	2020	2021	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Final	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.**

Women's and Maternal Health

Improving the health of women before, during, and between pregnancies remains a priority for Delaware's Title V Maternal and Child Health (MCH) Program. Delaware continues to advance a life-course approach to women's health by increasing access to preventive well-woman care, strengthening preconception and interconception health, improving prenatal and postpartum care, and addressing the clinical and social factors that contribute to maternal and infant morbidity and mortality. Through collaborative partnerships and evidence-based strategies, the Division of Public Health (DPH) is working to improve health outcomes, reduce disparities, and ensure women and families have access to coordinated, high-quality, and culturally responsive care.

The Delaware Healthy Mother and Infant Consortium (DHMIC) serves as the state's collective impact organization for maternal and infant health, bringing together leaders from public health, healthcare, Medicaid, community-based organizations, academia, policymakers, and individuals with lived experience to improve maternal and infant outcomes. Guided by its Five-Year Strategic Plan, DHMIC provides statewide leadership to advance maternal health policy, strengthen cross-sector partnerships, improve healthcare quality, and address the social drivers of health that influence pregnancy and birth outcomes.

During the reporting period, DPH continued to support implementation of the DHMIC Strategic Plan by working collaboratively with DHMIC leadership, appointed members, and committee infrastructure to advance priority initiatives aligned with Delaware's Title V priorities and maternal health goals. Strategic efforts focused on strengthening governance, increasing member engagement, enhancing cross-sector collaboration, and advancing systems-level initiatives that improve maternal health outcomes and reduce disparities.
DHMIC's work continues to be guided by three long-term aspirational goals:

1. Eliminate racial and ethnic disparities in maternal and infant mortality.
2. Reduce Delaware's preterm birth rate through implementation of evidence-based clinical and community strategies.
3. Develop and sustain innovative models of care that improve maternal health, address health-related social needs, and promote birth outcomes.

Staff within the Division of Public Health's Family Health Systems Section provide operational and programmatic support for DHMIC and its committees, facilitating implementation of strategic priorities, coordinating statewide initiatives, supporting policy development, and fostering collaboration among healthcare providers, community organizations, state agencies, and families with lived experience.

Well Woman and Black Maternal Health Committee

The Well Woman and Black Maternal Health Committee continues to advance a comprehensive, evidence-based approach to improving the health of women across the reproductive life course. The committee promotes access to preventive well-woman care, reproductive life planning, preconception health, prenatal and postpartum services, behavioral health, and respectful maternity care while working to eliminate persistent racial and ethnic disparities in maternal morbidity and mortality.

Through collaboration with healthcare providers, community organizations, consumers, and public health partners, the committee supports initiatives that strengthen patient-centered care, elevate the voices of women and families, promote culturally responsive healthcare, and increase awareness of maternal health resources. Recent priorities have included implementation of Her Story 2.0, expansion of the statewide Maternal Health Resource Map, promotion of maternal health warning signs education, integration of behavioral health and Community Health Workers into maternal care, and support for policy and quality improvement initiatives that improve access to care before, during, and between pregnancies.

HER Story 2.0: Elevating Voices to Improve Maternal and Child Health Outcomes

HER Story 2.0 is a maternal and child health storytelling and community engagement initiative designed to elevate the voices, experiences, and perspectives of women across the reproductive life course, including before pregnancy, during pregnancy, postpartum, and between pregnancies. Building upon the success of the original HER Story

project, HER Story 2.0 creates a platform for women to share their journeys, celebrate the joys of motherhood, discuss challenges encountered within healthcare systems, and offer advice to other women on self-advocacy, navigating care, and accessing support services.

The project recognizes that lived experience is a powerful tool for education, awareness, and systems change. Through personal testimonials and storytelling, participants highlight factors that contributed to positive experiences, identify barriers to care, and provide insights into opportunities for improving maternal health outcomes. The initiative places particular emphasis on amplifying the voices of women from populations disproportionately impacted by adverse maternal and infant health outcomes, helping to inform policy, practice, and community-based interventions. A distinguishing feature of HER Story 2.0 is the intentional inclusion of fathers, partners, and support persons. The project acknowledges the critical role that partners play in maternal, infant, and family health. Through interviews and testimonials, fathers and partners share their perspectives on pregnancy, childbirth, postpartum experiences, and caregiving. These narratives explore the importance of partner engagement, advocacy, communication, and emotional support, while highlighting how family-centered approaches can contribute to healthier outcomes for mothers and infants.

HER Story 2.0 aligns with Title V Maternal and Child Health priorities by promoting patient-centered care, advancing optimal health for all, strengthening family engagement, and elevating consumer voices in maternal health improvement efforts. The project serves as both an educational resource and a catalyst for dialogue among healthcare providers, policymakers, community organizations, and families. By centering authentic experiences, HER Story 2.0 seeks to foster greater understanding of maternal health challenges and successes, empower women and families to advocate for their needs, and support the development of responsive systems of care that improve outcomes for women, infants, and families across Delaware.

Through storytelling, HER Story 2.0 reinforces a core message: every woman's experience matters, every family's voice deserves to be heard, and meaningful improvements in maternal and child health begin by listening to those most directly impacted.

DHMIC Data Committee and Maternal Health Task Force

The DHMIC Data Committee serves as Delaware's primary maternal health data and analytics workgroup, providing leadership for data-driven decision-making, quality improvement, and performance measurement across the maternal and child health system. Working in close collaboration with the DHMIC Maternal Health Task Force, the committee supports statewide efforts to improve maternal health outcomes through enhanced data integration, surveillance, and evaluation.

The committee brings together representatives from public health, Medicaid, healthcare systems, academia, community organizations, and maternal health programs to strengthen Delaware's maternal health data infrastructure and improve the collection, analysis, interpretation, and dissemination of maternal health information. Priority areas include monitoring well-woman visits (National Performance Measure 1), postpartum care (National Performance Measure 4), respectful maternity care, maternal morbidity and mortality, and health issues.

During the reporting period, the committee expanded efforts to integrate data from Medicaid, HEDIS, the Pregnancy Risk Assessment Monitoring System (PRAMS), Healthy Women Healthy Babies, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Federally Qualified Health Centers, the Delaware Perinatal Quality Collaborative (DPQC), and other statewide data systems to provide a more comprehensive understanding of maternal health outcomes and healthcare utilization.
Recognizing the importance of combining quantitative and qualitative information, the committee also advanced strategies to incorporate lived experiences and patient perspectives into maternal health monitoring through initiatives such as Her Story 2.0. In addition, the committee is developing public-facing dashboards, infographics, and other data visualization tools to improve communication of maternal health indicators, disparities, and progress toward statewide goals.

Under the leadership of Chair Dr. Alethea Miller and Vice Chair Dr. Linsey Ashkenase, the committee refined its mission and strategic direction to strengthen Delaware's maternal health data ecosystem and support evidence-based policy, program development, and continuous quality improvement.

Education, Public Awareness, and Community Engagement
Education and community engagement remain foundational components of Delaware's maternal health strategy. Through the DEThrives initiative and in partnership with Aloysius Butler & Clark (AB&C), the Division of Public Health continues to implement statewide communications campaigns that promote well-woman care, preconception health, respectful maternity care, postpartum care, and available maternal health resources.

Using a multi-platform communications strategy that includes videos, social media, blogs, podcasts, digital storytelling, and educational campaigns, DEThrives reaches women, families, healthcare providers, and community partners with culturally responsive messaging that promotes healthy behaviors and increases awareness of available services. Messaging continues to reinforce the statewide theme, "Health Begins Where You Live, Learn, Work & Play," recognizing that health is influenced not only by healthcare, but also by the environments where people live, work, learn, worship, and raise their families.

Recent communications efforts have expanded to include Her Story 2.0, promotion of the Maternal Health Resource Map, maternal health warning signs education, annual DHMIC Summit highlights, Black Maternal Health Week activities, and awareness campaigns supporting preventive care before, during, and between pregnancies. These coordinated outreach efforts strengthen public awareness, empower women and families to advocate for their health, and connect communities with the resources needed to improve maternal and infant outcomes across Delaware.

Delaware Healthy Women and Infant Consortium (DHMIC) 20th Annual Summit. On April 13th, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 20th annual summit to celebrate and share the successes of the work that has been done in the last twenty years addressing the infant and maternal mortality rates and how those rates can continue to improve in 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 *Learning from the Past. Leading in the Present. Shaping Maternal & Child Health for the Future.*

This year, the summit sold out with 383 Eventbrite registrations, with 300 in-person attendees (the venue's maximum capacity is 350), which included about 12 walk-ins, 25 speakers for the event, and 44 people who represented the innovation stations or vendor tables. 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.

The day started with 206 attendees participating in the networking session (all checked in before 8:45 a.m.) where there were 20 different innovation stations, organized by four different categories depending on the services each organization offered: 1) public health and community resources, 2) infant nutrition, lactation, and fetal health, 3) child development and home visiting, and 4) maternal health and postpartum support.

The emcee for the event, Ivan Thomas, Founder and CEO of DETV, kicked off the summit with a four-piece brass brand to tie into the celebratory feel of the day. DHMIC Chair, Priscilla Mpasi, MD, FAAP, DHMIC Vice-Chair, Tiffany Chalk, CMP, and Lt. Governor Kyle Evans Gay 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, Senator Marie Pinkney, a DHMIC appointed member, and Representative Kamela Smith, presented the Black Maternal Health Awareness Resolution in the morning. Christen Linke Young, DHSS' Cabinet Secretary, also made an appearance in the afternoon thanking the community for their continued work in the maternal and child health space. There was a total of 25 speakers throughout the day, which were comprised of dignitaries, past and present DHMIC leadership, one keynote speaker, and two different breakout sessions, ranging from topics that included elevating patient voices in health care advocacy, innovations in Medicaid, the fourth trimester, hearing from the March of Dimes' Chief Medical and Health Officer, Dr. Michael Warren, who shared what the Maternal and Child Health Bureau Directors from neighboring states such as New Jersey, Virigina, Maryland, Pennsylvania, and West Viriginia are doing in their states, and how the DHMIC's work has transformed over the past 20 years.

Many information sharing strategies were available during the Summit such as providing ten different 3 foot by 6-foot-tall milestone gallery boards that told the DHMIC's story from inception until now, including highlights of what happened during certain years, changes of statistics, and pictures of the community members who have helped contribute to the work. An interactive Roadmap themed activity was offered to attendees to encourage group discussions and education with the innovation stations, and an interactive photobooth was offered which printed out

a picture and allowed attendees to contribute to creating a mosaic wall that created one large picture at the end of the event.

DEThrives social media published about 19 posts/stories during the event which earned more than a total of 410 engagements (likes, comments, shares, tagging, clicks) on DEThrives social media channels (Facebook and Instagram), earned over 6K impressions (number of times a post has been displayed) which is over double from last year's impressions, 481 video views (over a 100 video view increase from last year's number), a 6.4% engagement rate (how often users stay and interact with the content), and DEThrives received about 34 shared posts/stories from attendees who tagged DEThrives using the hashtags #DHMICSummit26 and #DEThrives which continues to earn high engagement rates on DEThrives' Instagram and Facebook pages. For comparison numbers, annual DHMIC Summit posts receive a range of about 10 to 190 engagements each, compared to regular non promoted DEThrives posts that earn an average of 10 to 25 engagements each.

Dr. Marshala Lee-McCall, a DHMIC appointed member, presented the annual Kitty Esterly, MD, Health Equity 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. Cassandra Codes Benjamin, MPA, Director of School Support Services for the Delaware Department of Education, received the outstanding individual award. The organization award was awarded to the Children and Families First (CFF) of Delaware. The announcement of these awards on DEThrives' Facebook was a top post earning 190 engagements, 61 post reactions, 5 comments, and 1 share.

News of the 20th DHMIC annual Summit were shared on 28 local and regional news media placements which was secured on 6 different media outlets such as WDEL, 6AB WPVI, Delaware Public Media, where the DHMIC Chair, Priscilla Mpasi, MD, FAAP, and Leah A. Jones, MPA, Section Chief, Family Health Systems, DHSS were interviewed. This resulted in an estimated 1.9 million impressions with an advertising equivalency of $19.5K.

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. 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.

Delaware's efforts to reduce maternal and infant mortality and morbidity are spearheaded by the Center for Family Health Research and Epidemiology, which is housed within the Family Health Systems (FHS) Section. FHS is led by the Title V/Maternal and Child Health (MCH) Director, while program operations are monitored by the Bureau Chief for the Center for Family Health Research and Epidemiology. This integrated leadership structure ensures that epidemiology, surveillance, maternal and child health programming, quality improvement, and policy development are closely aligned to advance statewide MCH priorities. These efforts are a cornerstone of Delaware's Title V federal-state partnership and are further strengthened by approximately $4.2 million in annual state funding appropriated to the Division of Public Health to support evidence-based strategies for the prevention of infant mortality. Together, these federal and state investments provide the foundation for a coordinated, data-driven approach to improving maternal and infant health outcomes, reducing disparities, and advancing optimal health across Delaware.

The Delaware Healthy Mother and Infant Consortium (DHMIC) has undertaken a comprehensive initiative to improve the health of women by applying a Life Course approach to better understand and address the factors that contribute to disparities in maternal and infant health outcomes. This approach recognizes that health is influenced by experiences across the lifespan and guides collaborative strategies to address the longstanding and persistent disparities in maternal and infant mortality experienced by Black mothers and infants compared with their White counterparts 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.

Maternal and Child Death Review: Informing Systems Improvement
The Delaware Title V Maternal and Child Health (MCH) Program maintains a strong partnership with the Maternal and Child Death Review Commission (MCDRC) to ensure that maternal, fetal, infant, and child death review findings are translated into meaningful policy, programmatic, and clinical improvements. The Commission, housed within the Delaware Administrative Office of the Courts, provides multidisciplinary surveillance and review that strengthens Delaware's efforts to prevent maternal and infant deaths and improve the health of women before, during, and between pregnancies.

The Maternal and Child Death Review Commission brings together experts from obstetrics, pediatrics, nursing, behavioral health, public health, Medicaid, social work, child welfare, education, emergency medicine, forensic pathology, law enforcement, and community organizations to conduct comprehensive reviews of maternal, fetal, infant, and child deaths. Through this multidisciplinary approach, the Commission identifies preventable factors, develops recommendations, and informs statewide quality improvement efforts that strengthen systems of care for women, infants, children, and families. The Maternal and Child Death Review Commission works closely with the Delaware Healthy Mother and Infant Consortium (DHMIC), the Delaware Perinatal Quality Collaborative (DPQC), and other statewide partners to improve maternal and infant health through policy development, quality improvement, provider education, and community engagement.

The Division of Public Health continues to strengthen Delaware's maternal and child death review infrastructure through multiple federal initiatives. Delaware co-leads two Centers for Disease Control and Prevention (CDC) cooperative agreements supporting the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registries, improving surveillance and prevention of sudden unexpected deaths among infants and children. In addition, the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE-MM) cooperative agreement supports dedicated maternal mortality review staff.

Findings from Delaware's maternal and child death reviews continue to demonstrate the complex interaction between clinical conditions, behavioral health, and health-related social needs. Women who experience stillbirth or infant loss, particularly following preterm birth, frequently face multiple pregnancy-related medical complications, behavioral health conditions, and significant social challenges. Delaware data indicate that approximately 40% of women experiencing these losses had a pre-existing mental health condition, while approximately one-third experienced postpartum mental health symptoms following the loss. Additional factors—including housing instability, financial hardship, intimate partner violence, trauma, and other adverse life experiences—often compound the emotional and physical impact of pregnancy loss and create barriers to recovery and ongoing healthcare engagement.
These findings continue to inform Delaware's maternal health strategy by reinforcing the need for integrated behavioral health services, comprehensive care coordination, trauma-informed care, bereavement support, Community Health Worker engagement, and stronger linkages between healthcare providers and community-based services. Lessons learned through the Maternal and Child Death Review Commission have directly influenced statewide initiatives, including implementation of the Healthy Women Healthy Babies (HWHB) 3.0 model, expansion of maternal mental health and substance use disorder services, Community Health Worker programs, Medicaid innovations, the Maternal Health Warning Signs Initiative, and quality improvement efforts led by the Delaware Perinatal Quality Collaborative.

The Delaware Maternal Mortality Review (MMR) Committee, operating under the Maternal and Child Death Review Commission (MCDRC), continues to serve as a cornerstone of Delaware's maternal health quality improvement infrastructure. Through comprehensive multidisciplinary case reviews, the Committee identifies contributing factors associated with maternal deaths and develops evidence-based recommendations that inform statewide policy, clinical practice, and systems improvement initiatives.

The recently published 10-Year Retrospective of Maternal Mortality Review (2015–2024) demonstrates the evolution

and maturation of Delaware's maternal mortality review process. During this period, the Committee completed comprehensive reviews of 75 pregnancy-associated maternal deaths, creating one of Delaware's most robust sources of maternal health surveillance data. Improvements in case identification, multidisciplinary review processes, and data collection have strengthened the state's ability to identify preventable deaths, understand contributing factors, and implement targeted interventions to improve maternal outcomes.

The ten-year review found that the majority of pregnancy-associated deaths were determined to be preventable, emphasizing opportunities to strengthen healthcare delivery, care coordination, behavioral health services, and community supports. Similar to national findings, substance use disorder and overdose emerged as leading contributors to maternal mortality, frequently occurring alongside serious mental health conditions and health-related social needs, including housing instability, intimate partner violence, and trauma. The review also demonstrated that maternal deaths most often occurred during the late postpartum period, reinforcing the need to extend coordinated care and support well beyond delivery and throughout the first year following pregnancy.
The retrospective also highlighted that maternal deaths are rarely attributable to a single factor. Instead, deaths often result from the interaction of clinical conditions, behavioral health challenges, social drivers of health, and barriers to accessing timely, coordinated care. These findings reinforce Delaware's commitment to implementing multidisciplinary, whole-person approaches that integrate obstetric care, behavioral health, substance use disorder treatment, care coordination, and community-based supports.

Recommendations from the Maternal Mortality Review Committee continue to guide statewide quality improvement efforts and have informed numerous maternal health initiatives, including expansion of Medicaid postpartum coverage, implementation of the Healthy Women Healthy Babies (HWHB) 3.0 model, Community Health Worker care coordination, innovative Medicaid Section 1115 waiver initiatives, enhanced behavioral health integration, contingency management for pregnant and parenting people with substance use disorders, the Healthy Women Healthy Babies Housing Pilot, and quality improvement initiatives led through the Delaware Perinatal Quality Collaborative (DPQC). Together, these coordinated investments reflect Delaware's commitment to addressing both the clinical and social factors contributing to preventable maternal deaths and advancing maternal health outcomes.

Maternal Health Warning Signs Initiative
Findings from the Maternal Mortality Review Committee also informed development of Delaware's Maternal Health Warning Signs Toolkit, a collaborative initiative of the Division of Public Health, the Maternal and Child Death Review Commission, the Delaware Perinatal Quality Collaborative, and the Delaware Healthy Mother and Infant Consortium. The toolkit provides multilingual educational materials for patients, families, and healthcare providers—including posters, flyers, provider letters, and tear-off prescription pads—to improve recognition of urgent maternal warning signs during pregnancy and the postpartum period. Resources are available in English, Spanish, and Haitian Creole through healthcare providers, birthing hospitals, community organizations, and DEThrives, helping women and families recognize symptoms requiring immediate medical attention and promoting timely access to life-saving care.

Partnership Between the Title V Maternal and Child Health Program and the Division of Medicaid and Medical Assistance (DMMA)
The Delaware Title V Maternal and Child Health (MCH) Program continued to strengthen its partnership with the Division of Medicaid and Medical Assistance (DMMA) to improve maternal health outcomes, increase access to care, and address the clinical and social needs of women across the reproductive life course. Through a formal interagency collaboration, Title V and DMMA worked together to align maternal health priorities, leverage Medicaid policy opportunities, and advance strategies that support women before, during, and after pregnancy.

As Medicaid finances approximately half of births in Delaware, collaboration between Title V and DMMA is essential to achieving statewide maternal and child health goals. During the reporting period, the partnership focused on improving access to preventive and reproductive healthcare services, increasing postpartum care utilization, reducing maternal health concerns, and addressing issues that impact maternal and infant outcomes.

Title V and DMMA collaborated on the advancement of key maternal health initiatives supported through Medicaid

policy and Delaware's Section 1115 Demonstration Waiver. These efforts included support for extended postpartum Medicaid coverage through 12 months after delivery, expansion of Medicaid-covered doula services, enhanced lactation supports, transportation assistance, nutrition services, and innovative approaches to addressing behavioral health and substance use disorders among pregnant and postpartum individuals.

The partnership also supported implementation of initiatives designed to address social and structural barriers to care, recognizing that housing instability, transportation challenges, food insecurity, and behavioral health needs can significantly impact maternal health outcomes and healthcare utilization. Through participation in cross-agency workgroups, the Delaware Healthy Mother and Infant Consortium (DHMIC), the Maternal Health Task Force, and other statewide initiatives, Title V and DMMA worked together to identify gaps in services, review maternal health data, and inform policy and programmatic improvements.

In alignment with Delaware's maternal health priorities, Title V and DMMA collaborated on efforts to strengthen care coordination and improve access to services during the postpartum period. Particular emphasis was placed on supporting continuity of care, maternal mental health, substance use disorder treatment, family-centered services, and community-based supports that improve engagement in care and reduce barriers to accessing needed services.

The partnership also contributed to ongoing quality improvement and optimal health efforts through data sharing, program evaluation, and the review of maternal health indicators related to well-woman care, postpartum visits, maternal morbidity, and patient experience. These activities supported a shared commitment to reducing disparities and ensuring that women receive timely, respectful, and culturally responsive care throughout the perinatal continuum.

Through continued collaboration, the Title V MCH Program and DMMA are advancing a coordinated, whole-person approach to maternal health that integrates clinical care, community supports, and social services. These efforts directly support Title V National Performance Measures related to well-woman care and postpartum visits, while strengthening Delaware's capacity to improve maternal health outcomes and promote access to care for women and families across the state.

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 factorsof 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
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, Speaker of the Delaware House of Representatives Melissa 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. In 2025, the ad-hoc committee released a short issue brief summarizing its accomplishments and concluded, 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 pregnant mothers.
- 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. Operationalized following the legislative mandate, Delaware Medicaid covers up to three prenatal and three postpartum visits (90 minutes each), alongside full labor and delivery attendance. An additional five postpartum visits are reimbursable upon provider recommendation, backed by care coordination across all three Managed Care Organizations (MCOs). DMMA presently has 21 doulas enrolled who receive ongoing education provided by the MCOs. 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.

Delaware continues to strengthen its maternal health system through innovative Medicaid policy, evidence-based interventions, and cross-sector collaboration designed to improve maternal and infant health outcomes, address health-related social needs, and reduce disparities. Through the Diamond State Health Plan Section 1115 Demonstration Waiver, the Division of Medicaid and Medical Assistance (DMMA) implemented a comprehensive Postpartum Nutrition Benefit that aligns with national *Food Is Medicine* strategies. Eligible postpartum Medicaid beneficiaries receive up to 12 weeks of home-delivered nutritious meals, or a shelf-stable food box alternative, coupled with weekly deliveries of diapers and wipes to address food insecurity and other health-related social needs during the critical postpartum period. To support continuous quality improvement and assess program impact, DMMA has established a standardized reporting and evaluation framework with Delaware's Medicaid Managed Care Organizations to monitor utilization, participant engagement, and maternal and infant health outcomes.

Delaware also expanded access to lactation consultation and breastfeeding support through Medicaid State Plan

Amendments, enhancing reimbursement for evidence-based lactation services that improve breastfeeding initiation and duration while reducing maternal and infant health risks. Enhanced benefits include outpatient lactation consultation, virtual breastfeeding support, and 24-hour clinical resources, strengthening continuity of care throughout the postpartum period.

To improve outcomes for pregnant and parenting people affected by substance use disorders, Delaware launched an evidence-based Contingency Management Pilot under the Section 1115 Demonstration Waiver. The initiative provides structured incentives to support engagement in treatment and adherence to medications for opioid use disorder (MOUD) for pregnant and parenting individuals through 12 months postpartum. By promoting sustained recovery and treatment retention, the program aims to reduce adverse maternal and neonatal outcomes and improve long-term family well-being.

Recognizing the importance of reducing stigma and improving provider capacity, DMMA partnered with Mercer, Bowling Business Strategies, and Doing Right by Birth to implement a statewide Pregnant and Parenting People Anti-Stigma Learning Series. This initiative includes Grand Rounds and continuing education webinars led by national experts focused on birth issues, trauma-informed care, implicit bias, and evidence-based treatment for pregnant and parenting individuals with substance use disorders. Following successful implementation within Delaware's birthing hospitals, the initiative is expanding to obstetric practices and additional clinical settings to strengthen provider knowledge and promote person-centered care across the maternal health continuum.

These initiatives complement Delaware's broader maternal health strategy, which includes expansion of Medicaid postpartum coverage, implementation of doula services, enhancement of evidence-based home visiting programs, implementation of the Healthy Women Healthy Babies 3.0 model, deployment of Community Health Workers in high-risk communities, implementation of the Healthy Women Healthy Babies Housing Pilot, statewide maternal quality improvement initiatives through the Delaware Perinatal Quality Collaborative, and continued collaboration through the Delaware Healthy Mother and Infant Consortium. Together, these coordinated investments advance a comprehensive and data-driven maternal health system that supports women before, during, and between pregnancies while improving outcomes for mothers, infants, and families.

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 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.

To improve awareness of available maternal and family health services, DPH and the Delaware Perinatal Quality Collaborative have also developed a web-based Maternal Health Resource Map, providing a centralized, user-friendly platform that connects women, families, healthcare providers, and community organizations to maternal and child health resources throughout Delaware. The interactive resource map allows users to identify services before, during, and between pregnancies, including prenatal and postpartum care, behavioral health, breastfeeding support, home visiting, community health workers, nutrition assistance, transportation resources, and other community-based supports. By improving access to timely information and strengthening connections to care, the resource map helps reduce barriers to services and promotes coordinated, person-centered care across the maternal health continuum.

Evidence-Based Home Visiting
Evidence-based home visiting remains a foundational component of Delaware's maternal and early childhood system of care and continues to play a critical role in improving maternal health, promoting healthy pregnancies, strengthening parenting, and supporting healthy child development. Home visiting complements clinical care by providing individualized, family-centered services that improve maternal and infant health, strengthen parent-child relationships, promote early childhood development, and connect families to healthcare and community resources.

Since the launch of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program in 2010, Delaware has successfully competed for federal funding to build and sustain a coordinated statewide continuum of evidence-based home visiting services. As recognized during the Delaware Healthy Mother and Infant Consortium's (DHMIC) 20th Anniversary Milestones, the establishment of MIECHV marked a significant milestone in Delaware's commitment to improving maternal and infant health through prevention, early intervention, and family support.

Today, Delaware's home visiting continuum includes nationally recognized evidence-based models, including Nurse-Family Partnership (NFP), Healthy Families Delaware (Healthy Families America model), and Parents as Teachers (PAT). Together, these programs provide comprehensive prenatal education, parenting support, developmental screening, care coordination, and referrals to behavioral health, nutrition, housing, and other community resources for families living in communities disproportionately affected by poor maternal and infant outcomes.

The Delaware Home Visiting Program continues to demonstrate significant statewide reach. During 2025, Delaware's evidence-based home visiting programs served 1,426 families, supported 1,375 children, and conducted 14,136 home visits, reflecting substantial growth in family engagement and service delivery across the state. Recognizing the long-term value of home visiting, research cited by Delaware's Home Visiting Program indicates a return on investment of approximately $1.80 to $5.70 for every dollar invested, reflecting improvements in maternal and child health, school readiness, family self-sufficiency, and reductions in child maltreatment and healthcare costs. Delaware has also strengthened communication between home visiting providers and healthcare professionals through standardized referral and feedback protocols that promote continuity of care and improve coordination among obstetric, pediatric, and primary care providers.

Recommendations from the Delaware Maternal and Child Death Review Commission continue to reinforce the importance of timely referrals to evidence-based home visiting services, particularly for pregnant and postpartum women experiencing behavioral health conditions, substance use disorders, pregnancy complications, or significant social stressors. In response, the Division of Public Health continues to partner with the Division of Medicaid and Medical Assistance (DMMA) to expand the sustainability of home visiting through Medicaid reimbursement strategies and strengthen integration with Delaware's broader maternal health system.

Looking ahead, Delaware continues to strengthen its coordinated home visiting continuum through partnerships with

healthcare providers, Medicaid, Community Health Workers, Healthy Women Healthy Babies (HWHB) 3.0, and the Family Connects universal nurse home visiting model currently under exploration. These coordinated investments ensure families receive the right level of support before, during, and after pregnancy while advancing Delaware's commitment to improving maternal health, reducing disparities, and promoting healthy outcomes for women, infants, and families.

Delaware Division of Medicaid and Medical Assistance (DMMA) launched Medicaid reimbursement for evidence-based home visiting programs, and it is slowly progressing, 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 2024-2025, 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.

The Family Planning Program, housed within the Family Health Systems Section that administers Delaware's Title V Maternal and Child Health Services Block Grant, continues to support the Delaware Contraceptive Access Now (DECAN) initiative. DECAN expands access to high-quality, patient-centered contraceptive care by increasing provider capacity through clinical education, hands-on training, and implementation of evidence-based contraceptive practices. These efforts support Title V priorities by improving access to comprehensive family planning services, promoting reproductive life planning, optimizing birth spacing, and contributing to improved maternal and infant health outcomes.

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.

During the reporting period, implementation was temporarily impacted by staffing changes among key partners, scheduling conflicts with the clinical trainer, and an extended medical leave of the program coordinator. Since returning, the coordinator has successfully reestablished training activities, strengthened partnerships, and resumed implementation efforts. As a result, the program anticipates increased provider participation and an expansion of DECAN training opportunities during the upcoming year. In addition, the Family Planning Program will convene program partners in August/September to review performance data, develop quality improvement strategies, and identify opportunities to strengthen DECAN implementation and increase access to evidence-based contraceptive services statewide.

In 2025 the Delaware Family Planning program completed four full in-person DECAN training sessions across the state. 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 2026, the DECAN program will have in person trainings on September 22, 2026 and November 18, 2026. The DECAN program collaborated with the TAPP Network implement the online DECAN non-clinical training, expanding access to standardized education and strengthening the capacity of non-clinical staff to support high-quality, patient-centered care. Offering the training in an online format provides greater flexibility for staff schedules, minimizes disruptions to clinic operations, and helps address staffing challenges by allowing participants to complete the training at times that best fit their workload.

There was a total of 16 staff members in 2025 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 14 clinicians trained in Nexplanon insertions/removals and 11 clinicians trained on IUD insertion/removals. A total of 8 provider sites took part in the 2025 DECAN trainings including support staff and providers from Delaware Division of Public Health, Westside Family Healthcare, Beebe Healthcare, Tidal Health, LaRed Health Center, Bay Health, Dover Air Force Base, and PPDE.

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.

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[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.

Plans for the Coming Year

During the coming year, the Delaware Title V Maternal and Child Health Program will continue implementing a coordinated, and data-driven maternal health strategy that improves the health of women before, during, and between pregnancies while reducing maternal and infant morbidity, mortality, and persistent racial and ethnic disparities. Guided by the Delaware Healthy Mother and Infant Consortium (DHMIC) Strategic Plan, Delaware will continue strengthening collaboration among public health, Medicaid, healthcare systems, community-based organizations, academic partners, and individuals with lived experience to improve maternal and infant health outcomes statewide.

Delaware will continue expanding access to comprehensive well-woman and reproductive healthcare by promoting preventive visits, reproductive life planning, and timely postpartum care throughout the reproductive life course. The Division of Public Health (DPH) will continue partnering with the Division of Medicaid and Medical Assistance (DMMA), healthcare providers, Federally Qualified Health Centers, hospitals, and community organizations to increase access to evidence-based clinical and community services while addressing barriers related to transportation, housing, behavioral health, nutrition, and other health-related social needs.

Implementation of the Healthy Women Healthy Babies (HWHB) 3.0 model will continue to be a priority. DPH will refine the model by strengthening value-based performance measures, integrating behavioral health and substance use disorder services, expanding Community Health Worker care coordination, incorporating fourth trimester quality measures, and enhancing referral pathways to evidence-based home visiting, housing, nutrition, and other supportive services. Evaluation activities will continue to measure the effectiveness of HWHB 3.0 and other maternal health interventions in improving maternal health outcomes and reducing disparities.

Delaware will continue working with DMMA to advance innovative Medicaid policies that improve maternal health, including ongoing implementation and evaluation of the postpartum nutrition benefit, Medicaid doula services, enhanced lactation consultation and breastfeeding supports, contingency management services for pregnant and parenting people with substance use disorders, and other initiatives authorized through the Section 1115 Demonstration Waiver and Medicaid State Plan Amendments. DPH and DMMA will continue monitoring performance measures and evaluating outcomes to inform future policy and program improvements.

The Delaware Healthy Mother and Infant Consortium will continue implementing its Five-Year Strategic Plan by strengthening governance, increasing member engagement, expanding public-private partnerships, and enhancing accountability through performance dashboards and data-informed decision-making. The annual DHMIC Summit will continue to serve as Delaware's statewide maternal health convening, highlighting progress, sharing best practices, promoting policy and quality improvement initiatives, and identifying emerging priorities to improve maternal and infant health.

DPH will finalize and produce Her Story 2.0 video vignettes and promote them to elevate the voices and lived experiences of women, fathers, partners, and families. These stories will continue to inform policy development, quality improvement, provider education, and public awareness while promoting respectful maternity care and improving the patient experience throughout pregnancy and the postpartum period.

Delaware will continue refining and enhancing the Maternal Health Resource Map to improve statewide access to maternal health, behavioral health, home visiting, nutrition, housing, breastfeeding, and community resources. The interactive platform will continue serving women, families, healthcare providers, Community Health Workers, and community organizations by strengthening referral networks and improving navigation to services before, during, and between pregnancies.

Building upon recommendations from the Maternal and Child Death Review Commission and Delaware's 10-Year Maternal Mortality Review, DPH will continue implementing strategies to strengthen maternal mental health, substance use disorder treatment, harm reduction, trauma-informed care, and postpartum care coordination.

The Division will continue collaborating with the Delaware Perinatal Quality Collaborative (DPQC), DHMIC, healthcare providers, and community organizations to implement maternal quality improvement initiatives, expand dissemination of the Maternal Health Warning Signs Toolkit, and improve recognition and response to obstetric emergencies through initiatives such as the Blue Band Initiative.

Delaware will continue strengthening its statewide continuum of evidence-based home visiting services through Nurse-Family Partnership, Healthy Families Delaware (Healthy Families America), and Parents as Teachers. DPH will continue partnering with DMMA to explore sustainable financing strategies for evidence-based home visiting and

evaluate opportunities to implement the Family Connects universal nurse home visiting model to complement Delaware's existing targeted home visiting system. These efforts will strengthen early engagement with families, improve care coordination, and promote healthy pregnancies, positive parenting, and optimal early childhood development.
Recognizing the importance of data-informed decision-making, DPH will continue strengthening Delaware's maternal health data infrastructure by expanding data integration across Medicaid, Healthy Women Healthy Babies, PRAMS, the Delaware Perinatal Quality Collaborative, home visiting programs, and other maternal health initiatives. The DHMIC Data Committee will continue developing dashboards, public-facing data products, and performance measures that support continuous quality improvement and accountability across Delaware's maternal health system.

Finally, Delaware will continue evaluating the effectiveness and sustainability of key maternal health initiatives, including Healthy Women Healthy Babies 3.0, Community Health Workers, the Healthy Women Healthy Babies Housing Pilot, the Medical-Legal Partnership, Medicaid innovations, and evidence-based home visiting. Findings from these evaluations will guide future investments, strengthen statewide systems of care, and ensure Delaware continues implementing evidence-based strategies that improve maternal and infant health outcomes for women and families throughout the state.

Celebrating 20 Years of the Delaware Healthy Mother and Infant Consortium: Building the Future of Maternal and Infant Health
In 2025, the Delaware Healthy Mother and Infant Consortium (DHMIC) celebrated its 20th Anniversary, marking two decades of statewide leadership, collaboration, and innovation dedicated to improving the health of women, infants, and families across Delaware. Established in response to recommendations from the 2005 Infant Mortality Task Force and codified in Delaware law, DHMIC has served as the State's collective impact organization, bringing together public health, healthcare providers, Medicaid, policymakers, community organizations, academic institutions, and families with lived experience to advance maternal and infant health and reduce disparities.

Over the past two decades, Delaware has made a significant and sustained investment in maternal and infant health. Today, the State invests approximately $4.2 million annually in State General Funds to support Healthy Women Healthy Babies (HWHB) and other maternal and infant health initiatives that improve outcomes for women before, during, and between pregnancies. These investments support evidence-based clinical and community interventions, quality improvement, Community Health Workers, maternal mental health, home visiting, housing stability, data and evaluation, and innovative models of care that address both the clinical and social factors influencing maternal and infant health. As part of this investment, the Division of Public Health continues to dedicate approximately $1.5 million in State General Funds annually to support implementation of the Healthy Women Healthy Babies (HWHB) initiative, Delaware's flagship maternal health model focused on improving outcomes for women and infants at greatest risk.

The 20th Anniversary DHMIC Summit celebrated many of the accomplishments achieved through these sustained investments and partnerships, including:

- Creation and continued evolution of the Healthy Women Healthy Babies (HWHB) initiative into the HWHB 3.0 value-based maternal health model.
- Expansion of evidence-based home visiting programs, including Nurse-Family Partnership, Healthy Families Delaware, and Parents as Teachers.
- Establishment of the Delaware Perinatal Quality Collaborative (DPQC) and implementation of statewide maternal and neonatal quality improvement initiatives.
- Expansion of Community Health Worker programs serving Delaware's highest-risk communities.
- Implementation of innovative Medicaid policies, including 12-month postpartum coverage, Medicaid reimbursement for doula services, enhanced lactation support, the postpartum nutrition benefit, and other Section 1115 waiver initiatives.
- Launch of the Healthy Women Healthy Babies Housing Pilot, addressing housing instability as a key driver of maternal and infant health outcomes.
- Development of the statewide Maternal Health Resource Map, improving access to maternal health, behavioral health, nutrition, housing, breastfeeding, home visiting, and community resources.
- Launch of Her Story 2.0, elevating the lived experiences of women and families to inform policy, quality improvement, and respectful maternity care.
- Expansion of maternal mortality review, data modernization, and quality improvement efforts that continue to guide statewide policy and investment decisions.

These accomplishments reflect Delaware's evolution from implementing individual maternal and child health programs to building a comprehensive maternal health system that integrates clinical care, public health, behavioral health, Medicaid, housing, nutrition, early childhood services, and community-based supports to improve maternal and infant health outcomes.

Looking Ahead
As DHMIC enters its third decade, Delaware will build upon this strong foundation by implementing the next phase of its strategic vision for maternal and infant health. The Consortium will continue serving as the State's convener for maternal and infant health policy, systems transformation, and cross-sector collaboration while advancing innovative, evidence-based strategies that improve outcomes for women, infants, and families.

During the coming year, DHMIC and its partners will continue strengthening implementation of the Five-Year Strategic Plan by expanding statewide collaboration, increasing accountability through performance dashboards and data visualization, and evaluating the effectiveness of major maternal health initiatives. Priorities will include continued refinement of the Healthy Women Healthy Babies 3.0 model; expansion of Community Health Worker integration; implementation and evaluation of the Healthy Women Healthy Babies Housing Pilot; strengthening timely postpartum care, maternal mental health, and behavioral health services; expanding evidence-based home visiting and Family Connects planning; enhancing the Maternal Health Resource Map and Her Story 2.0; and partnering with the Division of Medicaid and Medical Assistance to evaluate innovative Medicaid policies that improve maternal and infant health outcomes.
Delaware will continue leveraging maternal mortality review findings, quality improvement initiatives, and statewide performance data to guide future investments and policy decisions. Through sustained state investment, strong public-private partnerships, and a continued commitment to health, DHMIC will build on 20 years of progress while advancing its vision that every woman has access to safe, respectful, and high-quality care before, during, and between pregnancies, and that every infant has the opportunity to celebrate a healthy first birthday and thrive throughout childhood.

During the coming year, the Delaware Maternal Health Task Force will continue serving as the implementation body for the Health Resources and Services Administration (HRSA) State Maternal Health Innovation (MHI) Program, advancing evidence-based strategies that strengthen Delaware's maternal health system and align with the priorities of the Title V Maternal and Child Health (MCH) Block Grant. Working collaboratively with the Delaware Healthy Mother and Infant Consortium (DHMIC), the Delaware Perinatal Quality Collaborative (DPQC), the Maternal and Child Death Review Commission (MCDRC), the Division of Medicaid and Medical Assistance (DMMA), healthcare providers, community organizations, and women with lived experience, the Task Force will continue translating maternal mortality review findings, quality improvement initiatives, and statewide data into coordinated systems change.

Building upon the foundation established during the first year of the State Maternal Health Innovation Program, the Task Force will continue implementing Delaware's strategic workplan to improve maternal health outcomes, reduce preventable maternal morbidity and mortality, and address persistent racial and ethnic disparities. Priority areas include strengthening maternal behavioral health services, improving care for pregnant and postpartum individuals affected by substance use disorders, expanding timely postpartum care, promoting respectful maternity care, and addressing health-related social needs through coordinated, multidisciplinary approaches.
The Task Force will continue evaluating innovative Medicaid maternal health initiatives implemented through the Division of Medicaid and Medical Assistance, including enhanced postpartum nutrition benefits, doula services, expanded lactation consultation and breastfeeding supports, contingency management for pregnant and parenting people with substance use disorders, and other Section 1115 Demonstration Waiver initiatives. Working with Medicaid Managed Care Organizations, the Task Force will review performance measures, utilization data, and maternal health outcomes to identify opportunities for continuous quality improvement and inform future policy decisions.

Recognizing the importance of workforce development and provider education, the Task Force will expand statewide Grand Rounds, anti-stigma learning collaboratives, and multidisciplinary training opportunities that promote trauma-informed care, implicit bias awareness, medications for opioid use disorder (MOUD), harm reduction strategies, maternal mental health, and culturally responsive care. These efforts will continue supporting implementation of recommendations from the Maternal and Child Death Review Commission and strengthening collaboration among obstetric providers, behavioral health professionals, pediatric providers, and community organizations.
The Task Force will continue advancing statewide initiatives that improve care coordination and community engagement, including implementation of the Maternal Health Resource Map, expansion of Her Story 2.0, integration of Community Health Workers into maternal care pathways, and strengthening referral networks connecting women to behavioral health services, evidence-based home visiting, nutrition supports, housing resources, and other community-based services before, during, and between pregnancies.

A major priority for the coming year will be implementation of Delaware's peer recovery support initiative in partnership with Impact Life, Health Management Associates, and community partners. This initiative will recruit, train, and certify Peer Support Specialists as doulas, creating a culturally responsive workforce that strengthens recovery supports, care coordination, and engagement for pregnant and postpartum individuals affected by substance use disorders.

The Task Force will continue partnering with the Delaware Perinatal Quality Collaborative to advance maternal quality improvement initiatives, including implementation of the Blue Bands Initiative, expansion of standardized fourth trimester care, promotion of timely postpartum visits, and dissemination of the Maternal Health Warning Signs Toolkit. These initiatives support Delaware's broader efforts to improve patient safety, reduce preventable complications, and ensure women receive coordinated, high-quality care throughout pregnancy and the postpartum period.

Data, evaluation, and continuous quality improvement will remain central to the Task Force's work. The Task Force will continue leveraging data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Medicaid, Healthy Women Healthy Babies (HWHB), Community Health Worker interventions, evidence-based home visiting programs, and the DHMIC Data Committee to monitor outcomes, evaluate program effectiveness, identify disparities, and guide future investments. Lessons learned through the HRSA State Maternal Health Innovation Program will be integrated into Delaware's Title V Maternal and Child Health priorities, ensuring that successful innovations are sustained and incorporated into the State's long-term maternal health strategy.
Through continued collaboration, innovation, and shared accountability, the Maternal Health Task Force will strengthen Delaware's coordinated maternal health system and advance the shared vision that every woman has access to high-quality, respectful, and comprehensive care before, during, and between pregnancies, resulting in healthier mothers, healthier babies, and stronger families.

Partnership with the Division of Medicaid and Medical Assistance
Over the coming year, the Division of Public Health (DPH) will continue partnering with the Delaware Division of Medicaid and Medical Assistance (DMMA) to implement innovative maternal health initiatives that improve outcomes during the postpartum period, a critical time for maternal morbidity and mortality. These efforts align with the HRSA State Maternal Health Innovation (MHI) Program and Delaware's Title V Maternal and Child Health priorities by expanding access to evidence-based clinical care, behavioral health services, and community-based supports for pregnant and postpartum individuals.
Under the clinical leadership of Dr. Alethea Miller, DMMA will continue advancing a comprehensive maternal health strategy focused on improving care for women experiencing mental health conditions, substance use disorders, and health-related social needs. Building on recent Medicaid policy advancements, priorities for the coming year include implementation, evaluation, and continuous quality improvement of several innovative initiatives designed to improve maternal health outcomes and reduce disparities.
Key priorities include:

- Expanding access to evidence-based practices that improve maternal and infant health outcomes for pregnant and postpartum women, particularly those at increased risk for adverse outcomes.
- Strengthening integrated perinatal behavioral health services, ensuring women have timely access to mental health care, substance use disorder treatment, recovery supports, and community resources throughout pregnancy and the first year postpartum.
- Addressing health-related social needs by improving access to nutrition, housing, transportation, care coordination, and other supportive services that reduce barriers to care and improve maternal well-being.
- Reducing barriers to engagement in behavioral health and substance use disorder treatment through innovative Medicaid initiatives, including contingency management, peer recovery supports, and enhanced care coordination.
- Continuing implementation and evaluation of evidence-based lactation consultation and breastfeeding supports, including expanded Medicaid reimbursement for lactation services and increased access to outpatient consultations, virtual support, and 24-hour clinical resources to improve breastfeeding initiation, duration, and maternal and infant health outcomes.
- Evaluating the impact of Medicaid innovations, including the Postpartum Nutrition Benefit, doula services, enhanced lactation benefits, and contingency management for pregnant and parenting people with substance use disorders, to inform continuous quality improvement and future policy development.

DPH and DMMA will continue collaborating through the Maternal Health Task Force, the Delaware Healthy Mother and Infant Consortium (DHMIC), the Delaware Perinatal Quality Collaborative (DPQC), and the Maternal and Child Death Review Commission to ensure that Medicaid innovations are aligned with statewide maternal health priorities and informed by quality improvement data, maternal mortality review findings, and the lived experiences of women and families. Together, these coordinated efforts will strengthen Delaware's maternal health system, improve continuity of care before, during, and between pregnancies, and advance outcomes for women, infants, and families.

Healthy Women Healthy Babies (HWHB) 3.0
The Healthy Women Healthy Babies (HWHB) 3.0 program is Delaware's flagship maternal health initiative and serves as a cornerstone of the State's strategy to improve maternal and infant health outcomes, reduce infant mortality, and eliminate persistent racial and ethnic disparities. The program provides comprehensive, coordinated services for women at greatest risk for adverse maternal and birth outcomes by addressing health before, during,

and between pregnancies through a whole-person, life-course approach.

HWHB 3.0 supports women by promoting healthy behaviors, improving management of chronic conditions, addressing behavioral health and substance use disorders, increasing access to nutritious foods, reducing tobacco and nicotine use, strengthening reproductive life planning, and connecting women to community resources that address health-related social needs such as housing, transportation, and food security. The program integrates Community Health Workers, behavioral health services, care coordination, and referral networks to ensure women receive comprehensive support beyond traditional prenatal care.

Nationally recognized by the Association of Maternal & Child Health Programs (AMCHP) as an innovative, evidence-based maternal health model, HWHB continues to evolve through a value-based, performance-driven approach that emphasizes measurable improvements in maternal and infant health outcomes. The model monitors key quality and performance indicators related to preconception care, prenatal care, postpartum care, birth outcomes, behavioral health, and health factors, while promoting accountability and continuous quality improvement.

The Division of Medicaid and Medical Assistance (DMMA) remains a critical partner in the continued evolution of HWHB 3.0. Through close collaboration between DPH and DMMA, Delaware has aligned Medicaid policy, maternal health quality improvement initiatives, and community-based interventions to improve care for women before, during, and after pregnancy. This partnership has supported implementation of innovative Medicaid initiatives, including postpartum nutrition benefits, Medicaid doula services, enhanced lactation consultation and breastfeeding supports, contingency management for pregnant and parenting people with substance use disorders, and expanded postpartum care, creating a more integrated maternal health system.
DPH and DMMA continue to meet regularly to align maternal health policy, quality improvement initiatives, and Title V priorities. Dr. Alethea Miller, Maternal and Child Health Clinical Lead for DMMA, serves as an appointed member of the Delaware Healthy Mother and Infant Consortium (DHMIC), co-chairs the DHMIC Data Committee, participates on the DHMIC Annual Summit Planning Committee, and provides clinical leadership for multiple statewide maternal health initiatives. This partnership has strengthened coordination across public health, Medicaid, healthcare systems, and community organizations while supporting implementation of the HRSA State Maternal Health Innovation Program.

During the coming year, DPH will continue refining and evaluating the HWHB 3.0 model to ensure services are producing measurable improvements in maternal and infant health outcomes. Priority activities include continued monitoring of value-based performance benchmarks, expansion of Community Health Worker integration, strengthening behavioral health and substance use disorder services, improving timely postpartum care, and increasing referrals to evidence-based home visiting, housing supports, nutrition services, and other community resources.

DPH and DMMA will continue collaborating to enhance performance measurement through integration of HWHB participant data with Medicaid claims, Pregnancy Risk Assessment Monitoring System (PRAMS) data, and other statewide maternal health datasets. These efforts will improve evaluation of healthcare utilization, maternal and birth outcomes, and the effectiveness of interventions while identifying opportunities to reduce disparities and improve care for women at greatest risk.

Evaluation findings will continue to inform quality improvement efforts, support implementation of Delaware's Maternal Health Innovation Program, and guide future investments in evidence-based maternal health strategies. Together, HWHB 3.0 and Delaware's Medicaid partnership will continue advancing an integrated, value-based maternal health system that improves outcomes for women before, during, and between pregnancies while promoting healthier babies, stronger families, and more favorable birth outcomes statewide.

During the coming year, the Division of Public Health (DPH), in collaboration with the Delaware Healthy Mother and Infant Consortium (DHMIC), will continue advancing a comprehensive maternal health strategy that addresses the clinical, behavioral, environmental, and social factors influencing maternal and infant health outcomes. Building upon the accomplishments recognized during DHMIC's 20th Anniversary, Delaware will focus on evaluating, sustaining, and expanding innovative, evidence-based initiatives that improve the health of women before, during, and between pregnancies while reducing maternal and infant morbidity, mortality, and persistent racial and ethnic disparities.

A major priority will be evaluating and strengthening statewide interventions that address health-related social needs, including the Healthy Women Healthy Babies (HWHB) Housing Pilot, Medical-Legal Partnership, Community Health Worker care coordination, the Maternal Health Resource Map, and other cross-sector initiatives designed to improve access to stable housing, nutrition, transportation, financial stability, behavioral health services, and community resources. As the Housing Pilot moves from development into implementation, DPH, the Delaware State

Housing Authority, Medicaid, healthcare providers, and community partners will monitor participation, housing stability, healthcare utilization, birth outcomes, and participant experiences to evaluate effectiveness, inform future policy decisions, and support long-term sustainability.
Delaware will continue refining the Healthy Women Healthy Babies (HWHB) 3.0 model by strengthening value-based performance measures, integrating behavioral health and substance use disorder services, expanding Community Health Worker engagement, enhancing fourth trimester care, and improving referrals to evidence-based home visiting, housing supports, nutrition services, and other community resources. Performance data from Medicaid, the Pregnancy Risk Assessment Monitoring System (PRAMS), Healthy Women Healthy Babies, and other statewide maternal health initiatives will continue to guide continuous quality improvement and evidence-based decision-making.

To strengthen public awareness and community engagement, DHMIC will continue hosting its Annual DHMIC Summit, bringing together healthcare providers, policymakers, public health professionals, community organizations, researchers, advocates, and individuals with lived experience to share emerging data, highlight successful initiatives, showcase innovative practices, and identify opportunities to further improve maternal and infant health outcomes across Delaware. The Summit will continue to serve as Delaware's premier statewide maternal and infant health convening and a catalyst for collaboration, policy development, and systems improvement.

As part of Delaware's commitment to advancing maternal health and ensuring that the voices and lived experiences of women and families inform policy and practice, the Division of Public Health (DPH), in partnership with the Delaware Healthy Mother and Infant Consortium (DHMIC), plans to host a statewide screening and facilitated discussion of The Ebony Canal, an award-winning documentary directed by four-time Emmy Award-winning filmmaker Emmai Alaquiva and narrated by Academy Award-winning actress Viola Davis. The documentary examines the historical and ongoing disparities in maternal and infant health experienced by Black women, while elevating the stories of mothers, families, clinicians, and national leaders to foster dialogue, awareness, and action to improve maternal health outcomes. Its mission is to inspire solution-driven approaches that move maternal health forward and ultimately save the lives of Black mothers and babies.

The statewide screening will convene healthcare providers, public health professionals, policymakers, community leaders, advocates, educators, and families to engage in meaningful dialogue about maternal health disparities, respectful maternity care, implicit bias, patient-centered care, and opportunities to advance birth health in Delaware. The event will complement Her Story 2.0 by amplifying the voices and lived experiences of Delaware women and families and reinforcing the importance of listening to patients to improve healthcare delivery, quality improvement initiatives, and maternal health policy. Lessons learned from the screening and facilitated discussions will help inform implementation of the DHMIC Five-Year Strategic Plan, strengthen provider education and community engagement efforts, and support Delaware's ongoing commitment to reducing maternal morbidity and mortality, eliminating disparities, and ensuring that every woman receives safe, respectful, and high-quality care before, during, and between pregnancies.

Delaware will continue exploring implementation of the Family Connects evidence-based universal nurse home visiting model as a complement to the State's existing continuum of evidence-based home visiting services, including Nurse-Family Partnership, Healthy Families Delaware, and Parents as Teachers. During the coming year, DPH will assess implementation readiness, financing strategies, referral pathways, and integration with Healthy Women Healthy Babies, Community Health Workers, Medicaid initiatives, and hospital systems to strengthen postpartum care coordination and ensure every family has access to appropriate supports following birth.
Health Management Associates (HMA) will continue serving as a strategic implementation partner to DPH and DHMIC by providing technical assistance, strategic planning, facilitation, quality improvement support, evaluation, and performance measurement. HMA will continue supporting implementation of the DHMIC Strategic Plan, strengthening committee infrastructure, facilitating multidisciplinary workgroups, and developing dashboards and evaluation tools that support accountability and continuous quality improvement.

Recognizing that maternal health disparities remain concentrated within Delaware's Healthy Women Healthy Babies high-risk communities, DPH, DHMIC, HMA, Medicaid, healthcare providers, and community organizations will continue partnering with trusted community-based organizations and individuals with lived experience to identify culturally responsive, evidence-based strategies that address the root causes of poor maternal and infant health outcomes. These collaborative efforts will continue strengthening Delaware's coordinated maternal health system while advancing the shared vision that every woman has access to safe, respectful, and high-quality care before, during, and between pregnancies, and that every infant has the opportunity for a healthy start and the best possible chance to thrive.

Implementation of the DHMIC Five-Year Strategic Plan
Implementation of the Delaware Healthy Mother and Infant Consortium (DHMIC) Five-Year Strategic Plan will

continue to be a priority during the coming year as the Consortium builds upon the momentum of its 20th Anniversary and continues advancing Delaware's vision for improving maternal and infant health outcomes. Under the leadership of the Governor-appointed Chair, Vice Chair, and DHMIC members, the Consortium will focus on translating strategic priorities into measurable action through strengthened governance, cross-sector collaboration, accountability, and continuous quality improvement.
Priority activities will include continued implementation of the DHMIC Strategic Plan by supporting committee work plans, monitoring progress toward strategic objectives, strengthening member engagement, and enhancing collaboration among public health, Medicaid, healthcare providers, community-based organizations, policymakers, and individuals with lived experience. The Consortium will continue to use data, maternal mortality review findings, and quality improvement measures to guide policy recommendations, prioritize investments, and evaluate statewide maternal and infant health initiatives.

Building upon significant accomplishments over the past year, DHMIC will continue supporting implementation and evaluation of innovative maternal health initiatives, including the Healthy Women Healthy Babies (HWHB) Housing Pilot, Her Story 2.0, the Maternal Health Resource Map, Community Health Worker integration, Medicaid maternal health innovations, and evidence-based home visiting strategies. The Consortium will work closely with the Division of Public Health and the Division of Medicaid and Medical Assistance to evaluate program outcomes, identify opportunities for sustainability and expansion, and promote evidence-based models that improve maternal and infant health outcomes.

The Consortium will continue convening its Annual DHMIC Summit as Delaware's premier maternal and infant health conference to showcase statewide progress, share emerging data, highlight innovative practices, recognize community leadership, and foster collaboration among healthcare providers, policymakers, researchers, community organizations, and families. During the coming year, DHMIC also plans to host a statewide screening and facilitated discussion of the Ebony Canal documentary to promote dialogue around maternal health disparities, respectful maternity care, and the lived experiences of women and families. This event will complement Her Story 2.0 and other public engagement efforts designed to elevate community voices and inform future policy and practice.

Recognizing the importance of accountability and sustainability, DHMIC will continue strengthening performance measurement through enhanced dashboards, evaluation tools, and reporting mechanisms that monitor progress toward strategic goals and Title V Maternal and Child Health priorities. Findings from these efforts will guide future investments, inform statewide policy development, and support continuous improvement of Delaware's maternal and infant health system.

Through continued leadership, innovation, and collaboration, DHMIC will build upon two decades of progress while advancing a coordinated and data-driven maternal health system that ensures every woman has access to safe, respectful, and high-quality care before, during, and between pregnancies, and that every infant has the opportunity for a healthy start and lifelong well-being.

DPQC Updates: Continuing to Strengthen Maternal and Infant Health in Delaware
Background and Evolution of DPQC
The Delaware Perinatal Quality Collaborative is Delaware’s statewide perinatal quality improvement structure. It brings together all Delaware birthing hospitals, clinicians, public health leaders, community partners, patient advocates, and maternal and infant health stakeholders to improve pregnancy outcomes and advance birth health. DPQC’s work is based on the understanding that preventable maternal and infant morbidity and mortality can be reduced when hospitals and public health partners share timely data, test evidence-based practices, learn from each other, and sustain improvements across the perinatal system. These data continue to guide statewide quality initiatives while supporting implementation of Delaware's Title V Maternal and Child Health priorities.

DPQC was first developed in 2009 through the Delaware Healthy Mother and Infant Consortium as a statewide collaborative to improve outcomes for women and infants. Since then, it has grown from a collaborative focused on core hospital-based priorities, such as obstetrical blood loss management, pregnant women with substance use disorder, infants born with Neonatal Abstinence Syndrome, and evidence-based clinical practice, into a broader statewide platform for maternal safety, neonatal improvement, postpartum progression, and surveillance.

DPQC is now formally established in Delaware Code Title 16 §197. This statutory foundation gives the collaborative a clear role in improving pregnancy outcomes for women and newborns through quality care review, audit, continuous quality improvement, evidence-based clinical practice, and bias and cultural competency training guidelines for hospitals and birthing centers. It also supports DPQC’s ongoing cooperation with DHMIC and helps connect hospital quality improvement with Delaware’s broader maternal and infant health strategy. The DPQC functions as an independent statewide collaborative while maintaining a strong partnership with DHMIC, the Division of Public Health (DPH), the Division of Medicaid and Medical Assistance (DMMA), the Maternal Health Task Force, and the Maternal and Child Death

Review Commission.

Over time, DPQC's work has continued to expand. The early focus was on building a trusted collaborative structure where hospitals could participate, share data, review trends, and learn from each other. The work then expanded into maternal safety and neonatal substance exposure, including obstetric hemorrhage, substance use disorder in pregnancy, and NAS/NOWS. More recently, DPQC has aligned with national patient safety bundles and quality metrics, including AIM and Society for Maternal-Fetal Medicine measures, while also expanding into postpartum care, recovery supports, and statewide data dashboards.

Today, DPQC's portfolio includes severe hypertension in pregnancy, obstetric hemorrhage, severe maternal morbidity surveillance, low-dose aspirin for preeclampsia prevention, Eat, Sleep, and Console for infants with Neonatal Opioid Withdrawal Syndrome, Improving Postpartum Access to Care, the Blue and White Band initiative, and SMHI work focused on peer support doulas and access to care for pregnant and postpartum women with substance use disorder.

DPQC's Role in Delaware's Maternal and Infant Health System
The Delaware Perinatal Quality Collaborative continues to play an important role in improving care for pregnant and postpartum women, infants, and families across the state. DPQC brings together all Delaware 7 birthing hospitals, including the Birth Center, and Nemours Children's Hospital, public health partners, clinicians, and community stakeholders to review data, identify gaps, and work together on quality improvement activities that can improve outcomes.

A major strength of DPQC is that hospitals are not working in isolation. They are able to share data, review trends, discuss challenges, and learn from each other in a structured and protected space. This is especially important because many of the issues being addressed, including severe maternal morbidity, obstetric hemorrhage, substance use disorder, and postpartum complications, require honest review of what is happening within hospitals and across systems. The collaborative structure allows Delaware to move from simply collecting data to using the data to improve practice.

Data, AIM Alignment, and Quality Improvement Support
DPQC continues to support hospital-based quality improvement through data collection, chart audits, dashboards, technical assistance, provider education, and peer learning. The work is aligned with Title V priorities, AIM patient safety bundles, HRSA maternal and child health goals, CDC priorities, and the work of the Delaware Healthy Mother and Infant Consortium.

Through AIM-related activities, DPQC continues to support hospitals with obstetric emergency response training, hemorrhage monitoring, maternal warning signs education, and provider training related to quality care for pregnant persons with substance use disorder. DPQC also continues to connect Delaware hospitals to national quality improvement resources and learning opportunities through AIM, HRSA, NNPQC, IHI, and other maternal health partners.

Severe Hypertension in Pregnancy
DPQC has continued its work on severe hypertension in pregnancy using the Society for Maternal-Fetal Medicine "Time to Treat" quality metric. This measure focuses on whether patients with severe hypertension receive antihypertensive treatment within 60 minutes.

As of April 2026, 81.9% of patients with severe hypertension were treated with antihypertensive medication within 60 minutes. This continues to be one of DPQC's strongest examples of how shared data and hospital-to-hospital learning can improve maternal safety. The work is not only about the percentage treated within 60 minutes. It also reflects improvements in recognizing severe-range blood pressures, notifying providers, documenting care, and responding quickly before complications worsen.

Low-Dose Aspirin and Preeclampsia Prevention
DPQC also continues to work with birthing hospitals on low-dose aspirin administration for patients at risk for preeclampsia. As of Q1 2026, 49.0% of eligible patients had correct administration of low-dose aspirin.

This remains an area where more improvement is needed, but it is still an important part of the maternal safety work because it focuses on prevention. Much of maternal safety work happens when a complication has already occurred. The low-dose aspirin initiative helps move the work earlier into pregnancy by supporting hospitals in identifying patients at risk and improving use of an evidence-based intervention that may reduce severe preeclampsia and

related complications.

Obstetric Hemorrhage and Severe Maternal Morbidity
Obstetric hemorrhage and severe maternal morbidity remain key DPQC priorities. As of April 2026, 7.4% of patients were reported as having obstetric hemorrhage. As of Q1 2026, the severe maternal morbidity rate was 118.4 per 10,000 hospitalizations.

DPQC continues to use hospital-based surveillance, chart abstraction, and data review to better understand hemorrhage trends and severe maternal morbidity. This work is important because accurate data are needed to know where risks are occurring, where there may be differences by hospital or population group, and where quality improvement efforts should be focused. DPQC has also worked with birthing hospitals to assess their capacity and capability to improve care for patients experiencing obstetric hemorrhage, including through AIM-related hemorrhage work.

Eat, Sleep, and Console and Neonatal Opioid Withdrawal Syndrome
DPQC has continued to support the Eat, Sleep, and Console model for infants with Neonatal Opioid Withdrawal Syndrome. ESC is a family-centered, non-pharmacological approach that focuses on whether an infant can eat, sleep, and be consoled. It also supports caregiver involvement and helps reduce unnecessary separation and medication use when appropriate.

Across calendar years 2024 and 2025, 76 infants were tracked across three birthing hospitals. Although the data did not show a statistically significant association between ESC intervention and length of stay, 63.6% of infants who received ESC intervention had a hospital stay of less than one week, compared with 50.0% of infants who did not receive ESC intervention.

These findings are encouraging and support continued monitoring. This work also connects closely to the broader SUD work because substance exposure affects both the infant and the mother. Improving care for infants with NOWS also means supporting the mother-infant dyad and strengthening linkages to services after delivery.

Improving Postpartum Access to Care
Improving Postpartum Access to Care will be one of DPQC’s major priorities moving forward. This work focuses on strengthening the progression from delivery to postpartum care, especially during the first few weeks after birth when complications can occur or worsen. This work directly supports Delaware's Title V Maternal and Child Health priorities by advancing National Performance Measure 4 (Postpartum Visit) through strategies that increase timely and comprehensive postpartum care, improve continuity of care across the perinatal continuum, and promote access to high-quality, patient-centered services for all birthing women.

DPQC is working with birthing hospitals to improve scheduling of postpartum visits within two weeks of delivery, strengthen discharge education, and increase awareness of postpartum warning signs. This is an important shift because delivery is not the end of maternal risk. Many women continue to be at risk after hospital discharge, and some of the most serious complications occur during the postpartum period. The goal is to make postpartum follow-up more consistent and to help connect women to care earlier.

Blue Band Initiative
DPQC will also move forward with the rollout of the Blue and White Band initiative. This initiative is intended to remind patients, families, and providers that postpartum women may still be at risk after delivery. The bands will help reinforce postpartum warning signs, encourage timely care-seeking, and support a more consistent message across birthing hospitals and providers.

This initiative fits directly with the Improving Postpartum Access to Care work. Together, the two-week postpartum visit scheduling effort and the Blue and White Band rollout help shift postpartum care from something that happens after discharge to a core part of maternal safety.

SMHI, Maternal Health Task Force, and SUD Access to Treatment
The State Maternal Health Innovation grant has become a major part of DPQC’s work and has helped expand the collaborative’s focus beyond hospital quality improvement alone. Through SMHI, Delaware is strengthening its maternal health system, with a particular focus on perinatal women with substance use disorder.

This work is important because overdose has been the leading cause of maternal death in Delaware for five consecutive years, and many maternal deaths occur during the late postpartum period, from six weeks to one year after delivery. Severe maternal morbidity is also increasing across hospital systems, with behavioral health conditions, untreated SUD, delayed recognition of warning signs, and gaps in postpartum care all contributing to

risk. These efforts align with Delaware's Title V Maternal and Child Health priorities by strengthening systems of care that improve maternal health outcomes, increasing access to evidence-based behavioral health and substance use disorder treatment during pregnancy and the postpartum period, reducing preventable maternal morbidity and mortality, advancing optimal health for all, and supporting coordinated, family-centered care across the continuum from pregnancy through the first year postpartum.

Through the SMHI grant, Delaware supported the development of the Maternal Health Task Force and the peer support doula model. The Maternal Health Task Force helps coordinate partners, guide implementation of the maternal health strategic plan, and improve outcomes for perinatal women, especially those with SUD. The peer support doula model works within this broader structure and is intended to strengthen care coordination, reduce stigma, and improve engagement in prenatal, postpartum, and SUD treatment services.

Peer Support Doula Program
The peer support doula program is one of the most promising parts of the SMHI work. It combines peer recovery support with traditional doula care so that women can receive emotional, physical, informational, and recovery-focused support during pregnancy, labor and delivery, and up to one year postpartum.

This model responds to several gaps that were identified through the work, including fragmentation across obstetric care, SUD treatment, pediatrics, home visiting, and social services; lack of clearly defined care coordination ownership; stigma and bias in clinical settings; inconsistent implementation of Plans of Safe Care; and limited infrastructure for extended postpartum support. Listening sessions also showed that women wanted trust-based relationships, non-judgmental support, culturally responsive care, and help navigating complex systems.

The program also includes workforce development. Impact Life is the implementing community partner responsible for recruiting, training, and supervising peer recovery support specialists as doulas. The Delaware Division of Family Services also trained doulas on Plans of Safe Care to improve implementation, documentation, and coordination across systems. The model creates a hybrid workforce that combines lived experience, recovery support expertise, formal doula training, and perinatal care competencies. As of the preliminary findings, there were five doulas, with the program beginning in September 2025.

The doulas support individualized care planning, birth plans, Plans of Safe Care, screening for mental health needs, education on maternal warning signs and infant care, and goal setting. They also help with care coordination by serving as a bridge between OB providers, SUD treatment programs, pediatric providers, home visiting, and social services. This includes referrals, warm handoffs, appointment scheduling, and follow-through.

Preliminary findings from September 2025 through March 2026 show that the peer doula program served 23 clients, with an average age of 29 years. Most clients were unemployed, and about 30.4% had current or past experience with the Division of Family Services. Clients identified emotional and recovery support, parenting skills, non-judgmental support, help navigating health care, baby resources, coping skills, housing, and childcare assistance as important needs. The most common barrier identified was transportation.

The recovery capital findings also show why this model matters. The overall BARC-10 score was 4.6 out of 6, suggesting moderate to strong recovery capital among clients. Areas of strength included personal responsibility, professional engagement, and commitment to recovery. At the same time, lower scores were seen for housing and community connection, showing that women still need support with stability, social connection, and community integration.

Food insecurity was reported by 59%, childcare barriers by 50%, utility threats by 50%, housing instability by 45%, and social isolation by 45%. These findings reinforce that improving outcomes for pregnant and postpartum women with SUD cannot be addressed through clinical care alone. Women need support with treatment access, transportation, housing, childcare, social support, and ongoing connection to trusted providers and peers.

Strengthening Access to SUD Treatment for Pregnant and Postpartum Women
Moving forward, one of DPQC’s priorities will be to strengthen access to SUD treatment for pregnant and postpartum women. This includes improving referral pathways, supporting warm handoffs, strengthening relationships between hospitals and treatment providers, and helping women stay engaged in care through pregnancy and the postpartum period.

This work is closely connected to the peer doula model. Peer doulas can help reduce barriers that often prevent women from engaging in care, including stigma, fear of punitive systems, transportation challenges, childcare needs, and difficulty navigating services. They can also help women understand and follow through with Plans of Safe Care,

postpartum visits, pediatric care, SUD treatment, and other needed services.

Data, Sustainability, and Long-Term Planning
As the SMHI and DPQC work moves forward, continued data collection and monitoring will be important. DPQC will continue to track service delivery, engagement, care plan completion, Plans of Safe Care, maternal outcomes, postpartum visit attendance, recovery capital, infant outcomes, NOWS, ESC adoption, safe sleep, and other indicators. This data will help refine the program and strengthen implementation over time.

Sustainability will also be a key focus. Future planning includes exploring Medicaid reimbursement for doula services, integrating the model with Managed Care Organization care models, establishing certification and credentialing pathways, developing data-sharing agreements, and planning for scalability and long-term sustainability.

Priorities for the Coming Year
Over the coming year, DPQC priorities will include continued implementation of Improving Postpartum Access to Care, rollout of the Blue Band initiative, and strengthening access to SUD treatment for pregnant and postpartum women. DPQC will also continue to support the SMHI peer doula model, including referral and enrollment pathways, individualized care planning, Plans of Safe Care, SDOH screening, care coordination, and ongoing data collection. The DPQC will continue implementing statewide quality improvement initiatives that align with Delaware's Title V Maternal and Child Health priorities, the DHMIC Five-Year Strategic Plan, and the HRSA State Maternal Health Innovation Program.

The Collaborative will also support implementation of Delaware's broader maternal health priorities by advancing integration of Community Health Workers, strengthening referral pathways to evidence-based home visiting and community resources, supporting implementation of the Maternal Health Resource Map, promoting Her Story 2.0 as a mechanism to elevate patient voice and experience, and collaborating with partners to improve care for women throughout the reproductive life course.

In addition to these priorities, DPQC will continue its core maternal and infant health quality improvement work. This includes timely treatment of severe hypertension, low-dose aspirin administration for preeclampsia prevention, obstetric hemorrhage and severe maternal morbidity surveillance, Eat, Sleep, and Console implementation, AIM-related training and technical assistance, and continued use of data to guide hospital-level and statewide improvement.

Overall Impact
Taken together, DPQC’s work shows how Delaware uses data, hospital engagement, public health partnerships, and community-based support to improve maternal and infant health. The impact is not only on individual measures, although those measures are important. The larger impact is that DPQC is helping Delaware build a more connected system of care.

Through IPAC, the Blue Band initiative, the SMHI peer support doula model, SUD treatment access, and ongoing AIM-related quality improvement, DPQC is supporting women and infants across the full perinatal period. This includes pregnancy, delivery, the neonatal period, and the postpartum year. The work supports Title V priorities by strengthening maternal safety, improving infant outcomes, addressing substance use disorder, improving postpartum care, supporting surveillance, and reducing preventable maternal and infant morbidity and mortality.

During the coming year, the Division of Public Health (DPH) will continue strengthening Delaware's life-course approach to women's health by expanding access to preconception, interconception, and well-woman care through healthcare providers, Healthy Women Healthy Babies (HWHB) 3.0 sites, family planning providers, Federally Qualified Health Centers, hospitals, and community-based organizations. These efforts support Delaware's Title V Maternal and Child Health priorities by helping women optimize their health before, during, and between pregnancies while reducing the risk of adverse maternal and infant outcomes.

DPH will continue working with healthcare providers to integrate evidence-based preconception and reproductive life planning into routine clinical care, including implementation of standardized pregnancy intention screening, reproductive life planning discussions, chronic disease management, behavioral health screening, nutrition counseling, tobacco and substance use screening, folic acid education, and referrals to community resources. These activities will continue supporting implementation of the Healthy Women Healthy Babies (HWHB) 3.0 model and strengthen continuity of care across the reproductive life course.

The Division will continue evaluating implementation of pregnancy intention screening and other quality improvement measures by monitoring benchmark data, identifying best practices, and working with providers to implement small tests of change that improve clinical workflows and increase opportunities for preconception counseling during routine healthcare visits.

Recognizing the importance of reaching women outside traditional healthcare settings, DPH will continue expanding public awareness through the DEThrives communications platform by promoting evidence-based messaging related to well-woman care, reproductive life planning, healthy pregnancies, postpartum health, and maternal wellness. Public education efforts will incorporate Her Story 2.0, the Maternal Health Resource Map, blogs, videos, podcasts, social media campaigns, and other digital communication strategies that elevate the voices of women and families while increasing awareness of available maternal health resources.

DPH will continue collaborating with the Division of Medicaid and Medical Assistance (DMMA), the Delaware Healthy Mother and Infant Consortium (DHMIC), the Delaware Perinatal Quality Collaborative (DPQC), and community partners to strengthen provider education, improve referral pathways, and align clinical practice with evidence-based maternal health initiatives. Together, these efforts will support Delaware's vision of ensuring that every woman has access to comprehensive, coordinated, care before, during, and between pregnancies, ultimately improving maternal health outcomes and giving every baby the healthiest possible start in life.

During the coming year, the Division of Public Health (DPH) will continue strengthening and sustaining the Delaware Contraceptive Access Now (DE CAN) initiative as a core component of Delaware's comprehensive reproductive and maternal health system. Working in partnership with the Division of Medicaid and Medical Assistance (DMMA), Title X providers, Federally Qualified Health Centers, Healthy Women Healthy Babies (HWHB) providers, hospitals, pharmacies, and community partners, DPH will continue promoting access to the full range of contraceptive methods while supporting healthy birth spacing, reproductive life planning, and improved maternal health outcomes.

Priority activities will include expanding evidence-based provider education and clinical quality improvement initiatives that promote person-centered contraceptive counseling, same-day access to contraception, pregnancy intention screening, and reproductive life planning as standard components of preventive and well-woman care. DPH will continue monitoring quality indicators and evaluating program outcomes to identify opportunities for continuous quality improvement and ensure women have access to the contraceptive method that best aligns with their individual needs, preferences, and reproductive goals.

The Family Planning Program will continue expanding flexible workforce development opportunities through both in-person and virtual DE CAN training. Implementation of a web-based learning management system will support standardized onboarding, continuing education, and competency-based training for clinical and non-clinical staff, helping providers maintain best practices despite workforce turnover and ensuring consistent delivery of high-quality contraceptive services statewide.

DPH will continue collaborating with the Delaware Board of Pharmacy, pharmacists, healthcare providers, and professional organizations to support implementation of Delaware's pharmacist-prescribed hormonal contraception law. Efforts during the coming year will focus on provider education, pharmacist training, public awareness, and strengthening referral pathways between pharmacists and primary care, family planning, and maternal health providers to improve timely access to contraception throughout Delaware.

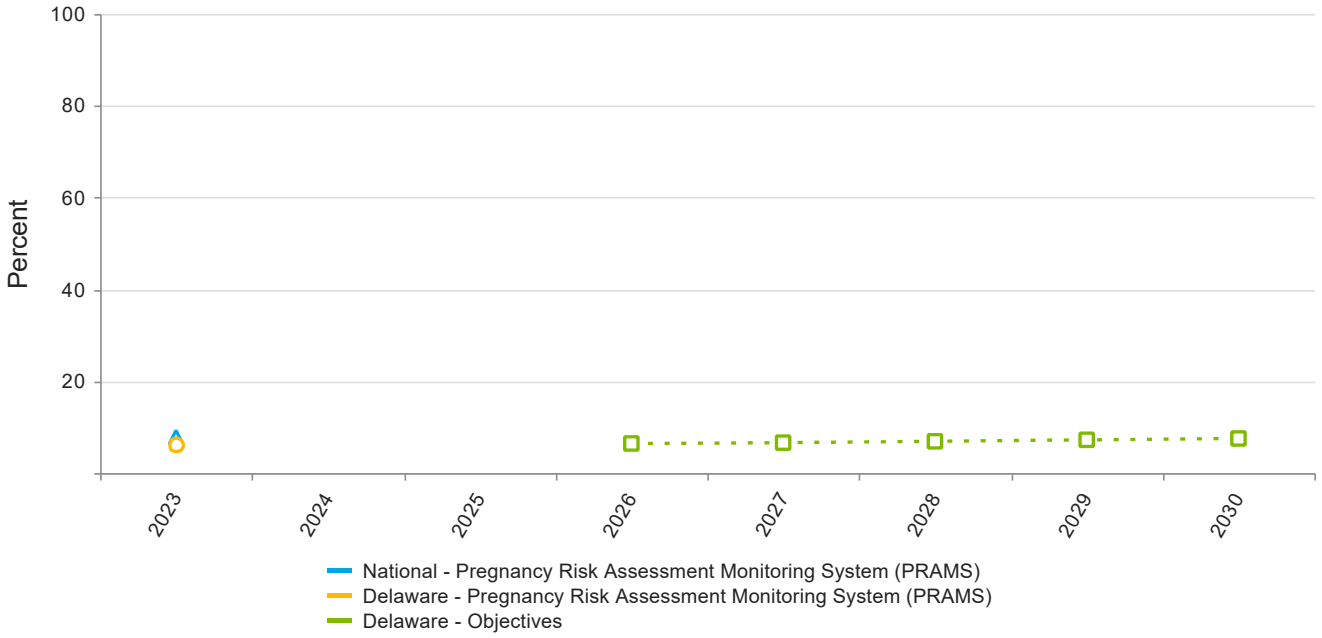
The Division will also continue supporting immediate postpartum access to long-acting reversible contraception (LARC) in Delaware's birthing hospitals by maintaining statewide infrastructure for purchasing, inventory management, and distribution of devices for uninsured and underinsured women. These efforts will help reduce barriers to postpartum contraceptive care, promote healthy pregnancy spacing, and support improved maternal and infant health outcomes.

Recognizing that reproductive healthcare is an essential component of Delaware's life-course approach to maternal and women's health, DE CAN will continue to be integrated with Healthy Women Healthy Babies (HWHB) 3.0, Title X, the Delaware Healthy Mother and Infant Consortium (DHMIC), Medicaid quality initiatives, and Title V Maternal and Child Health priorities. Delaware will continue evaluating program outcomes, monitoring access across populations, and identifying opportunities to expand evidence-based practices that improve reproductive autonomy, maternal health, and birth outcomes for women and families across the State.

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	**2025**
Annual Objective		
Annual Indicator	6.1	6.1
Numerator	581	581
Denominator	9,474	9,474
Data Source	PRAMS	PRAMS
Data Source Year	2023	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

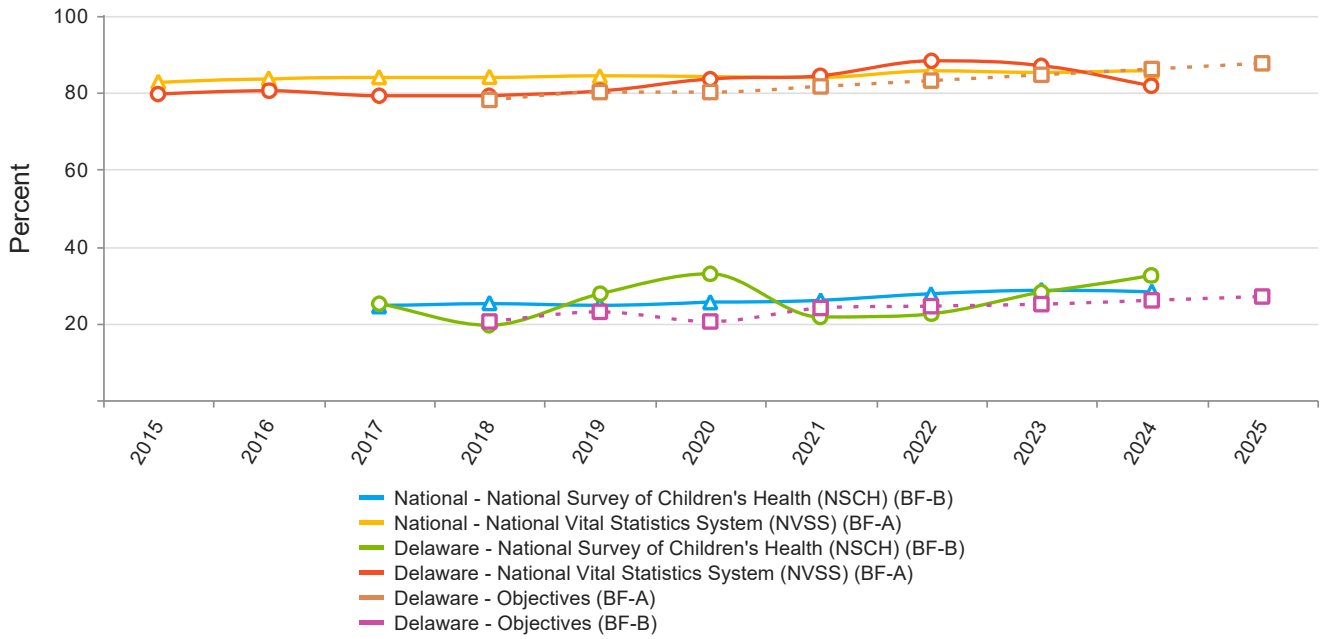
State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 1
Priority Need
Pregnant and parenting women have stable housing and are connected to essential resources and services that can improve their outcomes.
NPM
NPM - Housing Instability - Pregnancy
Five-Year Objectives
By 2030, decrease 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**	**2025**
Annual Objective	84.5	86	87.5
Annual Indicator	88.1	86.9	81.7
Numerator	9,316	8,893	8,413
Denominator	10,573	10,234	10,300
Data Source	NVSS	NVSS	NVSS
Data Source Year	2022	2023	2024

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**	**2025**
Annual Objective	25	26	27
Annual Indicator	22.4	28.0	32.3
Numerator	6,100	7,724	9,288
Denominator	27,226	27,596	28,736
Data Source	NSCH	NSCH	NSCH
Data Source Year	2021_2022	2022_2023	2023_2024

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	60	62	64	66	68
Annual Indicator	57	55.3	48.2	48.2	69.4
Numerator			27	27	59
Denominator			56	56	85
Data Source	MIECHV program daa	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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.**

Perinatal Infant Health Annual Report

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 Delaware Healthy Mother and Infant Consortium (DHMIC) Social Determinants of Health (SDoH) Committee continues to lead cross-sector efforts to address the social and structural factors that influence maternal and infant health outcomes across Delaware. Through partnerships among public health, healthcare systems, Medicaid, housing agencies, transportation partners, community-based organizations, and faith-based organizations, the committee advances strategies that improve access to well-woman, prenatal, postpartum, and interconception care while addressing barriers that contribute to health disparities.

During the reporting period, the committee supported implementation of several initiatives designed to address health-related social needs. A major focus was the development and implementation of the Healthy Women Healthy Babies Housing Pilot, an innovative partnership that provides housing stability for pregnant women experiencing housing insecurity. Stable housing is recognized as a key protective factor that supports healthy pregnancies, improves continuity of care, and promotes positive maternal and infant outcomes.

The committee also continued to identify barriers related to transportation, food insecurity, and access to community resources that affect healthcare utilization and maternal health outcomes. Findings from statewide assessments have informed targeted strategies to improve access to well-woman visits, prenatal care, postpartum care, behavioral health services, and pediatric care, particularly for families experiencing social and economic challenges.

To improve access to services, DHMIC partnered with the Division of Public Health to develop a web-based Maternal Health Resource Map, an interactive resource designed to help women, families, healthcare providers, and community organizations locate maternal health, behavioral health, nutrition, housing, breastfeeding, home visiting, and other community resources throughout Delaware. The resource map strengthens statewide referral networks, improves care navigation, and increases awareness of services available before, during, and between pregnancies.

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 a year ago, the housing workgroup was established under the DHMIC SDOH Committee, and was 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 has supported 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 continued to address housing instability and preventing pregnant women from homelessness aimed at improving maternal and infant health outcomes.

DPH in collaboration with DHMIC partners plan aimed 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 was 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.

With this in mind, Health Management Associates (HMA) continued 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 worked 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 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.

The SDOH Committee convened a housing workgroup, which held a design session in late 2025 to develop a targeted pilot program specifically for pregnant women experiencing unstable housing. This pilot program integrates housing stability, maternal health, and supportive services, aiming to create a scalable, evidence-based model for improving outcomes among pregnant women facing housing insecurity. Research shows that lack of stable housing increases the risk of adverse birth outcomes, poorer maternal health, and ongoing family hardship.

The proposed initiative includes the purchase of State of Rental Assistance Program (SRAP) vouchers, providing safe and stable housing for a total of 20 pregnant women in Delaware. Participants will receive up to 24 months of housing support. The program will rigorously evaluate outcomes related to maternal health, housing stability, and economic self-sufficiency, generating evidence to inform future policy decisions and guide potential program expansion.

DPH continued our partnership with Community Legal Aid Society, Inc. (CLASI) for the implementation of Medical-Legal Partnership (MLP) program. This program strengthens the ability of maternal and child health and home visiting programs to address the legal and social factors that impact the health and well-being of pregnant women and families with young children. Stable housing is a critical social determinant of health, and legal barriers such as eviction, unsafe housing conditions, housing discrimination, denial of public benefits, and landlord disputes can place families at increased risk for poor maternal and infant health outcomes.

Through a Medical-Legal Partnership, healthcare providers and home visitors can identify legal issues during routine interactions and connect families directly to CLASI for legal assistance. CLASI helps eligible families resolve housing-related legal challenges, secure access to safe and affordable housing, prevent unnecessary evictions, and ensure that pregnant women and families receive the housing protections and public benefits for which they qualify. Addressing these legal needs early can reduce stress during pregnancy, improve continuity of prenatal and pediatric care, decrease housing instability, and support healthier birth outcomes.

By integrating legal services into the maternal and child health system, this partnership has created a more coordinated, family-centered approach that addresses both medical and legal needs. Our partnership with CLASI helps families achieve greater housing stability, reduced health inequities, and improved long-term outcomes for parents and children by ensuring that legal barriers do not prevent families from accessing safe, stable, and healthy living environments.

[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).

Perinatal Application Year

Through systems-building, policy development, and community partnerships, the SDOH Committee will continue to advance Delaware's Title V priorities by addressing the non-clinical factors that influence maternal health and promoting equitable, family-centered systems of care. A major priority will be evaluating and strengthening statewide interventions that address health-related social needs, including the Healthy Women Healthy Babies (HWHB) Housing Pilot, Medical-Legal Partnership, Community Health Worker care coordination, the Maternal Health Resource Map, and other cross-sector initiatives designed to improve access to stable housing, nutrition, transportation, financial stability, behavioral health services, and community resources.

As the Housing Pilot moves forward an Implementation Workgroup will kick-of in August 2026 with the pilot launching later in the Fall. The Housing Pilot Program for Pregnant Families is designed to address the intersection of housing instability and maternal health by providing a holistic support system for vulnerable families. The program's primary goal is to offer safe and stable housing for pregnant women throughout pregnancy and the postpartum period, recognizing that secure housing is foundational to both physical and mental well-being.

The pilot includes the purchase of State of Rental Assistance Program (SRAP) vouchers, providing safe and stable housing for a total of 20 pregnant women in Delaware. Participants will receive up to 24 months of housing support. The program will rigorously evaluate outcomes related to maternal health, housing stability, and economic self-sufficiency, generating evidence to inform future policy decisions and guide potential program expansion.

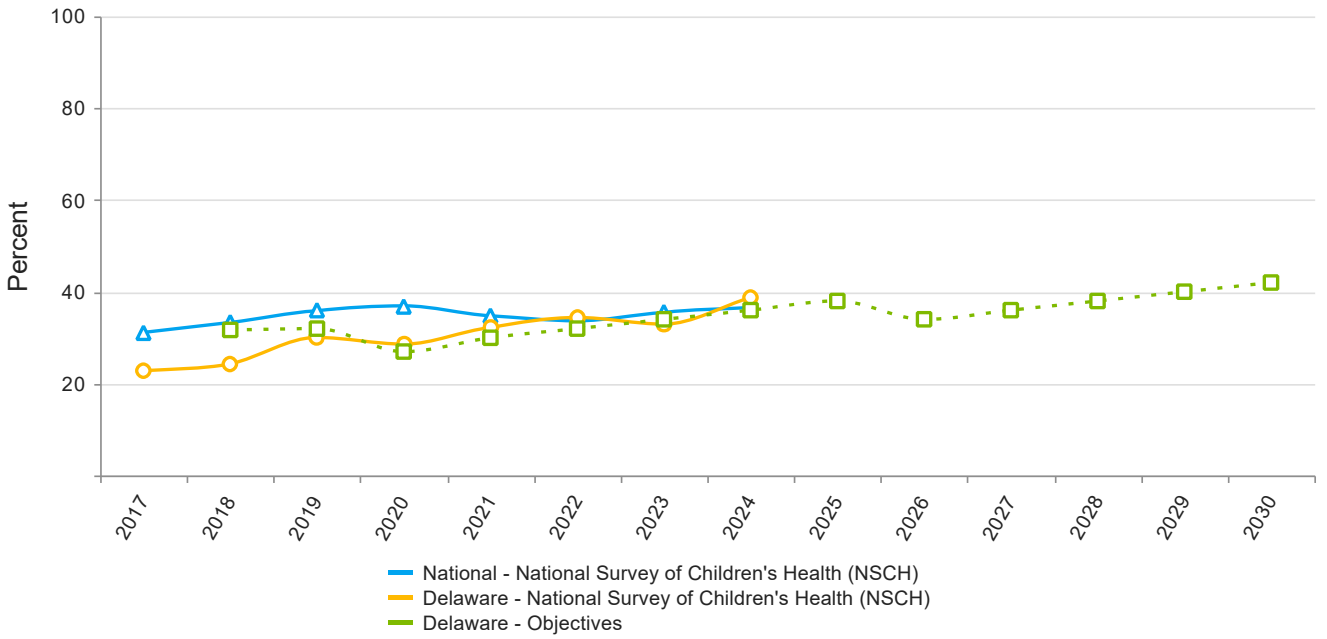
Beyond housing, the initiative aims to improve maternal and infant health outcomes, with a particular focus on reducing rates of preterm birth and low birth weight. By ensuring access to prenatal and postpartum care, behavioral health services, and nutrition support, the program seeks to mitigate health disparities and promote healthier beginnings for infants.

A key objective is to foster self-sufficiency among participants. This includes supporting workforce engagement, educational attainment, and income growth, empowering women to achieve greater economic independence and stability for their families.
Finally, the program is committed to rigorous data collection and evaluation. By gathering evidence on health, housing, and economic outcomes, the initiative will inform future policy decisions, guide program expansion, and contribute to the development of sustainable housing strategies for Delaware's most vulnerable populations.
DPH, the Delaware State Housing Authority, Medicaid, healthcare providers, and community partners will monitor participation, housing stability, healthcare utilization, birth outcomes, and participant experiences to evaluate effectiveness, inform future policy decisions, and support long-term sustainability.

DPH will continue our partnership with Community Legal Aid Society, Inc. (CLASI) for the implementation of Medical-Legal Partnership (MLP) program. This program strengthens the ability of maternal and child health and home visiting programs to address the legal and social factors that impact the health and well-being of pregnant women and families with young children. Stable housing is a critical social determinant of health, and legal barriers such as eviction, unsafe housing conditions, housing discrimination, denial of public benefits, and landlord disputes can place families at increased risk for poor maternal and infant health outcomes. The MLP program is currently integrated with our Healthy Womens Health Babies program as well as our evidence-based home visiting programs.

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	30.0	32.0	34	36	38
Annual Indicator	29.1	32.1	34.3	32.8	38.8
Numerator	6,073	7,257	8,614	8,638	10,352
Denominator	20,867	22,604	25,117	26,363	26,655
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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					
	2021	2022	2023	2024	2025
Annual Objective	92	94	96	98	100
Annual Indicator	82.2	81	77	76	84.6
Numerator	412	439	412	419	500
Denominator	501	542	535	551	591
Data Source	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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	2025
Annual Objective			75	85
Annual Indicator		31.3	38.1	35.9
Numerator		45	86	56
Denominator		144	226	156
Data Source		MIECHV ASQ and OEL ASQ	CHADIS Pilot Project Data	CHADIS Data System
Data Source Year		2023	2024	2025
Provisional or Final ?		Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	54.0	56.0	58.0	60.0	62.0

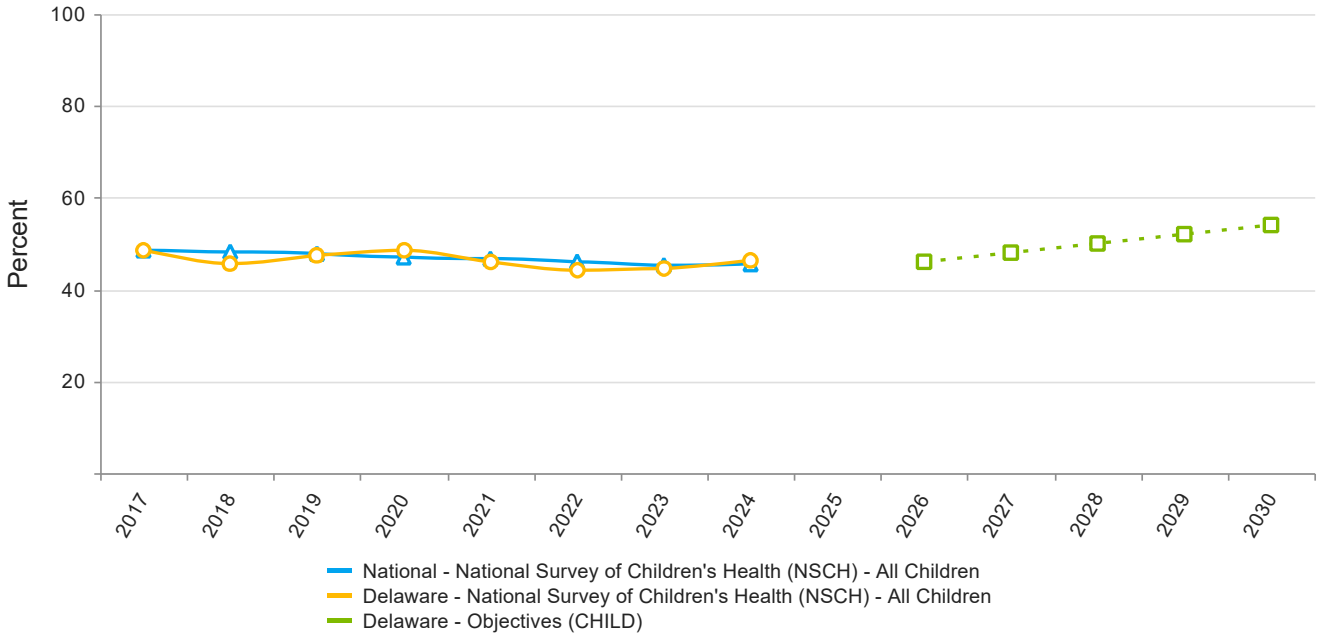
ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.

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**	**2025**
Annual Objective			
Annual Indicator	44.2	44.7	46.2
Numerator	91,124	92,739	96,704
Denominator	206,169	207,631	209,415
Data Source	NSCH-All Children	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023	2023_2024

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	2025
Annual Objective		
Annual Indicator	72.9	77.7
Numerator	462	497
Denominator	634	640
Data Source	MIECHV Program Data	MIECHV Program Datat
Data Source Year	2024	2025
Provisional or Final ?	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

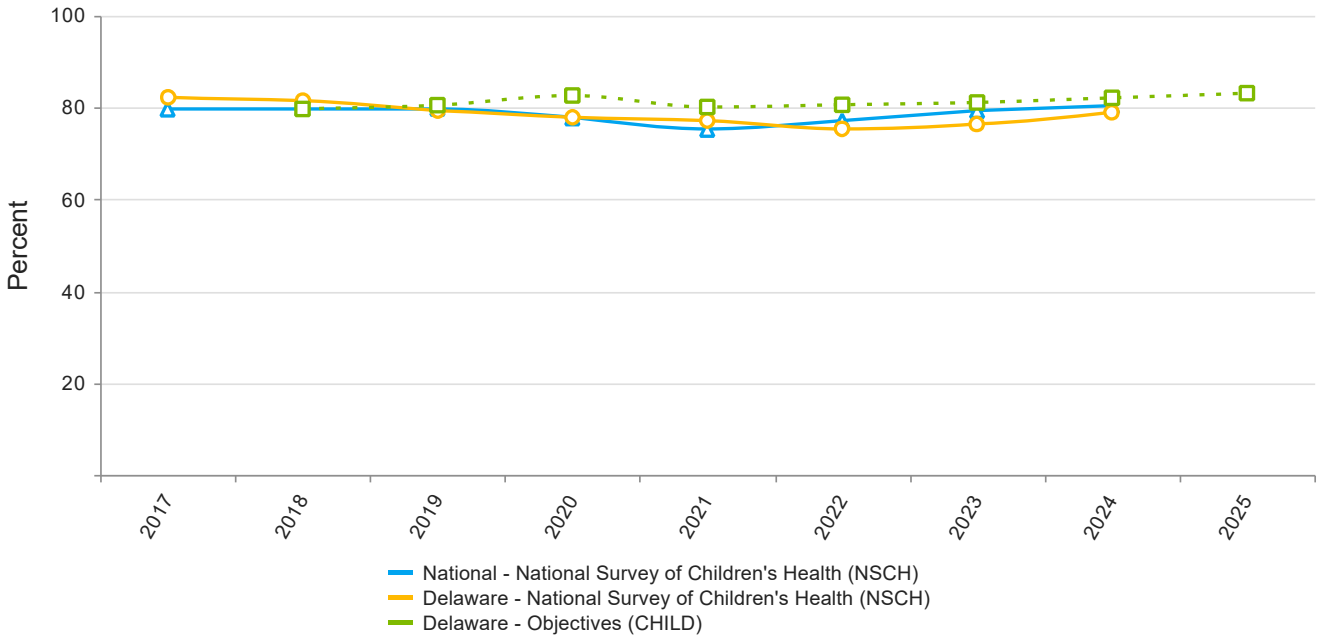
Flourishing - Young Child

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	80	80.5	81	82	83
Annual Indicator	77.4	77.3	75.4	76.2	78.8
Numerator	148,645	149,188	147,612	152,458	157,534
Denominator	192,077	193,050	195,852	200,007	200,018
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	81	82	83	84	85
Annual Indicator	73.6	77.3	75.4	76.2	78.8
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019-2020	2020-2021	2021-2022	2022-2023	2023/2024
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**	**2025**
Annual Objective			725	765
Annual Indicator	683	1,000	788	16
Numerator				
Denominator				
Data Source	MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final

Developmental Screening

Division of Public Health's Maternal Child Health Bureau's Early Childhood Comprehensive Systems (ECCS) program ensures families are connected to a full range of services and supports. The ECCS program assists states to build connected, family-centered systems that improve access to high-quality care for families with young children by identifying needs early and linking children to resources and services.

The Early Childhood Comprehensive Systems (ECCS) program helps states build connected, family-centered systems that improve access to high-quality care for families with young children by identifying needs early, while linking children and caregivers to services like health care, mental health support, parenting resources, and basic needs such as food and housing. In Delaware, the ECCS program utilizes the Help Me Grow model to address critical gaps in early identification by offering developmental and behavioral screenings, referrals, and follow-up services. Families are also empowered through the increased awareness of developmental milestones and available resources.

Help Me Grow (HMG) is a comprehensive, system-building initiative designed to promote optimal early childhood development by connecting families with young children to community-based services and supports. Grounded in the science of early brain development, HMG ensures that all children, particularly those at risk for developmental delays, are identified early and linked to appropriate interventions.

The program operates through four core components: a centralized access point (often a call center or coordinated intake system), family and community outreach, child health care provider engagement, and data collection and analysis. Together, these elements create an integrated network that improves coordination across health care, early learning, and family support systems.

According to HMG national center analysis, it is estimated that HMG in Delaware services has saved over $600,000 in one-year period, mostly within the special education and public assistance settings. The net savings were approximately $39,000.

The Help Me Grow Advisory committee is the leadership team providing advice, guidance and support to the on-going activities and operations of the Help Me Grow system. It is a coalition of multi-faceted child-serving programs with a common goal and shared interests. Through these partnerships with multiple stakeholders including pediatricians, childcare providers, and social service agencies, the HMG system enhances cross-sector collaboration to reduce fragmentation in service delivery to children and their families.

Other outcomes of the strategic planning process was an increased effort to promote Help Me Grow within the community; educate and inform parents and caregivers; continue efforts to improve developmental and behavioral screening while tracking data trends to identify gaps in the system while supporting advocacy and systems change.

Help Me Grow Strategic Planning:

A great part of ECCS activities in 2025 focused on implementing the strategic action plan which was started in 2024. The core Help Me Grow leadership received technical assistance from Help Me Grow national center over a period of weeks, to develop a four-year strategic plan for 2025-2029. The sessions led the team through prioritizing their target audience, agreeing on the theories of change, including approaches for implementation and measurable outcomes. Following this strategic planning, the leadership began the year 2025, restructuring previously established sub-committees which had been non-functional over time. This restructuring included limiting the number of sub-committees to just four (4) to align with the four (4) components of the HMG model and assign leads (with funding supported by the ECCS program) to share responsibility with a team of advisory committee members with interest in that component. The four components of the HMG model are: The Centralized Access Point; Child Health Provider Outreach; Family and Community Engagement and Data Collection and Analysis.

At the end of the planning sessions, Help Me Grow Delaware identified the following as the strategic direction for 2025-2029:

Increase Awareness of Help Me Grow system: Since the launch of HMG in 2012, surveys and anecdotal reports not

only show the lack of awareness of the centralized access point, Help Me Grow at 211, but lack the knowledge of Help Me Grow as a system-building model with 3 other components (Health Provider Outreach; Family and Community Engagement and Data Collection and Analysis).

Inform and Educate Parents and Caregivers: Community and parental knowledge about early detection and intervention cannot progress without sustained efforts to continuously inform and educate families and communities regarding the benefits of leveraging the first thousand days of children's life, including understanding and looking out for developmental milestones in children. An educated and knowledgeable population improves children's well-being and school readiness.

Developmental and Behavioral Screening Promotion: The ECCS program intends to continue and improve the gaps experienced since the launch of the state's developmental screening initiative in 2012. Though the program promotes developmental screening across the state, its main target audience has been the pediatric community.

Coordinated and efficacious communication between health, education and community: Collaborations within early childhood community lead to meaningful outcomes that impact program design, policy development including cross-cutting challenges or gaps.

Data tracking trends and data utilization to support quality improvement and advocacy. Improve data-sharing opportunities with early childhood partners to track services and access while identifying gaps, and use the data to inform and guide decisions.

A shared approach to young children's healthy development. Work collaboratively toward integration with early childhood health and learning agencies and other stakeholders to address gaps families encounter within the system.

Each of the restructured sub-committees were assigned to either one or more of the priority areas. Since its establishment, the sub-committees have been meeting on a regular basis and have begun operationalizing action items within the action plan.

Help Me Grow Simulation

An outcome of the strategic direction to promote awareness of the Help Me Grow system was to target early childhood providers through innovative simulation adapted from the Poverty Simulation which has been produced by United Way. On March 26, 2025, and October 16, 2025, a simulation of the HMG system and its four components was held in New Castle County and Sussex County, Delaware. The simulation event walked participants through the four components of the HMG System to include the Centralized Access Point (CAP) for families and professionals to get information and referrals, Family and Community Outreach to promote child development and connect with families, Child Health Care Provider Outreach to support early detection and intervention in healthcare settings, and Data Collection and Analysis to improve the system's effectiveness. The event demonstrated the inter-connectedness of HMG activities and how it contributes to and aligns with Delaware's early childhood system. The intent was to expose participants to an experiential event, for a lasting post-event impact.

The rationale to hold a simulation was to reverse the notion Delaware providers and families have in their understanding of the HMG system, its activities and how it can benefit families. The approach therefore was to walk participants through the HMG activities, illustrating how all the different activities align to build the system.

The Comprehensive Health and Decision Information System (CHADIS)

The Comprehensive Health and Decision Information System (CHADIS) pilot project was officially launched in November 2022 at four (4) community pediatric practices are participating in the pilot: Beacon Pediatrics (Sussex County, DE), Bear Internal Medicine and Pediatrics (New Castle County, DE), Bright Futures Pediatrics (Kent County, DE) and Rainbow Pediatrics (Sussex County, DE). The purpose of this project is to address care coordination of the developmental screening process and referral to early intervention services.

The goal is to improve gaps that exist in the system by establishing a closed-loop feedback system between pediatric practices and early intervention agencies. 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; leverage HMG @ 211 services for wrap around services and as a support for referrals for social determinants of health and for those children currently ineligible for early intervention services.

To facilitate the referral process and close the feedback loop, the Delaware referral platform was custom-built into CHADIS, with feedback from Birth to Three (B23), Child Find (CF) and HMG 211. Participating practices have access to a 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). These are all available under the CHADIS portal.

Pediatric practices can now use the online referral platform to make referrals directly to the Birth to Three program, Early Childhood Special Education and HMG@211 programs. The pilot project has also enabled the early intervention programs to access and process referrals from the pediatric practices via an 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.

We continue with efforts to strengthen the CHADIS project and to address barriers to full utilization by practices and early intervention, to increase communication and close the feedback loop. A CHADIS continuous quality improvement (CQI) meeting was held with representatives from Child Find on February 7, 2025, to discuss ways to overcome barriers to Child Find's usage of CHADIS. Child Find has expressed concerns about the setup of the referral platform, ranging from adding steps to their established workflow to duplicating efforts related to developmental screening, including confidentiality and consent related to a referral. Additionally, we have encountered challenges promoting social determinants of health referrals via the Help Me Grow@211 helpline.

We continue to work collaboratively with the IDEA Part C lead out of Department of Education to address challenges that arise as the Early Childhood Special Education staff receive referrals via the CHADIS platform. We also meet on a bi-weekly basis with CHADIS staff (director of Health Informatics Program) to discuss options to address identified Child Find concerns.

Currently, the priority is to create an alternate workflow to ensure CHADIS referrals are received by the appropriate Child Find office and that evaluation summaries are sent back to the referring practice to close the feedback loop.

This is particularly important to ensure a smooth scale-up of the CHADIS project.

In addition to CHADIS CQI efforts, the ECCS program has been working with pediatric practices currently utilizing PEDS online to progress to the CHADIS referral platform, to scale up the project to increase the availability and access to outcomes information on families referred to early intervention.

As part of the scale up efforts, meetings have been held with Bayhealth Pediatrics in Milford, as well as practices currently utilizing the state PEDS Online portal, to include Just Kids Pediatrics, Kaza Medical Group Pediatrics, Kent Pediatrics, Millcreek Pediatrics, Advocare Newark Pediatrics and ABC Pediatrics. Bayhealth Pediatrics signed up to begin implementing CHADIS in October 2025. In addition, Just Kids Pediatrics and Advocare Newark Pediatrics have expressed interest in implementing CHADIS and are currently working with the CHADIS team on next steps.

We continue to prioritize CQI efforts as we look to offer CHADIS to other practices that may be interested in implementing the system. We're currently finalizing the creation of a White Paper on Delaware's CHADIS project, outlining the purpose, goals and benefits of the project to families, pediatric practices and early intervention agencies.

From December 2024 through November 2025, the four participating pediatric practices administered approximately 7,123 screens through the CHADIS platform. These screens were a combination of Ages and Stages and PEDS developmental screens, including MCHAT. Within that period, 183 referrals to early intervention were captured. This is data that had never been captured by the ECCS program, even though the two early intervention programs would track referrals received but not at a comprehensive level across the state and that was a gap. The CHADIS project is an attempt toward a comprehensive approach to tracking early intervention referrals statewide.

Despite meaningful progress with the project, several ongoing challenges continue to impact the ability to fully realize a comprehensive, data-driven developmental screening and referral system in Delaware. One persistent challenge is the variability in developmental screening tools used by primary care pediatric practices. While a few practices utilize the state-supported PEDS Online portal, others prefer alternative validated screeners such as ASQ (Department of Education), SWYC (used by Nemours), or developmental milestone tools embedded within their electronic health records. For those practices that do not use the PEDS Online state portal and do not participate in the Delaware CHADIS project, the state is unable to capture their screening data, track referrals, or assess whether children successfully connect to early intervention services. This limits the ability to identify system gaps, monitor outcomes, and ensure that the referral feedback loop is closed.

Although CHADIS has the technical capacity to capture data from multiple screening tools, including ASQ and SWYC, access to this data in a usable, standardized format remains a challenge. The development, testing, and implementation of new CHADIS functionality is necessarily deliberate and time intensive. Continued collaboration is required to operate a customized dashboard that captures comprehensive developmental screening and referral data across practices.

A significant system-level challenge continues to be limited utilization of the CHADIS referral platform by both pediatric practices and early intervention referral agencies. Contributing factors include workflow concerns, limited familiarity with the platform, and staffing constraints. For referral agencies, CHADIS represents an additional system outside of their established workflows, requiring separate logins to receive referrals, provide updates, and close the feedback loop. This challenge is compounded by frequent staff turnover, making consistent platform use difficult to sustain.

For the CHADIS referral platform to function as intended—as a true closed-loop system—both practices and referral agencies must engage consistently at each step of the referral process. Continued efforts are needed to address workflow concerns, increase understanding of system benefits, and support sustainable adoption among all partners.

Parents' Evaluation of Developmental Status

State appropriation allocated to the Division of Public Health's Early Childhood Comprehensive System program in 2012 enables pediatric practices to utilize the PEDS Online (Parents' Evaluation of Developmental Status) screening tool at no cost. Since its inception, the ECCS program has collected and analyzed this data to inform policy and improve screenings. The CHADIS project is an example of using developmental screening data to inform

quality improvement. For this fiscal year, there were a total of 9,840 (community practices) PEDS Online screens completed on children 0-59 months between July 1, 2024, and June 30, 2025, which corresponds to an estimated 6,231 unique children or 63.3% of total screens completed were unique. This compares to 7,291 (non-Nemours) PEDS Online screens completed on children 0-59 months between July 1, 2023, and June 30, 2024, which corresponds to an estimated 4,864 unique children or 66.7% of total screens completed were unique. This equates to a 35.0% increase in total screens completed and a 28.1% increase in the number of unique (i.e., unduplicated) children. The challenge for this activity continues to be the low frequency of new pediatric practices that sign on to implement the PEDS online portal.

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 15 practices. The model of the initiative was to have a coordinator with a nursing background to manage the recruitment and training of the practices. The first few years had a qualified nurse in that position who would set up in-person visits with practices to conduct staff training. The eventual challenge turned out to be the lack of time, on the part of practices, to squeeze in 30 minute in-person visits. The other challenge was that compensation for the coordinator position was not comparable to the amount a registered nurse (RN) would make, so posing a difficulty. Currently, this position is held by a retired pediatrician and our physician champion, who works six (6) hours per week, with the DEAAP to address issues related to developmental health promotion and child health provider outreach. This role is more extensive than the role of the initial nurse coordinator.

Collaborations and Partnerships

The ECCS program's collaboration with the Delaware Chapter of the American Academy of Pediatrics led to a presentation at the recent DEAAP annual conference. The event was to bridge the gap between pediatricians and early intervention programs, especially the Part B program. The ECCS administrator collaborated with her peers from the Birth to Three (Part C) and Child Find (Part B) programs to present on bridging the gap. The presentation focused on building the awareness of pediatricians about the early intervention program, including the Help Me Grow system, especially the centralized access point to assist with socio-economic referrals. The "Bridging Services, Building Futures conference was intended to raise awareness among primary care pediatricians about Birth to 3, Child Find and the Help Me Grow System. The event brought together approximately 40 pediatricians including vendors from related agencies and programs.

As a system, it is essential for HMG to engage primary care pediatricians to not only support their work but to increase their awareness of community services and resources. Over the years, the ECCS program has had challenges with outreach to pediatricians due to the nature of their work. For this strategic planning year, the Health Provider Outreach sub-committee decided to change their target audience within the health system and focus on engaging pediatric residents. As the preparation and training program to usher postgraduate medical students into licensed practice as they hone-in their specialty, exposing them to community services and resources would increase their penchant to tap into those resources as they go into practice.

This led to the creation of pediatric residency proposal, called "Pediatric Residency Advocacy Community Experience (PRACE) Project" to engage pediatric residents in the HMG System and foster relationships with community partners. Working with our DEAAP contract lead, we're collaborating with the current Chair of the Delaware Chapter, AAP Early Literacy Committee and Interim Pediatric Residency Director at Nemours to develop the resident project for 1st and 2nd year residency to be presented in their 3rd year of residency. The plan is to reinforce and create awareness and engage 1st year residents in the HMG System and to establish a strong, grassroots connection with the system amongst pediatric residents. This is a work-in-progress that will continue through the next fiscal years.

An emerging opportunity identified during the very end of this fiscal period involves addressing barriers faced by Spanish-speaking families in connecting with Child Find (Part B within the school districts) services. We met with

Westside Family Health to address these challenges where they raised the potential of leveraging Help Me Grow@211 as a centralized access point to support referrals to Child Find and Early Childhood Special Education. We have since identified a workflow that will support this endeavor and are poised to launch this concept with the federally qualified health center (FQHC). The approach offers a promising pathway to improve access, and communication, with potential for replication across other practices experiencing similar challenges.

Between December 18th - December 30th, DEThrives ran a short reel to generate awareness of the Help Me Grow program and services at Delaware 211. The ad was to encourage families who may need extra assistance during the colder months to seek help from HMG at Delaware 211 if they may need assistance with finding food, shelter, warm clothing, assistance with keeping their house warm and more. Paulina Gyan, the ECCS/HMG Program Administrator of DPH, was featured in the reel. The ad targeted women over the age of 18+. The ad earned over 29K impressions (# of times a post has been displayed), reached almost 14K unique users, had a 2.14 frequency (# of times a user is exposed to an ad over a certain time frame, for reference it takes a user up to 5 views to actually read an ad), a 66.03% video click through rate (CTR) (the benchmark of the video VTR is 10%+).

The ECCS program further collaborates with DEAAP to support and expand Reach Out and Read in Delaware primary care pediatric practices. Leveraging the strong alignment between early literacy, child development, and health, efforts focus on:

- Engaging physicians and practice staff to raise awareness of developmental screening, referrals, early intervention, and community resources.
- Collaborating with community partners on literacy-based initiatives that connect families to health and social support; and
- Recruiting new partners to provide books and early childhood health resources aligned with the 13 well-child visits.

These efforts will further strengthen the integration of literacy, health messaging, and developmental surveillance, while enhance sustainability and reach of the ROR program statewide.

WIC Partnership:

The ECCS's partnership with the WIC program has progressively improved over the past three years. Previous attempts, pre-Covid, to strengthen the partnership did not work out as expected. The ECCS/HMG program had collaborated with WIC using the University of Delaware's *Learn the Signs Act Early* funding, to pilot a developmental screening project, where WIC participants would be asked if they had had a recent screening for their age-appropriate children. Unfortunately, the project, like any project supported by grants, came to end.

Fast forward in 2023, after discussions regarding WIC referrals at the centralized access point (HMG@211) with the WIC representative who sits on the Help Me Grow Advisory committee, we collaborated on a framework where WIC families who visit the WIC offices in public health clinics are referred to HMG@211 when they express challenges with social determinants of health. From 2023, when the project started to date, the total number of referrals to Help Me Grow@211 have increased progressively, from less than 100 referrals in 2023; 157 in 2024 to 397 in 2025. Based on the current data, the average referrals processed is approximately 33 per month. An analysis of 2024 referrals indicated majority of the families referred needed food. The 2025 data was not available for reporting.

In subsequent years, we will track WIC clinic performance, in terms of their total referrals made to the centralized access point. This will enable WIC leadership to provide support to those WIC offices to improve their referrals. We will also track the peak periods for increased WIC referrals to prepare staffing, not only at the WIC offices but also within the centralized access point -HMG@211.

KIDS COUNT Partnership:

KIDS COUNT in Delaware works to improve the lives of children, youth and their families through data-driven advocacy, policy change and program improvement. As a national and state-by-state effort the organization tracks the well-being of children. In Delaware, KIDS COUNT is a project of the Center for Community Research & Service at the University of Delaware.

For the past 5 years, the ECCS/HMG project has had a strong relationship with the organization. The Policy and Research Analyst, Erin Nescott, is a member of the Help Me Grow Advisory committee and participates in the CORE Team meetings. The CORE Team is a team of 7 partners who work with the ECCS/HMG Administrator to deliberate on the goals, objectives and implementation of ECCS/HMG activities. Erin also serves as the co-chair of the Data Collection and Analysis sub-committee and works closely together with the external evaluator, Vikrum Vishnubhakta to discuss data and epidemiology related concerns. In recent times, she has been instrumental in collaborations on the HMG Simulations and leading in writing a Letter of Intent (LOI) to apply for a Caplan foundation grant.

Referral and Linkages: Centralized Access Point

For linkages and referrals to community resources or services, the Help Me Grow centralized access point housed at Delaware 211 received 4,314 calls during this period. Many of these calls came from individuals residing in zones at risk for adverse maternal and child health outcomes - an indication that the services are reaching populations that need it the most. The partnership between Help Me Grow and Delaware 211 saw increases in the number of monthly contacts or calls from 100-200 on average in 2020 to 400-500 in 2025.

Concurrently, the HMG@211 staff supports Delaware's universal developmental screening mandate by assisting with 5,638 Ages and Stages referrals from childcare centers to early intervention services. The Birth to Three program funds 2 FTEs, housed within HMG@211, to support Ages and Stages developmental screens administered at childcare centers statewide. The staff at HMG@211 is responsible for forwarding the screens that show delays to the early intervention program. The centralized access point was also successful in targeting individuals residing in areas considered at highest risk for adverse maternal and childhood health outcomes. According to HMG@211 call reports, majority of calls were from those zip zones.

The role of the HMG@211 staff since the launch of the program in 2012 has evolved progressively and successfully to be viewed statewide as a sustainable and reliable "bridge" to supports and resources for families. Staff have evolved beyond their original simple role of providing telephonic referrals to families to being the warm hand-off for families referred by managed care organizations eligible to enroll in home visiting programs; connecting WIC families to services and supports; working with the school districts to channel delayed ASQ developmental screen results to early intervention programs.

For the coming years, we look forward to tracking their performance in being a warm hand-off for families of Westside Family Health (a federally qualified health center-FQHC) with delayed developmental screen results to the school districts' Early Childhood and Special Education programs.

A unique feature of Help Me Grow at 211 is the follow-up that occurs if the caller consents to the follow-up. Though there are competing programs that provide referrals to community services and resources, there's none that provides 100% follow-up services. The follow up feature builds assurance and confidence in callers and acts as safety net when callers face challenges as they navigate the system. This impact is supported by the number of callers who report that their needs were met (93 percent). The challenge is connecting with some families after they have agreed to follow-up calls. For one reason or the other the contact information on record does not work. 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.

Database Change:

This year, Delaware 211 invested in a new data system which impacted the data system that HMG@211 had been using since its launch – iCarol. Currently called 211 Ops, the new system allows for more data collection and tracking of variables that had hitherto not been possible. The new system provides significant improvements compared to iCarol, in both functionality and data collection. Call documentation is more streamlined and efficient, allowing specialists to capture and track information more quickly and accurately during interactions with families.

In addition to documenting contacts and referrals, 211 Ops enables staff to track 'unmet' needs by specific need category and by the agency or program where services were unavailable, providing deeper insight into gaps in community resources. The system also allows referrals and resource information to be sent directly to families via text and email and supports follow-up communication through both channels. These enhanced capabilities improve client engagement, strengthen reporting and outcome tracking, and provide more actionable data to support service planning and community impact assessment.

Public Assistance

Over the years, as an affiliate of the Help Me Grow, HMG Delaware has had to provide feedback on the national level, regarding the income of individuals who call the centralized access point (CAP). This is information that's not captured, as a matter of confidentiality, by the CAP. To address this gap, Delaware came up with proxies that could provide a measure of individual incomes based on their eligibility to qualify for such services. The proxies were Medicaid, WIC, SNAP/EBT; TANF and Purchase of Care (POC). Individuals who call into the Helpline are asked if they are enrolled in any of these services/programs. After 2-3 years of tracking this data, it was evident that Medicaid was the most common assistance program that was self-reported, followed by WIC. An opportunity that evolved organically from this query was that individuals, not enrolled in any of these services, but were seeking public assistance, requested guidance to enroll. Staff now respond to this need by connecting those individuals to the related programs/or services. To date, the most sought assistance is WIC and SNAP/EBT. We will continue to monitor this data to determine trends and make data-driven improvements.

Family and Community Engagement (FACE):

To ensure families are connected to a full range of services and support including education and awareness, the Early Childhood Comprehensive Systems program leverages the Family and Community Engagement (FACE) component of the Help Me Grow system to achieve these goals. Family engagement in early childhood requires commitment to create and sustain an on-going relationship that supports family well-being while fostering parent/child relationships. The ECCS program operationalizes this idea through the Books Balls and Blocks (BBB)project. The BBB project is a free and fun family event where parents and caregivers can participate with their children to get their developmental screens done while the children are drawn in to "play", with a focus on learning how games and activities can stimulate a child's development or growth.

This is a contracted project through DYE Training and Consult and L.E.T.S Play, inc. which organizes opportunities directly targeting parents or in partnership with childcare providers across the state. Their goal is to promote parental or community knowledge developmental milestones and to encourage parents to complete a developmental screen to leverage early detection. Books Balls and Blocks events are held either virtually or in-person. In-person BBB events are held in partnership with a childcare center or organized directly by HMG and BBB leadership.

In-person BBB events offer interactive stations where parents and caregivers can play with their child. Each station focuses on a specific area of developmental skills. If parents fill out the Ages and Stages Questionnaire, it helps them determine if their child is on track. The interactive stations could be used by parents to assess how their child is doing in terms of their growth, when they are filling out the ASQ. The stations help a child's brain and physical development improve as they play. It also helps identify skills such as hopping on one leg, using scissors, pointing at objects, and recognizing pictures in a book.

Books, Balls, and Blocks was invited to attend the Annual Winterthur Museum Day on August 23rd, 2025 in Winterthur, DE. The day was filled with family friendly activities that offered a range of hands-on activities, performances, and educational experiences throughout Winterthur's historic grounds. It was a chance for BBB to connect with the community with hands-on play, introducing the Ages for Stages Questionnaire, and sharing more information to families who would like more information about BBB, Developmental Screening, the QT30 app, HMG services, or other related services the BBB staff could help assist with.

Online or virtual BBB gives kids a chance to explore and practice focused skills on a single topic such as communication, language, cognition, problem solving and gross or fine motor skills. Virtual BBBs focus on these key skills as ASQ data over the past 4 years indicate delays in those areas for children, birth to 5 years in Delaware. These online events happen on Zoom. During the online BBB, staff help parents and caregivers play with their child in a way that encourages skill growth. A child's fine motor, communication, and problem-solving skills could grow with each BBB session. Three BBB Zoom sessions, typically held on Saturdays, target specific age groups: 12 to 23-month-old and 36 to 48-month-old children.

A recent survey in April 2025 of 19 families that participated in virtual BBBs, indicates parents found the sessions very helpful, knowledgeable and a phenomenal way for children to hit their milestones and interact with their peers. Most of the families reported they had joined the sessions for these reasons: to seek communications and problem-solving approaches, ways to develop their child's brain, speech and language development and kindergarten preparation. They were unanimous in the need for more information on community resources to assist with their children's development.

In addition to the Books Balls and Blocks project, Family and Community Engagement is also accomplished through informational displays tables at community events or providing training to interested early childhood programs. These community event interactions range from events in libraries, University of Delaware, early childhood centers; nursing sororities; managed care organizations; the Parent Information Center and United Way. In 2025, we reached out to 610 individuals in community agencies and trained another 224 individuals on developmental screening, linkages and referrals.

Data Collection and Analysis (DCA):

Data collection and analysis crosscut all the other HMG components to track the trends in the child health domain. It supports evaluation and helps to identify systemic gaps, while bolstering advocacy efforts, and guides quality improvement. For its strategic direction, the DCA identified the following as approaches to achieve the Theory of change; sharing data on a routine basis to stakeholders to highlight beneficial data points; collecting and analyzing Help Me Grow data to drive continuous quality improvement and advocacy at the state and local level. The annual report was an activity that stemmed from the goal of sharing HMG data with stakeholders. The annual report is currently out for review and once approved, will be disseminated broadly to early childhood stakeholders including posting on the Delaware Thrives website.

Following the annual report will be policy briefs in collaboration with KIDS COUNT in Delaware. The DCA continues with tracking and analyzing HMG@211 call data and reports it quarterly to the HMG Advisory committee. The committee is represented by about thirty child-serving providers who provide guidance and advice for the HMG System. Another activity the Data Collection and Analysis team has been working on is to develop a data sharing agreement with key stakeholders who administer developmental screens in the state. Delaware has a fragmented history when it comes to developmental screening promotion.

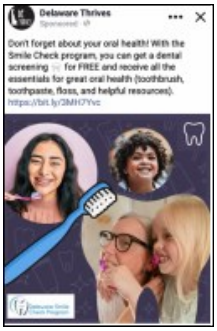
The Division of Public Health, through the ECCS/HMG program has promoted the use of Parents' Evaluation of Developmental Screens (PEDS) instruments within pediatric practices over the past 14 years. The Department of Education, with the recent universal developmental screening legislation mandating all licensed childcare centers to administer annual developmental screens, has endorsed the use of the Ages and Stages questionnaire (ASQ).

Nemours and ChristianaCare, (Delaware's Children's hospital, and hospital system, respectively) currently use the Survey of Well-being of Young Children (SWYC)screener. Such a situation poses an overall data integration challenge for the state, regarding developmental screening. Through the activities of the ECCS/HMG, the Maternal Child Health Bureau owns data for Help Me Grow@211 and PEDS online data within pediatric practices. The data sharing agreement would have the Department of Education and Nemours sharing their data with MCHB which would be analyzed by Forward Consultants, the MCHB external evaluator, and shared with all the parties. This was an agreement that existed years ago but went into default with changes in leadership and organizational culture at Department of Education and Nemours. We currently have MOUs that are under review for signatures.

The Maternal Child Health Bureau continues to support the marketing and communications of program activities and projects through the support of an external communications vendor, Aloysuis, Butler and Clark (AB&C). The company supports MCH programs to manage the flow of information to align with MCHB goals and objectives. Paying special attention on messaging that influences population's attitudes and beliefs regarding early childhood health and overall health. This is accomplished through the creation of Delaware Thrives website which features all programs and projects under the Family Health System. The website fosters communication with families and providers while enabling users' easy access to reach out with inquiries and concerns.

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 ECCS program intends to move in the future to actualize the goals identified for the 2025-2029 strategic direction. We will continue with the promotion of the Help Me Grow centralized access point to increase community utilization. For outreach to health care, we plan to provide education to resident pediatricians to sensitize their hearts and minds on the importance of developmental screens, including being knowledgeable about community resources and services.



Between July 11th - July 25th, 2025, DEThrives ran a single image ad on FB/IG's in-feed and in reels to promote the Healthy Smiles landing page. The ad targeted adults aged 18-45 years old who are parents of children under the age of 18 who live in Delaware. The purpose of the ad was to educate parents about the Smile Check program and oral health resources the Healthy Smiles page offered. The ad earned over 143K impressions (# of times a post has been displayed), reached over 95K unique users, and earned a 1.5 frequency (# of times a user is exposed to an ad over a certain time frame, for reference it takes a user up to 5 views to actually read an ad).

Medical Home

Evidence-based home visiting plays a critical role in helping families establish and maintain a medical home by serving as a trusted bridge between families and the healthcare system. Home visitors build ongoing relationships with families, identify barriers to care, and provide individualized support that increases access to preventive and primary healthcare services.

Home visitors connect families to a medical home by:

- Facilitating early enrollment with a primary care provider. Home visitors help pregnant individuals and families identify and establish care with a pediatrician, family physician, or other primary care provider before or shortly after a child's birth, ensuring children receive continuous, comprehensive care.
- Promoting preventive healthcare. Families are educated about the importance of well-child visits, developmental screenings, immunizations, oral health, and recommended maternal postpartum care. Home visitors encourage adherence to preventive care schedules and reinforce recommendations provided by healthcare providers.

- Reducing barriers to care. Home visitors help families overcome challenges such as lack of transportation, insurance enrollment, scheduling appointments, language barriers, and understanding how to navigate the healthcare system.
- Supporting care coordination. Home visitors facilitate communication between families and healthcare providers and help coordinate referrals to specialists, behavioral health providers, early intervention services, nutrition programs, and other community resources when concerns are identified.
- Identifying concerns early. Through regular developmental screenings, home visitors can recognize emerging concerns and ensure timely referrals to the child's medical home for evaluation and follow-up.
- Reinforcing provider recommendations. Home visitors help families understand diagnoses, treatment plans, medications, and follow-up instructions, increasing adherence and empowering parents to actively participate in their child's healthcare.
- Building family confidence and health literacy. By providing education on child development, maternal health, nutrition, safe sleep, breastfeeding, and injury prevention, home visitors strengthen parents' ability to make informed healthcare decisions and effectively communicate with their medical providers.

The Delaware Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program achieved a 77% well-child visit rate, meaning that more than three out of every four children enrolled in home visiting received their most recent recommended preventive healthcare visit according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. This performance reflects the program's strong commitment to connecting families with a consistent medical home and ensuring children receive routine preventive care, developmental monitoring, immunizations, and timely health screenings. HRSA identifies this measure as the percentage of enrolled children who received their last recommended well-child visit based on the AAP schedule.
This achievement highlights the important role that evidence-based home visiting plays in improving access to healthcare. Home visitors educate families about the importance of preventive pediatric care, help schedule appointments, address barriers such as transportation or insurance, and reinforce the value of maintaining regular well-child visits. These efforts strengthen partnerships between families and healthcare providers while promoting healthy child development and early identification of developmental or health concerns. Research has consistently shown that home visiting is most effective when integrated within a comprehensive, family-centered medical home.

Nutrition

New Castle County Community Health Services (NCC CHS) continues to expand access to evidence-based nutrition services, with a strong emphasis on supporting the health and development of infants, children, and adolescents. During the past year, Registered Dietitian Nutritionist (RDN), Madison Powel, provided individualized nutrition counseling through 151 nutrition appointments.

Clients were referred to the nutritionist after accessing services through NCC CHS, including Child Health and Immunizations, Adult Health, Sexual and Reproductive Health and Family Planning, Tuberculosis, Birth to Three, the Health 2 Go Mobile Health Clinic, the Women, Infants, and Children (WIC) Program, and the Lead Program. Referrals from the Women, Infants, and Children (WIC) Program, the Lead Program, and Birth to Three connect young children and their families with nutrition counseling for concerns such as elevated blood lead levels, iron deficiency, selective eating, food allergies and intolerances, poor growth, and feeding challenges associated with developmental delays. In addition, both Child Health and Sexual and Reproductive Health Programs provide opportunities to support children and adolescents with nutrition counseling that may promote healthy growth and development, healthy weight management, adequate nutrient intake, and the establishment of lifelong healthy eating behaviors during a critical stage of physical and emotional development. These referral pathways create opportunities for early nutrition intervention, empowering children, adolescents, and their caregivers with the knowledge and skills needed to establish healthy eating habits and reduce future health risks.

This year, DPH has launched the expansion of wellness visits for adolescents and young adults as well as sports physicals for returning students. These initiatives have created additional opportunities to integrate nutrition into preventive healthcare for children and adolescents. Routine laboratory testing, including fasting blood glucose,

hemoglobin A1c, lipid panels, hemoglobin, and lead screening, allows nutrition concerns and disease risk factors to be identified early. For adolescents, counseling emphasizes building the knowledge, confidence, and skills needed to make informed food choices, establish healthy habits, and take an active role in managing their own health. For younger children, nutrition counseling focuses on empowering parents and caregivers with practical strategies to support healthy growth and development, address feeding challenges, and create a positive home food environment. Services may include individualized meal planning, grocery shopping guidance, energy and nutrient recommendations, portion size education, disease-specific nutrition therapy, healthy recipes, and collaborative goal setting to promote realistic, sustainable behavior change for the entire family.

All nutrition recommendations are based on current evidence and national practice guidelines, including the USDA MyPlate framework, the Dietary Guidelines for Americans (2020–2025 and 2025–2030), the Centers for Disease Control and Prevention (CDC), the Academy of Nutrition and Dietetics (AND), and disease-specific organizations such as the American Heart Association (AHA) and American Diabetes Association (ADA). When appropriate, clients are also connected with additional statewide programs and community resources to further support their health.
Additionally, DPH has implemented the MyHealth patient portal to increase access to care and encourage greater patient engagement. The portal empowers both adults and adolescents to take a more active role in managing their health by allowing them to schedule appointments, access health information, and participate in nutrition consultations in person, by telephone, or through telehealth. These expanded care options also improve convenience for parents and caregivers, increase access to nutrition services, and help reduce barriers to receiving timely, individualized nutrition care.

NCC CHS also supports community outreach and adolescent health education through partnerships with local schools and participation in public health initiatives. On August 7th, 2025 NCC CHS held their first Sports Physical Day. The Child Health and Immunizations Program was able to provide many sport physicals to help prepare returning students for safe participation in school athletics while encouraging lifelong healthy habits. On April 28, 2026, the Hudson State Service center hosted the Brandywine Lifesavers. This program brings middle school students from the Brandywine School District to learn about careers in healthcare and the important role public health plays in improving community well-being. NCC CHS also held their HIV testing week from June 22nd until June 26th, 2026, to increase awareness of HIV prevention and available resources.

In addition to providing nutrition services and community outreach, 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, the nutritionist has 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 held on June 4th, 2026, and the Delaware Academy of Nutrition and Dietetics (DAND) annual conference held on March 13, 2026. Furthermore, the nutritionist has completed nutrition trainings and webinars with a focus on pediatric nutrition, child feeding, adolescent health, and emerging nutrition topics, including GLP-1 medications, genetically modified ingredients, and organic vs. non-organic foods.

Lastly, the nutritionist continues to contribute to statewide public health nutrition initiatives through membership in the Division of Public Health's Advancing Healthy Lifestyles (AHL) Coalition, which works to improve the health and well-being of Delaware residents by promoting healthy lifestyle behaviors. This past year, she authored the AHL blog article Feeding the Feelings, which highlights strategies for developing a healthier relationship with food and supports nutrition education efforts that benefit children, adolescents, and families. She also served her second year on the Delaware Academy of Nutrition and Dietetics Board of Directors as Newsletter Editor, helping to disseminate evidence-based nutrition information, support nutrition professionals, and advance the practice of dietetics

throughout Delaware. These statewide collaborations strengthen the Nutrition Program by ensuring that children and adolescents receive nutrition care that reflects current evidence-based practices and emerging public health priorities.

Developmental Screening

As mentioned in the annual report, Delaware Early Childhood Comprehensive Systems program went through strategic process in 2024 and spent 2025 implementing the objectives and activities identified for their strategic direction. We will continue with the strategic direction for the 2027 application through 2029 when the plan ends. We will continue with the promotion of the Help Me Grow centralized access point to increase community utilization. For outreach to health care, we plan to provide education to resident pediatricians to sensitize their hearts and minds on the importance of developmental screens, including being knowledgeable about community resources and services.

In assisting families and professionals to connect children to the network of community resources, the Help Me Grow@211 project intends to continue to look out for outreach opportunities that could expose potential stakeholders to the benefits of calling the one-stop-shop to link the needy families they serve. To this effect, we're currently in collaboration with Westside Family Health, to utilize the care coordination skills and expertise of HMG@211 staff, to support the Federally Qualified Health Clinic (FQHC) manage their referrals when delayed developmental screens need early intervention support. This will be the first venture of HMG@211 staff supporting a pediatric practice with early intervention referrals. The effort also has the potential for families with social determinants of health needs to be assisted by the HMG@211. The data that is tracked here will inform Delaware if the model needs to be expanded across the state.

The purchase of the new data system (211Ops) is an opportunity for the Early Childhood Comprehensive Systems program (ECCS) and Help Me Grow System to capture certain trends and data which had not been possible with the previous iCarol system. Having access to such data will assist with continuous quality improvement of the centralized access point including how we can assist vulnerable families. For instance, we're now able to track certain WIC data which was previously not possible. This new variable will provide insights into WIC offices' frequency in referring families to HMG and assess peak times for WIC referrals to the centralized access point. Such data will improve WIC office performance while preparing both WIC and HMG@211 to be ready for the peak periods with more resources and staffing.

The partnership between WIC and ECCS/HMG was sustained in 2023 and the data, since then, has indicated a progressive increase each year of the number of families referred to HMG@211. For the coming fiscal year, we will continue to strengthen this partnership and seize opportunities that are data-driven and beneficial to the families we serve.

Since 2012, HMG Delaware and the ECCS program have been collecting and analyzing data related to developmental screening, centralized access point call reports, health provider screens and referrals to early intervention outreach and family and Community engagement satisfaction data. Delaware now has a repository of data that could serve as a basis toward an integrated early childhood data system across the state. With this purpose in mind, ECCS/HMG has reached out to Department of Education's Office of Early Childhood Intervention and the state's major children's hospital, Nemours to establish a data-sharing agreement, through Memoranda of Understanding. We will continue to pursue this path till there's political will and funds available for the state to consider such an initiative.

The Data Collection and Analysis sub-committee maintains, collects, and analyzes HMG data to drive continuous quality improvement. One of the strategic outcomes was to share Help Me Grow data on a routine basis to stakeholders to highlight beneficial data points, needs or gaps. For the past fiscal year, we were successful in writing an annual report, which is yet to be disseminated to stakeholders. The plan is to use the annual report to develop policy briefs for the upcoming fiscal year, in addition to writing another annual report for 2026.

The Data Collection and Analysis team has also considered ways to support ECCS/HMG activities through assistance with grant writing. The assistance of the two evaluators on the team will guide HMG Delaware to seek grants from foundations and other organizations, not only to sustain existing activities but support innovative ideas. In

May 2026, we completed a letter of Intent (LOI) in response to a grant from the Caplan Foundation. We're also ready to respond to upcoming Early Childhood Comprehensive Systems Federal grants.

Family and Community Engagement (FACE) activities are accomplished through the Books Balls and Blocks initiative (BBB). We plan for the upcoming fiscal year to hold an In-person BBB event that will entail collaborating with a host of early childhood programs while ensuring access to administering developmental screens. The FACE team will continue with the virtual BBB sessions.

One of the tenets of the FACE is to build parent understanding of healthy child development and available supportive services to families in the community. The ECCS/HMG parent leadership strategy for the upcoming year is to utilize a peer support model where trained advocates wrap holistic support around families. These parent leads will serve as an essential bridge to connect their peers with health, educational and social information. Over the years ECCS/HMG has developed parent leadership programs, however such efforts have not been successful regarding sustainability. This concept leverages parent's lived experience such effort to engage parents by raising the value of their roles through extensive training and compensation.

During the past fiscal year, the ECCS program deployed a simulation approach to engage participants, so they have interactive experience with the HMG system services. Memory retention is optimal when adult learners learn by doing or demonstration. The result is change in knowledge, attitude and behavior. For FY 2025, the ECCS program targeted child-serving providers in southern Delaware. For the upcoming year, the Help Me Grow simulation will be held in Kent County, but it will be held as a workshop session within the "Making a Difference Conference".

The conference is an annual professional development event hosted by the Delaware Institute for Excellence in Early Childhood (DIEEC) tailored for educators and childcare professionals. The event will be held in October 2026. In the same way, Delaware's HMG will feature the simulation event on the national level at the upcoming Help Me Grow National Virtual Forum in November 2026. The Forum is an exciting opportunity for those engaged in HMG systems across the nation to learn from one another and develop new supportive connections that build thriving early childhood systems for the children and families we serve. Delaware's intent for showcasing this innovative approach to promoting the HMG model is to share the concept with other HMG affiliates for replication within their states.

The engagement of medical providers through the Child Health Care Provider Outreach offers early detection and intervention efforts while linking them to the network of community resources to support families. We will continue with the outreach to resident pediatricians through the "Pediatric Residency Advocacy Community Experience Project" to engage pediatric residents in the HMG System and foster relationships with community partners. The focus, this upcoming year, is to provide overviews of early childhood programs or services that could be helpful to residents when they graduate out of residency.

The ECCS program will continue to expand and improve its collaborating efforts with other partners and stakeholders. The partnership with 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. In same vein the collaboration with the WIC program will continue as we determine other data variables that will improve services to the children and their families.

The ECCS program intends, in fiscal year 2027, to support the efforts of the Department of Education's Office of Early Childhood Intervention (OECI) as they implement the Preschool Development Grant to expand early education access, support early childhood workforce and modernize family resources. The $11.3 million federal grant is an opportunity for the ECCS/HMG program to partner with OECI to share insights gained over the past fourteen years as related to developmental screening and HMG@211 call data. It is the Early Childhood Comprehensive System goal to contribute toward Delaware's efforts to establish an early childhood data integration system.

Medical Home

We will continue to partner with Local Implementing Agencies (LIAs) of evidence-based home visiting programs to ensure families are connected to and engaged with a consistent medical home. Through ongoing program oversight, technical assistance, quality improvement, and cross-sector partnerships, we will reinforce practices that promote timely access to preventive healthcare and improve coordination between home visiting, pediatric providers, and community services.
Our support will include providing guidance and training to home visitors on the importance of establishing a medical home, conducting developmental surveillance, encouraging adherence to the American Academy of Pediatrics' recommended well-child visit schedule, and assisting families in overcoming barriers to healthcare access such as transportation, insurance enrollment, and appointment scheduling. We will continue to monitor program performance using federal MIECHV benchmark and performance measure data, including rates of well-child visits, and work with LIAs to implement continuous quality improvement strategies when opportunities for improvement are identified.

In addition, we will strengthen partnerships with pediatric providers, Medicaid managed care organizations, Help Me Grow, Early Intervention, and other community-based organizations to improve referral pathways and care coordination. By promoting strong communication among providers and supporting families in navigating healthcare systems, we will help ensure children receive timely preventive care, developmental screenings, immunizations, and referrals for additional services when needed.

Through these efforts, we aim to improve access to comprehensive, family-centered healthcare, support healthy child development, and advance positive maternal and child health outcomes across Delaware.

The MCH Bureau will leverage our social media platforms as a key strategy to educate families about the importance of establishing and maintaining a medical home. Through engaging, family-friendly content shared across multiple platforms, we will explain what a medical home is, the core components of comprehensive, coordinated, continuous, family-centered, culturally responsive, and accessible care, and how having a medical home supports children's health and development. Social media campaigns will also provide practical information on finding a primary care provider, preparing for well-child visits, understanding preventive care, and accessing community resources. By delivering consistent, easy-to-understand messaging, we will increase awareness of the benefits of a medical home and empower families to actively engage in their child's healthcare.

Nutrition

The Public Health Nutritionist plays a vital role in improving the health and well-being of individuals and families throughout the community by providing evidence-based nutrition services that support both disease prevention and chronic disease management. Through individualized counseling, collaboration with healthcare providers, interpretation of laboratory values, and targeted nutrition interventions, the Nutrition Program within New Castle County Community Health Services (NCC CHS) helps address concerns such as obesity, diabetes, hypertension, elevated cholesterol, iron deficiency, lead exposure, and healthy growth and development across the lifespan. As NCC CHS continues to expand access through telehealth, preventive screenings, wellness visits, and integrated clinical care, nutrition services remain an essential component of a comprehensive public health approach.

An ongoing goal of the Nutrition Program is to expand access to reliable, evidence-based nutrition information that supports the health and development of children and adolescents. In the coming year, the program plans to develop educational materials that clinic staff can use when counseling children, adolescents, and their caregivers on common nutrition-related concerns. These resources will provide practical guidance on topics such as healthy growth and development, age-appropriate nutrition, selective eating, iron deficiency, lead exposure reduction through nutrition, healthy weight management, sports nutrition, and establishing lifelong healthy eating habits. By equipping staff with consistent, evidence-based educational tools, children, adolescents, and their families will receive

reinforced nutrition guidance at multiple points throughout their care.

The Public Health Nutritionist also plans to maintain and regularly update bulletin boards throughout clinic locations with current nutrition information, seasonal health messages, community resources, and wellness-focused educational content. These displays will serve as an additional avenue for health promotion, helping to increase awareness, encourage healthy lifestyle behaviors, and connect patients and visitors with available nutrition services. Through these efforts, the program aims to strengthen nutrition education within the clinic setting and support informed health decisions across the community.

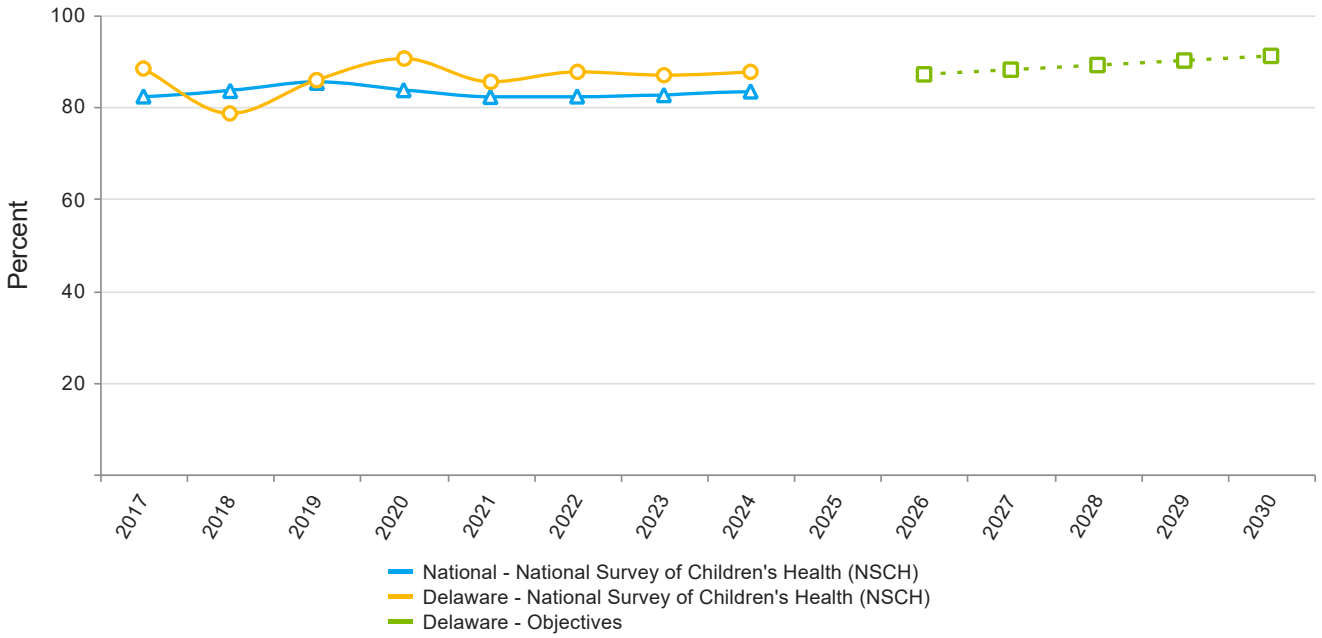
In the coming year, NCC CHS has goals to implement billing for eligible nutrition services as a strategy to support the long-term sustainability and growth of the program. Reimbursement for medical nutrition therapy and related services will help strengthen the program's ability to continue providing high-quality, evidence-based nutrition care to individuals and families throughout the community. Revenue generated through billing can be reinvested into program development, educational resources, and expanded service offerings, allowing the Nutrition Program to reach more residents while maintaining its commitment to public health prevention and chronic disease management.

In the coming year, the Public Health Nutritionist will continue to expand community outreach and nutrition education efforts through participation in key public health events, including Back-to-School Day at the Hudson State Service Center, sports physical clinics at both Hudson and Porter State Service Centers, HIV Testing Awareness Day, and collaborative community events with local community programs.
In addition to providing nutrition consultations, continuing education is a vital component of maintaining Registered Dietitian credentials and licensure while ensuring that nutrition services reflect current evidence-based practice. The Nutritionist plans to attend the Annual Delaware Healthy Mother & Infant Consortium Summit, the Annual Delaware Diabetes Wellness Expo, the Delaware Academy of Nutrition and Dietetics Annual Conference, the Advancing Healthy Lifestyles (AHL) Coalition Annual Conference, and the Annual World Breastfeeding Celebration hosted by the Delaware WIC Program. In addition, the Nutritionist will complete relevant webinars, trainings, and continuing education opportunities focused on adolescent and child health, maternal and child nutrition, chronic disease prevention, and other emerging public health nutrition topics to strengthen clinical knowledge and enhance the quality of services provided to the 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	**2025**
Annual Objective		
Annual Indicator	86.8	87.5
Numerator	13,797	16,022
Denominator	15,887	18,304
Data Source	NSCH	NSCH
Data Source Year	2022_2023	2023_2024

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

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		58.1
Numerator		25,574
Denominator		44,055
Data Source		Adolescent Wellness SBHC Raw Data Reports
Data Source Year		2025
Provisional or Final ?		Provisional

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

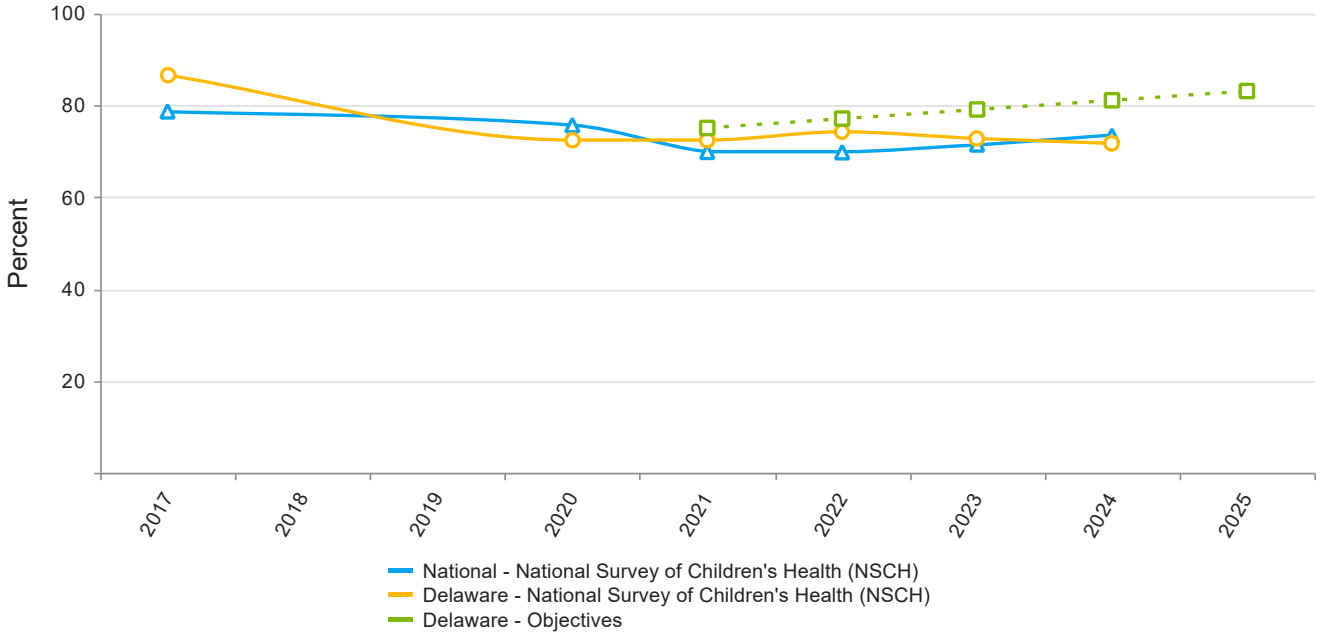
State Action Plan Table (Delaware) - Adolescent Health - Entry 1	
Priority Need	
Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening	
NPM	
NPM - Mental 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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	75	77	79	81	83
Annual Indicator	71.9	71.8	74.2	72.6	71.8
Numerator	48,388	51,420	53,987	52,895	53,406
Denominator	67,333	71,653	72,759	72,862	74,365
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	25	75	75	80	85
Annual Indicator	76.2	74.2	66.7	82	75.5
Numerator	4,902	4,958	4,420	6,028	4,603
Denominator	6,429	6,678	6,631	7,352	6,097
Data Source	SBHC Porgram Data	SBHC Program Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Final	Final

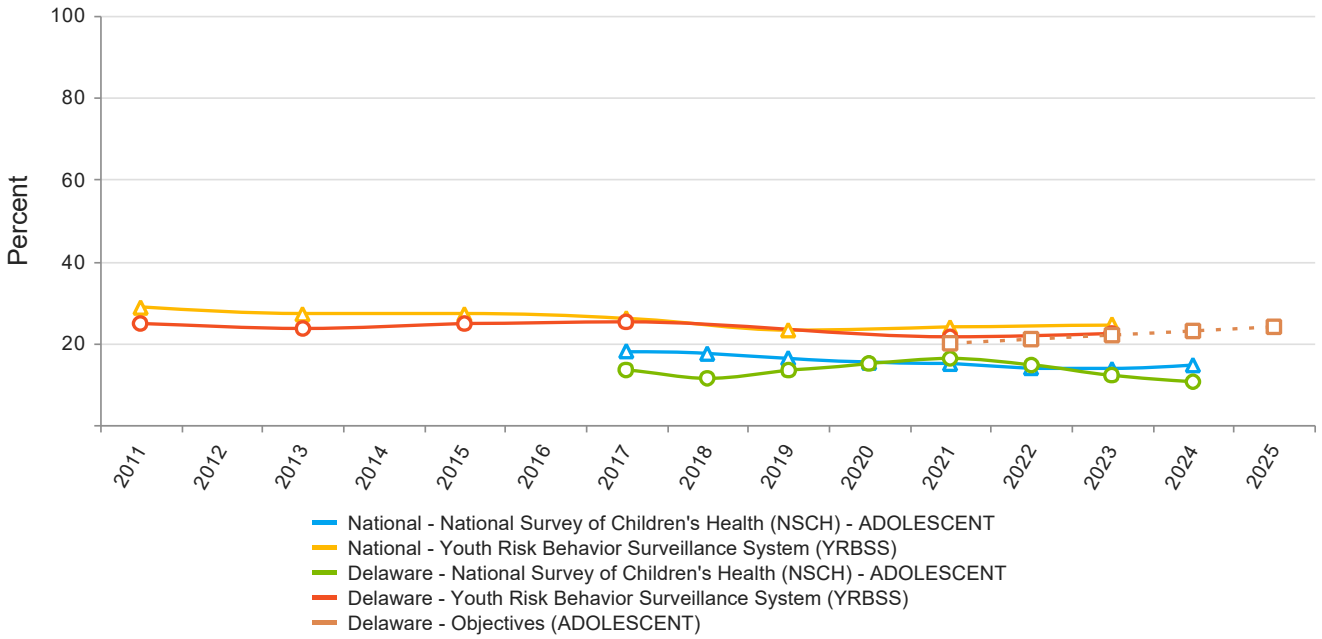
2021-2025: ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.

Measure Status:				Active
State Provided Data				
	2022	**2023**	**2024**	**2025**
Annual Objective			55	60
Annual Indicator	48.2	53.6	52	47.5
Numerator	4,530	3,413	5,262	4,706
Denominator	9,407	6,367	10,121	9,912
Data Source	SBHC Program Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Provisional

2021-2025: ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:			Active	
State Provided Data				
	2022	**2023**	**2024**	**2025**
Annual Objective			0.2	0.3
Annual Indicator	0.1	0.2	0	0
Numerator	99	337	53	53
Denominator	140,263	141,729	142,495	142,495
Data Source	DOE Program Data	DOE Program Data	DOE Program Data	DOE Program Data
Data Source Year	2022	2023	2024	2024
Provisional or Final ?	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: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	20	21.0	22	23	24
Annual Indicator	14.9	16.0	14.8	12.1	10.7
Numerator	9,878	11,362	10,707	8,813	7,976
Denominator	66,257	70,996	72,524	72,721	74,207
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	20	22	22	23	24
Annual Indicator	25.1	21.6	21.6	22.4	22.4
Numerator	9,329	8,529	8,529	9,237	9,237
Denominator	37,230	39,459	39,459	41,212	41,212
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2021	2021	2023	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**	**2025**
Annual Objective			12	15
Annual Indicator	14.3	21.4	21.4	21.4
Numerator	6	9	9	9
Denominator	42	42	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023	2024	2024
Provisional or Final ?	Final	Final	Final	Final

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 16-17 2025
Teen Dating Violence workshop at the Fall Provider Meeting	In person	October 23 2025
Crash Course in Best Practices for Teaching Sex Ed at VoTech School District for the district's health teachers	In person	November 2025
Curriculum Booster Training for Champion Teachers	In person	November 2025
Parent Information Session for Girls Scout Troop 66	In person	January 2026
Parent information session for Child Inc	In person	November 2025
School Based Health Center Training New Castle County: Supporting Teens	In person	March 2026
Teacher Training - Best Practices in Sex Education	In Person	March 2026

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 2024/2025 school year, the School Based Health Centers in Delaware schools administered 1,709 depression screenings, 2,323 STI screenings, 17,159 Emotional (Mental Health) evaluations, and 5,926 risk assessments. In addition to this. These numbers have increased from the previous school year.

The School-Based Health Center (SBHC) Operational Meeting, held in conjunction with the Title X Family Planning Program on November 13, 2025, brought together mental health and medical providers from SBHCs, Division of Public Health (DPH) clinics, Federally Qualified Health Centers (FQHCs), community health centers, and DPH/Family Health Services staff. The meeting, themed "Rooted in Resilience: Embracing Change, Growing Together," provided opportunities for collaboration, professional development, and information sharing to improve health outcomes for Delaware's youth and families.

Breakout sessions included Pediatric Mental Health Consultation: Delaware Child Psychiatry Access Program (DCPAP) presented by Colleen Leitner, MD; Addressing Care Gaps in the HIV and STI Prevention Continuum presented by Wayne Duffus, MD, PhD; and Clearing the Air: Patient-Centered Reproductive Health in the Misinformation Age presented by Ariel Remericky. The keynote address, "Change: Turn Uncertainty Into Opportunity," was delivered by a Senior Consultant with Franklin Covey.

The Spring Provider Meeting (May 20, 2026) also included a Quality Insights presentation titled "HPV: Prevention In Action – Protecting The Next Generation Through Vaccination," delivered by Anna Gurdak, BASW, MBA.

These educational opportunities enhanced participants' knowledge of adolescent, maternal, and child health while reinforcing the importance of health, patient-centered care, leadership, and cross-sector collaboration to improve outcomes across Delaware.

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. 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.

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. 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.

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.

As of May 2026, Delaware has 33 recognized School-Based Health Centers (SBHCs) operating in high schools and 26 in middle and elementary schools. All public non-charter high schools in the state are equipped with an SBHC.

In 2024, three elementary schools and one middle school established new SBHCs, expanding access to essential health services for students. These participating schools are listed on the sitemap.

In 2026, East Side Charter was recognized to provide SBHC services to students at the school. Looking ahead to the upcoming fiscal year, Delaware anticipates the recognition of additional elementary and middle school SBHCs, further strengthening access to critical health services within school communities.

Adolescent Health - Application Year (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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, 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. Enrollment in SBHCs continues to grow, along with the number of visits conducted to serve students throughout the state. The increasing demand for services has prompted widespread interest in expanding SBHCs to more elementary, middle, and high schools across Delaware. Currently, Delaware operates SBHCs in 33 public high schools and 26 public middle and 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.

Recognizing the growing need for accessible healthcare services, Delaware intends to establish four new SBHCs in rural middle schools. The state also plans to expand the network of SBHCs in rural Sussex and Kent County elementary and middle schools to provide comprehensive physical, behavioral, and preventive health services. This expansion may include activities that support planning, clinical readiness, regulatory compliance, equipment installation, technology infrastructure, and systems development necessary to successfully launch and sustain new SBHCs.

SBHCs are key components of Delaware's strategy for meeting the physical and behavioral healthcare needs of children so they are healthy, engaged, and ready to learn. This is accomplished through health promotion, the delivery of medical and mental health services, health education, and information and referral services that extend beyond those provided directly by SBHC staff. These comprehensive services are intended to improve health outcomes and support the overall well-being of adolescents.

A major advancement in reproductive health services occurred when school boards across 21 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, including youth, pregnant and parenting teens, and adolescents involved in the juvenile justice system.

The Adolescent Wellness Program also supports ongoing collaboration and professional development through its annual Fall Forum. This event brings together providers from SBHCs, schools, healthcare organizations, and community-based agencies across Delaware. The forum provides opportunities for networking, sharing best practices, and participating in educational sessions focused on emerging trends, current challenges, and topics affecting adolescent health. By fostering collaboration among professionals serving youth, the Fall Forum helps strengthen service delivery, promote innovation, and enhance the quality of care provided to adolescents throughout the state.

Supporting students is a growing priority. In partnership 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 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 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.

The program is actively working with providers to improve the quality, accuracy, and consistency of data collection and reporting. Through ongoing collaboration, technical assistance, and data validation efforts, providers are strengthening the completeness and reliability of submitted data. These improvements will support the development of meaningful reports that effectively tell the story of program impact and outcomes, as well as the creation of dashboards that provide timely, actionable insights for program monitoring, decision-making, and continuous quality improvement.

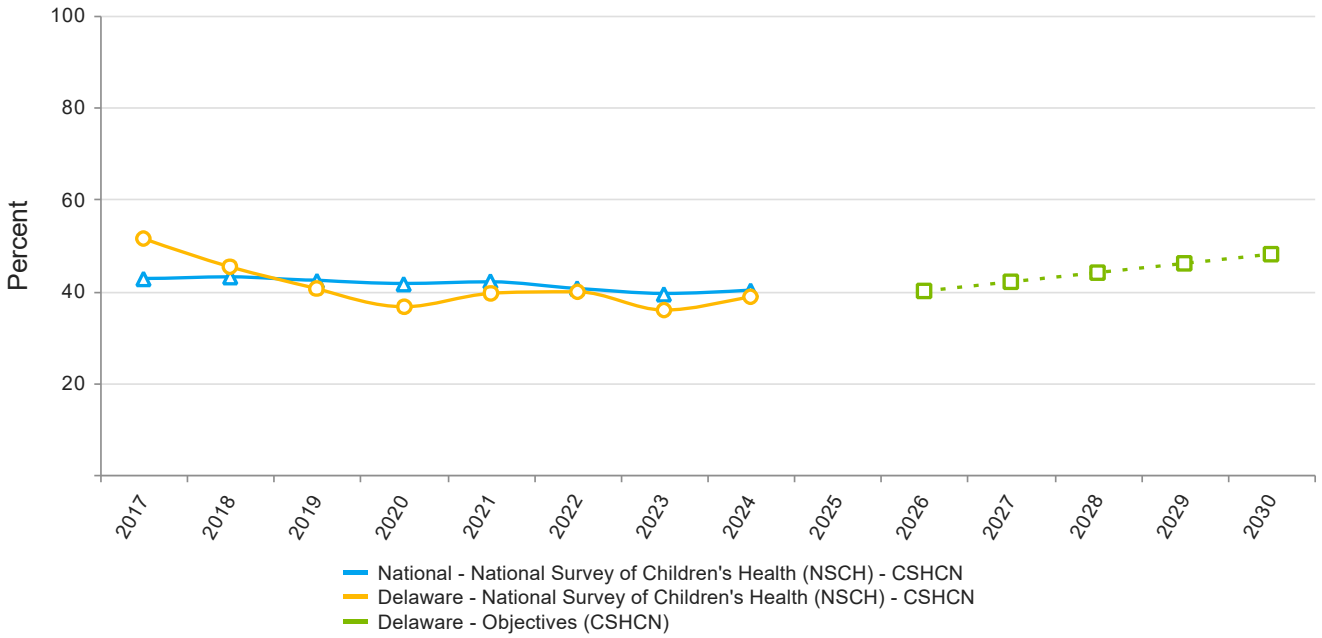
Looking ahead, Delaware remains committed to increasing the number of adolescents receiving annual preventive well visits. These visits are critical for identifying physical, emotional, and social health needs early and ensuring access to appropriate care and resources. SBHCs are instrumental in achieving 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. Continued growth in enrollment, utilization, and community demand demonstrates the value of these services to students and families across the state. With strong stakeholder commitment, innovative partnerships, strategic expansion into underserved rural communities, and a clear vision for the future, SBHCs are poised to expand their impact and continue improving the health and well-being of Delaware’s youth for years to come.

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**	**2025**
Annual Objective			
Annual Indicator	40.2	35.8	38.8
Numerator	18,442	21,932	23,374
Denominator	45,845	61,253	60,241
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023	2023_2024

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

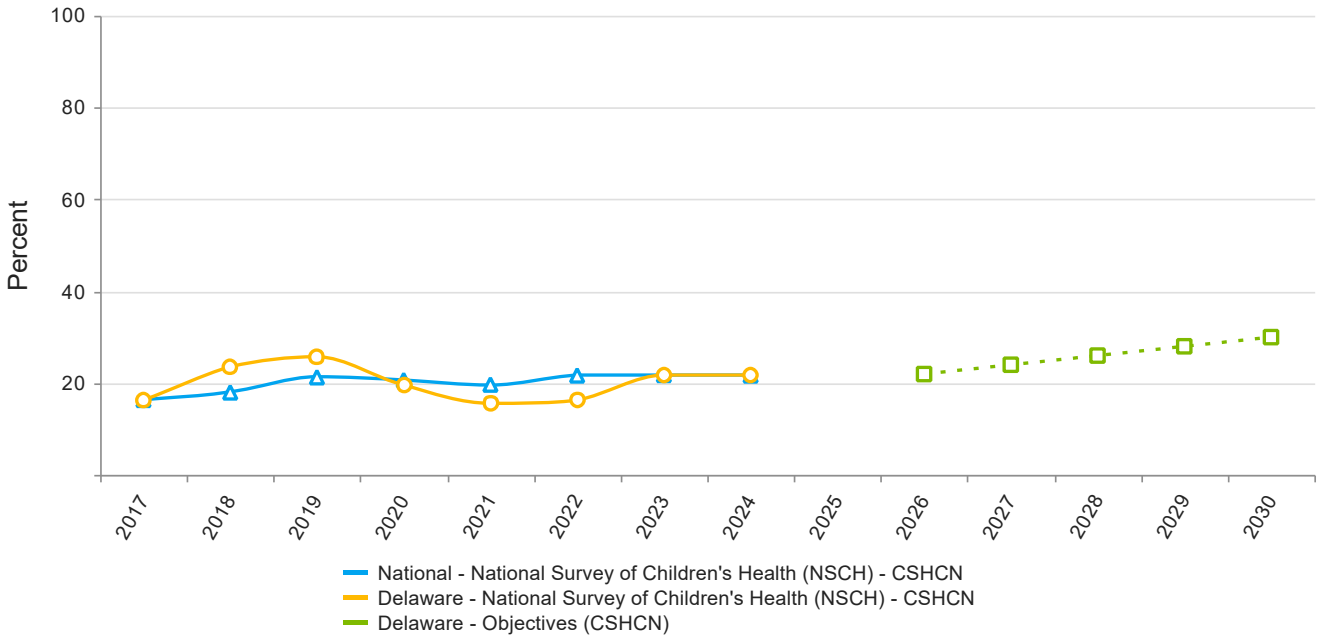
ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.

Measure Status:	Active

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator	72.9	77.7
Numerator	462	497
Denominator	634	640
Data Source	MIECHV Program Data	MIECHV Program Datat
Data Source Year	2024	2025
Provisional or Final ?	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	**2025**
Annual Objective		
Annual Indicator	21.7	21.7
Numerator	5,781	5,860
Denominator	26,596	27,001
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2022_2023	2023_2024

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.

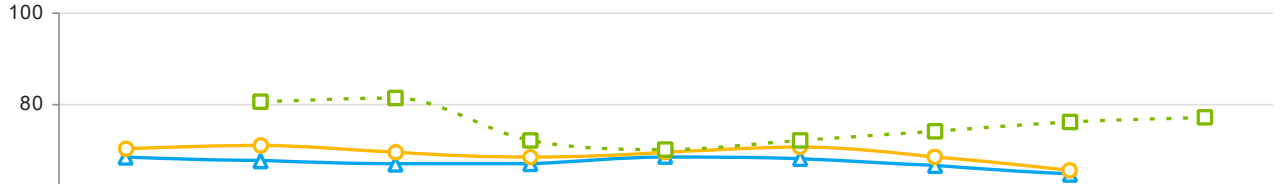
ESMs	Status
ESM TAHC.1 - Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12-17.	Active

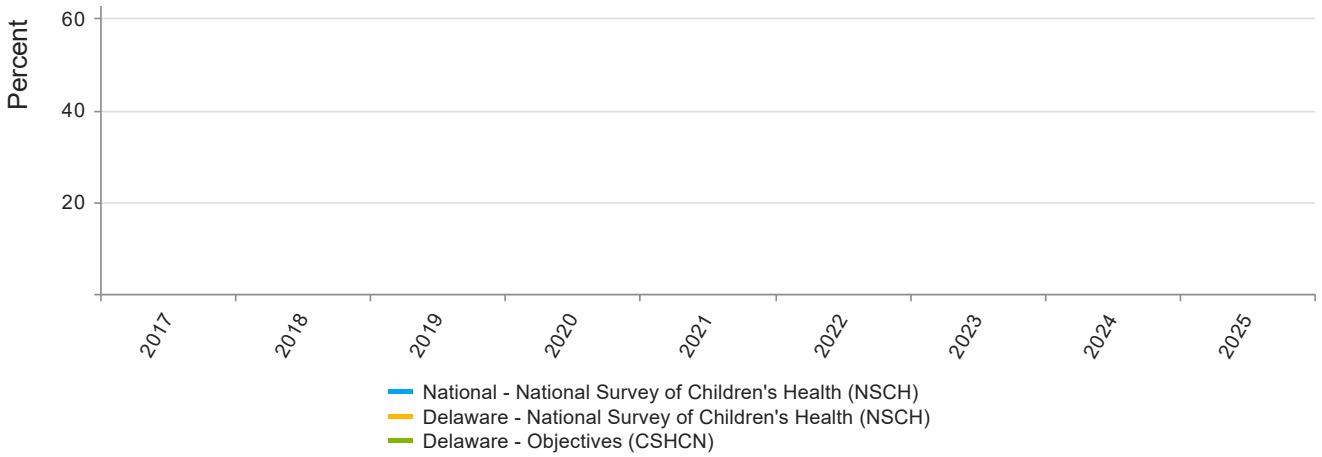
NOMs

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	70.0	72.0	74	76	77
Annual Indicator	67.2	68.8	70.7	68.5	65.4
Numerator	136,015	140,169	145,366	141,609	135,624
Denominator	202,319	203,715	205,678	206,831	207,267
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	90	92	94	96	98
Annual Indicator	89.1	91.5	90.6	93.8	91.9
Numerator	595	644	598	656	598
Denominator	668	704	660	699	651
Data Source	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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**	**2025**
Annual Objective			80	85
Annual Indicator	73.3	73.3	60	60
Numerator	11	11	9	9
Denominator	15	15	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	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.

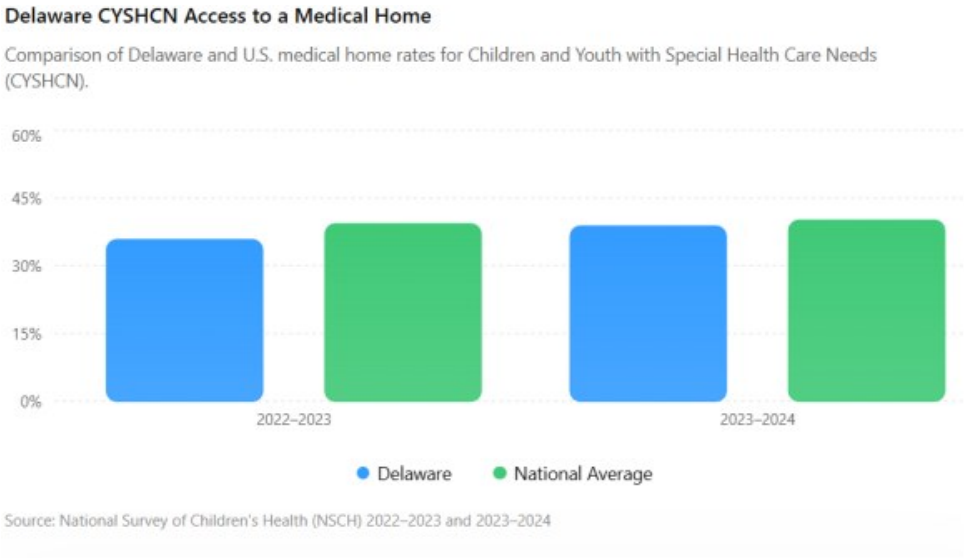
Measure Status:			Active	
State Provided Data				
	2022	**2023**	**2024**	**2025**
Annual Objective			75	85
Annual Indicator		100	100	100
Numerator		609	554	424
Denominator		609	554	424
Data Source		CYSHCN Mini Grantee data	CYSHCN Mini Grantee data	Family SHADE/MCH Program Data
Data Source Year		2023	2024	2025
Provisional or Final ?		Final	Final	Final

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.

According to the 2023-2024 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 60,241. Of these CYSHCN, 38.8 percent (n = 23,374) have a medical home in comparison to the nationwide average of 40.1 percent. Conversely, 61.2 percent (n = 36,867) of Delaware CYSHCN do not have a medical home as compared to 59.9 percent of CYSHCN nationwide.

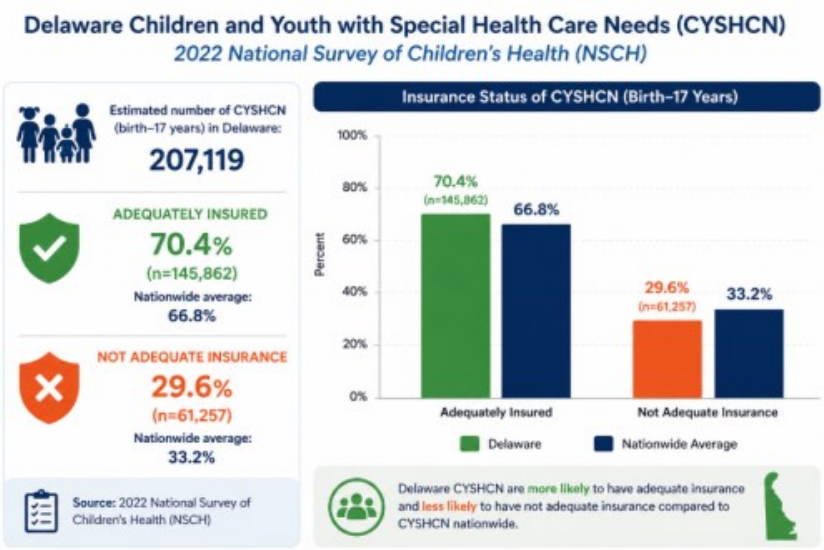
Delaware achieved a 3.0 percentage-point increase in medical home access for CYSHCN, rising from 35.8% to 38.8% between reporting periods. This improvement represents positive movement toward ensuring that more children receive comprehensive and coordinated healthcare services. Delaware continues to strive toward reducing the gap between Delaware and the national average and connecting more children and families to coordinated, comprehensive healthcare services.

Below is a graph that illustrates the rise from 2022 to 2024 between Delaware and the National Average.



According to the 2022 National Survey of Children's Health (NSCH), the estimated number of CYSHCN between birth and age 17 years is 207,119. Of these CYSHCN 70.4 percent (n=145,862) were adequately insured in comparison to the nationwide average of 66.8 percent. Conversely, 29.6 percent (n=61,257) of Delaware CYSHCN's insurance was not adequate as compared to 33.2 percent of CYSHCN nationwide. Delaware would like to highlight that our CYSHCN are more likely to have adequate insurance compared to the nationwide average.

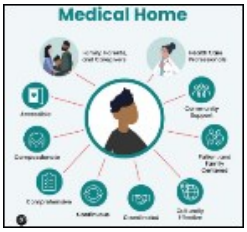
Below is an infographic chart that compares Delaware to the nationwide average of CYSHCN with and without adequate insurance.



The National Survey of Children's Health (NSCH) discontinued the collection of adequate insurance data for Children and Youth with Special Health Care Needs (CYSHCN) after the 2022 reporting year. Delaware focused on bringing this National Performance Measure to a close in calendar year 2025. Additionally, Adequate Insurance was no longer designated as a National Performance Measure (NPM) for the 2025–2030 Maternal and Child Health Block Grant cycle.

On July 8, 2025, DEThrives ran an Instagram and Facebook post stressing the importance of the Family Support and Healthcare Alliance Delaware (SHADE) and how it connects special-needs children and their families with the care, resources, and events they need to thrive. Learn more today by visiting the #LinkInBio.

As part of Delaware's statewide needs assessment process in calendar year 2025, families and subject matter experts identified Transfer to Adult Health Care for CYSHCN as a priority area and selected it as a new National Performance Measure (NPM) to replace Adequate Insurance. Transfer to Adult Health Care for CYSHCN focuses on supporting youth (age 12-17) with special health care needs as they prepare to shift into adult health care systems and services. In addition, Delaware will continue to prioritize Medical Home as a longstanding National Performance Measure. The state has focused on improving access to medical homes for more than five years and remains committed to advancing coordinated, comprehensive, and family-centered care for CYSHCN through ongoing systems improvement efforts.



The MCH team collaborated to determine how we can help share what the term 'Medical Home' means. We aimed to create a diagram for the CYSHCN population and for all Delawareans to have a better understanding of what is meant when we talk about a 'Medical Home.' On June 30th, 2026, a Medical Home themed post will be published on our social media outlets to express to our community what a Medical Home means. The posts will be displayed in a carousel display where multiple pictures are available to wipe through for more information.

Family SHADE (Support and Healthcare Alliance Delaware)
In Yr. 2025 The Family SHADE programmatic approach extended family and professional partnerships at all levels of decision making that best served our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resources for community organizations serving CYSHCN.

Delaware's Parent Information Center led the Family SHADE project in its 4th cohort. The Children's Beach House (CBH) and Down Syndrome Association (DSA) focused on National Performance Measure Medical Home and Adequate Insurance. Teach Zen (TZ) addressed National Performance Measure Developmental Milestones for CYSHCN. All 3 mini grantees served CYSHCN for 3 consecutive years. Each of the grantees had a different clientele and very different procedures for recruiting clients into their programs and providing services. CBH recruited a cohort of 50 CYSHCN in January that they continued to work with through the grant period providing social and health care services through the year, and which culminated with their visit to the Beach House in summer, 2025. Through CBH social and health care services, they identified if CYSHCN had adequate insurance and if they had a medical home. DSA throughout the grant period gradually recruited new CYSHCN clients beginning in December, so there was a cumulative increase in clients served during the grant year until they exceeded their target of 50 by 22 at the end of October. DSA gained new clients during the grant but continued to serve those recruited in earlier years. Both CBH and DSA worked directly with children and their families. Teach Zen provided services through participating in child Day Care programs. In FY2023 and FY2024, services were provided directly to students, but also directly and indirectly to teachers. In FY2025, TZ worked directly with teachers and administrators at the Day Care Centers. TZ's work in FY2025 involved repeated contact directly with teachers and some access to student demographics, but no direct contact with CYSHCN or families.

Through August, Children's Beach House (CBH) continued to work with its cohort of at-risk children and youth that had been identified in January. In the months from February to May, activities focused on student physical and mental health needs, school related issues, preparation for the summer beach house experience and then preparation for the needs of the coming school years. In addition to meeting social-emotional learning goals, families were supported with practical needs. Assistance was provided in obtaining annual health physicals and ensuring that at least one participant was successfully connected with a consistent medical home and verified if the families served had adequate insurance. Strengthening the overall well-being of both the child and family was the focus for families of CYSHCN.

During May, CBH staff supported youth and their families in preparing for the end of the school year and in record compilation for upcoming camp. With the end of the school year in May, Family Engagement Coordinators participated in over a dozen IEP meetings with classifications for ADD, ADHD, ODD, Autism, hearing-speech and language disorders, and other unspecified learning disabilities and health impairments identified and incorporated into student planning for the fall return to school. Also, in May the second Parent Advisory Board meeting was held; and the need for seeking better parent engagement identified, as noted below. Early June focused on getting the Camp ready for the youth, and youth began arriving at Camp in mid-June. Participants spent a week at camp between June 15th and August 8th, with the SHADE participants spread across the larger camp cohorts with assignments into camp groups based on emotional development, age and social emotional needs. Participation in the Children's Beach House residential camp program is the culmination of the CBH program from the child's perspective, a unique experience designed to foster personal growth, build resilience, and strengthen connections among peers. The program provided a structured environment where children stepped away from their daily routines and immersed themselves in activities that encouraged teamwork, responsibility, and self-discovery. Goals were intentionally tailored to each age group and centered on social-emotional learning, ensuring that children developed skills that were not only developmentally appropriate but also transferable to their home, school, and community life. These outcomes were made possible through the combined efforts of camp staff, family engagement coordinators, and community partners who worked collaboratively to create an atmosphere of safety, belonging, and growth.

The hard work and passion CBH served was 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 working 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.

An important component of CBH work in FY2025 has been the development and increasing use of a Parent Advisory Board. This began in January with the work of the Family Engagement Coordinators, and, after a slow start-up, CBH reached out to parents in English and Spanish, to see what changes needed to be made. Their survey results revealed much about how to better reach and involve parents. The findings included getting information on how often to meet, what days and times work best for meeting, and garnering suggestions on giving advance notice on times and especially agendas for meeting. Most interesting (not only for CBH but for other SHADE activities, and for work with at-risk youth and families in general) were the responses to:

It appears parents are interested in attending if advance scheduling is done and if they think it is important and will address the needs of the children. The Board repeatedly met to address parent concerns and desires. They devised events that would be both entertaining and useful for parents, a successful effort happened in August when the Family Engagement Coordinators organized a Luau-themed family barbecue. As part of this event, families received backpacks and school supplies to support a smooth progression into the new academic year. The strong engagement and buy-in from families through the Parent Advisory Board has continued to strengthen relationships, creating a supportive network.

Down Syndrome Association (DSA) continued to provide services on a continual basis throughout the year, with incremental addition of clients monthly. In the 10 months of the current contract, between 5 and 16 new CYSHCN and their families were recruited each month into the continuum of services provided by DSA and Nemours Children's Health. This brings the total to 72 new SHADE participants in FY2025, well above the target of 50. The SHADE project has slowed monthly new admissions over the 3 years of mini-grant funding as the agency's publicity and outreach work have reached most of the at-risk families with a Down Syndrome child or youth in Delaware. Most new enlistees are very young, and referrals come from health care workers who make families aware of DSA and its services and link families to DSA outreach workers for assessments and intake. New clients' complete assessments, medical appointments with Nemours Children's Health, and other services provided through direct contact with the community liaisons and outreach workers supported by the grant. All new DSA clients also received initial and then ongoing Developmental Screening assessments which had not been available to them previously. Each of the new monthly cases represent a child and family linked to a comprehensive medical home. It is important to note that DSA activities are more about continuing client support than the new clients recruited monthly. Given the nature of their medical conditions, all these clients will be part of the DSA system and the coordinated medical services from Nemours Children's Health up to the age of 22, as long as they remain in Delaware. So, although a few clients have aged out of the SHADE program or moved out of state, close to 500 DSA CYSHCN clients are continuing to be provided with services under the DSA SHADE award through the community liaisons and outreach workers and the family assistance programs. As noted by DSA, being able to utilize SHADE funding for outreach and recruiting has identified Down Syndrome clients in areas not previously reached (particularly downstate communities), and DSA has been able to bring them into the umbrella medical home services offered by DSA's partnership with Nemours Children's Health hospitals and its clinic. Clients recruited now can be sustained in services based on the ongoing relationship with Nemours Children's Health and the continuing contact with DSA and

its community coordinators. All the DSA SHADE clients are linked with a comprehensive medical home through the combined and coordinated services of DSA and Nemours Children's Health. Services through DSA and Nemours remain available beyond 18, up through age 21. Specifically related to the SHADE program services emphasis on outreach to families, DSA has documented the initial and continuing benefits of having parent and self-advocates in the Nemours Children's Health clinic and satellite services. Advocates and outreach workers eased the process of entering the system, help negotiate access to new services as needed over the clients move from infancy through childhood and adolescence and help with the procedures and protocols of state and federal requirements.

Teach Zen (TZ), as they delineated in their approved work plan, did not provide direct services to children in their FY2025 activities. Rather, they changed their focus to work on the potentially more important and long-term continuing impact for Teach Zen in training day care teachers. During FY2025, Teach Zen's One Love, One Heart program supported three early childhood centers teachers, training them in implementing self-regulation strategies and deepening teachers' use of Ages and Stages Questionnaire (ASQ) data to address behavioral and developmental concerns. This is a marked change from TZ's work in the earlier two years of Family SHADE funding where they worked with students directly, and the influence on teachers and staff was palpable but more second hand initially as they observed TZ work with students.

Beginning in mid-December, TZ started a repeated series of one-on-one coaching sessions with lead teachers in classrooms at each of the twos, threes, and fours (shorthand for each of increasingly older classroom's groupings) in three-day care centers. Sessions were repeated with teachers in each month into June. Each of these schools had participated with TZ in the classroom sessions in FY2024 where TZ worked directly with students as well as providing guidance to teachers. The direct training sessions continued into June for a total of 54 sessions (3 lead teachers at three schools for each of 6 months). In the first six weeks, training sessions focused on seeing what teachers had learned, what they hoped to gain, and what they needed reinforcement on to support the development of self-regulation skills in all children, particularly those with special health care needs. Of value to the teachers was the opportunity to have problem solving sessions for dealing with student issues which teachers were currently dealing with, as well as more general concerns. Across all sites, educators reported that structured breathing, movement, and co-regulation exercises helped create more connected and calm classrooms. With administrators' agreement, classrooms sought to institute calming corners in their classrooms. These were not the "naughty" or "time out" chair for punishment; rather they were used as and recognized by teachers and students alike as safe spaces that allowed children to self-regulate or seek co-regulation when overwhelmed. Teachers found this approach with a non-pejorative setting provided a spot for some children at some times to calm and self-regulate. Teachers were especially receptive to this approach helping with CYSHCN.

The second major component of the TZ work with childcare teachers developed somewhat serendipitously, building on suggestions from the January 27th, 2025, Family SHADE Technical Assistance Meeting. TZ began focused assistance to these teachers and their Centers for their "Ages and Stages" reporting that the State planned to require from centers. This involved coaching educators (both teachers and administrators) to use ASQ (the Ages and Stages Questionnaire) data more intentionally—particularly when working with children presenting behavioral or developmental concerns. Teachers expressed the need for a system that flags recommended ASQ follow-ups and notifies both administrative staff and teachers. Teachers felt they needed to be looped into the ASQ process from the start, both to provide context to the responses for the child and then to make use of the information in the classroom. And finally, teachers needed to have the ability to communicate both with center administrators and the parents about children's needs.

In June after the follow-up sessions, TZ created, with evaluator assistance, a questionnaire for the childcare staff being trained in 2025. In July TZ submitted a short report on the teacher results. Based on the final reports from the teachers' evaluations, this effort with the ASQ was particularly helpful to the centers as they work on their State reporting. By the spring, all the teachers were now aware of and making use of the ASQ data. All but one teacher reported a decline in behavioral issues in classroom with the use of the calming tactics and the "compassionate questioning" of kids. And all of scale of 1-5 with 5 highest, all but one teacher recommended Teach Zen's One Love, One Heart program a 5 (the one outlier gave it a 3). TZ's coaching revealed systemic challenges (e.g., teachers often lacked access to ASQ reports, follow-up screenings were missed due to the absence of tracking systems, and parents were sometimes hesitant to pursue referrals) but teachers also strongly felt the program helped them and

their students, and they appreciated the tools and strategies that helped them reframe children's behaviors.

The chart below concluded the work completed by the Family SHADE mini-grantees in calendar year 2025. It summarizes the services provided to CYSHCN directly and indirectly.

	Children's Beach House	Down Syndrome Association	Teach Zen
		FY 2025	
Target and completion for clients served by mini-grant in FY2025	New client recruiting occurred in January for FY2025. The planned cohort of 50 was identified and the youth and their parents agreed to their participation. The 2025 client cohort consists of 37 from Sussex County, 6 from Kent County, and 7 from New Castle County. In total, 32% are Caucasian, 20% African-American, 30% Hispanic, 2% Native American, and 16% Mixed. Cohort remained stable throughout contract until one participant left the program in August	10 New clients in May and 8 new clients in June, 7 new clients in July, 3 in August, 2 in September, and in October, and 16 in October, bringing the total to 72 for FY2025 and 507 in the multiple years of DSA SHADE support. The 72 new clients exceeded the target of 50 for the FY2025 mini-grant.	No student clients were served in FY2025. A total of 54 Training sessions with teachers began in January for FY2025 with recurring sessions planned monthly through June. Sessions with teachers in each of 2 year olds, 3 year olds and 4 year olds were held on: 12/10/2024 1/28/2025, 2/25/2025 3/27/2027, 4/29/2025 5/19/25, 6/4/2025, 6/5/2025, 6/12/2025

Wrapping Up Calendar Year 2025 of the Family SHADE Project

In preparation for the next 5 years (FY2026-FY2030) of our approach in serving CYSHCN and their families, a rigorous needs assessment was conducted in the prior 2 years, which provided us with guidance in executing the National Performance Measures (NPMs) addressing Medical Home for CYSHCN and Transfer to adult health care for CYSHCN age 12-17. In FY 2025-2026 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 a resource for community organizations serving CYSHCN. Families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems of change to best serve families of CYSHCN. Also, under the PIC Family SHADE project, the awarded mini-grantees (Children's Beach House, Down Syndrome Association of Delaware and Teach Zen) rendered services to CYSHCN and their families in their unique delivery of service, as stated earlier. Our MCH Title V State System Development Initiative (SSDI) Director-Elizabeth Orndorff led the statewide Needs Assessment review bootcamp which included data collection from Delaware statewide Focus Group which we referred to as Chat-n-Chew analysis with family members of CYSHCN, Stakeholder Survey results, Data infographics created for our National Performance Measures (NPMs), and results of our key informant interviews, as well as our workforce capacity evaluation. Participants that contributed at the bootcamp brought their unique lens to the table and provided input and feedback as it related to topic areas surrounding their specific health domains in addition to the data collected through the needs assessment results. The perspectives received allowed for prioritization of our CYSHCN priority areas to focus on for the next five years. The two NPMs that were of most importance were Transfer to Adult Health Care for CYSHCN age 12-17 years and Medical Home. Medical Home was and continues to be an NPM that has been addressed in Delaware for over 5 years and will continue to be a NPM for CYSHCN. This needs assessment served as our foundation and guidance to drive our efforts in meeting the needs of CYSHCN through our Family SHADE project. On January 27, 2025; the CYSHCN Director-Isabel Rivera-Green coordinated an all-day in-service technical assistance training at the Route 9 Public Library in New Castle, DE. The purpose of the in-service was to bring together and share with our contracted vendor-Parent Information Center (PIC) who led the Family SHADE project and the awarded mini-

grantees. Also, 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 were in attendance. The all-day in-service was intentional for our vendor and mini-grantees to be aware of the needs assessment outcomes identified for Delaware CYSHCN. The goal was to position the vendors and mini-grantees by making them aware of the needs for CYSHCN that were identified and how they can collaborate with the Maternal Child Health Title V toward closing the gap on the new National Performance Measures (NPMs) for CYSHCN which would be the focus for FY2026-FY2030. Participants in the in-service were Centers for Disease Control and Prevention (CDC) Maternal Child Health (MCH) Title V Family Health Systems Epidemiologist-Katie Labgold, Family Health Systems, MCH-Title V State Systems Development Initiative Director (SSDI)-Elizabeth Orndorff, Parent Information Center Team-Meedra Surratte, Yvonne Bunch, Steven Martin, and Mary Andrews. The mini-grantees that attended from their perspective agencies were, Children's Beach House -Jacqueline Donaldson and Down Syndrome Association -Lauren Camp-Gates. A representative from Teach Zen could not attend the technical assistance in-service, however PIC would take back the information to the program lead-Kyma Fulgence.

In our approach to addressing the 2 National Performance Measures (NPMs) -Medical Home and Transfer into adult health care for CYSHCN age 12-17, the in-service resulted in being beneficial to all in attendance. We discussed the MCH Evidence Strategy Planning Tool which we adopted from www.mchevidence.org. The tool provided us with a structured framework that assisted us in identifying and closing gaps in health outcomes through strategic, evidence informed planning. Our CDC Maternal Child Health (MCH) Title V Epidemiologist-Katie Labgold facilitated the in-service and provided her expertise on assisting us with attaining our goals, priority needs, strategies, and objectives based on our needs assessment results. We also completed the Fishbone Diagram which allowed us to identify contributing factors and determining root causes as well as prioritizing important causes and positive/negative contributing factors. Our outcomes provided us direction in being intentional in Results-Based Accountability (RBA) and Root-Cause Analysis (RCA) which allowed us to understand our state's story behind the needs assessment data that guided our work in FY2025 and the upcoming approach for the next 4 years to FY2030. Unfortunately, due to reallocation of funding and federal changes outside of the state of Delaware's control; our CDC Maternal Child Health (MCH) Title V Epidemiologist-Katie Labgold was terminated in the spring of 2025.

Outcome of the all-day in-service technical assistance training on January 27, 2025:

National Performance Measure: Medical Home

Priority Need: All children, with and without special health care needs, have access to 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 relevant educational messages and resources on the medical home model of care.

Objectives:
• By 2030, increase the percent of parents of CYSHCN who feel that they are part of a medical home model of care.

National Performance Measure: Transfer to Adult Health Care, CYSHCN age 12-17 yrs.

Priority Need: All CYSHCN receive the necessary organized services to make the shift to adult health care.

Strategies:
• Mini-grantees will educate the adolescents they serve with special health care needs, ages 12 through 17, on the importance of a transfer plan for adult health care.

• Mini-grantees will educate families of CYSHCN on their knowledge and awareness of an organized transfer process to prepare for the transfer to the adult health care system.

• The Family Leadership Network (FLN) will customize a transfer plan tool kit to educate families on the questions to ask their doctors regarding progression to adult health care.

Objectives:
• By 2030, increase the percent of adolescents with special health care needs who received services necessary to make the transfer to adult health care.

The outcomes of the in-service technical assistance provided by the CYSHCN Director-Isabel Rivera-Green and the Maternal Child Health Title V team members on January 27, 2025, provided those serving CYSHCN and their families with data on the service gaps that have been identified by families of CYSHCN and subject matter experts that serve these families in Delaware. As the end of the contract year with Parent Information Center serving as the leader of the Family SHADE project was scheduled to end in November of FY2025, the in-service provided knowledge on gaps in service for CYSHCN as well as positioned PIC and mini grantees to competitively apply in an upcoming competitive request for proposals (RFP) in FY 2026. Due to procurement policies and procedures, a competitive RFP would be issued for the Family SHADE project to afford new vendors the opportunity to apply for the Family SHADE project as well as PIC.

In May of 2025 a competitive Request for Proposal (RFP) HSS-25-044 was issued for the Family SHADE (Support Healthcare Alliance DE) “Mini-Grant” Project for Children with Special Healthcare Needs. The scheduled timeline was:

Public Notice	May 12, 2025
Deadline for Questions	May 26, 2025
Non-Mandatory Pre-Bid Meeting	June 2, 2025 @ 1 PM EST
Response to Questions Posted by	June 16, 2025
Deadline for Receipt of Proposals	**July 1, 2025 1:00 PM EST (This date was extended and amended in the RFP to July 8, 2025).**
Estimated Notification of Award	September 1, 2025
Estimated Project Begin Date	December 1, 2025 **(Start date with new vendor was February 1, 2026.)**

While the RFP for the Family SHADE (Support Healthcare Alliance DE) “Mini-Grant” Project for Children with Special Healthcare Needs was going through its process. The Parent Information Center (PIC) continued services through the mini grantees and the Family Leadership Network (FLN).

On November 14, 2025, DEThrives ran a post on Instagram and Facebook that advertised the Family Support and Healthcare Alliance Delaware (SHADE) and provided information on empowering families and kids with special needs through support, resources, and community events.

Later in FY2025 leadership recommended eliminating a few Evidence-Based or Informed Strategy Measures (ESMs) for the CYSHCN program that were identified at the January 27, 2025, technical assistance in-service. The in-service was attended by the PIC -Family SHADE lead, mini-grantees, CDC Epidemiologist, SSDI and CYSHCN Director. Leadership recommended moving the ESMs to strategies across different domains to simplify things for our first FY 2026. The survey conducted by mini-grantees for medical home was moved to strategies. Since we will be starting a new contract for our Family SHADE project that serves CYSHCN, the specifics of conducting a survey could possibly change which could help us create stronger ESMs around it next year. So, we revised and identified one ESM for medical home using Home Visiting data and one ESM on Transfer into adult health care.

The revisions resulted in:

Medical Home Evidence-Based or Informed Strategy Measure (ESM):

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.

Transfer into Adult Health Care Evidence-Based or Informed Strategy Measure (ESM):

Increase the number of adolescents with a progression plan into an adult health care system of care for CYSHCN ages 12-17.

On November 30th, 2025, Parent Information Center (PIC) Family SHADE project lead did not apply for the Request for Proposal (RFP) for the Family SHADE project and PIC's contract was coming to an end. The new contract was not finalized by December 1, 2026, with the newly awarded vendor. Therefore, we were able to extend PIC's contract until January 31, 2026. The objective of extending PIC's contract was to create a warm passing from PIC to the new vendor -University of Delaware Center for Disabilities Studies (UD/CDS) who would assume the new role as the Family SHADE lead overseeing the mini-grantees and reintroducing PIC as a subcontractor under the leadership and guidance of UD/CDS. PIC's new role would be to oversee the Family Leadership Network (FLN) with the guidance of UD/CDS.

PIC Family Leadership Network Luncheon & Shift of Family SHADE Project

PIC led a Family Leadership Network Luncheon on January 30, 2026. The focus was on supporting the shift of project activities, including coordination of the Family Leadership Network (FLN) and mini-grantee support, to the new vendor-University of Delaware/Center for Disabilities Studies (UD/CDS). Initial planning meetings were held with PIC and UD/CDS staff to discuss progression planning and project implementation. Subsequent meetings were paused temporarily due to contractual matters while changeover details were being addressed. Targeted outreach and promotion were conducted to existing FLN members to encourage participation. While several registered FLN members were unable to attend due to inclement weather that week, the event engaged several new participants and provided an opportunity to expand awareness of the FLN and related project activities.

Project Activities:

Activity	Date	Member(s) Present	Additional Information
Planning Meetings	11/3/2025 2/20/2026	M. Andrews/S. Mallory (CDS)	
Email to FLN members	11/15/2026 3/9/2026		Changes/information Interest meetings
Eblast	1/9/2026		Invitation to luncheon
Planning Meetings	12/2025	M. Surratte/YMB Consulting	Logistics, program details and updates for luncheon
Scope of work	3/3/2026	PIC/CDS	Review of activities under contract.
Planning Meetings	1/2026	M. Surratte/YMB Consulting	Final logistics for luncheon
Planning Meeting PIC	12/9/2025	M.Andrews/YMB Consulting/S. Martin	Planning of event, review of discussion topics and agenda.
Follow up email	10/23/2025	PIC/CDS	Discussion around project/FLN
Communication	12/11/2025	PIC/CDS/YMB	Sent information and agenda for the event. Connected team to YB and MS
Communication	1/20/2026	PIC/CDS	Confirmation of event and review of materials.
Phone calls to FLN members to confirm	11/2025	PIC	Called all members to confirm participation
Phone calls to invite to roundtable event	12/2025	PIC	Calls made to members to confirm participation

The mini-grantees and YMB Consulting supported engagement with Family Leadership Network members and helped ensure strong participation and coordination for the luncheon event.

Mini Grantee Support

- Facilitate Transfer to new vendor
- Provide final technical assistance and support to mini-grantees. Support mini-grantees with preparation for luncheon

YMB Consulting Activities:

- Provided promotional and logistical support to mini grantees in preparation for the luncheon.
- Assisted project staff with the changeover of the mini-grantee program to a new vendor to support continuity of program operations.
- Conducted outreach to Family Leadership Network (FLN) members to encourage attendance.
- Coordinated correspondence and follow-up communication with FLN members and mini-grantees to support participation in the luncheon.

Outcome of the Family Leadership Network Luncheon

The Luncheon Presentations and Roundtables took place at the Christiana Hilton on January 30, 2026. It served as a recognition of the accomplishment of Family SHADE Project under the Parents Information Center (PIC) and as segue into the new partnership of PIC with the University of Delaware's Center for Disability Studies. About 27 attended, representing PIC staff, providers, parents, FLN members, staff from UD Disability Center, and state officials.

The agenda (attached) was closely followed. The three summaries of the mini-grantees, (two in person, one by video) showed the real progress made by all three in the past two years. The presentations and accomplishments demonstrated how mini grants can support new activities by existing community providers (DSA and CBH) and also

initiate a new activity and service by a new community provider (Teach Zen).

One sad factor for the Family Leadership Network Luncheon, was the paucity of FLN members attending. The weather that day, the lack of childcare, and other day time commitments for FLN members were reasons for very few FLN attending. In the roundtable discussions, there were many useful comments on how to engage parents of children with special health care needs in SHADE, and how to provide more resources and support so that participation in Family SHADE would be a positive and not just an increased burden for parents. Major discussion points included better publicity and ways to reach parents involving "pushing" out more notifications, diversifying the social media sources used, and partnering with other social service agencies and activities to publicize resources and to encourage SHADE collaboration with other community efforts.

The evaluation was originally intended to be distributed as a paper handout to participants. However, it was instead administered online at the time of the event, which allowed data collection but resulted in a lower response rate than anticipated.

Only six forms were submitted by the beginning of the following week. Nevertheless, the evaluation forms responses provided by attendees were uniformly positive toward the event, with praise for the location, the presentations and progress of the mini-grantees, and, most especially, the interest in the issues raised in the roundtable discussions and the sense of collaboration in problem solving. It seemed to be a good forum for the new contract coordinators from the University of DE/Center for Disabilities Studies (UD/CDS) to get ideas for redirecting Family SHADE project in the next few years. UD/CDS leadership took notes and shared ideas for engaging parents moving forward. A promising note was that UD/CDS may have potential ability to provide childcare services for Family SHADE project activities in the future.

One lesson about getting evaluations from people was made very clear by the relatively few evaluation responses submitted post-meeting. As was pointed out in the roundtable discussions, it is probably necessary to give some incentives for getting respondents to provide evaluations. Evaluations need to be done at the time. Necessarily it needs to be near the end of the meeting, and time needs to be specifically allocated for it. There needs to be some combination of "carrots and sticks" to get evaluation responses.

Overall, the luncheon demonstrated the partnerships that are made in Delaware between agencies. Although PIC will not lead the Family SHADE Project, they will continue to be part of it under the leadership of the University of Delaware/Center for Disabilities Studies (UD/CDS). PIC will continue to work with the current FLN members and work with UD/CDS to recruit new FLN members.

The University of Delaware/Center for Disabilities Studies (UD/CDS) began reviewing the historical data from the prior 4 Cohorts and the impact the mini-grantees have made in the lives of CYSHCN. They will take prior learned lessons and continue to enhance the CYSHCN System of care by assuring that data will be captured to measure impact of CYSHCN and their families through measurable outcomes on medical home and CYSHCN transfer to adult healthcare services as captured in our needs assessment which will guide the work for the next 5 years 2026-2030.

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 University of Delaware/Center for Disabilities Studies (UD/CDS) -Family SHADE project team has met and discussed with our MCH Title V team to make sure that we plan congruently with our domain leads, that we are 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. Our existing aligned current work and priorities that we are addressing are to serve CYSHCN and their families and improve the system of care by adhering to the results identified at the state level in comparison to the national average data located at the Resource Center for Child and Adolescent Health www.childhealthdata.org. This approach has allowed us to measure 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 compare to the national average 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 information along with the 6 core CYSHCN guided us with identifying a baseline

and a starting point as we began to move forward to developing 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.

In FY 2025, Delaware continued to implement the development of a crosswalk through our MCH Title V Block Grant by developing an alignment with the 6 core indicators for CYSHCN and 4 key areas which focuses on: optimum health for all, access to care, quality of life and well-being, and financing of services. We continued to implement this approach throughout the domains and national performance measures in the delivery of service for our CYSHCN population.

Below is a chart that identifies the CYSHCN 4 key areas and the 6 core CYSHCN indicators.

	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 shifts 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.					

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. These Learning Communities Engaged, educated, and trained health professionals and service providers in the statewide EHDI system about the 1-3-6 recommendations; the need for hearing screening up to age 3, the benefits of a family-centered medical home and the importance of communicating accurate, comprehensive, up-to-date, evidence-based information to families to facilitate the decision-making process to enroll in early intervention services. 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 worked in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family

(F2F) initiative with Family Voices. Our Family Delegate role became vacant in 2025 due to other commitments for the parent. The Family Leadership Network (FLN) members went from 11 members to 9 due to family schedules that did not allow parents to participate in FLN activities and meetings. The Director of CYSHCN continues to work with the other Maternal Child Health Title V program domain leads in a continued effort to infuse CYSHCN and their families. The Parent Information Center (PIC) team monitored and evaluated through every phase of the projects the impact that was made on CYSHCN and their families. The PIC team provided 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, reviewed the NPMs and aligned their data collection tools and their projects to mirror their projects initiatives with the Maternal Child Health Title V NPMs listed below during the calendar year of 2025.

- 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 (Transfer 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 Learning Communities offered bi-monthly to CYSHCN Families in Yr. 2025. Of those Learning Communities, 54 parents attended and 24 professionals. 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.

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 ended calendar year 205 with 9 FLN members. The FLN members have consisted of parents/guardians of children birth to 26 that have a special health care need. The network membership included training, quarterly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals for services. The FLN members met virtually and in person with 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 repeated from prior years: 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 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 parents of CYSHCN from Sussex County which is our Southern geographic area of Delaware. Announcements for the Family Leadership Network was posted on the https://DEthrives.com.

Although they could not recruit 15 FLN members over 4 years as they set out to do, they had several Learning Communities for FLN members and families of CYSHCN to attend. In calendar year 2025, 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.
    - All 3 mini-grantees increased the % of CYSHCN that they served as noted in the prior chart in this report. Children's Beach House, Down Syndrome Association and Teach Zen exceeded their expectations on the impact that they made with CYSHCN and their families.
- ESM #2 Increase the % of families enrolled as a member in the Family Leadership Network (FLN).
    - Throughout the span of the Family SHADE Project under the leadership of PIC, they were able to recruit 9 members at the end of the contract in November of 2025.
- ESM #3 Increase the % of families served through the Family Voices Managed Care Organization (MCO) Calls/Zoom meetings.
    - In the 2025 calendar year, they had 152 participants attend the MCO Calls/Zoom meetings.

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 solve problems. 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. 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 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 2023 there were 10,900 total occurrent births, 10,736 infants were screened. Of those screened there were 10,444 infants that passed and a total of 292 did not pass. Of those that did not pass there were a total of 11 with no hearing loss and a total of 19 with Permanent hearing loss.

Of the 19 infants diagnosed with total permanent hearing loss, 15 were referred to Part C Birth to Three, 4 were not referred to Part C Early Intervention due to one expiring and 3 infants no longer being eligible for Part C Early Intervention Services. There were 7 enrolled in the Part C Birth to Three Early Intervention program. Also, there were 5 families that signed their Individualized Family Service Plan (IFSP) after 6 months of age. These families were referred to Hands & Voices Guide by Your Side where families had the option of accepting services. These 19 families were also referred to the Statewide Programs for the Deaf, Harf of Hearing, and Deaf-Blind Mentorship program. Of the 19 diagnosed infants, 7 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 were 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.

Nemours Children's Health was recognized in State Spotlight for Advancing excellence in Delaware through simulation and collaboration. Published March 31, 2025, pediatric simulation is vital for effectively equipping clinicians to handle pediatric emergencies. Maria Carmen G. Diaz, MD, FAAP, FACEP, chair of the EMSC Advisory Committee of Delaware and medical director of simulation at Nemours Institute for Clinical Excellence (NICE), is partnering with Delaware EMSC to elevate pediatric simulation across the state by incorporating it into recognition program site visits.

Part of Nemours Children's Health, NICE, established in 2013, integrates simulation services across Nemours Children's Health, Delaware Valley, and its American Heart Association and the Emergency Nurse Association training centers. NICE's collaborative teaching and education efforts enhance participants' technical, cognitive, and behavioral skills in a controlled, realistic environment. Currently, all Delaware hospitals and free-standing EDs participate in a Pediatric Emergency Care Facility Recognition Program through the Delaware EMSC Program. Recognition programs create a statewide system of care with defined pediatric standards, metrics, and ongoing collaboration. In partnership with NICE, Delaware EMSC incorporates collaborative, simulation-based sessions as part of site visits. This provides teams with the opportunity to demonstrate and highlight their pediatric specific skills and use of their own pediatric equipment. Historically, their first round of site visits over 10 years ago, was done with a checklist to ensure facilities had appropriate pediatric equipment and supplies. After numerous site visits were made, facilities wanted to do more than just confirm presence of equipment and wanted to discuss optimal usage of what was on that checklist. This prompted site visits to be more interactive. During each site visit, teams used their own equipment and supplies as they resuscitated a simulated pediatric patient. This allowed teams to showcase their pediatric specific inventory as they highlight their skills and knowledge. The simulations ensures adherence with statewide standards and as a forum for shared learnings and best practices. Resource: State Spotlight: Advancing excellence in Delaware through simulation and collaboration • EIIC

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.

Parent Information Center -Family Voices is a national family-led organization of families and friends of children and youth with special health care needs (CYSHCN) and disabilities. Family Voices in collaboration with the National Family to Family (F2F) Network 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. Delaware's Family to Family Health Information Center (F2F HIC) promotes optimal health for children and youth with special health care needs (CYSHCN) and access to an effective health delivery system that is family-centered. F2F ensures the including of families in healthcare decision-making and policy-making at local, county, and state levels to promote positive systems change.

Several programs, including navigating health and insurance systems, peer-to-peer emotional support, and support for families whose children have behavioral or emotional issues. F2F staff can help navigate the healthcare system, access resources and services and find answers to questions. F2F offers the support parents need, helping them save time and reducing your frustration. The Family to Family Health Information Center is made possible through a grant from HRSA. For more information about Delaware Family Voices under the Family to Family Health Information Center, visit Delaware Family Voices website. Delaware Family Voices – Family to Family Health Info Center

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 empower. 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.
- 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.
- Including and 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 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 Maternal Child Health Title V priorities and strategic plans for the coming year targeting families of CYSHCN assuring that we are meeting the needs through a congruent and collaborative initiative addressing NPM Medical home, and transfer to an adult healthcare system for CYSHCN.

On March 6th, DEThrives ran its first Medical Home themed post on Facebook and Instagram to explain what a Medical Home is. From convenience to family-centered, what's a medical home and why is it so important for support? A medical home is where patients, clinicians, medical staff, and families come together for complete and high-

quality primary care.

Through the Maternal Child Health (MCH) Title V Block Grant and our statewide needs assessment, we have identified two national performance measures (NPMs) that were emerging concerns by families of CYSHCN. One of the NPMs identified was medical home. The Evidence Based Strategy Measure (ESM) for Medical Home is to 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.

The second NPM is to increase the percentage of adolescents with special health care needs (expanded criteria), ages 12 through 17 who received services to prepare for the progression to adult health care. The ESM for Progression to Adult Health Care is to increase the number of adolescents with a transfer plan into an adult health care system of care for CYSHCN ages 12-17.

These two NPMs were significant measures identified by families of CYSHCN and subject matter experts that serve them. The NPMs 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 agencies, we will focus on these two national performance measures. Delaware will strategically plan to implement the development of a crosswalk through our MCH Title V Block Grant by developing an alignment with the 6 core indicators for CYSHCN and 4 key areas which focuses on:

1. Optimal Health for All
2. Access to Care
3. Family Quality of life and well-being
4. Financing of Services

In calendar year 2026, we will work intentionally on addressing 2 CYSHCN ESMs for CYSHCN. Our CYSHCN ESMs for the calendar year 2026-2027 are:

1. **Medical Home: ESM** -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).

2. **Progression to Adult Health Care, CYSHCN Age 12-17: ESM** -CYSHCN percent of adolescents with special health care needs, ages 12 through 17, receive services necessary to make transfers to adult health care system.

Our approach will align throughout the domains and national performance measures in the delivery of services for our CYSHCN population.

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 and a contract has been issued as of February of 2026 with the University of Delaware Center for Disabilities Studies (UD/CDS). UC/CDS will be subcontracting with Parent Information Center (PIC) of Delaware. This partnership allows for continuity of relationships between PIC and the families and agencies they have worked with and served in the prior year’s serving CYSHCN through the Family Shade Project.

The UD/CDS will serve as the lead agent for the Family SHADE project. The goal of the Family SHADE project is to use a collective impact approach to build state and local capacity to serve children and youth with special health care needs (CYSHCN) through a mini-grant initiative paired with community learning. Led by the voices of families through the Family Leadership Network (FLN), Family SHADE’s work focuses on Title V National Performance Measures (NPM) for CYSHCN. As of February 1, 2026, Family SHADE is housed at the University of Delaware Center for Disabilities Studies (UD/CDS) and includes a partnership with The Parent Information Center (PIC). UD/CDS will serve as the “prime contractor” and backbone agency leading Family SHADE activities, with PIC supporting the engagement of families through the FLN.

The UD/CDS will focus on key workplan activities that will drive Family SHADE. The activities and goals are outlined

below:

1. **Activity 1**: Support the **Family Leadership Network (FLN)** in partnership with Parent Information Center (PIC) who is a sub-contractor of UD/CDS. FLN will contribute in providing expertise and guidance on mini-grant initiatives, learning community activities, and data collection efforts designed to build state and local capacity to support CYSHCN.
2. **Activity 2:** Administer a **mini-grant program** to fund local coalitions and organizations in implementing interventions that address the Title V state and national performance measures (NPM) and the national standards for systems of care for children and youth with special health care needs.
3. **Activity 3:** Support families of CYSHCN and the organizations that serve them through the **coordination of community workshops/learning communities**, networking events, and information dissemination activities.

The University of Delaware/Center for Disabilities Studies (UD/CDS) will target the two NPMs that are specific to the CYSHCN population however, other Title V NPMs can be addressed to improve through a CYSHCN system of care.

The University of Delaware/Center for Disabilities Studies (UD/CDS) renewed the mini-grantees that served in the prior cohort under the leadership of Parent Information Center (PIC). They continued to utilize Children's Beach House and Down Syndrome Association so that there wouldn't be an interruption of service for CYSHCN and their families. They will serve families for one year under the leadership of UD/CDS. Teach Zen did not return for Cohort 5 due to networking with other organizations that afforded Teach Zen to begin a Montessori program. This approach allowed for building relationships between the mini-grantees and the UD/CDS.

Through UD/CDS leadership and partnership with Parent Information Center of Delaware, and regularly monthly scheduled meetings with the Maternal Child Health CYSHCN Director-Isabel Rivera-Green, technical support and collaborative initiatives will allow for meeting gaps in service delivery and opportunities to build capacity through fluid communication between all agencies. The Family SHADE project 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. UD/CDS will serve as the backbone agency and coordinating body that will bring together various 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 will meet the needs of Delaware families. The aim of the Family SHADE project, as part of the Title V CYSHCN work in Delaware, will 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 UD/CDS will review the historical data from the prior 4 Cohorts and review the impact the mini-grantees have had on the lives of CYSHCN. The UD/CDS will continue to take prior lessons learned 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 transfer to adult healthcare services. UD/CDS in partnership

with PIC will work toward growing the Family Leadership Network (FLN) membership. The FLN members will consist of parents/guardians of children birth to 26 that have a special health care need. The network members 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 UD/CDS will execute the Family SHADE project by prioritizing and aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identifying 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 UD/CDS will build on the established relationship PIC has with 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 UD/CDS 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 meet monthly with UD/CDS to monitor progress made on meeting the 2 identified National Performance Measures: Medical Home and Preparation of Transfer to adult health care system for CYSHCN (12-17). These NPMs were identified by our statewide needs assessment. The Family SHADE project will target these identified emerging issues statewide. 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.

Delaware will continue to utilize the six core indicators as outcomes for CYSHCN to guide system improvement efforts and advance positive outcomes for CYSHCN and their families. Through a coordinated and intentional approach, Delaware is committed to improving the lives of CYSHCN by ensuring that children, youth, and families have the resources, support, and opportunities necessary to thrive within their communities from childhood through adulthood.

Delaware's CYSHCN system of care will focus on four critical key domains:

1. Optimal health for all
2. Family and child well-being and quality of life
3. Access to Easy to Use Services and Supports
4. Adequate and Continuous Insurance/Financing of services

Resource:https://publications.aap.org/pediatrics/article/149/Supplement%207/e2021056150E/188220/Progress-Persistence-and-Hope-Building-a-System-of?autologincheck=redirected

These key domains will serve as the foundation for ongoing planning, implementation, and evaluation activities. Delaware will align current initiatives, priorities, and resources with the findings from the statewide needs assessment to strengthen the CYSHCN system of care and address identified gaps and opportunities. This strategic approach will support continuous quality improvement by identifying system strengths, weaknesses, and emerging opportunities to enhance services and support for CYSHCN and their families.

To assess progress and system performance, Delaware will monitor state-level data and compare outcomes with national benchmarks to evaluate the effectiveness of its CYSHCN system of care. This data-driven approach will guide Title V programs in aligning priorities, investments, and activities with the overarching goal of creating a coordinated, family-centered, and an optimum health care system of services for CYSHSN and their families.

The six Core Indicators for CYSHCN will serve as the foundational framework for measuring the effectiveness and

quality of Delaware's system of care. These outcomes represent the essential components of a high-quality, family-centered health care system and include:

1. Screening: Children are screened early and continuously to identify special health care needs and facilitate timely intervention.
2. Partnerships: Families of CYSHCN are recognized as essential partners and actively participants in decision-making at all levels of care and system development.
3. Community-Based Services: Services and supports are organized, coordinated and accessible, enabling families to obtain needed care without unnecessary barriers or burdens.
4. Medical Home: Children receive continuous, comprehensive, and coordinated care within a designated medical home.
5. Insurance: Families have access to adequate and continuous health insurance coverage and financial resources necessary to obtain the services and support needed.
6. Progressions: Youth (ages 12-17) receive the services and supports necessary to successfully progress to adult health care. Also, making sure we do not overlook the needs for employment, independent living, and community participation.

By utilizing these six core indicators and the Title V Block Grant framework, Delaware will continue to strengthen its CYSHCN system of care, promote family-centered services, and improve health and quality of life outcomes for children, youth, and families across the state. Resources: https://www.childhealthdata.org/ and https://nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/

Family SHADE Mini-Grant program and Family Leadership Network (FLN) 2026-2027

The University of Delaware/Center for Disabilities Studies (UD/CDS) will focus on the following Evidence-Based Strategic Measures (ESMs) to address the National Performance Measures (NPMs) targeting CYSHCN and their families.

ESM	Target	Strategies
NPM -Medical Home		
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. Increase percent of parents of CYSHCN enrolled in FLN who learn and attain concept of medical home.	CYSHCN have access to a medical home model of care Number of Parents that learn the concept of medical home model of care criteria	-Utilize universal practices to promote CYSHCN to 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. Disseminated FLN interest surveys to both existing and prospective members interested in participating in the FLN - Conducted brief (30-minute) interest meetings to share more information about new FLN structure - Developed FLN flyer to recruit additional family members of CYSHCN to participate in the FLN - Created FLN informational PowerPoint to share information about the FLN with potential members
Increase the percent of children served by Family SHADE's mini-grantees that are meeting the medical home model of care criteria.	Number of CYSHCN that are meeting the medical home model of care criteria	- Confirmed the continuation of three previous mini grantees - Reviewed mini-grantee's final reporting and brainstormed sustainability goals for upcoming mini-grant cycle.
NPM -Progression to Adult Healthcare		
Increase the number of adolescents with special health care needs, ages 12 through 17, served by mini-grantees with a progression plan that prepares them for adult health care.	Number of CYSHCN ages 12-17 years with a progression plan that prepares them for adult health care	Reviewed mini-grantee's final reporting and brainstormed sustainability goals for upcoming mini-grant cycle after the current 5th cohort.

UD/CDS will serve as the new fiduciary for the mini-grantee project over the final 5th Cohort. UD/CDS will recruit FLN members in partnership with Parent Information Center. Once the FLN membership reconvenes, the FLN members will identify Learning Communities that are of interest. Below are Learning Communities that have been of interest to our parents in the past that will be repeated for new FLN members:

- Children's Community Alternative Disability (CCADP) Program Information Session
- Emergency Preparedness
- Medical Progressions for adult health care overview
- How to Have Effective Individualized Health Care/Individualized Health Care Plan (IHP)
- Medical Home
- Social Security for Progression-Age Youth
- Care Notebook

Through year 5 of the Family SHADE mini-grant program, UD/CDS will continue to collect the data on 2 mini-grantees which are 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 Progression into adult health care for CYSHCN ages 12-17. The current mini-grantees have received information on the priorities that the MCH 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.

The UD/CDS will provide the mini-grantees with a variety of state and local training and technical assistance activities designed to strengthen the capacity of mini-grantees, FLN members and members of the community to address the needs of CYSHCN and their families. UD/CDS will plan for community training activities that will engage two target audiences:

1. Mini-grant applicants, recipients, and other coalitions and community organizations seeking funding
2. Families of CYSHCN and organizations that serve them

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 UD/CDS 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 Progression 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 mini-grantees and UD/CDS which will serve 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 NPMs Medical Home and Health Care Transfer 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. The 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 MCH Title V Domains while addressing the CYSHCN 6 core indicators. Our Family Delegate role will need to be reappointed due to our current Family Delegate stepping down from the role. The UD/CDS will monitor and evaluate every phase of the project's impact 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 UD/CDS Family SHADE team 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 Progression to 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.

The Family SHADE project will continue to enhance the data collection process for 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 the mini-grantees to promote togetherness and receive feedback on where there are gaps in service delivery for CYSHCN population. Family SHADE will work toward recruiting 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 FLN meetings will be scheduled regularly and they will align in conjunction with Learning Community Workshops. 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.

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 Transfer 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 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 they are 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 support 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 are 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.

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 ongoing representation of 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 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 - transfer 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 various 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 transfer 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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	50	75	75	100	100
Annual Indicator	80	76	84	84	76.9
Numerator	20	19	21	21	30
Denominator	25	25	25	25	39
Data Source	FHS Data	FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Provisional	Final

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

None

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

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.

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.

It is critical to the success of DPH to foster a culture that encourages and supports the professional development of its employees. Our employees' professional development should be an ongoing process to ensure they stay current in their fields and prepare for future challenges. Planning for continuous professional development must be tied to the employee's performance plan and career goals.

DPH's objective is to develop employees through a wide variety of progressive and efficient training programs and training resources to improve their knowledge, skills, and abilities as part of the DPH Workforce Development Plan, and help them advance in their career. The intent is to help build and retain a workforce of skilled and capable employees and encourage future career development. DPH believes that training and development are integral components of work performance and are inherently tied to our vision, mission, and strategic priorities. It is the responsibility of the supervisor and the employee, working in partnership, to determine the work goals and training needs for each employee.

Each Personal/Professional Development Plan is uniquely tailored to the needs of the individual and the DPH. It is a *personal action plan*, jointly agreed on by the employee and the supervisor, which identifies short and long-term employee goals. It also identifies the training and other developmental experiences needed to achieve those goals for the benefit of the DPH.

This plan is designed to be continuous in nature. That means that employees and supervisors don't need to try and cram training and professional development opportunities into one year. Learning is an on-going process. It's important to note that not all learning happens in a classroom. 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 reading an article in a professional periodical and putting the concepts to work on the job.

Supervisors are encouraged to 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.

FHS again recently partnered with *FranklinCovey*, a training company that helps create behavior change in the four areas that matter most to our long-term success: provide training and assessment services in the areas of leadership, individual effectiveness, culture, and achieving strategic goals.

We held our 2025 Family Health Systems (FHS) Annual Employee Retreat this past fall to reflect on where we've been, where we are now and where we are headed. We celebrated our accomplishments, contributions, new employees, and more. Our theme was Navigating Change, Empowering Growth. Our Retreat objectives were:

- Align with DPH Strategic Priorities: Promote healthy lifestyles, enhance population health, improve performance management, reduce substance use disorder and overdose deaths, and advance health

factors.

- Stay Focused on Our Direction and Guiding Principles: Review the FHS Vision, Mission and Values that guide our work.
- Celebrate and Plan Ahead: Acknowledge achievements, recognize team members, and set new goals for FY26, in collaboration with management program staff, and community partners. (Strategies, tactics, and planning will be carried out at the program and project level.)
- Enhance and Nurture Collaboration: Foster improved relationships in how staff engage and interact with colleagues and approach their work.
- Inspire Creativity: Encourage actions that spark creativity, improve teamwork, and enhance how our section operates and communicates.
- Promote Healthy Lifestyles: Engage in fun activities like yoga, mindfulness, self-care practices, and take time to enjoy the walking trail.

The speaker for our 2025 Retreat was from *FranklinCovey*. The workshop was titled, 'Change: How to Turn Uncertainty into Opportunity'. When we recognize that change follows a predictable pattern, we can learn to manage our reactions and understand how to navigate change, both functionally and emotionally. This allows us to consciously determine how to best move forward - even in the most challenging stages. Change: How to Turn Uncertainty Into Opportunity helps individuals and leaders learn how to successfully navigate any workplace change to improve results.

Delaware's MCH leaders have multiple complex responsibilities, and 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 various stakeholders, to find evidence, to learn quality improvement methods, and to understand health factors. Leaders are also concerned with staff development and succession planning. They prioritized workforce skills around program evaluation, data literacy, systems thinking, and change management. Because of the demands our leaders face, FHS also facilitated a one day retreat, designed specifically for them. 6 Critical Practices of Leading Teams was developed to learn about the foundational behaviors that help you lead your team to sustained success. In this exercise, we learned what those 6 Practices were and how they help teams be successful. Our group responded well to the content. The vast majority of our staff have a growth mindset and would find continued training and development supportive during these unprecedented changes we find ourselves in, changes that will likely continue for the next couple of years. Having concentrated times to focus on any of these content areas would be a great way to integrate our new Immunization team. *FranklinCovey* suggested that for the next year, we consider offering short sessions that encourage people to reinforce what was introduced, get to know each other, and to trust our leadership.

FranklinCovey specializes in building exceptional leaders, teams, and cultures that get results. Our leadership has invested in a relationship with *FranklinCovey* to support our personal and professional growth. 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.

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 SSDI Director/Title V Coordinator works closely with Delaware's assigned *FranklinCovey specialist* to discuss the needs of our MCH staff and programming that might be beneficial.

Over the past year, FHS staff have engaged in our first initial training plan, which focused on some high-level competencies that we all could benefit from. *FranklinCovey* developed a personalized four-month structured Learning Journey for us to begin with. The intent was to give our learners some quick microlearning resources they

can engage in each week that align to the specific skill areas identified. Each month will have a specific competency focus with short articles, videos, modules, and application exercises they can use to build their skills.

1. **Establishing Credibility** - Some managers make the mistake of solely focusing on establishing credibility with their managers, rather than simultaneously establishing credibility with their teams. During this course, staff learned focused ways to do both.
2. **Leading Chage** - For a leader, change is everything, and you need to be ready to lead it. Without change, your team can't grow or improve and risks being bulldozed by the shifting circumstances around them. During this segment, staff focused on the critical role they play as a leader and how to help their team envision change successfully.
3. **Resilience & Well Being** - Resilience is our ability to stay strong or bounce back in hard times. Most people think of it as a personality trait, like curiosity, or a singular skill, like productivity. But this module shows that resilience has many facets you can build. These tips can help your team build resilience like a muscle, so they can not only handle what gets thrown at them but also prepare for what comes next. In addition, how you handle the demands of your job day-to-day has a huge impact on your happiness. Explore how to maintain your energy and revitalize yourself.
4. **Motivating Your Team** - When things are chaotic, confusing, or just plain hard, help your team work through their frustrations and challenges. You'll learn valuable information to help you identify new opportunities and reframe existing work so they feel more engaged in the long run.

Once this Learning Journey was complete, the SSDI Director, along with our *FranklinCovey* specialist, started the discussions with FHS leadership on the next steps in our FranklinCovey training opportunities. Our goal is 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. We’re looking for practical resources that provide leaders with the mindsets, skillsets and toolsets needed to excel in their critical roles of leading others effectively.

Staff have also 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.

In addition, *FranklinCovey* has offered FHS leadership a client-only webinar series focused on a challenge a lot of organizations are currently facing: how to clearly show the impact of leadership development. Leadership development matters more than ever, but it’s also under more scrutiny. Executives are asking tougher questions, budgets are tighter, and there’s real pressure to show that training efforts are actually driving business results.

This session was focused on walking through a practical way to connect leadership development to our strategic priorities and measurable outcomes. This course covered how to:

- Connect leadership development to what matters most in your organization
- Identify the specific behaviors that drive results
- Measure both behavior change and business impact using data you already have

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.

A well-trained and motivated workforce is essential for FHS to thrive, and that is where the Train the Trainer model comes in. By creating a training program where internal employees help others gain needed skills, it establishes a learning culture and supercharged talent development across all of FHS. With the help of *FranklinCovey*, FHS has decided to pursue the development of any employee who wishes to pursue this opportunity. We feel this equips key individuals and empowers employees to play a unique role in educating others, which helps our workforce

development and change initiatives succeed. This is offered to anyone willing to further their skills, offering flexible learning schedules, meeting the employees where they are, allowing them to find the right training course, and delivered when and how they prefer it.

The core advantage of a Train the Trainer model is its effectiveness to teach new skills and knowledge to a wide range of people within FHS by involving internal resources to scale training delivery. Also, becoming an internal trainer and picking up new competencies is a great professional development opportunity for the people involved. Another added benefit of the Train the Trainer model is developing a competent internal training team. Once people attend a train-the-trainer program and they start teaching their own colleagues, their competence as instructors will keep growing. Next time, when FHS needs internal trainers for another subject, we already have a group of employees who are skilled in training delivery.

The Division of Public Health recently introduced the Division's Strategic Plan. This multi-year plan is a community-focused collective health approach, created by and for the people of our state. It represents the dedicated work of our many partners in health from across the state who have come together with single shared mission: to improve the health and well-being of every Delawarean.

This Strategic Plan is more than a document; it's a blueprint for transformation. Rooted in data from the 2023 State Health Assessment and shaped by robust community input, the plan identifies five priority health outcomes: mental health, chronic disease, maternal and infant health, avoidable injuries, and premature death. To drive change in these areas, we've aligned them with the vital conditions that influence health: meaningful work, safe housing, reliable transportation, lifelong learning, and the basic needs of daily life.

One Objective is focused on Enhancing and Maintaining a Competent Workforce. DPH places a strong emphasis on the value of its workforce, demonstrated by the creation of the Office of Performance Management (OPM), a dedicated section focused on workforce development and organizational improvement. The mission of OPM is to collaborate with DPH leadership to implement:

- An effective performance management system using performance standards, measures, progress reports, and ongoing quality improvement actions to enhance the capacity and improve performance of the division;
- A dynamic and actionable strategic plan;
- Effective organizational workforce development programs; and
- Activities that will lead to and support accreditation by the Public Health Accreditation Board (PHAB).

To enhance and maintain a competent workforce, the DPH uses a strategic Workforce Development Plan informed by timely Public Health Core Competency and Training Needs Assessments. A Quality Improvement (QI) Policy and Plan guide the division in creating a culture of continuous improvement. Established structures, including the Quality Improvement Council and the QI Facilitator Team, ensure improvement efforts and professional development remain central to the agency's work. The OPM Chief leads efforts to advance workforce capability and organizational performance through clear measures, defined standards, target setting, and ongoing progress tracking, all of which are reviewed at monthly Strategic Leadership Group meetings.

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 began the effort to develop an Accountability Matrix, which would provide specific workgroup, contact, and data information about each National Performance Measure to ensure no overlap exists and to track progress. The matrix would also cross reference each health domain to include all advisory boards and current focus. We believe this would help the entire MCH community weed out duplication and determine if enough is being done within each health domain and NPM. We planned to include data sources, to aid our staff and partners with updated information. We hoped this document will provide a 'birds eye' view of potential collaboration. A first draft has been created, but unfortunately, with the lack of epidemiology support, this has not been a continued focus.

In addition, our Workforce Development team determined that creating ongoing learning resources and videos would be imperative to the development of our workforce. We plan to 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 plans 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. 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.

FHS staff completed our first "Learning Journey" in the spring of 2026, and the SSDI Director, along with our FranklinCovey specialist, worked with FHS leadership and began discussions around a "Development Menu" of trainings. FHS is requesting a more tailored approach for different teams and even individual employees. Therefore, this approach is more of a "menu" option of trainings. Each Bureau Chief can review these training courses during their 1:1's with each employee and talk through the courses, and options, and recommendations that are available. Each Bureau Chief will either assign the trainings in the FranklinCovey portal, or the employee can go through the menu options at their leisure. FHS leadership wanted to make it easier for all staff and not make Professional Development training burdensome.

Because some employees will review the material at their leisure, the structure could possibly be different from the assigned Learning Journey we just came out of. On the other hand, for those employees who will have training assigned, it might appear very similar to the Learning Journey we just completed.

FHS leadership is also in discussions regarding ways to implement a challenge to increase engagement. Ideas to advertise the challenge within each section, individual vs. individual, as well as team vs. team, are some ideas that are being discussed. We're hoping this could be accomplished over the summer months and announced during our Annual Employee Retreat, usually held in September.

We are currently planning our 2026 FHS Annual Employee Retreat that will, like always, have a professional development component added. The agenda for the day is still being finalized; however, the theme is tentative around positive working relationships. FHS will again schedule activities and exercises focused on working together as a team. Each year, our activities have brought everyone together to laugh, socialize, and enjoy each other's company outside of the office setting.

III.F. Public Input (Last Modified: FY 2027 Application/FY 2025 Annual Report)

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 the 2026 Application Year/2024 Annual Report 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. In addition, all our Title V team attends an abundance of internal Division of Public Health and Department of Health and Social Services meetings, work groups, and advisory boards to ensure that Title V is represented.

Our children and youth with special health care needs vendor, the University of Delaware Center for Disabilities Studies (UD/CDS) implements our newly revitalized Family Support Healthcare Alliance Delaware (SHADE) project. Delaware utilized Family SHADE's 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. UC/CDS will be subcontracting with Parent Information Center (PIC) of Delaware. This partnership allows for continuity of relationships between PIC and the families and agencies they have worked with and served in the prior year's serving CYSHCN through Family SHADE.

The UD/CDS will serve as the lead agent for the Family SHADE project. The goal of the Family SHADE project is to use a collective impact approach to build state and local capacity to serve children and youth with special health care needs through a mini-grant initiative paired with community learning. Led by the voices of families through the Family Leadership Network (FLN), Family SHADE's work focuses on Title V NPMs. UD/CDS will serve as the "prime contractor" and backbone agency leading Family SHADE activities, with PIC supporting the engagement of families through the FLN.

The UD/CDS will focus on key workplan activities that will drive Family SHADE. The activities and goals are outlined below:

1. Support the FLN in partnership with PIC. FLN will contribute in providing expertise and guidance on mini-grant initiatives, learning community activities, and data collection efforts designed to build state and local capacity to support CYSHCN.
2. Administer a mini-grant program to fund local coalitions and organizations in implementing interventions that address the Title V NPMs and the national standards for systems of care for CYSHCN.

3. Support families of CYSHCN and the organizations that serve them through the coordination of community workshops/learning communities, networking events, and information dissemination activities.

There is a planned approach to engage family and community partnerships every step of the way. 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 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 reviewed the Title V MCH Services Block Grant Guidance and developed a timeline and work plan. We also convened our Needs Assessment Steering Committee periodically for status awareness and input. Our team 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 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 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 organizations.

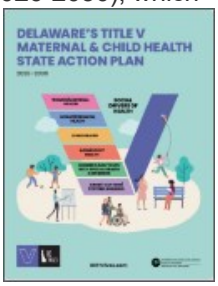
Other stakeholders are periodically contacted by MCH for input and feedback through various meetings, conferences, surveys, and other community activities. MCH periodically reaches out to the public for feedback or updates regarding the MCH community and our annual submission of the Title V Block Grant. 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 FY27 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 2026 Block Grant Application/2024 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.

Within the past year, Delaware developed additional graphics for our partners to use as additional resources. The first, a colorful snapshot is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. Maternal and Child Health services in Delaware are guided by this five-year State Action Plan (2026-2030), which reflects the input and needs of partners from across the state including state agencies, MCH providers, families and consumers, and members of the public. This five-year plan aligns with MCH legislation, mission and vision, and performance measure framework.



The second is a complement to our State Action Plan. This Snapshot offers an at-a-glance, high-level summary for the public, our partners, our stakeholders, and Delaware families to better understand our five-year plan. This report identifies the priority needs within each of the six domains, the program objectives, key strategies, and relevant national and state performance measures for addressing each objective.

In an effort of continued involvement, the Division of Public Health's (DPH) Maternal & Child Health (MCH) Bureau is happy to report that we have recently revised the DEThrives Title V landing page with new content and updated materials. Title V supports mothers, children, and families during each stage of life, from infancy through adulthood, and we fund work that promotes family-centered, proven methods that improve a person's health. Title V supports doctors, nurses, behavioral health clinicians, public health professionals, Community Health Workers, Home Visitors, and others - working together to care for Delawareans. Our investments and partnerships contribute to building healthy people and communities.

During early 2026, we invited our partners to review our recently submitted FY2026 Block Grant Application, which also includes our FY2024 Annual Report. New to the site, was our updated State Action Plan and our State Action Plan Snapshot. The newly designed Title V landing page is simple to use and easy to navigate. Our reimagined site still contains information on our recent 2025 Five-Year Needs Assessment process, reports, survey results, studies, and more. Throughout our Needs Assessment we reached out to our valuable community partners and stakeholders, to help us identify the priorities in the health of mothers, children and families in Delaware. Many participated in our Stakeholder Survey, Key Informant Interviews, and/or our Workforce Capacity Analysis. Also on our Title V landing page are our information data sheets, to help the public and our partners better understand each National Performance Measure. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions.

All Title V information and documents can be found in one central location, our DEThrives website. We encourage families and stakeholders to download a copy of our Title V documents and share with your community partners.

Following the submission of our FY27 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. Delaware strives for a collaborative effort with our partners and stakeholders and have a bi-directional exchange of information, resulting in a shared output with the application/annual report. Any major adjustments that are suggested will be considered for research and update.

III.G. Technical Assistance (Last Modified: FY 2027 Application/FY 2025 Annual Report)

Delaware is requesting technical assistance to strengthen epidemiology capacity through Title V MCH epidemiology training and structured onboarding for new and existing staff. Over the past year, the program has experienced significant changes in epidemiology staffing, including the loss of its CDC-assigned Maternal and Child Health epidemiologist and the expiration of a contracted epidemiology resource. These changes have reduced the program's dedicated MCH epidemiology expertise and created a need to build internal capacity to ensure continuity in data analysis, performance monitoring, and strategic planning.

In the absence of dedicated MCH epidemiology staff, Delaware is relying on epidemiologists from within the Division of Public Health to support Title V activities. While these epidemiologists possess strong analytic and public health skills, many do not have specialized training or experience in Maternal and Child Health epidemiology, including familiarity with the Title V Block Grant, National Performance Measures, MCH-specific data systems, life course theory, and maternal and child health frameworks. Technical assistance is needed to provide targeted onboarding and professional development that will build MCH-specific epidemiology competencies and enable these staff to effectively support the Title V program.

Requested technical assistance would include training on Title V performance measurement, MCH epidemiology principles, needs assessment methodologies, data visualization and communication, health equity analysis, and the use of national and state MCH data sources. Support in developing an onboarding framework and identifying available MCH epidemiology training resources would also help ensure that future staff can quickly acquire the knowledge needed to support the program.
Strengthening internal epidemiology capacity will improve Delaware's ability to analyze and interpret MCH data, identify emerging trends and disparities, inform program and policy decisions, and evaluate the impact of Title V investments. This assistance will help establish a sustainable epidemiology infrastructure, reduce reliance on limited external resources, and ensure that the Title V program continues to use high-quality data to improve health outcomes for women, children, youth, and families across Delaware.

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 - 2025 MCDRC Annual Report.pdf

Supporting Document #02 - Social Media_May 25-May 26.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FHS MCH OrgChart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY 27 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,104,488	
A. Preventive and Primary Care for Children	$ 675,926	(32.1%)
B. Children with Special Health Care Needs	$ 866,141	(41.1%)
C. Title V Administrative Costs	$ 185,661	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,727,728	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,912,592	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 3,954,663	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,867,255	
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)	$ 15,971,743	
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)	$ 6,664,056	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 22,635,799	

OTHER FEDERAL FUNDS	FY 27 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 152,725
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	$ 5,105,489
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	$ 1,070,842

	FY 25 Annual Report Budgeted		FY 25 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,126,787 (FY 25 Federal Award: $ 2,104,488)		$ 2,104,888	
A. Preventive and Primary Care for Children	$ 673,445	(31.7%)	$ 638,077	(30.3%)
B. Children with Special Health Care Needs	$ 775,206	(36.4%)	$ 827,619	(39.3%)
C. Title V Administrative Costs	$ 204,299	(9.6%)	$ 167,754	(8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,652,950		$ 1,633,450	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,148,719		$ 10,425,098	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,761,872		$ 2,761,872	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,910,591		$ 13,186,970	
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)	$ 15,037,378		$ 15,291,858	
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)	$ 5,879,035		$ 6,313,151	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,916,413		$ 21,605,009	

OTHER FEDERAL FUNDS	FY 25 Annual Report Budgeted	FY 25 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 217,887	$ 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	$ 4,274,693	$ 4,754,584
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) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 152,725	$ 152,725
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730	$ 1,070,842

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- 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 27 Application Budgeted	FY 25 Annual Report Expended
1. Pregnant Women	$ 376,760	$ 471,438
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 675,926	$ 638,077
4. CSHCN	$ 866,141	$ 827,619
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,918,827	$ 1,937,134

IB. Non-Federal MCH Block Grant	FY 27 Application Budgeted	FY 25 Annual Report Expended
1. Pregnant Women	$ 5,175,893	$ 5,372,896
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 3,844,560	$ 4,051,563
4. CSHCN	$ 892,138	$ 1,000,640
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 9,912,591	$ 10,425,099
Federal State MCH Block Grant Partnership Total	$ 11,831,418	$ 12,362,233

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 27 Application Budgeted	FY 25 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	$ 1,036,087	$ 1,421,775
3. Public Health Services and Systems	$ 1,068,401	$ 683,113
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	$ 2,104,488	$ 2,104,888

IIB. Non-Federal MCH Block Grant	FY 27 Application Budgeted	FY 25 Annual Report Expended
1. Direct Services	$ 1,344,512	$ 1,334,912
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,344,512	$ 1,334,912
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 5,970,222	$ 6,005,128
3. Public Health Services and Systems	$ 2,794,488	$ 3,085,058
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		$ 1,137,879
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,536
Durable Medical Equipment and Supplies		$ 147,508
Laboratory Services		$ 0
Other		
HWHB Services		$ 46,989
Direct Services Line 4 Expended Total		$ 1,334,912
Non-Federal Total	$ 10,109,222	$ 10,425,098

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: 10,990 **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	10,955 (99.7%)	817	37	37 (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 that the family is connected to recommended treatment services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

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 2025

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	3,510	45.0	0.0	55.0	0.0	0.0
2. Infants < 1 Year of Age	10,955	51.0	0.0	49.0	0.0	0.0
3. Children 1 through 21 Years of Age	15,762	58.0	0.0	0.0	0.0	42.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,995	49.0	0.0	30.0	1.0	20.0
4. Others	2,706	15.0	0.0	4.0	70.0	11.0
Total	32,933					

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	10,550	Yes	10,550	100.0	10,550	3,510
2. Infants < 1 Year of Age	10,917	No	10,955	100.0	10,955	10,955
3. Children 1 through 21 Years of Age	256,143	Yes	256,143	100.0	256,143	15,762
3a. Children with Special Health Care Needs 0 through 21 years of age^	76,797	Yes	76,797	100.0	76,797	3,995
4. Others	785,262	Yes	785,262	100.0	785,262	2,706

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2025**
	Field Note: 3,324 served by HWHB programs and 186 served by evidence-based home visiting programs.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2025**
	Field Note: Total number of infants receiving newborn screen.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2025**
	Field Note: 4,398 children were referred to Birth to Three and of which 1,224 were ineligible for services and were referred to alternate programs such as HMG. 640 children were served by home visiting programs and 13,898 received a developmental screen through PEDS, CHADIS or ASQ portal.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2025**
	Field Note: 3,174 served by Birth to Three and 821 served by Family SHADE.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2025**
	Field Note: 2,706 served by Family Planning program (FPAR data)	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2025**
	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:	**2025**
	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:	**2025**
	Field Note: Number of infants receiving a newborn screening	
4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2025**
	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	
5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2025**
	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.	
6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2025**
	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 2025

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	21,717	4,983	2,713	2,387	52	679	13	0	10,890
Title V Served	21,717	4,983	2,713	2,387	52	679	13	0	10,890
Eligible for Title XIX	4,362	1,087	1,543	1,570	25	97	7	0	33
2. Total Infants in State	10,392	4,536	2,739	2,336	48	659	11	0	63
Title V Served	10,392	4,536	2,739	2,336	48	659	11	0	63
Eligible for Title XIX	4,291	1,065	1,535	1,532	25	95	6	0	33

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Delaware

Form 7 was last revised in FY 2026 Application/FY 2024 Annual Report

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.jones@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	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

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 – Application Year

State: Delaware

Application Year 2027

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 9 State Priorities – Needs Assessment Year – 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 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
2023	129.3	11.5	129	9,980
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 confidence interval width >160% times the estimate 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
2020_2024	NR	NR	NR	NR
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 confidence interval width >160% times the estimate 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
2024	13.1	0.6	437	33,484
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 confidence interval width >160% times the estimate 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
2024	9.5 %	0.3 %	997	10,543
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
2024	10.6 %	0.3 %	1,113	10,547
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
2023	5.9	0.8	62	10,489
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 confidence interval width >160% times the estimate 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
2023	8.7	0.9	91	10,489
2022	9.7	1.0	105	10,872
2021	7.8	0.9	82	10,536
2020	8.1	0.9	85	10,449
2019	9.1	0.9	97	10,621
2018	8.9	0.9	95	10,716
2017	8.8	0.9	96	10,951
2016	8.7	0.9	97	11,089
2015	11.2	1.0	126	11,292
2014	9.5	0.9	105	11,077

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a confidence interval width >160% times the estimate and should be interpreted with caution

In 2025, NCHS expanded the definition of perinatal mortality to include all fetal deaths with stated or presumed gestation of 20 weeks or more. All historical data have been updated to account for the expanded definition.

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
2023	6.1	0.8	64	10,427
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 confidence interval width >160% times the estimate 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
2023	3.7	0.6	39	10,427
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 confidence interval width >160% times the estimate 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
2023	2.4	0.5	25	10,427
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 confidence interval width >160% times the estimate 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
2023	163.0	39.6	17	10,427
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 confidence interval width >160% times the estimate 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
2023	115.1	33.2	12	10,427
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 confidence interval width >160% times the estimate 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
2023	8.9	0.9	90	10,095
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 confidence interval width >160% times the estimate 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
2023_2024	61.8 %	4.2 %	19,242	31,112
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
2023_2024	11.3 %	1.3 %	22,657	199,706
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
2024	19.4	4.3	20	103,110
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 confidence interval width >160% times the estimate 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
2024	33.7	5.1	43	127,776
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 confidence interval width >160% times the estimate 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
2022_2024	14.8	2.8	29	195,418
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 confidence interval width >160% times the estimate 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
2022_2024	3.7	1.0	14	377,441
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 confidence interval width >160% times the estimate 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
2022_2024	7.9	1.5	30	377,441
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 confidence interval width >160% times the estimate 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
2023	138.5	11.1	156	112,663
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 confidence interval width >160% times the estimate 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
2023	170.3	11.6	215	126,239
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 confidence interval width >160% times the estimate 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
2024	45.2 %	2.8 %	79,051	174,727
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
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
2023_2024	90.4 %	1.2 %	188,769	208,748
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: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2024	20.5 %	2.0 %	26,716	130,145
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

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

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 disorder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023_2024	8.7 %	2.0 %	6,012	69,030
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
2023_2024	18.3 %	2.1 %	13,723	74,790
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
2023_2024	13.9 %	2.1 %	8,378	60,454
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
2023_2024	77.6 %	2.8 %	46,537	59,961
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
2023_2024	43.8 %	3.8 %	20,291	46,321
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
2023_2024	63.1 %	2.3 %	89,889	142,542
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
2023_2024	17.3 %	1.5 %	35,394	204,453
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**	**2025**
Annual Objective			
Annual Indicator	89.0	88.9	88.9
Numerator	8,744	8,290	8,290
Denominator	9,828	9,324	9,324
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	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**	**2025**
Annual Objective			
Annual Indicator	81.5	76.8	76.8
Numerator	7,046	6,240	6,240
Denominator	8,649	8,125	8,125
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2022	2023	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	**2025**
Annual Objective		
Annual Indicator	2.8	2.8
Numerator	262	262
Denominator	9,283	9,283
Data Source	PRAMS	PRAMS
Data Source Year	2023	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	**2025**
Annual Objective		
Annual Indicator	6.1	6.1
Numerator	581	581
Denominator	9,474	9,474
Data Source	PRAMS	PRAMS
Data Source Year	2023	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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	30.0	32.0	34	36	38
Annual Indicator	29.1	32.1	34.3	32.8	38.8
Numerator	6,073	7,257	8,614	8,638	10,352
Denominator	20,867	22,604	25,117	26,363	26,655
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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	**2025**
Annual Objective		
Annual Indicator	86.8	87.5
Numerator	13,797	16,022
Denominator	15,887	18,304
Data Source	NSCH	NSCH
Data Source Year	2022_2023	2023_2024

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**	**2025**
Annual Objective			
Annual Indicator	40.2	35.8	38.8
Numerator	18,442	21,932	23,374
Denominator	45,845	61,253	60,241
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023	2023_2024

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**	**2025**
Annual Objective			
Annual Indicator	44.2	44.7	46.2
Numerator	91,124	92,739	96,704
Denominator	206,169	207,631	209,415
Data Source	NSCH-All Children	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023	2023_2024

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	**2025**
Annual Objective		
Annual Indicator	21.7	21.7
Numerator	5,781	5,860
Denominator	26,596	27,001
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2022_2023	2023_2024

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**	**2025**
Annual Objective	84.5	86	87.5
Annual Indicator	88.1	86.9	81.7
Numerator	9,316	8,893	8,413
Denominator	10,573	10,234	10,300
Data Source	NVSS	NVSS	NVSS
Data Source Year	2022	2023	2024

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**	**2025**
Annual Objective	25	26	27
Annual Indicator	22.4	28.0	32.3
Numerator	6,100	7,724	9,288
Denominator	27,226	27,596	28,736
Data Source	NSCH	NSCH	NSCH
Data Source Year	2021_2022	2022_2023	2023_2024

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	80	80.5	81	82	83
Annual Indicator	77.4	77.3	75.4	76.2	78.8
Numerator	148,645	149,188	147,612	152,458	157,534
Denominator	192,077	193,050	195,852	200,007	200,018
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	75	77	79	81	83
Annual Indicator	71.9	71.8	74.2	72.6	71.8
Numerator	48,388	51,420	53,987	52,895	53,406
Denominator	67,333	71,653	72,759	72,862	74,365
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	78	80.0	82	84	86
Annual Indicator	72.8	75.9	71.9	80.1	76.4
Numerator	117,625	125,530	116,483	135,447	132,056
Denominator	161,675	165,284	161,938	169,192	172,801
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2020	2021	2022	2023	2024

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: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	20	21.0	22	23	24
Annual Indicator	14.9	16.0	14.8	12.1	10.7
Numerator	9,878	11,362	10,707	8,813	7,976
Denominator	66,257	70,996	72,524	72,721	74,207
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024
Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	20	22	22	23	24
Annual Indicator	25.1	21.6	21.6	22.4	22.4
Numerator	9,329	8,529	8,529	9,237	9,237
Denominator	37,230	39,459	39,459	41,212	41,212
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2021	2021	2023	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)					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	70.0	72.0	74	76	77
Annual Indicator	67.2	68.8	70.7	68.5	65.4
Numerator	136,015	140,169	145,366	141,609	135,624
Denominator	202,319	203,715	205,678	206,831	207,267
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019_2020	2020_2021	2021_2022	2022_2023	2023_2024

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					
	2021	2022	2023	2024	2025
Annual Objective	50	75	75	100	100
Annual Indicator	80	76	84	84	76.9
Numerator	20	19	21	21	30
Denominator	25	25	25	25	39
Data Source	FHS Data	FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Final	Final	Final	Provisional	Final

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	28	27	26	25	24
Annual Indicator	45	42.8	42.8	38.9	25.6
Numerator				3,890	2,472
Denominator				9,999	9,671
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	PRAMS Data
Data Source Year	2020	2021	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Final	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.**

Field Level Notes for Form 10 SPMs:

None

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

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		97.1
Numerator		538
Denominator		554
Data Source		HWHB Program Data
Data Source Year		2025
Provisional or Final ?		Final

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	2025
Annual Objective		
Annual Indicator	70.7	79.4
Numerator	29	50
Denominator	41	63
Data Source	MIECHV Program Data	MIECHV Program Data
Data Source Year	2024	2025
Provisional or Final ?	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:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**

Field Note:
Program Data is from October 1, 2024, through September 30, 2025.

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					
	2021	2022	2023	2024	2025
Annual Objective	92	94	96	98	100
Annual Indicator	82.2	81	77	76	84.6
Numerator	412	439	412	419	500
Denominator	501	542	535	551	591
Data Source	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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	2025
Annual Objective			75	85
Annual Indicator		31.3	38.1	35.9
Numerator		45	86	56
Denominator		144	226	156
Data Source		MIECHV ASQ and OEL ASQ	CHADIS Pilot Project Data	CHADIS Data System
Data Source Year		2023	2024	2025
Provisional or Final ?		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

State Provided Data		
	2024	2025
Annual Objective		
Annual Indicator		58.1
Numerator		25,574
Denominator		44,055
Data Source		Adolescent Wellness SBHC Raw Data Reports
Data Source Year		2025
Provisional or Final ?		Provisional

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	2025
Annual Objective		
Annual Indicator	72.9	77.7
Numerator	462	497
Denominator	634	640
Data Source	MIECHV Program Data	MIECHV Program Datat
Data Source Year	2024	2025
Provisional or Final ?	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	2025
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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	60	62	64	66	68
Annual Indicator	57	55.3	48.2	48.2	69.4
Numerator			27	27	59
Denominator			56	56	85
Data Source	MIECHV program daa	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	81	82	83	84	85
Annual Indicator	73.6	77.3	75.4	76.2	78.8
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019-2020	2020-2021	2021-2022	2022-2023	2023/2024
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**	**2025**
Annual Objective			725	765
Annual Indicator	683	1,000	788	16
Numerator				
Denominator				
Data Source	MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	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.	
2.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: These numbers dropped drastically because the forms were redirected to a different email address where we no longer have the ability to track the data.	

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	25	75	75	80	85
Annual Indicator	76.2	74.2	66.7	82	75.5
Numerator	4,902	4,958	4,420	6,028	4,603
Denominator	6,429	6,678	6,631	7,352	6,097
Data Source	SBHC Porgram Data	SBHC Program Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023	2024	2025
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**	**2025**
Annual Objective			55	60
Annual Indicator	48.2	53.6	52	47.5
Numerator	4,530	3,413	5,262	4,706
Denominator	9,407	6,367	10,121	9,912
Data Source	SBHC Program Data	SBHC Program Data	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022	2023	2024
Provisional or Final ?	Final	Provisional	Final	Provisional

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).	
2.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: Tidal Health data for February 2025 was not included as it is still pending.	

2021-2025: ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:			Active	
State Provided Data				
	2022	**2023**	**2024**	**2025**
Annual Objective			0.2	0.3
Annual Indicator	0.1	0.2	0	0
Numerator	99	337	53	53
Denominator	140,263	141,729	142,495	142,495
Data Source	DOE Program Data	DOE Program Data	DOE Program Data	DOE Program Data
Data Source Year	2022	2023	2024	2024
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: Project THRIVE ended on 6/30/2025. No more data is available to report. TVIS is requiring data, so data entered is identical to 2024 data.	

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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	17,250	8,500	9,000	9,500	10,000
Annual Indicator	8,015	8,109	9,937	10,618	10,797
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning
Data Source Year	2021	2022	2023	2024	2025
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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	90	86	88	90	92
Annual Indicator	84.2	86.1	89	92.4	75.5
Numerator		6,335	5,920	8,848	9,500
Denominator		7,354	6,655	9,574	12,585
Data Source	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB PISQ Data
Data Source Year	2021	2022	2023	2024	2025
Provisional or Final ?	Provisional	Final	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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	63	60	65	70	75
Annual Indicator	53.1	58.6	58.6	65.9	42.7
Numerator				2,618	1,723
Denominator				3,971	4,035
Data Source	PRAMS data	PRAMS data	PRAMS data	PRAMS data	PRAMS Data
Data Source Year	2020	2021	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Final	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**	**2025**
Annual Objective			12	15
Annual Indicator	14.3	21.4	21.4	21.4
Numerator	6	9	9	9
Denominator	42	42	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023	2024	2024
Provisional or Final ?	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.	
2.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**
	Field Note: This program was 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					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	90	92	94	96	98
Annual Indicator	89.1	91.5	90.6	93.8	91.9
Numerator	595	644	598	656	598
Denominator	668	704	660	699	651
Data Source	MIECHV program data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2021	2022	2023	2024	2025
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**	**2025**
Annual Objective			80	85
Annual Indicator	73.3	73.3	60	60
Numerator	11	11	9	9
Denominator	15	15	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023	2024	2025
Provisional or Final ?	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**	**2025**
Annual Objective			75	85
Annual Indicator		100	100	100
Numerator		609	554	424
Denominator		609	554	424
Data Source		CYSHCN Mini Grantee data	CYSHCN Mini Grantee data	Family SHADE/MCH Program Data
Data Source Year		2023	2024	2025
Provisional or Final ?		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.

3.	**Field Name:**	**2025**
	Column Name:	**State Provided Data**

Field Note:
Teach Zen did not serve CYSHCN Directly in the final 4th Cohort (There were 4 cohorts Teach Zen, DSA and CBH did not participate in the mini-grantee project in cohort 1). Teach Zen worked with teachers which indirectly impacted 200 students Yr. 2025. Therefore, 534 new clients were served in 2025 in total by mini-grantees, 364 existing client were served in Yr. 2025 for a total of 898 CYSHCN served by the mini-grantees. Teach Zen had finished activities in June of Yr. 2025, CBH a little into September, and DSA continued to recruit new clients into their sustainable program through October, 2025. Our Annual Indicator was higher than 100%, 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
Population Health 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
Population Health 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.

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.)
Population Health 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.
Population Health 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>
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</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>Population Health 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.
Population Health 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.
Population Health 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.
Population Health 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Children at risk for developmental delays residing in high-risk regions of the state.</td></tr><tr><td>**Denominator:**</td><td>Children with a higher risk of developmental delays in lower risk regions of the state.</td></tr></table>
Data Sources and Data Issues:	Ages and Stages Questionnaire screening data in childcare and education. CHADIS developmental screening data.
Evidence-based/informed strategy:	Show a reduction of at least five percent in the disparity outcomes for children at risk for developmental delays.
Population Health 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.
Population Health 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.
Population Health 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>% 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.</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>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.</td></tr>
<tr><td>Denominator:</td><td>The denominator represents the total number of high school students enrolled in SBHCs during the designated reporting period.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Report data submitted by medical providers who operate the contracted SBHCs.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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).</td></tr>
<tr><td>Population Health Significance:</td><td>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.</td></tr>
</table>

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.
Population Health 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</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>Number of adolescents with a special health care need with a transition plan</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents with a special health care need served by a mini-grantee</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Family SHADE/MCH Program Data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Increase the percent of adolescents with special healthcare needs, ages 12 through 17, served by a mini grantee that have a transition plan.</td></tr>
<tr><td>Population Health Significance:</td><td>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.</td></tr>
</table>

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:	<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 MCH staff that have completed at least one professional development opportunity.</td></tr><tr><td>**Denominator:**</td><td>The number of MCH staff employed.</td></tr></table>
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.
Population Health 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
Population Health 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
Population 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.
Population 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
Population Health 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:	<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 mental health assessments completed within a SBHC</td></tr><tr><td>**Denominator:**</td><td>The number of students enrolled in a SBHC</td></tr></table>
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.
Population Health 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide children enrolled in a Delaware school access to mental health services</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>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>
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</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DOE Program Data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Population Health Significance:</td><td>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</td></tr>
</table>

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:	**Unit Type:** Count **Unit Number:** 20,000 **Numerator:** Total # of women of reproduction age that received family planning servicess **Denominator:**
Data Sources and Data Issues:	FPAR Title X/Family Planning Data
Population Health 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
Population Health 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>Population Health 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.
Population Health 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
Population Health 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.
Population Health 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.
Population Health 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 2025

	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	No	
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	10	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

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Form 12 Products And Publications