Maternal and Child Health Services Title V Block Grant

Delaware

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

July 15, 2023

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 2022 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 2020 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 Jones Woodall, MPA
Chief, Family Health Systems
MCH Director

Family Health Systems
Delaware Division of Public Health
Jesse Cooper Building, Garden Level
417 Federal Street
Dover, DE 19901
(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 F of the 2021 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: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Delaware Maternal and Child Health/Title V Program is housed within the Department of Health and Social Services, Division of Public Health (DPH), Family Health Systems (FHS). Housed within FHS is our Bureau of Adolescent and Reproduce Health, Bureau of Maternal and Child Health and the Center for Family Health Research & Epidemiology. Delaware's Title V MCH Director also serves as the FHS Section Chief. Therefore, all programs within FHS are under the direction of the MCH Title V Director. This allows for greater collaborative relationships between the three Bureaus under FHS.

Delaware's Title V priorities and plans for the coming year are presented below by population domain, as defined by the MCHB. In some of the health areas, we are building on years of previous work and partnerships and have very detailed action plans forward. In others, we are forging into new territory as we build our expertise and establish new relationships.

Population Domain: Women's and Maternal Health

Defining the Need: In 2021, 81.4% of Delaware women, ages 18-44, had received a routine check-up within the last year (Behavioral Risk Factor Surveillance System). Access to preventive health care is critical to identify health issues early, prevent the onset of disease, and prepare women for healthy pregnancies.

Accomplishments to Date: Through a partnership with the Delaware Healthy Mothers and Infants Consortium, there has been much work to educate our population about preconception health, in which preventive health visits play a key role. This work includes social media outreach around the theme that "Health Begins Where You Live, Learn, Work & Play." Over the last year, DPH has developed a new 5 year DHMIC Strategic Plan, which includes a well women care initiative as a priority, supported new Delaware Healthy Mother and Infant Consortium (DHMIC) leadership, implemented Healthy Women Healthy Babies (HWHB) 3.0 program model to focus on a) performance/value based care b) address the social determinants of health c) coordinate and provide referral linkages with community health workers and d) strengthen integration of behavioral health into the model, operated and sustained 10 HWHB Zones community based interventions, and supported the training and deployment of community health workers deployed in high risk zones to support HWHB to link women of reproductive age to maternal and child health support and services.

Plans for the Coming Year: We will also continue to educate and counsel women of reproductive age about all contraceptive methods that are safe and appropriate for them, including long-acting reversible contraceptives (LARCs). DPH will work with partners to implement a law passed over a year ago that allows pharmacists in DE, along with 11 other states, to administer or dispense contraceptives under a standing order from DPH and regulations will be published to support implementation. Delaware will continue to transition the HWHB program 3.0, providing preconception, nutrition, prenatal and psychosocial care for women at the highest risk focused on value-based care by monitoring a core set of benchmark indicators. In partnership with Maternal and Child Death Review Commission, roll out and distribute maternal health warning signs materials and toolkit to providers. Delaware will work on a sustainability plan to support Healthy Women Healthy Babies Zones or community based interventions to address the social determinants of health, providing coaching and technical assistance using a learning collaborative approach.

Population Domain: Perinatal/Infant Health

Defining the Need: According to the 2022 Breastfeeding Report Card, 83.6 % of babies born in Delaware in 2019 were “ever breastfed or fed breast milk” ; equal to the national estimate of 83.2%. Within this measure, there are disparities by both race/ethnicity and household income level. According to Pregnancy Risk Assessment and Monitoring System (PRAMS) data, the percentage of women who ever breastfed increased by 12% from 79.2% in 2012 to 88.6% in 2021 and currently breastfeeding increased by 23% from 48.8% in 2012 to 60.1% in 2021 among women with a recent live birth. There were differences in breastfeeding rates by race and ethnicity. For instance, based on PRAMS data, the 2021 prevalence of ever breastfed among Black non-Hispanics was 85.0% as compared to 88.0% among White non-Hispanics, 91.4% among Hispanics, and 96.7% among other races non-Hispanic. Similarly, the 2021 prevalence of currently breastfeeding among Black non-Hispanics was 48.1% as compared with 64.4% among White non-Hispanics and 57.7% % among Hispanics, and 71.9% among other races non-Hispanic.

Accomplishments in the Past Year:
The following activities have been accomplished this past year with the use of Title V funding and through partnerships with entities such as the DHMIC, WIC and the Breastfeeding Coalition of Delaware (BCD). According to the Gibbious findings in the First and Second Quarter Report of Fiscal year 2023 and the WIC WOW Data System:

- Breastfeeding initiation at increased by 4% in the last two quarters.
- Breastfeeding Initiation rates in the WIC population has increased by 2% from the 1st to the 2nd quarter.
- Exclusivity increased by 3% from the 1st to the 2nd quarter.
- 12-month Duration remained level during the 1st and 2nd quarter

DE WIC built a cross-functional team that includes WIC program staff, local clinic staff, birthing hospital leadership, and community peer counselors to meet quarterly to review the latest breastfeeding rates and develop big and small strategies to enhance the peer counselor role and breastfeeding supports across the state. In coordination with the team, the WIC program does an annual survey of participants to identify issues and inform participant-driven strategies.

Plans for the Coming Year: The Breastfeeding Coalition of Delaware was selected as one of the HWHB mini-grant awardees. Their goal is to improve breastfeeding rates for women of color to the HWHB high-risk zones of Wilmington, Claymont, and Seaford by providing access to community resources, education, and peer support. The project, Delaware Breastfeeding Village is offering accessible support, engaging groups, text check-ins, access to variable levels of lactation support, and incentives for participation. In addition, the Breastfeeding Coalition of Delaware hired three diverse breastfeeding peer counselors (BPC) and one lactation consultant to provide breastfeeding support to women. WIC and Medicaid eligible mothers can participate in a 6-month program where they receive support from a breastfeeding peer counselor and a lactation consultant if needed.

Population Domain: Child Health
Defining the Need: The priority is for children to receive developmentally appropriate services in a well-coordinated early childhood system. Delaware continues to steadily adopt strategies to improve upon developmental screening. According to the 2020/2021 America’s Health Rankings, only 32.1% of Delaware children, ages 9-35 months, received a developmental screening - below the national average of 34.8%. A significant decrease for the nation as well as the state. In addition, Delaware aims to increase access to comprehensive oral health care for children most at risk for oral disease. According to the 2020/2021 NSCH, 77.3% of Delaware children, ages 1 through 17, have had a preventive dental visit in the past year.

Accomplishments in the Past Year: In addition to partnering with the Office of Early Learning to implement universal developmental screening across the state, MCH has also been successful in piloting the Child Health and

Development Interactive System (CHADIS) including building a referral platform. This will aid in developmental screening coordination, especially capturing families referred from health care to early intervention programs. A total of 9,214 PEDS online screens were completed on children 0-59 in 2022. This corresponds to an estimated 6,574 unique or unduplicated children. For the past year, Books Balls and Blocks (BBB) events reached over 60 families virtually and face-to-face. There was also a concerted effort to organize events targeting fathers. Though not well attended we recognize the impact of dads on their children and plan to organize another such event. Since July 2020, over 30 online BBB sessions have been carried out with 124 online evaluations completed. From July '22, through May '23, the Delaware Smile Check Program provided a dental screening to 2,670 students. During that same time frame, 2,550 students received a fluoride varnish application. There were162 students that were identified as having an urgent dental need and 742 with suspected dental decay. Through case management we were able to confirm 269 students that received follow up treatment with a dental provider in the community.

Plans for the Coming Year: In addition to collaborating with the Office of Early Learning to implement universal developmental screening, MCH plans to scale-up the CHADIS pilot at the beginning of the year, especially within pediatric practices. There are also plans to collaborate with early intervention programs to ensure families referred to early intervention do not fall between the cracks, especially children deemed ineligible to EI services. We also will continue to support efforts to increase the number people/providers/ parent leaders trained to use the ASQ and PEDS. MCH supports BOHDS efforts to incorporate dental into school-based wellness programs across the state to improve access to care for preventive dental treatments. BOHDS will continue to pursue expansion efforts for x-rays and restorative treatment to be offered. BOHDS will continue to collaborate with schools interested in including dental into their school-based wellness centers across the state.

Population Domain: Adolescent Health

Defining the Need: The priority need is to increase the number of adolescents receiving a preventive well-visit annually to support their social, emotional and physical well-being. The 2020/2021 NSCH shows that the percentage of Delaware adolescents who have had a preventive medical visit in the past year rests at 71.8%, compared to 69.6% nationally. In addition, Delaware strives to increase the number of adolescents who are physically active. According to the 2020/2021 NSCH, Delaware is average among its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day, one to three days per week.

Accomplishments in the Past Year: All schools have returned to in person learning with the option of remote learning and/or hybrid learning, increasing the accessing to School Based Health Centers (SBHC) at the beginning of the year. Many SBHC's implemented telehealth at the onset of COVID which is still in place to ensure are students have access to treatment when needed. During the 2021/2022 school year, the SBHCs in Delaware schools administered 4,094 depression screenings, 941 STD screenings, 1,753 Emotional (Mental Health) evaluations, and 4,395 risk assessments. In addition to this, SBHC's in Delaware completed 4,854 physical exams (well child), and 1,283 nutritional counseling sessions. MCH recently partnered with DOE to promote Project THRIVE, which helps Delaware students, grades pre-k through 12th grade, who are struggling with traumatic situations, such as physical or emotional abuse, community violence, racism, bullying, and more. DPH's Physical Activity, Nutrition & Obesity Prevention partnered with BGC to introduce a new program called Triple Play at 3 Delaware locations. This healthy lifestyle program focuses on the three components of a heathy Self, Mind, Body, and Soul. The goal of the program is to improve knowledge of healthy habits, good nutrition, and physical fitness; increase the numbers of hours per day youth participate in physical activities; and strengthen their ability to interact positively with others and engage in healthy relationships.

Plans for the Coming Year: Delaware's School Based Health Centers (SBHCs) provide prevention-oriented,

multi-disciplinary health care to adolescents in their public-school setting and contribute to better outcomes. In most recent years there have been seven SBHC established in elementary schools with epilogue language from FY2020 expanding SBHCs in elementary schools at two per year in high needs elementary schools throughout the state. Along with establishing SBHC's in elementary schools many of the SBHC's are exploring the opportunity of expanding services to more students by opening "spoke" sites. Having these additional sites will provide critical services to students in our state. PANO will continue to facilitate the connection between youth-serving organizations (YSOs) and schools to support the health and well-being of youth and to strengthen community partnerships. These partnerships focus on the link between a community-based, youth-serving organization and the health and social-emotional well-being of participating youth.

Population Domain: CYSHCN

Defining the Need: The priority is to increase the percent of children with and without special health care needs who are adequately insured. Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 28,111. According to the 2020/2021 NSCH, 68.8% of Delaware children are adequately insured in comparison to the national average of 68.2%. This includes CYSHCN between the ages of 0 through 17. Among the sub-group of children health care needs, 65.4% are continuously and adequately insured, compared to 69.7% of non-CYSHCN children.

Accomplishments in Past Year: The Parent Information Center (PIC) completed their 2nd year as DPH's vendor to implement the newly revitalized Family Support Healthcare Alliance Delaware (SHADE) project. The program's approach included family and professional partnerships at all levels of decision making, to best serve our CYSHCN and their families. PIC implemented the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. Family SHADE served as a learning network and resource for the community agencies serving CYSHCN. PIC also succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of two competitive mini-grant opportunities that were innovative and aligned with our MCH National Performance Measures (NPMs) 11, 12 and 15. The two awarded mini-grantees were Jay's House and Tomaro's C.H.A.N.G.E. (creating healing, answers, & necessary guidance for excellence). During this process there were opportunities to build capacity for Jay's House through networking with other organizations within the community through their awarded year. They found that the mini-grant project's most valuable component was the networking with other organizations. Although they did not apply for year 2 of the mini-grant funding they were able to collaborate with another organization to serve children with Autism which is Jay's House's passion. Tomaro's C.H.A.N.G.E. will be returning for year 2 to complete the year 1 project that they had difficulty executing and required reformatting of their program.

Plans for the Coming Year: PIC will continue to implement Learning Communities to families and organizations that serve parents of CYSHCN through the Family SHADE project. The FLN membership will continue to grow and will align MCH's NPMs through the services rendered by organizations in Delaware that serve families of CYSHCN. Family SHADE will strive to enhance capacity and sustain programs that serve CYSHCN. The project will continue to provide technical assistance and quality assurance to Tomaro's C.H.A.N.G.E. who will be transitioning into year 2 of the mini-grant project since they had to reformat their program in year one. PIC will provide technical assistance and quality assurance to the newly awarded mini grantees who are working on developing a Logic Model, Work Plan, Evaluation Plan, Evaluation Tool, Sustainability Proposal and a COVID Response Plan. The 3 agencies that were awarded and will begin to implement services soon are: 1. Down Syndrome Association of Delaware, 2. Children's Beach House and 3. Teach Zen. Through ongoing programmatic meetings with the CYSHCN Director and the PIC Team, Family SHADE will work toward educating families of CYSHCN on the available medical insurance coverage that is available in Delaware through innovative approaches.

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

Title V MCH funding serves as the backbone funding source for addressing essential MCH and public health programs and priorities addressing infrastructure and Core Public Health Functions. The types of initiatives impacted by Title V, include chronic disease prevention, access to care, particularly in underserved or rural health areas, programs that reduce infant mortality, newborn screening, and personal care services for children and youth with special health care needs. Title V funding also helps Delaware address Preventive Health Services. Through Title V, 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.

Title V funding also supports 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.

In the past few years, we have allocated funds to address social determinants of health including the integration of the medical legal partnership model within our home visiting programs and our Healthy Women Healthy Babies (HWHB) providers offices. More recently, funding has been allocated to key community organizations to address community needs with a range of services and/or programs that will propel Delaware forward in two areas, systems of care for children with the special health care needs and infant mortality. Three years ago, we released a new RFP for our HWHB Zones work which includes mini-grant awards to improve maternal and infant health outcomes in Delaware using community-based approaches. Proposed projects are assessed using several criteria, including whether the applicant uses an actionable, community-based intervention designed to support identified high-risk communities across the state and they must be linked to reducing disparities related to maternal/child health. After two successful cycles, we just released a third and awarded two additional grants. We now have 10 total mini-grant awardees.

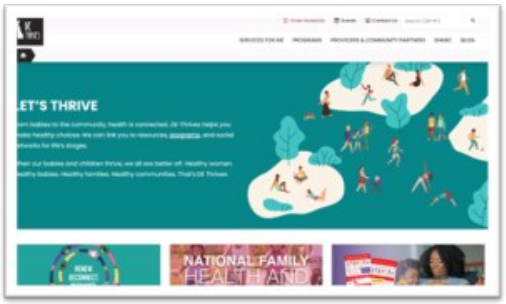
Two years ago, we released a similar RFP to award mini grants to improve systems and standards of care for children with special healthcare needs. Two community-based organizations were selected the first year and four additional were awarded earlier this year.

III.A.3. MCH Success Story

After two years in the making, Title V and the MCH Bureau is proud to present the newly designed website, DEThrives.com, *where healthy communities are made of healthy people*. As a convener and facilitator, our Title V team collaborated with DHMIC members, stakeholders, the University of Delaware, and many other partners who were content experts in different subject matter to help develop the improved infrastructure, navigational features, and overall user experience for the revamped website.

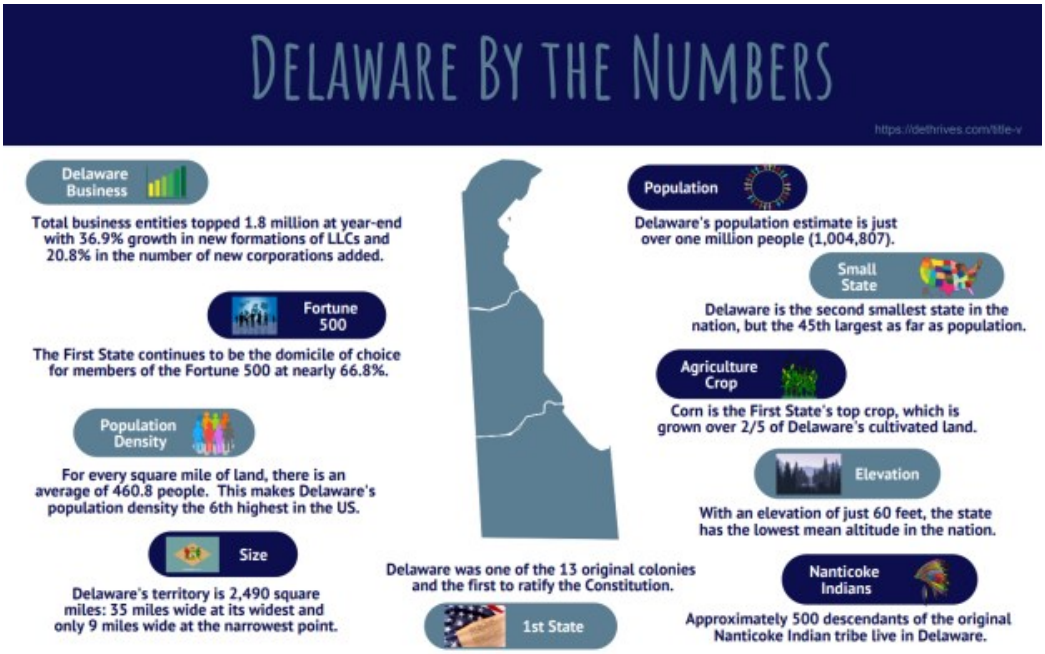
When creating the newly designed website, one of the goals was to present the evidence-based maternal and child health messaging in a way that users and our partners could easily understand, resonate with, engage with, and share broadly. This was done by presenting the material in a relatable, respectful, and educational way that any user, i.e., a teen, an adult, a pregnant woman, or a parent, would understand when visiting the site. It was important to use this revamped platform along with our social media channels (Facebook, Instagram, and Twitter), to present our Delaware based programs and initiatives from a trusted educational figure rather than telling our audience what we think they should do to improve their health.

Material on the site is sorted by programs, audience type, and professional content that providers and community partners could utilize. Items such as filters, life stages, and the related programs and services bars, are new items that were added to the site to improve navigation and user experience so the user could easily find the type of content they are searching for on the site. Since the site went live in early April, it has earned its highest ranking of total users that visited the site in one day. There was also an increase in the number of pageviews the DHMIC page received, which was 219 views in late April, where the average user visit to the DHMIC page was 77 in April.



To ensure the user experience and functionality of the site is working at its best, additional features will be added such as adding Spanish and Haitian Creole translated items on the site, additional content will constantly be added such as stating the importance of mental health, urgent maternal warning signs, and others. The DEThrives site is dedicated to share resources to improve the health of all Delaware women and their babies before, during, and after pregnancy, men, young adults, parents, and those who are planning to have children or to not have children.

III.B. Overview of the State



Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. 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, 2021, was 1,018,396, according to the Census.
Delaware's population increased by 2.9% from 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 2022, 68% of Delaware residents were White and 24% were Black. The Hispanic population is steadily increasing, from 8.7% in 2013 to 10.1% in 2022. About 20.8% 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, in the northern third of the state, is the largest in population with about 575,494 residents or about 57% of the state's total population. New Castle County has a large population of African American residents (nearly 27%) 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, 11%. Kent County, home to the state's capital of Dover, has an estimated 186,946 residents (64% White and 28% Black). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2022 population was approximately 255,956 (83% White, 12% Black). Like New Castle, Sussex County also has a growing Hispanic population, estimated at 9.6% for 2022.
In 2020, statewide, it is estimated that there were about 185,176 women of childbearing age and over 250,000 children and adolescents aged 0-21 years of age. Data shows 10,792 births for 2020 and preliminary data shows 10,504 births for 2021. According to 2020-2021 combined years of data 21.1% have special healthcare needs (National Survey of Children's Health/NOM 17.1).

Economic Indicators
In Delaware, 17.3 percent of children lived in poverty in 2017-2021, which remained stable with 17.2 percent in 2016- 2020. The highest rates are among those children aged 0-4 at 20.7%. According to Kids Count in Delaware, one in ten Delaware children in single mother households live in poverty. From 2017-2021, 11.1% of children in poverty were living in a single female householder compared to 4.4 living with a married couple. The median family income in 2021 was $82,100 for all Delawareans, the median family income for non-Hispanic white was $102,200 and $55,200 for Black or African American.

In 2020, 47.9% of all births were to unmarried women. In 2020, 34 percent of births were to single non-Hispanic white women, a slight increase from 32 percent in 2002. The percentage of births to single Hispanic women increased from 56 percent in 2002 to 62 percent in 2020. Unmarried non-Hispanic black women had the highest percentage of births from 2002 to 2020, remaining stable at approximately 70 percent during this time. (Delaware Health Statistics, 2020). As of 2022, an average of 61,155 households per month received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP). (KIDS Count in Delaware, 2023).

Availability of Health Providers

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

Services for CYSHCN

In Delaware, Children and Youth with Special Health Care Needs (CYSCHN) are served by the Birth to Three Program for infants and toddlers aged 0-3 and by evidence-based home visiting program services. 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. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. The CDW program provides developmental assessments of children birth to 3 years of age and service coordination for developmental services and therapies. CDW 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 the Alfred I. DuPont Hospital for Children (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 families and 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 John Carney took office as Delaware's 74th Governor in January 2017. Governor Carey 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 Molly Magarik. 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. Currently, Dr. Elizabeth Brown is the interim director who also fills the Medical Director role for the Division of Medicaid and Medical Assistance. DPH remains steadfast to it 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.

Authority and regulatory charges for the Division of Public Health come from Title 16 of the Delaware Administrative Code, which governs health and safety. Specific to Family Health, the code includes regulations for operation of a Birth Defect Surveillance and Registry Program and an Autism Surveillance and Registry Program, both of which are funded in part by Title V. The Delaware Healthy Mother and Infant Consortium (DHMIC) is also established in code and is charged with coordinating efforts to prevent infant mortality and improve the health of women of childbearing age and infants in the State. Last year, the DPQC was formally established in Delaware Code and signed by the Governor during a virtual press conference in July 2020. Data collection and analysis is crucial to the DPQC's efforts to improve the care and outcomes of DE's women and their babies. The foundation of the collaborative is to share current data to use for benchmarking and QA/QI, identify best standards of care/protocols, realignment of service providers and service systems, continuing education of professionals and increasing public awareness of the importance of perinatal care. As such, our Title V Program works closely with the DHMIC to align our priorities and strategies as much as possible. We also have regulations in Title16 for school-based health centers which were codified in 2012, and subsequently regulations were established and updated in 2017. The Newborn Hearing and Metabolic Screening Programs, which are not primarily funded by Title V, but work in close coordination with the program are also established in the Title 16 code.

As of January 1, 2023, DPH was charging the birth facilities and midwives $135.00 per newborn for the newborn metabolic screening including lab and follow up services. The DPH contracts with A.I. duPont Children's Hospital to administer the statewide program which includes both the program and laboratory services. A.I. duPont Children's Hospital currently sub-contracts with Perkin Elmer to provide the laboratory services. Since outsourcing the program in 2018, the program has not increased the $135 fee. 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 AI. duPont 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 the process. The Advisory Committee also 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. The program drafted the revisions needed to update the regulations to reflect the changes approved by the Board to change the timeline for storage of the specimens and collection of the specimens, the updated regulations were approved. The program also drafted changes to revise the legislative code which was approved during this most recent legislative session.

Current Priorities of the Division of Public Health
The Division of Public Health 2019-2023 Strategic Plan provides a clear and proven path for the division to continue to lead the state's public health system. DPH is embarking on the Public Health 3.0 approach. Public Health 3.0 refers to a new era of enhanced and broadened public health practice that goes beyond traditional public health department functions and programs. Cross-sectoral collaboration is inherent to the Public Health 3.0 vision. 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. We spent the better part of eight months re searching and analyzing our existing goals, strategies, and data; examined current national and local public health challenges; and considered future public health challenges. As a result, we have identified five strategic priorities, of which our new strategic plan is based: Promote Healthy Lifestyles; Improve Population Health and Reduce Health

Care Costs; Achieve Health Equity; Reduce Substance Use Disorder and Overdose Deaths. The DPH is doubling its efforts to work collaboratively alongside Delaware state agencies and external stakeholders to address the immediate and long-term health consequences of substance use disorder and violence in communities. To tackle these complicated issues, DPH sees its role as providing prevention expertise, as well as technical assistance related to evidence based population health practices.
DPH staff will actively implement this strategic plan by improving our services, participating in robust workforce development activities, and practicing the LeadQuest 10 Principles of Personal Leadership.
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 health care 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. Final updates were made and the *DPH Division Director formally adopted the DPH 2019-2023 Strategic Plan* on January 1, 2019. The Strategic Plan remains active until the end of the 2023. We believe once a permanent Division Director is place, work on a new Strategic Plan will begin.

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 four 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 in January 2020 and we were able to acquire an extension on our submission deadline due to COVID. Once again, we assembled DPH PHAB Domain Teams and have begun organizing to develop and collect required reaccreditation documents. Like our first 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 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.

The findings, goals, and strategies that are part of both the Delaware SHIP and DPH's strategic plan was intentionally factored into the Title V needs assessment process, with the goal of leveraging the results of these comprehensive planning efforts. We believe the input gathered from professional MCH stakeholders, families, and community members through surveys, focus groups, and interviews will reinforce the priorities of healthy lifestyles; population health; reducing health care costs; achieving health equity; and addressing substance use disorder and overdose deaths.

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 2020 was 5.5 per 1,000 live births as compared to 5.4 per 1,000 for the U.S. The five-year infant mortality rate (2016-2020) was 6.5 per 1,000 (11.6 per 1,000 for Black non-Hispanics and 3.8 per 1,000 for White non-Hispanics). The five-year Black infant mortality rate decreased from 12.6 per 1,000 (2012-2016) to 11.6 per 1,000 live births (2016-2020) while the five-year White infant mortality rate decreased from 4.6 per 1,000 (2012-2016) to 3.8 per 1,000 live births (2016-2020). The five-year Black to White disparity ratio was about 3 times.
- **Breastfeeding.** According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2021 data, the percentage of women who ever breastfed increased by 12% from 79.2% in 2012 to 88.6% in 2021 and currently breastfeeding (i.e., at the time of survey) increased by 23% from 48.8% in 2012 to 60.1% in 2021 among women with a recent live birth. There were differences in breastfeeding rates by race and ethnicity. For instance, based on PRAMS data, the 2021 prevalence of ever breastfed among Black non-Hispanics was 85.0% as compared to 88.0% among White non-Hispanics, 91.4% among Hispanics, and 96.7% among other races non-Hispanic. Similarly, the 2021 prevalence of currently breastfeeding (or at the time of survey) among Black non-Hispanics was 48.1% as compared with 64.4% among White non-Hispanics and 57.7% % among Hispanics, and 71.9% among other races non-Hispanic.
- **Teen Births.** The teen birth rate in the U.S. in 2020 was 15.4 per 1,000 females aged 15-19 years and the corresponding teen birth rate in Delaware in 2020 was 14.6 per 1,000 females aged 15-19 years. Between 2014 and 2020, the teen birth rate in Delaware declined by approximately 29.5 % (2014: 20.7 per 1,000 females aged 15-19 years). The disparity ratio in teen birth rates was 4.5 times for Black teens (27 per 1,000 females aged 15-19 years) and 5.2 times for Hispanic teens (31 per 1,000 females aged 15-19 years) to White teens (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.** As per the National Survey of Children's Health (NSCH), in 2020-2021, an estimated 89.8% of Delaware children reported to be in excellent/very good health (White non-Hispanic: 93.4%; Black non-Hispanic: 86.0%; Hispanic: 82.1%; and Other non-Hispanic : 94.1%) as compared with 90.2% in the U.S. (White non-Hispanic: 93.4%; Black non-Hispanic: 86.0%; Hispanic: 85.8%; and Other: 91.1%). Health status varied by income status in Delaware like the U.S. overall. Health status improved with increased household incomes. For instance, in Delaware, 85.6% of children in households at 0-99% federal poverty level (FPL) indicated excellent/very good health as compared to 96.1% in 400% or greater FPL category.
- **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. With the exception of 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) 2012-2021 data, the prevalence of smoking before pregnancy among women with a recent live birth declined by 46% from 27.2% in 2012 to 14.7% in 2021. Similarly, the prevalence of smoking during last three months of smoking among women with a recent live birth declined by 45% from 18.6% in 2012 to 10.3% in 2021. Lastly, the prevalence of smoking after pregnancy among women with a recent live birth declined by 38% from 13.3% in 2012 to 8.2% in 2021. However, the declines smoking prevalence was not uniform among different racial and ethnic groups. For instance, 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. While the decline in smoking prevalence before pregnancy between 2012 and 2021 for White non-Hispanic was 49%, the decline among Black non-Hispanic women was 27.8%. 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 2021 10.2% of White non-Hispanic women reported smoking as compared to 8.3% of Black non-Hispanic women. While the decline in smoking prevalence during last three months was 42% among White (non-Hispanic) women, the decline among Black non-Hispanic women was 18%.
- **Medical Home.** As per the NSCH 2020-21 data, 46.3% of Delaware children received coordinated, ongoing, comprehensive care within a medical home as compared to 46.6% in the U.S. However, there were notable disparities with regards to children with medical home. For instance, in Delaware, 33.3% of Black non-Hispanic children (37.1% in the U.S.), 34.5% of Hispanic children (34.7% in the U.S.), 46.0% other non-Hispanic children (44.6% in the U.S.), and 57.3% of White non-Hispanic children (55.6% in the U.S.) indicated having a medical home. Further, there were differences due to special health care needs (CSHCN) status

having a medical home. Further, there were differences due to special health care needs (CSHCN) status. For instance, 38.3% of children in Delaware with special health care needs indicating having a medical home as compared to 42.2% 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 has established health equity as a strategic priority for the entire division and released the second version of the Heathy Equity Guide for Public Health Practitioners and Partners. The Delaware Division of Public Health (DPH), the University of Delaware's School of Public Policy & Administration, and other partners created the guide to help Delawareans better understand tools and strategies that promote health equity and support upstream population health approaches. The document is designed to assist all sectors which can include but are not limited to government, education, workplaces, private sector, nonprofit agencies, faith-based institutions, and health care settings address underlying causes of health inequities in communities and promote optimal health for all in Delaware. Every person deserves equal access to safe communities that foster opportunities to achieve optimal health and well-being. 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 efforts and launching an online Health Equity Action Center.

Recognizing the importance of social determinants of health, a place-based, community approach has been established as a key component. In 2019, a request for proposal was posted to solicit proposals for a backbone organization to manage what we are calling the Healthy Women Healthy Babies (HWHB) Zones project. This is the main focus of the Delaware Healthy Mother and Infant Consortium's efforts as it aims to reduce the infant mortality rate. A comprehensive update on this initiative can be found in Well Woman application year narrative.

Health Care Reform Efforts in Delaware

Health care spending per capita in Delaware is higher than the national average. Historically, health care spending has outpaced inflation and the state's economic growth. Health care costs consume 25% (or approximately 1 billion in FY 2017) of Delaware's budget. Medicaid cost per capita and the growth in per capita spending have been above the national average. These challenges are not unique to Delaware – affordability is of equal concern to private employer sponsors of Commercial health insurance, as well as some consumer segments who have seen increases in deductibles, copays, and coinsurance. Delaware's demographics and the percentage of our citizens with chronic conditions are key drivers of both spending and poor health outcomes. Delaware's population is older and is aging faster than the national average – we will be the tenth oldest state by 2025. We are also sicker than the average state, with higher rates of chronic disease, in part driven by social determinants including poverty, food scarcity, and violence. The hospital landscape is more concentrated in Delaware than in most other markets, with just six acute care hospital systems across the state, with most populations relying on a single hospital for their care. Our hospital systems vary widely in both scale as well as operational efficiency. Primary care and some other physician specialties remain fragmented. Other physician specialties are concentrated. Behavioral health care is in short supply in some parts of the state. Increased demand for health care, as well as inefficiencies in the supply of health care, in combination lead to 25% greater historical spend per capita than the U.S., which itself has among the highest cost health care systems in the world. While we spend more on care, our investments have not led to better health or outcomes for Delawareans. We spend more than average, not to get better access or higher quality care, but simply to address the challenges of an older and sicker population.

After receiving federal grant monies through the Centers for Medicare and Medicaid's State Innovation Model (SIM) project, Delaware has made a significant investment in transitioning to value-based payment models. Value based payment models enable collaboration between providers and health systems in addition to allowing a greater focus on keeping people healthy through improving primary care. This is vastly different from the traditional Fee for Service model that aligns payment for services with volume, regardless of patient outcomes and whether the overall population of the state is getting healthier. The State has supported these changes from a policy perspective by setting the expectation for Medicaid Managed Care Organizations (MCOs) and State Employee/Retiree Third-party administrators to offer and promote the adoption of value-based models.

In 2017, House Joint Resolution 7 authorizes the Department of Health and Social Services to establish a health care spending benchmark linked to growth in the overall economy. In 2018, the Department of Health and Social Services (DHSS), the Delaware Health Care Commission (DHCC) and the Delaware Economic and Financial Advisory Council (DEFAC) worked together to establish the spending and quality benchmarks. Insurers reported initial calendar year 2018 baseline data in 2019, giving them and the Department experience in collecting and reporting data, which is essential to the benchmarks and improving the process moving forward. Governor Carney established

heath care spending and quality benchmarks in Executive Order 25, issued in November 2018. The spending benchmark is set on a calendar year by the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee.
The first spending benchmark went into effect on Jan.1, 2019, and was set at 3.8%. That spending benchmark was not met, as the finalized health care spending for 2019 grew at a rate of 5.8%. For calendar year 2020, the spending benchmark was set at a more ambitious target of 3.5%, which was met as the Total Health Care Expenditures (THCE) per-capita change from the prior year was estimated at -1.2%. Delaware's spending benchmark is the year-over-year percentage change in total health care expenditures (THCE) expressed on a per capita basis. For Calendar Year 2021, the spending benchmark was set at a 3.25 percent growth rate. Delaware's total Calendar Year 2021 THCE was approximately $9.1 billion. The per capita amount was $9,088, which represents a 11.2% year-over-year increase. The 11.2% per capita increase is significant, but this figure reflects Delaware's health care market rebounding from the reduction in health care spending and utilization in Calendar Year 2020 caused by the COVID-19 pandemic.

The quality results for 2021 were similar to 2020. While Delaware made progress in some important measures, the report shows us there is still significant work to be done to improve the health of Delawareans in other areas.
Overview of Quality Results:

- Adult obesity: The benchmark for 2021 was to reduce the percentage of Delaware adults who are obese to 28.7%. The 2021 result: 33.9%; a decrease from 2020, but still 5.2 percentage points higher than the benchmark.
- Use of opioids at high dosages: The 2021 benchmark: 11.6%; the 2021 result: 9.6%. This is a positive observation.
- Opioid-related overdose deaths: The benchmark for 2021 was to reduce the mortality rate to 14.7 deaths per 100,000. The 2021 result: 48.1 deaths per 100,000. This is an increase from 2020.
- Emergency department utilization: The benchmark for 2021 was to reduce Emergency department utilization to 178 visits per 1,000. The 2021 result: 163 visits per 1,000. This is a positive observation.
- Persistence of beta-blocker treatment after a heart attack: The benchmark rate for 2021 was to increase the percentage of patients who receive beta-blocker treatment to 87.2% of commercial insurance patients and to 83.1% for Medicaid patients. The 2021 results: 88.5% for commercial insurance patients and 80.7% for Medicaid patients. While the Medicaid patients did not reach the benchmark, this is an improvement from the 2020 results of 78.1%.
- Statin therapy for patients with cardiovascular disease: The benchmark rate for 2021 was to increase the percentage of patients who receive statin therapy to 81.0% of commercial insurance patients and 63.8% for Medicaid patients. The 2021 results: 81.8% for commercial insurance patients; 66.1% for Medicaid patients. For both markets, results were better than the respective benchmark. To learn more about the health care spending and quality benchmarks, visit the Health Care Commission website.

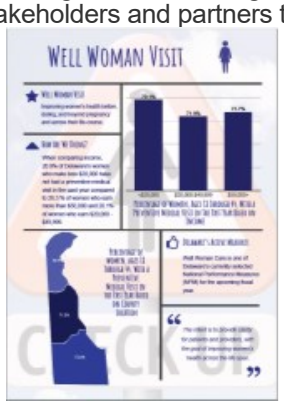
III.C. Needs Assessment

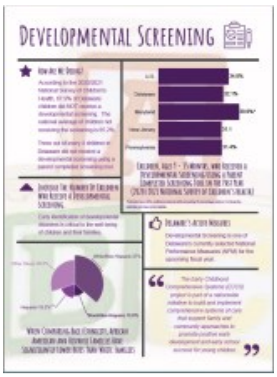
FY 2024 Application/FY 2022 Annual Report Update

Delaware completed our comprehensive Title V Five-Year Needs Assessment in 2020. This FY 2024 Application/FY 2022 Annual Report application is our fourth year into the 2021-2025 grant cycle.

During this summer of 2021, Delaware reconvened our Title V team to prepare for the likelihood of emerging and shifting priorities due to the impacts of the COVID-19 pandemic on Delaware's maternal and child health population. The first goal of our Title V team was to use a data-informed method to identify and prioritize Delaware's top health issues as a result of the pandemic. Additionally, keeping the pandemic in mind our team aimed to incorporate stakeholder and public input into finalizing any modifications to the priority areas by population domain for action planning. The Steering Committee was responsible for reviewing and understanding the data, surveying our MCH team for emerging issues and concerns, and identifying priority areas of concern from the national health areas.

Previously, MCH created detailed and specialized Health Infographics for each of the 15 National Performance Measures. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it related to each measure. Information such as Delaware's goals and objectives, Delaware's baseline data, and how Delaware compares to our neighboring states was included. This spring, 2023, MCH amended these Health Infographics once the 2020/2021 NSCH data was released. All of our Title V and Needs Assessment information, including our Health Infographics, is found in one central location, our DEThrives website. We encourage all of our stakeholders and partners to check back often for updated information and resources.





As reported last year, Delaware developed another graphic for our partners to use as an additional resource. This colorful snapshot is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. This State Action Plan offers an at-a-glance snapshot for the public, our partners, and our stakeholders 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.

After reviewing the available data and convening as a team, we determined the best course of action would be to survey our partners for input in their specialized maternal and child health population domain. Evaluation activities included an effort led by the SSDI Project Director in working with Forward Consultants for this ongoing Title V Mini Needs Assessment process. Together, we modified our 2020 Needs Assessment Professional Stakeholder Survey. Our finalized objectives for our Mini Needs Assessment were:

- Gauge the impacts of the pandemic on our partners within each health domain

- Learn how our partners were adapting to the ongoing challenges of the pandemic
- Be more informed of the ways each program is adjusting
- Support programs that continue to address the MCH population
- Identify ways MCH can better support our Title V funded partners with technical assistance

We wouldn't be removing any priorities previously selected as a result of the 2020 Needs Assessment; rather, we would be addressing additional priorities that rose to the top. Therefore, part of our survey included additional questions for our Title V partners of the various ways we were able to provide technical assistance. The Division of Public Health (DPH) coordinates and collaborates with many organizations and other state agencies to implement activities that address grant goals and objectives. We asked for various ways Title V could provide technical assistance to our partners to be better responsive to their needs.

Another focus Title V wanted to gain a pulse on due to the pandemic, were Social Determinants of Health (SDOH) on Delaware's MCH population. Our aim was to see if the women, children, adolescents, and families in Delaware's unmet needs have changed since the beginning of the pandemic. We understand that poor health tied to unmet social needs is a widespread problem and these factors impact a person's physical and mental well-being, along with their ability to access quality health care. Title V is making an effort to ensure that Delaware has it on the forefront of all our activities. Our Professional Stakeholder Survey included questions pertaining to the top three most important things that women, children and families need to live their fullest lives in our community. In addition, we canvased our partners to learn what are the top three greatest unmet needs of women, children, and families in Delaware.

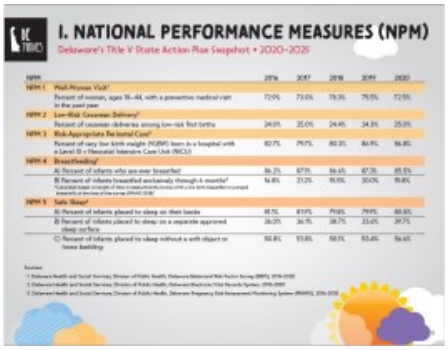
Interestingly, when asked about SDOH, employment was listed most often as a SDOH that women, children, and families need to live their fullest lives. However, it was not considered as much of as an unmet SDOH in the survey respondents' communities. Both food security and child-care were listed as among the top three SDOH-related responses that women, children, and families need to live their fullest lives as well as SDOHs that are unmet in communities.

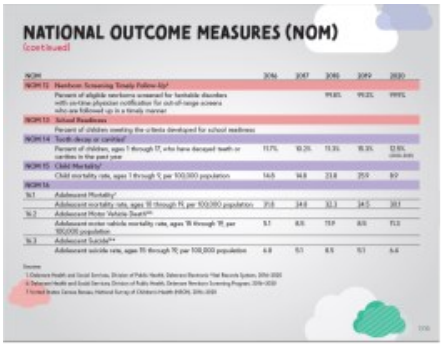
Our Title V team requested Forward Consultants complete an in-depth analysis of the results of this Mini Needs Assessment and compare these results to the results of our Five-Year Needs Assessment results. Our team was specifically interested in understanding any differences or likenesses that resulted when comparing the stakeholder responses in selecting important NPMs pre-COVID and post pandemic. Specifically, we asked if anything stood out that would lead us to deviate from our current course and wanted to justify any changes. Interestingly, there were no major differences in NPM-related responses in either survey.

As a result of our Title V team meetings, internal review of data and Professional Stakeholder Survey and analysis, our Title V team determined that Well-Woman Visit and Adolescent Well Visit will continue to be top priorities for MCH to focus on even through the pandemic. Through the priority of Adolescent Well Visit, we will continue to incorporate mental health in addition to physical activity.

We learned that our Title V funded partners ranked "provide data" as either the first or second choice by 60% of Title V partners. Therefore, our Title V team decided that our SSDI Project Director would work with our CDC Epidemiologist to include relevant MCH population data on our State Action Plan Snapshot created the previous year. Our intentions were for our partners and stakeholders to be able to view Delaware's MCH data in one document. This would also include previous year's data, so our partners can track the information from year to year. During the past grant cycle, our SSDI Project Director was able to schedule regular meetings with our two-Family Health Systems (FHS) epidemiologists and begin the task of compiling all MCH data into one central location. Both epidemiologists, Khaleel Hussaini, CDC assignee epidemiologist, as well George Yocher, FHS epidemiologist, are also members of our Title V team. Our goal was to gather and organize Delaware's data pertaining to each NPM as well as all the NOMs. Two data sheets were created as a result of the Mini-Needs Assessment survey.

During this grant cycle, in the spring 2023, MCH updated these Performance Measures data sheets once the 2020/2021 NSCH and other data sources were released. We hope this MCH Performance Measures data sheet supports our partners and our stakeholders with the very important maternal and child health work they do.





This year, we again reconvened our Title V team 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. Our team has met in person throughout the 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 also reviewed our State Action Plan based on guidance received from the National Center for Education in Maternal and Child Health. Delaware received the MCH Evidence Center's annual Evidence-based/informed Strategy Measure report for the 2023 Application/2021 Annual Report. Based on these findings, Delaware began conversations and used 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 National Performance Measure.

This year, Delaware spent a significant amount of time diving into our available data and comparing it to our current Strategies, State Performance Measures, and selected Evidence-Based or Informed Strategy Measures. Our Title V team met periodically to review Delaware's State Action Plan. In addition, our SSDI Coordinator then routinely worked with each domain leader, thoroughly reviewing the current Strategies and selected ESMs to modify or altogether update each, according to our identified Priority Needs and Objectives. We also worked with our CDC Epidemiologist on ways to capture and report data for each selected ESM. We want to tell Delaware's story, the significant and the insignificant. New Strategies and ESMs were added to the plan in addition to deleting ones that have been completed. We are strengthening Delaware's State Action Plan, which will improve the health of mothers, and children in Delaware.

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.

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 has four aims to improve the health of women in babies in the state: reduce infant mortality, decrease preterm birth, decrease maternal mortality rate, and decrease disparity rate. Each of the aims has focus areas with strategic priorities to accomplish the aims.

- Delaware's annual infant mortality rate (IMR) fell by 40% from a high of 9.0 deaths per 1,000 live births in 2015 to 5.4 deaths per 1,000 live births in 2020 and for the first time the Delaware IMR was similar to the U.S.'s IMR. While we have made strides in the overall reduction in our infant mortality rate, the racial disparity persists. Statistics reinforce the significant need in Delaware for continued and aggressive programming to mobilize communities and partners to educate and motivate underserved and high-risk populations to embrace healthier behaviors before, during, and after pregnancy.
- Delaware's preterm birth rate declined 3.7%, from 10.7% in 2019 to 10.3% in 2020, according to the CDC. However, racial and ethnic differences in preterm birth rates remain. Babies born too soon and too small are the main causes of Delaware's infant mortality rate.
- In Delaware, severe maternal morbidity (SMM) rose by 57% from 51.0 per 100,000 delivery hospitalizations in 2016 to 80.0 per 100,000 delivery hospitalizations in 2021, according to the Delaware Child Death Review Commission's Maternal Mortality Review Report. Risk factors for pregnancy-related complications include obesity, preeclampsia, high blood pressure, and substance use disorder, all of which are on the rise among Delaware women of reproductive age. 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 behaviors is only one part of the solution.
- According to Delaware Health and Social Services (DHSS), health disparities are all differences among populations in measures of health and health care from illness, injury, disability, or mortality. It can be described as differences in coverage, access, or quality of care. DHMIC works to identify and eliminate health disparities and collaborates with state, local, and private sectors.

In the domain of CYSHCN, a key partnership group is Family SHADE (Support and Healthcare Alliance Delaware). 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 in addition to advocating for solutions to recognize gaps in services and supporting its member organizations. Delaware believes in the provision of supports and services to families of children with special healthcare needs that foster (1) empowerment and not dependency; (2) equity and equality; and (3) an individually defined quality of life. In addition, caregivers must be viewed as experts in regard to their children within a context of self-determination and family culture. Effective family support of CYSHCN requires a multi-faceted, family-centered approach. Family SHADE works with committed partner organizations (either formal organizations or parent groups) to ensure that parents, siblings and extended families have the resources, information, and social and emotional support to care for children with special needs.

Delaware utilized the Parent Information Center (PIC), which began their 1st year as the new vendor to implement the newly revitalized Family SHADE project. The programmatic approach included family and professional partnerships at all levels of decision making, to best serve our CYSHCN and their families. PIC implemented the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The FLN network membership is a member network which offers trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. In the first year, they were able to recruit 12 family members that had a child or youth with special health care needs in their family. These families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive system changes to better serve families of CYSHCN. Family SHADE served as a learning network and resource for the community agencies serving CYSHCN. PIC succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of competitive mini-grant opportunities that were innovative and aligned with our Maternal Child Health NPMs.

Through PICs leadership, they prioritized aligning the Learning Communities with the MCH's NPMS as well as topics addressing gaps in service and identifying needs that were impacting families of CYSHCN. The learning communities were accessible to families and organizations serving CYSHCN. Through these initiatives, the Family SHADE project built state and local capacity and exercised 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 NPMs and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely attained surveys to track and gather information and topics being requested by the Family SHADE community by taking pre, post, and overall evaluation surveys during focused learning communities. These surveys assisted in determining what knowledge was gained by the participant as well as what topics families and community organizations wanted to see in future learning communities.

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 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 have partnered with Project LAUNCH and the Division of Substance Abuse and Mental Health in combating the opioid epidemic. The State of Delaware created a committee bringing together the Division of Public Health, Division of Family Services, and the Division of Substance Abuse and Mental Health. The group is made up of key leadership including all three Division Directors, two Deputy Directors and senior program directors including both the Title V Director and Deputy Director/MIECHV Project Director. The group decided to work on three key goals, a MOU, training for direct service staff and education.

The purpose of the MOU stems from both The Department of Health and Social Services and The Department of Services for Children, Youth and Their Families recognizing that each has an important role to improve the lives of families impacted by substance use disorder. The MOU was jointly developed for the agencies to:

- Work as a team on shared client cases to attain the most positive outcomes;
- Provide each client with the most comprehensive care; and
- Prevent duplication of activities.

The MOU states that each agency agrees to establish a multi-disciplinary coordination committee. The focus for the committee was training, messaging, case management, and the development of procedures. Since the development of this MOU, it has been decided that each of Delaware's three counties will have a committee focused on the above-mentioned items.

Delaware has officially kicked off our 2025 Five-Year Needs Assessment planning process. Our SSDI Director along with our MCH Deputy Director have met to develop the plan for our public input process. MCH aims to have several methods used to gather public input, including regular email updates to stakeholders, surveys, community forums/listening sessions, key informant interviews and focus groups. Qualitative data such as focus groups and key informant interviews can be considered the stories behind the data. The timing and sequence of gathering public input will be iterative with each activity laying the groundwork for subsequent activities. Division staff plan to attend coalitions, programs, and special initiative meetings across the state to discuss the Needs Assessment process and solicit input.

MCH plans to conduct Focus Groups regarding several MCH issues related health care and their community. Our goal is to have maternal health groups focused on questions related to women's health, groups focused on mothers and children and youth with special health care needs, father/partner groups, and preconception groups with African American women without children. In addition, Delaware plans to add some groups of adolescent/young adults with a mental health focus. MCH will also conduct a Professional Stakeholder Survey that would be distributed to our

stakeholders of MCH service agencies, organizations, coalitions, and programs for input on MCH population needs, system gaps and leverage points. The survey will also provide stakeholders an opportunity to rank the 15 National Performance Measures. The results and findings from the survey will inform our decision-making efforts to select our NPMs, SPMs, and ESMs.

During our 2025 Needs Assessment preliminary discussions, MCH has determined that Key Informant Interviews will also be conducted to learn more about system strengths and needs and to better understand the landscape of services and supports. MCH plans to identify stakeholders to participate in key informant interviews with partners representing every population domain. MCH will add an additional interview with a mental health worker in a high-risk School Based Health Center.

MCH is seeking to improve our Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) outreach, statewide. We aim to ensure the resources we have for Home Visiting (HV) are targeting the right areas of the state so that we are doing a better job with enrollment and retention of HV families in the areas of the state where it historically has been lacking or at higher risk regions of the state. Our goal is to take a more data driven approach. In addition, we will be looking at the existing disparities. What some of the disparities that the families in these zip codes are facing. We will talk with the HV families in these areas of the state and ask them what are some of the pressing issues involving their specific area of the state and what are methods they think would be helpful for improving retention and engagement of families in HV. Our approach is both data driven as well as looking and listening to what our families are saying on the ground.

Another key item that was identified in our HV Retreat and our Steering Group, was the lack of family involvement and feedback from families and what they're experiencing. MCH does not have a lot of information on families that don't accept services. Our plan is to complete various Focus Groups to hear from families that are engaged in the program, what they are experiencing, how the program has helped them, what benefits they have gained, and if they did not stay in the program we'd like to know why. MCH is searching for more buy-in from the families and to form relationships with our families to get them more engaged and to really listen to their feedback and bring them to the table. We're hoping to not just talk about their experiences, but to also help us craft policies, to provide input to our mission and vision statements, and to hopefully have a family advocate leader at the table with us to do some of the MIECHV work.

MCH is also pursuing Key Informant Interviews with MIECHV families who began HV services, then stopped before completion. We want to obtain a pulse of what reasons persuaded the family to discontinue services. We will also be conducting Key Informant Interviews for MIECHV families who declined HV services completely. We are trying to understand what reasons led families to altogether refuse HV assistance.

Forward Consultants assisted MCH with developing Focus Group questions. Our Steering Committee then helped us to think through and modify the questions to best ask our families, specifically since they are on the ground serving families. We were looking for help with what questions to ask as well as language to use and not to use when approaching families. Forward Consultants will be conducting the Stopped Services and Refused Services Key Informant Interviews. Our social marketing vendor, AB&C will be facilitating the Focus Groups. Forward Consultants with then complete a data analysis. We hope to learn why families are and are not engaged, and use that information to make what we do better and maybe even easier.

In addition to the wide range of organizational collaborations listed above, we also value partnership with families and consumers. As part of our 2020 Five-Year Needs Assessment process, we commissioned 12 discussion groups statewide, with a total of 92 women and men participating. Four maternal health groups focused on questions related to women's health. Three groups were conducted in English and one group was in Spanish. Four groups focused on mothers and children and youth with special health care needs. Two of those groups were in English and two were conducted in Spanish. Two father/partner groups were conducted. And lastly, two preconception groups were held with African American women without children.

Parents continue to be engaged through surveys administered by Family SHADE. Through guidance from PIC, Jay's House implemented activities that promoted family inclusion within MCH. Surveys were sent to families to collect data which measured the impact of their program on the CYSHCN population. In addition, Jay's House staff followed up with potential CYSHCN families to garner their interest, support questions about the program and identify resources and services that would support the family. Through the tracking of enrollment forms, surveys and questionnaires data was tracked to include CYSHCN services and supports needed, services implemented, and suggestions from families of CYSHCN.

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 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 problem solve. 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 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.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,993,981	$2,027,826	$2,027,826	$2,042,781
State Funds	$10,287,704	$10,287,704	$10,128,656	$10,128,656
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$2,973,146	$2,973,146	$2,957,897	$2,957,897
SubTotal	$15,254,831	$15,288,676	$15,114,379	$15,129,334
Other Federal Funds	$6,162,044	$6,162,064	$6,890,346	$8,067,874
Total	$21,416,875	$21,450,740	$22,004,725	$23,197,208

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

	2024	
	Budgeted	Expended
Federal Allocation	$2,073,458	
State Funds	$10,016,039	
Local Funds	$0	
Other Funds	$2,659,797	
Program Funds	$0	
SubTotal	$14,749,294	
Other Federal Funds	$7,166,969	
Total	$21,916,263	

Expenditures

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

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

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

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

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

It should be noted that, per the definition of "direct service" on p.95 of the Appendix to the Title V Block Grant guidance, Delaware does not fund direct services with the federal Block Grant funds. We do, however, use state funds appropriated for infant mortality initiatives to pay for direct services through the Healthy Women, Healthy Babies program.

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 $14,749,294 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 $15,290,916 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); Early Childhood Comprehensive Systems (ECCS); Pregnancy Risk Assessment and Monitoring System (PRAMS); Title X; and Universal Newborn Hearing Screening.

Any significant variations from previous years' reporting are described in the field-level notes on those forms. In general, these variations do not represent changes in the way we are budgeting our funds, but rather in how we are categorizing and reporting our budget, based on the revised block grant application guidance and forms. For example, one significant variation for FY17 is the amount of federal funds budgeted for "direct services". In previous years, our budget breakdowns reflected a substantial amount of expenditures for direct services. However, after reviewing the new definition of "direct service" in the 2016 Title V Block Grant guidance, we have determined that staff salaries that were previously considered to be direct service are now categorized as "enabling services". As reported on form 3b, we are not planning to use any Title V funds for direct services for FY17. Another example of a variation is the amount budgeted for infants in FY16 (Form 3a). We do have funds budgeted to support infants (for ex.salaries of home visitors). However, the linkages in the online versions of forms 2 and 3 required the dollar amounts entered in certain fields to match. Therefore, we added the amount budgeted for infants to the amount budgeted for children 1-22 and inserted that amount in Form 3a. This is reflected in the field level notes.

FY24 Budget – Federal Title V Funds

Personnel Costs **$1,429,629**

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, Child Development Watch, 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 $628,829

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

Travel $10,000

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

Supplies $5,000

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

FY 24 TOTAL BUDGET $2,073,458

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 $12,675,836 in state funds to the Maintenance of Effort agreement. This includes support for 40 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 2024 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 2024 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 FY2024 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.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

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 and School Based Health Centers, Infant Mortality Elimination program, Center for Family Health and Epidemiology, Title X/Family Planning, and 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, race and racism, 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

Developing and utilizing innovative and evidence-based or -informed approaches to address cross-cutting issues

Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core public health functions and address specific health priorities. The aim is to have DPH working at the "bottom of the public health pyramid on population based and infrastructure building services.

Title V MCH plays a very important role in the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) process. It requires that our MCH partners across the state be engaged in the process, in order to access data, provide various perspectives in the analysis of data, and make a determination of contributing factors that impact health outcomes, particularly as it relates to women, infants and children. Assets and resources must also be identified and addressed as well learning directly from the community about attitudes about health behavior, socioeconomic and environmental factors, and the social determinants of health. The Title V priorities and State Action Plan build off the priorities identified through the SHA and SHIP process, as well as the DPH Strategic Planning priorities.

Mentioned throughout the application, the Healthy Women, Healthy Babies program promotes access to care, by providing an evidence-based framework to improve women's health, mental health, and nutrition before, during & after pregnancy. The framework uses a Life Course perspective model that conceptualizes birth outcomes as the end product of the entire life course of the mother leading up to the pregnancy – not simply only the nine months of pregnancy. The goal is to provide assistive services to encourage the woman to maintain a healthy weight, nutritious diet, receive appropriate amounts of folic acid, manage chronic disease, address environmental risk factors such as smoking, substance abuse or other stress-inducing circumstances, as well as the development of a personalized reproductive life plan (for all women and men). The model is a value/performance-based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health and incorporates the role of community health workers to further support outcomes.
Looking ahead, content for our Well Woman Initiative is robust on our DEThrives site to inform women of childbearing age (15-44 years old) the issues around maternal health in Delaware. This content focuses more on the consumer than the provider, providing evidence-based education about annual well woman visits for example and provides a call to action message to help encourage women to play an active role in their maternal health.

DHSS recently began seeking applicants for the HWHB Zones mini-grants for Cycle 3 and Cycle 4. This was for new funding and recruiting for two new applicants using community-based approaches to improve maternal and infant health outcomes in Delaware. This was a new cycle of funding for an ongoing initiative that had its first funding

cycle in 2019. This would be a 20-month cycle of funding that will run from November 1, 2022 through June 30, 2024. DHSS also wanted to celebrate the current cycle of HWHB Zones mini-grantees for their work and accomplishments over the last 3 years which was the last cycle of funding. A webinar, titled the "2022 HWHB New Mini-Grant Funding Cycle Kickoff" was held for interested applicants to learn more information and the recording of it along with the PowerPoint slides can be viewed on the HWHB program landing page here. The objectives were to recruit applicants for the latest cycle of HWHB Zones mini-grant funding, generate awareness of and participation of applicant webinar, and highlight the impact and word of the Cycle 3 HWHB mini-grantees. DHSS also sent out a Press Release to increase awareness of this mini-grant funding opportunity throughout Delaware. The following was the target audience:

- 501(c)(3) organizations with actionable, community-based interventions designed to support identified high-risk communities across the state that must:
  - Serve communities with the highest rates of infant mortality and where the health of pregnant people is most at risk.
  - Focus on reducing racial/ethnic disparities related to maternal and child health in their communities.
  - Develop strategies based on the perspectives of, priorities of, and partnerships with those living in the HWHB Zone.
- Additional criteria:
  - Organization must have an operating budget under $3 million.
  - Proposed program must be linked to reducing disparities related to maternal/child health.
  - Target population is women of childbearing age (ages 15 to 44) who are considered high risk (living in a targeted HWHB Zone), as well as partners of these women.

Implementing the core public health functions of assessment, assurance, and policy development through program efforts

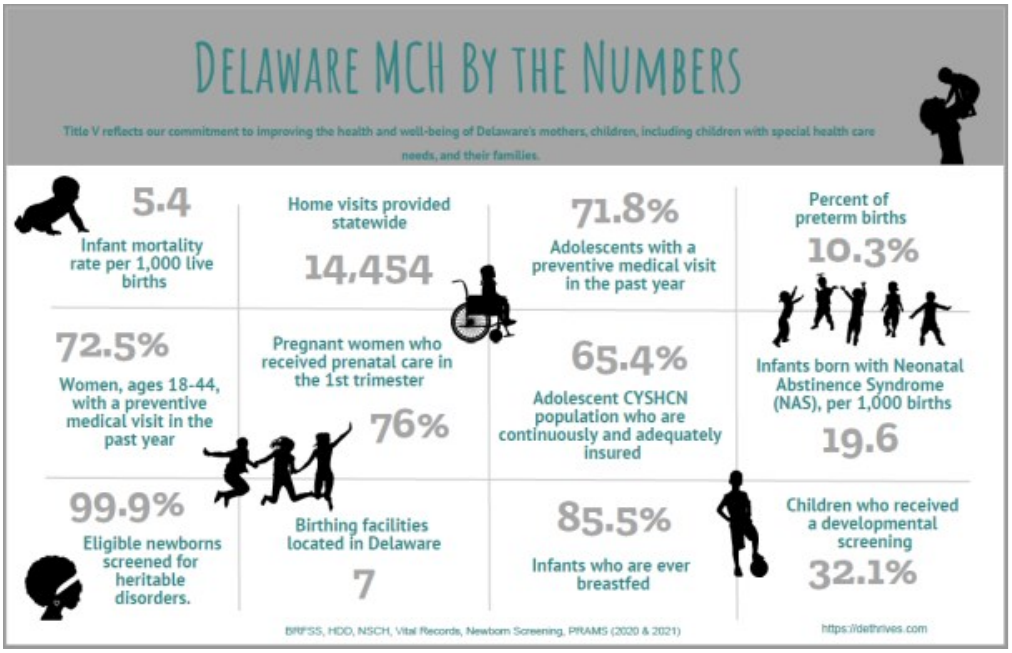
"Delaware Thrives" (DEThrives) is the branding theme and umbrella for all maternal and child health social marketing programming, developed in partnership with the Delaware Healthy Mother and Infant Consortium (DHMIC), which the state funds along with other federal funding sources, such as Title V, and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

A press release was recently published, sharing that Governor Carney signed a package of legislation which totaled to six house bills to help decrease maternal and infant mortality rates by expanding services in Delaware. Members such as Delaware Representative Minor-Brown, Senator Pinkney, and other members of the General Assembly worked on pieces of the legislation. The goal of these bills was to break down barriers and remove other obstacles some mothers and families have faced when receiving healthcare treatment in Delaware. These bills are also a part of the "2022 Delaware Momnibus, a series of 8 bills Rep. Minor-Brown is working on to improve maternal and infant healthcare statewide. Listed below are the House Bills that were signed:

- House Bill 340 revamps the Child Death Review Commission to include more focus on maternal concerns. The commission will be renamed the Maternal and Child Death Review Commission to reflect its existing dual focus. The definition of "maternal death" will also be updated and the Commission would reflect diverse membership that would include a midwife and one maternal and one child advocate from statewide non-profit organizations. In an effort to be transparent, the group will be required to publicly post its draft report and accept written public comment.
- House Bill 344(S) requires the Delaware Perinatal Quality Collaborative to establish a subcommittee to develop bias and cultural competency training for healthcare employees. The subcommittee will develop training guidelines designed for use in all healthcare fields and shall release the initial guidelines by July 1, 2023. The subcommittee will review data every year thereafter and revise the guidelines as necessary.
- House Bill 342 expands existing restrictions on the use of restraints on women who are giving birth or in labor to include pregnant women and those in the 13-week post-partum period.
- House Bill 345 ensures pregnant women or women who have given birth within the past six weeks who are subject to the custody of the Department of Corrections at Level IV or V have access to midwifery and doula services by requiring the department to make reasonable accommodations for provision of available midwifery or doula services.
- House Bill 343 requires the Division of Medicaid and Medical Assistance (DMMA) to present a plan to the General Assembly by November 1 for coverage of doula services by Medicaid providers. The services will be provided by a trained doula designed to provide physical, emotional, and educational support to pregnant and birthing persons before, during, and after childbirth. This will include support and assistance during labor and childbirth, prenatal and postpartum support and education, breastfeeding assistance, and parenting education.

- House Bill 234 requires DMMA to extend Medicaid postpartum coverage to 12 months from the end of pregnancy through the state plan amendment option created by the American Rescue Plan Act of 2021.

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 (HHS) 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.



Supporting coordinated, comprehensive, and family-centered systems of services

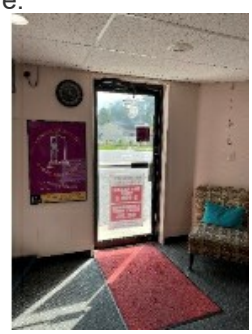
MCH and community partners recognized and celebrated the 10th anniversary of Black Breastfeeding Week between August 18th - August 25th, 2022. This observance is particularly important to address since black babies in Delaware are almost 3 times more likely to die than white babies before their first birthday. DEThrives created a blog post title "Back Breastfeeding Week 2022", that listed free community events to help promote Black Breastfeeding partner events. These local events ranged from a community doula program, a community "Group Latch" about breastfeeding, a "Painting with a Twist" opportunity to paint a breastfeeding inspired canvas, a coffeehouse style book reading of "Free to Breastfeed: Voices of Black Mothers", and online Zoom celebration title "The Big LATCH!", and a documentary titled "Aftershock" which showcased the discussion of the black maternal health crisis followed by a panel discussion of women's health and reproductive rights led by Delaware State Representative Melissa Minor Brown and other community partners. A Save the Date Flyer was also produced to help spread the awareness of the observance and the community events. Interviews on the topic occurred along with an e-blast email that was sent out to increase awareness of this observance and to increase awareness of the importance and benefits of breastfeeding, particularly in the black and brown population, for mother and their families.

In addition, a single image newsfeed ad was published recognizing Black Breastfeeding Week. Once the ad was clicked, it redirected the user to the "Black Breastfeeding Week 2022" blog post which shared a list of community events and resources celebrating this observance. The ad targeted women aged 18-35, proxy pregnancy and new parent audiences living in Delaware. The objective of the ad was to drive traffic to the "Black Breastfeeding Week

2022's" blog post on the DEThrives site.

MCH also ran a Home Visiting campaign via DEThrives, which targeted high-risk zip zones in Delaware with an emphasis in the Wilmington and Newark areas. The target audience for this campaign included: pregnant women, new parents, or parents of children aged 0-5 years old since that is one of the qualifications a person must meet to be enrolled in a Home Visiting program in Delaware. The campaign consisted of traditional and digital media. The traditional media that was included in the campaign were items such as:

- Framed posters, ceiling posters, self-standing banners, and window clings were distributed to laundromats, hair and nail salons, pharmacies, grocery stores, and convenience stores which was slated to be in about 125 locations statewide in Delaware.



- A radio ad (in both English and Spanish) was shared on top stations targeting women ages 18 – 34 years old, under the contemporary hits, urban, and Spanish radio stations
- Direct mail such as postcards were mailed to the targeted zip codes for pregnant women and new parents with a household income of less than $75K in the high-risk zip zones.

Digital advertisements were placed on apps, with exposure to YouTube and Connected TV. Some examples of distribution include AppleTv, Comcast, firetv, Roku, Vizio, Amazon echo, Samsung, TMobile, Xbox, Playstation, etc. Ads also had a chance to populate on games from apps. Ads gave in-app bonuses for engaging with the campaign content. For example, if someone was playing the app game called "Candy Crush", the user could watch an add about HV in an exchange to earn an extra life in the game. HV ads were also displayed on banner ads on websites as well as Native ads, which were displayed on websites. Native ads are displayed in a way where it doesn't disrupt the user's experience when viewing content on a webpage. Lastly, paid social media posts on Facebook, Instagram, and others were displayed as story ads or newsfeed ads.

With a long-term goal of progression toward universal developmental surveillance and screening, Delaware's EC community emphasizes a coordinated, comprehensive and holistic approach which takes into account the impact of the social determinants of health of the child and his/her family. 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.

In 10/21, DPH contracted with our new vendor Parent Information Center (PIC) to execute the Family SHADE project with a revitalized and programmatic approach, which will include family and professional partnerships at all levels of decision making, to best serve our children and youth with special health care needs (CYSHCN). PIC implemented the Family Leadership Network (FLN) which is a network for parents/guardians of children, birth to 26, that have a special health care need. The FLN network membership is a member network which offers trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. Family SHADE served as a learning network and resource for the community agencies serving CYSHCN. PIC succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of competitive mini-grant opportunities that were innovative and aligned with our Maternal Child Health National Performance Measures (NPMs).

Through the Family SHADE project, two community-based organizations were awarded mini-grants. Jay's House and Tomaro's C.H.A.N.G.E. (Creating Healing, Answers, & Necessary Guidance for Excellence) were awarded mini-grants. The Family SHADE project, focused on providing these two community agencies with technical assistance

on implementation and evaluation of their project so that they were in alignment with our selected National Performance Measures. They each developed an implementation plan and an evaluation plan with the technical assistance of the PIC team and through the Family SHADE project. They received technical assistance through the Learning Communities offered by the Family SHADE project. The scope of work included the recruitment and retention of children and families in the Wilmington area.

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

The State of Delaware's Department of Human Resources implemented a Workplace Wellness Policy and Procedures in June 2022. The Workplace Wellness Policy provides guidance on the foundation and infrastructure for Executive Branch agencies to establish and maintain workplace wellness initiatives. Workplace wellness initiatives focus on promoting a healthy lifestyle — including exercise, healthy eating, tobacco cessation, and preventive care — as well as supporting employees' social and emotional wellness — including stress management and mental health. As the state's largest public employer, the State of Delaware has a responsibility to lead by example by promoting a culture of health; reducing health care costs, unplanned absences, and disability and workers' compensation claims; improving health-related productivity; and enhancing morale and staff retention.

Serving as a leader, convener, collaborator, and partner in addressing MCH issues

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 18th, 2023, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 17th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial and geographical disparities that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. The 2023 theme was "RENEW. RECONNECT. RECHARGE. Join our journey as we strengthen our commitment to healthy women, babies, and communities". 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.

In between the three keynote speakers, there were group breakout sessions and a panel discussion moderated by DHMIC members and DPH leadership, innovation stations that showcased the Healthy Women Healthy Babies (HWHB) mini-grantees, a visual artist that captured the day's theme, topics, and experiences in illustration and graphic form which will be used for media use, and multiple activities that encouraged group discussions among attendees and education with the innovation stations.

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 10 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. Examples of our role as Title V leaders and conveners are discussed throughout the application, including the DHMIC, Help Me Grow and Early Childhood Comprehensive Systems work.

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, FranklinCovey and our internal DPH training office.

This past year, we offered two essential roles of leadership courses, “Create a Shared Vision” and “Strategy and Execute Your Team’s Strategy and Goals”. Both trainings were provided in ½ day in person off site training center. These trainings were selected as we are kicking off strategic planning for the Family Health Systems sections and the Bureaus within the Section and we want all team members to be active participants in the process. Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by 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.

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.

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

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

In Delaware, the majority of Title V block grant funding is used to support approximately 13.25 positions (FTEs) across the division that are involved with MCH programs and services, including Child Development Watch, adolescent health, home visiting, 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 their families. The majority 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.

To maximize the reach and impact of these funds, we rely heavily on collaboration and coordination with a variety of other agencies, coalitions, and partners with shared goals. These partnerships are described in more detail in the Needs Assessment Summary section, III.C.2.b.ii. of our FY21 application.

The MCH leadership team has a significant amount of professional experience, and all staff have been in their roles for at least three years. Elizabeth Orndorff is our most recent hire in August 2019 as our new Title V Block Grant Coordinator. Elizabeth also serves as our State Systems Development Initiative (SSDI) Project Director. Isabel Rivera-Green, MSW, has been serving as the Director of Children & Youth with Special Health Care Needs since September 2018. Before this role, Isabel was also in the MCH unit as the Early Hearing Detection Intervention (EHDI) Coordinator from October 2015 until she was hired as the CYSHCN Director.
In addition, Leah Woodall, MPA, the state MCH Director for Delaware and Section Chief for the Family Health Systems Section, is in her tenth year serving in these capacities, having previously served as the MCH Bureau Chief and Deputy Director for three years. Crystal Sherman has served in the role of MCH Bureau Chief and Title V Deputy Director since October 2015.
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, *FranklinCovey* and our internal DPH training office.

All MCH staff are encouraged to utilize the MCH Self-Assessment tool as a guide to develop their professional development goals annually. Supervisors are tasked with reviewing and coaching staff on the development of their goals and ensuring time is allotted for professional development. Leadership meets regularly 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.
In October 2018, 30 staff members from administrative to leadership roles, participated in a two-day training on *FranklinCovey 7 Habits of Highly Effective People*. 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 training was very interactive and involved role playing so participants could put what they were learning into practice. The 7 Habits Objectives during this training included habits like:

- Paradigms and Principles of Effectiveness
- Be Proactive
- Begin with the End in Mind
- Put First Things First
- Private Victory to Public Victory
- Think Win-Win
- Seek First to Understand, Then to Be Understood
- Synergize
- Sharpen the Saw
- Living the 7 Habits

All MCH have access to an All Access Pass to the entire *FranklinCovey* Library which provides a refresher of all the habits 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 *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. 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.
In the last couple of years, we provided an opportunity to participate in the following *FranklinCovey resources* :

- The 5 Choices – Course Summary: Learn a process which will dramatically increase their ability to achieve life's most important outcomes. Backed by science and years of experience, this course will make you more productive and give you an inner sense of fulfillment and accomplishment. This time and life management workshop will help you make the right choices as you plan your day, week, and life, by aligning tasks with your most important goals. You will move from being buried alive to being extraordinarily productive!
- Implicit Bias – Course Summary: Bias is a natural part of the human condition—of how the brain works. And it affects how we make decisions, engage with others, and respond to various situations and circumstances, often limiting potential. There is nothing more fundamental to performance than how we see and treat each other as human beings.
- Change Management Model – Course Summary: Although we all can change our behavior, we rarely ever do. As you understand the change model, you can help people work through short-term turbulence so they can get to longer-term benefits of the change.
- 6 Critical Practices – Course Summary: This program was developed to equip first-level leaders with the essential skills and tools to get work done with and through other people. The program is ideal for new first-level leaders who need to transition successfully from individual contributors to leaders of others. However, this program also applies to leaders who have been in their roles for some time and are looking for practical and relevant guidance on how to effectively lead and manage their teams.

This past year, we offered two essential roles of leadership courses, "Create a Shared Vision" and "Strategy and Execute Your Team's Strategy and Goals". Both trainings were provided in ½ day in person off site training center. These trainings were selected as we are kicking off strategic planning for the Family Health Systems sections and the Bureaus within the Section and we want all team members to be active participants in the process.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.
It's important to note that not all learning occurs in a classroom or on an electronic device. Learning can be as simple as a supervisor observing an employee performing a task and offering suggestions on how to improve that performance (i.e. on-the-job training). It can occur during staff, one-on-one, and, performance feedback meetings, or by reading an article in a professional periodical and putting the concepts to work on the job. All supervisors at the DPH are encouraged to and can 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.

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. With regard to specialized cultural and linguistic competency training, DPH offers in-house training opportunities. In addition, DPH offers training opportunities through a collaborative agreement with Johns Hopkins Bloomberg School of Public Health/Mid-Atlantic Public Health Training Center.
As part of the Governor's Trauma-Informed Care initiative, DHSS required every employee complete the online course titled: DHSS Trauma Informed Awareness Training. This training is also part of the new employee/supervisor curricula for future new hires. DHSS Trauma Informed Awareness Training examines the pervasive effects trauma has on individuals, families and organizations. Trauma results from many experiences such as an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects. 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.
DPH Policy Memorandum Number 65 outlines the Health Equity and Cultural Competency Policy for the Division of Public Health. The purpose of the policy states that DPH's policies, processes, programs, services, interventions, and materials will be provided in a manner that considers the social and cultural and linguistic characteristics of the

population we serve and strive to improve health equity as outlined in Title VI of the Civil Rights Action of 1964. The policy gives direction to when all DPH employees must complete health equity and cultural competency training courses.

The Division of Public Health released a Second Edition Health Equity Guide for Public Health Practitioners and Partners in November 2019. This guide will help support our work around the social determinants of health and will be a valuable resource to enhance our collective work to move upstream to improve the conditions that create not only health, but also the inequities related to health.

Delaware's MCH program does not include parents or family members who fill staff positions in our department, and we do not have a dedicated staff member to focus on evaluation, data-analysis, or epidemiology. To fill this gap, we have a contractual relationship with JSI and Forward Consultants to provide this level of support. In addition, we are pleased to have a CDC MCH Epidemiology assignee, Khaleel Hussaini who came aboard in May 2016 and is still with us in Delaware. He brings a wealth of MCH experience primarily from his leadership roles at the Department of Health in Arizona.

Khaleel S. Hussaini is a Centers for Disease Control and Prevention (CDC) Maternal and Child Health Epidemiologist (MCH) assignee to DPH. In addition to his routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, Dr. Hussaini provides scientific and technical assistance to Division staff and stakeholders in the areas of maternal and child health outcomes, development of surveillance databases, and integration of technologies. Dr. Hussaini's work plan and projects are contingent upon DPH and Title V's urgent priorities for the upcoming year.

III.E.2.b.ii. Family Partnership

One of the most impressive examples of 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, March of Dimes, and more. The consortium has several committees addressing standards of care, health equity, education and prevention, and data and quality improvement. 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. Delaware's Perinatal Cooperative is a subcommittee of the consortium. Staff from the Family Health Systems Section of DPH staff these committees and support the partners in advancing shared work. Collectively, the DHMIC follows a life course model. (For more information, visit www.dethrives.com)

In the domain of CYSHCN, a key partnership is the Parent Information Center who contractually oversees Family SHADE (Support and Healthcare Alliance Delaware), a collaborative alliance of family partners and organizations dedicated to supporting families of children with disabilities and chronic medical conditions. The Parent Information Center offers several ways for parents to be engaged including educational opportunities for parents to learn, engage with each other as well community providers. Members of the Parent Information center workforce are parents themselves and bring a wealth of knowledge and expertise.
The Family SHADE program has evolved over the two years and is now focusing on awarding mini-grants and providing the necessary technical assistance for the awardees to be successful. Learning communities are also being offered to community organizations serving this population to get organizations an opportunity to learn and support each other as well. Topics have included newborn screening, fetal alcohol syndrome and data and evaluation. Family SHADE has also held Symposiums with on transition and developmental screening.

The DHMIC, Family SHADE and the Delaware Early Childhood Council represent three 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. 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.

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 Department of Services for Children Youth and their Families (DSCYF) and the Department of Health and Social Services (DHSS) recognize that each Department has an important role to improve the lives of families impacted by substance abuse. For this reason, the agencies signed a Memorandum of Understanding in 2016. County level teams were developed and meet quarterly. We plan to continue to staff and/or participate in all three of the county meetings.

The Home Visiting Community Advisory Board's Outreach Subcommittee recently decided that family feedback would be helpful to help determine why families enroll in home visiting, why the leave or refuse program services. A plan to conduct focus groups and key informant interviews has been developed and a snippet of it is below.

HOME VISITING FOCUS GROUP PLAN

This document serves as a plan for conducting home visiting-related focus groups. It is suggested that three types of

focus groups be held:

- **CQI Focus Groups (*n* = 15).** This group comprises of families that have been enrolled in home visiting for at least six months and are representative of families with whom the home visitor generally interacts (this is discussed in the Selection section below). The intent of this focus group is to determine what has been working well in home visiting and what can be improved. It is suggested that three focus groups, each of which comprises of five families, participate (*n* = 15) with seven families invited to participate in each focus group given that at least one or two families typically do not show up or opt out of participating in these groups. These three focus groups will occur as follows: one in Wilmington, one in Kent County, and one in Georgetown/Seaford.
- **Refusal Focus Group (*n* = 20).** This group comprises of families that have never been enrolled in home visiting programs and have refused to enroll in any home visiting program. The intent of this focus group is to determine the extent to which the focus group members have opted to not enroll in home visiting services due to personal issues, lack of interest, or not feeling that home visiting services would be beneficial to them. Given the nature of this group, it is suggested that this group be set up as individual interviews via online platform.
- **Stopped Services Focus Group (*n* = 10).** This group includes families enrolled in home visiting services that have recently stopped or are planning to stop home visiting services. The group must have stopped services within six months of enrolling within home visiting services. The intent of this group is to understand why the family has opted to leave home visiting and the extent to which this is due to personal reasons and/or aspects of home visiting that the family did not find useful. This may arguably be the most difficult group to recruit given that many families that have stopped services may have moved or lost contact with home visitors; with that said, it is advised that this group be set up as individual interviews via online platform.

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.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Delaware's epidemiologists complement the Maternal and Child Health (MCH) Block grant by promoting MCH data infrastructure. Delaware relies on the ability to use data, and therefore, has a trained workforce in data analysis and data systems. This ensures that Delaware's Title V team has the needed MCH data collection and analysis capacity. With these resources we are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. This in turn facilitates the creation of effective programs, which leads to health improvements in the MCH population.

Delaware has two dedicated Full Time Equivalents (FTE) epidemiologists in our MCH section, Khaleel S. Hussaini and George Yocher. By ensuring access to MCH data, Delaware's epidemiologists are able to analyze and present information which programs can then use to make data informed decisions. 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.

Khaleel S. Hussaini, PhD, is a Centers for Disease Control and Prevention (CDC) Maternal and Child Health Epidemiologist (MCH) assignee to the Delaware Division of Public Health. Dr. Hussaini's position is a federal/state funded partnership, which is funded by our Title V grant or our State Systems Development Initiative (SSDI) grant.

Dr. Hussaini provides scientific and technical assistance to Division staff and stakeholders in the areas of maternal child health outcomes, the development of surveillance databases. His current research examines Neonatal Abstinence Syndrome and its implications on maternal and neonate health. Dr. Hussaini is also working on initiatives specific to social determinants and life-course with a focus on women's mental health and its impact on child health. His work focuses on population health through application of health informatics principles. Prior to joining the Delaware Division of Public Health as a CDC MCH Assignee, Dr. Hussaini was a Research Assistant Professor at the University of Arizona College of Medicine – Phoenix in the Department of Biomedical Informatics. Dr. Hussaini received his Doctorate in Philosophy in Sociology with a minor in Statistics from Arizona State University, and a Masters from Cornell University.

Dr. Hussaini's research has focused on immigrant adaptation specifically those relating to acculturation, assimilation, and global identities and intersection of civil society and its implications on maternal and child health and well-being. Methodological interests relate to application of quasi-experimental designs for evaluating public health interventions, with special focus on propensity score analyses, regression discontinuity designs, and regression point-displacement designs. In addition to his routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, Dr. Hussaini provides scientific and technical assistance to Division staff and stakeholders in the areas of maternal and child health outcomes.

George Yocher, MS, MS is an epidemiologist within the Family Health Systems (FHS), Center for Family Health Research & Epidemiology section, Division of Public Health. George Yocher's position is a state funded position. George is part of our Title V team and one of our Steering Committee members. George primarily oversees our Pregnancy Risk Assessment Monitoring System (PRAMS) data research.

George received two Masters of Science degrees, one in Economics and the other in Epidemiology, both from the University of Massachusetts, Amherst. George has advanced statistics training as well as epidemiology training. In addition to overseeing our PRAMS project and research, George also analyzes our Healthy Women, Healthy Babies data as well as some data related to our Community Health Worker (CHW) project from Quality Insights. Quality Insights is supplying CHWs for work in several areas of the state.

Delaware's MCH epidemiologists have direct (for some), 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)

- Neonatal Abstinence Syndrome Surveillance (Based on HDD)*
- Pregnancy Risk Assessment Monitoring System (PRAMS)*
- 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*
- Delaware Perinatal Quality Collaborative (DPQC) (specific to quality indicators) *

**FHS oversight*

If a program partner or other epidemiologist outside of FHS needs access to FHS data, they can do so by coordinating with our MCH program managers or through our epidemiologists.

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

Towards the end of 2021, Delaware executed a stakeholder survey to gauge the effects of the pandemic on our partners and to determine if additional priorities had emerged or shifted as a result. In addition, we were specific to seek additional input from our Title V funded partners on any technical assistance Title V can provide. Title V was concerned about how we can be more intentional with supporting our partners. We were asking our partners for ways we could be responsive to their needs. We asked our partners to rank their pressing needs, which included: providing data, assist with data to apply for resources, strategic planning, disseminate information via social media outlets and guide a grant writing process.

As a result of this mini–Needs Assessment, our SSDI Project Director scheduled regular meetings with our two-Family Health Systems (FHS) epidemiologists to begin the task of compiling all MCH data into one central location. Both epidemiologists, Khaleel Hussaini, CDC assignee epidemiologist, as well George Yocher, FHS epidemiologist, are also members of our Title V Steering Committee team. Our goal was to gather and organize Delaware's data pertaining to each National Performance Measure as well as all the National Outcome Measures. A data sheet was created for our Title V partners, who requested MCH provide data as a way to support and assist them with their needs.

Access to MCH data allows for program development and progress monitoring of the MCH Block grant Action Plan. This year, we again reconvened our Title V team 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. When possible, our team has met in person throughout the 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) to gauge Delaware's health population.

Our Title V team met periodically to review Delaware's State Action Plan. We reviewed all previously selected Strategies, Objectives, and ESMs for each of our Priority Needs. Collectively, we determined which Strategies and ESMs have been successfully completed. In addition, our team also identified new ESMs that could be incorporated into Delaware's State Action Plan moving forward. These new ESMs were added to the Plan to continue to strengthen Delaware's maternal and child health population.

Delaware's Title V team also reviewed our State Action Plan based on guidance received from the National Center for Education in Maternal and Child Health. Delaware received the MCH Evidence Center's annual Evidence-based/informed Strategy Measure report for the 2023 Application/2021 Annual Report. Based on these findings,

Delaware began conversations and used 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 National Performance Measure.

We also applied to the Graduate Student Epidemiologist Program (GSEP) fellowship program for program monitoring and evaluation, supervised by Dr. Hussaini. Our internship project was to entail use of linked administrative datasets, such as Medicaid claims data, Hospital Discharge Data, and Vital Statistics data to develop infographics and data/research briefs on social/emotional wellness, injuries, women, and children. In addition, there was to be an opportunity to evaluate program effectiveness of either one or two programs in Delaware based on availability of resources. Those two programs were School Based Health Centers and Healthy Women Healthy Babies. Dr. Hussaini had previously conducted the evaluation and published results on a previous version of these state-funded programs. Delaware was hosting two Harvard Practicum students scheduled to begin in January of 2022 to develop a program/evaluation logic model of the school-based health centers. It was anticipated that the completed logic model would serve as a basis for evaluation of a pilot elementary school-based health centers using datasets mentioned above. Dr. Hussaini will mentor GSEP students to develop the evaluation methods and execute the program evaluation. With regards to Healthy Women Healthy Babies (2.0), if accepted, the GSEP interns will work with Dr. Hussaini to not only develop the logic and evaluation model but also execute specific components of the program. One specific component is the impact of the program on social determinants of health among participating women in Healthy Women Healthy Babies (2.0).

Timely completion of any of the evaluation project would also entail in presentation of the findings at scientific conferences and/or potential peer-review publication(s). To ensure ongoing rewarding experiences, Dr. Hussaini would work with GSEP interns to use existing linked datasets such as linked Hospital Discharge Data and Birth Certificate data for 2010-2019 for mother and infant dyads to develop data/research briefs on cross-cutting and emerging issues in MCH and/or address gaps in current surveillance and public health practice specific to neonatal abstinence syndrome, severe maternal morbidity, and opioid use disorder among women of childbearing ages. MCH was successfully matched, but due to logistical constraints (i.e., changes in executive leadership, FHS staffing changes) we did not respond in time. In addition, skill compatibility (restricted knowledge of DHSS approved software such as SAS) played a factor in our process and we could not host. We are waiting on another match and once we receive their resume, we can meet with them and secure the internship.

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

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

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

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 systems.

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

Resources deployed by the SSDI program include not only financial, but also project management and epidemiological resources. 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 current 5-year SSDI grant cycle, the SSDI Program Manager has and will continue to support the ongoing Title V MCH Block Grant program data needs associated with the Five-Year Needs Assessment process and the annual needs assessment update. The SSDI Program Manager will also provide valuable program management for some of the Title V National Performance Measures. The SSDI Program Manager led the Title V 2020 Five-Year Needs Assessment as well as our Mini Needs Assessment on the impact of the COVID-19 pandemic on our maternal and child health population.

The SSDI program is instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee to Delaware, Dr. Khaleel Hussaini. Additional contractual dollars are allocated to working with Forward Consultants to support projects that provide evaluation services such as the Title V Mini Needs Assessment survey and 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. In accordance with the CDC, the goal of the birth defects surveillance and registry program is to determine frequency of major birth defects and autism, identify risk factors for birth defects and autism, investigate the causes of birth defects and autism, develop preventive strategies to decrease occurrences of birth defects and autism, analyze incidence, prevalence and trends of birth defects and autism through epidemiological studies, and, investigate the morbidity and mortality rate results from birth defects and ways to decrease the autism morbidity burden associated with the disorder.

Khaleel S. Hussaini, PhD, is a Centers for Disease Control and Prevention (CDC) Maternal and Child Health Epidemiologist assignee to the Delaware Division of Public Health. In addition to his routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, he provides 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. He continues to work on informing the Delaware Perinatal Quality Collaborative (DPQC) on COVID-19, providing scientific and technical assistance.

His current research examines Neonatal Abstinence Syndrome and its implications on maternal and neonate health. Dr. Hussaini is also working on initiatives specific to social determinants and life-course with a focus on women's mental health and its impact on child health. His work focuses on population health through application of health informatics principles. His research has focused on immigrant adaptation specifically those relating to acculturation, assimilation, and global identities and intersection of civil society and its implications on maternal and child health and well-being. Methodological interests relate to application of quasi-experimental designs for evaluating public health interventions, with special focus on propensity score analyses, regression discontinuity designs, and regression point-displacement designs.

He continues to serve as a local resource for Delaware Maternal Mortality Review Committee under the auspices of Child Death Review Commission (CDRC), and Delaware Medicaid and Medical Assistance (DMMA), severe maternal mortality and morbidity (SMM) to assist in Center for Medicaid and Medicare Services (CMS) learning collaborative on SMM. Dr. Hussaini has continued to work with DMMA to advocate for proper utilization of SMM claim codes as part of an ongoing learning collaborative funded by CMS. In addition, he has continued to assist with Center for Family Health and Epidemiology team members within Family Health Systems to assist with data collection and tracking for Healthy Women Healthy Babies (HWHB) program version 2.0. In addition, he recommended and utilized Drug Enforcement Agency (DEA) census data to develop gap analysis for Delaware Perinatal Quality Collaborative (DPQC) Opioid Quality Improvement Initiative (CDC Grant) for identification of potential trainees. The financial support of Dr. Hussaini's contract emphasizes the value provided to assuring we have the richest data to inform our Title V decisions.

Dr. Hussaini has updated and completed a 100+ page report using PRAMS data for 2012- 2019 that provide prevalence estimates for a variety of indicators before, during, and after pregnancy. These indicators are stratified by age, SES, and race and place to highlight health disparities. Dr. Hussaini completed the 2010- 2019 SMM brief. One manuscript is a multistate collaborative effort to examine preterm births before and during the COVID-19 pandemic. The multistate paper was rejected by the journal. The second one is a research letter that examines a variety of perinatal quality indicators and specifically increase in cesarean deliveries pre-lockdown and post-lockdown in Delaware during COVID-19. The paper was cleared by CDC however, has not been published yet. The third manuscript is based on linked birth certificate, hospital discharge, and PRAMS data that examines the impact of adverse maternal experiences and NAS. The manuscript "Adverse maternal experiences and neonatal abstinence syndrome" was published. The one manuscript that examines postpartum contraceptive use among NAS and non-NAS deliveries was cleared by CDC and is currently under peer review. Dr. Hussaini also created and updated data brief on reproductive health using the latest BRFSS and PRAMS data. It is available on our DEThrives website.

Within the last few years, MCH was able to access key data elements to support the Title V program. We were able to obtain data from state-wide school surveys that we typically haven't had access to in the past. We worked with the University of Delaware, Center for Drug and Health Studies (CDHS) to obtain access to the Delaware School Survey (DSS) as well as the Middle School Youth Risk Behavior Survey (YRBS).

The DSS provides information on substance use, risk and health behaviors, and protective factors. The DSS is administered to 5th, 8th, and 11th grade students annually in the spring. The Middle School YRBS will provide information on tobacco use, alcohol and other drug use, mental health, unintentional injuries (including drinking and driving), violence, bullying, healthy eating, sexual behaviors, parental relationships, protective factors, and other health behaviors. The Middle School YRBS is administered to middle and high school students every two years on the odd years. In addition, we were also able to obtain data access to the Youth Tobacco Survey (YTS). The YTS provides information on tobacco use and attitudes and is administered to middle and high school students every two years on the even years.

A significant development Delaware gained in accessing data during the past few years was the facilitation of a Memorandum of Understanding (MOU) between DPH and Department of Education (DOE). The MOU enables the availability of school enrollment data for all students in Delaware with limited identifiers for linkage. The primary goal of this data sharing agreement is to develop high need school-level profiles for providing access to elementary/middle school-based health centers as well as potentially assessing health outcomes.

Final 2020 vital statistics data was received in June of 2022. Timely access to 2021 record-level data for vital statistics (i.e., birth and death data) has continued be a challenge. The full report for 2021 vital statistics information has not yet been received. Only Hospital Discharge Data (HDD) for 2021 has been received, no birth or death data. However, monthly birth certificate aggregate data used for monitoring perinatal quality indicators has been available on a timely basis. These data are used to ascertain monthly trends in hospital births, low risk cesarean births, non-

medically indicated early term deliveries, preterm births, size for gestational age, prenatal care etcetera. Our MCH epidemiologist has been able to access National Vital Statistics data, which includes state specific information data for some internal reporting purposes. COVID-19 data specific to women of childbearing ages, and pediatric population for surveillance has not been available, which has led to a local knowledge gap about the changing epidemiology of COVID-19 in the Title V MCH population. This past year's school YRBS survey data was available as well as local DSS data.

Additional evaluation activities supported by the SSDI program include an effort led by the SSDI Project Director for our ongoing Title V Mini Needs Assessment process. Our objectives for our Mini Needs Assessment were:

- Gauge the impacts of the pandemic on our partners within each health domain
- Learn how our partners were adapting to the ongoing challenges of the pandemic
- Be more informed of the ways each program is adjusting
- Support programs that continue to address the MCH population
- Identify ways MCH can better support our Title V funded partners with technical assistance

We learned that our Title V funded partners ranked "provide data" as either the first or second choice of Title V partners. Therefore, our Title V team decided that our SSDI Project Director would work with our CDC Epidemiologist to include relevant MCH population data on our State Action Plan Snapshot created the previous year. Our intentions were for our partners and stakeholders to be able to view Delaware's data in one document. This would also include previous year's data, so our partners can track the information from year to year.

We sought to answer the identified need of our partners; how we could better support our Title V funded partners with technical assistance. During the past grant cycle, our SSDI Project Director was able to schedule regular meetings with our two-Family Health Systems (FHS) epidemiologists and begin the task of compiling all MCH data into one central location. Both epidemiologists, Khaleel Hussaini, CDC assignee epidemiologist, as well George Yocher, FHS epidemiologist, are also members of our Title V team. Our goal was to gather and organize Delaware's data pertaining to each NPM as well as all the NOMs. Two data sheets were created as a result of the Mini-Needs Assessment survey. During the spring 2023, MCH updated these Performance Measures data sheets once the 2020/2021 NSCH and other data sources were released. We hope this MCH Performance Measures data sheet supports our partners and our stakeholders with the very important maternal and child health work they do.

These activities provide clear and concise evidence of epidemiological and data enhancement activities that support ongoing Title V Needs Assessment and performance measure reporting 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 would also like to report 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). The data from Birth Defects Registry Data, PRAMS data, Medicaid data, program specific data such as Healthy Women Healthy Babies, School-Based Health Centers, Title X Family Planning data are matched as needed for program evaluation and monitoring purposes. As noted previously, there has been a significant knowledge gap with regards to the impact of COVID-19 on the Title V MCH population as these data are not easily accessible for surveillance purposes and/or linkage to enhance the epidemiological knowledge base.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Delaware's MCH Block Grant is complimented by other funding sources within the Family Health Systems (FHS) that increase our data capacity efforts, which support up to date Maternal and Child Health (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.

The accomplishment of our mission will facilitate the Division in realizing its vision of creating an environment in which people in Delaware can reach their full potential for a healthy life. The Division of Public Health (DPH) Family Health Systems section solicits services in the area of maternal, child, adolescent, children and youth with special health care needs, health epidemiology, research, and evaluation. It is the intention of FHS to integrate data and epidemiology into research and evaluation of programs and activities.

In addition to our State Systems Development Initiative (SSDI) grant, other key components of our MCH epidemiological and data enhancement activities support our Title V program and activities. FHS is committed to contracting consistent, high-quality support in research, epidemiology and program evaluation for our section and its associated programs. Forward Consultants is our epidemiology, research, and evaluation (ERE) contractor and FHS is confident they have the experience and capacity to carry out all required activities with assistance and guidance from the DPH, FHS section. Our ERE contracting services maintain and improve existing methods of information collection for FHS MCH statistical analysis. Examples include linked infant birth and death records, poor birth outcomes registry, and birth certificate data analysis.

The contract covers 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, data collection methods to assess the impact of preconception care and enhanced prenatal care services, and literature review of provider cultural competence and health equity.

Our Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Needs Assessment was also facilitated by our ERE contracting services. MCH leveraged and aligned the activities of our MIECHV Needs Assessment as well as our Title V Five-Year Needs Assessment. Combining efforts to gather the information and data required for both needs assessments helped leverage staff and fiscal resources across the two programs and aligned the data collected by each to better meet the needs of women, infants, and children in the state of Delaware. Coordinating the two needs assessments, helped avoid duplication of effort and strengthened a statewide approach to addressing the needs of young children and their families.

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

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

During the previous grant cycle, Forward Consultants has assisted MCH with the development of a dashboard that would capture developmental screenings and referrals from pediatricians to early intervention programs through the CHADIS platform. In addition, our ERE has worked with Delaware's core team to implement House Bill 202, which mandates licensed child-care facilities to administer developmental screens on an annual basis. Forward Consultants also leads the Data and Surveillance sub-committee of the Help Me Grow Advisory committee to track,

analyze HMG/2-1-1 data and recommend improvement. Lastly, our ERE participated in the HMG National Return on Investment (ROI) sessions and developed a detailed ROI for Delaware.

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

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

The following are examples of programs that require ERE services:

- Healthy Women, Healthy Babies
  - This is composed of: preconception care, prenatal care, interconception care services, and infant care (home visiting)
- Adolescent health services through school-based wellness centers
- Children with special health care needs (traumatic brain injury, birth defects and newborn screening)
- Violence and injury preventions services
- Pregnancy Risk Assessment Monitoring (PRAMS) system
- Fetal Infant Mortality Review (FIMR)
- Reproductive health
- Women's health
- Men's health
- Community health

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, focused on addressing the social determinants of health, leveraging talents and resources, and striving to find new ways to provide services.

Extensive data shows that unplanned pregnancies have been linked to increased health problems in woman and their infant, lower education attainment, higher poverty rates, and increased health care and societal costs. Some of the social determinants of health include income, education, housing, culture and customs, occupation, health behaviors (drinking, smoking, drug use, exercise), and stress. DPH will strive to promote and provide training on cultural competency to improve access to health services for Delaware's under-served populations.

Working with Forward Consultants, Newborn Screening was recently able to look into the Early Hearing Detection and Intervention (EHDI) system. Based on the data we can identify where the gaps are within the system. One of the gaps that can be identified in the system is the lost to follow up. Although Delaware has a great system in place to help keep the lost to follow up rate down, there is still work to be done to close the gaps.
The Diversity and Inclusion Plan will help accomplish the following:

- Engage, educate, and train health professionals and service providers in the EHDI system about the 1-3-6 recommendations;
- Emphasize the need for hearing screening up to age 3 years;
- Enhance the benefits of a family-centered medical home; and
- Strengthen the importance of communicating accurate, comprehensive, up-to-date, evidence-based information to families to facilitate the decision-making process.

Given this background, the relatively rural population in both Kent County, Delaware and Sussex County, Delaware comprises the target population chosen for the Diversity and Inclusion Plan. Specifically, individuals and families residing in the following three regions of the state will be of focus: Smyrna/West Dover, East Dover, and Georgetown/Seaford.

In 2019, 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, environmental and social determinant of health data to the public. The innovative technological showpiece allows users to navigate the data at the smallest geographical area available, to understand and explore data about the factors that influence health. Just recently published on My Healthy Community is Delaware's 2014-2018 Suicide Surveillance Study, where Delaware

completed a comprehensive look at suicide. This is a perfect example of how Delaware is making data more transparent, accessible, and easy to understand. Sharing community-level statistics and data allows Delawareans to understand what is occurring in their neighborhoods, make informed decisions about their health, and take steps to continue improving our quality of life.

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

The Division of Public Health in convinced that access to data is a key factor in making progress toward a stronger and healthier Delaware. The ability to easily access such crucial information like substance use and overdose data by zip code enables Delawareans to compare it to larger areas and examine trends. For the first time, Emergency Department non-fatal drug overdose data from DPH, and Prescription Monitoring Program (PMP) data will be available thanks to a partnership with the Division of Professional Regulation. Addiction, air quality, chronic disease and drinking water quality impact every one of us and when communities become aware of the level at which these issues are occurring in their neighborhoods, it can spur action that can improve the quality of life for current and future generations.

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

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

These data are gathered through the Behavioral Risk Factor Surveillance System (BRFSS). The Behavioral Risk Factor Survey (BRFS) is an annual survey of Delaware's adult population about behaviors which increase the risk of disease, premature death, and disability. BRFS is a cooperative effort of the Delaware Division of Public Health and the CDC and is primarily funded by CDC. Delaware has been collecting behavioral risk factor data continuously since 1990. Interviewing is conducted every month of every year, and data are analyzed on a calendar-year basis. The BRFS 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.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Delaware DPH supports every section within the Division to develop a Continuity of Operations Plan Standard Operating Guidelines (COOP SOG). This COOP SOG is a recovery plan that works as a companion plan with the Delaware Emergency Operations Plan (DEOP) and other Division of Public Health (DPH) preparedness plans and provides a framework to minimize potential impact and allow for rapid recovery from an incident that disrupts operations. This plan encompasses the magnitude of operations and services performed by the section and is tailored to the section's unique operations and mission essential functions.

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

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

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

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

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

- SHOC Level 1 activation indicates heightened assessment and is used for events such as a mass public gathering requiring the deployment of DPH resources, or the presentation of a suspicious substance associated with a credible threat.
- SHOC Level 2 activation is the result of a localized event with a potential statewide impact, such as a severe weather warning, or a confirmed regional or Delaware case of a disease with potentially urgent public health

implications and/or widespread impact.
- SHOC Level 3 is activated during a statewide emergency, such as a pandemic disease or illness or a credible threat of or an actual terrorist attack in the state or region

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

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

Our FHS system did not play a big role in emergency planning and preparedness related to the pandemic. All DPH staff essentially function as essential personnel and can be tasked with assisting and supporting a response team effort and be reassigned duties (as stated in performance plans). We saw this as an example, during Covid, whereby staff were assigned SHOC roles – i.e., call center, call center coordinators, support during testing and vaccination pods, Nurses/APNS reassigned to support DPH clinics to support response efforts/vaccination pods, data/epidemiologists support data system entry and analytics and contact tracin.

Our Title V Director was brought into School Reopening response efforts, whereby we are receiving ARP funds, CDC ELC and CDC Crisis Response PH Workforce Supplemental Funding to address impact of Covid 19. We are using funds to support home visiting program expansion and emergency supplies, funding to hire CHWs in high-risk communities and screen for SDOH and make referrals to much needed health and social support services, funding to hire a Family SHADE CYCHN Consultant, funding for SBHCs, funding to support a DPH/DOE/SBHC Liaison to assist with school based health programming, prevention and response/recovery efforts.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Delaware's Title V program aims to ensure access to quality health care and needed services for maternal and child health (MCH) populations across the state. We have been successful at leveraging partnerships and resources to maximize services available to the MCH population. Delaware's Title V program is responsible for grants and cooperative agreements from numerous federal funders and generates revenues through the provision of services such as the Part C and Newborn Screening programs.

Delaware's Title V program has mostly shifted away from a direct service delivery orientation to a preventive, population-based assurance role that could be responsive to new national programs and policies and the changing economic climate. Our MCH partners typically refer uninsured pregnant women, women of childbearing age, children, and adolescents to resources to access primary and preventive and reproductive health care services such as DPH clinics, FQHC and HWHB providers.

One of the most significant roles that our Maternal and Child Health program plays is supporting the implementation of the Affordable Care Act as it relates to preventive health services for women. Specifically, many MCH partners, including the Division of Public Health is a lead partner in an initiative to increase access to the most effective methods of birth control (i.e. IUDs and implants), which involved reimbursement policy changes, building provider capacity through training and technical assistance, increasing awareness of family planning services, and removing barriers to same day access to long-acting reversible contraceptives (LARCs). For more details on our accomplishments and planned activities to promote LARCS, please see the narrative for the domain of Women/Maternal Health. Medicaid continues to be a strong partner in this work for LARC access as well as our sustainability efforts.

Healthy Communities Delaware (HCD) involves business, community, and organizational participants, and is managed as a collaboration among DPH, the University of Delaware Partnership for Healthy Communities, and the Delaware Community Foundation. We work in partnership with Delaware communities experiencing inequities. HCD works on community-driven priorities around the vital conditions (social determinants of health)—conditions into which we are born, grow, live, learn, work and play that affect our health. They use a collaborative, place-based approach with the goal of collective impact. From April 2020 through July 2022, over $3 million has been invested through Healthy Communities Delaware to our partnering communities statewide. The statewide Healthy Communities Delaware network includes 14 geographic communities and 21 community-based organization/coalition partners. Each receives investment and support to advance the Vital Conditions goals that their neighborhoods have prioritized neighborhood hubs to serve as food pantries and provide prevention care and resources; hiring bilingual resource navigators; and replacing deteriorating buildings with affordable rental units. Projects will engage residents in identifying the needs of their communities, building trust, and directly providing food, education, and care. Healthy Communities Delaware invests in communities wherever they may be in the Community Transformation Process (right), and supports their journey with communications, evaluation, and grant-writing assistance. The Healthy Communities Delaware Network began in 2020 with investments in 9 communities and 14 community-based organizations. Some of the progress they have made since June 2020 includes:

- 3 comprehensive community assessments and action plans
- 6 COVID assessments and action plans
- 1 vacant lot assessment and plan
- 5 community gardens maintained
- 531 home revitalizations services
- 3 parks/playgrounds revitalized
- 1 vacant lot revitalized

Senate Bill 227 and Executive Order 25 was passed/issued in 2018 which 1) requires the Delaware Health Care Commission to collaborate with the Primary Care Reform Collaborative to develop annual recommendations to strengthen the primary care system in Delaware 2) requires all health insurance providers to participate in the Delaware Health Care Claims Database. 3)require individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate for the next 3 years. The scope of the Primary Care Reform Collaborative long-term recommendations would include payment reform, value-based care, workforce and recruitment, directing resources to support and expand primary care access, increasing integrated care (including for women and behavioral health), and evaluating system-wide investments into primary care using claims data.

The Primary Care Reform Collaborative released their annual report in May 2020 and highlighted how the landscape of our health care delivery and life in general has been drastically altered since the last report. The necessary

measures to ensure recovery from the health pandemic that has swept the globe has also paralyzed the normal rhythm and function of every aspect of life. For health care, it has starkly highlighted deficiencies, gaps and disparities but it has also accelerated innovation, partnerships and collaboration, which hopefully will drive the development of successful solutions for the former.

Department of Health and Social Services (DHSS) Secretary Molly Magarik presented the State's third annual Benchmark Trend Report at an April 2023 Delaware Health Care Commission (DHCC) meeting. The report displays trends in Delaware's health care spending and quality, comparing new 2021 data against a set benchmark, and 2020 data. The report continues the State's efforts to improve health care quality for all residents, while simultaneously working to monitor and reduce the economic burden of health care spending. In November 2018, Governor John Carney signed Executive Order 25, establishing a state health care spending benchmark, an annual per-capita-rate-of-growth benchmark for health care spending, and multiple health care quality measures that are to be evaluated and adjusted every three years. The first spending benchmark went into effect on Jan. 1, 2019, and was set at 3.8%. That spending benchmark was not met, as the finalized health care spending for 2019 grew at a rate of 5.8%. For calendar year 2020, the spending benchmark was set at a more ambitious target of 3.5%. This benchmark was met as the 2020 Total Health Care Expenditures (THCE) per-capita change from the prior year was estimated at -1.2%. THCE encompasses health care spending associated with Delaware residents from private and public sources. Total Health Care Expenditures increased by $39 million in calendar year 2020, totaling $8.1 billion. However, with Delaware's population increasing by 1.7% from 2019 to 2020, the per-capita total decreased from $8,268 in 2019 to $8,173 in 2020. "While the decreases in per-capita health care spending and the spending growth rate appear at first glance as a positive change, it is important to note that the COVID-19 pandemic had a significant impact on preventative health care services, health care facility utilization, service delivery, and payer/provider finances," Secretary Magarik said. "These benchmark findings need to be viewed in the context of the extraordinary circumstances we faced in 2020. And that makes equitable comparisons with previous calendar years extremely difficult." The 2020 Trend Report also provides insight into Delaware's health care quality by presenting data on six quality measures. "Unfortunately, the results of the quality measures are mixed," Secretary Magarik said. "While Delaware made progress in some important measures, the report shows us there is still significant work to be done to improve the health of Delawareans in other areas. At DHSS, we look forward to working with health care providers, insurers, legislators, businesses, other government leaders and, most importantly, consumers to help build a healthier Delaware."

To learn more about the health care spending and quality benchmarks, visit the Health Care Commission website.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

As of June 15, 2018, Title V and Title XIX have an updated current MOU (please see section titled Title V-Medicaid IAA/MOU). The purpose of the MOU is to improve the maternal and child health service delivery and public health outcomes for underserved populations throughout the State of Delaware. In particular, the implementation of the MOU seeks to:

- Provide coordination between the Division of Medicaid and Medical Assistance (DMMA) and the Division of Public Health 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 without duplication of effort.

Further, the MOU enables the agencies to:

- Define the roles of staff in each agency;
- Clarify expectations of each agency;
- Provide guideline for case referral and case management;
- Establish joint training schedules; and
- Organize mechanisms for information sharing and problem resolutions

The MOU also directs the DPH and DMMA to establish a multi-disciplinary coordination. This committee should focus on training, messaging, case management and coordination procedures.

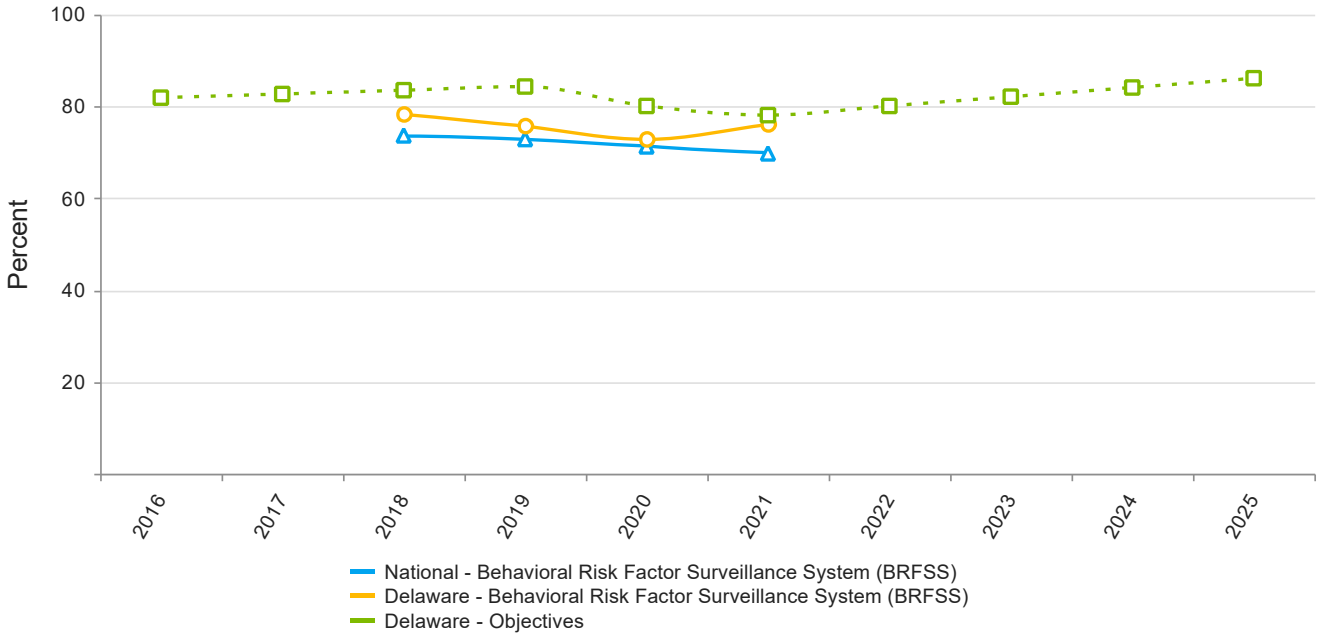
The DMMA hired a Maternal and Child Health Quality Assurance Administrator recently, and DPH sees this as a fantastic opportunity to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies. The DMMA Medical Director, Dr. Liz Brown is a close partner as a DPQC member as well as a previous member of the Preconception CoIIN. Currently, key MCH leadership including the Title V Director meet monthly with both DMMA staff members along with other DMMA policy staff members. We are not pursuing a separate coordination meeting at this time as we feel it is more important for DMMA staff to have the time to participate in several MCH partner meetings such the DHMIC, Doula Committee, etc. We will continue to meet monthly as a small group to tackle internal matters to ensure we are a united team and that we continue to make progress on things like a plan to implement doula reimbursement and to support other meaningful MCH policy.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			80	78	80
Annual Indicator		78.2	75.6	72.8	75.9
Numerator		127,950	124,769	117,625	125,530
Denominator		163,676	165,041	161,675	165,284
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	82.0	84.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - # 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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	15,500	15,700	17,000	17,250	8,500
Annual Indicator	16,386	16,672	8,488	8,015	8,109
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	9,000.0	9,500.0	10,000.0

ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			90	86
Annual Indicator		88	84.2	86.1
Numerator				6,335
Denominator				7,354
Data Source		HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	88.0	90.0	92.0

ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			63	60
Annual Indicator		62	53.1	58.6
Numerator				
Denominator				
Data Source		Medicaid Claims Data	PRAMS data	PRAMS data
Data Source Year		2019	2020	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	65.0	70.0	75.0

State Performance Measures

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

Measure Status:	Active				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	56	52	30	28	27
Annual Indicator	42.4	44.7	45.8	45	42.8
Numerator					
Denominator					
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	26.0	25.0	24.0

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	5.0	5.0	5.0

State Action Plan Table

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

Priority Need

Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By July 2025, increase percentage of women with birth interval > 18 months.

Increase the number of HWHBs Zone Mini-grantees focused on MCH Priority High Risk Areas engaged in MCH funded activities from 6 to 8 in 2020 to 8 to 10 in 2025.

By 2025, increase the number of women receiving a timely postpartum visit.

Strategies

Convene the Well Woman Workgroup with expertise in women's health and preconception health to develop a framework for optimizing the health and well-being of women of reproductive age.

Work with DPH's seven contractual health providers using a performance and outcomes based approach to deliver the Healthy Women Healthy Babies program services across the state.

Work with 6 HWHBs Zones Mini-Grantees focused on MCH Priority High Risk areas engaged in MCH funded activities.

Patient Reminders-Support providers in disseminating reminders and education materials (e.g., postcard, text, email, phone) to women about the importance of scheduling annual preventative visits

In collaboration with the Delaware Healthy Mother and Infant Consortium's Well Woman Workgroup, develop a Media Campaign-Utilize media outlets to increase awareness of the importance of preconception health and reproductive life planning as well as promote preventive well woman medical visits.

Patient-Navigators-Adopt protocols where clinic staff and Community Health Workers (e.g., WIC, HWHBs providers) assist with referrals to make preventative visits

Collaborate with the Delaware Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes for women and babies.

Provider Education-Host a webinar series for providers about annual preventive visits and strategies to address missed opportunities

Support the development and implementation of the housing pilot for pregnant women in collaboration with the DHMIC's Social Determinants of Health workgroup.

Ensure the data reports produced by Title V describe releveant disparities and discuss potential root causes, implications, and recommendations for moving towards equity and improved health outcomes for women and babies.

ESMs	Status
ESM 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics	Active
ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention	Active
ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.

SPM

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

Objectives

By July 2025, decrease the number of live births that were the result of an unintended pregnancy.

Strategies

Work with the DHMIC as well as inter-agency and community-based partners to improve messaging regarding birth spacing and reducing unintended pregnancy

Promote routine pregnancy intention screening

State Action Plan Table (Delaware) - Women/Maternal Health - Entry 3

Priority Need

Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.

SPM

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

Objectives

Decrease the Black/White Infant Mortality Ratio from 3.8 in 2020 to 2.0 in 2025

Strategies

Ensure the data reports produced by Title V describe relevant disparities and discuss potential root causes, implications, and recommendations for moving towards equity and improved health outcomes for women and babies.

Support the development and implementation of the housing pilot for pregnant women in collaboration with the DHMIC's Social Determinants of Health workgroup.

Launch training on the use of the DPH Health Equity Guide to provide information and resources to local community-based organizations and other providers to incorporate an equity framework into planning.

Women/Maternal Health - Annual Report

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

Over the last year, the Delaware DPH team worked on developing a new Five Year Delaware Healthy Mothers and Infants Consortium's (DHMIC) strategic plan. The MCH Director was involved in the strategic planning process, as well as several other MCH stakeholders that were involved in the Title V MCH Needs Assessment process and selection of priorities, which helped with alignment of goals and strategies. The DHMIC Five Year Strategic Plan is available on Dethrives.com and is driving our new leadership onboarding and membership engagement process.

The DHMIC is currently undergoing a change in leadership, after 20 plus years of consistent leadership as well as a significant membership turnover, never experienced before. Dr. David Paul and Susan Noyes, MSN, RN, stepped down as Chair and Co-Chair on the DHMIC Executive Committee after serving for nearly two decades. DPH staff worked with the Governor's Boards and Commissions to elevate the DHMIC Nominations committee recommendations for leadership successors as well as vacant positions to allow for a smooth transition over a very condensed 3 month timeframe. A very special tribute video was developed and show cased at the 17th Annual DHMIC Summit and can be viewed Annual Summit 2023 | Delaware Thrives (dethrives.com) . Onboarding the new leaders and members will require a historic overview of the inception and purpose of DHMIC, a review of its current infrastructure and revisiting its bylaws and committee structure. Staff in the Division of Public Health's Family Health Systems Section largely provide staff support to the committees and help carry out and execute strategies to support the DHMIC's strategic plan. The current Committees and workgroups include:

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

2. The Social Determinant of Health Committee which seeks to understand where people live, work, play and pray can help create actionable engagement strategies to improve health outcomes by addressing barriers rooted in structural racism. 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 focus on housing for pregnant and parenting women and a guaranteed basic income demonstration program as a priority. The Social Determinants of Health Committee of the Delaware Healthy Maternal Infant Consortium, is undergoing a change in leadership and Representative Minor-Brown will be paired with a new

co-chair, focused on two demonstration projects to address housing insecure pregnant women launched in Spring 2022. Some basic program model components are described below:

- GBI Eligibility
  - Pregnant women in 1st or 2nd trimester
  - Eligibility based on current income; under 185% FPL
  - Eligibility based on $1,000 extra earnings per month
  - Live in a HWHB High risk Zones

- Minimum requirements:
  - Program recipients must be a part of the evaluation (survey and interview) every 2-3 months
  - Work with a Case worker/Community Health Worker, preferred weekly to 2x per month; required every quarter
  - Work with a Financial Coach and Career Team (if applicable); preferred weekly tot 2x per months; required every quarter

Updates on both projects are below:

a) Guaranteed Basic Income Demonstration Project

Currently both cohorts totaling 40 women are enrolled and receiving $1,000 per month for 24 months. Eligibility includes women in their first or second trimester, under 185% of federal poverty, and that live within specific zones shown to have disparate birth outcomes. Once determined eligible, women are informed using a Federal Reserve Bank of Atlanta tool, of any benefits that might be impacted by receiving $1,000 extra each month. It is up to each eligible woman to decide if she would like to enroll.

Seventy eight percent (78%) of women enrolled are Black, eighteen percent (18%) are Hispanic, and 5% are Caucasian. Two rounds of surveys, interviews and focus groups have focused on: Changes to financial well-being and access to services, Immediate impacts on stress and well-being, Initial feedback on the program, including the coaching and case management, and Preliminary spending patterns. Initial interview findings include program is easy to enroll and access the funds, work with case managers has been helpful, and program has positively impacted their lives with improved mental health, reduced stress, improved access to food, healthcare, daycare, and transportation, and lastly, other children have experienced positive impacts. The average income of enrolled women prior to enrollment was $1,146 per month, and after enrollment was $2,246. Participants are becoming connected with Medicaid, WIC, food assistance, and housing assistance. Stress level decreased from pre-survey to first quarter survey, and most women reported an increased ability to get clothing, childcare, phone, medicine/health care. The top three expenditures are groceries/food/restaurants (30%), rent (12%) and wholesale or discount stores (9%). It is important to note, even with the GBI program, women reported spending about 48% of their monthly income on rent.

b) Housing Stabilization Demonstration Project

In partnership with the Delaware Housing Assistance Program (DEHAP), the program launched last fall with a focus on women at risk of losing their housing as opposed to those who have already lost their housing. Women were identified by HWHB providers and referred into the program. Due to the restrictions of DEHAP, some women had already received the benefit and thus were no longer eligible. A total of 11 applicants were received, of which 9 were ineligible. The two eligible applicants were in the process of enrolling when DEHAP announced they were closing the program due to lack of funds. The social determinants of health committee will continue to pursue housing options for pregnant moms and are currently seeking some alternative longer-term solutions.

DPH is supporting the GBI demonstration project, Healthy Women Healthy Babies Opportunity, with State Infant Mortality funds as well as ARPA funds to expand and support this demonstration project, which was approved by the Office of the Governor.

Health Management Associates (HMA) was hired contractually by the Division of Public Health to analyze conditions in Delaware that would inform these two demonstration pilots, such as housing stability, enrollment size and criteria, funding availability, and evaluation needs. As part of this, HMA also engaged childbearing women who are or who have been housing insecure to help in the design of the pilot. The findings should help

the DHMIC's implementation workgroup and the SDOH Committee make recommendations to the broader DHMIC on how to design and monitor these demonstration pilots.

3) Maternal and Infant Morbidity/Mortality workgroup, which examines the data and evidence of the health status of women in Delaware, particularly those in the 14- to 44-year-old age range and those with poor birth outcomes (e.g., premature birth, low birth weight). This group works to foster leadership, identify gaps in data, cultivate relationships, enhance provider knowledge, review findings, reframe postpartum/interconception care, enhance capacity for statewide quality improvement, and explore best practices to address risks.

Education and prevention are a cornerstone of the DHMIC work, utilizing the latest social media platforms. In partnership with a social marketing firm, Aloysius Butler and Clark (AB&C), the Division of Public Health and several Maternal and Child Health partners we continued to develop, update and launch messaging through the use of social media, whereby we continue to post messages via blogs, Twitter, Facebook, YouTube, and most recently added Instagram, in which all MCH programs and initiatives participate. The branding tagline, Delaware Thrives, evolves around the theme that "Health Begins Where You Live, Learn, Work & Play". This year, DPH launched the newly designed website (www.DEThrives.com) at the 17th Annual DHMIC Summit, which is easy to grow, easy to maintain, and easy to navigate, and one that is search relevant.

On April 18, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 17th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial, ethnic and geographical disparities that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. The 2023 theme was "*RENEW. RECONNECT. RECHARGE. Join our journey as we strengthen our commitment to healthy women, babies, and communities."*.

This was the first in-person summit in three years, largely due to the COVID-19 pandemic. There were 365 registrants maxing out the venue's capacity. 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.

Lt. Governor Bethany Hall-Long provided opening remarks on the importance of why we should continue the work to address maternal and infant mortality in Delaware. There were three keynote speakers with Q&A that presented topics on the importance of reducing racial and ethnic inequities, ensuring quality, equity, and respectful care for women and their babies, and the importance of having a strong and fearless team alongside you to ensure health equity can be made available for all regardless of racial differences.

In between the three keynote speakers, there were group breakout sessions and a panel discussion moderated by DHMIC members and DPH leadership, innovation stations that showcased the Healthy Women Healthy Babies (HWHB) mini-grantees, a visual artist that captured the day's theme, topics, and experiences in illustration and graphic form which will be used for media use, and multiple activities that encouraged group discussions among attendees and education with the innovation stations.

During the Summit, it was also the launch of the newly designed DEThrives.com website which houses DHMIC information along with Maternal and Child Health programs and initiatives and free community based resources for teens, women, men, families, and the community, to live healthier lives. The message that DEThrives encompasses is the same as the DHMIC's, where healthy communities are made of healthy people – healthy mothers, healthy babies, healthy families, healthy communities. There were nearly 170 users who visited the newly designed site during the summit (compared to the average count of 89 users), over 160 users who viewed the DHMIC section of the website during the summit and almost 220 views on the DHMIC section of the website the day after the summit (compared to the average 77 view average). There were over 2K impressions (number of times a post has been displayed), over 150 total engagements (any action a user does on a post such as liking, commenting, or sharing the post), and more than 40 tags on social media for users who utilized hashtags of #DEThrives and #DHMICSummit2023 during the summit and into three days after the summit to help spread the word of the event and the newly designed website on social media.

DPH's Interim Director, Dr. Liz Brown, presented the annual Kitty Esterly, MD, Health Equity Champion Awards which

recognizes a person or organization who puts in the extra effort to address and change the causes of infant mortality with a health equity approach by improving the overall health and well-being of mothers and the community. The individual award was given to Mona Liza Hamlin, MSN, RN and the organization award was given to "Black Mothers in Power". The announcement of these awards on DEThrives' social media accounts ranked as one of the highest performing in the total number of engagements (any action a user does on a post such as liking, commenting, or sharing the post) on Facebook, Instagram, and Twitter. Also, photos from the Summit can be viewed here on our FB page.

Senator Marie Pinkney, a DHMIC member, presented the Black Maternal Health Awareness Week Resolution at the Summit, which recognizes that the week of April 11th through April 17th will be now be known as "Black Maternal Health Awareness Week" in Delaware. The DPH/Family Health Systems team drafted the resolution to elevate this important week.

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

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

DPH is proud to share accomplishments resulting from implementing 10 Healthy Women Healthy Baby (HWHB) Zones community-informed strategies that aim to increase awareness, educate, better serve women of reproductive age and amplify the voice of black maternal health grass roots organizations. The primary focus is innovation and to spread evidence-based programs and place-based strategies to improve the social determinants of health and equity in maternal and infant health outcomes, as a complement to our medical intervention, HWHBs 2.0. The first-ever mini grants support the shared initiative to narrow the wide variance in birth outcomes between black women and white women by building state and local capacity and testing small-scale innovative strategies. DPH worked with 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 determinants of health in priority communities throughout Delaware. This year we added two new mini grantees, for a total of ten active mini grantees awarded including: Delaware Adolescent Program, Inc. (DAPI), Delaware Coalition Against Domestic Violence (DCADV), Delaware Multicultural and Civic Organization (DEMCO), Hispanic American Association of Delaware (HAAD), Kingswood Community Center (cycle 1 only), Black Mothers in Power, Parent Information Center (PIC), Delaware Breastfeeding Coalition, Rosehill Community Center, Life Impact, and Christina Cultural Arts Center. This past year, we added two new mini grantees addressing two priority areas including fatherhood/partner involvement and engagement and food insecurity. A short description of the awarded community-based interventions are described below.

- Delaware Adolescent Program, Inc.: serves teen mothers and their partners providing mentoring services and Support for social and emotional well-being and support in navigating the health and social services system.
- Delaware Coalition Against Domestic Violence: This organization provides support to victims of domestic violence and administers flexible Health Access Funds to support the safety and health of the participants. DCADV also trains health care providers on best practices for domestic violence assessment and response.

- Delaware Multicultural and Civic Organization (DEMCO): Provides life skills supports and job training education to young women of childbearing age, including those who are pregnant and parenting
- Hispanic American Association of Delaware: This organization provides pregnancy and postpartum support in Spanish to women ages 15-44 who live in ZIP code 19720 in New Castle County.
- Rose Hill Community Center: Provides fitness, nutrition counseling and self-improvement classes to women at no cost as well as case management support to pregnant women receiving Guaranteed Basic Income.
- Parent Information Center (PIC): Train six doulas, who will provide nonclinical emotional, physical, and informational support before, during, and after labor and birth. In partnership with community organizations, the program will also provide virtual training on childbirth education, breastfeeding initiation, prenatal nutrition, healthy family relationships, and community supports; empower women to be their own self-advocates; provide one-on-one coaching calls with pregnant women (prenatal and postpartum) starting six weeks before due date and continuing six weeks postpartum; offer postpartum support groups with other new parents as well as breakout sessions on breastfeeding, sexuality, mental health, and infant development; and create an awareness campaign focused on prenatal and postpartum support.
- Black Mothers in Power (BMIP), a grassroots organization focusing on Black mothers in the community and underserved populations. The BMIP will provide and sponsor a doula program to train 10 black women to become certified doulas through the National Black Doula Association. The organization will be training five doulas in New Castle County and Kent County, and will be focusing on engaging at-risk pregnant women who live in high-risk zones. Each doula will help women during the critical times of pregnancy, birth and postpartum, and early parenting.
- Breastfeeding Coalition of Delaware will provide breastfeeding support groups to the HWHB high-risk zones of Wilmington, Claymont, and Seaford. It will offer accessible support, engaging groups, text check-ins, access to variable levels of lactation support, and incentives for participation. In addition, the Breastfeeding Coalition of Delaware will hire three diverse breastfeeding peer counselors (BPC) and one lactation consultant to provide breastfeeding support to women. At the completion of the program, the Breastfeeding Coalition of Delaware will host a baby shower for participants, where they will provide needed baby supplies, education, and support to pregnant and postpartum women.
- Impact Delaware, Inc. Impact Life is an innovative behavioral Health Organization whose mission is to build a solid foundation of recovery through unique recovery residences, peer support, workforce development, cultural and spiritual experiences, opportunities for peer leadership and service work projects. This organization is piloting two programs. The first program is a cashless grocery store in New Castle County modeled off “Greater Goods” in Philadelphia, under this program Individuals come to a local bi-weekly pop-up food distribution event and are given and allotted number of tokens per person in which they can use to shop for food. Impact life is also creating a Pilot program of a “Door Dash” type mobile food distribution in Western Sussex County. Due to the rural area and lack of resources, individuals would sign up for bi-weekly food distribution that would be delivered to them. This reduces the transportation barrier as well as the shame that can be associated with food insecurity. They will also provide Education programs that teach individuals how to grow their own food at home and make nutritious meals in Western Sussex.
- Christina Cultural Arts Center mission is to change the trajectory of a child's life by making affordable arts, education, career pathways, gallery exhibitions and live performances accessible to all in a welcoming environment. CCAC will provide self-care workshops and activities which will focus on the health and wellness of the parent/adult caregivers in a child’s life. They are expanding CCAC’s activities to appeal, attract, and maintain participation of fathers and to provide quarterly Fatherhood Initiative meetings and plan to hold activities and include a fatherhood track in 4 Self-Care Weeks.

At the time of this writing, the third full year Evaluation report for the Healthy Women Healthy Baby Zones will be released in September 2023. Some of the preliminary findings from the participants demonstrate progress and a positive impact as it relates to the overall NPM1 Well Woman:

- Demographic data: 500 women and girls served; majority of participants from Zip codes 19702, 19720, 19801, 19804, 19805, 19901, 19904; 605 of participants were black, 35% were white, 6% identified as "multi-racial/other"; 105 participants said Spanish was their primary language; About ½ have a high school diploma or GED.
- Most common expressed needs by the women screened and engaged in the mini grantee interventions were referred to resources for stable housing, utility assistance, help reading health materials (health literacy), and access to food. Nearly half struggle with childcare, transportation, social support or access to medical care.
- 72% of participants have either been pregnant, are parenting, or is currently pregnant.
- Participants were screened for pregnancy intention and referrals were made as appropriate to local family planning provider sites and Healthy Women Healthy Babies providers. The majority of participants are not intending to become pregnant in the next year.
- Of the DEMCO participants, on average 82% of participants felt that they had improved their professional skills and increased confidence to prepare for employment.
- Of the DCADV participants, 96% of flex fund recipients reported that the funds "Significantly" or "Completely" reduced their financial stress.
- Of the Rosehill participants, 59% of participants lost weight. On average, participants lost 3lbs over the course of the program.
- Of those that participated in the DAPI intervention, they were asked "To what extent did the program increase resilience to relationship pressure and intention to apply refusal skills?" 75% of students reported confidence applying refusal skills ("I would feel comfortable saying no to my partner when I don't feel like having sex").
- Participants showing statistically significant improvements in depression, anxiety and stress.
- Adapted wrap around services and support during Covid-19 included "flex funds", computers and internet needs. Flex funds were most commonly used to meet basic needs such as food, diapers, winter coats, and feminine hygiene products, to support needs of children, to pay utility bills, to meet physical needs, and to buy essential furnishings.

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.

The DHMIC embraced the focus and framework of a preconception health approach, to optimize the health of women before, between and beyond pregnancies. Delaware developed the Women's Wellness initiative, *Every Woman Every Time Delaware: Reimagining the Preventive Medical Visit*, which at its core seeks to strengthen the dynamic interplay between a woman and her health care provider(s) by encouraging honest and open communication about her reproductive and general health care needs. The initiative focuses on four broad areas including 1) Pregnancy intention screening; 2) Assessment of health risk behaviors, and prevention and education tools 3) management of chronic health conditions 4) identification of social determinants of health with linkage to services. DHMIC, through DPH has a contractual support position, a Women's, Infants, and Families Nurse Consultant that devotes time and expertise to lead the Women's Wellness initiative. This year, a new WIF Nurse Consultant was hired to focus on a one year workplan. Some of the core responsibilities include:

- Identify and develop life course perspective tools for health care providers and community outreach centers.
- Develop and carry out education programs. Prepare educational materials and assist in planning and develop health and educational programs for health care providers, peer counselors, consumers and community.
- Act as a resource and support workgroup activities to advance preconception health as well as the Healthy Women Healthy Babies 2.0 as it relates to well women care.
- Promote at the grass roots level the programs and initiatives of the DHMIC, this may include conducting workshops, conferences, and seminars such as decreasing unintended pregnancy rates, improving well woma care/preconception care, postpartum rates, birth spacing, etc.; required to speak before special interest group community organizations, medical and health care groups, or the general public.
- Provide expert consultation in women's and fetal/infant health and recommend modifications to programming based on knowledge of best practices.

The WIF Nurse Consultant promoted the Preconception Peer Education Program and encourages new colleges and universities to adopt and operationalize the program. The PPE program was implemented in May 2007 by the Office of Minority Health (OMH) of the Department of Health and Human Services, supported by DPH and the DHMIC for replication. This national program was launched as part of its initiatives to eliminate health disparities among racial and ethnic minorities in the U.S. The Preconception Peer Educators (PPE) Program was developed to raise awareness among college students about being well before, during, and beyond pregnancy. The overarching goals of the PPE program are to reach college-aged populations with targeted messages stressing the importance of preconception health and health care, train college students, particularly minority students as peer educators, and provide them with the tools necessary to educate other students of reproductive age (15-44) on their respective campus about the importance of receiving preventive care, education, and counseling before deciding to create a baby. While the program initially was going strong at the University of Delaware, there were some changes in leadership that made sustainability a little rocky and therefore, the WIF Nurse Consultant worked tirelessly over the last year to re-engage the University of Delaware to establish the program and provided a training to the new UD advisors and new students. The WIF Nurse Consultant provided technical assistance and support to the University of Delaware to ensure sustainability of the University of Delaware's PPE chapter.

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 begun having 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 is led by DHMIC member and legislator, Representative Mimi Minor Brown, to continue to address 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. There are barriers to designing a reimbursement structure and process for seeking Medicaid reimbursement. Some of these barriers include establishing minimum requirements for certification & training, reasonable reimbursement rates for both Doulas and Medicaid, and billing coverage if doulas enroll as independent providers. 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 credentialing association and we do not know how many doulas there are in the state/people interested in offering doula services.

DPH engaged doulas across the State of Delaware to gather their insights on issues related to training and certification to inform the development of a statewide infrastructure to increase access to high quality doula are for women most at risk of poor birth outcomes in the state. The stakeholder engagement study aimed to gain an in-

depth understanding of community-based doulas' knowledge, attitudes, feelings, beliefs and experiences in relation to training and certification, as well as other perceived needs in the state. Our specific research questions included the following: How do doulas perceive training and certification requirements for their practice? Assuming certification is required for Medicaid reimbursement, what core competencies do doulas believe should be included in approved training programs in order to meet the needs of low-income women and women of color? What supports do doulas believe are needed to better serve the Medicaid population in Delaware? Three focus groups were conducted in September and November 2022 for a total of 11 participants. A brief summary of findings:

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

DMMA, per HB 343, passed in 2022 by the Delaware General Assembly, finalized a doula care services benefits package under Medicaid. Over the past year, DMMA has been meeting with doula stakeholders in Delaware to collaborate on designing a Medicaid doula benefit. During this time, the workgroup discussed the various authority options through the Centers for Medicare and Medicaid Services (CMS), the benefit design, reimbursement, and credentialing requirements. 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. Next steps are to support the Delaware doula stakeholders in working with the Delaware Certification Board to develop a process and system to verify doula credential.

Healthy Women Healthy Babies (HWHB) program 3.0, was a focus over the last year and will be rolled out in the coming year using a similar 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 will be an important focus on incorporating a strong behavioral health component to 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 equity-driven 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; social determinants of health screening, etc.).

Data collection and analysis is central to this new HWHBS 2.0 model as well as continuous quality improvement (CQI) for ongoing learning and improvement. This means that tracking, assessing, and improving outcomes for the HWHB program require a deliberate CQI plan and effort by providers which emphasizes quality improvement. 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 leveraged additional 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 determinants of health such as housing, transportation, food insecurity, and access to mental health services.

There is strong evidence that home visiting supports good maternal and women's health outcomes. Since 2010, Delaware has competitively applied for and has been awarded the Maternal Infant Early Childhood Home Visiting Grant (MIECHV) funding through the Affordable Care Act. Funding is used to support evidence-based home visiting programs through increased enrollment and retention of families served in high risk communities. Delaware grant funds are also used to sustain and build upon the existing home visiting continuum within Delaware, which includes three programs including Healthy Families America (known programmatically as Smart Start) Nurse Family Partnership, and Parents as Teachers. This year, Delaware received a highly competitive $1.89M Maternal, Infant, Early Childhood Home Visiting (MIECHV) Innovation and Implementation grant earlier this year, which DPH's Maternal and Child Health Bureau administers and manages. The grant seeks to develop data and technology approaches that improve delivery of home visiting services. In addition, the grant leverages existing administrative data to measure and assess social and structural determinants of health (SSDOH) contributing to disparities in access and/or outcomes of families enrolled in home visiting services. Delaware's proposed innovation will strengthen the referral linkages across evidence-based home visiting programs and agencies that hire, train and deploy community health workers. In doing so, families currently enrolled in evidence-based home visiting programs who have unmet adverse SSDOH that cannot be readily nor robustly addressed by home visitors will be referred to community health workers who have the capacity and capability to assist these families.

Delaware Division of Medicaid and Medical Assistance (DMMA) launched Medicaid reimbursement for evidence-based home visiting programs. 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.

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.

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, Delaware Contraception Access Now (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 enables 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 they do not want to become pregnant, DE CAN trains health centers to counsel patients on the full range of contraceptives available to them. DE CAN enables 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.

Delaware CAN includes health centers that serve nearly 80% of women of reproductive age in the state. Nearly 2,000 women in Delaware have taken advantage of the "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 is quality improvement and implementation coaching that follows each training. During the quality improvement phase of the initiative, Upstream and health centers work 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 serve 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 are 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. Developments in the last year, include drafting regulations to support a bill passed into law that would extend and authorize Pharmacists to dispense and administer hormonal birth control. The Adolescent and Reproductive Health Bureau team will support 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 will promote healthy birth spacing and give women more access to all methods of birth control. Currently the largest hospital system in the state, Christiana Health Systems offers these services, as well as Nanticoke Health Systems and Bayhealth Medical Centers. Beebe Medical Center has trained their providers and have implemented this service in the past year. The Division of Public Health continues to work with all hospitals statewide on training and technical assistance with these new processes and procedures. Furthermore, Delaware's Division of Medicaid and Medical Assistance also implemented a reimbursement policy change approved by the Centers for Medicare and Medicaid Services (CMS) allowing the cost of long acting reversible contraception (LARC) to be carved out of the federally qualified health center (FQHC) prospective payment system (PPS) rate.

DPH has developed a Contraceptive Counseling training based on Upstream, USA's team approach patient-centered contraceptive counseling model and continues to provide support to Sub-Recipient Sites on sustainability of this initiative. This training is offered on a quarterly basis to all Title X Family Planning sites as well as Delaware Social Service Organizations to provide patient-centered contraceptive counseling for their clients experiencing challenges including substance use disorder, mental health issues, homelessness and domestic violence. A partner resource page has been developed by Upstream, USA so that tool kits and documentation are available to providers to support and sustain the project.

In 2022 the Delaware Family Planning program completed four full in-person training sessions on February 23, 2022, May 26, 2022, August 24, 2024 and October 26, 2022. As of today, for 2023, we have completed two full training sessions on February 23, 2023 and April 27, 2023 along with one site requested contraceptive counseling training on March 27, 2023. 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. On June 5, 2023 we had a non-clinical training virtual training for DOC. The DECAN program will have two additional trainings in 2023 on August 24, 2023 and October 26, 2023.

There was a total of 29 staff members in 2022 whom were trained on the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and newly added cultural competency. There was 11 clinicians trained in Nexplanon insertions/removals

and 7 clinicians trained on IUD insertion/removals. A total of 6 provider sites took part in the 2022 DECAN trainings including staff and providers from Westside Family Healthcare, Beebe Healthcare, Tidal Health, Department of Corrections, LaRed Health Center, and Henrietta Johnson Medical Center. So far in 2023 there has been 19 staff trained in the non-clinical portion of the DECAN training as well as 4 clinicians trained in Nexplanon insertion/removals and 4 clinicians trained in IUD insertion/removals.

To assess DE CAN's long-term impact, the University of Maryland in partnership with the University of Delaware, is conducting 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 is also exploring 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 will be shared with key stakeholders. Data collection activities include: Title X patient survey, Delaware Primary Care Physician survey, interviews with women, male partner interviews, sustainability survey and stakeholder interviews and surveys. Some very preliminary 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.

Women/Maternal Health - Application Year

In May 2005, the Infant Mortality Task Force at the time issued a report that included 20 recommendations to reduce the number of Delaware babies who die before their first birthday (rate of infant mortality) and to eliminate the racial disparity in the rate at which these babies die. The infant mortality rate is generally regarded as proxy for the overall health of a community. The infant mortality rate (IMR) for black babies is 2.7 times that of white babies in Delaware. Maternal age, chronic illness (asthma, hypertension, diabetes), nutrition, infection (STI, HIV), stress, unwanted pregnancy, smoking, and other drug use and lack of prenatal care are all factors that increase the risk of adverse pregnancy outcomes and maternal complications.

In 2005-2006, the Division of Public Health (DPH) and key stakeholders developed the infrastructure required to implement the Infant Mortality Task Force recommendations. To this day, DPH partners with Medicaid to develop policy and wraparound services supplementing direct care services for preconception, prenatal, and postnatal care. The Delaware Healthy Mother and Infant Consortium (DHMIC) was established by Governor appointment to monitor and evaluate implemented programs and services and adopts by-laws necessary for efficient functioning, election officers, appointments of members and meets on quarterly basis. Additionally, the DPH's Center Family Health and Epidemiology was established to provide scientific expertise and technical support to DPH and the DHMIC. The goal of the DPH staff are to help measure the impact of all programs that provide services in MCH, provide expertise in application for federal and other supplemental funding opportunities, and facilitate evaluation of all MCH-related programs. In addition, the CDC-assigned State MCH Epidemiologist supervises the research and data projects within the Center, and offers scientific advising for all MCH-related projects. In 2019, DHMIC and DPH and stakeholders went through a shift in our intervention framework, focused more on addressing the social determinants of health required to achieve desired physical health outcome goals.

This year, DPH led a comprehensive strategic planning process to develop a five year plan for the DHMIC, which led to another huge paradigm shift, largely related to a change in leadership, whereby the Chair and Vice Chair with more than two decades of experience leading the DHMIC, both stepped down at the same time in the Spring of 2023. A very special tribute video was created which highlighted many accomplishments, under Dr. David Paul and Susan Noyes' leadership, which was shared at the 2023 Annual DHMIC Summit. Over the next year, DPH and the DHMIC will be laser focused on orienting new leadership, new members and addressing themes captured during the DHMIC strategic planning process expressed by members and stakeholders: a desire for revisiting the committee structure and membership engagement, improved communications and transparency, and accountability strategies such as data dashboards to measure and report on success.

The DHMIC established the Healthy Women Healthy Babies (HWHBs) program in July 2009. A significant amount of state funds, approximately $4.2M, is invested in several infant mortality reduction initiatives as well as improved health outcomes for women and babies. The primary focus of the IMTF/HWHB funding has been to reduce the number of Delaware babies who die before their first birthday. The strategy has been to identify women at the highest risk of poor birth outcomes and to address any underlying medical conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk. The success of this effort lies in the fact that since its inception, our infant mortality rate had dropped almost 30% over the last decade of intense efforts and evidence-based program interventions. In the past few years, substantial funding has been directed at addressing the social determinants of health which are the major drivers behind the racial disparity. In FY 21 and FY22 in state General Funds $1.5 million has been budgeted to this SDOH effort and will remain a priority. Additional ARPA funds have also been leveraged to support two demonstration projects, one on addressing housing instability and preventing pregnant women from homelessness and a second on a guaranteed basic income pilot, both aimed at improving maternal and infant health outcomes. Over the next year we plan to monitor and share preliminary data and impact of the demonstration projects. The guaranteed basic income demonstration pilot was launched in April 2022 and the housing

instability project will focus on short and long term policy and systems changes.

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

The HWHB program is housed under the Division of Public Health in the Family Health Systems Section and has completed three full years of the new refreshed model to improve preconception, prenatal, and birth outcomes of Delaware women, particularly those at increased risk. The new model is a value/performance-based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health and incorporates the role of community health workers to further support outcomes. The Division of Medicaid and Medical Assistance (DMMA) was an essential partner in the transformation of the HWHBs 2.0 model and continues to play a role in the program's enhanced model and performance-based redesign. In the next year, we plan to continue to review benchmark data indicators and demographic data as well as explore data linkages of HWHBs 2.0 patient data with Medicaid claims data to monitor benchmarks and outcomes. We have one year remaining in this 5 year cycle to assess whether the new model is moving the needle on producing evidence on improving health outcomes for women and birth outcomes. DPH will issue a RFP to solicit bids for HWHBS 3.0 in January 2024. Two years ago, Medicaid hired a MCH Quality Assurance Administrator or clinical lead who is a Nurse Practitioner, and this position had turnover in November 2022, and was only recently filled in the Spring of 2023. DPH was convening reoccurring monthly meetings with this individual along with the DMMA Medical Director to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies. However, due to staff turnover, and the DMMA Medical Director being tapped to serve as Interim DPH Director, and balancing two leadership roles, it has been challenging to meet regularly. As of this writing, DPH was notified that the Interim DPH Director is leaving state employment and her post in interim leadership and her last day is August 4, 2023. Over the next year, we plan to re engage and hope to meet monthly again to discuss policy, programming and interventions impacting the maternal and child health population.

The HWHB Program was developed using a life course framework to explain health and disease patterns, particularly health disparities, across populations and over time. Health is interconnected or a series of inter-dependent stages over the course of one's life. The life course framework recognizes the interaction of behavioral, biological, environmental, psychological and social factors that contribute to the health and well-being throughout an individual's life. The available research is clear that the path to more significant and sustained improvement in the statewide maternal and infant mortality rate and in eliminating the persistent racial disparity lies in addressing the social determinants of health - the social context factors that compromise the health of families which then makes them susceptible poor outcomes.

Over the next year, DPH in collaboration with DHMIC partners plan to further track and analyze benchmark data and the performance based approach to the to the Healthy Women Healthy Babies program, a medical intervention and develop HWHBs 3.0.. DPH will also monitor and support 10 community based interventions in high risk zones implemented across the state that 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, access to early childhood education, medical legal partnership, financial literacy, etc. The plan for the coming year, is to discuss the findings with new DHMIC leadership, Committees and and prepare recommendations that take into

account the ROI, costs and sustainability, and explore alternative evidence based models, such as guaranteed basic income models (i.e. Abundance birth project in San Francisco, CA). In the coming year, Health Management Associates (HMA) will continue working closely with DPH and DHMIC to serve as a backbone agency as part of the maternal and infant mortality reduction work to build state and local capacity, and test the 10 small scale innovative strategies to shift the impact of social determinants of health tied to root causes related to infant mortality. The primary focus is innovation and to spread evidence-based programs and place-based strategies to improve the social determinants of health and equity in maternal and infant health outcomes. HMA will work with DPH and DHMIC to staff and facilitate the SDOH Workgroup, staff and facilitate a Doula Adhoc Committee, the Well Woman Committee and provide coaching and technical assistance to the 10 local community based interventions, schedule quarterly learning collaboratives for partners, provide extensive coaching and technical assistance to existing and new mini-grant awardees, and create shared metrics and tools for quality improvement and overall evaluation.

Implementation of the Delaware Healthy Mother and Infant Consortium (DHMIC) Five Year Strategic Plan will be a priority in the upcoming year. Plans are underway to onboard the newly Governor appointed DHMIC Chair, Vice Chair, and new members and orient them to the current infrastructure, roles and responsibilities, programs and interventions, and strategic priorities.

The Delaware Perinatal Quality Collaborative (DPQC) was established in February 2011 as an action arm and under the umbrella of the DHMIC and now functions as its own board and is charged to collaborate closely with DHMIC. The DPQC is composed of representatives from birth hospitals and the Birth Center in Delaware. The collaborative benefits from the leadership of neonatologists, primatologists, nursing directors, hospital administrators and advocates. A Medical Director, who serves as a long standing DHMIC member, is a well-respected perinatologist and is also the Chair of the Maternal and Child Death Review Commission. The Medical Director and the Perinatal Nurse Specialist are tasked with oversight, education and technical assistance on workflow and process issues that will support changes in practice. The Perinatal Nurse Specialist effectuates changes in practices using academic detailing to explain and implement standards, enhancing access to information and resources, and assessing the program's impact on a continuous basis. The DPH, Center for Family Health Research and Epidemiology, receives and compiles data for quality improvement purposes and provides the cooperative with access to data and resources. In 2020, the DPQC was formally established in Delaware Code and signed by the Governor during a virtual press conference. It was not until June 2023, that formal Governor appointments were solidified, due to staff turnover. DPH did not have a role in identifying any of the representatives of the hospitals/birthing institutions. Those selections were coordinated by the Delaware Healthcare Association reaching out to the institutions and asking them for their representative. The plan is to update and approve bylaws this coming year and set up structures to organize the work of the DPQC. The Bylaws were discussed at a meeting in March but the group could not vote to approve it because they had not been appointed.

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

1. Enter binding memoranda of understanding among member institutions to hold each other accountable for sharing quality improvement data and for following the protocols for securely handling the shared data.
2. Enter into agreements with data storage and or transmission companies to provide their services to the Collaborative to enable it to do its work.
3. Apply for funding to support the work of the quality collaborative.
4. The confidence that the quality improvement data that members share will not be released to the public. The quality improvement focus of the Collaborative requires that member-birthing institutions be able to share their

quality data freely without concern that unauthorized persons may have access to information. The legislation would enable the collaborative to close some of its meetings to the public. Placing the DPQC in statute will allow for sharing of more confidential data and cases that could potentially be a violation of state data laws but are important for continuous quality improvement and learning among providers/ birthing institutions. (i.e. patient data protection including HIPPA). For example, even a medical chart review of 10 patients should not be shared publicly, but this is how the birthing hospitals/institutions learn from each other. The same applies to case reviews.

5. Continue to function in cooperation with the DHMIC.

Over the next year, DPH will revisit the staffing infrastructure and support to the DPQC and will research other state models over the next year.

Preconception peer educators (PPE) provide community outreach to increase infant mortality awareness with an emphasis on preconception and interconception health targeting the 18+ population. They primarily engage minority serving colleges and universities and develop public/private partnerships. PPE is a state-wide initiative originally created by the Office of Minority Health but brought to fruition in Delaware by the DHMIC. PPE consists of college students becoming trained peer educators via statewide training. Once trained, these students are expected to raise awareness and educate their campus and community about Delaware's problematic infant mortality rate and its effect on families in the area. This involves discussing issues with young women and men to ultimately understand that their personal decisions have a major effect on their future family. The main messages that PPE aims to present are:

1) Delaware's trend of high infant mortality and how this relates to unintended pregnancy
2) the glaring health disparities that exist among black and other minority groups and how this translates within the state's infant and maternal mortality rates
3) the importance of always having a plan to become (or not become) pregnant and how physical, mental, and emotional health contribute to one's preparation for pregnancy.

Currently, the PPE's most prominent chapter was re-established this year at the University of Delaware. PPE at the U of D's educational outreach has included presentations in high school classrooms, informative kiosks on campus, educational presentations to Greek life organizations, and even occasional abroad experiences in Jamaican villages. Over the years, this chapter has evolved in many ways, but currently its students as well as the DHMIC are less focused on community and abroad outreach and more focused on the internal organization of each chapter, technical assistance as well as their presence on campus. The DHMIC Woman, Infant and Families Nurse Specialist provides the support and technical assistance to the PPE chapters, but it is becoming more apparent that more focus needs to be on creating standardized operations and procedures within this chapter to keep the organization afloat when faced with turnover of leadership and participants. In the coming year, efforts will focus on sustaining the UD PPE Chapter, working with the new faculty advisor.

Over the next year, we will continue incorporating preconception health education into the clinic-based setting, mainly through our family planning sites as well as our Healthy Women Healthy Babies provider sites. This is an excellent opportunity that will align and enhance Delaware's efforts to transform the HWHBs 3.0 program. Delaware will sustain the Preconception CoIIN work through HWHBS 3.0, and bring lessons learned to scale working with 7 health care providers in Delaware. Milestones include working with providers on implementing small tests of change in asking the Pregnancy Intention Screening Question at the practice site level and gathering data to report on this benchmark indicator, implementing preconception health education in practice based setting, development of education materials and social marketing messaging via DEThrives Facebook, Twitter, and blogs for patients, practice workflow, and prioritizing preconception screening of patients.

DE CAN Sustainability. DE CAN has paved the way for improving access to all methods of contraception, including

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

DPH is very pleased to share that there continues to be a sustained funding investment, since FY21, through State General Funds in the amount of $1.5M to support the sustainability and ongoing programmatic costs of Delaware Contraceptive Access Now (DE CAN). DPH in-kind support will continue through DPH and DMMA, a contractual MCH Epidemiologist (.15 FTE) as well as the State Pharmacy as a mechanism to track, store and distribute LARC devices to participating Title X network providers to support the ongoing sustainability, infrastructure and ongoing operational costs. In addition, DPH gained two (2) new state funded full-time FTEs to sustain limited program operations. At a minimum, the next phase of DE CAN ensures that health care providers (through the Title X network) who serve low-income uninsured women, are equipped to provide the most effective long acting reversible contraceptive methods. Furthermore, DPH continues to sustain limited training and technical assistance as designed by Upstream, in consultation with the Delaware DPH, to support the 39 community health centers[1] through attrition and staff turnover who serve the majority of low-income women.

The DECAN training plan for the upcoming year includes five in-person trainings which include both non-clinical and clinical portions. Each training session varies in number of attendees and audiences depending on the needs of providers/clinics but the preparation is usually geared towards 10-15 people. DECAN non-clinical trainings can now be requested for site specific locations or opt for a virtual training. The Family Planning team is currently working with the TAPP Network to build and develop a virtual training platform for the DECAN non-clinical training which can will allow staff to register and participate in the training fitting into their schedule. The Family Planning Program will monitor participants and track completion through the new Learning Management System.

In addition, the Family Planning team drafted regulations to support implementation of a bill passed in 2021 that authorizes and permits pharmacists to dispense and administer hormonal birth control. The regulations help Delaware comply with the law and help establish a protocol to implement the law into practice. Over the next year, the Family Planning team will need to develop a training curriculum, expanding current DE CAN training tailored to pharmacists. This will require research, planning, coordinating with the Board of Pharmacy, other stakeholders as needed and leveraging national technical assistance, and assembling a team to assist with developing a training curriculum.

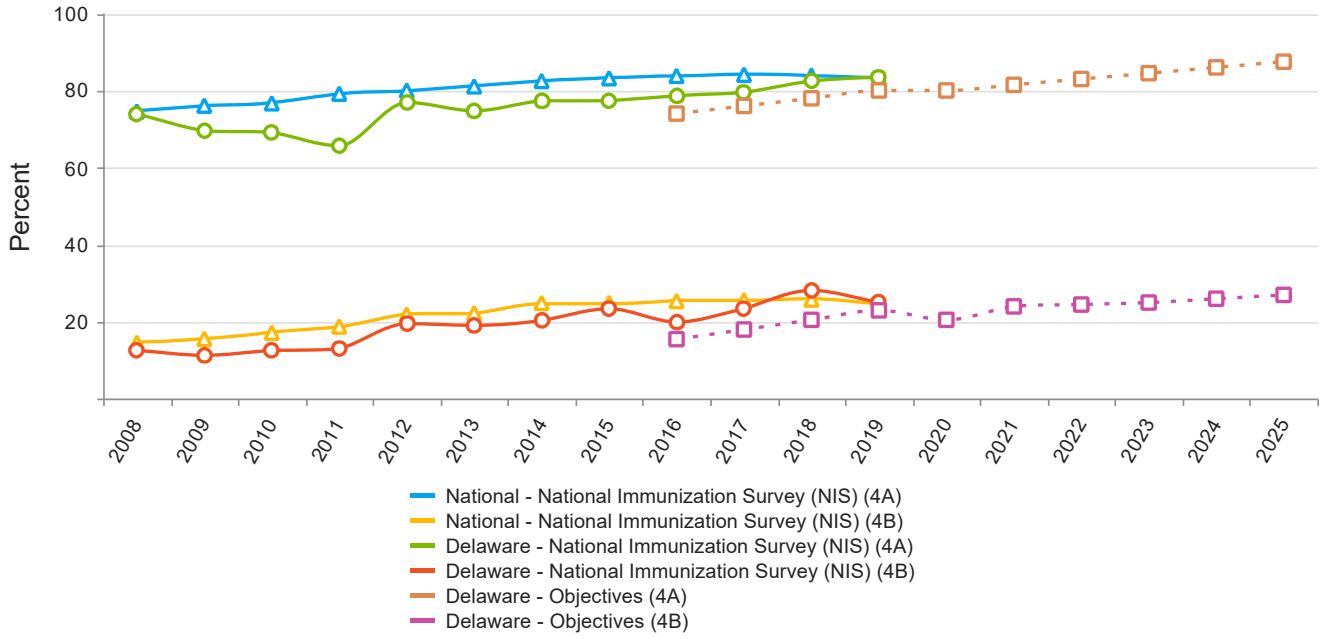
In addition, DE CAN funding will also support a stock of LARCs for those birthing hospitals that provide LARCS immediate postpartum so that access continues for uninsured women. These funds will ensure that a system is in place to sustain access to the most effective methods of contraception, LARCs (IUDs and implants), to Delaware's uninsured and under-insured women of reproductive age.

[1] In CY2022, Title X had a total number of 39 provider sites, including SBHCs that provide reproductive health services.

Perinatal/Infant Health

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	78	80	80	81.5	83
Annual Indicator	77.4	78.5	79.7	82.4	83.6
Numerator	7,840	8,010	8,564	8,253	8,057
Denominator	10,127	10,209	10,741	10,019	9,637
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.5	86.0	87.5

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20.5	23	20.5	24	24.5
Annual Indicator	23.6	19.8	23.6	28.2	25.0
Numerator	2,319	2,019	2,478	2,713	2,298
Denominator	9,811	10,187	10,493	9,615	9,184
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	25.0	26.0	27.0

Evidence-Based or –Informed Strategy Measures

ESM 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	61	65	58	60	62
Annual Indicator	54.2	54.9	47.9	57	55.3
Numerator					
Denominator					
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV program daa	MIECHV Program Data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	64.0	66.0	68.0

State Performance Measures

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:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 1
Priority Need
Improve breastfeeding rates.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By July 2025, increase breastfeeding initiation rates in Delaware from 77% to 84%.
Strategies
Continue to strengthen hospital efforts in supporting mothers/babies through comprehensive breastfeeding policies.
Partner with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to ensure that home visitors have the expertise and supplies to support breastfeeding among their clients.
Coordinate and standardize breastfeeding messages for all DE DPH programs that work with prenatal and postpartum women.
Support efforts to increase the number of racial and ethnic minority IBCLCs.
Provide training and coaching to MIECHV home visiting staff to promote breastfeeding best practices.
Support hospitals to maintain or receive baby friendly designation.

ESMs	Status
ESM 4.1 - Increase the number of birthing facilities that receive baby friendly designation	Inactive
ESM 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

According to the 2022 Breastfeeding Report Card, 83.6 % of babies born in Delaware in 2019 were “ever breastfed or fed breast milk” ; equal to the national estimate of 83.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding initiation are lowest for Black, non-Hispanic infants, as well as infants in low-income households. These disparities are mirrored in the data for longer-term breastfeeding, with the overall rate dropping to just 25% of infants who are breastfed exclusively for 6 months; equal to the national average of 24.9%.

According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2021 data, the percentage of women who ever breastfed increased by 12% from 79.2% in 2012 to 88.6% in 2021 and currently breastfeeding (i.e., at the time of survey) increased by 23% from 48.8% in 2012 to 60.1% in 2021 among women with a recent live birth. There were differences in breastfeeding rates by race and ethnicity. For instance, based on PRAMS data, the 2021 prevalence of ever breastfed among Black non-Hispanics was 85.0% as compared to 88.0% among White non-Hispanics, 91.4% among Hispanics, and 96.7% among other races non-Hispanic. Similarly, the 2021 prevalence of currently breastfeeding (or at the time of survey) among Black non-Hispanics was 48.1% as compared with 64.4% among White non-Hispanics and 57.7% % among Hispanics, and 71.9% among other races non-Hispanic.

This data shows the need for improvements in overall breastfeeding initiation but also improvement in the disparities that exist in Delaware. In addition, the input gathered through our needs assessment process showed overwhelming support from partners to address this area. Through a survey of MCH stakeholders, breastfeeding was ranked as the number one national performance measure for our Title V program to address in the perinatal/infant domain, and 72% indicated that there was a strong desire among stakeholders to address the issue.

The following activities have been accomplished this past year with the use of Title V funding and through partnerships with entities such as the DHMIC, WIC and the Breastfeeding Coalition of Delaware (BCD).

The DE WIC program is pleased to share the findings of the most recent participant survey launched this Spring. The survey revealed a 97% Satisfaction Rate with WIC services, based on willingness to refer the WIC program to a friend or colleague.
The survey was successfully sent out via the WIC program’s texting service used to communicate events, helpful suggestions, and appointment reminders. Of the 220 Participants who answered the survey, 85% found the texting service was useful with others giving suggestions to further refine the program’s messages and timing. When asked about their experiences with WIC clinics, 87% were happy with the quality of services, 82% were satisfied or very satisfied with WIC staff, and 81% found appointments were easy to schedule.
Participants shared that the majority of those responding had talked with a Breastfeeding Peer Counselor and 96% felt the experience was good to excellent. Participants sought help from peer counselors on topics such as breastfeeding goals, latching techniques, pumping, and emotional support. All findings will help inform future improvement efforts while also providing an opportunity to thank staff for the great results!

According to the Gibbious findings in the First and Second Quarter Report of Fiscal year 2023 and the WIC WOW Data System:

- Breastfeeding initiation at increased by 4% in the last two quarters
- Breastfeeding Initiation rates in the WIC population has increased by 2% from the 1st to the 2nd quarter
- Exclusivity increased by 3% from the 1st to the 2nd quarter
- 12-month Duration remained level during the 1st and 2nd quarter

WIC programs offer peer counselors. “Peer” means that the counselor has breastfeed their own baby and can help other mothers breastfeed. According to Gibbious findings of the May FY 2023 second quarter, a participant contacted by a peer counselor is 95% more likely to be breastfeeding at 3 months and 81% more likely to be breastfeeding at 6 months.

The Delaware WIC Program will again be hosting the Annual Breastfeeding Event virtually on August 3, 2023. The guest speaker is Laurel Wilson of Mother journey. Her topics of discussion include:

- “Addressing Sore Nipples and Painful Mammary Tissue”,
- “The Potential Impact of Perinatal Cannabis”,
- “Gut Reaction” and “The Milk Sharing Conundrum”

Delaware WIC offices are scheduled to reopen on August 9, 2023, with a modified schedule pending FNS approval. The virtual breastfeeding classes remain successful and will continue to be offered. Currently, classes are offered the first and third Wednesday of each month at 11am and 5pm. However, a third breastfeeding class was added on the third Saturday of each month starting at 11am.

The Community Breastfeeding Partnerships with the Delaware WIC Program, Christiana Health Care Systems, The Latin American Community Center, Nemours Pediatrics, Westside Family Health, The Breastfeeding Coalition of Delaware, The Perdue Chicken Plants of Milford and Georgetown and The Delaware Healthy Mother and Infant Consortium continue to be robust and are thriving.

One clear need in our state is to enhance the supports that are available to women in the early days and months after birth, when breastfeeding is being initiated and becoming a routine. Over the past several years DPH has worked on expanding state breastfeeding capacity - promoting the transformation of Delaware hospitals into Baby Friendly hospitals and improving access to professional and peer support for breastfeeding in the community. Four out the six birth facilities in the state have received baby friendly designation including our largest birthing hospital. The other two birthing facilities are interested, however little progress has been made. One of the birthing facilities, Nanticoke was bought by Tidal Health and being designated a Baby Friendly facility was not a pressing priority. In the most recent CDC Maternity Practices in Infant Nutrition & Care, Delaware scored an 84 which slighting higher than the national average of 81. The BCD continues to provide support to birthing facilities to maintain certification.

DE WIC built a cross-functional team that includes WIC program staff, local clinic staff, birthing hospital leadership, and community peer counselors to meet quarterly to review the latest breastfeeding rates and develop big and small strategies to enhance the peer counselor role and breastfeeding supports across the state. In coordination with the team, the WIC program does an annual survey of participants to identify issues and inform participant-driven strategies. Some initiatives that the Delaware program has successfully implemented include a major push to inform moms of their breastfeeding rights, increased breastfeeding awareness by state employees in co-located facilities and integrating the peer counselors into the WIC clinics to support groups and foster one-on-one interactions. The team has recently begun looking at service patterns and seeing where targeted intervention can improve supports. The WIC team is also exploring the use of telehealth with our WIC Breastfeeding Peer Counselors in providing virtual breastfeeding classes to our WIC moms.

The observance of Black breastfeeding Week Aug 25 – 31st 2022 is particularly important to address since black babies in Delaware "are almost 3 times more likely to die than white babies before their first birthday. Delawareans could help reduce infant mortality by eliminating disparities in breastfeeding. DEThrives created a blog post titled "Black Breastfeeding Week 2022", which also ranked as the number one searched for blog post during this quarter (July – September 2022), that listed free community events to help promote Black Breastfeeding Week partner events. These local events ranged from a community doula program, a community "Group Latch" about breastfeeding, a "Painting with a Twist" opportunity to paint a breastfeeding inspired canvas, a coffeehouse style book reading of "Free to Breastfeed: Voices of Black Mothers", an online Zoom celebration titled "The Big LATCH!", and a documentary titled "Aftershock" which showcased the discussion of the black maternal health crisis followed by a panel discussion of women's health and reproductive rights led by Delaware State Representative Melissa Minor Brown and other community partners. A Save the Date Flyer was also produced to help spread the awareness of the observance and the community events. Interviews on the topic occurred along with an e-blast email that was sent out to increase awareness of this observance and to increase awareness of the importance and benefits of breastfeeding, particularly in the black and brown population, for mothers and their families. Between August 18th – August 25th, 2022, a single image newsfeed ad was published recognizing Black Breastfeeding Week. Once the ad was clicked, it redirected the user to the "Black Breastfeeding Week 2022" blog post which shared a list of community events and resources celebrating this observance. The objective of the ad was to drive traffic to the "Black Breastfeeding Week 2022's" blog post on the DEThrives site. The ad reached over 16K users, had over 62K impressions, 76 clicks, and a 3.8 frequency. This ad also earned the most social engagement this quarter, specifically on DEThrives' Facebook and Twitter platforms, with 109 overall (the term "overall" is defined as adding up the analytic #s found on all 3 platforms of FB, IG, and TW) post reactions.

Perinatal/Infant Health - Application Year

With the selection of breastfeeding as a priority for our Title V program, we are building on our partnership with the BCD and the DHMIC, as well as our previous year's activities to improve breastfeeding rates in our state – both initiation and duration

The BCD developed and finalized their Strategic Plan in 2019 and includes several goals under the specific domains below that they continue to implement. Obviously, due to the pandemic implementation of some of these activities were delayed.
Breastfeeding Friendly Environments:

- Healthcare providers achieve breastfeeding friendly environments.
- Support Delaware hospitals in obtaining and maintaining Baby Friendly Hospital accreditation.
- Businesses support their employees in breastfeeding or providing breast milk to their families for one year or longer after the birth of each child.
- Insurers cover the needs of a nursing mother and her child.
- Become a resource to providing breastfeeding friendly environments at community events.

Education:

- A breastfeeding-literate population that promotes and supports breastfeeding
- Coordination and collaboration amongst entities providing education on breastfeeding.

Policy and Advocacy:

- Create and promote policies that support breastfeeding and advocate for the rights of the breastfeeding women and children.

Internal Organization:

- The BCD is a sustainable and effective organization, funded, structured, and aligned to do its work.

However, the BCD recently acknowledged that they have more work to do in providing equitable breastfeeding support. Some steps, they are planning to take as a coalition are as follows:

- Create a more diverse board. Ensure membership is not just diverse but that there are opportunities to contribute and take leadership.
- Zero tolerance for racism for members and those who attend coalition events.
- Create learning opportunities on subjects such as implicit bias, equity and inclusion for the community. These will be taught by black women who live and work in our communities.

The BCD was able to use a contractor to survey the existing workplace support programs and use these programs to create a plan for implementing a wide-scale workplace support program. The following materials have been developed:

- A business "sell sheet" that summarizes the reasons that businesses should support breastfeeding in Delaware;
- A workplace support in Delaware presentation that outlines the laws and facts about businesses supporting breastfeeding in Delaware;
- A template letter for women to give to their employers when wanting to return to work while breastfeeding;
- List of key stakeholders for workplace support outreach; and social medial messages for support outreach.

Members of the BCD have been meeting and supporting one large employer in Delaware to assist them in creating a workplace support program. The partnered with the site to create gift bags to advertise the health center to pregnant moms and families that includes resources for pregnancy and lactation. This employer now has lactation rooms stocked with pumps and supplies though a MOU with WIC. They are also offering breastfeeding friendly items in baskets to moms and dads who work there.
We will continue to utilize social marketing techniques to influence women's decisions around infant feeding. Promoting messages and materials through our DE Thrives website is one strategy. The Delaware Division of Public Health (DPH) and the Delaware Healthy Mother & Infant Consortium (DHMIC) are dedicated to awarding mini grants to support local organizations whose results-driven work strives to reduce infant and mother mortality as well as morbidity among minority populations in Delaware.

The Breastfeeding Coalition of Delaware was one of the awarded community-based organizations through the DHMIC Healthy Women Healthy Babies Zone project. The Delaware Breastfeeding Village is an incentive based breastfeeding program that brings families together who may be at high risk for breastfeeding barriers. Black mothers, mothers from low-income families, mothers experiencing housing instability, and non-English speaking mothers are at high risk and are offered text support and monthly breastfeeding education and groups. The program consists of two, 6-month cohorts. In each 6-month cohort, there is a monthly 1-hour breastfeeding education session. Additionally, participants are offered ongoing support and engagement with peer counselors. In Cycle 3, it is intended that there will be 75 mothers per cohort for a total of 150 mothers at the end of 12 months. Process Data Demographic information from the mothers is captured during their initial application and attendance at the breastfeeding education sessions is tracked. Additionally, peer counselors and the IBCLC log their encounters with mothers and the supplies distributed and staff complete timesheets each month to track hours spent supporting the mothers.

Intended outcomes of the program include:
1. Increased breastfeeding duration
2. Identification of most important breastfeeding barriers among new mothers.
3. Identification of the most important supplies used to overcome breastfeeding barriers 4. Increased awareness of the level of staff engagement required to improve breastfeeding behaviors
5. Increased satisfaction with the breastfeeding program Beginning with Cohort 2, participants are completing periodic surveys after breastfeeding education sessions.

These surveys ask mothers about their current feeding methods, breastfeeding exclusivity and duration, any breastfeeding difficulties, overall experience with breastfeeding, what they have learned in the program and any impacts of participating in the program. These data will be available in the next Cycle 3 report.

Pay for Performance Data measures for BCD include the following:

- Process Measure: Peer counselors will have least 1 touch per mother for each month of the 6- month cohort.
- Outcome Measure: At least 50% of the mothers will report offering at least some breast milk to their baby at 6 months.

In Cohort 1, peer counselors have at least one touch per month per month with 72% of the mothers. In order to meet their P4P measure, BCD will need to increase their touches with mothers. In terms of their P4P outcome measure, as of the end of the first cohort in Cycle 3, 85% of mothers report that they are offering their baby breastmilk. BCD's evaluation has not changed since its initial implementation at the beginning of Cycle 3 however, coaches are beginning conversations with BCD about incorporation of national benchmarks into future evaluation work

Thursday, Aug. 25, marks the start of the annual Black Breastfeeding Week (BBW22). Now in its 10th year, this milestone is cause for celebration. It's an opportunity to recognize how far we've come in raising awareness about the racial disparity in breastfeeding rates; how much we've grown — BBW has expanded exponentially, with more than 800 community events nationwide; and how much work there is still to do.
Statewide events are planned for World Breastfeeding with specific efforts focused on Black Breastfeeding Week on behalf of Delaware Healthy Mother Infant Consortium (DHMIC) with partners from WIC and the Breastfeeding Coalition.

One-week, countless ways to help and support Black and Brown mothers on their breastfeeding journeys. In Delaware, Black babies are 2.5 times more likely to die than white babies before their first birthday. According to the CDC, increased breastfeeding by Black mothers could decrease infant mortality rates by as much as 50%.

After conducting our required MIECHV benchmark evaluation, we selected CQI projects. Our CQI work will be focused on our breastfeeding rates and safe sleep practices of our families. Our FY 23 MIECHV CQI plan update was developed and is awaiting approval. Our performance data collected indicated that reported breastfeeding initiation rates were low. The percentage of infants aged 6 to 12 months who were enrolled in home visiting for at least 6 months and were documented to be breastfed for any amount at 6 months of age was 55 percent. Breastfeeding initiation has been an ongoing state priority for the DHMIC as well as for Title V so it makes sense for MIECHV to align with our priorities.
All MIECHV funded programs are aware that breastfeeding and safe sleep practices need to be improved upon and the current methods by which they are carrying out CQI (e.g., trainings, messaging) have assisted to an extent. We have and will continue to give considerable latitude to programs on how they plan to carry out CQI on these constructs and we will continue to provide TA as needed.

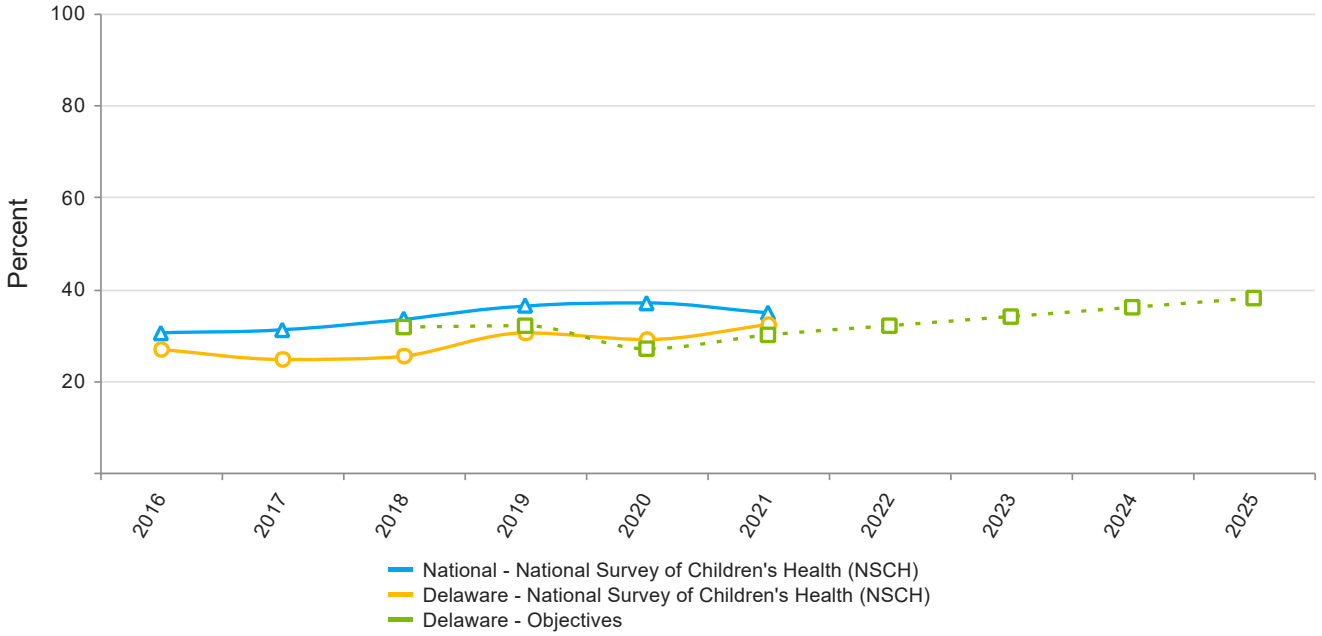
Delaware has moved in a new direction with annual home visitor wrap-around training. The new training plan was organized around the home visitor competencies as described in the *National Family Support Competency Framework for Family Support Professionals*. One of the many competencies is "Child Health, Safety, and Nutrition and there are three training modules around breastfeeding included, 1. Breastfeeding 1: Helping Mothers Choose Breastfeeding, 2. Breastfeeding 2: Helping Mothers Initiate Breastfeeding and 3. Breastfeeding 3: Helping Mothers Continue Breastfeeding.

Finally, we will continue to support our home visiting program to ensure that home visitors have the expertise and supplies they need to support women in breastfeeding. This will include helping a core set of staff, spread geographically across the state, to earn and maintain the IBCLC credential when requested. We are hoping to have home visitors with IBCLC certification within all of our evidence-based home visiting models (Nurse Family Partnership, Healthy Families America and Parents as Teachers).

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31.7	32	27	30	32
Annual Indicator	24.8	25.5	30.3	29.1	32.1
Numerator	5,633	5,939	6,522	6,073	7,257
Denominator	22,753	23,289	21,559	20,867	22,604
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	34.0	36.0	38.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - 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				
	2019	2020	2021	2022
Annual Objective			92	94
Annual Indicator	91.4	83.3	82.2	81
Numerator	433	398	412	439
Denominator	474	478	501	542
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	96.0	98.0	100.0

ESM 6.2 - # of new pediatric practices to adopt PEDs

Measure Status:	Inactive - The measure was not strong and we are currently piloting CHADIS and have not been as focused on increasing the number of practices adopting PEDS.

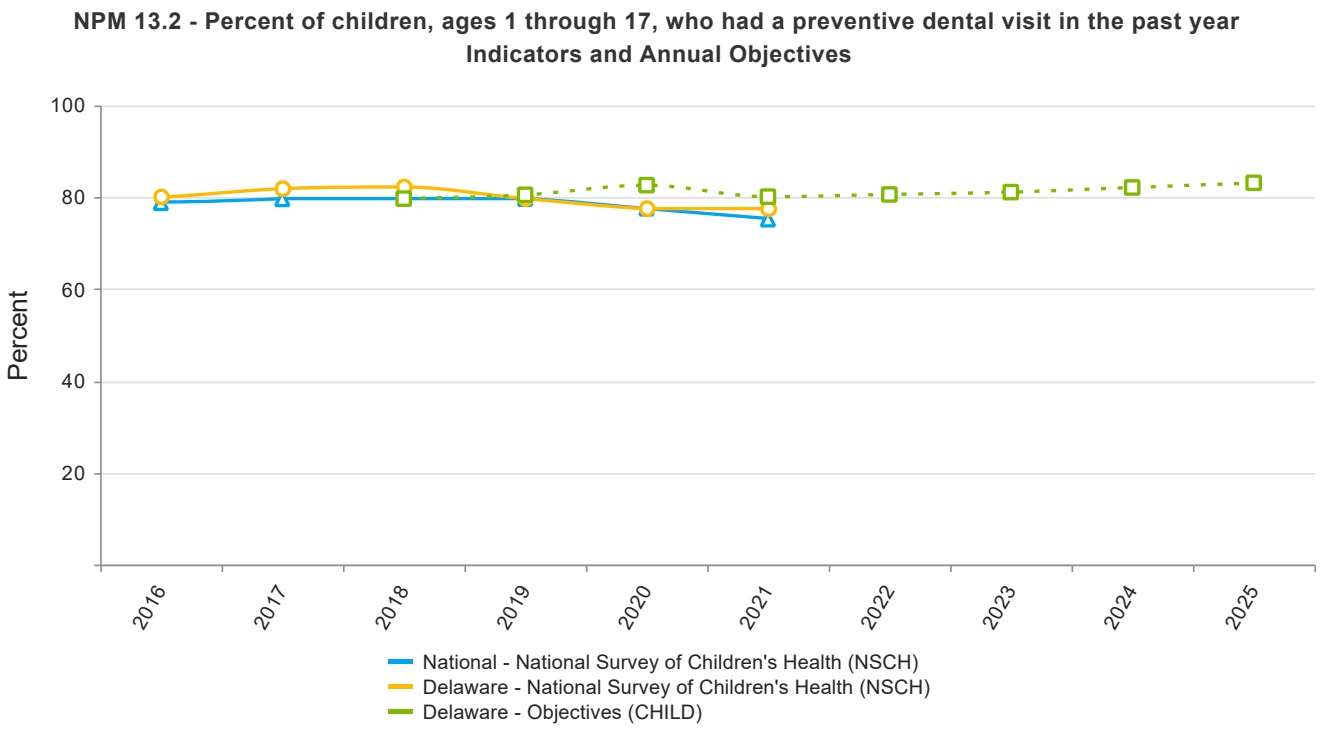
State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	39	42	45	47	49
Annual Indicator	40	43	43	43	43
Numerator					
Denominator					
Data Source	DE APP	DE APP	DE APP	DE APP	DE APP
Data Source Year	2018	2019	2020	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

ESM 6.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.6	80.4	82.5	80	80.5
Annual Indicator	81.6	82.0	79.7	77.4	77.3
Numerator	155,485	154,827	149,645	148,645	149,188
Denominator	190,614	188,877	187,697	192,077	193,050
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.0	82.0	83.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			81	82
Annual Indicator	80.6	78.8	73.6	77.3
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	83.0	84.0	85.0

ESM 13.2.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	683
Numerator	
Denominator	
Data Source	MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	725.0	765.0

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 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By July 2025, increase the percent of children, ages 9-71 months, receiving a developmental screening using a validated parent-completed screening tool.	
Strategies	
Train medical and childcare providers on developmental screening.	
Utilize Home Visiting/MIECHV programs to provide the Ages and Stages Developmental Screening tool to clients.	
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	
Recruit new pediatric practices to adopt PEDS	
Continue to host Books, Balls and Blocks events for families to educate families on developmental milestones, age appropriate activities and provide an opportunit for children to receive developmental screening.	
Pilot CHADIS with 4 pediatric practices.	
ESMs	**Status**
ESM 6.1 - 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 6.2 - # of new pediatric practices to adopt PEDs	Inactive
ESM 6.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Delaware) - Child Health - Entry 2

Priority Need

Improve the rate of Oral Health preventive care in children.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By 2025, the percent of children 1-17 who had a preventive dental visit in the past year will increase to 87%

Strategies

Promote practice of early childhood medical providers providing oral health screenings, fluoride varnish application, anticipatory guidance, and dental referrals by age one.

Collaborate with Medicaid to increase the number of children and youth who have had a preventive dental visit in the past year.

Increase oral health referrals among children and youth through School Based Health Centers.

Work with Family SHADE and BODS to promote avaialble dental service for CYSHN

Continue to foster discussions with school districts to develop a dental program within SBHCs to promote dental health as an integral part of the overall health of students.

Incorporate oral health education into school curriculum.

Collaborate with DE AAP to promote early literacy through purchasing the book "Brush, Brush, Brush" that are distributed by a dental hygienist to pediatric provider offices for children ages 1-5.

ESMs	Status
ESM 13.2.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	Active
ESM 13.2.2 - Increase the referrals received for dental services via the DEThrives website.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Child Health - Annual Report

Developmental Screening

Our 2020 Needs Assessment showed that Delaware is among the lowest of its surrounding states when comparing children, ages 9-35 months, who received a developmental screening in the past year. According to the 2020/2021 National Survey of Children's Health (NSCH), 32.1% of Delaware children received the screening. This is slightly below the national average of 34.8% of children having a completed developmental screening. Developmental Screening was selected as the Most Important National Performance Measure in the Child Health Domain according to our stakeholders. In addition, it was ranked as the second highest priority, when ranking all priorities overall.

Studies indicate that each year, about three million children across the nation enter Kindergarten without the cognitive, social, and emotional skills necessary to be ready for school and life. The situation is even more dire as kids struggle through the aftermath of the pandemic and its impact on mental health, cognitive social and physical health. Developmental health surveillance and screening, and its promotion, is critical to early identification and intervention to ensure that developmental health disorders are treated to improve the overall outcome and trajectory of the child's growth and life.

The ECCS/HMG program continues to collaborate with the Office of Early Learning (OEL) to assure a comprehensive approach to attaining universal developmental screening in all early care and education (ECE) facilities, as mandated through HB 202. The OEL has been meeting regularly, with its partners, to implement the use of the Ages and Stages Questionnaire (ASQ) within licensed childcare facilities. The ECCS programs serves as the voice for how these changes could impact health care.

Over the past three to four years, the Help Me Grow @211 service was expanded to include two new hires to focus on the uptake of Ages and Stages screens. Funding support for this effort came from the Birth to Three program. With the increase in capacity, there has been a successful decrease in the backlog of ASQ screens. The staff will be instrumental when the statewide mandate (HB202) comes into effect.

In November 2022, the MCH/ECCS partnership to implement the CHADIS pilot project went LIVE! This meant a successful integration of the four pediatric practices' Electronic Medical Records to the CHADIS web platform; the building of a referral platform for users to send and receive referrals; the training of all partners - this includes Child Development Watch and Child Find staff, the four pilot pediatric practices and their staff; Help Me Grow@211 staff including ECCS and DEAAP staff. The main purpose for this project is to streamline care coordination gaps in the developmental screening continuum. Child Health and Development Interactive System (CHADIS) is a web-based patient engagement and data collection system for comprehensive developmental/physical and mental health for all ages.
MCH/ECCS is in partnership with the Delaware Chapter of the American Academy of Pediatrics (DEAAP); Medical Society of Delaware, Early Intervention programs (Child Developmental Watch and Child Find) and Help Me Grow@2-1-1- (Centralized Access Point). They are joined by four pediatric the practices from each of Delaware's three counties.

The pilot is in its final stages where data is used to support scaling up and spread. Since November, when CHADIS went live, the four pediatric practices have submitted about 3,110 Peds screens to early intervention programs (Child Developmental Watch and Child Find) for assessment, if eligible for their services.

As the CHADIS pilot project transitions to the scaling up and spreading stage, the ECCS/AAP staff work with CHADIS staff to improve barriers or challenges as and when it becomes known. Such challenges range from training and re-training staff as they use the system; reviewing the system to assure efficiency for parents and other users, including ensuring the robustness of the data to answer the initial pilot question. Anecdotal feedback from users indicate satisfaction with the general utility of the system. The areas that need improvement pertains to a necessary cultural shift by early intervention providers to follow through with the feedback loop to physicians, and continued promotion of Help Me Grow @211 as a service that addresses referrals regarding the social determinants of health.

A total of 9,214 PEDS online screens were completed on children 0-59 months between January 2022 to December 2022. This corresponds to an estimated 6,574 unique or unduplicated children. There's a decrease in the number of screens since four pediatric practices are participating in the CHADIS pilot project. Of the total number of screens administered (9,214) by pediatric practices, 4.7% (426) were high risk for delays. Additionally, of that number of screens (9,214), 2,559 (94.3%) of children between 18 to 24 months screened for the MCHAT, passed the test while 155 (5.0%) failed.

The DPH/MCH partnership with the Delaware Chapter of the AAP has evolved over time, to identify synergies and

partnership with pediatric and other early childhood programs which has resulted in more collaborations now, than ever. Over time, it became apparent that recruiting pediatricians to implement developmental screening was difficult, however they appeared to have more interest in early literacy, through the Reach Out and Read program.

As a strategy, the proposal now is to package early childhood programs, services, and supports such as lead screenings, oral health, Food Bank of Delaware, developmental screening, and Help Me Grow @211 while leveraging the Reach Out and Read program. This has also led to the expansion of topics featured of the DEAAP's web page dedicated to online education targeting pediatricians and family practitioners. The online training was initially developed to provide an overview of developmental screening best practices, Delaware's developmental screening initiative, PEDS online tools, the referral process, and early intervention program information, including care coordination and community resources (Help Me Grow/2-1-1).

With the expansion, is the inclusion of information on lead screening, oral health, food insecurity through the Food Bank of Delaware, and addressing issues of social determinants of health through accessing Help Me Grow @211. The course will be made available on an online education platform that health providers or other stakeholders could access for professional development

Through Books Balls and Blocks activities, we continue with building parent/family leadership and capacity to advocate for themselves and their communities. This past year, the virtual sessions targeting children, birth to age three, led to the creation of "Parent Meet Up" sessions. This need became apparent since most of the parents would linger after their kids' sessions to address issues they were having in their families. The outgrowth of this need was a monthly virtual meeting targeting parents. Once a month a 15-minute general information on parenting such as "potty training" or "feeding" is shared with parents and then the agenda is open for parent-generated questions and discussions.

A collaboration with HMG@211 has also led to reaching a broad array of families. Staff at HMG@211 promote BBB events and other HMG events by sending text messages to the target population the day before a session, including reminder emails to registrants. We also continue to organize community events (virtual and in-person, when appropriate) such as Books, Balls and Blocks events to increase families understanding of developmental screening and milestones, while creating opportunities to administer the Ages and Stages Questionnaire screener. Events organized in the past year include collaboration with libraries, United Way of Delaware, Winterthur Museum, Managed Care Organizations such as Highmark, community centers and Chi Eta Phi Sorority Inc.

During the past year BBB, reached over 60 families virtually and face-to-face. There was also a concerted effort to organize events targeting fathers. Though not well attended, we recognize the impact of dads on their children and plan to organize another such event.

Since July 2020, over 30 online BBB sessions have been carried out with 124 online evaluations completed. The satisfaction evaluation from parents shows most parents would recommend the BBB events to friends and families since they found it enjoyable and satisfactory. The majority of participants indicated the BBB sessions were helpful in assessing their child's growth or skills. They also indicated a willingness to follow up for early intervention services should a developmental screen indicate their child was at risk for delays.
The BBB webpage, Facebook posts and streaming on DEThrives shows views from other users who visit the social media page to view the BBB online sessions with their children. Recent data shows that virtual recordings have been viewed over 200 times beyond the initial posting.

For 2023 to 2024, the ECCS/HMG program will work with the Help Me Grow national center to assist the Help Me Grow Advisory committee members in strategic planning. Below are some of the areas or goals:

- Disparities in developmental screening: on-going developmental screening data indicates some disparity when it comes to Hispanic families. We will conduct research to study its veracity.
- CHADIS: discuss the scaling up and spread including its sustainability.
- Pursue ways to improve race and poverty data collection within HMG efforts to ensure we are addressing challenges that exist across the state for vulnerable populations.
- Increase partnerships with child-serving programs such as Women Infants and Children and home visiting to leverage areas of mutual opportunities and benefits for families.
- Business engagement: discussion will center on how MCH/ECCS can leverage relationships with the business community to promote developmental screening knowledge within the workforce.

DEThrives ran a single image newsfeed ad to promote HMG at Delaware 211 services. The ad targeted women and men aged 18-65+, new parents, parents of children 0-12, and grandparents who lived in Delaware. The objective was to increase site traffic to the HMG landing page. The HMG landing page earned 474 pageviews during the quarter (Oct. – Dec. 2022) and 130 of those sessions stemmed from users clicking on this post. In terms of performance metrics, the ad reached over 18K users, and had over 48K impressions, earned 192 clicks. In terms of the social engagement metrics, the post earned 26 post reactions, 1 post comment, 9 post shares, and 4 post saves.

The HMG system was first developed in November of 2012 with the help of the MCH Bureau of the DPH and a partnership with Delaware 211. A decade later, HMG Delaware celebrated its 10th anniversary. The title of the event was "A Decade of Help Me Grow Delaware: Where Families Grow, Learn, and Thrive" and was sponsored by the Delaware Health and Social Services (DHSS), United Way of Delaware, and Delaware 2-1-1. It was a free, all day, in person, two-part, event hosted at the Route 9 Library and Innovation Center in New Castle, Delaware. The two-part session was made up of the morning and early afternoon that catered to partners and stakeholders while the second part of the event offered in the early afternoon acted as a Community Resource Fair for the general public, where a Books, Balls, and Blocks (BBB) session was offered for children and their parents.

The first part of the day was kicked off by sharing a proclamation reading recognizing that November 9th, 2022, will be known as the "Help Me Grow/211 10th Year Anniversary" in the state of Delaware. It was then followed by talks from different speakers such as Ms. Kimberly Martini-Carvell, the HMG National Director, who provided a recording of her personal speech for Delaware's HMG program and also mentioned HMG national goals and direction. Fireside style chats were done by Norma Everett, an Early Childhood Advocate, Matthew Denn who led the 2009 legislation that mandated private insurers to cover Developmental Screenings, and Dr. Doug Tynan, a retired Child Psychologist from Nemours and was a huge contributor in the QT30 messaging. Two participants shared their experiences of using HMG services, how it has helped them and their families, and any advice they could give to others about the free HMG services.

About 41 people registered for the event beforehand, there were about 60 participants present throughout the day, and over 10 vendors who participated in the Community Resource Fair. Giveaways were also given out to families who were present during the second part of the day as a thank you. An evaluation was also provided after the event to receive feedback from the two-part event. Based on the feedback, most people appreciated learning the HMG history, the HMG recognition and accomplishments, the real-life stories of HMG participants, and networking with other agencies.

News of this event was shared on social media with partners reposting it. There was also an eblast message that went out to partners and stakeholders to share news of the event and to increase enrollment. After the event, DHSS released a Press Release sharing news of the celebratory event.

Dental Visit

According to the 2020/2021 National Survey of Children's Health (NSCH), 77.3% of Delaware children, ages 1 through 17, have had a preventive dental visit in the past year. Delaware is slightly above the national average of 75.1% of children with a preventive medical visit. The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders. Our stakeholders recognize that dental health equals overall health and the Title V team has identified that MCH is able to align our collaborations and resources to make an impact on this population.

During the last reporting cycle, MCH supported the Bureau of Oral Health and Dental Service (BOHDS) efforts to complete the Basic Screening Survey. The students in 3rd grade were screened in addition to students in kindergarten. Challenges persisted due to fears of COVID, increase of COVID cases during the screening period and additional factors. However, the total number of students screened was four times higher than the last survey completed over 5 years ago. A total of 4,236 students participated in the survey. 2,088 third grade students were screened and 2,135 kindergarten students. The following document represents a snapshot of the data that will be in the upcoming report.

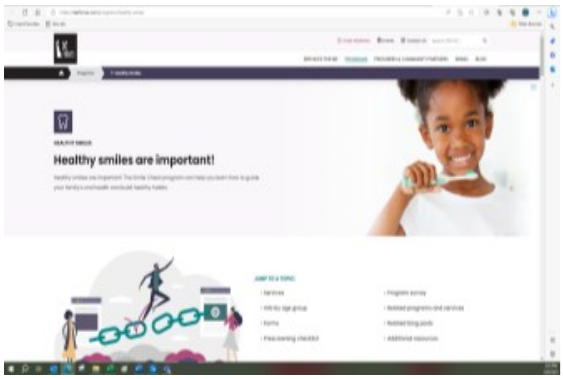
ASTDD Results.pdf

BOHDS released the report detailing the results of the survey in 2023. The information will be used to assist with updating the oral health state action plan and developing oral health programs. Also attached is the Delaware Health and Social Services Dental Data Brief. We learned that 53% of Delaware's third grade children have at least one tooth with decay experience, which is lower than the national average of 60%. In addition, 45% of Delaware's kindergarten children have at least one tooth with decay experience, which is higher than the national average of 42%. In Delaware, there are significant oral health disparities. Tooth decay remains more common in children from lower-income household and among Hispanic children.

DE Data Brief_2022.pdf

The Delaware Smile Check Program originated as a school-based preventive oral health outreach and case management program in 2017 that provided dental screenings, fluoride varnish applications and referrals to a dentist. Over time this program has been evaluated and has transitioned to meet the needs of the community and improve outcomes. From July 1, 2022, through May 30, 2023, the Delaware Smile Check Program provided a dental screening to 2,670 students. During that same time frame, 2,550 students received a fluoride varnish application. There were162 students that were identified as having an urgent dental need (pain or swelling) and 742 with suspected dental decay. Through case management we were able to confirm 269 students that received follow up treatment with a dental provider in the community.

During the last reporting cycle, an oral health landing page (https://dethrives.com/smile-check) was posted live on our DEThrives.com website. The term "Healthy Smiles" is where general oral health information is placed on the DEThrives site in collaboration with the Bureau of Oral Health and Dental Services (BOHDS). The term "Smile Check" is the name of the dental program by the BOHDS, known as the "Delaware Smile Check Program". The "Smile Check" landing page easily allows the public to enroll their child for virtual or in-person school dental services. Organizations and schools are also encouraged to participate in this program and to receive "Smile Check" services by signing up. Items such as the "Dental Resource Guide", dental tips for children with special needs, a prescreening checklist, on-site and virtual forms are available in both English and Spanish.



After more than two years of planning and preparation, our newly designed DEThrives website when live on April 3, 2023. The newly designed dental site still has all the same information that was on the original site, but it is now designed in a way where the user's experience and the website's functionality are significantly improved by making it

easier to navigate and find dental information.

MCH worked with the Bureau of Oral Health and Dental Services to create an online sign-up form for the Delaware Smile Check Program. Students can access the online form through a QR code or a link. During this reporting cycle, 689 student consent forms were completed, and 115 school/organizational consent forms were completed using the DE Thrives website.

The Bureau of Oral Health and Dental Services has been working with schools to integrate dental into the school wellness centers. A portable dental clinic was opened in Warner Elementary School. It includes 4 dental chairs and offers comprehensive examinations, dental cleanings, fluoride application, dental sealants, and oral health education. In addition, we are looking at options to expand into taking x-rays and restorative treatment. To date, 38 students have been seen at the Warner Elementary School location.

- 38 students received an examination
- 30 students have received a dental cleaning
- 29 students received a fluoride varnish
- 83 sealants were completed
- 20 of the students were found to have dental decay and connected to a provider for treatment

MCH assists with marketing oral health activities, events, education through DE Thrives Facebook, Twitter and sharing with other Title V partners. The Bureau of Oral Health and Dental Services coordinates with MCH to release information through DEThrives at a minimum monthly on Facebook and Twitter. This includes preventive education and oral health events available to the public to support children and their families to maintain good oral health and improve oral health literacy. Together, MCH and BOHDS are also in development of blog posts to raise public awareness and to emphasize the importance of good dental habits. We are currently reviewing old dental related blog posts and checking to ensure the information and hyperlinks are correct and up to date with the resources provided. We are also ensuring the language and tone in which the post was written are appropriate. We are attempting to have general dental health blogs in addition to holiday related ones with certain messaging (e.g., a Halloween related blog post to reduce the consumption of sticky, sugary sweets).

The Bureau of Oral Health and Dental Services is dedicating a considerable amount of effort and time towards drafting and garnering support to make changes to current Delaware legislation. Encouraging dentists to practice in Delaware has been hindered by the requirement that “All applicants for Dentist licensure, regardless of years in practice, must pass the Delaware Practical Board Examination in dentistry and the Delaware Jurisprudence Examination.” This test has often been an obstacle to encouraging dentist to practice in Delaware. The first step to improving access was to remove the Delaware testing requirement for dentists who will be employed by a Federal Qualified Health Centers and the Bureau of Oral Health and Dental Services to make it easier to attract dentists for these organizations. In May 2023, Senate Bill 28 was passed allowing for a new type of license for these organizations to bypass the Delaware Practical Board Exam. Below is a link to the legislation.


Senate Bill 28 2023.docx

The Bureau of Oral Health and Dental Services has been working closely with the Redding Consortium and the Department of Education to pass legislation that will require all students entering kindergarten to receive a dental screening. This legislation is significant because it will allow us to gather data for all students in kindergarten, provide a point for early intervention and improve dental literacy. This bill passed the house on May 9, 2023, and is on the Ready List. Below is a link to the legislation.


House Bill 83.docx

Dental Hygienists from the Bureau of Oral Health and Dental Services hosted 16 educational events at Delaware Public Libraires for Storytime. Each session was one to two hours long. Children are read a book about oral health, given an oral health activity and assistance is provided to families if they need help with finding a dentist, securing dental insurance or have dental questions. In addition, two educational sessions were held about oral and systemic health. The sessions included doctors and nurses from Christina Hospital.

Our Fluoride Varnish training program is active and currently being advertised. This is a program where a BOHDS

dental hygienist provides training to staff at pediatric medical offices for applying fluoride varnish during a well child visit for children under the age of five, who do not have a dental home. Smile for Life courses are assigned prior to training to allow staff to ask any questions. Topics such as, age of first dental visit, how to take care of teeth, bottle mouth, nutrition and appropriate dental supplies and toothpaste are discussed with staff. All staff are given the BOHDS dental helpline phone number if they need assistance, or the families need to be connected to a provider or secure dental insurance. After training is provided, the office is given a certificate indicating they completed the training. BOHDS supplies infant and child toothbrushes and toothpaste as well as infant tooth wipes and education materials are distributed to the offices who are providing fluoride varnish. To date, 5,681 dental education, toothbrushes and tubes of toothpaste have been distributed to pediatric medical offices for their patients.

BOHDS coordinated and participated two Special Olympics events during this reporting cycle. This included dental screenings, education, and providing assistive devices for oral health products and instructions on use. Over 100 participants received dental screenings and education and 46 participants required assistive devices for toothbrushing. In addition, Reach out and Read is an early literacy program collaboration with oral health education. BOHDS buys the books needed for this program, provides fluoride varnish training to staff who are participating, as well as supplying the oral health supplies. During this past grant cycle, 1,000 Brush, Brush, Brush books were purchased and distributed by a dental hygienist. We recently ordered an additional 3,000 books to continue with this partnership.

AAP OVER VIEW REACH OUT AND REA

MCH continues to support BOHDS through expanding oral health information, messaging, and marketing on the Delaware Thrives website. Between December 27th, 2022 – January 9th, 2023, DEThrives ran a single image newsfeed ad to promote the Delaware Smile Check program. The ad targeted women aged 18-45 (since women usually schedule their family's health appointments), new parent and parents of children aged 0-17 audiences who live in Delaware. The objective was to maximize clicks to the Healthy Smiles program page. There was an average 0.39% click through rate (the percentage of impressions that turn into views). The last time there was a promoted dental post was back in May 2022 and that post received a 0.16% click through rate. So, this ad far surpassed that previous number. From this post, the Healthy Smiles program page earned 56 sessions with the average user spending 28 seconds on the site. In terms of the social engagement metrics, the post earned 6 post reactions, 2 post saves, and 1 post share.

MCH has also helped build a lasting connection and relationship between CYSHCN and BOHDS. Information has been shared to assist families with finding a dental provider. The Delaware Smile Check Program has targeted schools that have many children with disabilities and collaborated with dental specialist that can meet the needs of the families for treatment. As the transition of the Family SHADE project took place in October of 2021, the Family SHADE website continued to promote the Bureau of Oral Health and Dental Services (BOHDS) to expand their reach to the CYSHCN population by putting the BOHDS information on their Family SHADE website. This continues to afford families easy access to dentists that are able to serve their CYSHCN. Having the BOHDS information on the Family SHADE website continues to make it more convenient for families to access the dentists that will best serve their CYSHCN and eliminate them calling each dentist to ask if they can serve their child.

Child Health - Application Year

Developmental Screening

Delaware continues to place a great focus on developmental screening as the Department of Education finalizes its mandate (HB202) to ensure all licensed child care facilities across the state conduct annual developmental screens using the Ages and Stages Questionnaire (ASQ). The Division of Public Health, through the ECCS/HMG program continues to support these efforts in addition to implementing and supporting the promotion of developmental screening using the Parents Evaluation of Developmental Status validated instrument within the health care setting. The ECCS/HMG program partners with Delaware Chapter of the American Academy of Pediatrics and the Medical Society of Delaware to accomplish this effort.

For the 2024 application year, the ECCS program continues to increase partnerships with the Department of Education's Office of Early Learning to assure a comprehensive approach to attaining universal developmental screening in all early care and education (ECE) facilities. The ECCS program serves as a voice to address developmental screening efforts within health care and push a systems and integrated approach to the mandate. Additionally, the DPH/MCH evaluator serves on the Core Team and provides data collection and analysis consultation.

The Birth to Three (B23) program continues its collaboration with Maternal Child Health program through the Help Me Grow@211 centralized access point. The B23 program funds two full-time staff who provide support and timely follow-up to developmental screens administered within the 16 school districts and child care facilities, mandated to conduct developmental screens annually. This support will be even more significant as the state rolls out the universal developmental screening legislation by end of 2023.

The ECCS program continues to track the Ages and Stages Questionnaire (ASQ) and PEDS screens. Memorandum of Understanding (MOU) between the Office of Early Learning (OEL) and MCH enables the sharing of ASQ data. ASQ and PEDS data analyses is shared with the Help Me Grow (HMG) Advisory Committee which has over 30 members representing multi-sector child serving programs. Through the Continuous Quality Improvement sub-committee of the HMG Advisory Committee, the data is analyzed for trends and further improvement activities.

The partnership between the Women Infants and Children program (WIC) became stagnant due to the pandemic and the MOU that was drafted was put on the shelf. That said, there has been great improvement as the WIC program has included referrals to HMG@211 on their system to address developmental health and issues pertaining to the social determinants of health this year. HMG@211 has been receiving referrals from WIC in last two months and the WIC program receives the feedback loop on the outcomes for those referred families. Additionally, there are plans for the Home Visiting lead and HMG@211 manager to attend WIC's supervisors' meeting to present an overview of how the two programs could strengthen their relationships with the WIC program.

For the past decade, the ECCS program has partnered with and funds the Delaware Chapter of the American Academy of Pediatrics to provide technical assistance for pediatricians and family practices that are implementing the Parents' Evaluation of Developmental Status (PEDS) tool. This effort has proved difficult as physicians tend to be reluctant for one reason or another. As a result, the number of pediatricians using the PEDS tool has declined. However, they show an interest in early literacy especially through the Reach Out and Read program. As a strategy, we plan to package a number of early childhood programs such lead screening, oral health, Help Me Grow@211, and the Food Bank while leveraging the Reach Out and Read program for the coming year.

Through a MOU with the Office of Early Learning, the ECCS program is able to collect and analyze ASQ screens. Below is a record of screening results in 2022. The results reflect the screens of the two preferred developmental screening instruments used by health providers (PEDS) and early care and education providers (ASQ).

For this application year, a total of 9,214 PEDS Online screens were completed on children 0-59 months between January 2022 to December 2022. This corresponds to an estimated 6,574 unique or unduplicated children. There's a decrease in the number of screens since four pediatric practices are participating in the CHADIS pilot project. Of the total number of screens administered (9,214) by pediatric practices, 4.7% (426) were high risk for delays. Additionally, of that number of screens (9,214), 2,559 (94.3%) of children between 18 to 24 months screened for the MCHAT, passed the test while 155 (5.0%) failed. In the application of the ASQ, the ECE providers administered 7,510 screens for the 2022, representing about 7,052 unduplicated children. The majority of the children screened ranged from 48-59 months (29%).

The number of pediatric practices using the PEDS tool remain consistent at 20, However, we plan to increase outreach through the CHADIS project to sway practices who are on the fence. It would be a great improvement to

have Federally Qualified Health Centers do developmental screening on a consistent basis.

In the Early Care and Education setting, the administration of the ASQ has been robust since most of the school districts across the state signed on to use the ASQ as the preferred tool. The backlog of completed ASQ screens within the Birth to Three range which needed follow-up has been eliminated since the additional hiring of two new full-time staff to join the Help Me Grow/2-1-1 staff.

We continue to partner with the Delaware Chapter of the AAP on an online education webinar targeting pediatricians and family practitioners. The training provides an overview of developmental screening best practices, Delaware's developmental screening initiative, PEDS online tools, the referral process, early intervention services, including care coordination and linkages to community resources (Help Me Grow/2-1-1). Work on this project has been stalled for some time with the departure of the IT staff working on it. Fortunately, another staff has been identified to continue the work. We will continue with the effort to expand the curriculum to include information on Lead Screening, oral health, Food Bank, HMG@211, and the Reach Out and Read program. The course will be made available on an online education platform that health providers or other stakeholders can access for professional development. The webinar will made available on the DEAAP website including DEThrives – the Family Health Systems/MCH website.

This year the DEAAP received matching grant funds of $250K from the Longwood Foundation. The AAP was then successful in raising funds for the $250K matching funds for a total of $500K. This enabled Delaware to officially become a Reach Out and Read affiliate. Working with the Reach Out and Read (ROR) national team, staff was hired to manage the program in Delaware. This full-time position will help the outreach to pediatric practices to include not only the ROR program but all the other early childhood programs that will be bundled as a package.

Through Books Balls and Blocks activities, we continue with building parent/family leadership and capacity to advocate for themselves and their communities. This past year, the virtual sessions targeting children, birth to age three, led to the creation of "Parent Meet Up" sessions. This need became apparent since most of the parents would linger after their kids' sessions to address issues they were having in their families. The outgrowth of this need was a monthly virtual meeting targeting parents. Once a month, a 15-minute general information on parenting such as "potty training" or "feeding" is shared with parents and then the agenda is open for parent-generated questions and discussions.

A collaboration with HMG@211 has also led to reaching a broad array of families. Staff at HMG@211 promote BBB events and other HMG events by sending text messages to the target population the day before a session, including reminder emails to registrants. We continue organizing community events (virtual and in-person, when appropriate) such as Books, Balls and Blocks events to increase families understanding of developmental screening and milestones, while creating opportunities to administer the Ages and Stages Questionnaire screener.

Events organized in the past year include collaboration with libraries, United Way of Delaware, Winterthur Museum, Managed Care Organizations such as Highmark, community centers and Chi Eta Phi Sorority Inc., among others. For the past year, BBB reached over 60 families virtually and face-to-face. There was also a concerted effort to organize events targeting fathers. Though not well attended, we recognize the impact of dads on their children and plan to organize another such event. Since July 2020, over 30 Online BBB sessions have been carried out with 124 online evaluations completed.

The satisfaction evaluation from parents shows most parents would recommend the BBB events to friends and families since they found it enjoyable and satisfactory. The majority of the participants indicated the BBB sessions were helpful in assessing their child's growth or skills. They also indicated a willingness to follow up with early intervention services should a developmental screen indicate their child was at risk for delays.

The BBB webpage, Facebook posts, and streaming on DEThrives shows views from other users who visit the social media page to view the BBB online sessions with their children. Recent data shows that virtual recordings have been viewed over 200 times beyond the initial posting.

The ECCS program is still in its quest to answer the question "How many high-risk screens were referred to early intervention and what were the results of those referrals?" Through the engagement and working steadily (over the past 3 years) on the CHADIS pilot project we're getting closer to solving the problem.

Child Health and Development Interactive System (CHADIS) is a web-based patient engagement and data collection system for comprehensive developmental/physical and mental health for all ages. The pilot project includes the Delaware Chapter of the American Academy of Pediatrics, Medical Society of Delaware, Division of

Public Health, Early Intervention (EI) programs, Child Development Watch (birth through 34 months), Child Find (3-5 years), and Help Me Grow@2-1-1- (Centralized Access Point). These partners are working with four pediatric practices representing Delaware's three counties that have diverse patients and provide Medicaid and non-Medicaid services. This project will enable physicians to screen families during well-child visits and track any referrals to early intervention services.

Over the past two years, the pilot project has been successful in building a referral platform for users to send and receive developmental screen results to either early intervention services such as Child Development Watch or Child Find, and also for EI programs to send feedback to the source of the referral. They also have the ability to send referrals to Help Me Grow @211 for referrals dealing with social determinants of health. Additionally, all partners have been trained on how to use the platform including a successful integration of pediatric practice Electronic Medical Records (EMR) to the CHADIS system.

In November 2022, the CHADIS went live which enabled the partners to access it within their EMRs. In the spirit of continuous quality improvement, the ECCS and AAP partners have met with pediatric practices and early intervention programs to determine their satisfaction. The response has overall been positive on all sides; however, there are areas of improvement in capturing the outcomes for referred families after EI services, feedback loop to physicians, and the re-training of EI staff to be more familiar with the referral platform, especially since there are staffing changes.

The next step in the very short term, is to plan for the scale up and spread of the system among pediatricians and other child serving programs that do developmental screens. This will be a great improvement of developmental screening processes in health care; however, the system has been structured to integrate with early learning partners. The success of this pilot could be a game changer for how referrals are made in healthcare and subsequently child care centers across the state. DPH will need the support and buy-in of stakeholders and gatekeepers for the scale up and spread of this project in the very near future.

As Delaware gears up to implement universal developmental screening statewide, MCH looks forward to the expansion it brings to achieve early detection. The mandate ensures that families who previously didn't have access to developmental screening, do so. The effort, as mentioned earlier, is led by the Department of Education and targets the early child care and education system. While this is a great feat and has to be applauded, it fails to consider developmental screening happening within the health care setting. This approach is a challenge to the early childhood community's vision of achieving a systems approach that serves the "whole child". MCH is committed to work with its DOE partners to assure the establishment of development screening in the early child care and education arena. MCH will collaborate in areas such as messaging and data sharing to ensure consistent messaging for providers and parents alike.

Through our social media platforms, DEThrives website, Instagram, You Tube, and Facebook, we have posted messages on the importance of developmental screening and milestones. We have revamped the website and updated messaging to be consistent with those in the early childhood and education arena, to reduce confusion parents face when challenged with different messaging on the topic.

Plans for the Coming Year:

- Continue partnership to support the Office of Early Learning with the implementation of the universal developmental screening legislation.
- Support efforts to increase the number people, providers, and parent leaders trained to use the ASQ and PEDS.
- Continue collaboration with early intervention programs to improve referrals following high risk developmental screens to ensure families are connected to treatment services.
- Work with the DEAAP and Medical Society of Delaware to assist enrolled practices to address challenges and improve their performance and support appropriate utilization of PEDS Online during well child visits.
- Promote early detection by encouraging physician practices to increase developmental screens and link families to community resources and services.
- Continue with the continuous quality improvement of CHADIS pilot project in preparation for the scaling up and spread within healthcare.
- Through Books Balls and Blocks activities, continue building parent/family leadership and capacity to advocate for themselves and their communities.
- Continue organizing community events (virtual and in-person, when appropriate) such as Books, Balls and Blocks events to increase families' understanding of developmental screening and milestones.
- Continue opportunities to promote Help Me Grow@2-1-1 as a one-stop-shop for linkages to community

resources and referrals, with a special focus on health providers.
- Continue with the CHADIS pilot project to ensure pilot practices are fully implementing the platform. Collaborate with partners to scale up and spread use within healthcare.
- Support efforts by the AAP to engage health providers to sign up for the Reach Out and Read program.

Dental Visit

Delaware is slightly better than the national average of children, ages 1 through 17, who have not had a preventive dental visit in the past year. According to the 2020/2021 National Survey of Children's Health, 22.7% of Delaware children have not had a preventive dental visit in the past year, which is only slightly better than the national average of 24.9% of children who have not.

MCH feels it is critical to continue to collaborate with the Bureau of Oral Health and Dental Services (BOHDS) while they develop new approaches and integrated new technology into schools and other programs to continue to provide education, dental screenings, and case management to the most vulnerable populations.

MCH (Maternal Child Health) will continue to support BOHDS (Bureau of Oral Health and Dental Services) efforts in reporting the results from the Statewide Oral Health Survey ASTDD. The survey was completed on 2,088 students in third grade and 2,135 students in kindergarten, between January 2022 – April 2022. The information was used to produce a report to be released to stakeholders that identifies the gaps in oral health access to care, insurance, and other barriers to care which were identified through the survey. BOHDS will develop access to care plans, preventive dental programs, and methods to reduce barriers to care to resolve inequities associated with care during the 2023/2024 fiscal year.

BOHDS will continue with Delaware Smile Check Program providing preventive dental treatments and case management to assist the public with removing barriers to dental treatment and improve oral health literacy.

MCH finds it beneficial to support BOHDS in their efforts to aid children who lack access to dental care, with the recent pass of legislation. This legislation will now allow alternate paths for dentists to obtain a license in Delaware when employed by a Federally Qualified Health Center (FQHC) or DPH, which have been a barrier to hiring a dentist in the state. MCH also sees the value in supporting legislation that was presented in 2023 after the pilot at Colonial School District. This legislation would require all newly enrolled students to receive a dental examination or screening in the 12 months prior to entering school for the first time. If legislation passes, BOHDS will work with the Department of Education, superintendents, and schools to develop processes, procedures, and documents necessary to begin the mandatory screenings on all kindergarten students in Delaware. In addition, MCH will support future legislation to expand the functions of a dental hygienist and dental assistant to be consistent with their level of training. BOHDS will begin a pilot program in preparation for the 2025 statutory changes mandating dental screening for kindergarten students. The goal is to screen 5,000 kindergarten students in 2024.

MCH supports BOHDS efforts to incorporate dental into school-based wellness programs across the state to improve access to care for preventive dental treatments. BOHDS has made dental preventive services, dental cleanings, examinations, fluoride, and dental sealants into one School Based Wellness Centers (SBWC) at Warner Elementary in 2023. BOHDS will continue to pursue expansion efforts for x-rays and restorative treatment to be offered. BOHDS will continue to collaborate with schools interested in including dental into their school-based wellness centers across the state.

Over the past few years Delaware has struggled to maintain the Delaware Oral Health Coalition. Changes in Directors, lack of resources, funding and COVID have prevented BOHDS from moving forward with an agenda, developing interest, and partners. BOHDS has built relationships with many community partners during this time that work toward improving the health of Delaware residents. The BOHDS Dental Director is making it a priority to reestablish The Delaware Oral Health Coalition in 2024 to address oral health access issues and work on improving oral health for all residents statewide. MCH will be supporting the reestablishment of the Coalition to continue the progress made advancing oral health care for children.

BOHDS will continue to expand their early intervention programs for pregnant women and infants. This includes education programs for pregnant women and infants collaborating with OBGYN, Lactation Specialists, Substance Abuse, and other organizations that serve infants and pregnant women. These programs target pregnant teenagers through DAPI and women who are struggling with addiction that are pregnant through DSAMH. Classes are designed to empower and inspire the women to self-advocate for the oral health of their children as well as themselves through receiving preventive dental treatment during pregnancy, and assuring their children receive routine preventive dental care and have a dental home by age one. This program has proven to be successful for the

women, infants, and other children in the family and MCH will continue to support the expansion of this service.

MCH finds it beneficial to support BOHDS' upgrade of their electronic dental software Dentrix to a new server. BOHDS has no other system available to enter information about patient procedures and conversations with the families regarding case management. Dentrix is the database that holds all information related to dental services and this information is shared with Medicaid through billing to report out for the state on the 416 reports for the Medicaid population. The data collected is not only shared with Medicaid but used to report data on our program activities to MCH and other stakeholders. Training and upgrading of the electronic dental records will improve data collection and system integration. In addition, dental is seeking to incorporate an epidemiologist into their organization to monitor oral disease, oral and systemic disease, population, special population, and capacity of oral health access to help target our programs and outreach.

MCH sees continued interest and benefit in supporting BOHDS with early intervention for dental services through various programs that target under age 5. BOHDS has provided training for fluoride varnish application, caries risk assessment and referrals to most pediatric providers in Delaware. A certificate is provided to offices that completed the recommended Smiles for Life Courses, participated in oral health training for all office staff and collaborated with one of the Division of Public Health Dental Hygienists during a well child visit to demonstrate how to incorporate billing, education, application of fluoride during the visit. BOHDS will continue with this program and expand oral health education and training to other healthcare professionals in schools, OBGYN offices and family practitioners.

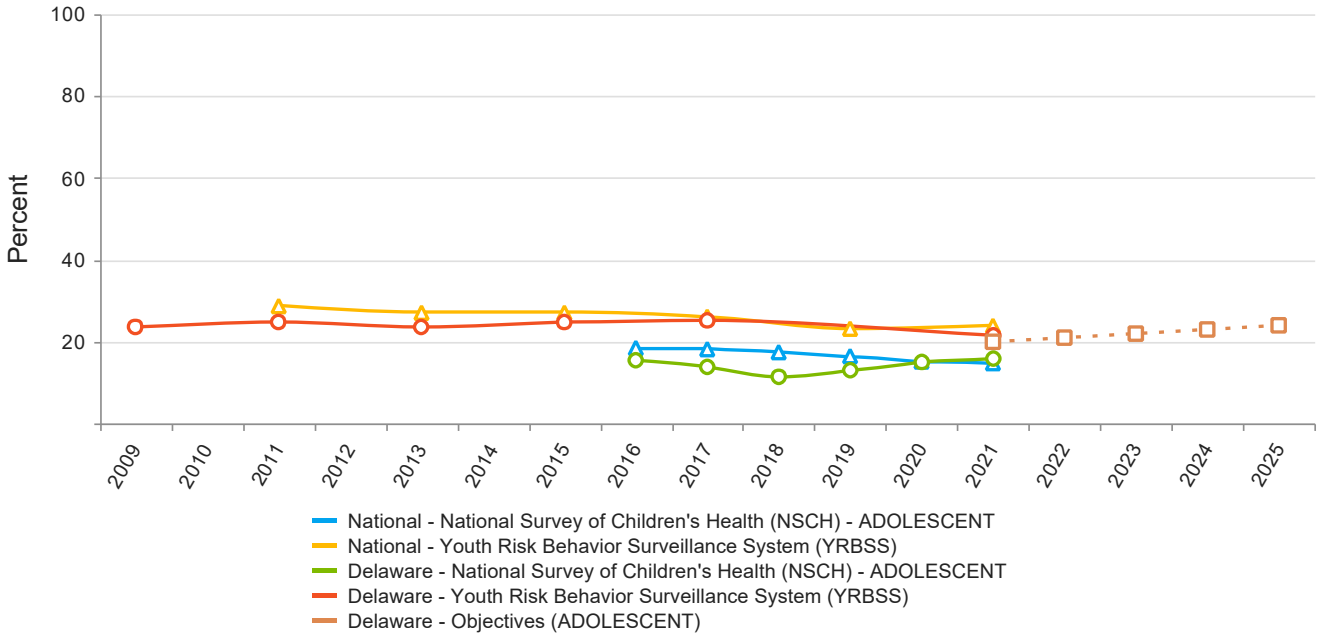
BOHDS will continue collaborating with Delaware AAP Early Literacy Committee by purchasing and distributing oral health books to pediatricians enrolled in the program and providing oral health supplies and educational materials for children under age five. BOHDS will also create oral health lesson plans that can be utilized by teachers, community workers, and medical professionals. In addition, outreach and education programs will continue to encourage vaccination for the Human Papillomavirus (HPV).

BOHDS has reorganized to dedicate a team for education that will focus on development and delivery of specialized oral health education and trainings for populations at greater risk for developing decay or injury and less likely to receive dental care. These programs will include individuals with systemic health conditions, people who are pregnant, experiencing substance abuse, people with disabilities, people with cancer, mental health challenges, over 21 enrolled with Medicaid or uninsured. Oral health will be promoted within the family, schools, workplace, and primary health-care system to reduce oral health inequalities, connect them to a dental home and improve oral health literacy. We will continue outreach and education about the benefits of fluoride and distribution of fluoride rinse for people living in areas with low or no fluoridation in the water or special populations at high risk for decay. MCH will support their efforts by continuing to market for their program, fairs, Storytime, education sessions, and newsletters through DE Thrives, Facebook, Twitter and over 200 community partners.

Adolescent Health

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	21
Annual Indicator	25.1	25.1	25.1	21.6
Numerator	9,329	9,329	9,329	8,529
Denominator	37,230	37,230	37,230	39,459
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2017	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	21
Annual Indicator	11.6	13.0	14.9	16.0
Numerator	7,828	8,196	9,878	11,362
Denominator	67,249	62,967	66,257	70,996
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	22.0	23.0	24.0

Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Determine which policy recommendations that address health promotion and disease prevention initiatives in schools and community-based settings that MCH can assist or lead implementation efforts.

Measure Status:	Inactive - Completed			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			Yes	Yes
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

ESM 8.2.2 - DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online resources and Tool Kit.

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			No	Yes
Annual Indicator		No	Yes	No
Numerator				
Denominator				
Data Source		MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

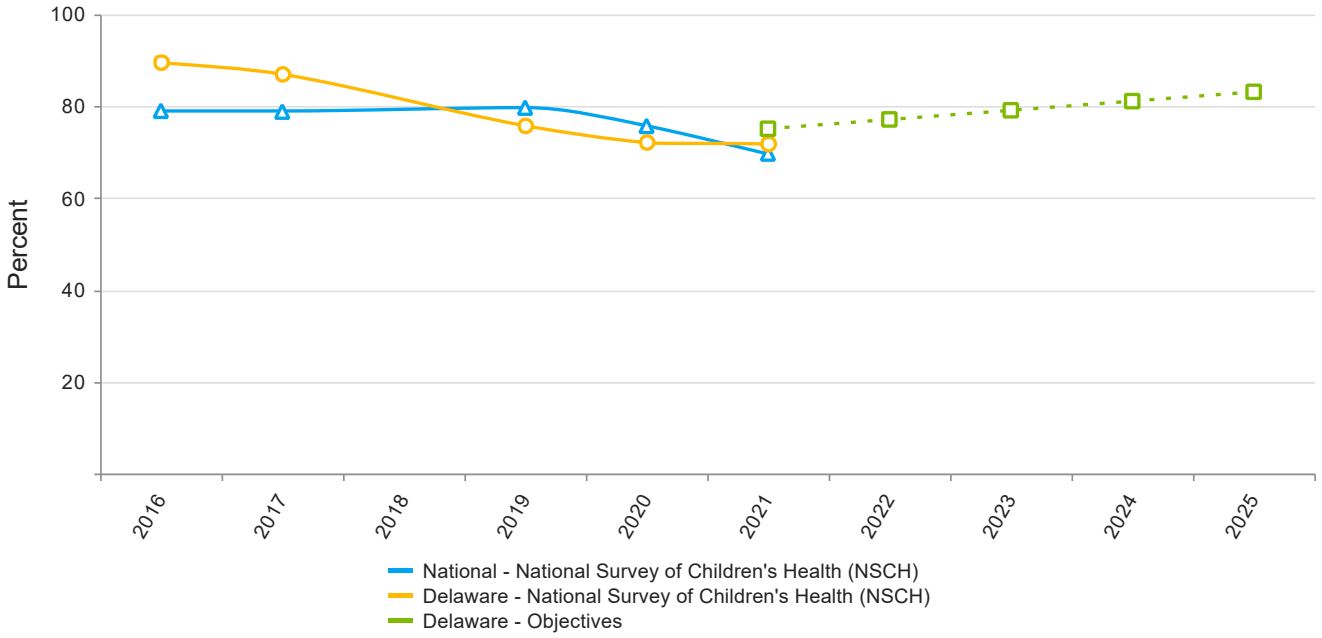
ESM 8.2.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	14.3
Numerator	6
Denominator	42
Data Source	PANO MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	12.0	15.0

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2019	**2020**	**2021**	**2022**
Annual Objective			75	77
Annual Indicator	86.9	75.7	71.9	71.8
Numerator	62,537	47,654	48,388	51,420
Denominator	71,966	62,974	67,333	71,653
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	79.0	81.0	83.0

Evidence-Based or –Informed Strategy Measures

ESM 10.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			25	75
Annual Indicator		29.2	76.2	74.2
Numerator		883	4,902	4,958
Denominator		3,027	6,429	6,678
Data Source		SBHC Program Data	SBHC Porgram Data	SBHC Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	75.0	80.0	85.0

ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees

Measure Status:		Inactive - Replaced		
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			2	15
Annual Indicator		15	15	15
Numerator				
Denominator				
Data Source		SBHC Program Data (1 Medical Vendor)	SBHC Porgram Data	SBHC Porgram Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

ESM 10.4 - % 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
Annual Objective	
Annual Indicator	48.2
Numerator	4,530
Denominator	9,407
Data Source	SBHC Program Data
Data Source Year	2021
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

ESM 10.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	0.1
Numerator	99
Denominator	140,263
Data Source	DOE Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	0.2	0.3

State Action Plan Table

State Action Plan Table (Delaware) - Adolescent Health - Entry 1

Priority Need

Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2025.

Strategies

Partner with adolescent serving organizations or agencies, including but not limited to family planning, substance abuse and/or community colleges to promote adolescent well visits.

Improve data collection at SBHCs

Communicate with and share resources with school nurses statewide to promote adolescent well visits.

Provide school-based access to confidential mental health screening, referral and treatment that reduces stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.

Ensure adolescents are enrolled in a health insurance program.

Use media strategies (e.g., facebook and instagram posts, websites) in conjunction with other strategies to promote comprehensive adolescent well visits and healthy lifestyles.

Partner with SBHC and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits.

Continue to work with our partners and health providers to implement the 13 strategic goals with the SBHCs which are a result of the SBHC strategic plan.

Collaborate with DOE and the DE State Education Assocation (DSEA) to promote mental wellness.

ESMs	Status
ESM 10.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.	Inactive
ESM 10.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed	Active
ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees	Inactive
ESM 10.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.	Active
ESM 10.5 - % of children and adolescents receiving services for Project THRIVE	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (Delaware) - Adolescent Health - Entry 2

Priority Need

Empower adolescents to adopt healthy behaviors.

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

Increase the percent of adolescents students who are physically active at least 60 minutes a day to 49%.

Strategies

Promote physical activity counseling during well-child visits including SBHC visits.
In collaboration with PANO, increase social marketing media and public communication (posters, flyers, etc.) promoting healthy lifestyle and available resources such as bike and walking trails.
Participate in Delaware "cluster collaborative meetings" to encourage coordination among DOE, DPH and DSAMH to address adolescent health and wellness
Align with Whole School, Whole Community, Whole Child model and develop a strategy that includes coordination and collaboration with child and adolescent health priorities.
Partner with SBHCs to provide COVID 19 strategies, mitigation practices, testing, vaccinations and resource allocation to middle and high school students as well as their family members.

ESMs	Status
ESM 8.2.1 - Determine which policy recommendations that address health promotion and disease prevention initiatives in schools and community-based settings that MCH can assist or lead implementation efforts.	Inactive
ESM 8.2.2 - DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online resources and Tool Kit.	Inactive
ESM 8.2.3 - Increase the percent of locations implementing the Triple Play model within DE schools.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health - Annual Report

Adolescence is a crucial phase in each person's life. Adolescence is the period of transition between childhood and adulthood. The many physical, sexual, cognitive, social, and emotional changes that happen during this time can bring anticipation and anxiety for both children and their families. Understanding what to expect at different stages can promote healthy development throughout adolescence and into early adulthood. It is also a time of multiple transitions involving education, training, employment, and unemployment, as well as the development from one state of life to another.

Puberty is a unique life cycle that offers people particular challenges and opportunities. Adolescence is considered a crucial phase in human life that requires extreme parental care, guidance, and empathy. Only with caution, we can ensure that our youth grow into healthy adults who can help improve our society and become their leaders for a bright and prosperous future. Therefore, the goal of effective youth care requires systematic steps to prevent, detect and treat physical and mental disorders in young people.

Adolescence is an important time for promoting good health and preventing disease. Unfortunately, this important time is one that is sometimes overlooked. Adolescent health includes the physical, social, emotional, cognitive, and intellectual domains. It is important to understand the factors that can affect adolescent health so that organizations and individuals who work with youth can support the health and healthy development of all adolescents.

Adolescent Well-Visit

According to the 2020/2021 National Survey for Children's Health (NSCH), the percent of Delaware adolescents who have had a preventive medical visit in the past year is 71.8%, which is only slightly above the national average of 69.6%. During the 2019/2020 combined results, 71.9% Delaware's adolescents had a preventive medical visit. We are holding steady with our numbers, but still have much work to be done. During Delaware's 2020 Needs Assessment, our stakeholders identified the adolescent well visit as the number two priority for this population domain and was ranked 7th important, overall. In general, preventive medical visits declined over 10 percentage points during 2016 through 2021.

Using National Survey of Children's Health (NSCH) data for 2016-2021, Delaware saw a 5-percentage point decline in two or more ACEs from 21.9% in 2019 to 16.4% in 2020. During the same timeframe, the U.S. saw 1-percentage point decline in two or more ACEs from 18.7% in 2019 to 17.4% in 2020. However, in 2021, the percentage of two or more ACEs among Delaware children 3-17 years was 17.8% (95%CI: 14.1-21.5), a one percentage point increase from 2020. In contrast, in 2021, the percentage of two or more ACEs among the U.S. children 3-17 years was 16.6% (95%CI: 15.8-17.3), a one percentage point decrease from 2020. In summary, two or more ACEs among Delaware children increased while in the U.S. it decreased, and the prevalence of two or more ACEs among Delaware and the U.S. children was not statistically different.

In partnership with Planned Parenthood of Delaware, training is offered for staff at School Based Health Centers (SBHCs) each year. Planned Parenthood 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 by Planned Parenthood of Delaware throughout the year. The following list represents trainings provided thus far this year. COVID-19 continues to impact Planned Parenthoods trainings, while some trainings remain virtual other trainings have been offered in person. The following courses have taken place thus far:

Professional Curriculum Training	In person	September 2022
Curriculum Booster	In person	October 2022
Supporting LGBTQ+ Youth	In person	May 2023
Sext Ed Webinar	Virtual	January 2022
Bilingual Professional and Parent Workshop	In person	December 2022
Parent Night at Glasgow HS	In Person	November 2022
Teaching Youth About Healthy Relationships	In person	4/5/22
Approachable Parent Workshop	In person	5/11/22

COVID-19 impacted School Based Health Centers across the state of Delaware this past school year. All schools have returned to in person learning with the option of remote learning and/or hybrid learning, increasing the accessing to SBHC's at the beginning of the year. Many SBHC's implemented telehealth at the onset of COVID 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.

COVID 19 efforts to promote education, testing, vaccines, and awareness has been 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 2021/2022 school year, the School Based Health Centers in Delaware schools administered 4,094 depression screenings, 941 STD screenings, 1,753 Emotional (Mental Health) evaluations, and 4,395 risk assessments. In addition to this, SBHC's in Delaware completed 4,854 physical exams (well child), and 1,283 nutritional counseling sessions. These numbers have increased from the previous school year.

The SBHC Operational meeting this year was held in conjunction with Title X Family planning on October 20, 2022, and May 3, 2023. It comprised of mental health and medical providers from SBHC's, providers and administrative representatives from DPH Clinics, Federally Qualified Health Care Centers, Community Health Care Centers, Planned Parenthood as well as DPH/FHS staff. The Adolescent and Reproductive Health Department attended an Annual Summit with DHMIC on April 26, 2022. Training and topics focused on mental health and service delivery this year. Topics of discussion comprised of the following:

- Isabella Weber: Education Programs – Planned Parenthood of Delaware 10/20/22
- Frank Hawkins: Education and Awareness -AIDS Delaware 10/20/22
- Darren Jones Ed.D PCC- Unconscious Bias 10/20/22
- Lisa Gruss- Quality Insights 05/03/2023
- Mindy McGrath 340b for Title X – NFPRHA 05/03/2023
- Rose L. Horton, MSN, RN, NEA-BC, FAAN- Count the kicks/ Not on my Watch Consulting Partners 04/18/2023
- Kay A. Johnson – Johnson Policy Consulting, LLC 04/18/2023
- Rebecca Vahle, MA- Family to Family Network

In addition to the above training, the Adolescent and Reproductive Health Unit completed a in person training: Reunite-Reignite-Re-Energize innovating for the Future May 23-23, 2023 in Atlanta, GA with Family & Youth Services Bureau. This conference afforded DPH the opportunity to engage with multiple speakers, interactive workshop sessions and opportunities for networking.

Legislation was submitted and approved; House bill No. 129; awarding $170,000 to two high needs elementary schools per year until all high needs elementary schools are in compliance. There are currently 20 high need elementary schools in the state of Delaware. August 31, 2022, Baltz Elementary and January 24, 2023 Frederick Douglass Elementary became a State Recognized School-Based Health Center Provider. As a SBHC they have applied for and are eligible to provide medical, mental health care treatment and health education to promote a healthy lifestyle. These centers will serve children allowing access to services such as sports physicals, and mental health counseling.

Mental and Behavioral health services continue to be an area of growth and development. In some locations SBHCs continue to struggle to provide services to students due to staffing shortages and frequent turnover rates. While others are able meet and exceed their projected goals to service for mental and behavioral health services. Some SBHCs are still experiencing difficulties servicing students due to the parameters of COVID 19; many have implemented telehealth services to provide an increasing needed service to students.

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.

Two former SBHC Strategic Steering Committee Members, Dr. Jon Cooper (Co-Chair) and Dr. Aileen Fink (Co-Chair) along with Pediatrician and Chair of the DHMIC, Dr. Priscilla Mpasi, answered SBHC related questions to raise awareness of what SBHCs offer. The questions they answered were organized into short form videos in December 2021. A compiled video was created where all three speakers were featured in the short 2:25 minute long video and was posted online on September 23rd, 2022. This video acted as an introductory video informing the public of what SBHCs are, the benefits of receiving SBHCs services for adolescents, what SBHCs have accomplished thus far in Delaware, and ways on how to get involved by visiting DEThrives.com/SBHCs. The collection of videos can be viewed on the DEThrives' YouTube channel on its own playlist found here. Currently, there are 34 recognized High School and Middle School SBHC locations and 15 recognized Elementary School SBHC locations in Delaware. Last year, there were 32 High School and Middle School SBHC locations and 7 elementary School SBHCs. These participating schools are shown on this sitemap.

The Take Care Delaware Implementation Team, comprised of law enforcement, educators and mental health providers, spent 2018-2019 working together to create guidelines for implementation. In July 2019, Governor John Carney signed Delaware House Bill 74 (Take Care Delaware program), enabling a partnership between law enforcement and schools to adopt a trauma-informed approach to children who have been identified at the scene of a traumatic event. With that, we had what we needed to address the needs of children traumatized by violence in their homes, schools and communities.

DPH worked with members of the Delaware State Police (DSP), DOE, and the Department of Services for Youth, Children, and their Families (DSCYF) to explore implementation of a program called Take Care Delaware. This program is modeled closely to the Handle with Care Model that was implemented in West Virginia, Maryland and Tennessee. This program provides a statewide trauma informed response to child maltreatment and children's exposure to violence. The model states that "If a law enforcement officer encounters a child during a call, that child's information is forwarded to the school before the school bell rings the next day. The school implements individual, class and whole school trauma-sensitive curricula so that traumatized children are "Handled With Care". If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school."

As of this reporting period, the program has been implemented in 17 different school districts across the state of Delaware. In addition, 22 Delaware law enforcement agencies are participating in the program. This year's program began during the 2022/2023 school year (8/28/22 – 6/22/23) and there have been 2,253 incidents generated, which equals to 3,695 notices.

Once this is complete, Take Care Delaware will begin the process again of scheduling meetings with additional New Castle County Vo-Tech and Charter Schools, as well. We recently established a partnership with DSP to support this effort in an attempt to address the social determinant of health impact on children who are exposed to violence in the home.

For our selected prior of increasing the number of adolescents receiving a preventive well-visit annually to support their social, emotional and physical well-being, we have focused on access and availability of mental health resources.

We partner with our School Based Health Centers to address increasing the number adolescents who receive an annual preventive medical visit. Our School Based Health Centers offer mental health support and counseling so even though bullying was not selected during this past Needs Assessment, we still plan to support the emotional well-being of adolescents. MCH also understands that bullying behavior can be triggered at much earlier ages. With this in mind, our Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and our Early Childhood Comprehensive System (ECCS) programs have a focus on social and emotional wellness and provide materials and education to the

families and communities they serve. School Based Health Centers have also expanded into elementary schools in Delaware as well.

As with previous years, we have partnered with the Cooperative Extension, University of Delaware, Health & Wellness Ambassadors. U of D Health Ambassadors are a team of Teen Leaders and Adult Mentors who advocate for a holistic healthy lifestyle across the state. Health and Wellness Ambassadors are role models and official representatives and promotors who help plan and implement the Delaware 4-H Healthy Living Program aimed at improving the health of themselves, their peers, and their community.

4-H Healthy Living Program topics include nutrition, fitness, mindfulness, substance prevention and life skills. Their goals are to promote healthy lifestyle choices, create media about healthy living, participate in community outreach and education, asset building, education, and promotion, and to create and facilitate community change.
The Health Ambassadors are trained in various holistic health topics and often help to teach programs in the community. They also help to plan and work at local healthy living events across the state. Adult Leaders are often college-aged health science major or graduates. Teen Leaders receive mentorship and support from Adult Leaders as part of the program.

Poor mental health in adolescence is more than feeling blue. It can impact many areas of a teen's life. Youth with poor mental health may struggle with school, grades, decision making, and their health. Unfortunately, because of the Covid-19 pandemic, we were unable to fully partner with our School Based Health Centers and Delaware school districts during the 2022/2023 school year. Our hope was to work with the School Based Health Centers and the school districts to promote teens who need emotional and mental health treatment. Once SBHC's are fully staffed, our goal is to begin the partnership once again with the Department of Education and the school districts to promote a health messaging campaign to address mental health treatment.

During the past grant cycle, DPH planned to work with the Department of Education to sponsor a poster contest that promoted teens to seek emotional and mental health treatment, when needed. Unfortunately, there is oftentimes a stigma associated with mental illness, emotional disturbances and seeking treatment. The purpose was for youth and adolescents to know they can request assistance when dealing with mental illness – and not feel ashamed about it. Mental illness can affect a person's thinking, feeling, mood, or behaviors. Young adults should feel comfortable when asking for help when dealing with mental or emotional concerns and should never feel embarrassed.
The original intention was for all Delaware middle school and high school students to be eligible to enter a creation to the poster contest. DPH was trying to raise awareness and reduce the stigma associated with seeking and accessing treatment for mental health concerns. Our goal was to engage teens to creatively address the topic of mental and emotional wellbeing. Teens and young adults should be encouraged and feel comfortable when asking for help dealing with mental or emotional concerns. MCH strategized on the prizes, as we sought to keep them aligned with "health" in mind. We chose items such as an Apple or Garmin watch, Beats or AirPods, and a one-year subscription to Spotify. We hoped to get the youth excited about an item that could help keep track of health-related topics such as exercising, walking, dancing, etc.

The goal was to launch the poster contest during the 2022/2023 school year. We were hoping to have teachers take on the poster contest as a class project or an extra credit assignment. Unfortunately, the contest rules, criteria and prizes were considerably delayed and have not yet cleared through the Deputy Attorney General's approval process within DPH. At this point, we are revisiting the poster project altogether and may pivot from the original poster plan. DPH is in the process of working with the U of D Cooperative Extension to engage the health and wellness ambassadors on the creation of electronic mental health messaging.

Whatever the project will look like, we plan to share the winning exhibit or message, along with all entries, on our DEThrives website. We will also advertise the exhibits on our other social media platforms as well. We feel this could also reach more adolescents who are struggling with seeking help for emotional or mental health concerns. MCH plans to work with our Adolescent Health Program Manager to expand the poster contest in the future by working with the School Based Health Centers.

In 2020, the Delaware Department of Education (DDOE) developed and launched Project THRIVE, which helps children receive trauma-informed support from their schools, communities and caregivers. Project THRIVE provides free mental health services to eligible Delaware students. Services are available to students, grades pre-k through 12th grade, attending Delaware public schools, private schools, parochial schools and homeschools.

Project THRIVE services help students who are struggling with traumatic situations, such as physical or emotional abuse, community violence, racism, bullying, serious illness or death in the family, and more. Trauma can harm mental and physical health, and limit school success. Project THRIVE offers access to a local network of

professional mental health providers, youth centered strategies aimed at recovery and healing, tools for self-regulating emotions and behaviors as well as strategies to improve a student's engagement in school. Project THRIVE services help students:

- Process and understand traumatic situations
- Attend school regularly
- Better control emotions and behaviors
- Develop coping skills for managing stress at home and school

Children and youth thrive in the presence of thriving caregivers. Project THRIVE is committed to supporting caregiver agency and helping them become good consumers of mental health care on behalf of their children. The mental health provider of choice will be supported in delivering trauma-specific mental health services.

During this past grant cycle, MCH partnered with the Department of Education (DOE) to expand advertisement of Project THRIVE. The need for self-identification of trauma has become a critical component to the success of Project THRIVE. MCH is committed to the success of this program and worked to conduct preliminary research and determined the path forward to deliver targeted advertising to reach youth to increase self-identification and subsequently, utilization of Project THRIVE's services. The advertisement campaign is focused on building awareness of Project THRIVE to adolescents. The existing video was adjusted to fit each advertisement platform. We selected YouTube, TikTok, Instagram, YouTubeKids, Snapchat and Spotify to advertise with.

The Project THRIVE campaign started on July 21st, 2022, and ran for three months. The purpose of the campaign was to spread awareness of the Project THRIVE name, messaging, and services to children and their parents. Web analytics were analyzed almost every week from the communication vendor to ensure that maximum optimization was done periodically during the campaign. Our communications vendor optimized and proposed adjustments by platform based on performance and outcomes within those three months. They closely monitored the traffic that was coming from each platform and adjusted the ways the ads were being presented (changed the image, changed the posting time, etc.) depending on the analytical metrics collected during the campaign. From doing this, DPH in collaboration with DOE was able to receive optimal results with the help of the changing tactics to maximize the reach with the campaign, then the chances of a user seeing information about this service increases. The call to action was to visit the newly created anchor link, de.gov/projectthrive, which brings you to the section of the DOE webpage that is more consumer friendly rather than reading about background information on the services first that may cater more to professionals. Th other quick call to action would be to dial 2-1-1, or text your zip code to 898-211 to learn more information or enroll in the services which would direct the user to Help Me Grow (HMG) services in Delaware.

Campaign videos were created (short form videos ranged from 10 to 15 seconds and long form videos went up to 40-second-long videos) to target students and their families. Screenshots of the video are found below. Due to optimization strategies that were presented during the second month of the campaign, it was decided for the vendor to draft social media posts on a collaborative platform called Airtable. It is a platform where DPH, DOE, or other partners could easily utilize well after the campaign concludes to continue the Project THRIVE messaging online. These drafted Project THRIVE social media posts included the topic, the post's description, the graphic and/or video for the post (can be viewed or downloaded), and any additional DPH/DOE notes. It also houses the hardcopy materials that were made for the campaign. No edits can be done to the Project THRIVE Airtable link so it safe to share the link to partners so they can easily access and share its contents.

The communication vendor looked at three key performance indicators during the campaign. Looking at the impressions was the best engagement tool since that meant that we were increasing awareness of this service which was the primary goal of the campaign. Secondly, looking at the click through rate (CTR) shows the percentage

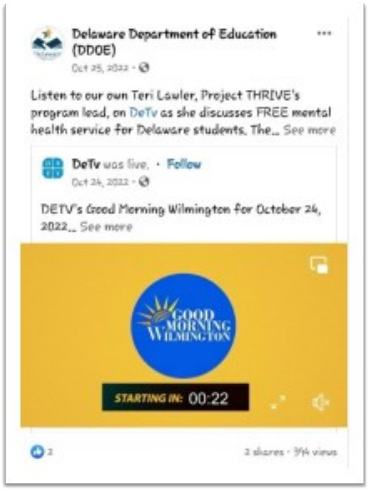
of impressions (number of times a post has been displayed) that turn into views. You can get an idea of the rate at which people are clicking on the ads. Lastly, analyzing the view rates shows the percentage of completed views divided by the impressions which shows you a percentage of people who have watched the entirety of the ad. Looking at the combined performance indicators, it would show us how many people are viewing the content and at what percentage are views turning into clicks and at what percentage are users actually viewing the entire ad. The communication vendor separated its analytical data by impressions, CTR, and view rates, but they also looked at each key performance indicator's numbers as a whole, by social media platform, and by creative to look for any additional patterns. The biggest limitation for the communication vendor during this campaign was not being able to have direct Google Analytic access to the DOE's Project THRIVE landing page and in return, they were unable to place tracking pixels on the page to collect certain analytics since the DOE did not grant the vendor access to the page. They were also limited in terms of optimizations such as the CTR since it would have been useful to collect the user's demographic info who visited the DOE landing page.

During the first month of the campaign alone, we were able to reach a third of Delaware, which is 300,000 unique users. The campaign earned over 6 million impressions where TikTok, Snapchat, Instagram and video ads made up the majority of the impressions. During the second month of the campaign, we gained a higher impression rate than the first month earning over 8 million impressions, where video ads continued to make up the majority of the impressions primarily by TikTok, followed by Instagram, and then Snapchat. During the third and final month of the campaign, we were again able to earn over 6 million impressions, where video ads made up the majority of the impressions for the third time in a row, primarily made by TikTok, Instagram, and Snapchat.

Overall, the campaign was able to reach a consistent 6-8 million impressions each month which was the primary goal for the media ads since large impression rates equal increased awareness of the Project THRIVE messaging. TikTok, Instagram, and Snapchat consistently ranked as the top three platforms that were frequented on average per month and that brought in the most impressions out of all the other media channels that were utilized. Video ads remained king during the campaign since that medium earned the most impressions and CTR every month – so, utilize videos when doing ads for this population. Limitations in collecting an accurate CTR occurred since the communication vendor did not have permission to analyze the Project THRIVE landing page to see the number of clicks earned and the landing page views. Therefore, our vendor could not provide any recommendations on how to improve the CTR since they did not have access to DOE's Project THRIVE's landing page. The view rate either barely met or exceeded the average YouTube ad view rate of 31.9% since the view rate ranged from 31%, 77%, and 41%. Lastly, by consistently looking at the analytics and optimizing accordingly even by making the tiniest tweaks such as reducing an ad run time by 1.5 seconds, the campaign saw great results.

Printed materials were also created by the communication vendors so the Project THRIVE name and messaging could be physically placed throughout Delaware schools. There were banners, 11"x17" sized posters, and stickers with QR codes linking back to DOE's page that were handed out in schools. The Title V Coordinator reached out to the DOE's school counselors, nurses, psychologists, deans, superintendent offices, principals, Public Information Officers (PIO), and other district leaders in an attempt for them to directly share the Project THRIVE messaging at their local schools, looping the videos in district and school offices, placing the Project THRIVE content in each of the Superintendent and Principals' weekly/monthly email blasts to families, etc. These were all ideas of MCH to spread the messaging during and even after the campaign. In contacting multiple schools throughout Delaware, only a handful replied sharing that they would be willing to share the messaging (along with SBHC

content). These school districts include: the Caesar Rodney School District, Capitol School District, Colonial School District, and the Appoquinimink School District. Currently, DPH's Social Marketing Coordinator contacts each school district on a monthly basis and shares SBHCs related content or Project THRIVE related content directly asking them to post these topics on their social media channels. Unfortunately, there have not been many shares from the multiple school districts, perhaps 1-2 shares maximum within the last three months. Project THRIVE and SBHC social media posts are also shared and asked for the DDOE's PIOs to post on social media which fortunately gets reposted consistently.



In lieu of continuing with paid media, MCH has pursued sharing the Project THRIVE content organically (free) with the help of DPH and the DOE. Through our paid communications vendor, DPH contracted to create various posts and stories. DPH is now organically posting and tagging the DOE on social media (Facebook, Twitter, and Instagram) so the content can be reshared by the DOE and other partners to help broaden the message. The call to action is to visit the newly created anchor link "de.gov/projectthrive" (brings you to the part of the DOE webpage that is more consumer friendly rather than reading about background info on the services first that may cater more to professionals) to learn more info and to dial 2-1-1, or text your zip code to 898-211 to learn more info or enroll in the services.

Thanks to the communication efforts between DPH and school districts, a PIO from the Colonial School District contacted the DPH's Title V Coordinator, sharing that there was a media opportunity to help share news of the Project THRIVE messaging. So, a live interview was scheduled at the DeTv news station in Wilmington, Delaware on October 24th, 2022, with Dr. Teri Lawler. Teri Lawler, is a psychologist under the Delaware Department of Education (DDOE), is the Program Lead for Project THRIVE, and also worked alongside DPH during the Project THRIVE campaign, and shared information about Project THRIVE. Teri had an 11-minute live interview that discussed key points of Project THRIVE services such as describing what Project THRIVE is and why it's needed, defined what "trauma" is, and shared the available resources such as DOE's trauma toolkit, the Project THRIVE campaign materials, and DOE's website de.gov/projectthrive to find for more information. The interview can be viewed on DeTv's Facebook page here between the 17:43 - 29:07 minute timeframe.

Physical Activity (ages 12-17)

The percentage of overweight children and adolescents (85th to 94th percentile) in Delaware has remained steady since 2019, where the NSCH shows 17.4% were overweight. According to the 2021 NSCH, 17.9% of adolescents in the same category are considered overweight currently. In addition, obese children and adolescents (95th percentile or above) in Delaware have reduced by over four percentage points from 18.4% in 2019 to 14.0% in 2021.

The prevalence of obesity among Delaware adults has continued to increase over the last few years. In 2012, the obesity prevalence in adults was 26.9%, and in 2021 that number increased to 33.9% of adult Delawareans. Conversely, the prevalence of overweight adults in Delaware has declined over the years from 39.1% in 2012 to 34.9% in 2021. To address these major public health challenges, DPH promotes policies and systems changes, and implements programs and strategies in the following areas: Physical Activity, Health Eating and Obesity Prevention.

According to the 2020/2021 National Survey of Children's Health (NSCH), Delaware is average among its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day, one to three days per week. Additionally, 21.5% of Delaware's adolescents are physically active zero days per week. Although Delaware is again average with its surrounding states when it comes to adolescents being physically active every day, resting at 16.0%, this percentage has trended upwards from 11.6% in the 2017/2018 NSCH and 13.0% from the 2018/2019 results. During our 2020 Needs Assessment, our stakeholders selected increasing physical activity among the adolescent population as the number one priority for this population domain and was ranked 5th overall.

The Physical Activity, Nutrition, and Obesity prevention (PANO) program in the Health Promotion Disease Section of the Division of Public Health (DPH) facilitates collaborative work efforts and interventions that address increased physical for Delaware families including children and adolescent. MCH has partnered with the PANO office to increase physical activity for adolescents, ages 12-17. In our Adolescent Health application report, we describe current and future work opportunities to leverage a parentship with PANO to impact the physical activity of our adolescents.

The Physical Activity, Nutrition, and Obesity Prevention (PANO) is a bureau within the Division of Public Health. PANO's long-term goal is to reduce the prevalence of adult and childhood obesity and other chronic diseases by promoting healthy lifestyles and improving health outcomes for Delawareans. PANO's objectives encompass the development and implementation of evidence-based policy, system, and environmental (PSE) strategies that will help Delawareans engage in regular physical activity, better nutrition, and make intentional lifestyle changes, lowering the risk of developing heart disease, cancer, chronic lower respiratory disease, diabetes, and other chronic diseases.

PANO provides support to the Delaware Cancer Consortium, Cancer Risk Reduction Committee, Healthy Lifestyles Subcommittee (HLSC). The HLSC developed health and wellness policy recommendations to the Office of the Governor, many of which impact the health and wellness of adolescents. To help implement some of these policy recommendations, PANO launched the Advancing Healthy Lifestyles: Chronic Disease, Health Equity & COVID-19 (AHL) initiative.

AHL foundational pillars include Coordinated School Health and Wellness, Community Capacity Building, and Workplace and Employee Wellness. Each component provides opportunities to implement evidence-based practices and programs that reach broad populations across the lifespan, with a cross cutting approach that overlaps and interrelates with one another. Each component is designed to engage and support specific objectives of the AHL initiative which will help develop a HLSC Action Plan, while connecting to partners in schools, the community, and the workplace.

PANO planned to engage Delaware schools through implementing a mini-grant program and supporting school health action teams to implement policy, systems, and environmental (PSE) strategies that promote healthy lifestyles for Delaware youth. However, the impact of COVID-19 presented various challenges. The realities of engaging and securing commitment with schools led to considering other ways to reach and support youth as they transitioned back to school in the fall of 2021. Community based, youth serving organizations (YSO) have a unique role in communities and often have additional flexibility that schools may not. The Boys and Girls Clubs of Delaware (BGC) reaches a large population of youth statewide with their extensive network, variety of programming, and relationship with schools. The Centers for Disease Control and Prevention highlighted 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 that widened during the COVID-19 pandemic. In September 2021, through AHL, PANO partnered with BGC to introduce a new program called Triple Play at 3 locations in Delaware; Milford, Laurel, and Western Sussex. This healthy lifestyle program focuses on the three components of a heathy self, Mind, Body, and Soul. The goal of the program is to improve knowledge of healthy habits, good nutrition, and physical fitness; increase the numbers of hours per day youth participate in physical activities; and strengthen their ability to interact positively with others and engage in healthy relationships. BGC delivers Triple Play once a week to youth in school-based sites, serving as a bridge between the extensive constellation of programs and resources of the BGC and the schools where youth are enrolled. Triple Play is primarily facilitated by 12-18 year-old high school student youth mentors (called Wowzers) and college interns, managed by BGC staff. The school-YSO partnership with BGC emphasizes systems change approach to adapt or replicate a proven health promotion model in multiple environments where youth work and play. In the Spring 2022, 148 Delaware youth participated in the Triple Play program at the 3 school-based locations. During summer 2022, 253 youth participated in Triple Play programming at 2 school-based locations, and at a BGC Center location in Sussex County. In Fall 2022, 106 youth participated in the Triple Play program at 3 school-based locations. On November 17, 2022, PANO hosted a webinar, through the Advancing Healthy Lifestyles Learning Series, to provide an opportunity for program facilitators and a teen Wowzer to share a summary on implementing Triple Play programming in Delaware, and highlight school and community partnerships to support after-school programming. A summary report and one-page infographic were also developed to share information on the program process and accomplishments. In Spring 2023, Triple Play programming was expanded to 6 school-based locations throughout Delaware, with 2 participating schools in each county.
PANO has facilitated technical assistance (TA) with three community partners on the planning and implementation of their community-based interventions, all of which impact children and families. PANO worked with the American Lung Association (ALA), University of Delaware (UD) Cooperative Extension, and two teams at Delaware State University (DSU) to provide TA on PANO-related interventions which include: an asthma self-management program to be

offered to children in schools and/or in youth-serving organizations (YSOs); improving access to healthy, locally produced food in targeted communities; a program for children with disabilities that will teach parents skills to increase the healthfulness of family meals, and increases physical activity for this population; and revitalizing a community space for health education and physical activity for children in an underserved community. Since July 2021, PANO has been working with these community partners to develop project and evaluation plans so that all projects can be implemented in 2022. The community partner evaluation and data collection plans are directly aligned with AHL outcomes, and each directly impact children and adolescent health. In Fall 2022, ALA conducted outreach to schools and YSOs throughout Delaware to provide asthma education and training to school nurses and support staff to offer ALA's Open Airways for Schools program which teaches elementary school children ages 8 -11 asthma self- management, and Kickin' Asthma, a program that empowers youth ages 11-16 to better manage their own asthma. Through AHL, PANO is collaborating with 8 Delaware schools to implement these ALA programs. In Fall 2022, UD Cooperative Extension launched pilot programming in 3 community stores in Dover, Harrington and Farmington which connected the community to fresh produce from a local farm. In Spring 2023, UD hosted nutrition education sessions in stores with Supplemental Nutrition Assistance Program Education (SNAP-Ed), supporting children and families in these targeted communities. In Fall 2022, DSU facilitated a semester of programming for Occupational Therapy college students to work with students with disabilities at the Charlton School, to help increase gross motor skills and physical activity. Seventeen DSU students and 27 Charlton students participated in the Fall and 19 DSU students and 20 Charlton students participated in Spring 2023. In Spring 2023, DSU also hosted a Dine and Discover series for the Charlton families and students, which was a collaboration with the DSU Occupational Therapy program and DSU Cooperative Extension SNAP-Ed program, addressing healthy eating and nutrition with a high-need population. In Summer 2022, DSU Allied Health Center hosted a half-day summer camp in a Dover community, reaching over capacity of serving 23 children ages 6- 12 years old. The camp offered structured play for increased physical activity, a vegetable garden, nutrition education and healthy snacks.

Through AHL, in Summer 2022, PANO also launched a mini-grant program which offered funding and technical assistance to 7 community based organizations implementing policy, system, and environmental changes to support healthy eating and physical activity in communities throughout Delaware. These efforts enable community-based organizations to achieve long-term and sustainable outcomes around health and wellness initiatives that support young Delawareans and the communities that care for them. See table below for program summaries for August 2022 to March 2023:

- 4-H held 13 events with youth and adults, including walking and "plogging" challenges as well as trainings and presentations.
- BGC guided youth participants through harvesting plants and seeds and maintaining soil beds on the BGC mini-farm.
- The City of Newark began construction on its new community garden, including installing the waterline and sidewalks and beginning fence installation.
- Delaware Breast Cancer Coalition hosted 16 "Yes2Health" classes and events, including programming on nutrition, healthy eating, and physical activity.
- Inner City Cultural League provided lessons, activities, and information on nutrition and physical activity during 15 youth-centered, family, and community events at locations throughout Dover.
- Worship Christian Center held weekly online discussions on healthy eating and nutrition and convened weekly walking club meetings at the Dover Mall.

YMCA facilitated 33 health and wellness outreach events with various partners and community participants.

PANO partners with the Office of the Lt. Governor to facilitate the annual Lt. Governor's Challenge. The focus of the annual Lt. Governor's Challenge is on emotional wellbeing; healthy living; chronic disease management and prevention; and mother/child health, within the workplace, school, community/neighborhood, or an individual. There were 24 nominations received in 2022. The planning team put a lot of effort in to promoting and educating on the nomination process and describing what a good nomination application looks like, defining and sharing examples of policy, system, and environmental (PSE) interventions. The awardees that have shown the highest degree and most comprehensive PSE changes earned the *Delaware Wellness Hero Award*, and winners of the *Delaware Health Leader Award* were commended for taking significant steps to improve the overall health of their community. Some of the winners that were selected include organizations that specifically impact the health and wellness of children and their families like the ECO Team at Welch Elementary School (Caesar Rodney School District), and the Community Education Building in Wilmington. Nominations opened March 2021 and closed on May 31, 2022. The Lt. Governor's Challenge awards were presented to 7 honorees in November 2022 at the Wilmington Public Library. PANO met with the review committee and selected awardees in August 2022. Visit www.ltgovernorschallenge.org to learn more about the Lt. Governor's Challenge and read more about the 2022 winners. Planning for the 2023 Lt. Governor's Challenge began in March 2023 with nominations closing in May 2023.

PANO collaborates with the Delaware Department of Education (DOE) on coordinated school health and wellness initiatives. To support DOE physical education regulations on annual physical fitness assessment, reporting and compliance standards, PANO supports the utilization and implementation of WELNET ® a physical fitness education and assessment tool, from Focused Fitness. PANO collaborates with DOE and Focused Fitness to provide physical education and physical activity resources to Delawareans. PANO provides technical assistance for WELNET ® implementation, professional development, and training opportunities for Delaware educators, and provides online resources. A WELNET® training was provided for Delaware educators on August 1, 2022. The training was recorded and added to DOE's professional development management system for teachers to view at any time. There were 44 teachers in live attendance, primarily teacher leads for school districts and charters, and 125 teachers who viewed on-line. There were also 4 webinar videos for teachers to view during in-service days. A representative from WELNET® also presented at the SHAPE Delaware conference in October 2022, to provide further training for a roster of 300 Delaware health and physical education (HPE) teachers in attendance. By January 2023, 58% of HPE teachers signed in to Focused Fitness and entered WELNET data for over 20,000 students and 74% of schools had student physical fitness assessment data entered into WELNET ®. DOE has been contracted with Focused Fitness since July 2022. PANO will continue to provide support and partnership for WELNET® and Focused Fitness resources.

PANO provides support to the Division of Public Health (DPH) Health Education Administrator who facilitates the various youth surveys statewide, such as the Youth Risk Behavior Survey (YRBS) and the School Health Profile (SHP). Select schools are currently scheduling participation in the 2023 Youth Risk Behavior Survey (YRBS). Data collection will occur during the 2023-2024 school year. The YRBS is a biennial (odd years), anonymous student survey for students in grades 6-12 that provide data on student physical, emotional, and psychological health. Its statistics, charts, and other data report not only on student trends in physical activity, but also on texting and driving, drinking, vaping and drug use, bullying, social media use, and other behaviors. The survey is conducted by the University of Delaware Center for Drug and Health Studies and 29 of 36 schools that were randomly selected by the CDC are scheduling participation. DPH is consistently working to improve response rates from the schools, and efforts to find ways to improve school participation will resume. The School Health Profile (SHP) is a biennial CDC survey that assesses school health policies and practices. These surveys are also conducted every other year by education and health agencies among middle and high school principals and lead health educators, and was last completed in 2022. The information obtained from the YRBS, and the SHP surveys are used to help develop state programs and initiatives and help to guide prevention efforts, which will improve the health and health outcomes for Delaware communities and youth.

PANO will continue to facilitate collaborative work efforts and interventions across the state that address health and wellness for Delaware families, children, and youth.

Nutrition Counseling

New Castle County Community Health Services has reinstated its Nutrition Program and is looking to expand services in the upcoming year, initiated in March of 2023 with the onboarding of a Registered Dietitian Nutritionist (RDN) after the position was vacant the previous year. In navigating the Nutrition Program in the direction to accept more participants, there has been a reestablishment of the nutrition referral system for Division of Public Health. Programs such as Family Planning, Child Health, Sexual Reproductive Health, and our Tuberculosis Clinic are able to refer to a RDN for nutrition counseling. Other state programs such as Child Development Watch, which focuses on children with developmental delays and/or disabilities has reestablished a referral process for nutrition consults. This expansion provides opportunity for the Nutrition Program to reach more community members including children and adolescents. Nutrition consultations have been resumed, with appointments being conducted either over the telephone or in person based on patient/parent preference and accommodations. Consults focus on the identified nutritional concern(s) and distributing knowledge and resources to help minimize obstacles along the path towards resolution or management of concerns.

Merging the RDN's prior pediatric experience as a WIC Nutritionist and referrals received thus far as the Community Health Nutritionist, common nutrition concerns include obtaining and maintaining healthy weight, encouraging the introduction of new foods, increasing the consumption of a broader variety of healthy foods, and the ability for participants to make more informed food choices to live a healthy lifestyle. Along with these common concerns, recognition and navigation of food preferences, allergies, intolerances, and sensitivities as well as digestive disorders, developmental disabilities, and chronic health conditions is critical. As the Nutrition Program grows, the increasing clientele will present health conditions such as diabetes, heart disease, obesity, high blood pressure as well as Celiacs Disease and Autism Spectrum Disorder, among others. With many influencing factors, individualized food plans are key to accomplishing nutrition and health goals.

With the goal to inspire healthy lifestyles, healthy eating guidelines, recommended daily intakes, and portion sizes of

foods are discussed with the client and are personalized based on the needs and preferences of the individual. Integrating client involvement and making them a partner in their health journey helps inspire positive choices and attainable goals on the way to managing and minimizing detrimental health outcomes. Combining client input and their health concern(s), food plans and recipes guided by USDA's MyPlate and the Dietary Guidelines for Americans 2020-2025 are provided and are tailored to the certain preferences and dietary needs of each client.

In addition to nutrition consulting, continuing education is a critical part of the career of an RDN to maintain registration and licensure, in addition to exploring research and staying up to date on current health and nutrition news and topics. Our RDN has recently completed trainings since beginning the role, which include Nutrition in Adolescent Growth and Development; Food Allergies, Intolerances and Sensitivities in Pediatric Practice: The Role of the Registered Dietitian Nutritionist; Reconsidering Feeding Difficulties in Clinical Practice; and Nutrition Intervention for Healthy Childhood Growth.

Adolescent Health - Application Year

The MCH team along with various stakeholders identified two priorities pertaining to adolescents during Delaware's 2020 MCH Title V Five-Year Needs Assessment process. Delaware selected National Performance Measures (NPM) 8.2, increase physical activity among adolescents 12-17 years of age and NPM 10, increase adolescents who obtain a preventative well visit annually as priorities. The Title V team chose to select the Adolescent Well-Visit with the goal of incorporating other priorities for this population within the well-visit measure. We plan to leverage our School Based Health Centers in the state to address priorities like well visit, physical activity, and mental health.

Adolescent Well-Visit

According to the 2020/2021 National Survey of Children's Health (NSCH), 28.2% of Delaware adolescents have had no preventive medical visit in the past year. This percentage has increased over the past few years as the number of Delaware adolescents was 24.3% during the 2019 NSCH. However, it was highest during the 2018 NSCH when the number of adolescents not receiving a preventive medical visit was 29.8%. We are aware the COVID-19 pandemic had an effect on adolescents receiving a medical visit; however, we will continue to make this a priority for Delaware.

Delaware's School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public-school setting, and contribute to better outcomes related to selected priorities, NPM 1 Well Woman Care, NPM 8.2 Physical Activity and NPM 10 Adolescent Well Visit. There continues to be a growing interest for expansion to elementary, middle, and additional high schools, especially given the recent COVID-19 pandemic. As we continue to transition out of the pandemic the enrollment and utilization of SBHCs has increased. School Based Health Centers are going through a paradigm shift, and there continues to be a large number of stakeholder interest and commitment to provide evidence based SBHC services based on national and in state innovations in practices and policies, to enhance the growing number of 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 & mental healthcare, sexual & reproductive healthcare, nutritional health services, screenings & referrals, health promotion & 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, and licensed nutritionist. 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, convened in 2022 and completed the Delaware School-Based Health Center (SBHC) Strategic Plan. The planning process was utilized to develop a model for expansion of SBHCs that was both financially sustainable and anchored in best practices. There were 13 goals established to include a comprehensive list of action items to ensure that SBHCs are responsive to the individual needs of Delaware's children — who, for a variety of reasons, may not otherwise have access to the health care system for critical health and wellness services.

The 13 goals of the plan include items, such as creating new SBHC sites where the need is greatest, establishing a new hub-and-spoke model for SBHC setup, fostering partnerships to increase the base menu of services, facilitating referrals to providers, adopting culturally linguistic appropriate services, increasing the capacity for telehealth, developing data collection infrastructure and analysis, establishing payer relationships and funding channels, and more. The plan will be governed by an independent body from public and private sectors, with a completion target date of 2025. The plan was developed to ensure that SBHCs are responsive to the individual needs of Delaware's children - who, for a variety of reasons, may not otherwise have access to the health care system for critical health and wellness services. In June 2021, Delaware released the Implementation Plan for Strategic Plan for School-Based Health Centers. We will also begin governance and implementation of the Plan as well as setting up a longer-term governance and accountability model to oversee implementation of the Plan and continued success of School Based Health Centers.

For the past 30 years, Delaware School Based Health Centers, located in now 33 public high schools and 15 public elementary schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to support individuals overall physical and mental health. Eventually, these young women and men will be our health consumers, so it is essential to support health and wellness during this critical period and coming of age. SBHCs provide at-risk assessment, diagnosis and treatment of minor illness and injury, mental health counseling, nutrition and health counseling and diagnosis and treatment of STIs, HIV testing and counseling and reproductive health services (middle and high school SBHC) with school district approval as well as health education. Given the

level of sexual activity among high school students, persistent high rates of sexually transmitted infections (STIs) and the numbers of unintended pregnancies, reproductive health planning services are very important.

In most recent years there have been seven SBHC established in elementary schools with epilogue language from FY2020 expanding SBHCs in elementary schools at two per year in high needs elementary schools throughout the state. As of this writing, two additional elementary schools are currently going through the process of certification. Along with establishing SBHC's in elementary schools many of the SBHC's are exploring the opportunity of expanding services to more students by opening "spoke" sites. Having these additional sites will provide critical services to students in our state. In FY2023, two new SBHC were established in high needs elementary schools; Frederick Douglass and Baltz elementary. 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 in grades K-5 allowing access to services such as sports physicals, well visits, immunizations, vaccines, and mental health counseling. The SBHC will not replace the primary care provider, it is considered a provider in an integrate network to provide behavioral and physical health services to the adolescents in Delaware. Addressing or discovering problems before they escalate, connecting children and families to resources in our community, improving health, and reducing long term health care cost are the goals.

Mental and Behavioral health services continue to be an area of growth and development. SBHCs continue to struggle to provide services to students due to staffing shortages and frequent turnover rates. It is imperative to promote and increase awareness and education regarding resources for Mental and Behavioral health. Some areas in Delaware experience limited access to healthcare. It is our goal to increase education, awareness, and resources to young women of reproductive age in the Sussex County area, focusing on the following:

Goals	Increase awareness- Educate young women of reproductive age
Target Audience	Young women of reproductive age and pregnant women in Western Sussex Latinx Women in Western Sussex
Key Messaging	Importance of being healthy before and during pregnancies Importance of early prenatal care and where to locate family planning Importance of postpartum

In addition, 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 couple of years, school district school boards voted and approved to add Nexplanon as a birth control method offered at 19 of the school-based health center 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 and if to get pregnant and ultimately reduce unplanned pregnancies.

MCH previously launched SBHC related information on social media. We launched phase one and phase two of this plan. Phase two consisted of informing the public where someone can find a SBHC and promoted enrollment in SBHCs (addressing the how and why with enrollment). The target audience included parents of elementary-aged children in Delaware.

Overall education, awareness, and continued support for adolescents in Delaware is an initiative where Delaware continuously explores avenues to engage the adolescent population. The goal is to increase avenues to distribute information to adolescents, using methods such as:

Social Media	Provider Websites
Bulletin Boards	School Staff
Radio Stations	SBHC Staff
Summits	Community Events
Flyers/Poster	School Events
Student Lead Events	

To be successful with the adolescent population information needs to be presented in a manner where it is received, accepted, and retrained by adolescents.

As adolescents transition into adults, we are working to ensure they have the resources to secure a primary care

doctor, transition Medicaid, and to thrive and have a prosperous adulthood. Community Health workers are assisting to fill gaps with insurance and primary care needs. Community Health workers educate, provide support, are health promoters, health educators, health advisors, and neighborhood health advisors.

In partnership with Planned Parenthood of Delaware, training is offered for staff at School Based Health Centers (SBHCs) each year. Planned Parenthood 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 by Planned Parenthood of Delaware throughout the year. Planned Parenthood of Delaware trains teachers to deliver curriculum to parents and students. PPHD also has community outreach activities to whose target populations are LGBTQ2S+, pregnant/parenting and juvenile delinquency youth.

Supporting LGBTQ+ teens is a growing need throughout the state of Delaware. Providing awareness, education and support for educators, behavioral health specialist, and medical professionals in the areas of health disparities, Delaware legal protections for LGBTQ+ teens suicide prevention and best practices to for supporting LGBTQ+ teens. Educators, parents, students, and communities are uniting across race, genders, and place to demand safe and affirming schools where all our students can learn, grow, and thrive. Planned Parenthood of Delaware has hosted several trainings throughout the year to earn the support our LGBTQ+ teens.

Our CDC assignee has been training and building capacity with our Management Analyst in the Bureau of Adolescent & Reproductive Health section to develop performance metrics, data quality audits, and reporting for School-Based Health Centers data submitted by medical sponsors. Our CDC assignee has also been reviewing YRBS and Delaware School Survey Data to inform surveillance strategies for socio-emotional health of adolescents. Our SBHC evaluation paper is now under publication. These data support the use of School Based Wellness Centers as a strategy to increase preventative well-visits, increase physical activity as well as support emotional well-being. A new SBHC data brief for state fiscal year (SFY) 2019-2020 was developed by linking SBHC enrollment data and Department of Education (DOE) school enrollment data. An updated analytic evaluation plan linking SBHC enrollment data, DOE school enrollment data, Medicaid claims data, HDD data, with the inclusion of SFY 2021 data (July 1, 2021, through June 30, 2022) is currently underway.

Delaware successfully applied and received CDC/Harvard evaluation practicum. Two students and staff from DPH (Bureau Chief of Adolescent Health, and Management Analyst, Dr. Hussaini) and DOE participated in the practicum during 2022. Dr. Hussaini worked with Bureau Chief of Adolescent Health to mentor the two Harvard students to develop a SBHC elementary evaluation plan. The program identified efforts to build strong relationships among SBHCs, school personnel, and the community, and ensure that trauma-informed and culturally & linguistically responsive care exist in SBHCs. The evaluation measures enrollment, utilization, and patient; along with intermediate outcome such as referrals to social services, referrals to PCPs, and connections to specialist services.

The evaluation consists of two key questions:

1. How do SBHCs in high-need elementary schools operate?
2. How does SBHC-facilitated health care and social services utilization impact the physical and psychosocial needs of students in high-need elementary schools?

Interviews and meetings were held with stakeholders to, and the following areas of measurements are also included in the evaluation:

1. Examining whether differing implementation practices between medical sponsors have impacts on quality of care, physical and psychosocial outcomes, and health equity.
2. Assessing current data reporting practices/measures and level of standardization across medical sponsors.
3. Gauging how SBHC systems could anticipate certain health or social needs within these high-need schools.
4. Developing relevant key indicators of health equity in this population.
5. Evaluating successes and barriers to the current implementation of SBHCs, e.g., stakeholder buy-in, communication efforts between SBHCs and other stakeholders, measurement, and data-related issues.
6. Establishing recommendations for each stage of the program which could increase efficiency, quality of care, and healthy outcomes for this population.

The logical model and evaluation tool developed during the CDC/Harvard Practicum has not yet been refined for the high-need elementary SBHCs. Unanticipated increase in supplies resulted in significant delays with construction in one of the related sites. With state-contracted high need elementary SBHCs in their infancy stages, our focus was on first steps

such as building walls, establishing appropriate spaces for provision of care, navigating fiscal nuances, and most importantly, nurturing the partnership between those high-need elementary SBHCs with the schools. By doing so, the needs of the students can most effectively be met. Evaluative measures such as those developed by the two CDC/Harvard Practicum students will be woven into the picture of high-need elementary SBHCs eventually and as both sites are seeing patients and have data collected.

For our selected prior of increasing the number of adolescents receiving a preventive well-visit annually to support their social, emotional and physical well-being, we have focused on access and availability of mental health resources.

We will continue to monitor the mental health status of Delaware's adolescent population. We know that COVID-19 had an impact on the emotional well-being of our MCH population, so it is important that we maintain our efforts in this area until we understand magnitude of this issue. We will continue to partner with our School Based Health Centers to increase the number adolescents who receive an annual preventive medical visit. Our School Based Health Centers offer mental health support and counseling to support the emotional well-being of adolescents. School Based Health Centers have also expanded into elementary schools in Delaware as well.

We plan to continue our partnership with the Cooperative Extension, University of Delaware, Health & Wellness Ambassadors. U of D Health Ambassadors are a team of Teen Leaders and Adult Mentors who advocate for a holistic healthy lifestyle across the state. Health and Wellness Ambassadors are role models and official representatives and promotors who help plan and implement the Delaware 4-H Healthy Living Program aimed at improving the health of themselves, their peers, and their community.

We will continue our work with the Department of Education to sponsor a poster contest that promotes teens to seek emotional and mental health treatment, when needed. We are in discussion what this will look like for the future, whether it is a paper poster contest or a digital media creation. We are hopeful, we can launch this project during the upcoming grant cycle.

We will continue to partner with the Department of Education to advertise Project THRIVE throughout each middle and high school within the State of Delaware. We will continue to cooperate with participating school districts to promote Project THRIVE and mental health services. As stated in our Adolescent Health Annual Report, MCH will continue to share the Airtable link with Project THRIVE messaging to our partners so they can easily access and share its contents. In addition, we plan to continue our working relationship with the various school districts to advertise adolescent health and Project THRIVE, as well as School Based Health Center messaging in each middle and high schools.

Physical Activity (ages 12-17)

Only 16.0% of Delaware adolescents, ages 12-17, are physically active at least 60 minutes each day, this is compared to the national average of 14.8%. Delaware's adolescents who are physically active at least 60 minutes each day, 4-6 days per week, rests at 19.4%, while the national average is 24.1%. Although, NPM 8.2 is a newly selected priority during this five year grant cycle, MCH has a long history of partnering with the Physical Activity, Nutrition and Obesity prevention (PANO) program In the Health Promotion Disease Prevention Section of DPH. MCH will continue to leverage this partnership to increase physical activity among adolescents.

Physical Activity, Nutrition, and Obesity Program's (PANO) activities for the Application Year will be focused on key healthy lifestyle and chronic disease intervention areas impacting youth and the families and communities they live in.

Through PANO's Program's Advancing Healthy Lifestyles (AHL): Chronic Disease, Health Equity & COVID-19 initiative, PANO will continue to support youth health through the AHL foundational pillar: Coordinated School Health and Wellness. Through AHL, PANO is facilitating the connection between youth-serving organizations (YSOs) and schools to support the health and well-being of youth and to strengthen community partnerships. Under the AHL initiative, these partnerships focus on the link between a community-based, youth-serving organization and the health and social-emotional well-being of participating youth. PANO will continue to partner with the Boys and Girls Clubs of Delaware (BGC) to implement the Triple Play program in Delaware. The goal of the program is to improve knowledge of healthy habits, good nutrition, and physical fitness; increase the numbers of hours per day youth participate in physical activities; and strengthen their ability to interact positively with others and engage in healthy

relationships. Triple Play is primarily facilitated by BGC youth mentors (called Wowzers) and college interns, managed by BGC staff. BGC will implement Triple Play at 9 locations across the state, 3 in each County. Each 10-week session will run from mid-June 2023 to early June 2024.

Through the AHL foundational pillar: Community Capacity Building, PANO will continue to facilitate technical assistance (TA) and implementation support to four community partner teams on the implementation of community-based interventions, all of which impact children and families. PANO has been working with the American Lung Association (ALA), University of Delaware (UD), and Delaware State University (DSU) to provide TA on PANO-related interventions. All four community partner teams implemented projects in July 2022 which ran through June 2023. Project implementation will continue from July 2023 to June 2024 and will include an asthma self-management program to be offered to children in schools and/or in youth-serving organizations (YSOs); improving access to healthy, locally produced food in targeted communities; a physical activity and nutrition education intervention for children with disabilities and their families that teaches parents skills to increase the healthfulness of family meals, and increases physical activity for this population; and, revitalizing a community space for health education and physical activity in a summer camp for children in an underserved community. We will partner with ALA to implement the Open Airways for Schools program which teaches elementary school children ages 8 -11 asthma self-management, and Kickin' Asthma, a program that empowers youth ages 11-16 to better manage their own asthma in schools during the September 2023 to June 2024 school year.

From May 2023 to October 2023, PANO will continue to partner with UD Cooperative Extension to further enhance a Farm to Store pilot project, which supports a relationship between a retail store and a local farm, to provide fresh produce to the community, which includes many children and families. This program also plans to expand to include a Farm to School component in the Fall of 2023 school year. Along with our partners, we will continue to provide movement-based and physical activities to youth with disabilities, ages 7 to up to 21 years old in the Caesar Rodney School District. DSU will also continue to host a Dine and Discover series, in partnership with DSU's Cooperative Extension program, which offers families healthy eating and nutrition for the whole family. This program will run September 2023 to June 2024 and plans to again serve Charlton students, with discussions about expanding to Capitol School District students.

The team at the DSU Allied Health Center started a community summer program for youth, ages 6 to 12, in the Capitol Park community, a low-income, high-need neighborhood of downtown Dover. Participating youth will have access to physical activity opportunities and nutrition education, and a community garden during the summer July 2023 to August 2023 season. This program will be implemented in partnership with various colleges and programs of DSU, as well as other community stakeholders. One of the goals of this project is to expand after-school programming to serving youth during the September 2023 to June 2023 school year.

PANO will partner with other state agencies and community organizations to sustain the AHL foundational pillar of Community Capacity Building. PANO will engage community partners who are primarily serving disparate or targeted communities, to develop strategies that address PANO related activities. These efforts will enable community-based organizations to achieve long-term and sustainable outcomes around health and wellness initiatives that support young Delawareans and the communities that care for them. PANO will promote policy, systems, and environmental (PSE) change strategies and interventions through community-based initiatives such as the Advancing Healthy Lifestyles (AHL) Community Mini-Grants and the Lt. Governor's Challenge. The AHL Community Mini-Grant program awards grants to communities and organizations that exhibit a strong commitment to tobacco prevention and control programs and are enhancing or expanding access to physical activity and healthy eating opportunities for children, families, and communities.

In September 2023, PANO will launch the AHL Community Mini-Grant program for a second year. The AHL Community Mini-Grants will award funding to schools, community-based, and youth serving organizations that provide physical activity, nutrition promotion and obesity prevention programs or implement PSE changes aligned with PANO's goals of improving health and reducing chronic conditions. In the Summer of 2023 PANO will invite community partners to apply for mini-grants in the range of $5,000-$15,000. Awardees must address the AHL outcomes of improving opportunities for physical activity, healthy food, and maintaining a healthy weight by applying a PSE approach. The 2023 Lt. Governor's Challenge launched in March 2023 and received 37 nominations by the close of the nomination period, May 31, 2023. The Lt. Governor's Challenge Review Committee will review nominee applications through the Summer of 2023 and announce the 2023 winners in the Fall of 2023.

PANO will continue to collaborate with the Delaware Department of Education (DOE) on the AHL foundational pillar Coordinated School Health and Wellness initiatives. PANO will provide funding for the physical fitness assessment and physical education tool, for the 2023 -2024 school year. We will continue to offer resources for technical assistance for WELNET implementation, professional development, and training opportunities for Delaware

educators. PANO will also provide technical assistance and resources to Delaware's professional Society of Health and Physical Educators (SHAPE DE), which makes up the professional workforce of health, physical activity, and physical education teachers throughout Delaware. SHAPE DE will host its annual convention in October 2023. The SHAPE DE annual convention is designed to provide SHAPE members and health education professionals the opportunity to share instructional ideas with each other and learn from local and national subject matter experts. Starting July 2023, PANO will provide event planning, communications, and technical support to SHAPE DE to help build the internal capacity of this non-profit organization that serves as a resource for Delaware health, physical activity, and physical education teachers.

PANO will continue to partner with DOE to facilitate improved responses from schools for school health data surveys, including the Youth Risk Behavior Survey (YRBS) and the School Health Profile (SHP). Select schools are currently scheduling participation in the 2023 Youth Risk Behavior Survey (YRBS) with data collection to occur during the 2023-2024 school year. DPH is consistently working to improve response rates from the schools, and efforts to find ways to improve school participation will resume. The School Health Profile (SHP) will be completed in 2024. The information obtained from the YRBS, and the SHP surveys are used to help develop state programs and initiatives and help to guide prevention efforts, which will improve the health and health outcomes for Delaware communities and youth.

PANO will continue to facilitate collaborative work efforts and interventions that address increased physical activity, improved nutrition, and healthier lifestyles for Delaware youth.

MCH will continue to support PANO by providing support to the Physical Activity, Nutrition, & Obesity Prevention, Division of Public Health through collaborative efforts to inform maternal and child health stakeholders, other community partners and home visitors about the Advanced Healthy Lifestyle Initiative Webinars on Coordinated School Health & Wellness, Community Capacity Building and Workplace/Employee Wellness.

DPH will continue to facilitate collaborative work efforts and interventions that address increased physical activity, mental health awareness, improved nutrition, healthier lifestyles, and information and resources for Delaware children and adolescents. MCH will continue to utilize DEThrives to engage and inform our adolescent population with up-to-date information pertaining to various needs and topics via social media posts, Facebook Instagram and Twitter. Subjects pertaining to Adolescents, such as My Life My Plan Teen, Addiction, Mindfulness, COVID-19, School Based Health Centers, Anxiety and Depression, Mental Illness, Exercise, and more have been posted. In working with our partners, MCH will continue to use social media to promote adolescent health comprehensively. Social media messages will be developed around the importance of preventative well visits, healthy lifestyles and emotional wellbeing. We just recently completed the newly designed DEThrives.com website. Audience pages are recognized under the "Services for Me" page, where content is organized by the user's life stage. These life stages include a "Teens" category. Additional maternal and child health messaging can be found on the different audience pages, which are organized by the different life stages an individual will be in. All web pages, either a program or audience page, will have a "Related Programs and Services" section at the bottom of the webpage that will list other pages or program pages that relate to the page the user is currently on. This is another way for the user to learn more information about related services DEThrives has.

Nutrition Counseling

New Castle County Community Health Services will continue to expand services in the upcoming year, with the onboarding of the Registered Dietitian Nutritionist (RDN), after the position was vacation during the previous year. We will continue navigating the Nutrition Program in the direct to accept more patients. The Nutrition Program will continue making appointments either over the telephone or in person based on patient/parent preference and accommodation. Consults will continue to focus on the identified nutritional concern(s) and distributing knowledge and resources to help minimize obstacles along the path towards resolution or management of concerns.

Being engaged in community health events and conferences throughout the state is critical to broaden the awareness of resources and networks to utilize in expanding nutrition services. New Castle County Community Health Services hosted the Brandywine Lifesavers Event at the Hudson State Service Center in April 2023. Brandywine School District's "Lifesavers" program is designed to create opportunities for all students to experience the healthcare field. As a tour guide, the RDN led a group of students to public health program stations including Sexual Reproductive Health, Child Health/Immunizations, WIC program and the Tuberculosis clinic, along the way introducing the programs as well as the RDN's role as a public health RDN.

In May 2023, the RDN attended the Division of Public Health Physical Activity, Nutrition, and Obesity Prevention

(PANO) program's Inaugural Advancing Lifestyles Conference: Improving Health Through Equity. Conference initiatives included reducing obesity and chronic conditions, achieving health equity by coordinating school health and wellness along with workplace wellness, and fostering connections between youth-serving organizations and schools to support the health and well-being on youth across the state. There were opportunities to engage in panel discussions and network with colleagues as well as other health professionals.

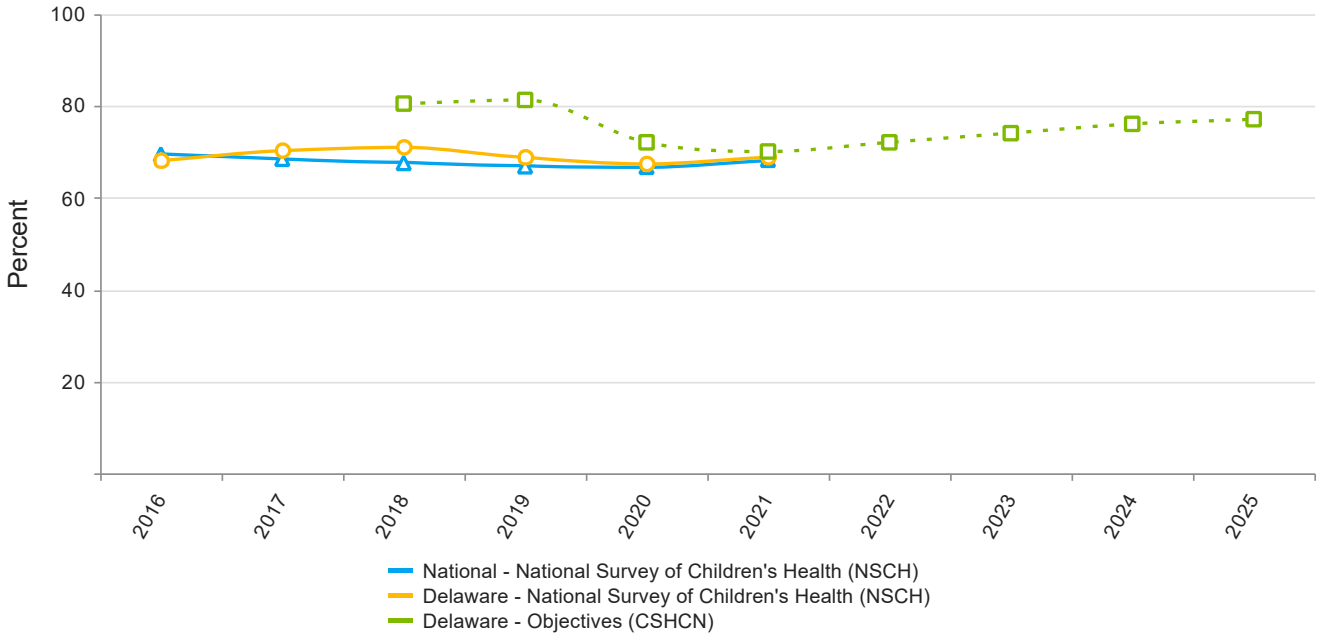
Upcoming events our RDN will be attending include the 21st Annual Diabetes Wellness Expo in Dover, hosted by the Delaware Diabetes Coalition (DDC) and sponsored by the Division of Public Health's (DPH) Diabetes and Heart Disease Prevention and Control Program (DHDPC) and the Physical Activity, Nutrition and Obesity Prevention Program. This Expo will focus on promoting diabetes self-management and living healthy lifestyle. More than 30 exhibitors and educational seminars will provide information about diabetes management, nutrition, exercise, medication adherence, hearing, and mental health.

On National HIV Testing Day, June 27th, 2023, the Community Health Services Registered Dietitian will be attending an event hosted by the Division of Public Health at the Hudson State Service Center for which I will be providing nutrition information tailored for those affected by HIV/AIDS.

Children with Special Health Care Needs

National Performance Measures

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Indicators and Annual Objectives



NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.4	81.2	72	70	72
Annual Indicator	70.2	70.9	68.6	67.2	68.8
Numerator	142,861	144,257	138,831	136,015	140,169
Denominator	203,480	203,436	202,281	202,319	203,715
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	74.0	76.0	77.0

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid

Measure Status:	Inactive - Completed

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		No	No	Yes	Yes
Annual Indicator		No	Yes	Yes	Yes
Numerator					
Denominator					
Data Source		MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

ESM 15.2 - # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.

Measure Status:	Inactive - Moved to a strategy as we will continue to participate and we didn't feel the measure was strong enough.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective			4	4	4
Annual Indicator		4	4	4	4
Numerator					
Denominator					
Data Source		MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			90	92
Annual Indicator		90	89.1	91.5
Numerator		564	595	644
Denominator		627	668	704
Data Source		MIECHV Program data	MIECHV program data	MIECHV Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	94.0	96.0	98.0

ESM 15.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	73.3
Numerator	11
Denominator	15
Data Source	Family SHADE/MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

ESM 15.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

State Action Plan Table

State Action Plan Table (Delaware) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase the percent of children with and without special health care needs who are adequately insured.

NPM

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objectives

By 2025, increase the percent of families reporting that their CYSHCN's insurance is adequate.

By 2025, increase the number of health plans whose member services staff are linked to relevant family organizations and programs to meet the needs of CYSHCNs.

Strategies

Support workforce development training for Title V staff and family organizations to ensure knowledge of insurance coverage options in the State of Delaware.

Continue to be involved in the Complex Medical Needs Advisory Council lead by Medicaid to address needed services that medicaid may or may not cover.

Health Insurance Enrollment Outreach and Support for un-/under-insured families.

Investigate providing care coordination to guide patients through supports with our family led organization.

Continue to implement the Family SHADE mini grantee program that aligns with the Title V MCH Block Grant performance measures and the National Standards for CYSHCN.

Continue to support the collaboration of a cross agency coordination committee between DPH and Medicaid.

Establish a LOA with our family delegate to attend the AMCHP annual conference and develop their knowledge and understanding on how to enhance Delaware's efforts on addressing a targeted NPMs.

Support and assist the Parent Information Center in providing training and technical assistance to the Family SHADE mini grantees on best practices for program development, management, evaluation and quality improvement as the selected contract vendor.

ESMs	Status
ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid	Inactive
ESM 15.2 - # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.	Inactive
ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants	Active
ESM 15.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.	Active
ESM 15.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Children with Special Health Care Needs - Annual Report

Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 28,111. According to the 2020/2021 National Survey of Children's Health (NSCH), 68.8% of Delaware children are adequately insured in comparison to the national average of 68.2%. This includes CYSHCN between the ages of 0 through 17. Among the sub-group of children with special health care needs, 65.4% are continuously and adequately insured, compared to 69.7% of non-CYSHCN children.

In Year 2022, Delaware utilized the Parent Information Center (PIC), which began their 1st year as the new vendor to implement the newly revitalized Family Support Healthcare Alliance Delaware (SHADE) project. The programmatic approach included 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. PIC implemented the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The FLN network membership is a member network which offers trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. FLN members received monthly stipends for attendance and participation pending there was funding available. In the first year, they were able to recruit 12 family members that had a child or youth with special health care needs in their family. These families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive system changes to better serve families of CYSHCN. Family SHADE served as a learning network and resource for the community agencies serving CYSHCN. PIC succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of competitive mini-grant opportunities that were innovative and aligned with our Maternal Child Health National Performance Measures (NPMs). These are the NPMs the mini grantees aligned their projects with:

1. NPM 11 - Percent of children with and without special health care needs, ages 0-17, who have a medical home.
2. NPM 12 - Increase the percent of adolescent with and without special health care needs who have received the services necessary to make transitions to adult health care.
3. NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured.

Through the Parent Information Center's leadership, they prioritized aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures as well as topics addressing gaps in service and identifying needs that were impacting families of CYSHCN. The learning communities were accessible to families and organizations serving CYSHCN. Through these initiatives, the Family SHADE project built state and local capacity and exercised testing small scale innovative strategies to improve the overall systems of care. PIC, in partnership with community organizations, focused on innovative strategies and improved the Title V national performance measures and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely attained surveys to track and gather information and topics being requested by the Family SHADE community by taking pre, post, and overall evaluation surveys during focused learning communities. These surveys assisted in determining what knowledge was gained by the participant as well as what topics families and community organizations wanted to see in future learning communities.

Through the Family SHADE project, in April 2022, two community-based organizations were awarded mini-grants. Jay's House and Tomaro's C.H.A.N.G.E. (Creating Healing, Answers, & Necessary Guidance for Excellence) were awarded mini-grants in the amount of $25,000.00 each. The Family SHADE project, focused on providing these two community agencies with technical assistance on implementation and evaluation of their project so that they were in alignment with the Maternal Child Health's NPM 11, NPM 12 and NPM 15.

During year 2022 and into year 2023, they each developed an implementation plan and an evaluation plan with the technical assistance of the PIC team and through the Family SHADE project. They received technical assistance through the Learning Communities offered by the Family SHADE project. The scope of work included the recruitment and retention of children and families in the Wilmington area specifically Edgemoor, Delaware, which includes the following zipcodes:19802,19809,19720, 19803, 19703. Through relationship building, partnerships and referrals for CYSHCN; Jay's House registered 21 families to become members of the Family SHADE program. Jay's House increased capacity in the Family SHADE program through the inclusion of CYSHCN families. Jay's House's team fostered and developed relationships with families on understanding the definition of a Medical Home and its importance. They worked with families on obtaining early childhood services for their child's specific age-group or developmental stage in the education system. They also worked with families of CYSHCN on preparation and transition to the adult healthcare system.

Jay's House divided the CYSHCN age groups into 5 sections:

1. Infancy (ages birth to 3): The Bamboo Group – which focused on connecting CYSHCN families to resources in the community with a healthcare focus. Jay's team worked with families on early screening and detection. They

also focused on obtaining a pediatrician and primary care physician, Early Childhood Education, Developmental Milestones Checklist, Daycare procurement and implemented strategies for preparation for pre-school and kindergarten.
2. Early Childhood (ages 4 to 8): The Aspen Group – focused on connecting CYSHCN families to services offered in the education system to support child development, school/family partnerships and extracurricular activities. Working with the families and schools to begin developmental testing if necessary to determine if an Individualized Education Plan (IEP) is necessary to implement. They established relationships with families and connected them with the appropriate doctors to create a Medical Home.
3. Middle Childhood (ages 9 to 12): The Cedar Group – focused on supporting CYSHCN children and families with middle school educational services offered such as IEP meeting attendance, IEP support (reading and interpreting the IEP), and IEP preparation (before the IEP meeting, outline what services and supports the child needs). The team worked with the families with securing therapists, and ensuring the child was on a schedule that met with their primary care physician on a regular basis. Also, supported the families with medicine procurement and securing medical resources in the community such as wheelchairs, medical devices, and other medical-related equipment to ensure the child had the appropriate medical supports in place.
4. Adolescence (ages 13 to 15): The Linden Group – focused on supporting CYSHCN and their families with implementing a Medical Home and/or solidifying the one that was already in place. Staff worked with the CYSHCN on securing that the services were in place and ensured a smooth transition into adolescent health care when appropriate.
5. Early Adulthood (ages 16 to 18): The Redwood Group - focused on supporting CYSHCN and their families with implementing a Medical Home and/or solidifying the one that is already in place. They worked with the CYSHCN and their family transitioning youth into adult health. They supported the family and youth with securing the appropriate adult health-care physicians to develop a Medical Home that best suited the youth.

Jay's House hosted a monthly meeting for CYSHCN families to meet and connect with one another. The goal of the meeting was to answer questions, implement a "topic of the month" to foster discussions to develop a sense of inclusivity and alleviate any feeling of alienation from being a parent or caregiver of a child(ren) who has a special healthcare need and increase membership through family referrals.

Jay's House launched a Parent/Caregiver Engagement event to introduce the organization to the community members and provided information and background on CYSHCN and the Family SHADE project. Jay's House representatives began recruitment efforts to engage with families and build partnerships through social media, school Guidance Counselors, after-school programs, and faith-based organizations.
Their team hosted a Medical Home Meeting which included families of CYSHCN and health care providers. This meeting included strategies to improve systems of care for CYSHCN families and connected families with health-care physicians in the area.
They ensured that families and children/youth received the resources and information necessary to have early detection, testing, and secure appropriate medical professionals which best served their child so that they can thrive and grow through their developmental milestones.

The Parent Information Center utilized the Family Leadership Network (FLN) in collaboration with Jay's House to engage families of CYSHCN to promote inclusion and receive feedback on where there were gaps in service delivery for CYSHCN population. At the beginning of 2022, there were 12 FLN members that were recruited and served as collaborative leaders who contributed feedback on their experience on service delivery to PIC and to Jay's House as well as other organizations that serve CYSHCN and their families. By the end of calendar year 2022 the FLN membership decreased to 11 members. The one member left the FLN due to personal commitments and had to discontinuing their participation.

In calendar year 2022, Jay's House implemented activities that promoted family inclusion with guidance from PIC:
- Jay's House hosted an Annual Summer Family Fun Day to foster relationship-building between families.
- Jay's House hosted a Back-to-School Event for the CYSHCN families and worked with them to ensure educational and medical supports were in place. They provided medical information for the families and continued to promote implementing the Medical Home model.
- Jay's House developed relationships with schools and medical professionals to create a system of care within a society that supports the CYSHCN families with resources and services.
- Jay's House hosted two family holiday events in November and December of calendar year 2022.
- They hosted the Medical Home Monthly Meetings.
- They worked with families and medical professionals on ensuring that children/youth were receiving appropriate services that aligned with their developmental stage.
- Supported families with community-based services and resources.
- Continued to collect data to measure impact of the program.

- Sent out surveys to families to collect data which measured the impact of the program.

Jay's House project was executed once the Parent Information Center provided their staff with technical support in the development of a logic model, workplan, implementation plan and an evaluation plan. Both implementation and evaluation plans addressed NPMs 11, 12, and 15 with the technical support and guidance of PIC. The areas of priority in the plans were:

- Increase percent of children with and without special healthcare needs who were adequately insured
- CYSHCN received the services necessary to make transitions to adult healthcare
- Children with and without special healthcare needs had a medical home
- Children receive developmentally appropriate services in a well-coordinated early childhood system

Jay's House developed a Strategic Outreach Plan that engaged potential CYSHCN families via social media, school Guidance Counselors, medical professionals, community centers and faith-based organizations. They scheduled meetings with families in-person and virtually to introduce the Family SHADE program and its benefits. Jay's House staff collected data to identify resources and supports needed for those children who are at an increased risk for chronic physical, developmental, behavioral, or emotional conditions. Jay's House worked with schools, medical professionals, community centers and faith-based organizations to support the Family SHADE program and build a CYSHCN network of support builders. Jay's House staff followed up with potential CYSHCN families to garner their interest, support questions about the program and identify resources and services that would support the family. Through the tracking of enrollment forms, surveys and questionnaires data was tracked to include CYSHCN services and supports needed, services implemented, and suggestions from families of CYSHCN.

Jay's House completed one year under the Family SHADE mini grant project. This project was the first of its kind and there were accomplishments as well as opportunities to learn from in the first year of the mini grant project.

Accomplishments:
Jay's House worked directly with parents, not with youth. The Program made use of families already associated with Jay's House and with new families recruited. The families served resided in the geographical area of the Philadelphia Pike corridor north of Wilmington to Claymont (zip codes 19802, 19809, and 19703). The reported activities occurred between late April and mid-October of calendar year 2022.

Project - Jay's House				
	Baseline (Number of Unduplicated CYSHCN Parent's Served)	Number of Unduplicated Participants	CYSHCN & Their Families Impacted	Percent of CYSHCN Impacted
Total participants	27 parents (20 families)	20 families (27 parents and at least 28 children)	At least 22 CYSHCN and their parents,	No real denominator

Twenty families worked with Jay's House on this mini-grant program, participating in multiple group sessions and individual consultations. Though the contractor was unable to provide a breakdown of the number of contacts with each family. It appears that most of the 20 families participated in most of the monthly informational and skills group sessions (four of which occurred). Through providing resources for the families at these sessions, there were real symbiotic benefits: the families learned more, and they got contacts with other organizations providing services for children with special health care needs. And concomitantly, through these referrals, the families publicized the availability of the Jay's House services in the community, particularly supportive services related to Medical Home Assistance. The positive feedback from families led to new contacts for Jay's House, both with clients and with other community organizations.

Of the 20 families, all had children with special needs, primarily autism. Among the 20 families, six families had other siblings without special needs, five had no other children, and two families had other children with special needs. Information was not collected on the other seven families, and they could not be re-contacted by the contractor.

From the contractor's perspective, the most valuable component of the mini-grant activities was the networking with other organizations. Of particular note, through a parent Jay's House connected with a woman who had to close her daycare during the pandemic. They are collaborating to open a daycare specifically for children with Autism and Developmental delays in 2023. Jay's House did not decide to apply for the year two, mini-grantee opportunity because of the new opportunity to open a daycare with a community organization targeting children with Autism and developmental delays.

As to community events and networking with other organizations, Jay's House participated with other community organizations in seven community events between July 7 and October 15 in calendar year 2022. Organizations

included Planned Parenthood, Kids Count, Safe Schools, the Division of Vocational Rehabilitation, AngelSense, Camp Bliss for Kids, Claymont Community Center, and the Colonial School District.

Opportunities for Enhancement:
The Parent Information Center found that Jay's House could have done a better job at the collection of data from the families that were part of the project. Information was not collected on seven of the families, and they could not be re-contacted by the contractor, Jay's House. The data collection should have been a priority so it could be evaluated and utilized to meet the gaps in the population served.

Tomaro's C.H.A.N.G.E. (Creating Healing, Answers, & Necessary Guidance for Excellence) also received a mini-grant in the amount of $25,000.00 in April of 2022. In the first year they worked on a Logic Model, Evaluation Plan, and a Health Survey Questionnaire with the technical assistance of the Parent Information Center. They intended on implementing the "YES" Program's "YES to Mindfulness!" which ensured that children who are experiencing difficulties, regardless of mental or behavioral health issue, have an opportunity to learn mindfulness techniques that can help them. The techniques were to teach their clients to master mindfulness techniques overtime. The techniques that they intended to teach tied in with therapeutic services, that would help improve a child's overall emotional psychological, and physical health using holistic methods that would otherwise be overlooked. The targeted population was intended for youth ages 10 through 17 who resided in Delaware. Although Tomaro's C.H.A.N.G.E. was located in Claymont, the program was to be implemented throughout the state to those that were interested in virtual participation. However, the project had a difficult time getting started and executing their program due to securing a location.

"Mindfulness" work was also originally planned to be a significant program addition for ongoing therapy clients, but the timing and access proved not conducive to working with current clients. Consequently, the program was delayed and reformatted as more of a stand-alone service. At the end of calendar year 2022, Tomaro's C.H.A.N.G.E. did not implement their program. In the beginning of calendar year 2023, the program took a new approach and in February 2023 they implemented weekly sessions at the Route 9 New Castle County Library. Youth and adolescent participants began attending the "Yes to Mindfulness Program" once a week for a series of five 60-90-minute sessions, where they were taught basic techniques of mindfulness and meditation to help youth and adolescent clients heal and manage their emotions and behaviors. The short-term goal improved behavior and mental state, with a long-term goal of ultimately leading to them becoming more healthy and productive adults. Data from year one (calendar year 2022) are available.

Project - Tomaro's CHANGE				
	Number of Unduplicated CYSHCN Parent's Served	Number of Unduplicated Participants	CYSHCN & Their Families Impacted	Percent of CYSHCN Impacted
Year 1	8	9	At least 4	No denominator

In the beginning of calendar year 2023 attendance at the sessions increased from two in Session 1, to nine in each of Sessions 4 and 5. There were a total of nine unduplicated participants with five participating in at least four sessions. The ages were: (1) age seven, (1) age eight, (3) age nine, (2) age 10, and (2) age 11. Three of the nine participants were male and six were female, with one set of twins. Two children were known to have medical doctors. Data collection forms are being reworked to gather explicit material on those with a medical home going forward.

CYSHCN criteria were noted for four participants: two participants were on medication for ADHD; one participant was suicidal in the past; and one participant had anger management issues, particularly in school. The youth with suicidal ideation was brought by a grandmother who is trying to help the child. The mother will not seek mental health assistance for the child, and the grandmother tries to arrange having childcare so she can bring the child to the sessions, which the child enjoys and for which the grandmother is grateful.

Tomaro's CHANGE did not utilize the $25,000.00 in the first half of the calendar year 2022. Their program required a lot of technical assistance from the Parent Information Center and they will continue to work under the guidance of PIC. They will resume their "YES to Mindfulness" in calendar year 2023. Tomaro's C.H.A.N.G.E. also had accomplishments as well as opportunities for enhancement.

Accomplishments:
They were able to develop a Logic Model, Evaluation Plan, and a Health Questionnaire Survey with the technical assistance from PIC and a new evaluator who has joined the team in calendar year 2023.

Opportunities for Growth:
Tomaro's C.H.A.N.G.E. and PIC will benefit from making sure they are monitoring and evaluating their project every step of the way moving forward. With PIC's new evaluator, they have a new data survey tool that captures the data that will allow PIC to track specific information around the CYSHCN families served such as: gender, age, geographical area served, special health care need, number of times attended, and if the adult participant is a parent or guardian. Also, measuring the satisfaction of the session as well as the knowledge gained during the Mindfulness Session with the utilization of a pre and post survey is also data that is captured from the participants moving forward in calendar year 2023.

Through ongoing programmatic meetings with the CYSHCN Director and the PIC Team, Family SHADE will work toward educating families of CYSHCN and enhancing the service delivery through building capacity of organizations throughout Delaware which serve families of CYSHCN. Targeting the national performance measures and the gaps in service that are identified through data collection. The CYSHCN program will execute the revitalized Family SHADE project in Delaware through innovative approaches such as Zoom meetings, emails, mail distribution and through the distribution contact list of partnering agencies that serve CYSHCN.

Family SHADE Summit:
In September of 2022, Family SHADE Project hosted their 1st Annual Family SHADE Summit. The summit consisted of a day retreat where parents and professionals participated in four breakout sessions addressing topics related to CYSHCN and their families and the relationship between services offered by the Division of Public Health, Division of Medicaid and Medical Assistance (DMMA), Delaware Healthy Mother Infant Consortium (DHMIC), Social Security Income (SSI), Life after high school, and Early Intervention (EI). There was also a panel of Family Leadership Network members that served as a parent panel at the summit. They shared CYSHCN parent experiences and ways professionals, and community organizations can support families more and get involved in CYSHCN topics/issues. There was also a presentation by the mini-grantees (Jay's House and Tomaro's C.H.A.N.G.E.) providing an overview of the services they offer.
The breakout sessions title and attendees were as follows:

1. Preparing youth for life after high school living independently/living independently as a parent (nine attendees)
2. Addressing the needs of CYSHCN and their families -The National Family Voices (14 attendees)
3. What is a Medical Home (Care Notebook Training) (12 attendees)
4. Understanding SSI (eight attendees)

Managed Care Organization (MCO) Calls/Virtual Meeting:
MCH provided 10 MCO calls/virtual meetings in calendar year 2022. The virtual meetings were offered every second Tuesday of the month at 11:00am. The Family Voices MCO calls/virtual meetings were offered in Spanish and English as these meetings have continued to be a wanted resource. The Parent Information Center oversees the Family Voices program and they have scheduled this forum where parents/caregivers can ask questions and/or discuss issues they are having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). In calendar year 2022, there were 318 participants that attended the MCO meetings. Of the 318 duplicative participants, there were 57 that were unique. The MCO impacted 15 (4%) CYSHCN and their families. Some common issues discussed on the calls/virtual meetings included: care coordination requests, in home care hours, denials, therapies, private duty nursing, supplies, equipment, medication, and more. These calls are beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs, who have questions and concerns regarding the Medicaid insurance they have for their children. 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.

Bureau of Oral Health and Dental Services (BOHDS) and Family SHADE project:
Through the Division of Public Health (DPH) website: www.DEThrives.com; the DPH and Family SHADE project in collaboration with BOHDS will continue to utilize the DEThrives platform to promote and provide essential public health services to improve and promote preventative care and oral health for children and youth with special health care needs. Improving access to Dental Care for Delawareans with Disabilities will help 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 will educate 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. Since our Family SHADE project is being led by a new vendor, we will revisit this idea of a Tool Kit and explore the implementation of the Toolkit for practitioners which will include a Tool Kit of resources which will include a patient assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

COVID Response Plan and Support:
In March of 2022-2023, the Family SHADE project received additional funding to hire a contractual full-time employee (FTE) 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 COVID response plans, education, and planning. The mini-grantees which were awarded funding through the Family SHADE project included a COVID response plan and COVID support in congruency with their implementation plan and their evaluation plan. During the September of 2022 Annual Summit, PIC had a booth where they offered the COVID vaccine to those who attended the summit. This made it convenient for CYSHCN and their families.

In 2022-2023, the Title V CYSHCN Director reached out to our Delaware Family Voices to take advantage of an opportunity offered by the National Family Voices. The opportunity consisted of technical assistance to Family Voices and the CYSHCN Director to establish a Collaborative Action Team Process: Diverse Family Engagement & Leadership. The State Collaborative Action Team Process included our DPH MCH CYSHCN Director and Family Voices parent lead organization. We worked together to develop a plan to enhance diverse family engagement and family professional partnerships at the individual, program, and /or policy level. Through the technical support from the National Family Voices Leadership in Family and Professional Partnerships (LFPP) we established a draft Strategic Plan that included sustainability and the start of the collaborative. However, due to leadership at Family Voices changing, we have not finalized our Collaborative Action Team Plan. We plan to reconvene with the new leadership - Parent Information Center (PIC) who has merged with the Delaware Family Voices parent lead organization.

Title V staff participated in the Children with Medical Complexity Advisory Committee (CMCAC) to support their recommendations:

- We will continue to keep the CMCAC in place.
- Perform a comprehensive data analysis as it relates to children with medical complexity.
- Strengthen systems of care for children with medical complexity.
- Be clear in contracts about the role of managed care organizations in identifying and providing services to children with medical complexity.
- Develop and/or strengthen existing resources for caregivers, providers, and the larger community involved in the care of children with medical complexity.
- Strengthen the network of home health providers for children with medical complexity.

While Preventative Dental Care Visits for Children and Adolescents/CYSHCN was not one of MCHs identified goals in calendar year 2022, our CYSHCN Director and Family SHADE will resume the collaboration with BOHDS for the upcoming 2023 year. The goal of the project will continue to promote and provide essential public health services to improve and promote preventative care and oral health for children and youth with special health care needs on our www.DEThrives.com Family SHADE website. Improving access to dental care for Delawareans with disabilities will help 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 will educate practitioners on best practices on serving the CYSHCN population. Delaware's BOHDS has been in the process of creating, "Dental Tips for Scheduling a Dental Visit for People with Disabilities." They continue to create a Disabilities Fillable Form which a parent can use to capture all the information needed prior to scheduling a dental appointment with a dentist that will see their CYSHCN. Through this collaborative initiative, we will continue to explore the implementation of a Toolkit of resources for practitioners which will include a patient assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in serving CYSHCN.

Delaware's Developmental Disabilities Council:
Delaware's CYSHCN Director is a governor appointed member to the Delaware Developmental Disabilities Council (DDC). The CYSHCN Director has actively served as the Chair of the Personnel Committee 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 approves our 5 Year Strategic Plan which is currently in draft mode on our state website awaiting approval. The DDC Strategic Plan can be accessed at: https://ddc.delaware.gov/contentFolder/pdfs/strategicPlan-DRAFT.pdf. The mission of the Delaware DDC is to promote and embrace inclusion, equality and empowerment.

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 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 five years is Education, Early Intervention, Housing, and Health/Healthcare. Aligning service delivery through Delaware's Title V priorities and strategic plans for the coming year targeting families of CYSHCN assures that we are meeting the needs through a congruent and collaborative initiative addressing NPM 11 (medical home), NPM 12 (transition to adult health care for CYSHCN) and NPM 15 (adequate insurance).

Children with Special Health Care Needs - Application Year

Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 28,111. According to the 2020/2021 National Survey of Children's Health (NSCH), 68.8% of Delaware children are adequately insured in comparison to the national average of 68.2%. This includes CYSHCN between the ages of 0 through 17. Among the sub-group of children with special health care needs, 65.4% are continuously and adequately insured, compared to 69.7% of non-CYSHCN children. Also, according to the 2020/2021 NSCH, 38.3% of Delaware children with special health care needs, ages 0 through 17, have a medical home, compared to the national average of 42.0%. This means, 61.7% of Delaware children with special health care needs, do not have a medical home. In addition, according to the 2020/2021 NSCH, 14.4% of Delaware adolescents with special health care needs, ages 12 through 17, received services necessary to make transitions to adult health care in comparison to the national average of 20.5%.

Delaware's Title V/Title XIX Memorandum of Understanding (MOU) will continue to establish the Cross-Agency Coordination Committee with our Medicaid partners. We reconvened our meetings with Medicaid to meet the needs of our MCH population with the data collected from the Title V Needs Assessment last year. Medicaid and the Division of Public Health (DPH) sees this as a fantastic opportunity to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women, babies and CYSHCN. We have established this committee and we will continue to meet. The committee will work together to be creative in establishing training, messaging, case management, and procedures in promoting accessibility to adequate insurance coverage.

In year four of this grant cycle, Delaware will utilize Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making, to best serve our CYSHCN and their families. Family SHADE will continue to 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. Our Parent Information Center (PIC) will continue to implement the newly revitalized Family SHADE project by executing the second year of competitive mini-grant opportunities and awarding and implement Learning Communities to families and organizations that serve CYSHCN. PIC will also continue to grow the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The network membership includes trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. FLN members will continue to receive monthly stipends for attendance and participation pending available funding. 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. PIC will continue to prioritize aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPMs) as well as topics addressing gaps in service and identified needs that are impacting families of CYSHCN. Through these initiatives, the Family SHADE project will build state and local capacity and test small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations will focus on innovative strategies and improving the Title V NPMs and support the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC will routinely take surveys to track and gather information and topics being requested by Family SHADE community by taking pre, post, and overall evaluation surveys during focused learning communities.

In February of 2023, PIC began the planning phase of implementing the second year of promoting request for proposals for the mini-grant program. A timeline was established for year 2 of the mini-grant program which afforded applicants a schedule to follow if they wanted to apply for the mini-grant opportunity. Below is the timeline that was established.

Overview of the Mini-Grant Process (Estimated Timetable)	
February 1, 2023, 12:00 p.m. & 6:00 p.m.	Required Zoom Information Session for Interested Applicants
February 24, 2023, 5:00 p.m.	Deadline for submission of application/proposal
March 7 - 9, 2023	Oral Presentations to the Selection Committee
March 17, 2023	Notification of Awards and MOU signed
March 23 - 24, 2023	Mandatory Orientation Conference Call for Recipients
March 27, 2023	Initial Payment to Recipients
August 31, 2023	Complete all mini-grant projects
September 15, 2023	Final reports (project and financial) are due
September 16, 2023	Program Presentation at annual Summit

Through year 2 of the revitalized Family SHADE mini-grant program, PIC began the planning process of implementing the second round of mini-grant funding opportunities. They awarded a total of three organizations to implement the following services which align with the Maternal Child Health Title V National Performance Measures. The mini grantees awarded are listed below.

1. Down Syndrome Association of Delaware – Will implement their unique partnership between the Down syndrome Association of Delaware and the Down Syndrome Program at Nemours Children's Health System to ensure families leave clinic feeling supported, with multiple contacts helping them address medical and non-medical concerns and care for their child, mentally, physically, and emotionally. Their Multi-Specialty Approach will provide a coordinated, multi-specialty approach to address every child's medical, developmental, and social needs helping them reach their full health and developmental potential. It is essential that families be able to access these resources on location, reducing barriers to these services by increasing convenience and providing innovative holistic support for the entire family. This project aligns with NPM 11- Access to a medical home.

2. Children's Beach House – Will implement a Youth Development Program described as "giving kids what all kids need." CBH will assist in establishing and meeting kid's needs such as relationships with friends, positive adult role models, the safety and security to try new things and develop natural skills and talents, and access to community resources to help them thrive. Through a rigorous case management program provided by the programs team of Family Engagement Coordinators (FEC), these FECs will work with each child and family to identify each child's unique interests and talents and to weave together a network of services and relationships that will help them to thrive. This will be in collaboration with the children's schools and learning specialists, as well as a wide variety of partnering government agencies and community-based nonprofits. This project aligns with NPM 11 - Access to a medical home.

3. Teach Zen – Will implement the One Love, One Hearth Curriculum in at-risk children of low-income families who are enrolled in an early childcare program who receive 50% funding from Purchase of Care. The program goal is to expose young children with special health care needs between the ages of 3 to 5 enrolled in a childcare program to Social Emotional Learning and self-regulation techniques to improve their overall emotional wellbeing. A One Love, One Heart Curriculum Instructor will visit each classroom for a total of 20-30 minutes (developmentally appropriate amount of time) to implement the day's activities. This project aligns with NPM 6 - Developmental Screening. The program will be for 12 weeks in length and covers the following topic areas:
    - Kindness and Compassion
    - Discovering the Benefits of using our Breathe to calm Ourselves
    - Handling Emotions/Various Self-Regulation Techniques
    - Positive Self Image
    - Sharing/Social Engagement (Games)
    - Cultural songs and community drumming

Tomaro's C.H.A.N.G.E. decided to continue their efforts with the support of the Parent Information Center (PIC) to implement their project in year 2, since they were not able to get their project implemented in year 1. Jay's House did not return for a second year because through year 1 they were able to develop a network with other organizations and they went on to collaborate and open a daycare specifically for children with autism and developmental delays. The funding from Jay's House's mini-grant award in year 1 had no correlation with the development of the daycare that Jay's House moved onto collaborating with partnering organizations that they met through their experience working under the Family SHADE mini-grant project. Therefore, Jay's House will not be returning to the Family

SHADE mini-grant project but will be a community resource for CYSHCN and their families.

The three organizations that were awarded: Down Syndrome Association of Delaware, Children's Beach House and Teach Zen will begin to work on the development of their proposed projects plans such as:

- Logic Model
- Work Plan
- Evaluation Plan
- Evaluation Tool
- Sustainability proposal
- COVID response plan

The Parent Information Center will take the lessons learned from the first year of the mini-grant program and enhance the program in year 2 by monitoring the mini-grantees closely and create a data collection tool that will be administered with all the mini-grantees to assure that data collection will seamlessly align with NPMs 6, 11, 12, and 15. The PIC team will monitor and evaluate through every phase of the projects the impact that is being made on CYSHCN and their families. The PIC team will provide technical support to the mini-grantees along with regularly scheduled monthly site visits by the project coordinator.

Also, through monthly regularly scheduled programmatic meetings with the CYSHCN Director, we will review the NPMs below and align their data collection tools and their projects to mirror their projects initiatives.

- Performance Measure 6 (Developmental Screening)
  Percent of children, ages 9 through 35 months, who received developmentally appropriate services in a well-coordinated early childhood system.
- Performance Measure 11 (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 12 (Transition to Adult Healthcare)
  Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.
- Performance Measure 15 (Adequate Insurance) Percent of children, ages 0 through 17, who are continuously and adequately insured.

The Parent Information Center will enhance their data collection process for all of the mini-grantees as well as data collection for their 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 newly developed data collection tool will capture knowledge gained through pre and post-tests provided to mini-grantee participants. The data collection will also capture the services provided, demographical information such as gender, age, location, special health care need, number of times attended, and if a parent/guardian was present.

PIC will utilize the Family Leadership Network (FLN) in collaboration with all of the mini-grantees to promote inclusion and receive feedback on where there are gaps in service delivery for the CYSHCN population. Currently, there are 11 FLN members that will serve as collaborative leaders who contribute feedback on their experience on service delivery to PIC and to the four mini-grantees which will serve CYSHCN and their families. This network will continue to consist of parents/guardians of children birth to 26 that have a suspected or diagnosed disability. The network membership will include 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 PIC has the monetary resources available for this network.

In calendar year 2024, Tomaro's C.H.A.N.G.E. (Creating healing, Answers, & Necessary Guidance for Excellence) will implement their reformatted project in year 2 of the mini-grant project lead by PIC since they were not able to implement their project in calendar year 2023 due to difficulties securing a location to execute their project. Therefore, the project was delayed and reformatted as more of a stand-alone service. The new approach will be to implement weekly sessions at the Route 9 New Castle County Library. Youth and adolescent participants will attend the "Yes to Mindfulness Program" once a week for a series of five 60–90-minute sessions, where they are taught basic techniques of mindfulness and medication to help youth and adolescent clients heal and manage their emotions and behaviors. The short-term goal will be to improve behavior and mental state, with a long-term goal of ultimately leading to them becoming more healthy and productive adults.

Family SHADE Symposium:
On July 15, 2023, The Family SHADE Project will host a quarterly symposium which will provide the CYSHCN community with the opportunity to engage in MCH Title V services provided to CYSHCN and their families. It will also be an opportunity for the Family Leadership Network to provide input on their life experiences to professionals serving CYSHCN. They will cover topics and services that align with the National Performance Measures 6, 11, 12, and 15.

Family SHADE Symposium:
The Family SHADE Project will host quarterly symposiums which will provide the CYSHCN community with the opportunity to engage in MCH Title V services provided to CYSHCN and their families. Some of the Symposium topics will be revisited from the symposiums in calendar year 2023. This will allow new families of CYSHCN to take advantage of attending workshops on topics such as:

- Transition: Medical and educational transitions for youth in Delaware
- Medical Home and Engaging the Family
- Communicating Visually: for families of children diagnosed with autism
- Supported Decision Making
- Student Led IEPs

2nd Annual Family SHADE Summit
On September 16, 2023; The Family SHADE Project will host the 2nd Annual Family SHADE Summit which will focus on highlighting innovative projects and other MCHB Title V programs supporting CYSHCN. The summit which will consist of a day retreat where parents and professionals will participate in workshops addressing topics related to CYSHCN and their families and the relationship between services offered by the Division of Public Health, Division of Medicaid and Medical Assistance (DMMA), Delaware Healthy Mother Infant Consortium (DHMIC), Social Security Income (SSI), and Early Intervention (EI). There will also be presenters from supporting caregivers as well as a presentation by the mini-grantees that have been awarded in year 2 which are: Down Syndrome Association, Children's Beach House, Teach Zen Inc. and last year's mini-grantee Tomaro's C.H.A.N.G.E.

Managed Care Organization (MCO) Calls:
MCH will continue to support the Family Voices Managed Care (MCO) Calls in Spanish and English as these calls have continued to be a wanted resource. The Parent Information Center oversees the Family Voices program and they have scheduled this forum where parents/caregivers can ask questions and/or discuss issues they are having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). Common issues discussed have included: care coordination requests, in home care hours, denials, therapies, private duty nursing, supplies, equipment and medication. During the call, MCO's and Medicaid representatives along with other partner organizations can help problem solve. These calls are beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs, who have questions and concerns regarding the Medicaid insurance they have for their children. 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.

Bureau of Oral Health and Dental Services (BOHDS) and Family SHADE project:
Family SHADE will continue to promote BOHDS to expand their reach to the CYSHCN population by putting the BOHDS information on DPH's Family SHADE website www.DEthrives.com. This will continue to afford families easy access to a dentist that is able to serve CYSHCN. Having the BOHDS information on the Family SHADE website continues to make it more convenient for families to access the dentist that will best serve CYSHCN and eliminate them calling each dentist to ask if they can serve their child. Improving access to dental care for Delawareans with disabilities will help 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 will educate 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. Since our Family SHADE project is being led by a new vendor, we will revisit this idea of a Tool Kit and explore the implementation of the Toolkit for practitioners which will include a Tool Kit of resources which will include a patient assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

COVID Response Plan and Support:
In March of 2022-2023, Family SHADE project received additional funding to hire a contractual full-time employee (FTE) 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 COVID response plans, education, and planning. As we move forward, the four mini-grantees which were awarded funding through the

Family SHADE project, will include a COVID response plan and COVID support in congruency with their implementation plan and their evaluation plan.

The Title V CYSHCN Director reached out to our Delaware Family Voices to take advantage of an opportunity offered by the National Family Voices. The opportunity consisted of technical assistance to Family Voices and the CYSHCN Director to establish a Collaborative Action Team Process: Diverse Family Engagement & Leadership. The State Collaborative Action Team Process included our DPH MCH CYSHCN Director and Family Voices parent lead organization. We worked together to develop a plan to enhance diverse family engagement and family professional partnerships at the individual, program, and /or policy level. Through the technical support from the National Family Voices Leadership in Family and Professional Partnerships (LFPP) we established a draft Strategic Plan that included sustainability and the start of the collaborative. Due to leadership at Family Voices changing, we have not finalized our Collaborative Action Team Plan, however we are scheduled to reconvene with the new leadership-Parent Information Center (PIC) who has merged with the Delaware Family Voices parent lead organization.

Title V staff will continue to participate in the Children with Medical Complexity Advisory Committee (CMCAC) to support their recommendations:

- We will continue to keep the CMCAC in place.
- Perform a comprehensive data analysis as it relates to children with medical complexity.
- Strengthen systems of care for children with medical complexity.
- Be clear in contracts about the role of managed care organizations in identifying and providing services to children with medical complexity.
- Develop and/or strengthen existing resources for caregivers, providers, and the larger community involved in the care of children with medical complexity.
- Strengthen the network of home health providers for children with medical complexity.

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 actively serve 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 approves our 5 Year Strategic Plan which is currently in draft mode on our state website awaiting approval. The draft DDC Strategic Plan can be accessed at: https://ddc.delaware.gov/contentFolder/pdfs/strategicPlan-DRAFT.pdf. The mission of the Delaware Developmental Disabilities Council (DDC) is to promote and embrace inclusion, equality, and empowerment.

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 is to foster an environment that empowers and supports all Delawareans with developmental disabilities to lead self-directed lives. Areas of emphasis for the next 5 years is Education, Early Intervention, Housing, and Health/Healthcare. Aligning service delivery through Delaware's Title V priorities and strategic plans for the coming year targeting families of CYSHCN assures that we are meeting the needs through a congruent and collaborative initiative addressing NPM 11 (medical home), NPM 12 (transition to adult health care for CYSHCN) and NPM 15 (adequate insurance).

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Strenghthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	75
Annual Indicator		68	80	76
Numerator		17	20	19
Denominator		25	25	25
Data Source		FHS Data	FHS Data	FHS Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	75.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Delaware) - Cross-Cutting/Systems Building - Entry 1

SPM

SPM 3 - Strenghthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Objectives

Build MCH capacity and support the development of a trained, qualified workforce by providing professional development opportunities.

All MCH staff will have at least one professional development goal annually included in their performance plan.

Strategies

Develop a system to capture increases in MCH staff completing training such as the MCH navigator self-assessment.

Incorporate MCH competencies more intentionally into MCH position descriptions and performance plans.

Incorporate health equity, disparities, and cultural appropriateness/competence concepts into all workforce development activities.

Deliver annual training and education to ensure that providers can promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs population into adulthood.

Cross-Cutting/Systems Builiding - Annual Report

Even though workforce development was not a formal priority, we have been focused on improvement and ensuring staff have the resources they need to feel confident in the job they are doing. However, we feel accountability is needed to ensure a more intentional approach as well as the ability devote resources and capacity to our community partners.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.
It's important to note that not all learning occurs in a classroom or on an electronic device. Learning can be as simple as a supervisor observing an employee performing a task and offering suggestions on how to improve that performance (i.e. on-the-job training). It can occur during staff, one-on-one, and, performance feedback meetings, or by reading an article in a professional periodical and putting the concepts to work on the job. Supervisors can also facilitate learning by adding a Professional Development section to employees' Performance Plans. Working together on this will help employees focus on his/her training goals and establish a more productive working relationship. To keep track of this, employees can use the DPH Personal/Professional Development Plan, as a tool to help them and their supervisors, develop goals and document uniquely tailored training needs and experiential learning exercises to expand their knowledge, skills and abilities to provide the best service possible to the citizens of Delaware.

In October 2018, 30 MCH staff members from across the Division of Public Health participated in a two-day training on *FranklinCoveys 7 Habits of Highly Effective People*. 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.

All staff have access to an All Access Pass giving them the ability to utilize the entire *FranklinCovey* Library. The All Access Pass was designed to help organizations achieve strategic initiatives, develop leaders, and build skills and capabilities across the organization in a completely nimble and flexible way that helps them overcome those challenges - all at the very best value. With access to *FranklinCovey* courses, assessments, videos, tools, and digital assets, we can utilize the content in a wide variety of ways and across multiple delivery modalities to best meet the needs of our organization. MCH has begun to refamiliarize ourselves with the All Access Pass to the *FranklinCovey* Library as we start returning to the office. We feel that prompting our leaders with the trainings and videos that are available to us, will awaken the spirit of developing leaders and further build their skills. Because the courses are offered in formats that are convenient to participants and on a schedule that is most convenient to them, we feel the continued education will reenergize our leaders. Our Title V Deputy Director has spoken with the *FranklinCovey* expert assigned to Delaware to discuss the needs of our MCH staff and programming that might be beneficial.
In September 2022, we offered three in-person trainings utilizing our partnership with Franklin Covey, two focused on strategic planning and the third is the Strength Finder course.

- ***Execute Your Team's Vision and Goals*** workshop
    - Discuss Systems and The Six Rights
    - Introduce the 4 Disciplines of Execution
        - Discussion about Wildly Important Goals
        - Identify Lead Measures that Lead to Goal Achievement
        - Discussion on Creating Scoreboards

        - Discussion on Accountability
    - Discuss Leader Implementation with Staff

- ***Create a Shared Vision and Strategy*** workshop
    - Discussion around Team Vision
    - Discussion around Team Strategy
        - Customer Needs – Who are your most important internal and external customers? What do they want or need from you?
        - Team Capabilities – What does your team do best? Where are the gaps?
        - Strategic Context – What organizational strategies do you need to link to? What other factors do you need to understand and consider?
        - Bottom Line – How does your team add value? How do you impact the bottom line/budget?
        - Begin to Draft Team Strategy and Strategic Narrative
    - Discuss Leader Implementation with Staff

- **Strength Finder using the Clifton Strengths Assessment** workshop.
    - It's your way to discover what you naturally do best,
    - Learn how to develop your greatest talents into strengths and,
    - Use your personalized results and reports to maximize your potential.

Our 2022 FHS Annual retreat took place in June and was appropriately title, Navigating Roadblocks. The retreat took place at Courageous Hearts, an organization that provides quality equine assisted psychotherapy and equine assisted personal and professional development. The day consisted of the following activities:

- Presentation & review of the year's accomplishments by the Title V Director, Leah Woodall
- Interactive presentation on Healthy Life Balance & Mental Health Self-care
- Experiential grounded activity with horses guided by two facilitation teams to explore concepts discussed about a healthy life balance & self-care
- Group up for processing & exploring our experiences from the morning activity. Interactive presentation will continue to explore healthy boundaries, identify signs of stress & identify supports within work & home environments.
- Experiential grounded team discovery activity with horses guided by two facilitation teams to further explore concepts of recognizing stress and supports, expand on learning & explore individual and team interactions with horses that promotes personal & professional insight & emotional growth
- Share experiences and to take individual & group photos

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. Therefore, we feel that it is in our best interest to pursue a collaboration with the Office of Performance Management to identify the training needs of MCH staff. Together OPM and MCH could develop a training plan that would strengthen Title V staff's capacity for data-driven and evidence-based decision making. Especially due to the pandemic, virtual and/or hybrid trainings would be afforded to each participant.

As part of the Governor's Trauma-Informed Care initiative, DHSS required every employee to 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. Trauma results from many experiences such as an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life

threatening and that has lasting adverse effects. 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.

Cross-Cutting/Systems Building - Application Year

Having a well-prepared work force is critical to meet the maternal and child health 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 Five-Year Needs Assessment, MCH conducted a Workforce Capacity Analysis where the objective was to identify Delaware's Title V program capacity, including the organizational structure, agency capacity and MCH workforce capacity.

Delaware partnered with John Snow Inc. (JSI) to facilitate and analyze our Workforce Capacity Analysis. An online survey was the source of the information. 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 questions:

- Among the Delaware MCH leadership, what is the focus of their current work and what are their related training needs?
- To what extent does Delaware MCH leadership serve as supervisors and how do they currently develop staff?
- For MCH leadership, what do they believe are the essential/critical skills needed in their workforce? Do they think their workforce needs more training/development in these areas?
- In what ways is staff training currently operationalized? Do these ways seem sufficient to address the articulated workforce development areas?

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 diverse stakeholders, to find evidence, to learn quality improvement methods, and to understand health disparities and Culturally and Linguistically Appropriate Services in Health (CLAS) education and outreach.

Leaders are also concerned with staff development and succession planning. They prioritized workforce skills around program evaluation and data literacy. They also prioritized 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.

Particularly for leaders themselves, but also for the workforce, on the job training is desired. Yet mechanisms for this approach may not be as strong as for formal training. 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. With regard to specialized cultural and linguistic competency training, DPH offers in-house training opportunities. 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. Performance Plans are reviewed annually, however supervisors meet with staff 1:1 regularly to provide support, coaching and feedback related to performance.

We plan to offer the Strength Finder training to all new staff or staff that were unable to attend last year.

- **Strength Finder using the Clifton Strengths Assessment** workshop.
    - It's your way to discover what you naturally do best,
    - Learn how to develop your greatest talents into strengths and,
    - Use your personalized results and reports to maximize your potential.

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. On the Job training was the preferred method to formal training however, in the current environment we are not sure this format will be the most practical. The FHS leadership team will be discussing this at future leadership meetings. We will also be working with our key partners to determine when and what training and/or professional development they would like to see how us offer this coming year.

We are currently planning our 2023 FHS Annual Employee Retreat that always has a professional development component. The agenda for the day is still be finalized however, the theme is "Stronger Together through the Power of Connection" with activities/exercised focused on working together as a team.

We are also beginning our 2023 Title V Needs Assessment process and we will be assessing workforce internally and externally in our process.

III.F. Public Input

During this past grant cycle, MCH solicited input from professional partners, stakeholders, and the public by posting our Title V FY 2023 Application/FY 21 Annual Report on our website, https://dethrives.com/title-v. Our DEThrives website is one that serves as the hub for information on many maternal and child health efforts in Delaware. The DEThrives website is available to everyone, including stakeholders, partners as well as the public.

As planned, MCH developed and delivered a series of comprehensive presentations highlighting our priorities. We have several advisory committees that meet regularly and provide ongoing input on MCH programs and priorities, including the Children with Medical Complexity Advisory Board, Help Me Grow and Home Visiting Advisory Board, the Birth Defects and Autism Registries Committee, Delaware Developmental Disabilities Council, Sussex County Health Coalition, and the Delaware Healthy Mothers and Infants Consortium (DHMIC). We have also attended meetings of Family SHADE, an alliance of organizations and families committed to working together to improve the quality of life for CYSHCN.

Our new vendor, the Parent Information Center (PIC) implements our newly revitalized Family SHADE project. PIC routinely attained surveys to track and gather information and topics being requested by the Family SHADE community by taking pre, post, and overall evaluation surveys during focused learning communities. These surveys assisted in determining what knowledge was gained as well as what topics families and community organizations wanted to see in the future. In addition, Jay's House, a community agency awarded a mini-grant through the Family SHADE project, sent out surveys to families to collect data which measured the impact of the program. Through the tracking of enrollment forms, surveys and questionnaire data was tracked to include CYSHCN services and supports needed, services implemented, and suggestions from families of CYSHCN.

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.

Delaware previously partnered with Forward Consultants for our ongoing Mini Needs Assessment process. Our 2020 Needs Assessment Stakeholder Survey was modified and our finalized objectives for our Mini Needs Assessment were:

- Gauge the impacts of the pandemic on our partners within each health domain
- Learn how our partners were adapting to the ongoing challenges of the pandemic
- Be more informed of the ways each program is adjusting
- Support programs that continue to address the MCH population
- Identify ways MCH can better support our Title V funded partners with technical assistance

Part of this survey included questions for our partners of the various ways Title V was able to provide technical assistance. DPH coordinates and collaborates with many organizations and other state agencies to implement activities that address grant goals and objectives. Title V was concerned about how we can better support our partners and be more responsive to their needs. As a result, we learned that our Title V funded partners ranked "provide data" as the most pressing need. Our Title V team decided that our SSDI Project Director would work with our CDC Epidemiologist to create a data sheet that included relevant MCH population data. We want our partners and stakeholders to be able to view Delaware's history of data in one document, tracking the information from year to year.

Our SSDI Project Director was able to schedule regular meetings with our two-Family Health Systems epidemiologists and began the task of compiling all MCH data into one document. Both epidemiologists, our CDC assignee epidemiologist, as well as our FHS epidemiologist, are members of our Steering Committee. Our goal was to gather and organize Delaware's data pertaining to each NPM and NOMs. Delaware's MCH Performance Data Sheet was created to provide data to support and assist our partners with their needs. During this past grant cycle, our SSDI Project Director updated the MCH Data Sheet with 2020/2021 NSCH data.

Through our 2020 Needs Assessment process, MCH created detailed and specialized health infographics for each of the 15 NPMs and various NOMs. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it related to each measure. Information such as Delaware's goals and objectives,

Delaware's baseline data, and how Delaware compares to our neighboring states were included on each infographic. This year, MCH amended these health infographics once the 2020/2021 NSCH data was released.

As part of the Title V MCH Block Grant, Delaware previously developed a colorful snapshot, which is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. It offers an at-a-glance snapshot for the public, our partners, and our stakeholders 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.

Following the submission of the Title V 2023 Block Grant Application/2021 Annual Report, the Title V Coordinator emailed our partners and stakeholders statewide regarding our completed application and provided a public comment period. The MCH Bureau usually receives comments, but rarely received suggested changes to the Block Grant application.

DEThrives ran a single image newsfeed ad to spread news of the DPH's Title V Block Grant. This was the first time that Title V work was mentioned on social media so the social media post was an introductory one providing general information of what the Block Grant is and how DPH plans to address each section of the grant. The ad targeted women and men aged 18-65+, with a proxy pregnancy audience, new parent and parents of children under 5 audiences, who live in Delaware. The objective was to maximize the number clicks to the Title V landing page. In terms of performance, the ad reached over 31K users, had over 60K impressions, earned 503 clicks, a 1.9 frequency, and a 0.97% engagement rate.

Other stakeholders are contacted by MCH for input and feedback through various meetings, conferences, surveys, and other community activities. MCH periodically reaches out to the public for feedback or updates regarding the MCH community. Such areas throughout this year included questions regarding the Block Grant Application, the introduction of our MCH Performance Measure data sheet, DHMIC updates, and more. Our stakeholder involvement and input has been taken into consideration as our team began to prepare for the FY24 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.

Family SHADE, our partner supporting our CYSHCN program, continued to engage parents and families through surveys administered by the Parent Information Center (PIC) and Jay's House. Both partners gained information from the CYSHCN population on services and supports needed, serviced implemented, and suggestions from families of CYSHCN. The surveys also assisted in determining knowledge gained as well as future learning topics families and community organizations requested.

As in years past, Title V supported a very important activity, the Managed Care Organization (MCO) health calls facilitated by Delaware Family Voices. These are a very important activity for partnering with families. These regularly scheduled calls give family members an opportunity to ask questions or discuss an issue. On the call 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 problem solve. These calls give families a non-adversarial venue discussion to share their concerns and 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.

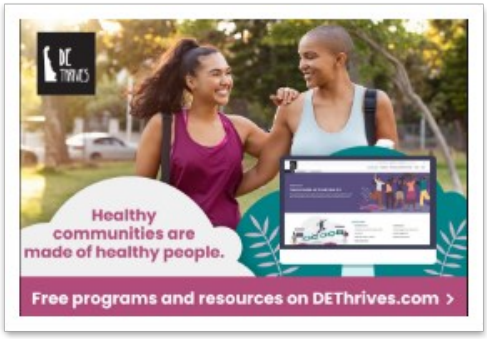
All our Title V information is found in one central location, our DEThrives website. Here MCH has all the detailed Title V information, including our FY23 block grant application, Delaware's Five-Year State Action Plan, infographics on each of our 15 NPMs, our State Action Plan Snapshot, the MCH Performance Measures data sheet, a framework of the Needs Assessment process, reports on our Focus Group studies, results of the Stakeholder Survey and more. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions.

DEThrives held a two-month campaign to launch the news of the newly designed DEThrives.com website. The target audience included women of reproductive age (15-44 years old), expectant parents, and parents of children aged 0-5. Media tactics included:

- Digital media: Placing ads on Facebook and Instagram platforms where posts are shared via newsfeed and story ads.
- Organic tactics included: Posting an IG reel. Quizzes and short, animated videos have also been posted that displayed a screenshare of some of the web pages that are available on the website.
- Streaming audio: Placing ads on radio stations, podcasts, and other on demand streaming services.
- Jun Group banner ads: Placing ads in game apps, where the user would let the ad play to earn an extra life in their game.
- Adtheorant quiz – Placing an ad on a website and is presented as an interactive quiz.

DPH communication vendor also presented a preview of the website during a DHMIC quarterly meeting. The news was also presented during a HMG Advisory Committee.

An eblast email was sent to DPH's Title V email listserv and other FHS related email lists such as the HMG Advisory Committee list to help spread the news of the revamped site and some of its new features. The Title V email listserv reached the following partners: DHMIC, DHMIC professionals, DHMIC community organizations, HWHB Zones mini-grantees, home visiting, family planning, Family SHADE parent/members, newborn screening, EHDI early childhood education, SBHC mental health providers, SBHC nurse practitioners, SBHC registered dieticians, SBHC administrative assistants, SBHC alliance members, school counselor supervisors, charter school nurses, lead school nurses, and school climate contacts. The eblast message consisted of messaging stating what the DEThrives site holds as a friendly reminder to partners and stakeholders, a hyperlink to download or print the new website flyer to share if interested, along with a link to the free toolkit materials for the website campaign. A hyperlink was also provided where specific professional and community partner resources could be easily found.



Additionally, news of a photography opportunity was shared where DPH will be conducting photoshoots across Delaware to help represent the programs and services the DEThrives site offers. The goal of this is to take real life pictures of actual Delawareans with recognizable backgrounds and depict photos of real life scenarios and situations to personalize the DEThrives site a bit more. Hardcopy items such as the website campaign poster and flyer will be delivered to areas such as: libraries, daycares, pediatricians, OB-GYNs, breastfeeding and maternity care facilities, Delaware WIC, and the Boys & Girls Clubs throughout Delaware. A QR code was also generated and placed throughout the campaign materials for a quick and easy access to the website.

Delaware has officially kicked off our 2025 Five-Year Needs Assessment planning process. Our Title V Coordinator along with our MCH Deputy Director have met to develop the plan for our public input process. MCH aims to have several methods used to gather public input, including regular email updates to stakeholders, surveys, community forums/listening sessions, key informant interviews and focus groups. Qualitative data such as focus groups and key informant interviews can be considered the stories behind the data. The timing and sequence of gathering public input will be iterative with each activity laying the groundwork for subsequent activities. Division

staff plan to attend coalitions, programs, and special initiative meetings across the state to discuss the Needs Assessment process and solicit input.

MCH plans to conduct Focus Groups regarding several MCH issues related health care and their community. Our goal is to have maternal health groups focused on questions related to women's health, groups focused on mothers and children and youth with
special health care needs, father/partner groups, and preconception groups with African American women without children. In addition, Delaware plans to add some groups of adolescent/young adults with a mental health focus. MCH will also conduct a Professional Stakeholder Survey that would be distributed to our stakeholders of MCH service agencies, organizations, coalitions, and programs for input on MCH population needs, system gaps and leverage points. The survey will also provide stakeholders an opportunity to rank the 15 National Performance Measures. The results and findings from the survey will inform our decision-making efforts to select our NPMs, SPMs, and ESMs.

During our 2025 Needs Assessment preliminary discussions, MCH has determined that Key Informant Interviews will also be conducted to learn more about system strengths and needs and to better understand the landscape of services and supports. MCH plans to identify stakeholders to participate in key informant interviews with partners representing every population domain. MCH will add an additional interview with a mental health worker in a high-risk School Based Health Center.

Following the submission of our FY24 Block Grant application, we plan to post the documents on our website. At that time, we will again solicit feedback and input into our Title V block grant application. Any major adjustments that are suggested will be documented for future consideration as the TVIS system will not be opened again after the submission of our application.

III.G. Technical Assistance

Our Title V Director recently participated in a focus group on trauma and it's impact on public health workforce morale. Questions posed during the focus group included:

- Has your team/division/unit implemented strategies to address workforce burnout, moral injury and mental wellbeing?
- What resources were used and how did you access them? How were they communicated?
- Were outcomes measured? How were these initiatives received by staff?
- Are these initiatives going to be sustained, and if so, how?
- Does your leadership support your wellness and resiliency, and if yes, how?
- Is there a staff member (or more than one staff member) in the agency responsible for all activities related to addressing workforce burnout, moral injury and mental wellbeing of the workforce? Is it written in their job description in a way where their performance/success is measured around staff wellbeing?

We are thinking through the possibility of designing a survey at some point for our DPH staff, and maybe gather some really good ideas to meet their needs. If there is an opportunity to participate or receive technical assistance around this topic, we would be very interested.

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 - Executive Summary_Final.pdf

Supporting Document #02 - DEThrives Social Media_Draft_2023.07.23.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,073,458	
A. Preventive and Primary Care for Children	$ 634,607	(30.6%)
B. Children with Special Health Care Needs	$ 812,645	(39.1%)
C. Title V Administrative Costs	$ 139,975	(6.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,587,227	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,016,039	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 2,659,797	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,675,836	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 14,749,294	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,166,969	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 21,916,263	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,684,909
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,892,092
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,238

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,042,781 (FY 22 Federal Award: $ 2,073,458)		$ 2,073,458	
A. Preventive and Primary Care for Children	$ 619,520	(30.3%)	$ 645,358	(31.1%)
B. Children with Special Health Care Needs	$ 660,500	(32.3%)	$ 872,301	(42%)
C. Title V Administrative Costs	$ 145,655	(7.1%)	$ 140,615	(6.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,425,675		$ 1,658,274	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,957,273		$ 9,957,273	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 2,053,906	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,053,906		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,011,179		$ 12,011,179	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 14,053,960		$ 14,084,637	
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)	$ 9,974,592		$ 9,974,592	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,028,552		$ 24,059,229	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 139,652	$ 139,652
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000	$ 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	$ 7,466,240	$ 7,466,240
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,033,700	$ 2,033,700
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 5, Other Funds, 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.
- The value in Line 6, Program Income, 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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 486,231	$ 415,184
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 634,607	$ 645,358
4. CSHCN	$ 812,645	$ 872,301
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,933,483	$ 1,932,843

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 5,219,512	$ 2,916,185
2. Infants < 1 year	$ 0	$ 2,950,785
3. Children 1 through 21 Years	$ 3,888,179	$ 965,251
4. CSHCN	$ 908,348	$ 965,251
5. All Others	$ 0	$ 2,331,185
Non-Federal Total of Individuals Served	$ 10,016,039	$ 10,128,657
Federal State MCH Block Grant Partnership Total	$ 11,949,522	$ 12,061,500

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 24 Application Budgeted	FY 22 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	$ 927,557	$ 1,886,595
3. Public Health Services and Systems	$ 1,145,901	$ 186,863
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	$ 2,073,458	$ 2,073,458

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 1,344,512	$ 1,344,512
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,344,512	$ 1,344,512
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 5,623,499	$ 6,043,574
3. Public Health Services and Systems	$ 3,048,027	$ 3,157,312
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		$ 1,146,062
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,555
Durable Medical Equipment and Supplies		$ 148,569
Laboratory Services		$ 0
Other		
HWHB Support activities		$ 47,326
Direct Services Line 4 Expended Total		$ 1,344,512
Non-Federal Total	$ 10,016,038	$ 10,545,398

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Delaware

Total Births by Occurrence: 11,363 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,363 (100.0%)	1,777	43	43 (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

The state of Delaware contracts with Nemours Children's Health for the blood spot screening of all infants born in the state of Delaware. Infants that screen positive for a disorder on the blood spot panel are referred to specialists at Nemours Children's Hospital - Delaware to confirm diagnosis and begin treatment. The specialists work with the infant's PCP to ensure proper follow-up care. For infants with metabolic disorders for which Nemours does not have expertise the Nemours team works in consultation with Children's National Medical Center to confirm diagnosis and, in partnership with the infant's medical home, provide treatment.

Form Notes for Form 4:

DPH does not cover older children which are under the Dept. of Education.
Children that are 0-3 yrs. of age and diagnosed Deaf/Hard of Hearing (D/HH) are referred to Part C - Early Intervention Services known as Child Development Watch (CDW). On the child's 3rd birthday they are transitioned into the Department of Education Part B program.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Includes some non-residents and tests sent by neighboring hospitals. Total Births by Occurrence is from New Born Screening, 2022 data. It is based on invoicing and some OOS births coming to Delaware for testing. It is difficult for NBS data system to filter only DE resident births. All conditions are tested for in the NBS program. Critical Congenital Heart Disease is not blood spot test but noted on card, same for hearing loss. CCHD is tracked by hospitals, not DPH.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2022**
	Column Name:	**Data Source Year Notes**
	Field Note: Calendar year 2022	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: There were 23 documented refusals for DE infants	
4.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: 164 infants referred to specialists. Of those 43 were confirmed and all were referred for treatment.	

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 2022

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	228	76.0	0.0	5.0	0.0	19.0
2. Infants < 1 Year of Age	11,363	39.0	0.0	59.0	2.0	0.0
3. Children 1 through 21 Years of Age	13,385	40.0	0.0	34.0	26.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,742	40.0	0.0	60.0	0.0	0.0
4. Others	1,074	75.0	0.0	3.0	0.0	22.0
Total	26,050					

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	10,482	Yes	10,482	100.0	10,482	228
2. Infants < 1 Year of Age	10,871	No	11,363	100.0	11,363	11,363
3. Children 1 through 21 Years of Age	247,684	Yes	247,684	100.0	247,684	13,385
3a. Children with Special Health Care Needs 0 through 21 years of age^	54,430	Yes	54,430	3.2	1,742	1,742
4. Others	745,420	Yes	745,420	100.0	745,420	1,074

^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:	**2022**
	Field Note: 84 from MIECHV home visiting, 228 from state funded home visiting program. HWHB serves pregnant women but no longer collects this information. Coverage is 100% from federal grant funds and state funds.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: 11,363 values from NewBorn Screening which includes some out of state births. In CY 2022 there were 23 refusals for NBS screening. On average there are approximately 20 parents that turn down NBS screening per year (source Nemours)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: FPAR (2141) + PEDS (6574) + CDW (3426) + MIECHV (587) + State Home Visiting (657) = 13,385. Data Source FPAR 1 to24 yrs old. PEDS count is unique children 0 - 8 yrs old; there were 9214 total screens. PEDS Count is lower than in past due to pilot program (CHADIS) that started in November 2022. CDW covers children to 3 yrs old; older children are under Dept. of Education. FPAR breakout: State: 678, Providers - 1463	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: CDW Found Eligible 1776. Referrals: 3426. CDW covers 0 to 3 yrs old. Older children are under Dept of Education.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Male caregivers 22 and 250 Female caregivers in MIECHV; 55 male caregivers and 747 female caregivers in state HV.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: All pregnant women are served by public health services. Safe sleep public service campaigns, breastfeeding information, LARC information, healthy women information (eg. My Life, My Plan).	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Value from Health Statistics Center, CY 2022. Comes from Table D1 of annual report. The value is preliminary as of June 26, 2023.	
3.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Value from Health Statistics Center, CY 2022. Comes from Table D1 of annual report. The value is preliminary as of June 26, 2023.	
4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Count value is population in DE, estimated by Census.	
5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Population count is estimate given by US Census Bureau, ages to 21 yrs old. 5a count (and percent served) from those with CSHCN served by Title V. DPH does not serve older children, they are under the Dept of Education.	
6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Denominator population comes from US Census Bureau of population 22+ yrs old. 100% served comes from substance abuse education and programming which covers all genders and ages. Other programs that cover a large percentage of population are safe sleep, breast feeding education materials, LARC (Long Acting Reversible Contraceptive) education.	

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.	Children with Special Health Care Needs 0 through 21 Years of Age, 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.
3.	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 2022

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	11,218	5,395	3,002	2,040	60	607	16	1	97
Title V Served	11,218	5,395	3,002	2,040	60	607	16	1	97
Eligible for Title XIX	4,532	1,260	1,709	1,373	27	111	5	0	47
2. Total Infants in State	10,407	4,807	2,905	1,966	54	566	15	0	94
Title V Served	10,407	4,807	2,905	1,966	54	566	15	0	94
Eligible for Title XIX	4,448	1,246	1,671	1,344	27	109	5	0	46

Form Notes for Form 6:

From Health Statistics Center. 2022 data, preliminary as of 6/26/23.

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Delaware

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 464-4357	(800) 464-4357
2. State MCH Toll-Free "Hotline" Name	Helpline and 2-1-1 Help Me Grow	Helpline and 2-1-1 Help Me Grow
3. Name of Contact Person for State MCH "Hotline"	Donna Snyder-White	Donna Snyder-White
4. Contact Person's Telephone Number	(302) 255-1804	(302) 255-1804
5. Number of Calls Received on the State MCH "Hotline"		50,454

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://dhss.delaware.gov/dph/chca/dphmchhome.html	https://dhss.delaware.gov/dph/chca/dphmchhome.html
4. Number of Hits to the State Title V Program Website		3,112
5. State Title V Social Media Websites	www.dethrives.com	www.dethrives.com
6. Number of Hits to the State Title V Program Social Media Websites		132,000

Form 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 J. Woodall
Title	Chief, Family Health Systems
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5754
Extension	
Email	leah.woodall@delaware.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Isabel Rivera-Green
Title	CYSHCN Director
Address 1	1351 W. North Street
Address 2	Suite 10
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5747
Extension	
Email	isabel.rivera-green@delaware.gov

3. State Family Leader (Optional)	
Name	Meedra Surratte, M.ED.
Title	Executive Director of Parent Information Center of Delaware/Delaware Family Voices
Address 1	404 Larch Circle
Address 2	
City/State/Zip	Wilmington / DE / 19804
Telephone	(302) 999-7394
Extension	
Email	msurratte@picofdel.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Delaware

Application Year 2024

No.	Priority Need
1.	Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.
2.	Improve breastfeeding rates.
3.	Children receive developmentally appropriate services in a well coordinated early childhood system.
4.	Empower adolescents to adopt healthy behaviors.
5.	Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.
6.	Increase the percent of children with and without special health care needs who are adequately insured.
7.	Improve the rate of Oral Health preventive care in children.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	Revised
2.	Improve breastfeeding rates.	Continued
3.	Children receive developmentally appropriate services in a well coordinated early childhood system.	Revised
4.	Empower adolescents to adopt healthy behaviors.	New
5.	Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.	New
6.	Increase the percent of children with and without special health care needs who are adequately insured.	Continued
7.	Improve the rate of Oral Health preventive care in children.	Continued

Form 10
National Outcome Measures (NOMs)

State: Delaware

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	79.3 %	0.4 %	8,202	10,340
2020	79.7 %	0.4 %	8,071	10,122
2019	76.9 %	0.4 %	8,001	10,408
2018	77.8 %	0.4 %	8,044	10,335
2017	78.9 %	0.4 %	8,426	10,676
2016	78.8 %	0.4 %	8,534	10,829
2015	78.6 %	0.4 %	8,666	11,022
2014	78.7 %	0.4 %	8,510	10,814
2013	76.8 %	0.4 %	8,144	10,602
2012	74.7 %	0.4 %	8,026	10,745
2011	75.7 %	0.4 %	8,297	10,954
2010	75.0 %	0.4 %	8,403	11,210
2009	74.7 %	0.4 %	8,089	10,824

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 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	82.8	9.1	83	10,021
2019	67.0	8.2	68	10,152
2018	68.8	8.2	71	10,326
2017	55.2	7.3	58	10,515
2016	63.1	7.7	67	10,621

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	18.9 ϟ	6.0 ϟ	10 ϟ	52,912 ϟ
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

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	30.8 %	0.5 %	3,229	10,480
2020	30.3 %	0.5 %	3,146	10,388
2019	29.1 %	0.4 %	3,072	10,560
2018	27.7 %	0.4 %	2,940	10,621
2017	25.5 %	0.4 %	2,765	10,846
2016	24.1 %	0.4 %	2,649	10,982
2015	25.0 %	0.4 %	2,792	11,153
2014	24.4 %	0.4 %	2,676	10,965
2013	22.7 %	0.4 %	2,454	10,818
2012	22.5 %	0.4 %	2,473	11,009
2011	22.7 %	0.4 %	2,550	11,247
2010	24.2 %	0.4 %	2,752	11,355
2009	23.8 %	0.4 %	2,749	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 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	3.0 %			
2020/Q4-2021/Q3	3.0 %			
2020/Q3-2021/Q1	3.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	1.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	1.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	2.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.3	0.8	66	10,430
2019	7.2	0.8	76	10,600
2018	6.9	0.8	74	10,660
2017	6.4	0.8	70	10,888
2016	6.4	0.8	70	11,020
2015	9.2	0.9	103	11,202
2014	7.4	0.8	81	11,007
2013	6.8	0.8	74	10,863
2012	8.2	0.9	91	11,056
2011	8.8	0.9	99	11,291
2010	7.5	0.8	85	11,401
2009	6.6	0.8	77	11,584

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	5.1	0.7	53	10,392
2019	6.4	0.8	68	10,562
2018	5.9	0.8	63	10,621
2017	6.3	0.8	68	10,855
2016	7.8	0.9	86	10,992
2015	9.1	0.9	102	11,166
2014	6.7	0.8	74	10,972
2013	6.4	0.8	69	10,831
2012	7.6	0.8	84	11,023
2011	8.9	0.9	100	11,257
2010	7.5	0.8	85	11,364
2009	8.0	0.8	92	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.2	0.6	33	10,392
2019	4.4	0.6	46	10,562
2018	4.0	0.6	43	10,621
2017	4.1	0.6	45	10,855
2016	5.0	0.7	55	10,992
2015	7.2	0.8	80	11,166
2014	5.0	0.7	55	10,972
2013	4.4	0.6	48	10,831
2012	6.1	0.7	67	11,023
2011	6.5	0.8	73	11,257
2010	5.0	0.7	57	11,364
2009	5.8	0.7	67	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	1.9	0.4	20	10,392
2019	2.1	0.4	22	10,562
2018	1.9	0.4	20	10,621
2017	2.1	0.4	23	10,855
2016	2.8	0.5	31	10,992
2015	2.0	0.4	22	11,166
2014	1.7	0.4	19	10,972
2013	1.9	0.4	21	10,831
2012	1.5	0.4	17	11,023
2011	2.4	0.5	27	11,257
2010	2.5	0.5	28	11,364
2009	2.2	0.4	25	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	182.8 ϟ	42.0 ϟ	19 ϟ	10,392 ϟ
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

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	NR	NR	NR	NR
2019	104.1	31.4	11	10,562
2018	113.0	32.6	12	10,621
2017	101.3	30.6	11	10,855
2016	118.3	32.8	13	10,992
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	129.3	34.6	14	10,831
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	105.6	30.5	12	11,364
2009	121.1	32.4	14	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	5.3 %	0.9 %	510	9,614
2020	5.8 %	0.9 %	550	9,485
2019	6.8 %	0.9 %	662	9,744
2018	6.4 %	0.9 %	624	9,746
2017	6.4 %	0.9 %	640	9,936
2016	6.2 %	0.8 %	637	10,202
2015	8.1 %	0.9 %	839	10,319
2014	6.3 %	0.8 %	639	10,225
2013	7.7 %	0.9 %	766	10,018
2012	6.0 %	0.8 %	612	10,186
2011	6.3 %	0.7 %	657	10,418
2010	7.3 %	0.8 %	755	10,402
2009	9.4 %	0.9 %	1,004	10,696
2008	7.0 %	0.7 %	778	11,166
2007	5.9 %	0.9 %	438	7,454

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	20.9	1.5	212	10,126
2019	18.8	1.4	193	10,255
2018	23.3	1.5	242	10,392
2017	24.2	1.5	258	10,647
2016	26.8	1.6	288	10,731

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.5 %	1.3 %	24,225	193,700
2019_2020	13.8 %	1.5 %	26,599	193,422
2018_2019	13.3 %	1.5 %	25,206	188,875
2017_2018	10.8 %	1.5 %	20,343	188,712
2016_2017	11.0 %	1.4 %	20,905	190,361
2016	11.7 %	1.7 %	22,451	191,338

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 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	13.9	3.7	14	100,513
2020	NR	NR	NR	NR
2019	24.9	5.0	25	100,413
2018	23.9	4.9	24	100,413
2017	14.9	3.9	15	100,707
2016	14.9	3.8	15	100,809
2015	15.8	4.0	16	101,233
2014	12.8	3.5	13	101,738
2013	18.6	4.3	19	101,932
2012	20.6	4.5	21	102,082
2011	18.8	4.3	19	100,869
2010	NR	NR	NR	NR
2009	16.8	4.1	17	101,227

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	49.4	6.3	61	123,453
2020	37.1	5.6	44	118,596
2019	32.2	5.2	38	117,881
2018	39.8	5.8	47	118,017
2017	30.5	5.1	36	118,145
2016	34.0	5.4	40	117,766
2015	27.3	4.8	32	117,211
2014	31.6	5.2	37	117,122
2013	32.5	5.3	38	116,766
2012	37.1	5.6	44	118,726
2011	31.9	5.2	38	119,280
2010	35.4	5.4	43	121,431
2009	39.4	5.7	48	121,966

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	15.8	2.9	29	183,513
2018_2020	13.3	2.7	24	181,058
2017_2019	11.0	2.5	20	181,122
2016_2018	9.4	2.3	17	181,393
2015_2017	8.8	2.2	16	181,147
2014_2016	9.4	2.3	17	180,556
2013_2015	12.2	2.6	22	179,785
2012_2014	11.6	2.5	21	181,255
2011_2013	10.9	2.4	20	183,456
2010_2012	11.2	2.4	21	188,321
2009_2011	13.0	2.6	25	191,829
2008_2010	13.9	2.7	27	194,904
2007_2009	15.4	2.8	30	194,529

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	8.7	2.2	16	183,513
2018_2020	7.7	2.1	14	181,058
2017_2019	8.8	2.2	16	181,122
2016_2018	9.4	2.3	17	181,393
2015_2017	8.3	2.1	15	181,147
2014_2016	6.6	1.9	12	180,556
2013_2015	6.7	1.9	12	179,785
2012_2014	9.9	2.3	18	181,255
2011_2013	13.1	2.7	24	183,456
2010_2012	13.8	2.7	26	188,321
2009_2011	9.4	2.2	18	191,829
2008_2010	5.6	1.7	11	194,904
2007_2009	5.1	1.6	10	194,529

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	21.1 %	1.4 %	43,039	203,996
2019_2020	21.7 %	1.6 %	43,902	202,724
2018_2019	21.5 %	1.6 %	43,524	202,837
2017_2018	22.3 %	1.7 %	45,379	203,587
2016_2017	23.1 %	1.6 %	46,973	203,603
2016	22.9 %	1.8 %	46,594	203,511

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 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.6 %	2.2 %	5,417	43,039
2019_2020	10.4 %	1.7 %	4,576	43,902
2018_2019	15.7 %	2.5 %	6,845	43,524
2017_2018	18.8 %	3.3 %	8,525	45,379
2016_2017	18.3 %	3.0 %	8,589	46,973
2016	18.5 %	3.1 %	8,616	46,594

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 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.8 %	0.6 %	4,890	172,664
2019_2020	4.4 %	1.1 %	7,632	171,629
2018_2019	4.0 %	1.0 %	6,721	167,698
2017_2018	3.9 %	1.0 %	6,517	168,465
2016_2017	4.2 %	1.0 %	7,253	172,095
2016	3.1 %	0.9 %	5,355	174,664

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 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	9.1 %	1.1 %	15,718	172,361
2019_2020	10.8 %	1.2 %	18,688	172,536
2018_2019	11.6 %	1.4 %	19,348	167,449
2017_2018	10.3 %	1.4 %	17,207	166,845
2016_2017	10.7 %	1.2 %	18,204	170,256
2016	12.0 %	1.7 %	20,659	172,211

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 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	47.2 %	5.3 %	10,816	22,928
2019_2020	49.7 %	5.7 %	12,346	24,827
2018_2019	54.6 %	5.6 %	13,898	25,437
2017_2018	56.7 %	5.7 %	14,525	25,613
2016_2017	64.3 %	5.2 %	16,333	25,398
2016	69.5 %	6.0 %	16,759	24,128

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 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	89.8 %	1.2 %	182,974	203,849
2019_2020	89.1 %	1.4 %	180,269	202,308
2018_2019	89.5 %	1.4 %	180,982	202,323
2017_2018	89.8 %	1.4 %	182,705	203,402
2016_2017	90.3 %	1.2 %	183,623	203,356
2016	91.1 %	1.4 %	185,058	203,190

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 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	18.5 %	0.6 %	855	4,610
2018	16.3 %	0.5 %	958	5,870
2016	16.2 %	0.4 %	1,116	6,906
2014	17.2 %	0.4 %	1,246	7,251
2012	16.9 %	0.4 %	1,292	7,642
2010	18.4 %	0.4 %	1,404	7,650
2008	17.3 %	0.5 %	1,097	6,328

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	17.0 %	1.4 %	5,649	33,156
2017	15.1 %	1.1 %	5,159	34,095
2015	15.8 %	0.9 %	5,380	34,119
2013	14.2 %	0.7 %	4,959	34,970
2011	12.2 %	0.8 %	4,169	34,173
2009	13.5 %	0.8 %	4,543	33,562
2007	13.2 %	0.8 %	4,389	33,287
2005	14.0 %	0.7 %	4,519	32,311

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	16.8 %	2.2 %	14,744	87,543
2019_2020	18.9 %	2.4 %	16,754	88,509
2018_2019	16.0 %	2.2 %	13,031	81,324
2017_2018	15.1 %	2.1 %	12,408	82,438
2016_2017	16.7 %	2.1 %	14,359	86,238
2016	16.8 %	2.6 %	14,304	85,051

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 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	3.4 %	0.6 %	7,063	209,107
2019	4.3 %	0.9 %	8,745	203,953
2018	3.8 %	0.9 %	7,804	203,319
2017	3.4 %	0.7 %	6,937	204,345
2016	3.7 %	0.7 %	7,474	204,214
2015	2.8 %	0.7 %	5,730	204,356
2014	5.0 %	1.0 %	10,145	204,238
2013	5.1 %	1.0 %	10,294	203,729
2012	3.6 %	0.7 %	7,271	204,974
2011	3.5 %	0.6 %	7,089	204,528
2010	5.6 %	0.9 %	11,456	205,695
2009	5.7 %	0.9 %	11,823	206,826

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 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	77.0 %	3.1 %	8,000	11,000
2017	76.2 %	3.0 %	8,000	11,000
2016	70.6 %	3.9 %	8,000	11,000
2015	70.1 %	3.9 %	8,000	11,000
2014	78.5 %	3.5 %	9,000	11,000
2013	75.3 %	3.7 %	8,000	11,000
2012	76.3 %	3.3 %	9,000	11,000
2011	75.1 %	3.5 %	9,000	12,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	58.2 %	2.3 %	112,755	193,892
2020_2021	61.9 %	1.9 %	118,391	191,262
2019_2020	68.1 %	1.6 %	130,544	191,694
2018_2019	66.0 %	1.6 %	126,523	191,672
2017_2018	65.2 %	1.9 %	125,814	192,884
2016_2017	65.4 %	2.3 %	125,447	191,903
2015_2016	69.2 %	2.7 %	132,417	191,243
2014_2015	66.2 %	2.2 %	127,154	192,133
2013_2014	66.7 %	1.9 %	128,042	192,065
2012_2013	67.4 %	3.2 %	129,839	192,518
2011_2012	55.1 %	3.1 %	107,291	194,657
2010_2011	52.1 %	4.3 %	101,548	194,909
2009_2010	46.8 %	2.7 %	84,412	180,367

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	83.5 %	2.6 %	48,226	57,770
2020	78.0 %	2.8 %	45,352	58,137
2019	75.4 %	2.9 %	43,615	57,824
2018	73.9 %	3.2 %	42,936	58,093
2017	75.3 %	2.9 %	43,430	57,644
2016	70.7 %	2.8 %	40,877	57,853
2015	65.2 %	2.9 %	37,503	57,505

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	89.6 %	2.0 %	51,783	57,770
2020	85.4 %	2.5 %	49,643	58,137
2019	89.7 %	2.2 %	51,845	57,824
2018	89.1 %	2.2 %	51,757	58,093
2017	89.6 %	2.2 %	51,660	57,644
2016	87.5 %	2.0 %	50,644	57,853
2015	88.7 %	1.9 %	51,004	57,505
2014	90.5 %	1.9 %	51,554	56,943
2013	84.4 %	2.3 %	48,139	57,056
2012	77.8 %	3.0 %	44,397	57,081
2011	80.7 %	2.3 %	47,258	58,593
2010	65.5 %	3.0 %	37,427	57,165
2009	53.4 %	3.3 %	31,064	58,209

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	90.8 %	1.9 %	52,457	57,770
2020	89.8 %	2.0 %	52,232	58,137
2019	89.0 %	2.2 %	51,454	57,824
2018	85.9 %	2.7 %	49,904	58,093
2017	90.5 %	2.0 %	52,145	57,644
2016	87.3 %	2.2 %	50,523	57,853
2015	87.5 %	2.1 %	50,332	57,505
2014	86.7 %	2.4 %	49,345	56,943
2013	81.8 %	2.6 %	46,657	57,056
2012	78.0 %	3.2 %	44,507	57,081
2011	78.2 %	2.5 %	45,835	58,593
2010	71.2 %	3.0 %	40,719	57,165
2009	58.4 %	3.3 %	33,991	58,209

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	13.5	0.7	425	31,410
2020	14.6	0.7	439	30,104
2019	14.9	0.7	444	29,792
2018	16.7	0.8	497	29,783
2017	18.5	0.8	552	29,906
2016	19.5	0.8	583	29,906
2015	18.1	0.8	540	29,829
2014	20.8	0.8	616	29,632
2013	24.4	0.9	728	29,860
2012	25.0	0.9	761	30,387
2011	29.0	1.0	900	31,023
2010	30.7	1.0	974	31,694
2009	33.5	1.0	1,081	32,283

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.7 %	0.6 %	5,469	203,480
2019_2020	2.9 %	0.7 %	5,760	201,776
2018_2019	2.5 %	0.7 %	5,014	201,501
2017_2018	3.1 %	0.8 %	6,267	203,075
2016_2017	3.5 %	0.9 %	7,102	203,324
2016	2.6 %	0.9 %	5,326	203,101

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 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Delaware

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			80	78	80
Annual Indicator		78.2	75.6	72.8	75.9
Numerator		127,950	124,769	117,625	125,530
Denominator		163,676	165,041	161,675	165,284
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.0	84.0	86.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	78	80	80	81.5	83
Annual Indicator	77.4	78.5	79.7	82.4	83.6
Numerator	7,840	8,010	8,564	8,253	8,057
Denominator	10,127	10,209	10,741	10,019	9,637
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.5	86.0	87.5

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20.5	23	20.5	24	24.5
Annual Indicator	23.6	19.8	23.6	28.2	25.0
Numerator	2,319	2,019	2,478	2,713	2,298
Denominator	9,811	10,187	10,493	9,615	9,184
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	25.0	26.0	27.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31.7	32	27	30	32
Annual Indicator	24.8	25.5	30.3	29.1	32.1
Numerator	5,633	5,939	6,522	6,073	7,257
Denominator	22,753	23,289	21,559	20,867	22,604
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	34.0	36.0	38.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	21
Annual Indicator	25.1	25.1	25.1	21.6
Numerator	9,329	9,329	9,329	8,529
Denominator	37,230	37,230	37,230	39,459
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2017	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	21
Annual Indicator	11.6	13.0	14.9	16.0
Numerator	7,828	8,196	9,878	11,362
Denominator	67,249	62,967	66,257	70,996
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	22.0	23.0	24.0

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2019	**2020**	**2021**	**2022**
Annual Objective			75	77
Annual Indicator	86.9	75.7	71.9	71.8
Numerator	62,537	47,654	48,388	51,420
Denominator	71,966	62,974	67,333	71,653
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	79.0	81.0	83.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.6	80.4	82.5	80	80.5
Annual Indicator	81.6	82.0	79.7	77.4	77.3
Numerator	155,485	154,827	149,645	148,645	149,188
Denominator	190,614	188,877	187,697	192,077	193,050
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.0	82.0	83.0

Field Level Notes for Form 10 NPMs:

None

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.4	81.2	72	70	72
Annual Indicator	70.2	70.9	68.6	67.2	68.8
Numerator	142,861	144,257	138,831	136,015	140,169
Denominator	203,480	203,436	202,281	202,319	203,715
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	74.0	76.0	77.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Delaware

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

Measure Status:	Active				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	56	52	30	28	27
Annual Indicator	42.4	44.7	45.8	45	42.8
Numerator					
Denominator					
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	26.0	25.0	24.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The 2017 value is from Delaware PRAMS 2016 data. It is an estimate based on live births, not the overall female population of 15 - 44 yr olds.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2018 data is from 2017 Delaware PRAMS data, which is an estimate based on live births, not the overall female population of 15 -44 yrs old.	
3.	**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.	
4.	**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.	

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	5.0	5.0	5.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This is only represents 4 months of data. Disparity ratio = HWHB Black preterm/State White preterm = 9.48/9.49 = 1 i.e., same. Difference in HWHB Black preterm and State Black preterm = 9.48 - 14.07 = -4.59 lower!	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: HWHB black participants (i.e., 584) 4 experienced a death in comparison to of all non-HWHB black participants (i.e., 2337) 19 experienced a death, which would be 4/584 vs. 19/2337 or 0.68/0.81 = 0.84	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Unfortunately, we had to use 2020 data has a place holder as our 2021 vital statistics data is not yet available to us.	

SPM 3 - Strenghthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	75
Annual Indicator		68	80	76
Numerator		17	20	19
Denominator		25	25	25
Data Source		FHS Data	FHS Data	FHS Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	75.0	100.0	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.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Delaware

ESM 1.1 - # 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					
	2018	2019	2020	2021	2022
Annual Objective	15,500	15,700	17,000	17,250	8,500
Annual Indicator	16,386	16,672	8,488	8,015	8,109
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9,000.0	9,500.0	10,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: New service sites; SBHC addition of reproductive health (La Red and Milford)	
2.	**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.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 50% drop due to COVID.	

ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			90	86
Annual Indicator		88	84.2	86.1
Numerator				6,335
Denominator				7,354
Data Source		HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	88.0	90.0	92.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			63	60
Annual Indicator		62	53.1	58.6
Numerator				
Denominator				
Data Source		Medicaid Claims Data	PRAMS data	PRAMS data
Data Source Year		2019	2020	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	65.0	70.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	61	65	58	60	62
Annual Indicator	54.2	54.9	47.9	57	55.3
Numerator					
Denominator					
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV program daa	MIECHV Program Data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	64.0	66.0	68.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Reported breastfeeding behaviors were missing for two (2) infants who met the criteria for the denominator. This continues to be a construct on which both LIAs are working to improve. Through their CQI efforts, the LIAs are providing education and resources to mothers both prenatally and postpartum in an effort to improve both breastfeeding initiation and duration.

ESM 6.1 - 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				
	2019	2020	2021	2022
Annual Objective			92	94
Annual Indicator	91.4	83.3	82.2	81
Numerator	433	398	412	439
Denominator	474	478	501	542
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	96.0	98.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - # of new pediatric practices to adopt PEDs

Measure Status:	Inactive - The measure was not strong and we are currently piloting CHADIS and have not been as focused on increasing the number of practices adopting PEDS.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	39	42	45	47	49
Annual Indicator	40	43	43	43	43
Numerator					
Denominator					
Data Source	DE APP	DE APP	DE APP	DE APP	DE APP
Data Source Year	2018	2019	2020	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: We technically have 43 registered, however only 20 providers are consistent with their utilization.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: We technically have 43 registered, however only 20 providers are consistent with their utilization.	

ESM 6.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.2.1 - Determine which policy recommendations that address health promotion and disease prevention initiatives in schools and community-based settings that MCH can assist or lead implementation efforts.

Measure Status:	Inactive - Completed			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			Yes	Yes
Annual Indicator		Yes	Yes	Yes
Numerator				
Denominator				
Data Source		MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 8.2.2 - DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online resources and Tool Kit.

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			No	Yes
Annual Indicator		No	Yes	No
Numerator				
Denominator				
Data Source		MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
A new vendor was selected for the implementation of the Fitness Gram and once it is fully implemented a stronger ESM will be developed to track progress.

ESM 8.2.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	14.3
Numerator	6
Denominator	42
Data Source	PANO MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	12.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			25	75
Annual Indicator		29.2	76.2	74.2
Numerator		883	4,902	4,958
Denominator		3,027	6,429	6,678
Data Source		SBHC Program Data	SBHC Porgram Data	SBHC Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	75.0	80.0	85.0

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.	

ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			2	15
Annual Indicator		15	15	15
Numerator				
Denominator				
Data Source		SBHC Program Data (1 Medical Vendor)	SBHC Porgram Data	SBHC Porgram Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numbers are not unduplicated and only one medical sponsor submitted program data. However, it was our largest medical sponsor that submitted the data. There were 6,273 mental visits among 3,027 unique students enrolled. This does not mean that all 3,027 received a mental health visit.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numbers are not unduplicated and only one medical sponsor submitted program data. However, it was our largest medical sponsor that submitted the data. There were 12,366 mental visits among 6,429 unique students enrolled. This does not mean that all 6,429 received a mental health visit.	

ESM 10.4 - % 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
Annual Objective	
Annual Indicator	48.2
Numerator	4,530
Denominator	9,407
Data Source	SBHC Program Data
Data Source Year	2021
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.5 - % of children and adolescents receiving services for Project THRIVE

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	0.1
Numerator	99
Denominator	140,263
Data Source	DOE Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	0.2	0.3

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			81	82
Annual Indicator	80.6	78.8	73.6	77.3
Numerator				
Denominator				
Data Source	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	83.0	84.0	85.0

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.

ESM 13.2.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	683
Numerator	
Denominator	
Data Source	MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	725.0	765.0

Field Level Notes for Form 10 ESMs:

None

ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid

Measure Status:	Inactive - Completed				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		No	No	Yes	Yes
Annual Indicator		No	Yes	Yes	Yes
Numerator					
Denominator					
Data Source		MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
An entire committee has not been established however, the Title V Director and Deputy Director meeting monthly with the DMMA Medical Director, MCH Quality Administrator and policy staff members. This arrangement currently meets our needs and helps us move priorities forward such as providing education around the extended postpartum coverage and Medicaid financing for home visiting.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
An entire committee has not been established however, the Title V Director and Deputy Director meeting monthly with the DMMA Medical Director, MCH Quality Administrator and policy staff members. This arrangement currently meets our needs and helps us move priorities forward such as providing education around the extended postpartum coverage and Medicaid financing for home visiting.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
An entire committee has not been established however, the Title V Director and Deputy Director meeting monthly with the DMMA Medical Director, MCH Quality Administrator and policy staff members. This arrangement currently meets our needs and helps us move priorities forward such as providing education around the extended postpartum coverage and Medicaid financing for home visiting.

ESM 15.2 - # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.

Measure Status:	Inactive - Moved to a strategy as we will continue to participate and we didn't feel the measure was strong enough.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective			4	4	4
Annual Indicator		4	4	4	4
Numerator					
Denominator					
Data Source		MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			90	92
Annual Indicator		90	89.1	91.5
Numerator		564	595	644
Denominator		627	668	704
Data Source		MIECHV Program data	MIECHV program data	MIECHV Program Data
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	94.0	96.0	98.0

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.	

ESM 15.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	73.3
Numerator	11
Denominator	15
Data Source	Family SHADE/MCH Program Data
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 15.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Delaware

SPM 1 - Percent of Delaware women with a recent live birth who indicated that their pregnancy was unintended.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Decrease the number of live births that were the result of an unintended pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers who responded to the PRAMS survey that their pregnancy was wanted later or unwanted **Denominator:** Number of women who responded to PRAMS
Data Sources and Data Issues:	PRAMS
Significance:	Unplanned pregnancies are expensive and cost women, families, government, and society. Extensive data show that unplanned pregnancies have been linked to increased health problems in women and their infants, lower educational attainment, higher poverty rates, and increased health care and societal costs. And, unplanned pregnancies significantly increase Medicaid expenses. By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.

SPM 2 - Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2025, reduce and maintain the disparity ratio among enrolled and non-enrolled women by five percentage points.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of black/Hispanic women in HWHB/HV or mini grantee who experienced an infant death. **Denominator:** Denominator: Number of black/Hispanic women non-enrolled in HWHB/HV or mini grantee (i.e., Medicaid) who experienced an infant death.
Data Sources and Data Issues:	MCH Program Data , Medicaid and Vital Statistics
Significance:	While Delaware has made significant improvements in our infant mortality rates, the disparity has remained. We have recently switched gears and transformed our HWHB program as well implement community mini grants to address black infant mortality in our state.

SPM 3 - Strenghthen Title 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
Data Sources and Data Issues:	MCH data
Significance:	There are many reasons why having a highly qualified workforce is important to ensure that employess are consistenly growing or sharpening their saw. Workforce development ensures staff are properly prepared to deliver and produce high quality work. Work foce development helps prepare are MCH workforce in succession planning and decreased staff turnover.

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 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

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
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.

ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase # of women served by the HWHBs program that were screened for pregnancy intention
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women that were screening for pregnancy intention **Denominator:** # of women served
Data Sources and Data Issues:	HWHB Program Data
Significance:	Asking the pregnancy intention question gives women an opportunity to discuss their future and offers providers to further discuss contraception option that are best for her based on her answer.

ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To reduce unintended pregnancies
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Medicaid women who use a most to moderately effective family planning birth control method **Denominator:** Medicaid women who use other types of family planning birth control
Data Sources and Data Issues:	Medicaid Claims Data
Significance:	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.

ESM 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants enrolled in home visiting receiving breast milk at 6 months of age **Denominator:** Number of infants enrolled in home visiting at 6 months of age
Data Sources and Data Issues:	MCH/MIECHV program data
Significance:	Our home visiting programs enroll the most vulnerable families that are of lower socio-economic status. Mothers in this population have lower rates of initiating breastfeeding as well as difficulty continuing to breastfeed through 6 months of age.

ESM 6.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool (NFP and MIECHV Programs)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children receiving a developmental screening **Denominator:** # of children enrolled in MIECHV program
Data Sources and Data Issues:	MIECHV program data
Significance:	Developmental screening using a validated screening tool at regular intervals is an important part of making sure a child is healthy. When a developmental delay is not recognized early, children must wait to get the help they need. The earlier a child with a delay is identified, the sooner they can start receiving support for the delay and may even enter school more ready to learn.

ESM 6.2 - # of new pediatric practices to adopt PEDs
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - The measure was not strong and we are currently piloting CHADIS and have not been as focused on increasing the number of practices adopting PEDS.
Goal:	Increase the number of pediatric practices who sign up to use the PEDS tool and receive training and TA.
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** The number of practices that sign up and receive subsequent training and TA. **Denominator:**
Data Sources and Data Issues:	DE APP
Significance:	In order to increase developmental screening, additional providers need to screen using a validated tool within the new recommended AAP guidelines. It is important for Delaware to continue to recruit new practices to receive training and offer ongoing TA to utilize the PEDs tool enhancing early detection and intervention.

ESM 6.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To ensure children are appropriately referred to early intervention services when needed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** number of children referred to services **Denominator:** number of children identified as having a high risk screen
Data Sources and Data Issues:	ECCS/MCH Program Data
Evidence-based/informed strategy:	It's the important for children identified as "high risk" receive appropriate services in a timely manner to mitigate developmental delays.
Significance:	Early detection and intervention can reduce the severity and longevity of developmental delays.

ESM 8.2.1 - Determine which policy recommendations that address health promotion and disease prevention initiatives in schools and community-based settings that MCH can assist or lead implementation efforts.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Inactive - Completed
Goal:	To identify which recommendation(s) MCH can assist or lead implementation efforts.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Did MCH identify which recommendation we can assist and/or lead? **Denominator:**
Data Sources and Data Issues:	PANO program data
Significance:	Habits developed during adolescence play a key role in adult health and help prevent diseases. It is important for adolescents feel empowered to have a lifestyle and have access to the resources and support needed to achieve a healthy lifestyle.

ESM 8.2.2 - DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online resources and Tool Kit.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Inactive - Replaced
Goal:	Increase adolscent physical activity
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** How many schools receive training **Denominator:**
Data Sources and Data Issues:	DPH and DOE Program Data
Significance:	Regular physical activity can help children and adolescents improve cardiorespiratory fitness, control weight, reduce symptoms of anxiety and depression, and reduce the risk of developing health conditions

ESM 8.2.3 - Increase the percent of locations implementing the Triple Play model within DE schools.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	All Children 6 through 17
Goal:	Goal of Triple Play
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of current DE school locations participating in the Triple Play Model **Denominator:** The total number of schools in DE
Data Sources and Data Issues:	PANO/MCH Data
Evidence-based/informed strategy:	Youth who participate in Triple Play have reported increases in physical activity, improved eating habits and improved relationships with their peers.
Significance:	Positive long-term health outcomes have been shown healthy lifestyle habits. The metrics are even more significant when considered how health behaviors during adolescence can impact health in adulthood. Partnerships between school and community organizations, including providers of out-of-school-time programs such as before-school, after-school, and summer programs, as a strategy to address health and educational inequities have a unique role in communities and often have additional flexibility that schools may not have.

ESM 10.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the number of adolscents idenfitied in need of services (i.e. mental health; nutrition; reproduction health)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children receiving an assessment **Denominator:** # of unique children enrolled and receiving services at a SBHC
Data Sources and Data Issues:	SBHC program data
Significance:	Standardized assessment are important to ensure adolscents receive the services specific to their need.

ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Replaced
Goal:	Increase the number of mental heath visits for adolscents enrolled in SHBCs and Medicaid
Definition:	**Unit Type:** Count **Unit Number:** 15 **Numerator:** Number of mental health visits conducted by a school based wellness center. **Denominator:**
Data Sources and Data Issues:	SBHC program data and Medicaid claims data
Significance:	Adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; taking regular exercise; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school and in the wider community are also important.

ESM 10.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Ensure adolescents enrolled in SHBCs receive appropriate assessments and resources/services as needed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of mental health assessments completed within a SBHC **Denominator:** The number of students enrolled in a SBHC
Data Sources and Data Issues:	SBHC Program Data
Evidence-based/informed strategy:	Unfortunately, there is not much evidence behind School Based Wellness Centers based on the number of students enrolled and accessing services including mental health support, we know they are providing services that are needed for this population.
Significance:	Ensure adolescents receive services and treatment related to identified behavioral concerns that is accessible.

ESM 10.5 - % of children and adolescents receiving services for Project THRIVE
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Provide children enrolled in a Delaware school access to mental health services
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Raw # of unduplicated students receiving trauma specific mental health services from a provider chosen by student or parent.</td></tr><tr><td>**Denominator:**</td><td>Total # of students enrolled in DE schools.</td></tr></table>
Data Sources and Data Issues:	DOE Program Data
Evidence-based/informed strategy:	Project THRIVE provides free mental health services to eligible Delaware students. Services are available to students – grades pre-k through 12 – attending Delaware public schools, private schools, parochial schools and homeschools.
Significance:	Project THRIVE services help students who are struggling with traumatic situations, such as physical or emotional abuse, community violence, racism, bullying, and more. Trauma can harm mental and physical health, and limit school success. The Delaware Department of Education (DDOE) developed Project THRIVE to help children receive trauma-informed support from their schools, communities and caregivers. Project THRIVE services help students: Process and understand traumatic situations; Attend school regularly; Better control emotions and behaviors and Develop coping skills for managing stress at home and school

ESM 13.2.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the percent of children enrolled in Medicaid, ages 1 through 17, who had a preventive dental visit in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children enrolled in Medicaid who received a preventative dental visit in the last year **Denominator:** Number of children who received a preventative dental visit in the last year
Data Sources and Data Issues:	National Survey for Children's Health
Significance:	Preventive dental visits ensures children have a bright and healthy smile. It also spares children the aches of tooth decay. We know the sooner families start regularizing their child's dental visits, the better their oral health will be throughout their lives.

ESM 13.2.2 - Increase the referrals received for dental services via the DEThrives website.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increasing access for dental services.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** the number of referrals received via DEThrives **Denominator:**
Data Sources and Data Issues:	MCH Program Data
Evidence-based/informed strategy:	Oral health is essential to overall health.
Significance:	Focused on improving access to oral health care and understanding the factors that contribute to improving oral health from a population health perspective.

ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Inactive - Completed
Goal:	Work with Medicaid partners to develop the structure, process, and policy that will support the creation of the Cross-Agency Coordination Committee (CACC).
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Structure and schedule for CACC **Denominator:**
Data Sources and Data Issues:	CACC meeting minutes.
Significance:	As described in our recently signed MOU, the CACC will work to establish a multi-disciplinary coordination committee who will be responsible for working together on training, messaging, case management, and procedures. The overarching goals of this committee is to ensure that the mothers and families in Delaware who are eligible for services are given a clear understanding of where and how they can obtain those services. This group will address any redundant services and activities between agencies as well as filling any gaps in services that exist.

ESM 15.2 - # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Inactive - Moved to a strategy as we will continue to participate and we didn't feel the measure was strong enough.
Goal:	For Title V/MCH to participate and stay engaged in the CMCAC meetings and share information with Family Shade and other CYSHCN partners.
Definition:	**Unit Type:** Count **Unit Number:** 4 **Numerator:** Number of meetings attended by Title V/MCH **Denominator:**
Data Sources and Data Issues:	MCH program data
Significance:	During development of Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity (the Plan), it became evident early in the planning process that there would not be enough time 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 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) was developed. 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 has the opportunity to receive the adequate and appropriate health care services they need and deserve.

ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	To increase the number of primary caregivers and children with health insurance
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of primary caregivers and children (families) with health insurance **Denominator:** # of families enrolled
Data Sources and Data Issues:	MIECHV program data
Significance:	Health insurance covers essential health benefits critical to maintaining generalhealth, preventive care, treating illness and accidents

ESM 15.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of families engaged in the Family Leadership Network.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of families enrolled in FLN **Denominator:** The number families identified as having a child with a special healthcare need.
Data Sources and Data Issues:	MCH Family SHADE data
Evidence-based/informed strategy:	Studies have shed light on the vital roles and functions that families of all backgrounds can perform to support their children's and youth's development and success.
Significance:	Research has shown that meaningful family engagement positively impacts youth outcomes across various domains. Family engagement with health care professionals improves care coordination and health outcomes at the individual, youth, and family level.

ESM 15.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	The goal is too serve as many families as each awardee has the capacity to serve.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children served by a Family SHADE mini-grantee **Denominator:** Total children that can be served by a Family SHADE mini-grantee.
Data Sources and Data Issues:	Family SHADE/MCH program data
Evidence-based/informed strategy:	Families and children with special healthcare needs have unique needs that requires additional support so by building capacity at the local level, we can increase the support available that is easily accessible to families and children.
Significance:	Building capacity at the local level to serve families with CYSHCN.

Form 11
Other State Data

State: Delaware

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Delaware

Annual Report Year 2022

	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	24		
2) Vital Records Death	Yes	No	Quarterly	24	Yes	
3) Medicaid	Yes	Yes	More often than monthly	0	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	No	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	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	10	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None