Maternal and Child Health Services Title V Block Grant

Delaware

FY 2025 Application/ FY 2023 Annual Report

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Table of Contents

I. General Requirements 4
I.A. Letter of Transmittal 4
I.B. Face Sheet 5
I.C. Assurances and Certifications 5
I.D. Table of Contents 5
II. MCH Block Grant Workflow 5
III. Components of the Application/Annual Report 6
III.A. Executive Summary 6
III.A.1. Program Overview 6
III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts 9
III.A.3. MCH Success Story 10
III.B. Overview of the State 11
III.C. Needs Assessment FY 2025 Application/FY 2023 Annual Report Update 19
III.D. Financial Narrative 27
III.D.1. Expenditures 29
III.D.2. Budget 30
III.E. Five-Year State Action Plan 32
III.E.1. Five-Year State Action Plan Table 32
III.E.2. State Action Plan Narrative Overview 33
III.E.2.a. State Title V Program Purpose and Design 33
III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems 40
III.E.2.b.i. MCH Workforce Development 40
III.E.2.b.ii. Family Partnership 43
III.E.2.b.iii. MCH Data Capacity 45
III.E.2.b.iii.a. MCH Epidemiology Workforce 45
III.E.2.b.iii.b. State Systems Development Initiative (SSDI) 49
III.E.2.b.iii.c. Other MCH Data Capacity Efforts 53
III.E.2.b.iv. MCH Emergency Planning and Preparedness 56
III.E.2.b.v. Health Care Delivery System 58
III.E.2.b.v.a. Public and Private Partnerships 58
III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA) 60
III.E.2.c State Action Plan Narrative by Domain 61
Women/Maternal Health 61
Perinatal/Infant Health 94

Child Health 105
Adolescent Health 128
Children with Special Health Care Needs 154
Cross-Cutting/Systems Building 187
III.F. Public Input 193
III.G. Technical Assistance 196
IV. Title V-Medicaid IAA/MOU 197
V. Supporting Documents 198
VI. Organizational Chart 199
VII. Appendix 200
Form 2 MCH Budget/Expenditure Details 201
Form 3a Budget and Expenditure Details by Types of Individuals Served 206
Form 3b Budget and Expenditure Details by Types of Services 208
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated 211
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V 214
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX 218
Form 7 Title V Program Workforce 220
Form 8 State MCH and CSHCN Directors Contact Information 222
Form 9 List of MCH Priority Needs 225
Form 9 State Priorities – Needs Assessment Year – Application Year 2021 227
Form 10 National Outcome Measures (NOMs) 228
Form 10 National Performance Measures (NPMs) 270
Form 10 State Performance Measures (SPMs) 282
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs) 288
Form 10 State Performance Measure (SPM) Detail Sheets 304
Form 10 State Outcome Measure (SOM) Detail Sheets 307
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets 308
Form 11 Other State Data 323
Form 12 Part 1 – MCH Data Access and Linkages 324
Form 12 Part 2 – Products and Publications (Optional) 325

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, 2024

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 2024 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 2023 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
1351 N. West Street
Dover, DE 19904
(302) 608-5754

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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.

Population Domain: Women's and Maternal Health
Defining the Need: In 2022, 81.9% 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 (DHMIC), there has been much work to educate our population about preconception health, in which preventive health visits play a key role. This work includes social media outreach around the theme that "Health Begins Where You Live, Learn, Work & Play." Over the last year, DPH has started to implement a new 5 year DHMIC Strategic Plan, which includes a well women care initiative and an aspirational goal to eliminate health disparities as a priority, supported new DHMIC leadership and members, implemented Healthy Women Healthy Babies (HWHB) 3.0 program model to focus on a) performance/value based care b) address the social determinants of health c) coordinate and provide referral linkages with community health workers and d) strengthen integration of behavioral health into the model, operate and sustain 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 the most effective methods, long-acting reversible contraceptives (LARCs). DPH will work with partners to implement a law passed two years ago that allows pharmacists in DE, along with 11 other states, to administer or dispense contraceptives under a standing order from DPH in addition to an implementation plan of regulations finalized this year. Delaware will continue to refine and implement the HWHB program 3.0, providing preconception, nutrition, prenatal and psychosocial care for women at the highest risk focused on value-based care by monitoring a core set of benchmark indicators. In partnership with Maternal and Child Death Review Commission, promote, educate and roll out and distribute maternal health warning signs materials and toolkit to providers. Delaware will 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%. Delaware scored a 93 on the 2022 mPINC is CDC's national survey of Maternity Practices in Infant Nutrition and Care with several indications receiving 100. 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: Delaware created and launched a website to capture nutrition education, with extensive information on breastfeeding that was once only offered to participants in the form of physical literature. They now will have this vital education wherever they are from their mobile device. This site can be accessed here: https://delaware.wicresources.org/breastfeeding/. FY 2024 Findings from the Gibbous Group will be

used to assess current program successes and opportunities to improve program operations. According to the Gibbious findings in the First and Second Quarter Report 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 Delaware WIC Program will again be hosting the Annual Breastfeeding Event virtually on August 2, 2024. Speakers, including Marsha Walker and Cierra Murphy-Higgs, have already committed to the day. 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: Delaware continues to steadily adopt strategies to improve upon developmental screening. According to the 2021/2022 NSCH, only 34.3% of Delaware children, ages 9-35 months, received a developmental screening – on track with the national average of 33.7%. In addition, Delaware aims to increase access to comprehensive oral health care for children most at risk for oral disease. According to the 2021/2022 NSCH, 75.4% of Delaware children, ages 1 through 17, have had a preventive dental visit in the past year.

Accomplishments in the Past Year: Staff at Help Me Grow 211 served about 3,970 families, linking them to resources, services including general information and education-related materials. Staff also referred nearly 2,338 families for basic needs and family supports or to a program. With recent legislation, licensed childcare centers began administering annual developmental screens of enrolled children using the Ages and Stages Questionnaire (ASQ). Over 900 childcare centers have been enrolled to begin yearly ASQ screens. This demand has elevated the follow-up support the DOE receives from HMG@211 staff. The Books Balls and Blocks project participated in 11 events and interacted with about 86 families, who were provided information on early childhood education and health. From July 1, 2023, through June 4, 2024, the DE Smile Check Program provided a dental screening to 2,602 students. In addition, 2,468 students received a fluoride varnish application. There were 302 students that were identified as having an urgent dental need and 767 with suspected dental decay. Of those, 166 were connected to a dentist and completed all dental treatment, while 42 qualified for Medicaid and are now insured under Medicaid or DCHIP.

Plans for the Coming Year: Through strategic planning, the ECCS program plans to re-introduce the HMG system across the state for better understanding by stakeholders. For the next 3-5 years, the ECCS program also intends to focus on 2 major high risk zip codes in the state. The ECCS program also intends to continue efforts to organize events targeting fathers. The Bureau of Oral Health and Dental Service will continue to expand current oral health education programs. BOHDS has a dedicated 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, pregnant people, experiencing substance abuse, people with disabilities, people with cancer, or mental health challenges. Oral health will be promoted within the family, schools, workplace, and primary healthcare to reduce oral health inequalities, connect them to a dental home and improve oral health literacy.

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 2021/2022 NSCH shows that the percentage of Delaware adolescents who have had a preventive medical visit in the past year rests at 74.2%, compared to 69.7% nationally. In addition, Delaware strives to increase the number of adolescents who are

physically active. According to the 2021/2022 NSCH, 72.3% of Delaware children, ages 6 through 11 are not physical active.

Accomplishments in the Past Year: Legislation was approved for two high needs elementary SBHC per year until all high needs elementary schools are in compliance. There are currently 20 high need elementary schools in Delaware. Two more elementary schools became a State Recognized School-Based Health Center Provider. As a SBHC are eligible to provide medical, mental health care treatment and health education. PANO has facilitated technical assistance with community partners on the planning and implementation of their community-based interventions, all of which impact children and families. PANO worked with many community partners to provide TA on: an asthma self-management program to be offered to children in schools and/or in youth-serving organizations; improving access to healthy, locally produced food in targeted communities; a program for children with disabilities that educates and teaches skills to increase healthy eating, and increases physical activity for this population; and revitalizing a community space for health education and physical activity for children in an underserved community.

Plans for the Coming Year: There continues to be a growing interest for expansion in schools and the enrollment and utilization of SBHCs has increased. There continues to be a large number of stakeholder interest and commitment to provide evidence based SBHC services based on innovations in practices and policies, to enhance the growing number of SBHCs within the local healthcare, education, and community landscape. PANO will partner with other state agencies and community organizations to sustain community capacity building. DPH will engage community partners who are primarily serving disparate or targeted communities. 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 change strategies and interventions through community-based initiatives.

Population Domain: CYSHCN

Defining the Need: According to the 2021-2022 National Survey of Children's Health (NSCH), 40.2% of Delaware CYSHCN, ages 0 through 17, have a medical home in comparison to the nationwide CYSHCN average of 40.7%. Among the sub-group of children with special health care needs that have a medical home, 42.3% of Delaware CYSHCN were insured at the time of the NSCH survey in comparison to the nationwide to the nationwide CYSHCN average of 41.6%. Through the Block Grant, Delaware will continue to actively work with partnering state and community contracted agencies to assure that all CYSHCN have a medical home and are adequately insured through statewide initiatives with grantees that serve CYSHCN.

Accomplishments in Past Year: The Parent Information Center (PIC) completed their 3rd year as DPH's 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 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, and referrals. FLN members received monthly stipends for attendance and participation pending that there was funding available. The FLN recruited 11 family members that had a child or youth with special health care needs in their family.

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 project will align MCH NPMs through the services rendered by organizations in Delaware that serve families of CYSHCN. To enhance capacity and sustain programs that serve CYSHCN, Family SHADE will continue to provide TA to newly awarded mini-grantees in year 4. PIC will provide TA and quality assurance to the newly awarded mini-grantees working on developing a Logic Model, Work Plan, Evaluation Plan, Evaluation Tool, Sustainability Proposal, and a COVID Response Plan. The CYSHCN Director in partnership with the EHDI Coordinator, FLN members, Family Delegate, and leadership within the MCH Title V will work together to develop a seamless crosswalk approach in the implementation of the CYSHCN Blueprint for Change Guiding Principles so that we are identifying needed areas where gaps in service delivery to CYSHCN and their families are not being met.

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.

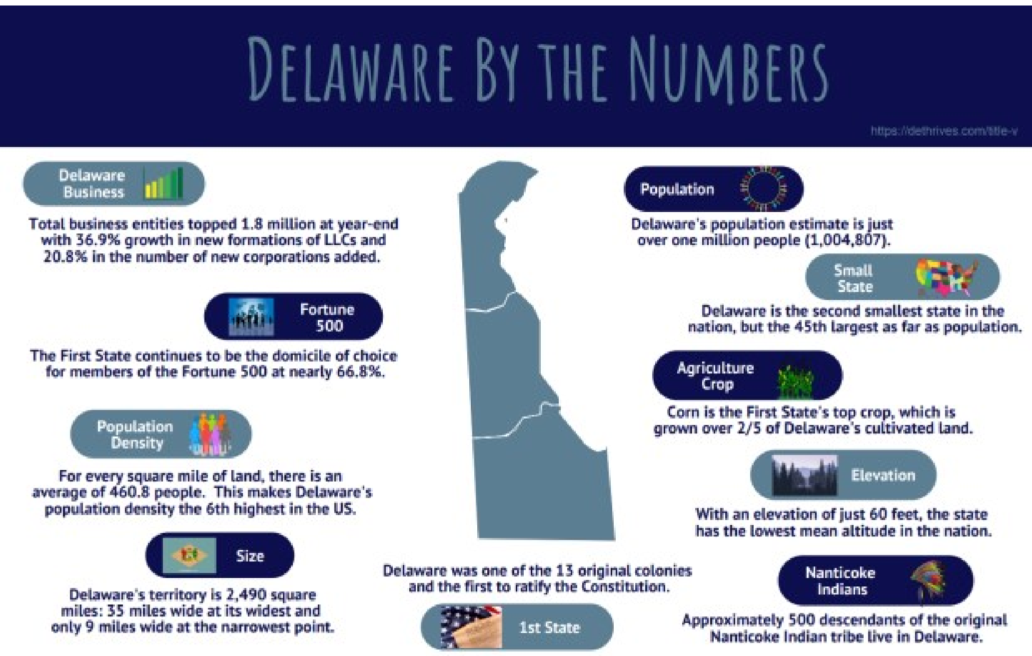
In the past few years, we have allocated funds to address social determinants of health including the integration of the medical legal partnership model within our home visiting programs and our Healthy Women Healthy Babies (HWHB) providers offices. More recently, funding has been allocated to key community 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. Earlier this year we released another RFP to continue 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 three successful cycles, 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 last year.

III.A.3. MCH Success Story

On May 7th, there was a Home Visitors Retreat held in Dover, DE with the theme, Caring for The Community While Taking Care of You. The retreat pulled in over 200+ registrants and had 170 in-person attendees, an 85% show rate. The retreat acknowledged and thanked the Family Support Specialists (FSS; commonly known as Home Visitors) for their hard work throughout the year and encouraged the importance of self-care and how that can carry over and improve the professional and personal life of a worker.
Segments of the day included topics of self-care and wellness, infant early childhood mental health, and a panel about autism so FSS staff could apply these topics to their "toolbelt" of resources to utilize during their workday. Moderators included leadership from the Home Visiting Community Advisory Board (HV CAB) which helped introduce keynote speakers and video remarks by Lt. Gov Bethany Hall-Long and DHSS' Cabinet Secretary Josette Manning to kick off the retreat.
Self-caring themed items that were made available to participants included massages (96 participants signed up to receive a massage), professional headshots (106 registrants received a professional headshot), resource tables, vendor tables, and giveaway items for networking opportunities and to encourage resource sharing amongst the different Home Visiting programs throughout the state.
A post event Press Release was also released to help share news of the event and to promote the Home Visiting program further.
During the event, DEThrives posted 12 posts and stories on Facebook and Instagram about the Retreat which earned the DEThrives channel 197 total engagements and 162 video views on the published posts/stories in one day alone. The top post that earned the most engagements (likes, comments, shares, clicks) on Facebook highlighted the panel about the autism topic which earned 145 engagements on the post. Short videos (<30 seconds) of participants were also recorded during the retreat which will be continued to be featured as reels on DEThrives social media platforms to share the Home Visiting messaging throughout the year.
The retreat was so well received with staff letting us know of grateful they were and how it made them feel valued and appreciated. We are planning to carry this topic forward later this year at our Family Health Systems Retreat.

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, 16.8 percent of children lived in poverty in 2017-2021, which is a slight decrease with 17.3 percent in 2017- 2021. The highest rates are among those children aged 0-4 at 19.1%. The median family income in 2022 was $98,000 for all Delawareans, the median family income for non-Hispanic white was $113,200, $78,800 for Black or African American, and $51,800 for Hispanic or Latino. In Delaware in 2021, about 1 in 10 (9.9%) of the total population experienced food insecurity. For children under age 18 in the state, the food insecurity rate was higher, at

1 in 7 (14.4%). However, since the conclusion of SNAP's emergency allotments in February 2023, concerns have risen about the re-emergence of higher rates of food insecurity with our Food Bank of Delaware seeing an increase in visitors.

In 2021, there were 10,871 births in Delaware; 9,882 were to Delaware residents and 989 were to non-residents. Additionally, 507 births to Delaware residents occurred out of state, for a total of 10,389 Delaware resident births, 37 more Delaware resident births than in 2020. The recent national declines in general fertility and live birth rates were also apparent in Delaware statistics. From 2008 to 2021, the general fertility rate (number of births per 1,000 women aged 15-44 years) declined from a high of 66.8 to 55.5 births per 1,000 women aged 15-44. The birth rate of women aged 15-19 (teens) exhibited the largest decline at 63 percent followed by women aged 20-24 that decreased 37 percent and women aged 25-29 that decreased 27 percent. During this period women in the 40-44 aged group had the largest increase at 42 percent from 8.3 to 11.7 births per 1,000 women followed by women aged 35-39 that increased 15 percent. Since 2008 the number of births to women aged 30-34 has not significantly changed.
In 2021, private insurance or Medicaid were listed as the primary source of payment in 93.4 percent of all live births; the remaining 6.6 percent were split between other, other government coverage, unknown, and self-pay. In 2021, in all race categories, majority of women over thirty (68 percent) had private insurance as their primary source of payment. Medicaid was still the primary source of payment for the majority of mothers under 20, covering 76.1 percent of non-Hispanic black mothers, and 66.4 percent of non-Hispanic white mothers in that age group.
As in previous years, the primary source of payment for delivery in 2021 varies tremendously based on marital status: The number of single non-Hispanic white women who used Medicaid as their primary source of payment (51.4 percent) was more than six times that of non-Hispanic white married women (8.4 percent). The number of single non-Hispanic black women who used Medicaid as their primary source of payment (61.9percent) was more than two times that of non-Hispanic black married women (28.7 percent). The percentage of single women of other non-Hispanic races who used Medicaid as their primary source of payment (56.1 percent) was nearly five times higher than among married women of other non-Hispanic races (12.3 percent). The number of single Hispanic women who used Medicaid as their primary source of payment (67.3 percent) was 1.4 times higher than Hispanic married women (48.2 percent).
After increasing steadily from 2002 to 2008, the percentage of births to unmarried women decreased by two percent from 2008 to 2021. Births to married women decreased steadily from 1994 to 2008 but increased by two percent from 2008 to 2021. In 2021, 47 percent of all births were to unmarried women. (Delaware Vital Statistics Annual Report, 2021)

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
-

Delaware has 3 FHQCs at 11 different locations across the state, 6 hospitals, 1 children's hospital, 7 urgent care centers with 15 locations and the Division of Public Health has several clinics across the state providing array of services. A complete guide to health care in Delaware can be found here, DHSS_Healthcare_Access_Guide.pdf (delaware.gov).

Services for CYSHCN

In Delaware, infants and toddlers with disabilities are served by Part C of IDEA, known as the Birth to Three Program

in Delaware as well as by evidence-based home visiting programs. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. The Birth to Three program provides developmental assessments of children birth to 3 years of age along with service coordination for developmental services and therapies. The program is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and Nemours Children's Hospital (the only children's hospital in Delaware) working together to provide early intervention to young children with special health care needs and their families.
The Children and Youth with Special Health Care Needs Director (CYSHCN) sits in the Division of Public Health's Maternal and Child Health Bureau in the Family Health Systems Section. This position is essential as it functions to bolster and cultivate family and professional partnerships by working closely with family-led organizations. Delaware's Birth to Three system works in coordination with the CYSHCN Director who oversees the Newborn Metabolic and Hearing Screening programs to ensure policies and procedures are in place for appropriate and timely receipt of needed intervention services. Delaware's Family SHADE is a collaborative alliance of family partners and organizations committed to improving the quality of life for children and youth with special health care needs, and their caregivers, by connecting families and providers to information, resources, and services; advocating for solutions to recognized gaps in services; and supporting its member organizations. Family SHADE is contractually lead by our Parent Information Center. In 2021, Family SHADE developed a process to award mini grants to community organizations to implement small place-based interventions to drive innovation and if proven effective brought to scale. Parent Information Center selected two community-based organizations to receive an award in 2022 and awarded four more community agencies a mini-grant this year.

Context for Title V within the State

Governor 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 Josette Manning. The Delaware Department of Health and Social Services is one of the largest agencies in state government. DHSS has 11 divisions and employs more than 4,000 individuals in a wide range of public service jobs. In one way or another DHSS affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.
The Division of Public Health (DPH) is one of the largest divisions within DHSS and home to Title V, the agency is responsible for planning, program development, administration, and evaluation of maternal and child health (MCH) programs statewide. DPH was mostly recently led by Karyl T. Rattay, MD, MS, FAAP. FACPM who served as the Division Director for thirteen years. Steve Blessing was appointed earlier this year; Steve led the Emergency Medical Services unit in DPH for several years and previously served as a Deputy Director for DPH. DPH remains steadfast to 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 July 1, 2024, DPH was charging the birth facilities and midwives $165.00 per newborn for the newborn metabolic

screening including lab and follow up services. The DPH contracts with Nemours Children's Hospital to administer the statewide program which includes both the program and laboratory services. Nemours Children's Hospital currently sub-contracts with Revitty to provide the laboratory services. The Delaware Newborn Screening Advisory Committee meets at least three times a year and is a governor appointed body. The Advisory Committee members, DPH and Nemours spent quite a bit of time discussing the last few years discussing and voting on necessary changes including the elimination of the mandated second screen, how long blood spots should be stored and expanding the newborn screening panel. All these items, eliminating the second screen, timeline for specimen collection and the length of time bloodspot cards are stored were approved by the Advisory Committee and all birthing facilities were included in the process. The Advisory Committee voted on and provided a recommendation to the DPH Division Director to add four additional conditions, Pompe Disease, Muccopolysaccharidosis Type I (MPS I), X-Linked Adrenoleukodystrophy (X-ALD) and Spinal Muscular Atrophy (SMA) to Delaware's screening panel. With the DPH Director's approval, the additional conditions were added to the panel January 1, 2020. Most recently, MPSII and GAMT were approved and screening for those two additional disorders will go live 7/1/2024. Delaware's screening panel now includes all conditions recommended by the RUSP.

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 2022 was 13.6 per 1,000 females aged 15-19 years and the corresponding teen birth rate in Delaware in 2022 was 14.7 per 1,000 females aged 15-19 years. Between 2017 and 2021, the teen birth rate in Delaware was 16.1. The disparity ratio in teen birth rates was 3 times for Black teens (26.7 per 1,000 females aged 15-19 years) to White teens (8.6 per 1,000 females aged 15-19 years). Despite the racial disparities, Delaware has made great, long-term strides in improving the teen birth rates among White non-Hispanic, Black non-Hispanic, and Hispanic teens through several population-based health interventions. In fact, between 1991 and 2020, the teen birth rate declined by approximately 85 % for White non-Hispanics, decreased by approximately 86 % for Black non-Hispanics, and decreased by 72 % for Hispanics.
- **Overall, Health.** 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. Except for those who were high school graduate or GED, all other educational categories had higher prevalence of good/excellent health. Between 2017 (71.8%) and 2021 (88.4%) the percent of women of childbearing age with less than a high school education reported a 23% increase in good/excellent health as compared to those who attend college or technical school during 2017 (81%) and 2021 (86.2%), which had a modest increase of 6.4%. In 2021, 98.8% of women of childbearing age who identified as other race (non-Hispanic) reported good/excellent health as compared to 87.6% White (non-Hispanic), 82.1% Black (non-Hispanic), and 85.5% Hispanic women. During 2017-2021, there was over 11 percentage-point increase in good/excellent health among other race (non-Hispanic) and 9-percentage-point increase among Hispanic women as compared to 4 percentage-point increase among White (non-Hispanic) and less than half a percentage-point increase among Black non-Hispanic women.
- **Smoking.** According to Pregnancy Risk Assessment and Monitoring System (PRAMS) 2012-2021 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. 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.

as compared to 12.2% 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 and again earlier this year, 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 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 health care spending benchmark is defined as the target annual per capita growth rate for Delaware's statewide total health care expenditures, expressed as the percentage change from the prior year's per capita spending. The spending benchmark is set on a calendar year (CY) basis. The spending benchmark is the forecasted growth in Delaware's per capita potential gross state product plus the following transitional market adjustments (i.e., add-on factors): +0.5% for CY 2020, +0.25% for CY 2021, and +0% for CY 2022–2023. Governor Carney's Executive Order (EO) 25 set the spending benchmarks for CYs 2019–2023 as follows: • CY 2019: 3.80% • CY 2020: 3.50% • CY 2021: 3.25% • CY 2022: 3.00% • CY 2023: 3.00% (revised to 3.10%) On an annual basis, the spending benchmark is subject to review and change by the Delaware Economic and Financial Advisory Council (DEFAC) subcommittee. For CY 2023, the spending benchmark will be changed to 3.10% per the DEFAC subcommittee's recommendation. For CY 2024, the DEFAC subcommittee recommended no change to the 3.0% spending benchmark at its May 2023 meeting. Subsequently, DEFAC recommended to the Governor in its June 9, 2023, report to maintain the 3.0% spending benchmark for CY 2024 and retain the current potential gross state product (PGSP) formula for determining the spending benchmark.

Per capita health care spending in Delaware increased 6.3% in 2022 to $9,657, outpacing a 3% growth rate benchmark, according to the State of Delaware's fourth annual Benchmark Trend Report. Along with tracking the year-over-year percentage change in total health care expenditures expressed on a per capita basis, the benchmark report also reflects data trends on nine health care quality measures and offers insight on health disparities to guide efforts to improve health equity throughout the State.
Annual trend reports dating back to the initial release in 2019 reflect continued per-capita growth in health care spending beyond established benchmarks. That year, spending grew at a rate of 5.8%, exceeding a 3.8% spending benchmark. While a 3.5% benchmark was met in calendar year 2020, in 2021, reflecting the rebound from the COVID-19 pandemic, health care spending grew at a rate of 11.2% compared to a benchmark of 3.25%. The 6.3% per capita increase in 2022 is significant, but there was an expectation of some continuing health care spending rebound effect in the post-pandemic period. Moving forward into 2023 and beyond, DHSS expects Delaware's health care market to be in a steadier state.

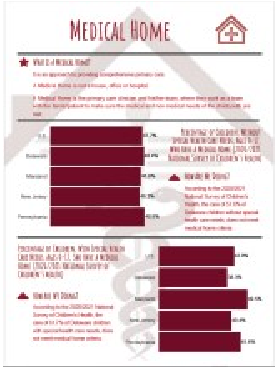
III.C. Needs Assessment

FY 2025 Application/FY 2023 Annual Report Update

Delaware completed our comprehensive Title V Five-Year Needs Assessment in 2020. This FY 2025 Application/FY 2023 Annual Report application is our last year into the 2021-2025 grant cycle. During this past five-year grant cycle, Delaware has routinely engaged in the necessary steps of the Needs Assessment process. Delaware has completed various activities, including data collection and analysis, program evaluation, key informant interviews, surveys, advisory councils, and other approaches to solicit individual feedback and conducted ongoing performance monitoring and assessment. In addition, Delaware has routinely engaged families, caregivers, individuals, and other stakeholders in the needs assessment process.

During the 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 MCH population. The first goal of our team was to use a data-informed method to identify and prioritize Delaware's top health issues as a result of the pandemic. Additionally, 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.

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. During the spring of 2023, MCH amended these Health Infographics with updated NSCH data. All of our Title V and Needs Assessment information, including our Health Infographics, is found in one central location, our DEThrives website.



Delaware developed a colorful graphic snapshot for our partners to use, which is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. 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.

Our team convened, reviewed the available data, and 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 for this ongoing Title V Mini Needs Assessment process. 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.

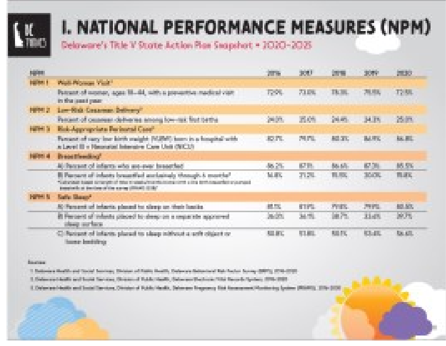
Another focus Title V wanted to gain a pulse on due to the pandemic, were Social Determinants of Health (SDOH) on Delaware's MCH population. Our aim was to see if the women, children, adolescents, and families in Delaware's unmet needs have changed since the beginning of the pandemic. We understand that 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 areas 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.

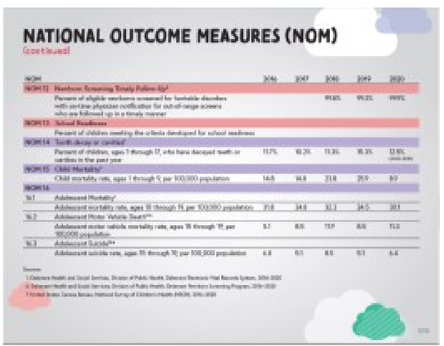
Interestingly, when asked about SDOH, employment was listed most often as a SDOH that women, children, and families need to live their fullest lives. However, it was not considered as much of as an unmet SDOH in the survey respondents' communities. Both food security and child-care were listed as among 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 completed an in-depth analysis of the results of this Mini Needs Assessment and compared 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 the survey 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. Our SSDI Project Director scheduled regular meetings with our two-Family Health Systems (FHS) epidemiologists to compile 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.

In the spring 2023, MCH updated these Performance Measures data sheets once updated 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.





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.

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.

During the past year, we again reconvened our Title V team throughout the year to assess the health needs of our population, Title V's program capacity, as well as Delaware's partnerships and ability to collaborate and coordinate efforts. 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).

Beginning in the fall of 2023, Delaware's Title V team continued to meet to prepare for the upcoming 2025-2030 Five-Year Needs Assessment. We identified the core members of our Internal Steering Committee, defined the roles and responsibilities of the team, and set expectations for each member. We are using the services of our epidemiology, research, and evaluation (ERE), Forward Consultants, for most of our Needs Assessment data needs. We approached our activities with an aggressive timeline, to ensure enough time was allotted for compiling the feedback and writing the Title V 2025 State Action Plan, along with the Title V 2026 Application Year/2024 Annual Report Block Grant.

Preparation (December 2023 - February 2024)

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

Assess Health Status of MCH Populations and State Program Capacity (March 2024 - May 2024)

- Conduct environmental scan of MCH initiatives and data.
- Assess infrastructure of MCH programs.
- Assess partnerships/engagement within MCH programs.
- Assess MCH workforce capacity.

Carry Out Needs and Capacity Assessment (June 2024 - October 2024)

This highly in-depth phase will involve in-person meetings from key stakeholders, which may be best to complete

in the Summer/Fall time frame.

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

Analyze (October 2024 - December 2024)

Any remaining work from the "Carry Out Needs and Capacity Assessment" phase will be completed here.

- Tabulation of rankings from prioritization evens and surveys.
- Review and approval of final list of priorities by Department of Health leadership.
- Analysis of identified priority health issues, identification of evidence-based strategies, and opportunity to seek input from the public and potential service populations on strategy acceptability and implementation recommendations.

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

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

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

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

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

As the Title V agency, DPH operates a comprehensive array of programs and services to promote and protect the health of Delaware's mothers and children, including children and youth with special health care needs. Within DPH, the Family Health Systems section houses many of these programs, as described within the application. However, the capacity to support the MCH population extends throughout all sections of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers and supports for healthy lifestyles (physical activity, nutrition, tobacco cessation), to name a few. An overview of DPH's partnerships, collaborations and coordination surrounding our programs and services for the MCH population is summarized 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 2nd 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. During this grant year, they were able to recruit 11 family members that served as collaborative leaders who contributed feedback on their experiences on service delivery to PIC and to the 4 mini-grantees which served CYSHCN and their families. This network continued to consist of parents/guardians of children birth to age 26 that had a suspected or diagnosed disability. The network membership included trainings, monthly learning community sessions, support with Individual Education Plans (IEPs), and referrals. 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 took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

The 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 previously partnered with Project LAUNCH and the Division of Substance Abuse and Mental Health in combating the opioid epidemic. As a result, a Memorandum of Understanding (MOU) was created.

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.

As in years past, Title V continues to support a very important activity, the Managed Care Organization (MCO) health calls/zoom meetings 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. Some common issues discussed include: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. These calls were beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they had for their children. 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:

2024 Application/2022 Annual Report – Needs Assessment Update

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

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,027,826	$2,042,781	$2,042,781	$2,073,458
State Funds	$10,128,656	$10,128,656	$9,957,273	$9,957,273
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$2,053,906
Program Funds	$2,957,897	$2,957,897	$2,053,906	$0
SubTotal	$15,114,379	$15,129,334	$14,053,960	$14,084,637
Other Federal Funds	$6,890,346	$8,067,874	$9,974,592	$9,974,592
Total	$22,004,725	$23,197,208	$24,028,552	$24,059,229

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

	2025	
	Budgeted	Expended
Federal Allocation	$2,126,787	
State Funds	$10,148,719	
Local Funds	$0	
Other Funds	$0	
Program Funds	$2,761,872	
SubTotal	$15,037,378	
Other Federal Funds	$5,879,035	
Total	$20,916,413	

III.D.1. Expenditures

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.

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III.D.2. Budget

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.

FY25 Budget – Federal Title V Funds

Personnel Costs **$1,562,678**

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 $549,109

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

Travel $10,000

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

Supplies $5,000

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

FY 25 TOTAL BUDGET $2,126,787

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

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

Preventive and Primary Care for Children

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

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

Administration

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

III.E. Five-Year State Action Plan

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

State: Delaware

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.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, School Based Health Centers, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Infant Mortality Elimination program, Family Health and Epidemiology, Title X/Family Planning, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, as well as others that require partnerships, coalition building and leadership.

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

DPH has implemented 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. Last 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. The two additional mini grantees addressed two priority areas including fatherhood/partner involvement and engagement and food insecurity.

Black Maternal Health Awareness Week was celebrated in several ways. State Representative Melissa Minor Brown, and appointed Delaware Healthy Mother and Infant Consortium (DHMIC) member, was invited to the White House to meet with President Biden and Vice President Kamala Harris to discuss the Delaware DPH and DHMIC HWHB Guaranteed Basic Income demonstration program.

Also for Black Maternal Health Awareness Week, Tiffany Chalk, Vice-Chair of the DHMIC, was invited to speak upon the BMHAW Resolution at Delaware's Legislative Hall.

Lastly, U.S. Representative Blunt Rochester hosted a roundtable event on black maternal health crisis. DHMIC Vice Chair, Tiffany Chalk, was asked by Congresswoman Lisa Blunt Rochester's team to provide a statement in support of Black Maternal Health Awareness Week because since she was a member of the US Congress Black Maternal Health Caucus. The invitation was also extended to Mona Liza Hamlin, Co-Chair of the DHMIC Well Woman/Black Maternal Health (WW/BMH) Committee to be a part of a roundtable highlighting the disparities in maternal and infant health outcomes in the black community during Black Maternal Health Week. State Representative Melissa Minor Brown, a DHMIC appointed member, was also asked to be a part of the roundtable as well. The invitation included Delaware healthcare leaders, Delaware State Representatives, and U.S. House members. Media coverage was done by Bay to Bay News and on Delaware Public Media.

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, X, Instagram, and blog posts to educate, inform, and provide resources, services and links to the Delaware maternal and child health population and our partners. MCH is using this strategy to engage and inform our population with up-to-date information pertaining to various needs and topics.

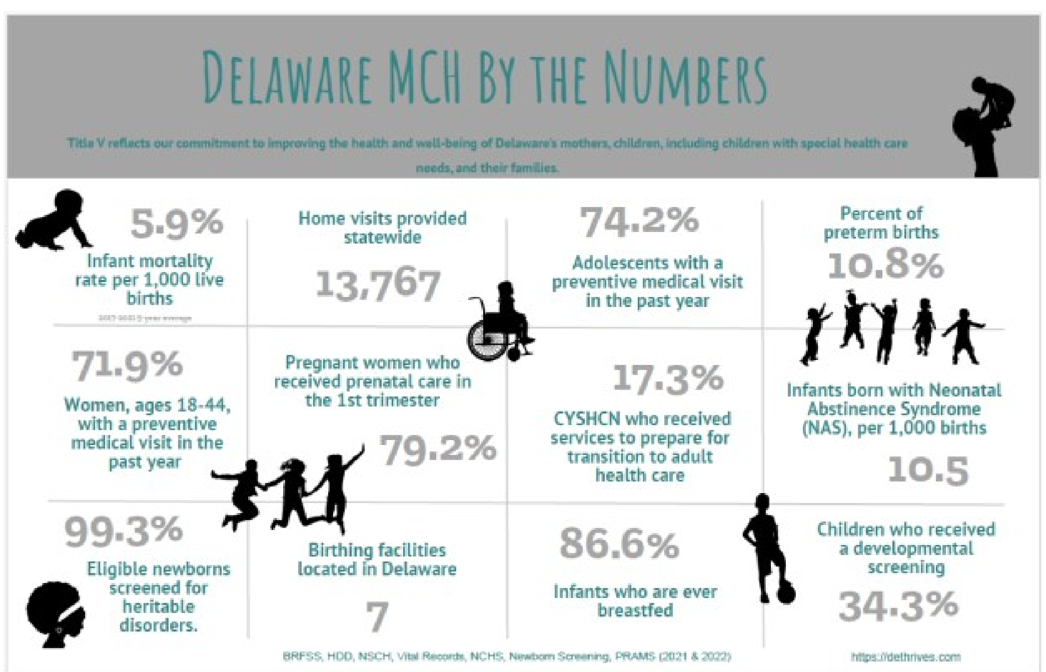
Several pending legislation updates are available for reporting, which aim to improve maternal and infant healthcare in Delaware. The goal of these bills was to break down barriers and remove other obstacles some mothers and families have faced when receiving healthcare treatment in Delaware.

- SS 1 for SB 301: An act to amend the Delaware Code relating to providing medication abortion prescription drugs and emergency contraception. This Act requires public universities to provide access to medication for the termination of pregnancy and emergency contraception. The medication and contraception must be

provided on-site, but consultation to provide them may be performed by a provider at the student health center or by a provider who is associated with a university-contracted external agency.

- HS 1 for HB 5: This Act amends the Delaware Code relating to reimbursement of school based behavioral health services. The State's Medicaid Plan still limits the reimbursement of Medicaid-covered, school-based behavioral health services to those provided under an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP), despite federal policy changes that allow for these services to be provided as a medical necessity without IEP or IFSP documentation.
- HS 2 for HB110: This Act to amend the Delaware Code relating to insurance coverage for termination of pregnancy.
- HB 274: An act to Amend the Delaware Code relating to insurance coverage of allergen introduction dietary supplements for infants. This Act requires that all health insurance plans subject to requirements under Delaware law, including Medicaid, provide coverage, at no cost when prescribed to infants, of at least 1 early peanut allergen introduction dietary supplement and at least 1 early egg allergen introduction dietary supplement.
- HB 345: This Act amends the Delaware Code relating to coverage for Doula services. This Act requires Medicaid coverage for additional postpartum visits with a doula upon recommendation of a licensed practitioner or clinician.
- HB 362: An Act to amend the Delaware Code relating to coverage for doula services. In 2023, the General Assembly passed a bill, which required the coverage of doula services under the State's Medicaid plan beginning in 2024. This Act would require similar coverage under private health insurance plans.

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 at state and local levels
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.

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

To help spread the news that the Urgent Maternal Health Warning Signs Toolkit was available to order and/or download on the DEThrives site, an interview (part 1, part 2) was held with WDEL during their Del-Aware segment. Another interview was held with WJBR on their public affairs program Focus on the Delaware Valley and could be listened on WJBR's website here. Lisa Klein, a Coordinator for the MCDRC and Meena Ramakrishnan, MD, an Epidemiologist for the MCDRC, were interviewed. To showcase these interviews on social, 30 second snippets of the interview were taken and made into two separate reels so the visual parts of the toolkit were showcased and the audio for the reel were pieces of the interview.

Two Home Visiting themed campaigns ran concurrently – the Home Visiting (HV) Campaign and Nurse Family Partnership (NFP) Home Visiting campaigns – had different goals set, depending on the timeframe. For the first three months of the HV campaign (known as flight 1) had the goal of generating awareness, brand recognition, and explained the purpose of the HV program to users. For the last two months of the campaign (known as flight 2) the goal was to encourage a user to consider signing up for the program and follow the call to action. The NFP campaign also had the goals of awareness during flight 1 and consideration during flight 2. Thirty second, 15 second, and 6 second videos were created for this campaign where four different videos were shown during a certain timeframe to help showcase the HV services from the NFP program specifically in high-risk zip zone areas particularly in the New Castle.

The HV campaign ads were placed on platforms such as on Facebook/Instagram newsfeeds as pictures and videos, Reddit, radio (in English and Spanish), website ads as images and videos, and on game apps. For the NFP HV campaign, ads were mainly displayed as short videos on Facebook/Instagram, YouTube, gaming apps, and on Spotify.

With a long-term goal of progression toward universal developmental surveillance and screening, Delaware's early childhood community emphasizes a coordinated, comprehensive, and holistic approach which takes into account the impact of the social determinants of health of the child and. 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 October 2021, 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 utilized the Family Leadership Network (FLN) in collaboration with all mini-grantees to promote inclusion and receive feedback on where there are gaps in service delivery for CYSHCN population. The FLN network membership is a member network which offers trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. They served as a learning network and resource for the community agencies serving CYSHCN. For a second year, PIC succeeded in the implementation of the revitalized Family SHADE project which consisted of the execution of competitive mini-grant opportunities that were innovative and aligned with our Maternal Child Health National Performance Measures (NPMs).

Through the Family SHADE project, three community-based organizations were awarded mini-grants. Down Syndrome Association of Delaware (DSADE), Children's Beach House (CBH), and Teach Zen were awarded mini-grants. Tomaro's CHANGE (Creating Healing Answers & Necessary Guidance for Excellence) decided to continue

their efforts with the support of the PIC to implement their project in year 2 since they were not able to get their project implemented in year one. These four organizations that were awarded developed skills that will further sustain their projects after the funding has ended. These organizations enhanced their skills so that they can compete and apply for future grant opportunities to grow their efforts in serving CYSHCN.

Serving as a leader, convener, collaborator, & 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.
Delaware will develop a crosswalk through our MCH Title V Block Grant and develop an alignment with the CYSHCN *Blueprint for Change*. The 6 Core Indicators will be implemented throughout the domains and national performance measures in the delivery of service.

The Director of CYSHCN along with the Parent Information Center - Family SHADE project team will strategize with our MCH Title V team to make sure that we are touching on all 6 core indicators and health equity, quality of life and well-being, access to services and financing of services. We will align the current work and priorities that we are doing to serve CYSHCN and their families and improve where we would like to improve the system with and address the needs that have been identified in our needs assessment. This approach will assist and guide our Title V programs in aligning current work and priorities with the *Blueprint for Change*: Guiding Principles for a System of Services for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. This table below is a starting point for our state to identify where we are and where we want to go in improving the system of services for CYSHCN. This approach will allow us to do a crosswalk in the Title V Needs Assessment and assist in reporting future Block Grant application related to Blueprint activities.

CORE INDICATOR#1 Children and youth are screened early and continuously	CORE INDICATOR#2 receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing	CORE INDICATOR#3 Community-based services are organized so families can use them easily	CORE INDICATOR#4 CYSHCN receive services necessary to make transitions to adult life, including healthcare	CORE INDICATOR#5 Families have adequate insurance and funding to pay for services they need	CORE INDICATOR#6 Families of CYSHCN Are partners in decision-making at all levels of care from direct care to the organizations that serve them
Health Equity	Healthy People 2030 defines healthy equity as "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Addressing poverty, damaging living conditions, and access to health and social services will mitigate adverse health effects. The principles and strategies will seamlessly acknowledge that poverty, discrimination, and their downstream consequences cause health inequities. Delaware will implement a crosswalk across our national performance measures which are: Well-women visit, Breastfeeding, Developmental Screening, Dental Visit (child/adolescent), physical activity (ages 12-17), Adolescent Well-visit, Adequate insurance, and workforce development.				
Quality of life & well-being	Historically, health care does not include a proactive focus on patient and family well-being and quality of life. Yet, studies have shown that parents and families of CYSHCN often experience disruptions to family life, social isolation, and chronic stress, and have significant and diverse psychosocial support needs. Data reveal that "CYSHCN and their families are at risk for adverse outcomes in economic, academic, and social emotional domains, in addition to physical health. Moreover, racial and ethnic disparities in access to opportunities and supports exacerbate the inequities that CYSHCN and their families experience.' Historically, the health system focused on measuring health outcomes, not necessarily metrics meaningful to families. These metrics should be developed in partnership with Families and can include the wellbeing and quality of life of the child from birth through adulthood, wellbeing of the family unit, and the ability to achieve dignity, autonomy and independence.				
Access to services	Access to services and supports is defined broadly and includes the 4 components of access to health care: coverage, services; timeliness; and a capable, qualified, and culturally competent workforce. This concept includes all social services necessary for CYSHCN and families to have full, thriving lives, including but not limited to education, early intervention, child welfare, foster care, health, and community-based supports. This critical area recognizes the educational system as an entry point and major deliverer of services for children and families. The ideal system is integrated across all sectors and anticipates families' needs. It aligns the delivery, payment, and administration of services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.				
Financing of service	Addressing health equity, well-being, quality of life, and access to care requires an adequately financed system of services. This includes both the overall systems of financing, including insurance design and organization of programs, as well as specific models and mechanisms for payment and eligibility. It supports models that improve quality and value, and recognize outcomes meaningful to stakeholders, including families, providers, and payers. Although the following principles and strategies focus on health care and related services, including care coordination, which is necessary in a system that is not fully integrated, CYSHCNC also may require an array of additional social services and educational supports.				

On April 17th, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 18th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial, ethnic, and geographical disparities that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. This year's theme was IMAGINE. IMPACT. INNOVATE. Driving Equity in Infant and Maternal Health. This year, the summit sold out, people were placed on a waitlist, and the summit earned 406 registrants maxing out the venue's capacity (maximum capacity at 360) with nearly 304 in-person attendees which included about 25 walk-ins. The event drew in many healthcare professionals, policymakers, community influencers, community partners, stakeholders, and citizens such as nursing students who were interested in learning ways on how to provide access to proper care for all Delaware mothers, before, during, and after pregnancy, their babies, and families no matter their socioeconomic, racial, or ethnic status.

In addition, regardless of your title and level in the organization, everyone at every level on the DPH Title V MCH team is engaged in the process of leadership. We conduct our work and our interactions with others using the 10 Principles of Leadership (LeadQuest) and these values as guideposts for our personal behavior, professional practice, and public health decisions. DPH has been focused on creating a culture of leadership for over 11 years, using this framework. Title V MCH has a proven track record of creating unity, building trusting relationships to help achieve success by working with others rather than stepping on or over people. We work on bringing people together, to establish a common vision and set of values along with programmatic systems and operations, such as planning, goal setting, communications and quality improvement. 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 State of Delaware's Department of Health and Social Services celebrated Trauma Awareness Month during May 2024. DHSS chose to highlight the importance of Self-Care, especially within our staff. DHSS leadership

recognized that many of its employees serve in roles where there is potential for vicarious and secondary trauma and/or compassion fatigue, in addition to the personal and public traumas anyone may be facing. Self-Care is an excellent strategy to build resilience which can protect everyone from the impact of traumatic events and help heal.

To help spread the word about Self-Care resources available to employees through our benefit package and within the community at large, DHSS hosted a 3K/5K Wellness Walk at a location in each county on May 17th. The Wellness Walk included a “Self-Care Map” that led to vendor tables where everyone received valuable information on the services offered while enjoying the great outdoors and getting some exercise! All staff (merit, exempt, casual/seasonal) and staffing agency workers in all our Divisions were encouraged to participate in this event for up to 2 paid hours as part of the workday.

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.

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 13.85 positions (FTEs) across the division that are involved with MCH programs and services, including Birth to Three, child and adolescent health, health education, and primary care. In this way, Title V funding has historically been leveraged to bolster the capacity of many DPH programs that serve mothers, children, adolescents, children and youth with special health care needs and their families. Most of these positions do not report directly to the Title V program, but rather to the administrator of the specific program or clinic that they work within.

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 four 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 11th 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. This is kicked off our ongoing partnership with *FranklinCovey*.

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.

Additional trainings that we were able to offer in the last few years through our partnership with *FranklinCovey* included*:*

- 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.

We have 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 were 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 both processes.

Later this year at our annual retreat, we will be offering training around maintaining positive working relationships and boundaries while working remotely, leading to a more cohesive and productive team dynamic.

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. Regarding 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, Katie Labgold, PhD, MPH joining us later this year. In addition to her routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, Dr. Labgold will provide 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. Labgold'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, consumers. The current co-chair is a community member with lived experience. 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, Delaware Family Voices is also under PIC. The Parent Information Center (PIC) offers several ways for parents to be engaged including educational opportunities for parents to learn, engage with each other as well community providers. PIC implements the Family Leadership Network for parents/guardians of children birth to 26 that have a suspected or diagnosed disability. The network membership includes trainings, monthly learning community sessions, and support with Individualized Education Plans, and referrals. Participants will receive monthly stipends for attendance and participation. Parents as Collaborative Leaders is used and includes training topics such as Defining Parent Leadership, Listening & Asking Clarifying Questions, Critical Elements of Collaboration and Tips for Leading Meetings. PIC's workforce includes parents, and this brings a wealth of knowledge and expertise to the table to better engage families.

The Family SHADE program has evolved over few years and 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 give organizations an opportunity to learn and support each other as well. Topics have included newborn screening, fetal alcohol syndrome and data and evaluation. Family SHADE has also held Symposiums that included presentations on transition and developmental screening.

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

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

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

The DHMIC, Family SHADE, Delaware Early Childhood Council, and the Interagency Coordinating Council represent four of the largest groups of partners that include consumers/families coming together around MCH issues, but there are many other advisory boards, councils, and coalitions that our MCH program works with to extend the reach of Title V, guide our work, and expand the overall capacity to support mothers, children, and families. Other committees include, the Help Me Grow Advisory Committee, convened by DPH, consists of representatives from organizations across the state. Similarly, the Home Visiting Community Advisory Board pulls together home visiting and partnering programs from across the state to ensure a coordinated continuum of home visiting services. In

addition, the Governor's appointed Early Hearing Detection and Intervention (EHDI) Board was created by legislation passed in 2012. The Newborn Screening Advisory Council, formed in 2000, helps the Division determine best practices for the program including the addition of new conditions to the Delaware screening panel. Additional key partnerships and collaborations include the Developmental Disabilities Council, the Sussex County Health Coalition, and the Breastfeeding Coalition of Delaware.

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

III.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.

Up until October 2023, Delaware had 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 to our partners, who can then use the information 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, was 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 was a federal/state funded partnership, which is funded by our Title V grant or our State Systems Development Initiative (SSDI) grant.

Dr. Hussaini provided scientific and technical assistance to Division staff and stakeholders in the areas of maternal child health outcomes, and the development of surveillance databases. His research examined Neonatal Abstinence Syndrome and its implications on maternal and neonate health. Dr. Hussaini was 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 focused on population health through application of health informatics principles. 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 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 related 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 provided scientific and technical assistance to Division staff and stakeholders in the areas of maternal and child health outcomes.

Khaleel Hussaini, our CDC MCH Epidemiologist for 7 years, moved on from our Family Health Systems (FHS) Section "family" as he accepted a very prestigious position with the CDC National Center for Health Statistics as a Branch Chief. Khaleel stayed with FHS until the end of September 2023. This was an amazing opportunity for Khaleel, and we all joined in wishing Khaleel warm wishes and much success in his new role. Khaleel was a part of our family, and will always be, and was instrumental to all of our programming with his analytic expertise and ability to translate data into action. He has been so valuable to our work and our team – from PRAMS, School Based Health Centers, Title V, Healthy Women Healthy Babies, several issue briefs on reproductive health/family planning and severe maternal morbidity and birth defects, Sudden Death in the Young Registry, DE Contraceptive Access Now, Delaware Healthy Mother and Infant Consortium and Delaware Perinatal Quality Collaborative….the list is never ending, and he already is truly missed.

Upon the departure of Khaleel, our MCH Director began the search for another CDC Epidemiologist Assignee. She spoke during the 2023Title V Federal State Partnership Town Hall Meeting and expressed how important the CDC and HRSA MCHB relationship is to ensure that our state MCH epi capacity needs are addressed, and that Delaware's epi assignee recently left. HRSA MCHB immediately connected our Director with Dr. Carrie Shapiro-Mendoza, branch chief, and the two talked at the Title V Partnership meeting about our needs. Delaware was connected to Dr. Laurin Kasehagen at the CDC, who was the interim/acting CDC Team Lead for the CDC MCH Epidemiology Program. Delaware's Title V Director worked with Dr. Kasehagen, until Dr. Amanda Bennett joined the CDC in late March. Dr. Bennett is CDC's new Team Lead for the MCH Epidemiology Program (MCHEP) within the Field Support Branch of CDC's Division of Reproductive Health. In this critical leadership role, Dr. Bennett supported our state MCH leaders through an assignment of a senior CDC maternal and child health epidemiologist.

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

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

Some proposed research projects the CDC MCVH Epi Assignee will be responsible for, include:
- Healthy Women healthy Babies 3.0
- Title V MCH Five-Year Needs Assessment and Annual Application
- Infant Mortality Report and Data Briefs
- Women of Childbearing Age Report
- School Based Health Centers

The application was submitted in late December 2023 and two candidates were identified as expressing interest in Delaware. Interviews were held in February 2024 and our Title V Director/Section Chief of FHS, our Bureau Chief of Center for Family Health and Epidemiology, and our PRAMS Epidemiologist served on interview panel. From the interviews, a suitable and mutual match was made by early March 2024. Simultaneously, Delaware DPH began working on a Memorandum of Agreement with the CDC to arrange funding and agreement terms.

As a result of this excellent partnership between the CDC and Delaware, we have selected Dr. Katie Labgold as our MCH CDC Epi Assignee. Although, the MOA is not final as of this writing, Delaware is extremely excited to enhance our Title V workforce capacity with Dr. Labgold. She brings a wealth of skills and experience in:
- Maternal and child health and chronic health outcomes
- Health disparities and health equity
- Applied epidemiology and fieldwork
- Statistical software and data management programs
- Spatial epidemiology and associated analytic software
- Working with large data sets and data linkage methods
- Primary data collection
- Vital statistics, hospital discharge records, and weighted population surveys
- Surveillance
- Evaluation
- Qualitative data collection and analysis
- Oral and written communication to diverse audiences (e.g., scientific, community-based)
- Collaboration with a variety of partners (e.g., federal, state/territorial, tribal, local, non-government including healthcare providers, community groups

Delaware hosted a site visit on May 17th, and this was an opportunity for the CDC MCH Epi candidate to onboard and meet internal and external partners. Dr. Katie Labgold is anticipated to start mid-June 2024, as she goes through the CDC recruitment and hiring process.

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 consistent, electronic, and timely access to:
- Behavioral Risk Factor Surveillance System (BRFSS)
- Delaware Birth Defects Registry
- Delaware School Survey (DSS)
- Evidence-Based Home Visiting
- Fetal Infant Mortality Review
- High School Youth Risk Behavior Surveillance (YRBS)
- Hospital Discharge Data (HDD)
- Maternal Mortality Review

- Medicaid claims data
- Middle School Youth Risk Behavior Surveillance (YRBS)
- Syndromic Surveillance Data (ESSENCE)
- Vital Records Birth
- Vital Records Birth-Death Linked
- Vital Records Death
- FHS program-specific data
    - HWHB*
    - FPAR TITLE X Family Planning data*
    - Newborn Bloodspot Screening*
    - Newborn Hearing Screening*
    - School-based health centers data*
    - Pregnancy Risk Assessment Monitoring System (PRAMS)*
    - Neonatal Abstinence Syndrome Surveillance (Based on HDD)*
    - Delaware Perinatal Quality Collaborative (DPQC) (specific to quality indicators) *

**FHS oversight*

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.

As a result of a mini–Needs Assessment, our partners expressed their request for MCH to provide data as their most pressing needs. 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.

During last year’s grant cycle, Delaware’s Title V team reviewed our State Action Plan in depth 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 and based on those findings, we in initiated 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. During last year’s grant cycle, Delaware identified new ESMs that could be incorporated into our State Action Plan moving forward. These new ESMs were added to the Plan to continue to strengthen our maternal and child health population.

During this grant cycle, 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. Our team did not identify any new ESMs during this grant cycle, to incorporate into our State Action Plan as we are nearing the end of this grant cycle.

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 primary focus of the State Systems Development Initiative (SSDI) is enhancing the data capacities of the Maternal and Child Health (MCH) Program. The key activities are preparing data for and performing data linkages on databases, reporting data for the MCH Block Grant and other MCH projects, increasing the number and quality of databases available for linkage and analysis, and producing the Five Year MCH Needs Assessment. SSDI was launched to complement the Title V MCH Block Grant Program and to combine the efforts of State MCH and Children and Youth with Special Health Care Needs (CYSHCN) Agencies. In general, SSDI is intended to assist state agency MCH and CYSHCN programs in the building of state and community infrastructure that results in comprehensive, community-based systems of care for all children and their families.

The Delaware SSDI grant is 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.

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

The program developed several key reports, research briefs, and manuscripts that were focused on a variety of MCH hot topics. Our Title V CDC epidemiologist assignee, PRAMS epidemiologist, as well as our epidemiology, research, and evaluation contractor collectively have produced an annual report that demonstrated many results and impact. This annual report is included within the Title V Block Grant as an attachment. Resources deployed by the SSDI program include not only financial, but also project management and epidemiological resources. The SSDI Program Manager will also provide valuable program management for some of the Title V National Performance Measures.

The SSDI program was historically instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee to Delaware. Additional contractual dollars are allocated to working with Forward Consultants to support projects that provide evaluation services such as the Title V Assessment survey, Key Informant Interviews, Workforce Capacity, our Boot Camp, and all related analysis. In addition, the SSDI program partially funds our birth defects active surveillance registry. Our Birth Defects Registry (BDR) identifies and records reportable birth defects diagnoses. The BDR is responsible for conducting case findings and ascertainment, medical record abstraction, and provides DPH with pertinent information and case review with the Birth Defect Medical Genetics Director.

Delaware is transitioning to a new MCH Epidemiologist. We anticipate our new CDC Assignee to begin shortly; however, we are able to meet our objectives through a combination of advanced work/processes set in place by the prior MCH Epidemiologist. In addition, the prior MCH Epidemiologist left the role relatively recently, allowing our MCH staff and contractors assisting wherever needed.

Our previous CDC MCH Assignee, continued to work with the Delaware Medicaid and Medical Assistance (DMMA) to advocate for proper utilization of severe maternal mortality and morbidity (SMM) claim codes as part of an ongoing learning collaborative funded by CMS. In addition, he had continued to assist with Center for Family Health and Epidemiology team members within Family Health Systems to assist with data collection and tracking for HWHB program version 2.0. With the addition of our new CDC Assignee, we aim to incorporate Delaware's Strategic Priorities by continuing to address infant and maternal mortality rates and racial, ethnic, and geographic health disparities. The primary focus of the IMTF/HWHB funding has been to reduce the number of Delaware babies who die before their first birthday. The strategy has been to identify women at the highest risk of poor birth outcomes and to address any underlying medical conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk.

Delaware's geographic size requires us to rely heavily on partnerships and collaborative projects in order to succeed

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

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.
Objective 1.1: Support the Title V MCH Block Grant program data needs associated with the 5-year Needs Assessment process and the annual needs assessment update.
Progress Update: Beginning in the fall of 2023, the SSDI Project Director identified and led core members of our Internal Steering Committee to prepare for the upcoming 2025-2030 Five-Year Needs Assessment. We defined the roles and responsibilities of the team and set expectations for each member. We are using the services of our epidemiology, research, and evaluation (ERE), Forward Consultants, for most of our Needs Assessment data needs. We approached our activities with an aggressive timeline, to ensure enough time was allotted for compiling the feedback and writing the Title V 2025 State Action Plan, along with the Title V 2026 Application Year/2024 Annual Report Block Grant. Our Title V Internal Steering Committee met throughout this year to assess the health needs of our population, Title V's program capacity, as well as Delaware's partnerships and ability to collaborate and coordinate efforts. We reviewed the most recent state and national data that was specific to Delaware's MCH populations. Our team used the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); and Delaware Health Statistics (birth records, death records, hospital discharge data). To prepare for the Title V Needs Assessment, our team has reviewed the Block Grant Guidance, developed a timeline and work plan, as well as convened our Needs and Capacity Assessment Steering Committee. Our members have already identified guiding principles/frameworks and core values, requested access to national, state, and local data sources, in addition to establishing a plan for community engagement and identified opportunities to raise awareness and share information about the assessment with partners.
Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.
Objective 2.2: Work with the State Medicaid agency to develop and/or maintain an interagency agreement that defines data sharing responsibilities.
Progress Update: Title V and Title XIX continue to have an updated and current Memorandum of Understanding (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 DPH for programs impacting women, infants, and children. • Provide coordination in the administration of programs that are designed to improve the health of children (particularly CYSHCN) 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.
- Organize mechanisms for information sharing and problem resolutions.

The MOU also directs DPH and DMMA to establish multi-disciplinary coordination. This partnership with DMMA will ensure the Title V program continues to have access to available data in the minimum/core data set as well as any data sets that are added in the future.

As in the past, our work will focus on ensuring that we have timelier access to data. Our epidemiological efforts are ongoing to work with our data partners to achieve real-time, or as close to real-time, access to data. Historically, we saw progress made in shortening the time it takes to gain access to portions of the data and collaboration efforts are being utilized to improve timeliness. However, since the beginning of the COVID-19 pandemic, we have experienced delays with the access to data.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming.

Objective 3.3: Conduct focus groups, environmental scans, or other data collection methods for obtaining community feedback on priority needs for addressing SDoH that are contributing to disparities.

Progress Update: MCH has contracted 14 Focus Group studies where the overall objective was to learn from the study's various subgroups about the general health care and reproductive health needs and concerns of women in Delaware, in order to improve service delivery and the health outcomes of women, children, and their families.

Since these were Chat and Chew discussion groups, every effort was made to select locations in the community that provided a relaxed, warm atmosphere to get people talking and to interact with one another - public libraries, community centers, and community agencies. Most discussion groups had either nine or 10 respondents, and the demographic makeup of the groups varied. Focus groups were conducted in both English and Spanish. Four maternal health groups focused on questions related to women's general health. Four groups focused on mothers of children and youth with special health care needs. Two fathers/partners groups were conducted. Two preconception groups were held with African American women of childbearing age without children. New to this Needs Assessment, MCH has added two additional focus groups consisting of adolescent males and females.

The Internal Needs Assessment Steering Committee is currently in the process of assessing the health status of MCH populations and state program capacity. We are in the middle of conducting environmental scans of MCH initiatives and data, and assessing the infrastructure of MCH programs. In addition, our team is also assessing the partnerships/engagement within MCH programs and assessing the MCH workforce capacity.

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

Objective 4.1: Develop or leverage existing surveillance systems to monitor emerging needs.

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

Delaware has also had recent progress with emphasis on the contributions of the SSDI grant in building and supporting accessible, timely and linked MCH data systems. Vital statistics data (i.e., birth and death) data are routinely matched to Hospital Discharge Data (HDD) to monitor Neonatal Abstinence Syndrome (NAS), SMM. The data from Birth Defects Registry Data, PRAMS data, Medicaid data, program specific data such as HWHB, SBHCs, 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 MCH population as these data are not easily accessible for surveillance purposes and/or linkage to enhance the epidemiological knowledge base.

With the help of the CDC Assignee, the SSDI Project Director has gathered local/state/national data that is used to support the Title V MCH Block Grant program activities just as has been done in previous years. This data contributes to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation. This information supported our on-going work associated with the Five-Year Needs Assessment and our FY25 Block Grant application.

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

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 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.

Forward Consultants continues to work with the CHADIS team to develop the dashboard that will capture developmental screening and referral data for both pediatricians and early intervention programs. This project has had a number of iterations. This grant period, Forward Consultants joined the Help Me Grow national center's Goal Concordant Care project with Delaware's HMG team. The project focused on identifying a process to assist families to accomplish short term goals while emphasizing the strengthening families model and protective factors. In addition, our ERE continues to work with Delaware's core team with the implementation of Title 14 (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 strategic planning sessions for DE HMG with technical assistance from the HMG National center.

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
- Title V Five-Year Needs Assessment

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 women and their infants, 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.

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

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

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

III.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 at 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. A call for proposals from existing community partners was advertised earlier this year, with proposals due in July 2024.

Three different Delaware Senate bills in Delaware are the foundation of the Delaware Enhanced Primary Care Model. In 2018, Senate Bill 227 (SB 227) established the Primary Care Reform Collaborative (PCRC) to develop recommendations for strengthening primary care in Delaware. Senate Substitute 1 for SB 116 in 2019 expanded the PCRC by creating the Office of Value-Based Health Care Delivery (OVBHCD) within the Department of Insurance. The laws aim to reduce healthcare costs by increasing the availability of high-quality, cost-efficient health insurance products that have stable, predictable, and affordable rates. Lastly, the Senate passed a bill to continue strengthening the primary care system. This bill states that by 2025, at least 11.5 percent of the total cost of medical care should be directed toward primary care.

The following press release regarding Delaware's fourth annual Benchmark Trend Report was presented on May 7, 2024.

Per capita health care spending in Delaware increased 6.3% in 2022 to $9,657, outpacing a 3% growth rate benchmark, according to the State of Delaware's fourth annual Benchmark Trend Report presented Thursday May 2 to the Delaware Health Care Commission (DHCC) by Department of Health and Social Services (DHSS) Secretary Josette Manning.

Along with tracking the year-over-year percentage change in total health care expenditures expressed on a per capita basis, the benchmark report also reflects data trends on nine health care quality measures and offers insight on health disparities to guide efforts to improve health equity throughout the State.

Annual trend reports dating back to the initial release in 2019 reflect continued per-capita growth in health care

spending beyond established benchmarks. That year, spending grew at a rate of 5.8%, exceeding a 3.8% spending benchmark. While a 3.5% benchmark was met in calendar year 2020, in 2021, reflecting the rebound from the COVID-19 pandemic, health care spending grew at a rate of 11.2% compared to a benchmark of 3.25%.
The 6.3% per capita increase in 2022 is significant, but there was an expectation of some continuing health care spending rebound effect in the post-pandemic period. Moving forward into 2023 and beyond, DHSS expects Delaware's health care market to be in a steadier state.
"We recognize the economic burden of the rising costs of health care and the benchmark continues to be a valuable tool for the State to compare health care spending year over year, and drive targeted initiatives to improve health care delivery," Secretary Manning said. "This report shows us there is still significant work to be done to improve the health outcomes of Delawareans."

Quality benchmark results
The 2022 Trend Report also provides insight into Delaware's health care quality on nine quality measures with data able to be analyzed by age, gender, and race/ethnicity for greater insight on health disparities. While the most recent report does show some improvement in use of opioids at high dosages, as well as the use of statin therapy for patients with cardiovascular disease, and both breast and colorectal cancer screenings for patients with commercial coverage, opportunities to meet benchmark continue to exist in most areas. Of note given recent reports of a concerning spike in drug overdoses in Sussex and Kent counties, the quality measures underscore urgency regarding Substance Use Disorder/Opioid Use Disorder Outcomes in Delaware.
Three of the measures – Breast Cancer, Cervical and Colorectal Cancer Screening – are new to the 2022 cycle of quality benchmarking.

Select Few of the Quality Results:

- **Adult obesity:** The benchmark for 2022 was to reduce the percentage of Delaware adults who are obese to 31.9%. The 2022 result: 37.9%; an increase from 2021, and still 6.0 percentage points higher than the benchmark.
- **Use of opioids at high dosages:** The 2022 benchmark: 10.8%; the 2022 result: 10.4%. This is a positive observation.
- **Emergency department utilization:** The benchmark for 2022 was to reduce Emergency department utilization to 160.7 visits per 1,000. The 2022 result: 168.4 visits per 1,000. The 2022 result is worse than 2021 and is higher (worse) than the benchmark.
  Statin therapy for patients with cardiovascular disease: The benchmark rate for 2022 was to increase the percentage of patients who receive statin therapy to 83.1% of commercial insurance patients and 73.1% for Medicaid patients. The 2022 results: 82.0% for commercial insurance patients; 64.5% for Medicaid patients. Neither market met the benchmark, but there was improvement in the commercial results from 2021.
- **Breast Cancer Screening:** The new benchmark rate for 2022 was to increase the percentage of patients who receive breast cancer screening to 75.7% of commercial patients and 57.9% for Medicaid patients. The 2022 results: 77.0% for commercial insurance patients; 53.8% for Medicaid patients. The commercial results exceeded the 2022 benchmark.

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 and DPH seen 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 recently recruited a new Medical Director after Dr. Liz Brown resignation earlier this year. Currently, key MCH leadership including the Title V Director have continued to meet monthly with the DMMA MCH Quality Assurance Administrator along with other DMMA policy staff members when needed. For example, we just recently met the DMMA Division Director and other staff to discuss the status of MCO contract negotiations regarding reimbursement for the Nurse Family Partnership and Healthy Families America programs. We are not pursuing a separate coordination meeting currently 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.

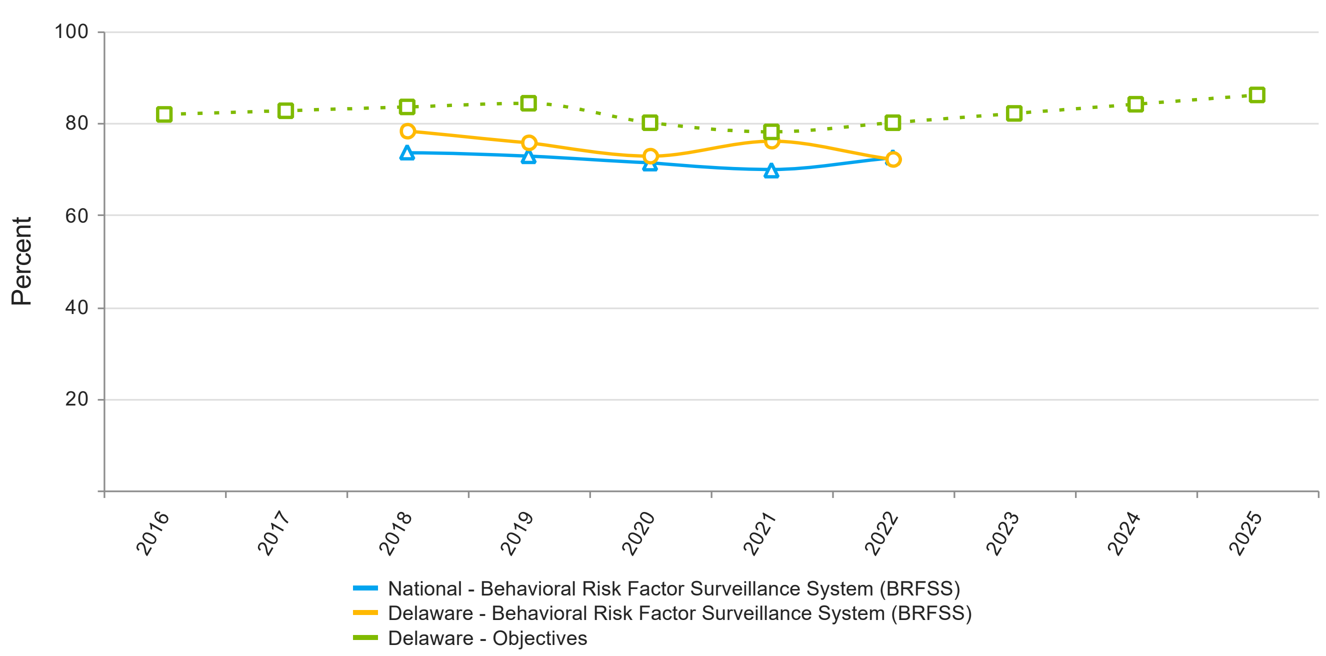
We are also beginning to think about updating the current MCO since it's over 5 years old and with new Division leadership now in place.

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

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		80	78	80.0	82
Annual Indicator	78.2	75.6	72.8	75.9	71.9
Numerator	127,950	124,769	117,625	125,530	116,483
Denominator	163,676	165,041	161,675	165,284	161,938
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	84.0	86.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	15,700	17,000	17,250	8,500	9,000
Annual Indicator	16,672	8,488	8,015	8,109	9,937
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

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

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			90	86	88
Annual Indicator		88	84.2	86.1	89
Numerator				6,335	5,920
Denominator				7,354	6,655
Data Source		HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	90.0	92.0

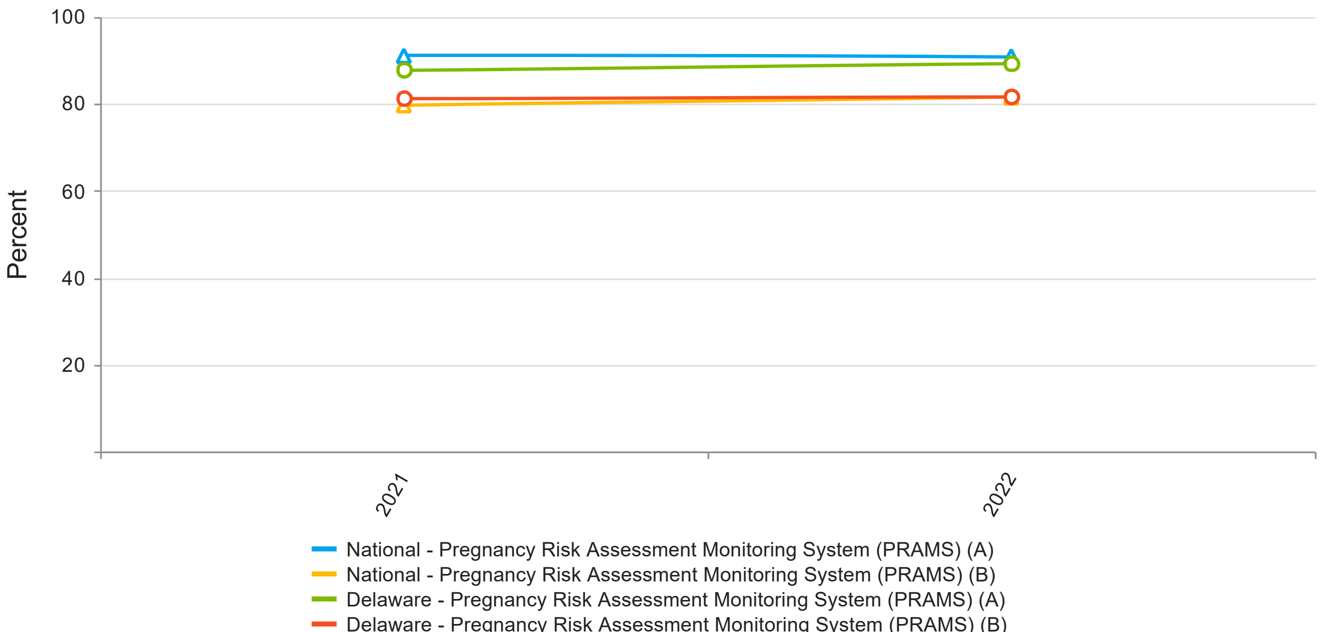
ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			63	60	65
Annual Indicator		62	53.1	58.6	58.6
Numerator					
Denominator					
Data Source		Medicaid Claims Data	PRAMS data	PRAMS data	PRAMS data
Data Source Year		2019	2020	2021	2021
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	70.0	75.0

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



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

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

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

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

Evidence-Based or –Informed Strategy Measures

None

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

	2019	2020	2021	2022	2023
Annual Objective	52	30	28	27	26
Annual Indicator	44.7	45.8	45	42.8	42.8
Numerator					
Denominator					
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2018	2019	2020	2021	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives

	2024	2025
Annual Objective	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	2023
Annual Objective			5	5	5
Annual Indicator		4.6	21.1	21.1	21.1
Numerator			4	4	4
Denominator			19	19	19
Data Source		HWHB Program Data and Vital Statistics Data	HWHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data
Data Source Year		2019	2020	2021	2021
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	5.0	5.0

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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 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Five-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 WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics	Active
ESM WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention	Active
ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method	Active

NOMs
NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM
NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM
NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW
NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB
NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB
NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM
NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal
NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP
NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS
NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

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

NPM

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

Five-Year Objectives

Increase the percent of women in the Healthy Women Healthy Babies program who attended a post partum check up within 12 weeks of giving birth.

Strategies

Incorporate a fourth trimester benchmark in the Healthy Women Healthy Babies program, that incentivizes providers to implement strategies to better meet the needs of women in the postpartum period, with an assessment, either in person or by phone with follow up as needed.

ESMs	Status
No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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

Five-Year 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 4

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.

Five-Year 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 implementing recommendations from the 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. In the next three to five years, DHMIC appointed members set the following aspirational goals:

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

The DHMIC leadership transition was smooth over the last year, however, required much planning, preparation of historical documents and orientation. Dr. Priscilla Mpasi completed her first year as Chair of the DHMIC along with Tiffany Chalk, who served as Vice Chair. DPH staff worked with the Chair and Vice Chair to onboard them to their new role over the last year as well as with the Governor's Boards and Commissions to elevate the DHMIC Nominations committee recommendations for new members to fill several vacant positions to allow for a smooth transition.. Onboarding the new leaders and members required developing a comprehensive package of materials with a historic overview of the inception and purpose of DHMIC, a review of its current infrastructure and revisiting its bylaws and committee structure. In addition, updates to DEthrives were made to introduce new members, including a press release announcing new members and leaders, and as a courtesy to help with elevating the subject matter expertise of the DHMIC and the work, each member had a professional photo headshot and bio prepared for the website. 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, experienced a change in leadership and Representative Minor-Brown was paired with a new co-chair, Ray Fitzgerald, Executive Director of the Wilmington Housing Authority, and together their expertise and passion is to focus on a demonstration project, Guaranteed Basic Income for pregnant women to address housing insecure pregnant women, which launched in the Spring 2022. Some basic program model components are described below:

- Guaranteed Basic Income 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) <u>Guaranteed Basic Income Demonstration Project</u>
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. As of this writing, some of the women are starting to be disenrolled from the program intervention, and as part of the evaluation, the team will be conducting exit interviews with the women and preparing the analysis of data collected for a comprehensive evaluation report.
<u>b) Housing Stabilization Demonstration Project</u>
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 demonstration program was suspended due to DEHAP closing the program due to lack of funds. As a result, the DHMIC reengaged key stakeholders in a discussion on housing insecure pregnant women, and convened a revived Housing Workgroup, which was established in June 2024 to help identify new policy, program and opportunities to improve the system. The workgroup plans to make recommendations to the broader DHMIC on how to address policy and systems issues related to Housing, and is passionate about "doing something actionable" while creating a 5-year vision.

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, particularly when it comes to increasing awareness of the importance of well woman care. In partnership with a social marketing firm, Aloysius Butler and Clark (AB&C), the Division of Public Health and several Maternal and Child Health (MCH) partners we continued to develop, update and launch messaging through the use of social media. We continue to post messages via short videos or reels, short animated posts to showcase interviews about our MCH work, blogs, Twitter, Facebook, YouTube, Instagram, and in the near future planning to maximize our reach by using LinkedIn, in which all MCH programs and initiatives and professionals participate and are showcased as a post and/or story so our messaging can be shown broadly on different social media platforms to reach different audiences based on age, gender, demographic, or general interests based on our user's life's stage. The branding tagline, Delaware Thrives, evolves around the theme that "Health Begins Where You Live, Learn, Work & Play to help encourage all to make healthier choices and to take action in their community." Last year, DPH launched the newly designed website (www.DEThrives.com) at the 17th Annual DHMIC Summit, which is easy to maintain, ~~and~~ easy to navigate, populates organically on a search engine tool such as Google which increases our reach to our audience, and one that is search relevant.

On April 17th, the Delaware Healthy Mother & Infant Consortium (DHMIC) held its 18th annual summit to discuss ways to prevent infant and maternal mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC focuses on understanding and addressing the racial, ethnic and geographical disparities that are present in high-risk zip zones to reduce poor health outcomes in mothers and their infants. This year's theme was *IMAGINE. IMPACT. INNOVATE. Driving Equity in Infant and Maternal Health.*

This year, the summit sold out, people were placed on a waitlist, and the summit earned 406 registrants maxing out the venue's capacity (maximum capacity at 360) with nearly 304 in-person attendees which included about 25 walk-ins. The event drew in many healthcare professionals, policymakers, community influencers, community partners, stakeholders, and citizens such as nursing students who were interested in learning ways on how to provide access

to proper care for all Delaware mothers, before, during, and after pregnancy, their babies, and families no matter their socioeconomic, racial, or ethnic status.

DHMIC Chair, Priscilla Mpasi, MD, Secretary Manning, and the Lt. Governor Hall-Long provided opening remarks on the importance of why we should continue the work to address maternal and infant mortality and morbidity in Delaware. There was a total of 31 speakers throughout the day, which was made up dignitaries, DHMIC leadership, two keynote speakers (one keynote speaker held a live podcast session), four different breakout sessions, and a panel discussion ranging topics on perinatal mental health, substance use disorder and the impact on women and families, the social determinants of health, Medicaid coverage to improve outcomes for women and babies, and more.

Many information sharing strategies and interactive stations were available during the Summit such as a surprise choir performance from the Delaware State University choir who performed a personalized song titled *Year of Decision* which was written around the DHMIC's message to help uplift, inspire, and emphasize *the IMAGINE. IMPACT. INNOVATE.* tagline the Summit aimed to provide for the participants. Innovation stations, also known as vendor tables, were located around the perimeter of the Ball room that showcased partners such as the Healthy Women Healthy Babies (HWHB) mini grantees, WIC, and one of the keynote speakers app, *Irthapp*. There was also a visual artist that captured the day's theme, topics, and experiences in illustration and graphic form which shares key takeaways of each presentation and is used for media use, mention of the DEThrives.com website throughout to find DHMIC material and additional resources as well as an activity that encouraged group discussions among attendees and education with the innovation stations. In addition, a poster was displayed of the DHMIC/DPH Guaranteed Basic Income (GBI) demonstration program as an additional resource around the recent work that's being done to help vulnerable mothers living in high risk communities with concentrated disadvantage. Multiple resource tables were located at the check-in table and breakout rooms for supplemental hardcopy materials relating to the materials that were presented throughout the day.

DEThrives social media published about 26 posts/stories during the event which earned more than a total of 1.9K engagements (likes, comments, shares, tagging, clicks) on DEThrives social media channels (Facebook, Instagram, X), earned over 102K impressions (number of times a post has been displayed), 20 link clicks (people clicked on provided hyperlinks, and received around 30 posts/stories from attendees who tagged DEThrives using the hashtags #DHMICSummit24 and #DEThrives which earned high engagement rates on DEThrives' Instagram and Facebook pages. For reference, organic/nonpaid posts could expect to see an average of 10-20 engagements but each post from the summit earned around 15-80 engagements.

DHMIC's Vice-Chair, Tiffany Chalk, presented the annual Kitty Esterly, MD, Health Equity Champion Award which recognizes a person and an organization who puts in the extra effort to address and change the root causes of infant mortality by improving the overall health and well-being of mothers and the community. Erica Allen was awarded the individual award and the organization award was awarded to the Hispanic American Association of Delaware (HAAD). The announcement of these awards was the promotional post on DEThrives' social media accounts in April which earned almost 2K engagements for that post alone.

News of Black Maternal Health Awareness Week and the 18th DHMIC annual Summit were mentioned on several media outlets such as WHYY/PBS, WDEL, Delaware Online, and Philadelphia Tribune as the DHMIC Chair, Priscilla Mpasi, MD, was interviewed. WDEL took two different audio segments (first segment, second segment) and rotated these stories from April 17th and the 18th which aired about 18 times. On WHYY, three stories were aired and published on WHYY.com and New Works. AB&C, DPH's communications vendor, helped secure a total of 27 media placements that reached over 2.1 million viewers which included the interviews being aired on local radio and online media outlets. Dr. Mpasi also talked about maternal mental health and that article ran on DelawareOnline and in the News Journal.

During the 18th annual Delaware Healthy Mother & Infant Consortium (DHMIC) Summit, Delaware State Representative Melissa Minor-Brown and State Senator Marie Pinkney, who are also DHMIC members, presented the *Black Maternal Health Awareness Week Resolution.* This observance recognizes the week of April 11th through April 17th as Black Maternal Health Awareness Week in Delaware which raises awareness of the health disparities for black mothers and their infants and a call for action by partners and providers to work towards improved outcomes. 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.

Delaware has made a significant investment of resources to focus on addressing maternal mortality and morbidity and specifically, implemented many programs and interventions to reduce our racial disparity in infant mortality. According to the March of Dimes, women in Delaware are overall at moderate vulnerability to adverse outcomes based on their availability of reproductive health services with a clear increase in vulnerability across the southern parts of the state. Access to prenatal care varies based on race/ethnicity and poverty with almost half of Hispanic women living in higher poverty areas experiencing inadequate prenatal care (43%). Black non-Hispanic women in Delaware experience higher rates of preterm birth compared to other groups, thus putting their infants at risk for complications and death. Our work to address maternal and infant mortality and morbidity is spearheaded by the Center for Family Health Research and Epidemiology, which is housed within the Family Health Systems Section, led by our Title V/MCH Director. These efforts are very much a part of our Title V federal state partnership and continue to be supported by $4.2M in state funding allocated to DPH for prevention of infant mortality. The DHMIC has undertaken an aggressive initiative to examine the 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.

The Title V MCH team works very closely with the Maternal and Child Health Review Commission, which currently sits in the Administrative Courts, and the data supports our prevention and education work to improve the health of women before, during and between pregnancies. The Maternal Mortality Review (MMR) Committee sits under the Maternal and Child Death Review Commission and reviewed 10 cases in 2023. Three cases involved women who were White non-Hispanic, four were Black non-Hispanic, two were Hispanic women, and one woman was biracial. Eight women were on Medicaid. For the fourth consecutive year, overdose remained the leading cause of death. The co-occurrence of mental health diagnoses and SUD represent a highly prevalent and highly associated risk factor for maternal death. The MMR Committee members identified the following three priority recommendations based on the 2023 cases: 1) Team-based care: A team-based, collaborative care plan with input from the patient and providers should be the standard approach to optimize a patient's health issues across physical, mental and social domains. The care plan would be a living document designed to follow a patient across multiple sites of care and to promote regular, timely communication between providers and between each provider and the patient. Care Coordination: 2) Care coordinators and peer support specialists can help navigate patients through the health care system and transition across different levels and sites of care, ensuring fewer patients are lost to follow up. All health care team members should know how to access or refer to care coordinators and peer support specialists to ensure follow up and communicate the care plan. 3) Quality of care: Providers should communicate laboratory results back to the patient and develop a plan to address any abnormal results in a timely manner.

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

To help spread the news that the Urgent Maternal Health Warning Signs Toolkit was available to order and/or download on the DEThrives site, an interview (part 1, part 2) was held on May 23rd, 2023 with WDEL during their Del-Aware segment with Peter MacArthur. Another interview was held on June 29th, 2023 with WJBR on their public affairs program Focus on the Delaware Valley and could be listened on WJBR's website here. Lisa Klein, a Coordinator for the Maternal and Child Death Review Commission (MCDRC) and Meena Ramakrishnan, MD, an Epidemiologist for the MCDRC, were interviewed. To showcase these interviews on social, 30 second snippets of the interview were taken and made into two separate reels so the visual parts of the toolkit were showcased and the audio for the reel were pieces of the interview.

One reel earned around 2.5K plays, reached almost 500 users, and had a total of 284 minutes viewed. The other reel produced 12 total engagements (any likes, comments, shares, tags, or clicks on the post) which was higher than the normal organic content that's typically put out by DEThrives.

Per AB&C's analytics, during June and July 2023, user visits to the Maternal Warning Signs toolkit webpage increased by 17% over the previous two months. 179 Maternal Warning Signs items were downloaded, 12 materials were added to cart for checkout, and there were 5 spikes on the toolkit webpage during this timeframe. Since the toolkit was first made available on the site, a total of 183 toolkit orders (out of 250 toolkits made) were placed.

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. Last 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. The two additional mini grantees addressed 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.

The third full year Evaluation report for the Healthy Women Healthy Baby Zones will be released in September 2023 and the final four year Evaluation report will be released in September 2024. 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: 2655 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, more than 2/3 of participants said they discovered new career paths, developed new skills, and became more committed to their continued education. And, 100% of all 291 participants during Cycle 3 applied for at least one job after using the career counselor.
- Of the DCADV 305 participants, 85% of flex fund recipients reported that the funds "Significantly" or

"Completely" reduced their financial stress. 96% of participants reported feeling more hopeful.
- Of the Rosehill participants, 59% of participants lost weight. On average, participants lost 3lbs over the course of the program.
- Of the Reach and Impact Life, 810 people were served, 55 pop up grocery store events were provided, 328 food deliveries were completed, and nutritional education was provided to 439 people.
- Of the 5,643 women that participated in the DAPI intervention, 201 participants completed a life plan, whereby 99% felt they would use it to help plan their future. 24 participants received multiple services spanning finance and empowerment classes, exercise and nutrition classes, events around career and college readiness, workshops on toxic stress, empowerment and self esteem activities, and father/partner involvement.
- PIC trained 50 Doulas with statistically significant gains in knowledge, and 93% were women of color. 107 women were served by doulas, and 91% were women of color served.
- BMIP trained 70 Doulas, and women reported high rates of knowledge gained and high rates of satisfaction.
- Participants showing statistically significant improvements in depression, anxiety and stress.

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.

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.

Last year, DPH engaged doulas across the State of Delaware to gather their insights on issues related to training and certification to inform the development of a statewide infrastructure to increase access to high quality doula are for women most at risk of poor birth outcomes in the state. The stakeholder engagement study aimed to gain an in-depth understanding of community-based doulas' knowledge, attitudes, feelings, beliefs and experiences in relation to training and certification, as well as other perceived needs in the state. Our specific research questions included the following: How do doulas perceive training and certification requirements for their practice? Assuming certification is required for Medicaid reimbursement, what core competencies do doulas believe should be included in approved training programs in order to meet the needs of low-income women and women of color? What supports do doulas believe are needed to better serve the Medicaid population in Delaware? Three focus groups were conducted in September and November 2022 for a total of 11 participants. A brief summary of findings:
- Training and Core Competencies – Any training required for Medicaid reimbursement should include full spectrum of care, from prenatal to postpartum. Cultural competency training is essential component. Need-based financial assistance for training should be provided to support access to doula care.
- Certification – Provide flexibility in training requirements and include a pathway for experienced doulas to

waive training requirements.

- Education of Health Care Providers – positive working relationships between licensed providers and doulas is critical for the delivery of high quality, integrated care. Raise awareness about doulas' scope of services and the value they offer to birthing people.
- Doula Representation – Representation of doulas in policy making, from planning to implementation is essential.
- Professional Development & Networking/Mentorship Opportunities - the State or health care organizations should develop training, TA and support systems for navigating the Medicaid reimbursement process.

DMMA, per HB 343, passed in 2022 by the Delaware General Assembly, finalized a doula care services benefits package under Medicaid. Additionally, building off of HB 80, which required coverage of doula services under the State's Medicaid plan beginning in 2024, HB 362 broadened access to doula services and improve maternal healthcare outcomes for more individuals by extending similar coverage to private health insurance plans. As this evolves, it will be important to monitor access and maternal health outcomes over the next year. Additionally, DMMA explored Medicaid doula benefit designs in other states, including meeting with Medicaid leaders in California and Virginia on their benefit design and development. Building on lessons learned from Virginia, DMMA connected with their Certification Board to learn more about certifying doulas for Medicaid reimbursement. The selected Certification Board has worked with Virginia and Rhode Island to develop their approach to their Medicaid Doula certification process. In January 2024, Medicaid designed and launched the benefits package and reimbursement structure and process for Doulas seeking Medicaid reimbursement. There are minimum requirements for certification & training, reasonable reimbursement rates for both Doulas and Medicaid, and billing coverage if doulas enroll as independent providers. As of this writing, there are 3 Doulas enrolled in Medicaid as a provider. Also, because many doulas see themselves as rooted in their communities and not necessarily the formal healthcare system, there is currently no single national doula network or standard of practice and we do not know how many doulas there are in the state/people interested in offering doula services, other than the data compiled from our two HWHBs mini grantees that trained Doulas in the State of Delaware.

Healthy Women Healthy Babies (HWHB) program 3.0, was 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.). Another important component to the program, providers are required to coordinate and collaborate with a Community Health Worker (CHW), Health Ambassador, Lay Health Advisor (LHA), or Promotora, defined as an individual who is indigenous to his or her community and consents to be a link between community members and the service delivery system, to further enhance outcomes for women and babies.

This year, we continued to support braiding funding streams to support community health worker expansion into high risk zones. The HWHB community health workers conduct community outreach in the high risk zones via a systematic approach in partnership with community based organizations to address well woman care aspects of health and social determinants of health such as housing, transportation, food insecurity, and access to mental health services. In order to measure the impact of hiring, training and deploying community health workers to engage women of reproductive age and provide linkages to services and resources in the community, DPH developed a dashboard for the client referrals and goals documented by the community health workers (CHW) from October 2020 to March 2024. In this time frame, 239 unduplicated clients were documented as having referrals and goals set with CHWs. In turn, 854 referrals and goals were reported among these 239 clients, which represents between three to four referrals (and goals) on average per client. We also monitored the number of clients by referral category as well as the number of times the clients were referred to the respective categories. The referral categories are listed in descending order by count of referrals. For example, Food-related referrals were the most reported referral category by count of referrals (*n* = 170; 19.9 percent) followed by Housing-related referrals (*n* = 120; 14.1 percent) and Baby Supplies-related referrals (*n* = 109; 12.8 percent). These three categories represented almost half (46.7 percent) of all referrals reported. It was very important to our team to try and measure closed loop referrals by tracking whether goals of the women encountered by community health workers were “Met”, “Partially Met”, “Unmet”, and “Not Reported”. About half of Food-related goals were “Met” whereas half of Housing-related goals were “Partially Met” or “Unmet” at the close of Q1 2024.

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

School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public school setting, and also contribute to better outcomes related to NPM 1 Well Woman Care. There is a growing interest for expansion to elementary, middle and additional high schools. School Based Health Centers are going through a paradigm shift, and there is a lot of stakeholder interest and commitment to understand national and in

state innovations in practices and policies, and explore options moving forward to enhance SBHCs in Delaware within the local healthcare, education, and community landscape. Delaware currently defines SBHCs as health centers, located in or near a school, which use a holistic approach to address a broad range of health and health-related needs of students. Services may also include preventative care, behavioral healthcare, sexual and reproductive healthcare, nutritional health services, screenings and referrals, health promotion and education, and supportive services. SBHCs are operated by multi-disciplinary health professionals, which includes a nurse practitioner overseen by a primary care physician, licensed behavioral health provider, licensed nutritionist, and or dental hygienist. SBHCs are separate from, but interact with, other school health professionals, including school nurses and school psychologists and counselors. SBHCs also operate alongside and interact with outside health care professionals and systems.

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

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

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

Launched in 2016, 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.

In February of this year, DPH in collaboration with many partners and stakeholders were successful in promulgating regulations authorizing Pharmacists to dispense and administer contraceptives. With the regulations finalized, DPH is now working on the implementation phase and will be hosting a kickoff meeting in September. This event will provide useful background information on the legislation and regulatory steps taken in Delaware thus far and will include facilitated small and large group discussions that result in clear action steps needed for the various components of this program, including training, resources, and payment for pharmacists as well as consumer support and awareness methods. The Adolescent and Reproductive Health Bureau team will support facilitation of the small group discussions as well as implementation.

The Division of Public Health's team, is working with five of the six Delaware birthing hospitals to ensure that all patients can receive the contraceptive method of their choice immediately after giving birth, including immediate post-partum LARCS. This change in policy 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 2023 the Delaware Family Planning program completed four full in-person DECAN training sessions across the state on February 23, 2023, April 27, 2023, August 24, 2023, and October 26, 2023. On March 27, 2023 a requested on-site contraceptive counseling training was given at Porter State Service Center and a virtual training was held on June 6, 2023 for Department of Corrections (DOC). These trainings included interactive conversations and games that cover topics such as the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and hands-on clinical Nexplanon and IUD training for clinicians. As of today, for 2024, we have completed two full training sessions on February 21, 2024 and May 21, 2024. The DECAN program will have two additional trainings in 2023 on August 21, 2024 and November 21, 2024.

There was a total of 33 staff members in 2023 whom were trained on the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and cultural competency. There was 11 clinicians trained in Nexplanon insertions/removals and 10 clinicians trained on IUD insertion/removals. A total of 7 provider sites took part in the 2023 DECAN trainings including support staff and providers from Delaware Division of Public Health, Westside Family Healthcare, Beebe Healthcare, Tidal Health, Department of Corrections, LaRed Health Center, and Henrietta Johnson Medical Center. So far in 2024 there has been 13 staff trained in the non-clinical portion of the DECAN training as well as 5 clinicians trained in Nexplanon insertion/removals and 5 clinicians trained in IUD insertion/removals.

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

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

It is noteworthy that the last five years also saw a more robust engagement of the social determinants of health in communities with concentrated disadvantage. This effort has increased the footprint of the social determinants of health engagement beyond what Medical Legal Partnership and Home Visiting services were already providing in the focus population. Healthy Women Healthy Babies Zones Mini grantees provided services over the last five years that range from addressing toxic stress, domestic violence, academic and life skills support, to job training education, fitness, nutrition, financial literacy, housing stabilization, and self-improvement, to conflict management, training doulas, father/partner engagement and breastfeeding support. DPH in collaboration with the Delaware Healthy Mother and Infant Consortium and stakeholders plan to do more in this area.

DPH led a comprehensive strategic planning process to develop a five year plan for the DHMIC, which led to another huge paradigm shift, largely related to a change in leadership, whereby the Chair and Vice Chair with more than two decades of experience leading the DHMIC, both stepped down at the same time in the Spring of 2023. Over the next year, DPH and the DHMIC will continue to be focused on orienting new leadership, new members due to some recent vacancies and address themes captured during the DHMIC strategic planning process expressed by members and stakeholders: a desire for revisiting the committee structure and membership engagement, improved communications and transparency, and accountability strategies such as data dashboards to measure and report on success. In addition, with Delaware's Governor primary in September and elections in November 2024, plans are also underway to prepare a short issue brief and update recent accomplishments of the DHMIC as well as the

history, purpose, Title V MCH priorities, Delaware Code codifying DHMIC as well as the importance of the Governor appointed DHMIC in supporting statewide comprehensive initiatives to improve the health of women before, during and between pregnancies, address health disparities and improve birth outcomes in the State.

The DHMIC established the Healthy Women Healthy Babies (HWHBs) program in July 2009. A significant amount of state funds, approximately $4.2M, is invested in several infant mortality reduction initiatives as well as improved health outcomes for women and babies. The primary focus of the IMTF/HWHB funding has been to reduce the number of Delaware babies who die before their first birthday. 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 prepare an evaluation report and share data and impact of the demonstration project, Guaranteed Basic Income program for pregnant women and the five year cycle data of the Healthy Women Healthy Babies Zones mini grant interventions. The guaranteed basic income demonstration pilot was launched in April 2022 and the housing instability project, while not as successful, will shift its 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 almost five years of the new refreshed model to improve preconception, prenatal, and birth outcomes of Delaware women, particularly those at increased risk. The new model, transformed in 2019, is a value/performance-based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health and incorporates the role of community health workers to further support outcomes. The Division of Medicaid and Medical Assistance (DMMA) was an essential partner in the transformation of the HWHBs 2.0 model and continues to play a role in the program's enhanced model and performance-based redesign. This past year, we released a RFP to accept bids to continue the program with some enhancements to the model, HWHBs 3.0. In the next year, we plan to continue to review benchmark data indicators and demographic data as well as explore data linkages of HWHBs 3.0 patient data with Medicaid claims data to monitor benchmarks and outcomes. We are finishing up the year in this 5 year cycle and prior to releasing the RFP, the DPH team assessed whether the new model is moving the needle on producing evidence on improving health outcomes for women and birth outcomes. DPH issued the RFP to solicit bids for HWHBS 3.0 in January 2024.

The collaboration between DPH and the Division of Medicaid and Medical Assistance to improve maternal health outcomes is imperative and continues. Three years ago, Medicaid created a new position and hired a MCH Quality Assurance Administrator or clinical lead who is a Nurse Practitioner, and this position was vacant in November 2022

during a transition in leadership and was filled in the Spring of 2023. DPH reconvened monthly meetings with this position. The DPH Title V MCH team meets with Dr. Alethea Miller, who is now in this position, to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies. In addition, Dr. Alethea Miller now represents the Division of Medicaid and Medical Assistance as the designee on the Delaware Healthy Mother and Infant Consortium was appointed as an official member this year and also served on the DHMIC Annual Summit planning committee. Over the next year, we plan to continue meeting on a monthly basis to discuss policy, programming and interventions impacting the maternal and child health population.

Over the next year, DPH in collaboration with DHMIC partners plan to further track and analyze benchmark data and the performance based approach to the to the Healthy Women Healthy Babies program, a medical intervention and implement HWHBs 3.0. DPH will review the data, impact and results of the 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 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 (BBO) as part of the maternal and infant mortality reduction work to build state and local capacity and revisit a new 5 year cycle to implement 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, as well as identify a community-based organization that can take over as the back bone entity, as a sustainable model. HMA will work closely with DPH to identify and procure a local entity to serve as the BBO. This process will start in the coming year, with a plan to have one selected in years one or two depending on the need to do an RFP. In addition, HMA will create a small and highly functional advisory committee that will report to DHMIC leadership to help with the BBO transition and provide recommendations and alignment with the Healthy Women Healthy Baby (HWHB) provider community. While the RFP five years ago mentioned an advisory committee as well, due to conflicts of interest, DHMIC's SDOH Committee did not serve in this capacity, and we intend to address that now with the advisory committee. Discussions are also underway to provide larger grants as opposed to mini grants, creating more competitive criteria for funding, and ensuring community-based organizations are well positioned to identify other funding mechanisms to sustain their services. The identified HWHB high-risk zones continue to experience extensive and complex hardships that are driving poor maternal and infant mortality and morbidity rates. In partnership with DPH, HMA, DHMIC and maternal and child health stakeholders will use our local connections to identify possible new and/or current mini-grant recipients that may be able to provide services to needed communities in high-risk zones. DPH, working in partnership with HMA, remains committed to engaging nontraditional, community-based nonprofits in this work, and will continue to strive to make the application process as low-burden as possible. However, this year, we propose to make the selection process more competitive, given that the number of awards will be limited to three to six grantees. The process will be further ironed out in discussion with the new advisory committee

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, extensive coaching and technical assistance to existing and new mini-grant awardees, and create shared metrics and tools for quality improvement and overall evaluation. For

mini-grant recipients from the previous cycles of funding who are not funded in the upcoming cycle, we are thinking through opportunities to offer technical assistance as requested by these agencies and allowable within our budget. For example, this technical assistance may involve partnering with a prior grantee to support their ability to identify sustainable funding options to continue to support and grow their programs. We believe that after five years (for those who were funded in the original cohort of grantees), the impact of the HWHB initiative overall, as well as that of each mini-grant recipient's initiative, will be well documented, making it easier to identify models that can sustain the grantees' work in the targeted high-risk geographic zones.

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

The Delaware Perinatal Quality Collaborative (DPQC) was established in February 2011 as an action arm and under the umbrella of the DHMIC and now functions as its own board and is charged to collaborate closely with DHMIC. The DPQC 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 finally approved and adopted by the DPQC in 2024.

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

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.

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

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

DPH is very pleased to share that there continues to be a sustained funding investment, since FY21, through State General Funds in the amount of $1.5M to support the sustainability and ongoing programmatic costs of Delaware Contraceptive Access Now (DE CAN). DPH in-kind support will continue through DPH and DMMA, a contractual MCH Epidemiologist (.15 FTE) as well as the State Pharmacy as a mechanism to track, store and distribute LARC devices to participating Title X network providers to support the ongoing sustainability, infrastructure and ongoing operational costs. In addition, DPH gained two (2) new state funded full-time FTEs to sustain limited program operations. At a minimum, the 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 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.

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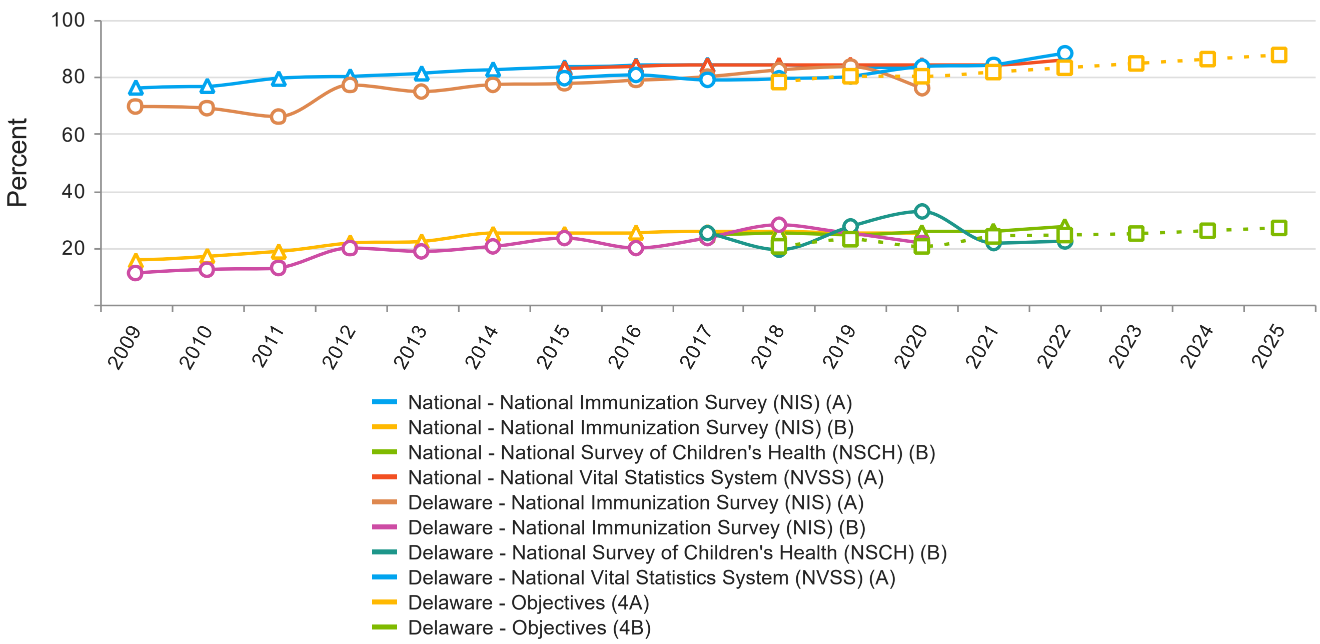
[1] In CY2022, Title X had a total number of 39 provider sites, including SBHCs that provide reproductive health services.

Perinatal/Infant Health

National Performance Measures

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



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80	80	81.5	83.0	84.5
Annual Indicator	78.5	79.7	82.4	83.6	76.1
Numerator	8,010	8,564	8,253	8,057	7,237
Denominator	10,209	10,741	10,019	9,637	9,513
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	84.5
Annual Indicator	88.1
Numerator	9,316
Denominator	10,573
Data Source	NVSS
Data Source Year	2022

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

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	20.5	24.0	24.5	25
Annual Indicator	19.8	23.6	28.2	25.0	21.9
Numerator	2,019	2,478	2,713	2,298	2,032
Denominator	10,187	10,493	9,615	9,184	9,264
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	25
Annual Indicator	22.4
Numerator	6,100
Denominator	27,226
Data Source	NSCH
Data Source Year	2021_2022

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

Evidence-Based or –Informed Strategy Measures

ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:	**Active**

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	65	58	60	62	64
Annual Indicator	54.9	47.9	57	55.3	48.2
Numerator					27
Denominator					56
Data Source	MIECHV program data	MIECHV program data	MIECHV program daa	MIECHV Program Data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	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	2023
Annual Objective			5	5	5
Annual Indicator		4.6	21.1	21.1	21.1
Numerator			4	4	4
Denominator			19	19	19
Data Source		HWHB Program Data and Vital Statistics Data	HWHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data	WHB Program Data and Vital Statistics Data
Data Source Year		2019	2020	2021	2021
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	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 - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Five-Year 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 BF.1 - Increase the number of birthing facilities that receive baby friendly designation	Inactive
ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting	Active

NOMs

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Perinatal/Infant Health - Annual Report

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

Delaware scored a 93 on the 2022 mPINC is CDC's national survey of Maternity Practices in Infant Nutrition and Care with several indications receiving 100. This was an improvement from the 2020 where Delaware scored an 84.

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 Delaware WIC Program has sustained breastfeeding community partnerships for more than eighteen years. These partnerships include Christiana Health Care Systems (the largest birthing hospital in the State), The Latin American Community Center, Westside Family Healthcare, Nemours Childrens Hospital, and the Food Bank of Delaware. Because of these partnerships,

WIC continues to take breastfeeding support to the heart of the community. Other partnerships include: The Breastfeeding Coalition of Delaware, The Delaware Healthy Mother and Infant Consortium, and the Perdue Chicken Plants of Milford and Georgetown Delaware. In concert with these partnerships the Delaware WIC Program has been able to reach approximately 80% of its eligible population.

The DE WIC program is awaiting FY 2024 participant breastfeeding survey findings from the Gibbous Group. These finding will be used to assess current program successes and opportunities to improve program operations. According to the Gibbious findings in the First and Second Quarter Report 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 2, 2024. Speakers, including Marsha Walker and Cierra Murphy-Higgs, have already committed to the day.

Delaware WIC offices offer remote and in person visits for breastfeeding moms. DE WIC also offers virtual breastfeeding classes. These classes have been successful and will continue to be offered. Classes are offered in English, Spanish and Haitian-Creole. Currently, classes are offered the first and third Wednesday of each month at 11am and 5pm, as well as a third breastfeeding class on the third Saturday of each month starting at 11am.

Delaware created and launched a website to capture nutrition education, with extensive information on breastfeeding that was once only offered to participants in the form of physical literature. They now will have this vital education wherever they

are from their mobile device. This site can be accessed here: https://delaware.wicresources.org/breastfeeding/.

The DE WIC program is pleased to share the findings of the most recent participant survey launched last 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!

Finally, the Delaware WIC Program hired two Breastfeeding Coordinators, in June 2024. They are currently in training and eagerly await sitting for IBCLC exam.

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.

On August 18th, 2023, DEThrives in conjunction with the Delaware Healthy Mother Infant Consortium (DHMIC) published an Op-Ed on DelawareOnline/The News Journal to encourage the community to understand the WHY of breastfeeding. Charmain Sampson, International board certified lactation consultant (IBCLC), a Health Program Coordinator of the Delaware WIC Program, authored the piece.

Between August 24th – September 7th, DEThrives ran a short animated video about the benefits of breastfeeding for mom and baby. The ad targeted those who were pregnant and parents of children aged 0-2 years old. This August promotional post (linked back to the DEThrives breastfeeding blog) earned the most engagement (likes, comments, shares on the post) during the quarter, garnished over 18K video plays, reached over 12K people, gained over 22K impressions (number of times a post has been displayed), had 56 link clicks (# of times a user clicked on the ad), and had a frequency (number of times a user is exposed to an ad during the ad run dates) of 1.88 (2.76 was the average frequency for this quarter – July through September 2023).

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.

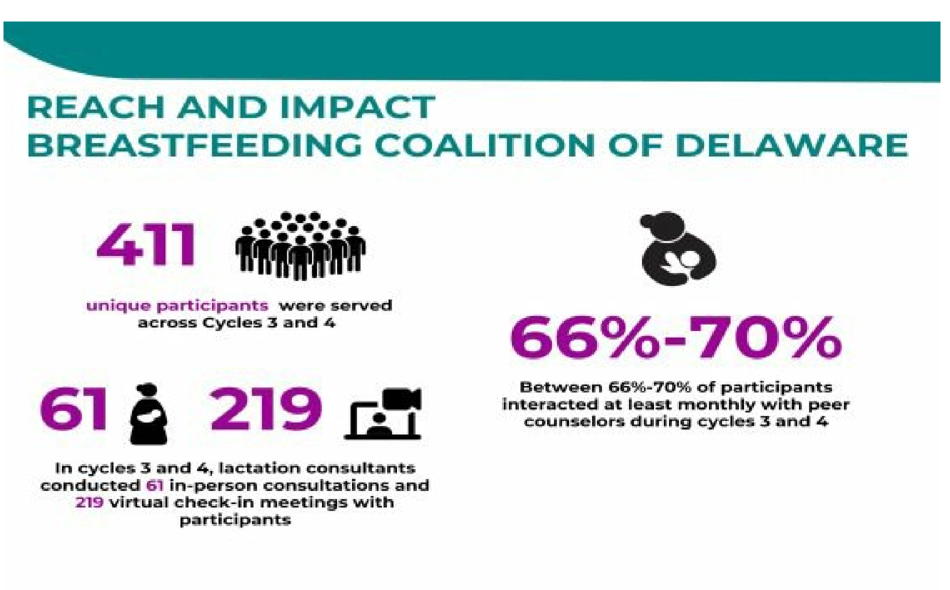
The Breastfeeding Coalition of Delaware was one of the awarded community-based organizations through the DHMIC Healthy Women Healthy Babies Zone project for Cycles 3 and 4 (January 2021-June 2024). The Delaware Breastfeeding Village is an incentive based breastfeeding program that brings families together who may be at high risk for breastfeeding barriers. Black mothers, mothers from low-income families, mothers experiencing housing instability, and non-English speaking mothers are at high risk and are offered text support and monthly breastfeeding education and groups. The program consists of two, 6-month cohorts. In each 6-month cohort, there is a monthly 1-hour breastfeeding education session. Additionally, participants are offered ongoing support and engagement with peer counselors. In Cycle 3, it is intended that there will be 75 mothers per cohort for a total of 150 mothers at the end of 12 months. Process Data Demographic information from the mothers is captured during their initial application and attendance at the breastfeeding education sessions is tracked. Additionally, peer counselors and the IBCLC log their encounters with mothers and the supplies distributed and staff complete timesheets each month to track hours spent supporting the mothers.
Intended outcomes of the program include:
1. Increased breastfeeding duration
2. Identification of most important breastfeeding barriers among new mothers.
3. Identification of the most important supplies used to overcome breastfeeding barriers 4. Increased awareness of the level of staff engagement required to improve breastfeeding behaviors
5. Increased satisfaction with the breastfeeding program Beginning with Cohort 2, participants are completing periodic surveys after breastfeeding education sessions.

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

Pay for Performance Data measures for BCD include the following:

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

In Cohort 1, peer counselors have at least one touch per month per month with 72% of the mothers. 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.



After conducting our required MIECHV benchmark evaluation this past, we were slightly above the national threshold

of 43.3% with 48.8%. The percentage of infants aged 6 to 12 months who were enrolled in home visiting for at least 6 months and were documented to be breastfed for any amount at 6 months of age was almost 50 percent which although higher than national, it's still low and something we will continue to focus improvement efforts on. Breastfeeding initiation has been an ongoing state priority for the DHMIC as well as for Title V so it makes sense for MIECHV to align with our priorities.

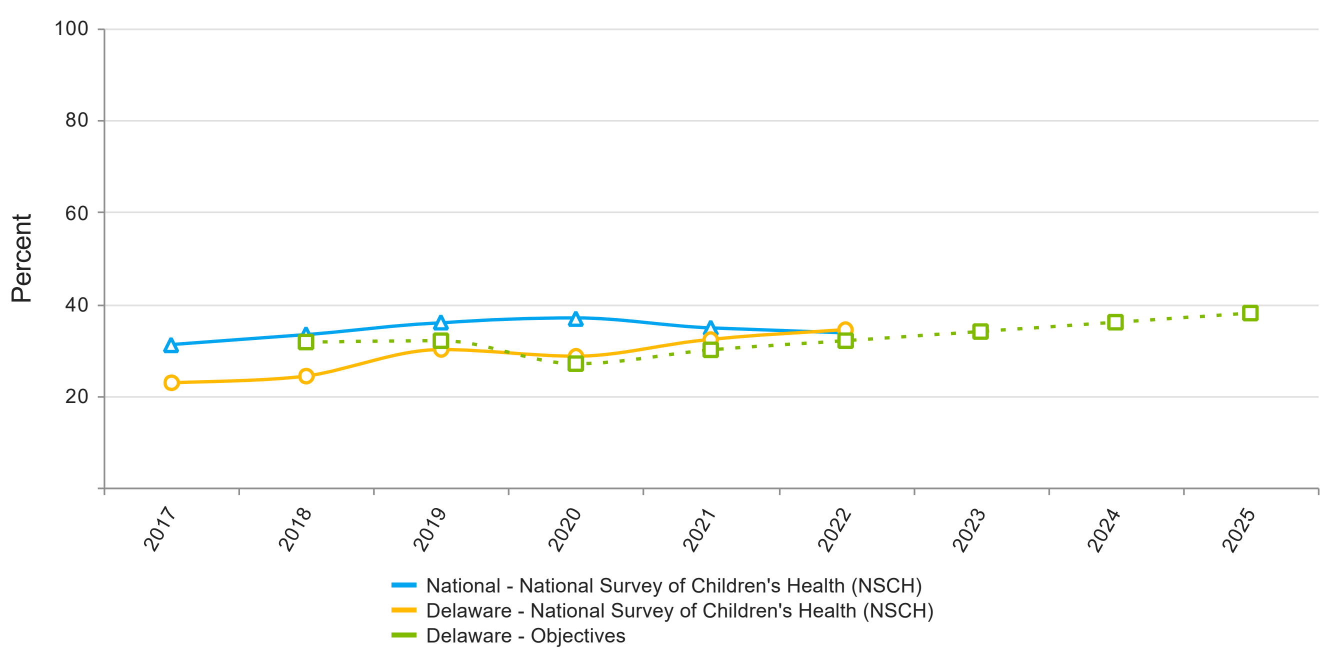
Delaware has moved in a new direction with annual home visitor wrap-around training. The new training plan was organized around the home visitor competencies as described in the *National Family Support Competency Framework for Family Support Professionals*. One of the many competencies is "Child Health, 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. This platform will be used for ongoing training and support as well as the identified peer experts for regarding breastfeeding when needed.

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	32	27	30.0	32.0	34
Annual Indicator	25.5	30.3	29.1	32.1	34.3
Numerator	5,939	6,522	6,073	7,257	8,614
Denominator	23,289	21,559	20,867	22,604	25,117
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

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

Evidence-Based or –Informed Strategy Measures

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			92	94	96
Annual Indicator	91.4	83.3	82.2	81	77
Numerator	433	398	412	439	412
Denominator	474	478	501	542	535
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	98.0	100.0

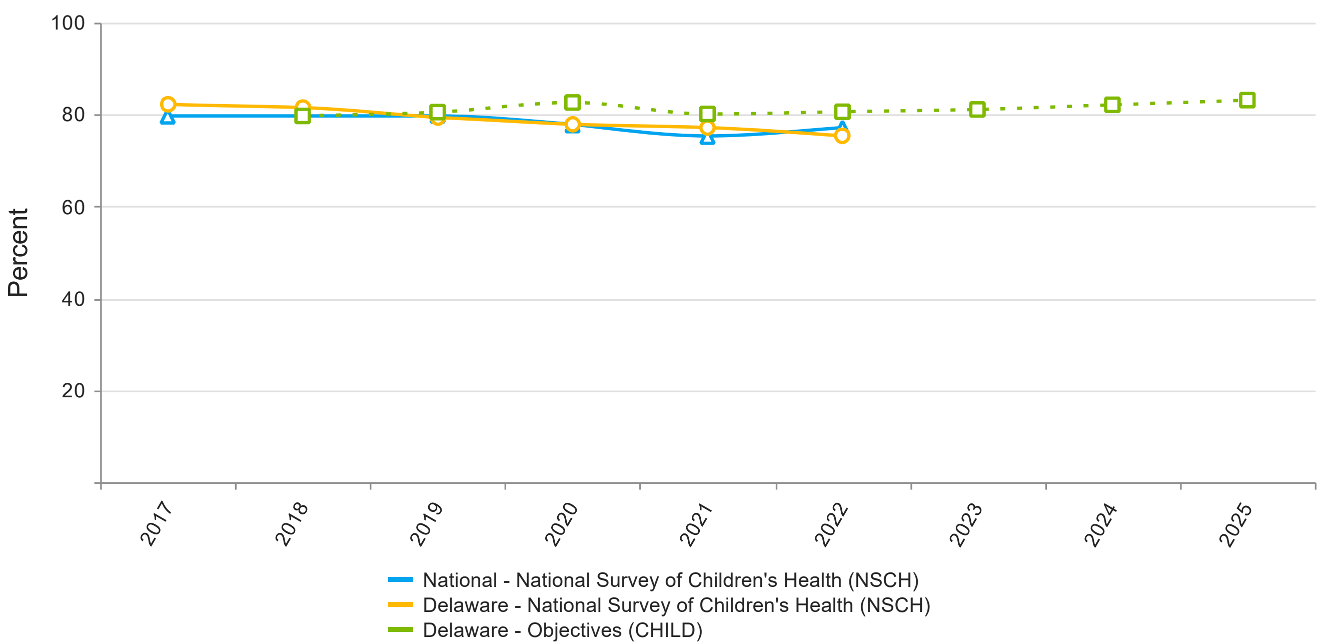
ESM DS.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator		52.2
Numerator		1,167
Denominator		2,234
Data Source		MIECHV ASQ and OEL ASQ
Data Source Year		2023
Provisional or Final ?		Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	2020	2021	2022	2023
Annual Objective	80.4	82.5	80	80.5	81
Annual Indicator	82.0	79.7	77.4	77.3	75.4
Numerator	154,827	149,645	148,645	149,188	147,612
Denominator	188,877	187,697	192,077	193,050	195,852
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	2025
Annual Objective	82.0	83.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			81	82	83
Annual Indicator	80.6	78.8	73.6	77.3	75.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

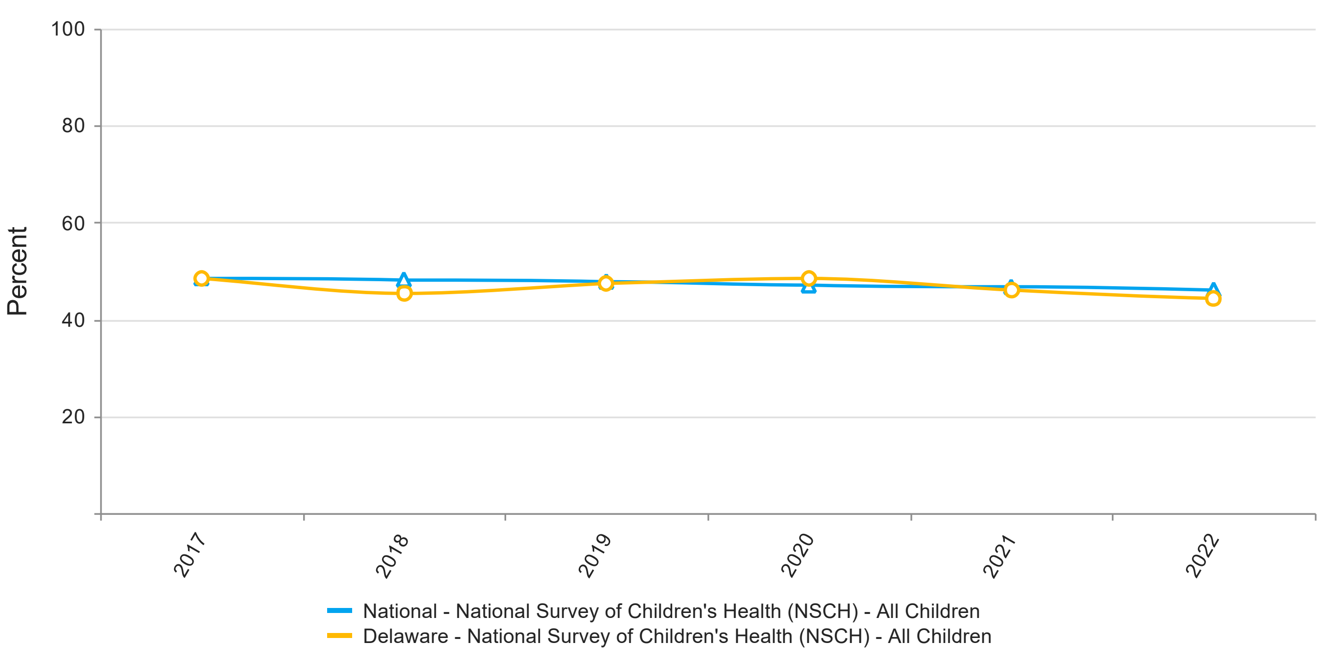
ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	683	1,000
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	725.0	765.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	44.2
Numerator	91,124
Denominator	206,169
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

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 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

Five-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 DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.	Active
ESM DS.2 - # of new pediatric practices to adopt PEDs	Inactive
ESM DS.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 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Priority Need

Improve the rate of Oral Health preventive care in children.

NPM

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Five-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 PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	Active
ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.	Active

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

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

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

State Action Plan Table (Delaware) - Child Health - Entry 3

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

Increase the percent of families reporting that their child has a medical home.

Strategies

Work with our partners to provide education and awareness around the importance of being connected to a primary care provider.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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 2021/2022 National Survey of Children's Health (NSCH), 34.3% of Delaware children received the screening. This is only slightly above the national average of 33.7% 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 Early Childhood Comprehensive Systems (ECCS) program continues to leverage the Help Me Grow (HMG) system model to promote cross-sector collaboration to advance an efficient and effective early childhood system across the state. Help Me Grow utilizes and builds on existing programs and services to advocate for or facilitate a comprehensive approach to early childhood systems building in Delaware.

The four cooperative and interdependent Core Components of the model underlie the goals and objectives of the Division of Public Health's ECCS program. To assist families and professionals to connect children to appropriate community-based programs and services, the ECCS program partners with Delaware Helpline (Delaware 211). Known as the Centralized Access Point (CAP), Help Me Grow@211 improves access to existing resources for vulnerable children through age eight.

Through Family and Community Outreach, the ECCS program supports education to advance developmental health promotion, including increasing awareness of the HMG system amongst families and providers. This is accomplished through Books, Balls and Blocks events as well as opportunities at health and community fairs. Through outreach to health professionals, the ECCS program supports early detection and intervention while assuring a medical home. The ECCS program collaborates with the Delaware Chapter of American Academy of Pediatrics (DEAAP) and other health partners to make the outreach possible.

The ECCS program continues to expand its partnership with the Delaware Chapter of the American Academy of Pediatrics (DEAAP), through the engagement of community pediatric practices and addressing barriers to developmental surveillance, screening, and referrals. From August 2023 to date, activities with the DEAAP include the work to implement a care coordination pilot project utilizing CHADIS; the promotion of Reach Out and Read (ROR) early literacy program in primary care and pediatric practices; the establishment of ROR Delaware affiliate and hiring a coordinator, as well as early childhood resources and developmental milestones education to practices and their patients.

ECCS collaboration with DEAAP and other community partners and stakeholders, typically focuses on addressing barriers/gaps in developmental screening implementation including physician education and the referral/early intervention process. Since 2021, the ECCS program and its partners have been working on a pilot project to implement the CHADIS system. CHADIS, Inc (formerly known as Total Child Health, Inc.) has developed a Comprehensive Health and Decision Information System (CHADIS) targeting health professionals. Delaware's pilot project addresses identified barriers/gaps observed within the referral system. Four (4) community pediatric practices participating in the pilot are Beacon Pediatrics (Sussex County, DE), Bear Internal Medicine and Pediatrics (New Castle, DE), Bright Futures Pediatrics (Kent County, DE) and Rainbow Pediatrics (Sussex County, DE). The practices are representative of the state as they represent Delaware's 3 counties, cater to patients with and without health insurance. The practice sizes range from small-sized to large-sized enrolment and serve immigrants as well as non-immigrants. Participating practices have access to the CHADIS platform and can select from nearly 600 questionnaires and screening tools available. In the newly built referral platform (customized for Delaware), practices can make referrals to early intervention services, to include the Birth to Three Regional program (B23) formerly Child Development Watch (CDW), Child Find (CF) and Help Me Grow@211 (HMG/211). All staff at pilot practices, early intervention programs and HMG@211 have been trained on how to access and use the CHADIS platform. The pilot project, with the newly built referral platform, was officially launched in November 2022.

Data tracked from November 2022 to March 2024, shows that the pilot practices have utilized the CHADIS system to administer a total of 7005 screens and have made close to 450 (6.4%) referrals to early intervention programs based on results indicating some developmental delays. In addition to administering developmental screens on the CHADIS platform, the 4 pilot practices continue to explore other screeners available to them on the CHADIS system. Practices are using screens to determine post-partum depression such as EPDS, (Edinburgh Postnatal Depression Scale); Patient Health Questionnaire (PHQ-9), the SCARED- (Screen for Child Anxiety Related Disorders) and the Vanderbilt Assessment Scale among others.

The customized referral platform allows for referrals with consent to early intervention programs while facilitating the feedback loop between the physician and the early interventionists. With this data, Delaware can track and determine the status of a referral initiated by pediatric practices. Regular quality improvement ensures that gaps and bugs in the system are addressed soon as observed.

The CHADIS pilot project is currently in the scaling up and the eventual spread phase. This phase includes the expansion of the CHADIS referral platform to a broader community of pediatric and family practices. We are currently in discussion with a Federally Qualified Health Center (FQHC) and a large pediatric clinic interested in implementing the system. At the same time, there are sustainability discussions.

Through the state funded PEDS online portal, community pediatric practices administered a total of 6,144 (non-Nemours) PEDS Online screens on children 0-59 months between July 1, 2022, and June 30, 2023. This corresponds to an estimated 6,012 unique children or 62.73% of total screens completed which were unique. Additionally, childcare centers administered a total of 3,822 screens using the Ages and Stages questionnaire. Out of the total screens 3,778 were unduplicated children.

The partnership with DEAAP led the ECCS program to fund Reach Out and Read (ROR) activities through a contractual agreement. The DEAAP received a $250,000 matching grant from Longwood Foundation to support ROR in Delaware. The ECCS program funding of ($3000) was allocated to continue the ROR activities such as purchasing books for doctors' offices. The DEAAP raised matching funds of $250,000 from partners to unlock the grant from the Longwood Foundation. The project will significantly improve accredited medical provider training, accurate program evaluation, book distribution, and clinic support - variables that lead to the powerful outcomes from the ROR evidence-based model.

It is noteworthy to learn that Delaware's ROR program goal is threefold – in addition to the traditional ROR message encouraging parents to read to their children to improve childhood literacy, the program distributes books on specific topics to advance health literacy - topics such as oral hygiene; kindergarten readiness and enrolment; food insufficiency, developmental and lead screening, etc. Additionally, the approach encourages physicians to share information and build relationships with families when providing anticipatory guidance.

The alliance with DEAAP, has led the ECCS program to build and/or strengthen relationships with the Bureau of Oral Health, the lead program, National ROR, the Food Bank and Delaware's Readiness teams. Currently, six state services centers are now implementing the Reach Out and Read program. An observation made through networking with physicians was that they were more amenable to implementing ROR than developmental screening. For this reason, our strategy moving forward is to leverage the appeal of ROR to promote developmental screening and surveillance. All practices interested in setting up ROR are encouraged to consider implementing developmental screening, lead screening and oral health.

In July 2023, licensed childcare centers in Delaware began implementing Title 14, the legislation requiring childcare centers to administer yearly developmental screens of enrolled children using the Ages and Stages Questionnaire (ASQ). Over 900 childcare centers have been enrolled to begin yearly ASQ screens. This demand has elevated the support the Department of Education receives from HMG@211 staff. As more childcare centers become familiar and step into this role, HMG@211 staff will in turn experience an increase in the number of families that need follow-up calls. This effort is supported with funding from the Birth to Three (B23) program. In the future, there needs to be an assessment of this effort in terms of staff capacity to accommodate the increased screens that will come from childcare centers.

Despite their increased roles, staff Help Me Grow@211, continue to provide support and resources to families that call the centralized access point or helpline. For the fiscal year 2023, staff served about 3,970 families, linking them to resources, services including general information and education-related materials. Staff also referred nearly 2,338 families for basic needs and family supports or to a program. A feature that distinguishes HMG @211 from other helplines, is follow-up services. HMG@211 will follow-up with callers once they have consented to it. This is done to determine if the initial referral provided was successful in assisting the family. Another benefit of the follow-

up service is how it promotes relationship-building among staff and callers. For fiscal year 2023, they followed up with 3,240 families out of the total calls of 3,970 received. Sixty-six percent of the families reported their needs were met after follow-up calls were made. HMG@211 served approximately 10,744 children who needed assistance with early identification of developmental delays, referrals and linkages to services including basic needs. The children ranged from prenatal through age 8.

Help Me Grow@211 recently (March 2024) started tracking callers who receive public assistance to address health equity concerns, this will provide more context to the nature of the population that's calling the helpline and determine other needs they might have. In less than 6 months of collecting this data, we observed that majority of the callers receive Women Infants and Children (WIC) and Medicaid benefits. Staff also assists callers who would like to apply for benefits such as TANF, WIC, Medicaid or SNAP/EBT; so far, the majority seeks assistance with signing up for WIC. We look forward to this data informing us of how best we can improve our services to serve vulnerable families.

The partnership between the Women Infants and Children program (WIC) continues with a dedicated staff from WIC referring clients to HMG@211. WIC referrals are sent each week to HMG staff. Some of the requests range from utilities, housing to food. From its inception, in less than a year, approximately 85 families have been served by HMG@211.

Outreach to families and the community is accomplished through the Books Balls and Blocks project. The ECCS program continues to build parent/family leadership and capacity, to advocate for themselves and their communities. This is done either in-person or online (especially during the pandemic and its aftermath). With the pandemic over, we have reduced the number of virtual events. Out of the 4 virtual sessions held in 2023, the BBB project brought together 59 online interactions. This does not consider other interactions that may have occurred on social media (Facebook, X, and Instagram) through the Delaware Thrives website. At these sessions parents with their young children up to age 3, received information on developmental milestones, the importance of developmental screens, handling behavioral concerns, including the importance of play using ECCS/MCH's app QT:30.

From April through to October 2023, Help Me Grow's BBB project participated in 11 events, such as Back-to-School events, health fairs and community fairs. At these in-person events across the state, they interacted with about 86 families, who were provided information on early childhood education and health. The events also provided the opportunity for 14 parents to complete the ASQ developmental screening tool. The BBB program partners with several community programs such as Black Nurses Sorority; Christina Cultural Arts Center; Parent Information Center; Winterthur Museum; Highmark; libraries; United Way; Delaware Early Childhood Centers; Head Start and Early Head Start programs.

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.

The ECCS program also intends to continue efforts to organize events targeting fathers. A couple events held this fiscal year brought a few fathers together however we will continue to promote this initiative and will not give up on it.

Through our social media platforms, DEThrives website, Instagram, You Tube, and Facebook, the ECCS program works with the Social Media Coordinator to post messages on the importance of developmental screening and milestones, including BBB activities.

The beginning of the year saw the ECCS program receiving technical assistance from Help Me Grow national center to begin strategic planning. Delaware has been a HMG affiliate since 2011 and has successfully implemented the HMG model, impacting the well-being of women and children. After 10 years, the strategic plan will facilitate reflection on HMG system current goals, objectives, and activities, while addressing gaps and challenges. Through an environmental scan, surveys and key informant interviews, the national center led Delaware through their intended impact, theory of change and an action plan for the next 3-5 years. The outcome of this strategic plan calls for the ECCS program to re-introduce the HMG system across the state for better understanding by stakeholders. For the next 3-5 years, the ECCS program also intends to focus on 2 major high risk zip codes in the state, mainly in southern Delaware.

DEThrives advertised a Quality Time 30 (QT-30) Campaign and Interviews. The campaign goal was to target parents/guardians and caregivers of children aged 0-8 years old in Delaware to generate awareness of the QT30 app and increase the number of app downloads. The campaign consisted of digital media (included images and videos displayed on Facebook/Instagram newsfeed ads, ads displayed on some app games, and Google app displays shown in places such as the Google Playstore), traditional media (hardcopy printed items), public relations and social media tactics.

Traditional hardcopy marketing materials such as 5'x2' stand-up banners were distributed across 42 preschools, childcare and daycare facilities focusing on low-income areas across the state.

OPINION

Prescribe quality time with your kids

The Op-Ed was published on Delaware State News' website and in the local newspaper. Interviews were held with WDEL (clip 1 and clip 2) and Delaware Public Media stating the purpose and some features of the app. Crystal Sherman, Chief of the Maternal and Child Health Bureau, authored the pieces and was interviewed. In addition, the WDEL's Lifestyle program interviewed Crystal Sherman and packaged the messaging into their public affairs program. Lastly, WHYY interviewed Crystal and the Op-Ed was published on "Bay to Bay News: Delaware State News".

Dental Visit

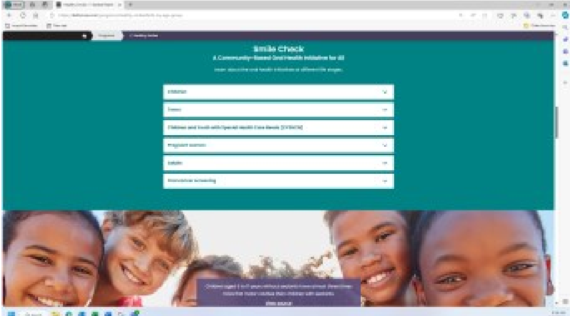
According to the 2021/2022 National Survey of Children's Health (NSCH), 75.4% of Delaware children, ages 1 through 17, have had a preventive dental visit in the past year. Delaware is slightly below the national average of 77.0% of children with a preventive medical visit. The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders. Our stakeholders recognize that dental health equals overall health and the Title V team has identified that MCH is able to align our collaborations and resources to make an impact on this population.

The Delaware Smile Check Program is a school-based preventive oral health and case management program serving grades pre-kindergarten through 12th grade. The program has expanded and is offered not only at schools but other non-traditional locations. The program has also expanded our target population to include infants through age 5, pregnant women and adults. The school-based Smile Check program screened 2,602 children from 07/01/2023 - 06/04/2024 and administered 2,468 fluoride varnish treatments to children in PreK through 12th grade.

- Services were provided to 948 uninsured students.
- 786 were insured by Medicaid.
- 80 insured by Delaware Healthy Children's insurance.
- 27 students with private dental insurance.
- 8 students that had private insurance in addition to Medicaid.

Screening Results:
- 767 students had suspected caries.
- 302 had an urgent dental need that included pain or swelling.

An oral health landing page (https://dethrives.com/smile-check) was previously 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.



DEThrives displays 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, 598 English student consent forms were completed, 150 Spanish consent forms were completed, and 127 school/organizational consent forms were completed using the DE Thrives website.

Families were provided with case management to connect and assist with removing barriers that are preventing the child or their family from receiving dental care. The families were contacted using their method of choice (text, email, or direct phone contact).

- 166 students were connected to a dentist and completed all dental treatment.
- 42 students qualified for Medicaid and are now insured under Medicaid or Delaware Healthy Children Program (CHIP).
- We have no method of verifying if any student purchased private insurance.

Families without insurance or with an annual maximum for dental coverage indicated the primary barrier to care is cost. Second barrier to care is finding a provider to provide care for free, accepts payment plans or accepts Medicaid.

Prior to the past school year beginning, contact was made with schools and organizations to distribute a Start Smiling flyer for children in English and Spanish. The goal is to communicate with family's importance of oral health, provide education and dental resources. 5,050 Start Smiling flyers were distributed to 57 schools in New Castle County, the United Way drive through pantry, community centers and state service centers. In addition, 950 flyers were also distributed to school libraries, public schools, laundry mats and community centers in Sussex County.

Information regarding mouth protection and sports injuries were distributed to 14 athletic directors from schools or community programs. Information provided to the directors pertained to what to do if an injury to the mouth occurs.

The Bureau of Oral Health and Dental Services collaborates with pediatricians across the state who are willing to discuss oral health and provide resources to their patients.
The Fluoride Varnish training program is offered to medical offices in addition to oral health supplies and contact points for questions. 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 5 without a dental home. Smile for Life courses are assigned prior to training to allow staff to ask any questions. It is discussed with staff age of first dental visit, how to take care of teeth, bottle mouth, nutrition and appropriate dental supplies and toothpaste. 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 completed, dental supplies including infant and child toothbrushes and toothpaste as well as infant tooth wipes and education are distributed to the offices who are providing fluoride varnish.

- 2,621 dental education, toothbrushes and toothpaste have been distributed to pediatric medical offices for their patients across the state.
- Fluoride Varnish training was given to 3 physicians, one registered nurse and 4 staff members.

MCH assists with marketing oral health activities, events, education through DEThrives Facebook, X and sharing with other Title V partners. The Bureau of Oral Health and Dental Services coordinates with MCH to release information through DEThrives at a minimum monthly on Facebook and Twitter. This includes preventive education and oral health events available to the public to support children and their families to maintain good oral health and

improve oral health literacy.

Dental Hygienists from the Bureau of Oral Health and Dental Services hosted 11 educational events at Delaware Public Libraires for Storytime. Children attended the events with an adult. 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. Of those children, 25 received a dental screening and 10 received a fluoride varnish. Five students were uninsured, 7 students were insured by Medicaid, and 13 had private dental insurance. Two children had suspected caries and no child had an urgent dental need. In addition, educational sessions were held about oral and systemic health. The sessions included doctors and nurses from Christina Hospital.

BOHDS coordinated and participated a Special Olympics event during this reporting cycle. Olympians received dental screenings and education. In addition, BOHDS provided assistive devices for oral health products and instructions on use. There were also 27 Community events attended by BOHDS representatives. Staff used puppets, food games, nutrition games and more to engage the public in conversations about oral health and HPV vaccination. Oral health education information was targeted to the population at each event.

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 provides the oral health supplies. During this past grant cycle, 1,000 Brush, Brush, Brush books were purchased and distributed by a dental hygienist to pediatric dental offices. We recently ordered an additional 3,000 books in English and Spanish due to the number of new providers that recently signed up for the Reach Out and Read program.

Through collaboration with WIC, the Delaware Breast Feeding Coalition, Sussex Pregnancy Center, DAPI and Doula's in Delaware, women's shelters, and other community organization for women, we distributed 675 infant oral health kits that included infant oral health education, infant toothbrush, toothbrush teether, tooth tissues, finger brush and toothpaste. Pregnant women received oral health education, oral health supplies and case management to a dental provider, if needed. Training programs were provided to 75 pregnant women and their infants. The training provides life like infants and guidance on how to hold the infant and use the oral health devices in the infants' mouth.

A dental helpline was set up to assist the public with finding a dental provider, for medical providers to contact and speak with a dental hygienist about and oral health problem or asking questions about a dental screening form that was sent home with the child.

- July 1, 2023 through June 17, 2024 - 370 phone calls were received from the public who needed assistance with finding a dentist and scheduling an appointment.

A cooperating and supportive dentist, Dr. Susan Pugliese and Dr. Karla Testa (Westside Family Health Care physician and Delaware's Oral Health Champion) presented to Acadia PA students at Christiana Care regarding oral health and the relation is shares with systemic health.

BOHDS support staff were assigned and completed training for Quality Improvement and Principles of Quality, Telephone Customer Service, Attitude for Service, HIPAA, and Client Confidentiality, and people of Cuban Heritage to enhance their skills when handling sensitive information and speaking with the public on the dental helpline. The new administrative specialists completed Smiles for Life to give them a basic understanding about dental health. Clinical staff were assigned CPR and completed the training.

MCH continues to support BOHDS through expanding oral health information, messaging, and marketing on the Delaware Thrives website. Periodically, DEThrives ran single image newsfeed ads to promote the Delaware Smile Check program. The ads targeted women (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.

MCH has also helped build a lasting connection and relationship between CYSHCN and BOHDS. Information has been shared to assist families with finding a dental provider. The Delaware Smile Check Program has targeted schools that have many children with disabilities and collaborated with dental specialist that can meet the needs of the families for treatment. The Delaware Smile Check Program is designed to provide parents, dental personnel, and medical providers with the tools needed to improve our state's oral and overall health.

The Family SHADE website continues to promote the Bureau of Oral Health and Dental Services (BOHDS) to expand their reach to the CYSHCN population by putting the BOHDS information on their Family SHADE website. This continues to afford families easy access to dentists that are able to serve their CYSHCN. Having the BOHDS information on the Family SHADE website continues to make it more convenient for families to access the dentists that will best serve their CYSHCN and eliminate them calling each dentist to ask if they can serve their child.

Child Health - Application Year

Developmental Screening

As is expected with a pilot project, there have been some setbacks and challenges. The ECCS program and its partners have been working to address challenges with early intervention accessing and processing referrals on the CHADIS referral platform and completing the feedback loop. For the application year, our goal is the ensure the gaps and bugs in the CHADIS platform is fixed for the early intervention programs, and any others that is observed. In addition, we are working on improving the monthly and weekly reports of data as well as the dashboard to track data needed for analysis of the pilot projects impact.

Efforts are also underway to scale up the project to increase its availability and access to outcomes information on families referred to early intervention while capturing and monitoring children deemed ineligible for early intervention services. Scaling up the CHADIS project would be beneficial to our efforts to address existing challenges with data collection as well as the CHADIS referral platform workflow issues. The outcome should be more complete access to data and outcomes information for families and, a reduction in families falling between the cracks.

The Maternal and Child Health Bureau also aims to capture more screening data from practices, even those that choose not to use PEDS Online tools, allowing for more robust and comprehensive data of developmental another screens (such as social determinants of health, depression, etc.) being done in primary care pediatric practices.

Through continuous quality improvement, we plan to work with Early Intervention programs such as Birth to Three and Child Find programs to improve and increase communications with pediatric practices, improve early intervention processing of referrals through the platform and assure a closed feedback loop.

We also plan to continue to encourage more pediatric and primary care practices to utilize PEDS Online and CHADIS referral platform during primary care well-child visits. We will continue to educate practices on PEDS Online, developmental surveillance and screening and referrals to early intervention/social services. We will support pediatric practices participating in the CHADIS pilot project and assist with the scale up of the CHADIS project within the pediatric community and other programs that would benefit utilizing the platform.

Our upcoming plans also include to re-introduce and promote Help Me Grow@211 to the community for better understanding of their role and benefits in navigating community services and resources. In addition, we will organize networking events targeting providers to promote HMG as the one-stop-shop for referrals to community services and resources for women and young children.

We will support and promote developmental screening through early literacy and the Reach out and Read program. The Division of Public Health will also support DEAAP efforts to seek opportunities and funding for early literacy pilot projects that support ROR practices to put books in the hands of more Delaware children and provide developmental and early childhood education and resources. We will begin conversations with the early learning and education partners on ways to integrate developmental screening on a statewide basis. In addition, we will determine a way to track and measure families enrolled in medical homes.

Medical Home

According to the 2021/2022 National Survey of Children's Health (NSCH), 44.2% of Delaware's children, ages 0 through 17, have a medical home. This is slightly below the national average of 46.1% who have a medical home. Having a medical home is a standard of care for all children, including CYSHCN. A medical home is an approach to providing comprehensive and high-quality primary care and should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

Our School Based Health Centers (SBHC), in high schools, middle schools, as well as elementary schools, already encourage each child and adolescent to select a pediatrician or family doctor. Each SBHC promotes ongoing comprehensive health care for students of all ages. In addition, SBHC's facilitate students' use of health care systems by establishing links with primary health care providers.

The Home Visiting Program welcomes families who are expecting a baby or have a young child at home up to age five (5) years. Evidence-based home visiting is a voluntary free service for pregnant women and families with children up to age five (5) years. A Family Support Specialist will get to know a family so that they can offer tailored support services to meet a family's needs. They can offer ways to help create a safe and healthy environment a young child to thrive in and help families understand their child's development while connecting them with additional

community resources.
In Delaware there are four Home Visiting programs:

- Nurse Family Partnership - [Children & Families First | Healthy Babies | Nurse-Family Partnership (cffde.org)]
- Healthy Families Delaware - [HFA | cffde]
- Parents as Teachers - [Parents as Teachers – Delaware Department of Education]
- Early Head Start - [Delaware Programs – Delaware Head Start Association (deheadstart.org)]

Families can choose when and where the visit happens. The Family Support Specialist can come to a family's home or a location of their choice. It is important that families feel safe and comfortable during the visit and have a sense of security knowing the Family Support Specialist is there for them every step of the way. The Family Support Specialist will work with the family to achieve their goals and can help during pregnancy and once baby comes. Each visit can happen weekly, every other week, or monthly depending on the family's needs. Families will learn about a variety of topics related to caring for themselves and their children, such as:

- Healthy pregnancy practices and preparing for labor and delivery
- Breastfeeding, safe sleep, preventing unintended child injuries, and healthy nutrition
- Identifying their baby's needs at different stages of development and doing activities with them that are appropriate for their age
- Promoting early language development and early learning at home
- Setting goals for the future, continuing education, finding employment, and childcare solutions
- Connecting families with other services and resources in the community

Delaware's Nurse Family Partnership's medically based model includes one-on-one home visits between a registered nurse educated in the NFP model and the client. Nurse home visitors provide the NFP intervention through the nursing process, clinical assessment, and individualized goal setting with the client. Nurses use visit-to-visit guidelines to support clients' goals and meet the individual needs of families.

Delaware's Home Visiting Program also supports two Community Health Worker programs that are available as a support to families in all three counties. Westside Family Healthcare and Christiana Care Health Systems have a Home Visiting Community Health Program that can offer supports to families involved in that medical system and others in the community. The Home Visiting Community Health Workers can families with resources and have various educational sessions and events that are free to attend.

- Westside's Family Health Community Health Worker Program works to improve maternal and child health before, during, and after pregnancy, and to promote child growth and development. The program supports moms and dads to be, and families and caregivers with infants and children under the age of 5. These services are for patients and non-patients.
- Christiana Care's Home Visiting Community Health Worker Program (HV CHW) assist families in understanding the benefits of having a Home Visitor and finding resources to help raise a healthy family for moms, dads, families thinking about having a baby, or currently pregnant. This program promotes good health before pregnancy and provides key maternal health messages including the benefits of breast feeding and the importance of safe sleep. HVCHW's work in targeted high-risk zip codes to connect pregnant women and young families to health care, social services, home visiting, and educational programs.

A new partnership with Quality Insights Delaware offers support from a Community Health Worker (CHW) to help women to get and stay healthy by linking them to key resources to meet specific needs related to the Social Determinants of Health. Quality Insights is leading an initiative in the state of Delaware to help connect diverse, underserved, and hard-to-reach women in our communities with the services they need to stay healthy, as well as provide them with guidance and support to overcome any barriers they may face in obtaining quality health care.

For FY 2026, we also intend to collect and track data on medical homes. The target population will be either callers to the HMG@211 helpline; families supported by the home visiting program enrolled in a medical home, and/or pediatric practices deemed as medical homes, whichever is feasible. This data will assist in enrolling more families into medical homes. A 2022 Data Resource Center for Child and Adolescent Health report stated that Delaware has about 45% of children birth – 17 years enrolled in a medical home. The American Academy of Pediatrics defines a medical home as a model of primary health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.

Dental Visit

Delaware is slightly lower than the national average of children, ages 1 through 17, who have had a preventive dental visit in the past year. According to the 2021/2022 National Survey of Children's Health, 75.4% of Delaware children have had a preventive dental visit in the past year, which is slightly lower than the national average of 77.0% of

children who have.

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.

BOHDS will continue with Delaware Smile Check Program providing dental screenings, preventive dental treatments, oral health education and case management and assist the public with removing barriers to receiving 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. BOHDS will proceed with the school based portable dental sealant program as new staff is onboarded for students that have Medicaid, DCHIP or who are uninsured.

MCH also sees the value in supporting legislation that was recently passed, after the pilot at Colonial School District. This legislation requires all enrolled students to receive a dental examination or screening. BOHDS has worked 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. Beginning September 2024 through May 2025, the Bureau of Oral Health and Dental Services will provide oral health screenings to all students in 103 public and charter kindergartens to comply with HB83 that amended Title 14 of the Delaware State Code. It is estimated this will reach 12,000 students.

BOHDS will continue to focus their 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 treatments, dental sealants, and silver diamine fluoride available to students into a 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 where children struggle with access to dental care.

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 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 to a new server. BOHDS has no other system available to enter information about patient procedures and conversations with the families regarding case management. Their current database holds all information related to dental services and this information is shared with Medicaid through billing to report out for the state on the reports for the Medicaid population. The data collected is not only shared with Medicaid but used to report data on their program activities to MCH and other stakeholders. Training and upgrading of the electronic dental records will improve data collection and system integration. By implementing the new electronic dental records software program, Denticon, they will integrate it with the existing data bases and websites. This will develop and improve data sharing between BOHDS and the Department of Education. Denticon will be programed to improve data collection and be utilized it in a way that increases the use of technology as a method of communication and sharing and delivering program information with greater accuracy and speed.

With the recent addition of an Epidemiologist to the Bureau of Oral Health and Dental Services, we now have the ability to design and develop methods to collect oral health data for the population in Delaware and the population and patients we serve. This data will assist us the targeting our preventive care, outreach, and educational efforts, improving program outcomes. The information will also be shared with stakeholders and used as a baseline and

discussion points for the Oral Health Coalition.

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.

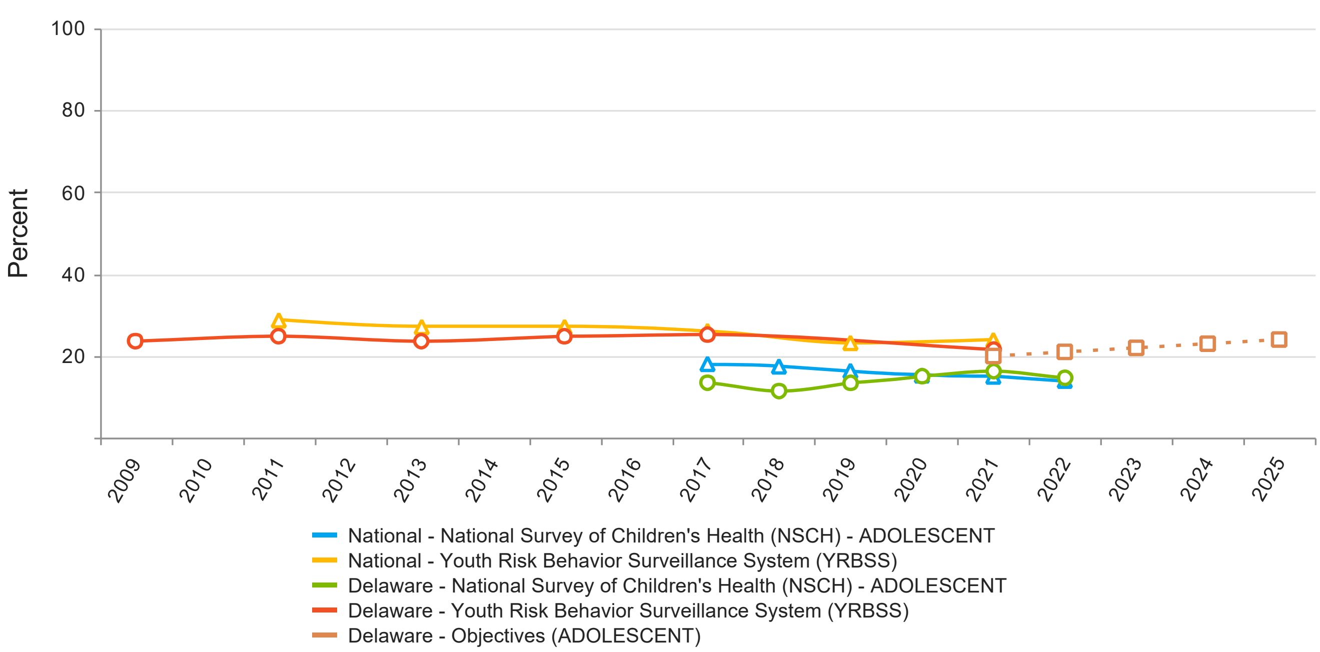
The Bureau of Oral Health and Dental Service has partnered with Delaware Chapter, American Academy of Pediatrics (DEAAP) Early Literacy Committee to promote early literacy and a dental home for children by age 1. Through this relationship we will continue to purchase approximately 1,000 Brush, Brush, Brush books and provide fluoride varnish training to the doctors, physician assistants and nurses. In addition, we supply the offices with oral heath educational materials, infant toothbrushes, tooth wipes, toddler and child toothbrushes and dental floss and their staff has a direct contact to a dental hygienist if they have any patients who need immediate dental care or have questions.

As new staff is added, BOHDS will continue to expand current oral health education programs to include child or health, early intervention, routine dental care, dental visits by age one, maintaining oral health, nutrition, HPV vaccination, and sport injuries. BOHDS has a dedicated 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, or mental health challenges. 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 their programs, fairs, Storytime, education sessions, and newsletters through DEThrives, Facebook, X, and with over 200 community partners.

Adolescent Health

National Performance Measures

**NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent
Indicators and Annual Objectives**



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2019	2020	2021	2022	2023
Annual Objective			20	22	22
Annual Indicator	25.1	25.1	25.1	21.6	21.6
Numerator	9,329	9,329	9,329	8,529	8,529
Denominator	37,230	37,230	37,230	39,459	39,459
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2017	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			20	21.0	22
Annual Indicator	11.6	13.0	14.9	16.0	14.8
Numerator	7,828	8,196	9,878	11,362	10,707
Denominator	67,249	62,967	66,257	70,996	72,524
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

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

Evidence-Based or –Informed Strategy Measures

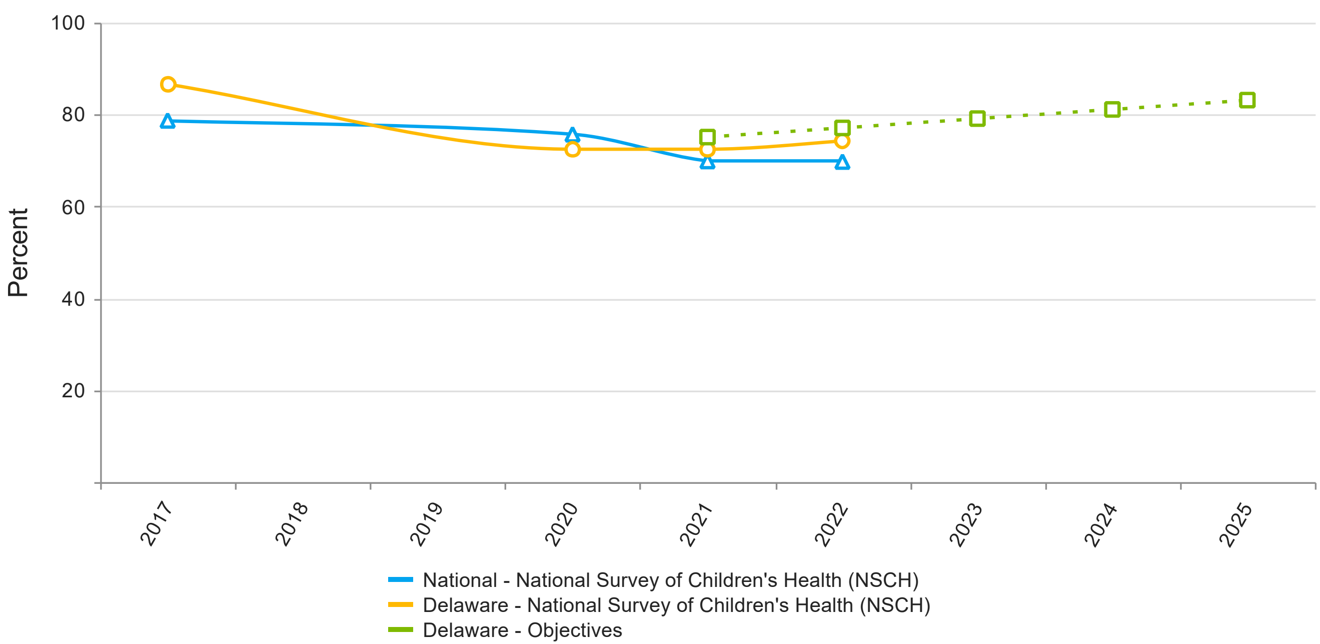
ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	14.3	21.4
Numerator	6	9
Denominator	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	12.0	15.0

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			75	77	79
Annual Indicator	86.9	75.7	71.9	71.8	74.2
Numerator	62,537	47,654	48,388	51,420	53,987
Denominator	71,966	62,974	67,333	71,653	72,759
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

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

Evidence-Based or –Informed Strategy Measures

ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			25	75	75
Annual Indicator		29.2	76.2	74.2	66.7
Numerator		883	4,902	4,958	4,420
Denominator		3,027	6,429	6,678	6,631
Data Source		SBHC Program Data	SBHC Porgram Data	SBHC Program Data	SBHC Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

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

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	48.2	53.6
Numerator	4,530	3,413
Denominator	9,407	6,367
Data Source	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022
Provisional or Final ?	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

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

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	0.1	0.2
Numerator	99	337
Denominator	140,263	141,729
Data Source	DOE Program Data	DOE Program Data
Data Source Year	2022	2023
Provisional or Final ?	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 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Five-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 AWV.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.	Inactive
ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed	Active
ESM AWV.3 - Increase the # of unique mental health visits provided to SBHC enrollees	Inactive
ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.	Active
ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE	Active

NOMs
NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM
NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle
NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN
NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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

Priority Need

Empower adolescents to adopt healthy behaviors.

NPM

NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Five-Year 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 PA-Adolescent.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 PA-Adolescent.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 PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.	Active

NOMs

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Adolescent Health - Annual Report

Adolescence is a phase of life between childhood and adulthood. It is a unique stage of human development and an important time for laying the foundations of good health. 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 2021/2022 National Survey for Children's Health (NSCH), the percent of Delaware adolescents (ages 12 through 17) who have had a preventive medical visit in the past year is 74.2%, which is slightly above the national average of 69.7%. We are holding steady with our numbers, but still have much work to be done. During Delaware's 2020 Needs Assessment, our stakeholders identified the adolescent well visit as the number two priority for this population domain and was ranked 7th important, overall.

According to the 2021/2022 NSCH, 20.0% of Delaware's children, ages 0 through 17, have experiences two or more adverse childhood experiences (ACEs). During the same time frame, the national average of children experiencing two or more ACEs was 17.4%.

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.

Teacher Training: Best Practices in Facilitating Evidence-Based Sex Education	In person	October 2023
STI Updates, Supporting LGBTQ+ Youth, and Relationships / Sexting / SEM	In person	December 2023
Academia Charter School Parent Workshop	In person	January 2024
Brennan School Parent Workshop	In person	March 2024
SBHC Training: Teen Dating Violence: Prevent, Recognize, Heal	In Person	May 2024

COVID 19 efforts to promote education, testing, vaccines, and awareness are still being promoted in various ways throughout the state. Using methods such as:

- Social Media
- Radio Stations
- Bulletin Boards
- School Staff
- SBHC Staff
- Flyers/Posters
- Medical Provider Websites

The SBHC Operational meeting this year was held in conjunction with Title X Family planning on October 17, 2023, and May 7, 2024. It comprised of mental health and medical providers from SBHC's, providers and administrative

representatives from DPH Clinics, Federally Qualified Health Care Centers, Community Health Care Centers, as well as DPH/FHS staff. The Adolescent and Reproductive Health Department attended an Annual Summit with DHMIC on April 17, 2024. On May 9, 2024, a SBHC forum was convened, featuring select representatives from each medical provider and staff from the Adolescent and Family Planning sections. This forum provided an opportunity for providers to network, discuss challenges, and emphasize the importance of partnerships, communication, and best practices for navigating change. This year's training topics encompassed a diverse range, including cultural humility, education on Syphilis, and best practices in operational changes. Topics of discussion comprised of the following:

- Danielle Johnson, BSN, RN Community Nurse Educator; *Understanding Delaware's HIV landscape and The Power of Cultural Humility on Health Equity; 10/17/23*
- Lori Holsey, Reginal Coordinator; *Understanding Delaware's HIV Landscape and The Power of Cultural Humility on Health Equity; 10/17/23*
- Dr. Jeanne Sheffield, M.D; Syphilis/Congenital Syphilis Rising Rates and Syphilis and Pregnant Women; 05/07/2024
- Mohit Mukherjee, M.ED; Change How to Turn Uncertainty Into Opportunity; 05/05/24
- Joia Crear Perry; National Birth Equity Collaboration; 04/17/24
- Kimberly Seals Allers, B.A, M.S.; About Joy & Healing in Black Birth; 04/17/24

In addition to the above training, the Adolescent and Reproductive Health Unit participated in an in-person training session on "Recruitment, Retention, and Classroom Management" from April 2-3, 2024, in Nashville, TN, in with the Family & Youth Services Bureau. Effective recruitment and retention of youth are critical to the success of adolescent pregnancy prevention programs. Developing and executing a recruitment and retention strategy requires forethought, diligence, and a comprehensive understanding of program data. This two-day workshop equipped us with the knowledge, skills, and resources to better understand how to use program data to inform recruitment and retention strategies.

From June 25-27, 2024, we attended the "Building Brighter Futures with Today's Youth Leaders" conference in San Francisco, California. This event provided an opportunity to learn effective strategies for partnering with organizations, communities, youth, and caregivers to enhance our program's capacity to meet the dynamic needs of the youth we serve. The conference featured multiple speakers, interactive workshop sessions, and numerous networking opportunities, enabling the DPH to engage with a diverse array of professionals and stakeholders.

Legislation was submitted and approved; House bill No. 129; awarding $170,000 to two high needs elementary schools per year until all high needs elementary schools are in compliance. There are currently 20 high need elementary schools in the state of Delaware. On 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.

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 Strategic Plan, SBHCs continue to evolve and develop, allowing students to utilize services needed such as mental health, reproductive health and well visits.

Programs implemented during the school day focus on reducing risk-taking behaviors, developing healthy behaviors, and emphasizing the importance of ongoing healthcare. Adolescents grappling with unhealthy mental health behaviors may struggle with academic performance, decision-making, and overall health. Unfortunately, due to the COVID-19 pandemic, we were unable to fully partner with our SBHC and Delaware school districts during the school year. As we continue to move forward past the pandemic, we are working to reestablish relationships with school districts and DOE to improve healthy behaviors and reduce risk-taking behaviors.

However, during the most recent school year, schools in Delaware have resumed traditional operations. We are actively promoting and encouraging SBHCs and school districts to educate and raise awareness about developing healthier behaviors and reducing risk-taking behaviors. Once SBHCs are fully staffed, our goal is to reestablish partnerships with the Department of Education and school districts to launch a health messaging campaign addressing mental health treatment.

Currently, Delaware has 35 recognized SBHCs located in high schools and middle schools, and 20 recognized SBHCs in elementary schools. Last year, there were 34 SBHCs in high schools and middle schools, and 15 in elementary schools. These participating schools are displayed on this sitemap. In the upcoming fiscal year, we anticipate the recognition of at least four additional SBHCs to provide essential services within the community.

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 20 different school districts across the state of Delaware. In addition, 24 Delaware law enforcement agencies are participating in the program. This year's program began during the 2023/2024 school year (8/27/23 – 6/21/24). Data available for this school year through April 10, 2024, shows there has been 2,168 incidents generated, which equals to 3,523 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 priority 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.

Poor mental health in adolescence is more than feeling blue. It can impact many areas of a teen's life. Youth with poor mental health may struggle with school, grades, decision making, and their health. Mental and behavioral health services remain areas of significant growth and development. SBHCs continue to face challenges in providing services to students due to staffing shortages and high turnover rates. Conversely, other SBHCs are successfully meeting and exceeding their projected goals for delivering mental and behavioral health services. Despite these successes, SBHCs continue to grapple with the high demand for mental health services. To address this, telehealth and referral services have been implemented in many SBHCs to help meet the demand and accommodate student needs effectively.

COVID-19 impacted School Based Health Centers across the state of Delaware. Many SBHC's implemented telehealth at the onset of COVID-19 which is still in place to ensure are students have access to treatment when needed. Upon availability of the vaccine to adolescents 12 and older, SBHC's have coordinated efforts for the vaccine with medical vendors in the latter months of the school year. The demand for mental health services has surged significantly since the onset of COVID-19. SBHC providers continue to deliver essential mental health services, aiming to decrease mental health and psychosocial issues among adolescents.

In 2020, the Delaware Department of Education (DOE) developed and launched Project THRIVE, which helps

children receive trauma-informed support from their schools, communities and caregivers. Project THRIVE provides free mental health services to eligible Delaware students. Services are available to students, grades pre-k through 12th grade, attending Delaware public 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 the last grant cycle, MCH partnered with the DOE to expand advertisement of Project THRIVE. The need for self-identification of trauma has become a critical component to the success of Project THRIVE. MCH is committed to the success of this program and during this grant cycle, MCH worked to continue with the developed advertisement campaign 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.

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.

DEThrives ran a single image ad on Facebook and Instagram to encourage young teens to consider healthier ways of bettering their future with the My Life My Plan: Teen webpage. The ad targeted teens aged 13-19 years old in Delaware and earned over 128K impressions, reached over 21K individuals, and earned 308 link clicks.

In addition, DEThrives ran another single image ad on Facebook and Instagram to inform users of sexually transmitted infection (STI) testing. The ad targeted adults 18-34 year olds in Delaware. The post earned over 198K impressions, 119 link clicks, and reached over 182K users. This post was the top awareness driver where 100% of all clicks and impressions came from users aged 18-34 year olds and from women aged 18-24 year olds.

DEThrives also intends to bring awareness to adolescent mental health by promoting the topic frequently. Our post asked adolescents what was the difference between mental health promotion and prevention in their health. Information provided was informing adolescents that promotion is encouraging and increasing protective factors and health behaviors. Prevention varies but includes treatment and precautionary intervention. The carousel post then scrolled through multiple images to help explain what the “protective factors” term means.

PARENTAL RESILIENCE
SOCIAL-EMOTIONAL COMPETENCE OF CHILDREN
SOCIAL SUPPORT
CONCRETE SUPPORT
UNDERSTANDING CHILD DEVELOPMENT
5 PROTECTIVE FACTORS

Through our social media platforms, DEThrives website, Instagram, You Tube, X, and Facebook, the Adolescent Health program works with the Social Media Coordinator to post messages on the importance of healthy choices for adolescents, which will empower them to adopt healthy behaviors.

Physical Activity (ages 12-17)

According to the National Survey of Children’s Health (NSCH), only 29.0% of male children, ages 6 through 11 in Delaware are physically active at least 60 minutes per day, compared to 29.4% of male children nationally. Comparably, only 26.5% of female children, ages 6 through 11 in Delaware are physically active at least 60 minutes per day, compared to 23.2% of female children nationally. Also according to the NSCH, 20.5% of Delaware’s children, ages 6 through 17 are obese, compared to a national average of 18.1%. 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 prevalence of obesity among Delaware adults has continued to increase over the last few years. In 2012, the obesity prevalence in adults was 27.0%, and in 2022 that percentage increased to 37.9% of adult Delawareans. Conversely, the prevalence of overweight adults in Delaware has declined over the years from 39.1% in 2012 to 33.9% in 2022. 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.

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.

PANO program’s long-term goal is to reduce the prevalence of adult and childhood obesity and other chronic diseases by promoting healthy lifestyles and improving health outcomes for Delawareans. PANO 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.

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. Since 2021, Triple Play has been expanded to 9 school-based sites, with 3 participating schools in each county. During the Summer and Fall of 2023, 1,409 youth participated in the Triple Play program at the 9 school-based locations. In Winter and Spring of 2024, 468 youth participated in the Triple Play program at the 9 school-based locations. In Summer of 2024, Triple Play programming continued in 9 school-based locations throughout Delaware, with 3 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 educates and teaches skills to increase healthy eating, and increases physical activity for this population; and revitalizing a community space for health education and physical activity for children in an underserved community. Through AHL, PANO is collaborating with Delaware schools and the Nemours Community Health Team to implement ALA programs.

UD Cooperative Extension partnered with the Delaware Farm and Food Policy Council to implement the Healthy Retail Initiative in 2 community stores in Harrington and Farmington which connected the community to fresh produce from a local farm. Additionally, UD hosted nutrition education sessions in stores with Supplemental Nutrition Assistance Program Education (SNAP-Ed), supporting children and families in these targeted communities. DSU facilitated two semesters 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. 35 Charlton students participated in the Fall and 10 DSU students and 28 Charlton students participated in Spring 2024 . DSU also hosted a lunch and learn series during the 2023/2024 academic year for the Charlton “Roads to Success” Program, 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 2023, DSU Allied Health Center hosted a half-day summer camp in a Dover community, reaching over capacity of serving 39 children ages 5-12 years old. The camp offered structured play for increased physical activity, a vegetable garden, nutrition education and healthy snacks.

The 2023/2024 Advancing Healthy Lifestyles mini-grant program 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 2023 to May 2024:

- 4-H held 32 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.
- La Red Health Center provided produce prescriptions to more than 200 families who were experiencing food insecurity.
- Delaware Breast Cancer Coalition hosted 89 "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 11 youth-centered, family, and community events at locations throughout Dover.
- Westside Family Healthcare implemented an expansion of the Feeding Families initiative to ensure access to healthy foods and sustained healthy eating habits for 43 participants
- Delaware State University hosted 7 student-led, campus-wide events aimed at promoting healthy lifestyles.

AHL's second annual conference provided a platform for cross sectional sharing on national, regional, and local best practices, challenges, opportunities, and success stories. The goal of the conference is to strengthen efforts to reduce obesity and other chronic diseases amongst Delawareans. The 2024 theme was Engaging Communities to Live Healthy Lifestyles, and sessions focused on building trust, emotional fitness and wellbeing, changing mindsets, and overcoming barriers to engaging in healthy lifestyles. 309 individuals representing multiple sectors including state and local government, nonprofit, healthcare, higher education, and K-12 education, registered for the event.

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. In Fall of 2023, there were 38 nominations received, and 6 were selected to receive an award. The Lt. Governor's Challenge awards were presented to the 6 honorees. In Spring 2024, there were 65 nominations received, which is the most nominations received to date. Two additional categories of winners were added in 2024: Circle of Excellence and Community Spotlight Recognition. The Lt. Governor's Challenge awards were presented to 19 honorees. Some of the winners that were selected in 2023 and 2024 include organizations that specifically impact the health and wellness of children and their families like the University of Delaware's Delaware Institute for Excellence in Early Childhood, Providence Creek Academy Charter School, Nemours Children's Health, W.B. Simpson Elementary School, and Rain Vasey, Soulful Arts Workshops Leader for Teens and Young Adults.

PANO continued to partner with the Sussex County Health Coalition (SCHC) to implement the Let's Get Healthy Sussex Initiative to increase healthy eating and beverage consumption, and physical activity in high need communities in Delaware. The SCHC's Let's Get Healthy Sussex Campaign included an awareness campaign, mini-grant program, and community-based partnerships to reach populations with healthy eating, lifestyle messaging and access to education through classes. The awareness campaign included curated PSAs through social media, radio stations, and news stations in Sussex County. The campaign has reached 331,392 with ad campaigns and 29,309 through social media. Mini-grants were awarded to 6 organizations who were able to reach over 1,800 high-risk community members in health education, physical activities, and healthy cooking classes. This initiative also provided access to a Health Literacy upskill program for community health workers through the Institute for Healthcare Advancement (IHA). Six community health workers in Sussex County completed the class with a Health Literacy Specialist certificate.

PANO collaborated 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 supported 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. During the 2022/2023 school year, 242 schools were provided access to the software. There was a 94% overall response rate for school districts and a 70% overall response rate for charter schools. DOE plans to target charter schools for compliance for the 2023/2024 school year. Data for the 2023/2024 school

year will be available in July 2024.

PANO provides technical assistance and resources to Delaware's professional Society of Health and Physical Educators (SHAPE DE), which makes up the professional workforce of health, physical activity, and physical education teachers throughout Delaware. SHAPE DE's annual convention was designed to provide SHAPE members and health education professionals the opportunity to share instructional ideas with each other and learn from local and national subject matter experts. Over 375 educators were pre-registered for the event, which is the highest number of registrants they have had at any convention to date. This year, PANO provided additional support for eight physical education teachers and two physical education students from Delaware State University to attend the SHAPE America National Convention. Attendees were able to interact and network with hundreds of teachers from across the nation to share best practices and hear from subject matter experts in the field. Each attendee is submitting a call for proposal and will be presenting at the SHAPE Delaware Convention.

The Division of Public Health's (DPH) Health Education Administrator facilitates the various youth surveys statewide, such as the Youth Risk Behavior Survey (YRBS) and the School Health Profile (SHP). Select schools participated in the 2023 YRBS and data collection occurred during the 2023/2024 school year. The YRBS is a biennial (odd years), anonymous 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 were randomly selected by the CDC to participate. DPH is consistently working to improve response rates from the schools, and efforts to find ways to improve school participation will resume. The 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 last completed in 2022.

In February 2024, PANO provided support to Camp Abilities Delaware to host their 2024 Winter Camp. Camp Abilities Delaware is an educational sports camp for children ages 5-17 who are blind or have low vision. The purpose of the camp was to empower children to be physically active, improve their overall health and wellness, encourage them to make food choices that support an active lifestyle, and develop their confidence and self-esteem through sport and physical activity. Camp Abilities Winter Camp was held at the University of Delaware's Virden Center in Lewes, DE. Over the weekend, 12 youth with visual impairments participated in different sports and improved fitness skills, 5 local high school students were trained on how to be allies for their peers with visual impairments, and 16 college students, teachers, professors, and community volunteers taught the youth.

Nutrition Counseling

After reinstating of the Nutrition Program in March of 2023, New Castle County Community Health Services has expanded nutrition services over the past year. Since August 2023 the Nutrition Program's Registered Dietitian Nutritionist (RDN) is on track to receive more than 100 referrals, with FY 23-24 to be the first complete fiscal year for the Nutrition Program since it was reinstated in March 2023. The majority of referrals have been for children under the age of 10 years old.

With the reestablishment of the Nutrition Program, Division of Public Health programs such as Family Planning, Child Health, Sexual Reproductive Health, and our Tuberculosis Clinic are able to refer to an RDN for nutrition counseling. Additional public health programs such as the Lead Poisoning Prevention Program, the New Castle County Community Health Services Mobile Health Unit, and the Women Infants and Children (WIC) Program have also established parameters for nutrition referrals. Children with elevated blood lead levels are referred to the Nutritionist for nutrition-focused lead poisoning prevention guidance, with emphasis on managing or reducing the amount of lead in the blood by consuming nutrients that compete with lead for absorption by the body. Referrals from the Mobile Health Unit include adolescents with pre-diabetes, diabetes or elevated glucose readings, elevated blood pressure readings, and cholesterol concerns. The WIC Program refers to the Nutritionist for concerning nutrition conditions

such as selective eating, food allergies and intolerances, elevated blood lead levels, and low hemoglobin levels for infants and children aged 1-5 years.

Other state programs, such as Birth to Three Child Development Watch (CDW), which focuses on children with developmental delays and/or disabilities have an established referral process for nutrition consults. This provides opportunity for the Nutrition Program to reach infants and children in the community and guide families through feeding challenges that often accompany children in the CDW program such as restrictive eating behaviors, food progression delays and food aversions which can lead to weight concerns. By partnering with children and their caregivers at an early age, concerning eating habits can be addressed with the goal to manage or resolve potentially harmful food-focused behaviors.

Nutrition consultations are conducted either over the telephone or in person based on patient/parent preference and accommodations. 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. Common nutrition concerns seen by the Nutritionist include obtaining and maintaining healthy weight, encouraging the introduction of new foods, increasing the consumption of a broader variety of healthy foods, and the ability for participants to make more informed food choices to live a healthy lifestyle. Along with these common concerns, recognition and navigation of food preferences, allergies, intolerances, and sensitivities as well as digestive disorders, developmental disabilities, and chronic health conditions is critical.

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 a RDN to maintain registration and licensure, in addition to exploring research and staying up to date on current health and nutrition news and topics. Trainings our RDN has completed this year include: *Nutrition for the Neurologically Impaired Child, Decoding the Nutrition Facts Label, Strengthening Health Outcomes in the Community Population Part 1: Recognizing Patients at Nutritional Risk, Strengthening Health Outcomes in the Community Population Part 2: Incorporating Nutrition into Practice, and Protein Metabolism and Aging*. Completion of these trainings included the curriculum to obtain the Certificate in Community Training from Abbott Nutrition Health Institute.

Being engaged in community health events and conferences throughout the state has broadened our awareness of resources and networks to utilize in expanding nutrition services.

On June 6, 2024, the Division of Public Health's Physical Activity, Nutrition, and Obesity Prevention (PANO) Program hosted the second annual Advancing Healthy Lifestyles (AHL) Conference: Engaging Communities to Live Healthy Lifestyles. AHL Conference initiatives include 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. The AHL conference provides an opportunity to engage in panel discussions and network with colleagues as well as other health professionals and those in careers which promote healthy living.

The PANO Program's Advancing Healthy Lifestyles Coalition has opened opportunities to build relationships amongst colleagues, healthcare professionals, and community members. Agreeing with the goal to reduce adult and childhood obesity, along with other chronic conditions, to achieve long-term health equity for schools, communities, and workplaces throughout Delaware, the RDN joined the AHL Coalition to help further their vision to uplift the wellbeing of all Delawareans and break down barriers to achieve healthy lifestyles. The RDN joined the blog writing committee to share nutrition and wellness information with the community, with her first blog *Nutrition, Immunity, and You!* published on the coalition's website in December 2023.

The annual HIV Awareness/Testing Event on Thursday June 27, 2024 in Newark, hosted by the Hudson State Service Center, provided on-site HIV screenings for all ages along with information and resources. HIV related nutrition information and resources including healthy food choices and food safety were provided along with the Nutritionist on site to answer questions and provide nutrition material tailored to those affected by HIV/AIDS in the community.

Adolescent Health - Application Year

During Delaware's 2020 MCH Title V Five-Year Needs Assessment process, the MCH team along with various stakeholders, identified two priorities pertaining to adolescents. 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 2021/2022 National Survey of Children's Health (NSCH), 25.8% of Delaware adolescents have had no preventive medical visit in the past year. This is below the national average of 30.3% of children. 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 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, SBHCs, located in now 35 public high schools and 20 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.

SBHC's operate in 16 elementary schools, offering medical, mental health care treatment, and health education to promote a healthy lifestyle. These centers serve children in grades K-5, providing access to services such as sports physicals, well visits, immunizations, vaccines, and mental health counseling. SBHCs are part of an integrated network of providers offering behavioral and physical health services to adolescents in Delaware. They do not replace primary care providers but instead work alongside them to address or discover problems before they escalate, connect children and families to community resources, improve health, and reduce long-term healthcare costs.

The epilogue language from FY2020 mandates the expansion of SBHCs in elementary schools, with two new centers being established each year in high-needs elementary schools throughout the state. Alongside the establishment of SBHCs in elementary schools, many centers are exploring opportunities to expand services to more students by opening additional "spoke" sites. These additional sites are critical in providing necessary services to students across the state.

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 20 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.

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 adulthood, we are working to ensure adolescents have the resources to secure a primary care doctor, transition Medicaid, and to thrive and have an 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 to support our LGBTQ+ teens.

A provider meeting will be organized for all direct providers within the School-Based Health Centers, the Alliance for Pregnancy Prevention Program, and the Sexuality Education Training Program. This meeting will feature keynote speakers who will deliver education and awareness sessions on critical topics including sex trafficking, domestic violence, adapting to change, and various aspects of mental health awareness.

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.

The demand for mental health services remains high and critical. As the need for these services continues to grow and access to qualified providers becomes increasingly challenging, School-Based Health Centers are working more closely with schools to identify and address areas where services are most needed. Partnerships and collaborations are strongly encouraged to fill gaps and determine the needs of the students.

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 as well as through our own DEThrives advertisement channels. 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 27.7% of Delaware children, ages 6-11, are physically active at least 60 minutes each day, compared to the national average of 26.3%. This leaves 72.3% children who are not physically active at least 50 minutes per day. 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.

The Advancing Healthy Lifestyles Coalition brings together organizations and agencies dedicated to tackling the challenges of obesity, physical inactivity, and poor diet. The vision is to uplift the wellbeing of all Delawareans and break down barriers to achieve healthy lifestyles. The mission is to bring together coalitions and partners to focus on healthy lifestyles and equity to leverage and expand resources in the community. The Coalition has established a strategic plan which establishes four core values as inclusivity, trust, collaboration, and collective action, and five strategic goals around collaboration and partnerships, community outreach engagement and access, program

development, marketing and communication, and policy, systems, and environmental change strategies. The Coalition has seven committees focused on improving healthy lifestyles and health equity, including a new Youth committee dedicated to improving the wellbeing of Delaware's youth.

Through the Advancing Healthy Lifestyles (AHL): Preventing Obesity to Reduce Chronic Disease initiative, DPH will continue to support youth health through the AHL foundational pillar: Coordinated School Health and Wellness. In partnership with the Department of Education, the goal is to develop a Healthy Schools Recognition Program that provides support and technical assistance for schools statewide to implement policy, systems, and environmental change strategies that promote physical activity and healthy eating. Healthy Schools criteria will be developed based on evidence, practice, and research-based strategies and policies, and will aim to increase awareness, create a culture of health at schools and childcare sites, increase healthy eating and physical activity, and reduce obesity prevalence among children and youth. The Healthy Schools Recognition Program will offer mini-grants and technical assistance to schools to provide support in making policy, systems and environmental (PSE) changes and gaining recognition. The schools will continue to implement PSE change strategies that improve the health and wellbeing of Delaware students and address obesity, physical inactivity, and poor nutrition in Delaware youth.

Through the AHL foundational pillar, Community Capacity Building, DPH will continue to implement support to community partners through the AHL Mini-Grant program. The AHL Community Mini-Grant program awards grants to communities and organizations that exhibit a strong commitment to obesity and chronic disease prevention and are enhancing or expanding access to physical activity and healthy eating opportunities for children, families, and communities. In September 2024, PANO will launch the AHL Community Mini-Grant program for a third 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 that improve health and reduce chronic conditions. Awardees must address the AHL outcomes of improving opportunities for physical activity, healthy food, and maintaining a healthy weight.

PANO will host the third annual Advancing Healthy Lifestyles Conference in June 2025. The AHL Conference serves as an annual convening that provides a platform for cross sectional sharing on national, regional, and local best practices, challenges, opportunities, and success stories. The goal of the conference is to strengthen efforts to reduce obesity and other chronic diseases amongst Delawareans. The annual conference will serve as an opportunity to close gaps in health inequities, assess progress, and further strengthen the work of community stakeholders. Visit the Advancing Healthy Lifestyles webpage for more information.

PANO will partner with other state agencies and community organizations to sustain the AHL foundational pillar of Community Capacity Building. DPH will engage community partners who are primarily serving disparate or targeted communities. 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 change strategies and interventions through community-based initiatives such as the Lt. Governor's Challenge. The Lt. Governor's Challenge recognizes an Individual, Workplace, Community, Town/City/ Neighborhood, or School for advancing the goals of a healthier Delaware in one of four focus areas: Emotional Well-Being; Healthy Living; Chronic Disease Management & Prevention; and Mother & Child Health. Visit www.ltgovernorschallenge.org to learn more.

PANO will continue to partner with the Sussex County Health Coalition to implement the Let's Get Healthy Sussex Initiative to increase healthy eating and beverage consumption, and physical activity in high need communities. The SCHC's Let's Get Healthy Sussex Campaign includes an awareness campaign, mini-grant program, and community-based partnerships to reach populations with healthy eating, lifestyle messaging and access to education through classes.

PANO will continue to collaborate with the Delaware Department of Education (DOE) on the AHL foundational pillar Coordinated School Health and Wellness initiatives. DOE has state regulations on physical education which includes a requirement for annual physical fitness assessment, reporting and compliance standards. PANO will continue to offer resources for WELNET implementation, professional development, and training opportunities for Delaware educators. For the 2024/2025 school year, PANO will provide support for DOE to hire a contractor to provide one-on-one, in person support for Delaware educators around the WELNET software and reporting requirements. PANO will also provide 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.

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). DPH is consistently working

to improve response rates from the schools, and efforts to find ways to improve school participation will resume. 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 X. Subjects pertaining to Adolescents, such as My Life My Plan Teen, Addiction, Mindfulness, COVID-19, School Based Health Centers, Anxiety and Depression, Mental Illness, Exercise, and more have been posted. In working with our partners, MCH will continue to use social media to promote adolescent health comprehensively. Social media messages will be developed around the importance of preventative well visits, healthy lifestyles, and emotional wellbeing. DEThrives contains a "Services for Me" page, where content is organized by the user's life stage. These life stages include a "Teens" category. Additional maternal and child health messaging can be found on the different audience pages, which are organized by the different life stages an individual will be in. All web pages, either a program or audience page, have a "Related Programs and Services" section at the bottom of the webpage that will list other pages or program pages that relate to the page the user is currently on. This is another way for the user to learn more information about related services DEThrives has.

Nutrition Counseling

After reinstating of the Nutrition Program in March of 2023, New Castle County Community Health Services (NCC CHS) has expanded nutrition services over the past year. Since August 2023, the Nutrition Program's Registered Dietitian Nutritionist (RDN) received over 100 nutrition consultation referrals.

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

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

In addition to nutrition consulting, continuing education is a critical part of the career of a RDN to maintain registration and licensure, in addition to exploring research and staying up to date on current health and nutrition news and topics. In the upcoming year I will attend health and nutrition trainings and webinars to complete CPEUs and continue to further expand my knowledge and resources focusing on nutrition concerns for children and adolescents.

A new initiative of NCC CHS mobile unit is Cholestech, a screening tool for cholesterol, blood pressure, and glucose blood levels. The mobile health unit provides on-site screenings for adults and adolescents and makes and referrals to the Nutritionist based on results from readings or at patient request. Nutrition counseling with the patient is centered around the goal to minimize, manage, or resolve the health concern through nutrition and a healthy lifestyle.

To strengthen and further the CHS knowledge around these health conditions, we will be attending the 22nd Annual Diabetes Wellness Expo in Dover on November 12, 2024, 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. Through exhibitors and educational seminars, the Expo promotes diabetes self-management and living a healthy lifestyle. Information and resources for diabetes management, nutrition, exercise, medication adherence, and mental health are provided along with on-site health screenings. The Expo provides a networking opportunity between colleagues and health professionals to strengthen professional relationships and broaden knowledge of programs and resources available to better serve the community as a whole.

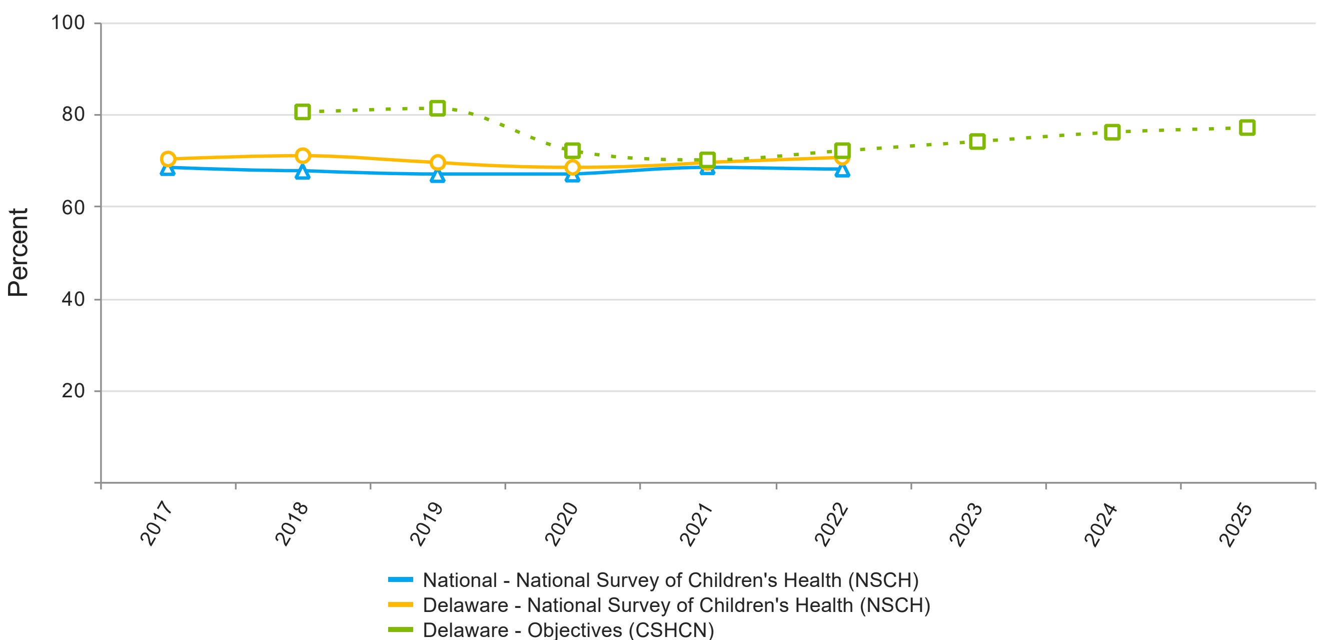
Additional upcoming events include the annual HIV Awareness/Testing Event on June 27, 2024 in Newark, hosted by the Hudson State Service Center, providing on-site HIV screenings for all ages along with health information and resources. HIV related nutrition material and resources including healthy food choices and food safety are provided along with the Nutritionist on site to answer questions and provide nutrition material tailored to those affected by HIV/AIDS in the community.

Agreeing with the goal to reduce adult and childhood obesity, along with other chronic conditions, to achieve long-term health equity for schools, communities, and workplaces throughout Delaware, the RDN joined the DPH and PANO Program Advancing Healthy Lifestyles Coalition to help further their vision to uplift the wellbeing of all Delawareans and break down barriers to achieve healthy lifestyles. The AHL Coalition has opened opportunities to build relationships amongst colleagues, healthcare professionals, and community members. As part of the blog writing committee to share nutrition and wellness information with the community, we plan to contribute additional blogs to provide nutrition and wellness education to the public.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI
Indicators and Annual Objectives



NPM AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.2	72	70.0	72.0	74
Annual Indicator	70.9	68.6	67.2	68.8	70.7
Numerator	144,257	138,831	136,015	140,169	145,366
Denominator	203,436	202,281	202,319	203,715	205,678
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

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

Evidence-Based or –Informed Strategy Measures

ESM AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			90	92	94
Annual Indicator		90	89.1	91.5	90.6
Numerator		564	595	644	598
Denominator		627	668	704	660
Data Source		MIECHV Program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	96.0	98.0

ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	73.3	73.3
Numerator	11	11
Denominator	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

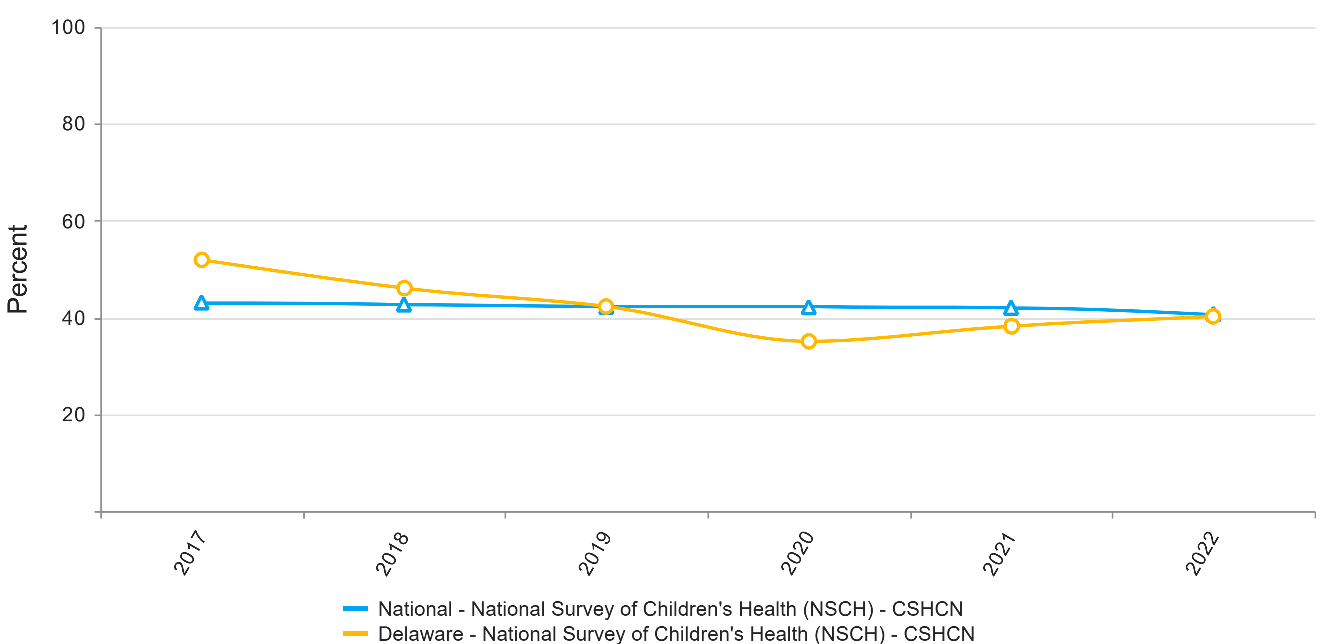
ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator		100
Numerator		
Denominator		
Data Source		CYSHCN Mini Grantee data
Data Source Year		2023
Provisional or Final ?		Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	40.2
Numerator	18,442
Denominator	45,845
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

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Evidence-Based or –Informed Strategy Measures

None

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 - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI

Five-Year 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 AI.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid	Inactive
ESM AI.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 AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants	Active
ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.	Active
ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.	Active

NOMs
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child
NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP
NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN
NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

State Action Plan Table (Delaware) - Children with Special Health Care Needs - Entry 2

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By July 2030, increase the percent of families reporting that their CYSHCN is connected to a medical home.

Strategies

MCH, in partnership with the Parent Information Center, will promote medical home education and awareness among CYSHCN and their families.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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 health care needs, 65.4% are continuously and adequately insured, compared to 69.7% of non-CYSHCN children.

Family SHADE

Delaware utilized Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making, to best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resource for community organizations serving CYSHCN. Families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems change to best serve families of CYSHCN. Parent Information Center (PIC) implemented the second year of the new approach to 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 has grown the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The network membership included trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. FLN members received monthly stipends for attendance and participation. The Family SHADE Learning Communities provided families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. PIC prioritized aligning the Learning Communities with the Maternal Child Health (MCH) national performance measures (NPM) as well as topics addressing gaps in service and identified needs that are impacting families of CYSHCN. Through these initiatives, the Family SHADE project contributed to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations focused on innovative strategies and improving the Title V national performance measures and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

Family SHADE Mini-Grant program

In 2023 Parent Information Center (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 PM & 6:00 PM	Required Zoom Information Session for Interested Applicants*
February 24, 2023, 5:00 PM	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 awarded a total of 3 organizations to

implement the following services which aligned with the Maternal Child Health Title V National Performance Measures (NPMs). The mini grantees which were awarded are listed below along with a final report of each program's outcomes.

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

	Baseline	April 5-May 5	May 5-June 5	June 5-July 5	July 5-August 5	August 5-September 5	End of Grant Period
		May	**June**	**July**	**August**	**September**	September 15
Age Range							
0-2	42	-	-	-	-	-	58
3-5	78	-	-	-	-	-	81
6-9	92	-	-	-	-	-	101
10-14	93	-	-	-	-	-	92
15+	196	-	-	-	-	-	207
Individuals with Down Syndrome	501	503	515	521	527	537	539
Number of visits	-	46	52	50	46	13	210
New clients	-	2	12	6	6	10	36

Goal 1: Increase percentage of DSADE youth who have access to the medical home - Down Syndrome Program

Outcome: 210 new clients gained access to the medical home and 36 new clients not only received access to the medical home but made first contact with our organization to start receiving support.

Goal 2: Increase families' feelings of support and wellbeing through the services provided by the Down Syndrome Program/Medical Home.

Outcome: Overall, very positive feedback on the importance of the medical home and value it has to families. Feedback from families provided on the next page.

Goal 3: Increase the number of families served by the DSADE.

Outcome: We saw 7.58% more families during this grant period, because of funding.

Feedback from families served:

"We love the Nemours clinic and the medical home it provides! Lauren Davey is super caring and patient. She answers all my questions and concerns. Lincoln enjoys going and the staff are very patient with him and his needs. We have seen Susan and Elizabeth there and they are always awesome and helpful."

"Amber and I have had the best experiences at the clinic. We have been twice so far. My favorite part- they schedule all of the appointments in one day. While it's a long day, it's so much better than having to schedule 5 different appointments!! The appointments have been very helpful to us, personally. We see many different doctor and therapist for Bradley, but when we go to this clinic, we receive in-depth knowledge, education and support specifically related to Bradley and Down Syndrome. For us, we love the added touch of having not only DSAD staff present but also the volunteers.

Bradley was hospitalized for RSV and Pneumonia for 8 days. Susan came and held Bradley so we could go celebrate our other daughter's birthday that we were missing. This clinic goes 'beyond the medicine'. The clinic doctors came up to visit Bradley while admitted. They were able to help us advocate. We cannot thank the clinic enough! 💙💛"

We have met some of the most wonderful people at the clinic! From doctors to advocates, everyone has always been so understanding and full of advice/information, pointing us in the right direction, etc. Our Parker is doing amazing because of the Nemours team and we are so thankful ❤️

2. Children's Beach House (CBH) – implemented a Youth Development Program described as "giving kids what all kids need." CBH assisted in establishing and meeting the needs kids had such as relationships with friends, positive adult role models, the safety and security to try new things and develop natural skills and talents, and access to community resources to help them thrive. Through a rigorous case management program provided by the programs team of Family Engagement Coordinators (FEC). These FECs worked with each child and family to identify each child's unique interests and talents and to weave together a network of services and relationships that helped them to thrive. This project was 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 aligned with NPM 11 -Access to a medical Home.

   During the mini-grant period, the Children's Beach House program encountered a multitude of distinctive situations that had a substantial impact on under-resourced families with children having special healthcare needs. The target participants serviced under the grant award resided across the state of Delaware, in Sussex, Kent, and New Castle counties. The demographic composition of this population was as follows:

- Gender: 30% male, 70% female
- Age Breakdown:
  - 5%-7 to 10 years old
  - 40%-11 to 13 years old
  - 55%-14 to 18 years old
- Race and Ethnicity Breakdown:
  - 20% mixed race
  - 40% African American
  - 20% Caucasian
  - 20% Hispanic

The program's objectives were as follows:

1. increase parents' understanding of their child's individual needs.
2. increase the ability to access resources and services to meet the needs of their child and family unit.
3. Children will increase their sense of belonging, in school at Children's Beach House and in the community.

A Likert scale, ranging from 1 to 4, was employed to gauge the outcomes. The results are as follows:

- The assessment revealed that 100% of parent-guardians reported a score of 3 or higher concerning their understanding of their child's individual needs, signifying a marked improvement from the previous year.
- Approximately 90% of parent-guardians reported a score of 3 or higher, indicating their enhanced capability to access resources and services for the welfare of their child and family unit.
- Among participants served under the FAMILY SHADE mini-grant, 50% reported a score of 3 or higher concerning their sense of belonging, within their educational institution, the Children's Beach House, and the community.

During the assessment analysis, participants supplied qualitative data explaining the lower scores on the sense of belonging scale. The participants highlighted the challenge of facing isolation within educational and community settings due to their disabilities. Furthermore, participants conveyed that they did not frequently perceive themselves as integral to the group or community. Nevertheless, they emphasized the development of their social aptitude and self-confidence through their engagement in the camp program. Parent guardians, moreover, emphasized the valuable insights they had gained regarding their children's needs and the resources available to support them, because of the diligent efforts of the family engagement coordinators.

The program achieved notable healthcare-related outcomes:

- By the close of the grant period, 100% of the children were successfully connected to a medical home.
- All children secured adequate health care coverage by the grant's conclusion.
- The program conducted a total of 100 contacts with primary care providers.

The program activities also focused on addressing the social-emotional developmental goals of participants by providing exposure and experience in a variety of confidence-building activities, including arts and crafts, swimming, boating, theater, and physical activities.

Utilizing an asset-based framework, we enhanced the protective factors for both the participants and their families. This was achieved through partnerships with primary care providers, collaboration with schools, and other community organizations. These collaborations allowed us to establish coordinated care plans for those in greatest need.

3. Teach Zen – Implement the One Love, One Heart Curriculum with at-risk children of low-income families who were enrolled in an early childcare program who receive 50% funding from Purchase of Care. The program succeeded in exposing young children with special health care needs between the ages of 3 to 5 who were enrolled in a childcare program to Social Emotional Learning and self-regulation techniques to improve their overall emotional wellbeing. A One Love, One Heart Curriculum Instructor visited each classroom for a total of 20-30 minutes (developmentally appropriate amount of time) to implement the day's activities. This project aligned with NPM 6. - Developmental Screening. The program was12 weeks in length and covered the following topic areas:
    - Kindness and Compassion
    - Discovering the Benefits of using our Breathing to calm Ourselves
    - Handling Emotions/Various Self-Regulation Techniques
    - Positive Self Image
    - Sharing/Social Engagement (Games)
    - Cultural songs and community drumming

Teach Zen (TZ) provided programs at 5 Centers in New Castle County, 1 in zip code 19801 and 4 in zip code 19805. With 12 sessions and 3 classrooms per center, a total of 180 classroom sessions occurred in the course of the program. The total number of educators reached at the five Centers is 15 (3 per Center); the total number of youth participating is 156 (varies slightly week to week). TZ's work at the Centers does not involve contact with the families; it is part of the Day Care curriculum, and parents are not present during TZ sessions. TZ worked with state and census data to estimate the number of Day Care programs and places in these zip codes to develop an estimate of Day Care youth reached. **Teach Zen** has put together a nice questionnaire for staff, which was completed in September of 2023. The results were used in the final summary which and will be germane to see if staff training of staff will lead to a longer term impact beyond **Teach Zen'**s direct contact in this limited mini-grant. This will speak to sustainability and support new efforts to introduce the program at other Day Cares. In August, Teach Zen was featured on DETV Channel 28 The Family SHADE Mini grant opportunity made it possible to impact the 5 centers in the New Castle County geographic area. This will speak to sustainability and support new efforts to introduce the program at other Day Cares. In August, Teach Zen was featured on DETV Channel 28 https://youtu.be/fMFyRuhfVkE and in an article: https://detvch.com/zen-teachings-efficacy-explored-teach-zen-inc-and-kyma-fulgences-impact-in-delaware/In.

The Table below summarizes cumulative activities.

Project Teach Zen	Sessions completed through August 3+	Staff being trained # unduplicated	Children being impacted weekly (approx.)*	Gender and ethnicity	% Purchase of Care and CYSHCN
Hilltop 19805	**12: 5/9, 5/16, 5/23, 5/30, 6/6, 6/13, 6/20, 6/27, 7/11, 7/18, 8/1, 8/8. Three classrooms at each session**	**3: class 1, 3 years class 2, 2-3 years class 3, 4-5 years**	**40: class 1, 17 class 2, 8 class 3, 15**	**class 1: F-11, M-6 B-16, H-1 class 2: F-4, M-4 B-8 class 3: F-9, M-6 B-14, H-1**	**100% POC youth 20% CYSHCN**
Leap of Faith 19805	**10: 6/22, 6/29, 7/6, 7/20, 7/27, 8/3, 8/10, 8/17, 8/24, 8/31. Three classrooms at each session**	**3: class 1, 2-3 years class 2, 4-5 years class 3, 3-4 years**	**39: class 1, 13 class 2, 13 class 3, 13**	**class 1: F-8, M-5 B-13 class 2: F-5, M-8 B-12, H-1 class 3: F=7, M=6 B-13**	**100% POC youth 15% CYSHCN**
Ministry of	**12: 5/24, 5/31,**	**3: class 1, 2-3**	**19: class 1,**	**class 1: F-3,**	**100% POC**

Caring 19805	**6/14, 6/21, 6/28, 7/5, 7/19, 8/2, 8/9, 8/16, 8/23, 8/30. Three classrooms at each session**	**years** **class 2, 3-4 years** **class 3, 4-5 years**	**5** **class 2, 6** **class 3, 8**	**M-2 B-5** **class 2: F-3, M-3 B-6** **class 3: F-4, M-4 B-4**	**youth 15% CYSHCN**
Guardian Angels 19801	**10: 5/22, 6/12, 6/26, 7/10, 7/17, 7/24, 7/31, 8/14, 8/21, 8/28. Three classrooms at each session**	**3: class 1, 2-3 years** **class 2, 3-4 years** **class 3, 4-5 years**	**26: class 1, 6** **class 2, 9** **class 3, 11**	**class 1: F-2, M-4 B-6** **class 2: F-3, M-6 B-9** **class 3: F-5, M-6 B-10, H-1**	**100% POC youth 10% CYSHCN**
Tender Care 19805	**12: 6/15, 6/22, 6/29, 7/6, 7/13, 7/20, 7/27, 8/3, 8/10, 8/17, 8/24, 8/31. Three classrooms at each session.**	**3: class 1, 2-3 years** **class 2, 3-4 years** **class 3, 4-5 years**	**26: class 1, 8** **class 2, 10** **class 3, 8**	**class 1: F-4, M-4 B-8** **class 2: F-4, M-6 B-10** **class 3: F-7, M-1 B-8**	**100% POC 15% CYSHCN**

+Weekly sessions not always every week due to holidays, scheduling. *weekly attendance varies slightly.

Post-program survey results from Teach Zen's mini-grant day care program were as follows:

Three classes from each of five-daycare programs participated in the "One Love, One Heart" Program carried out by Teach Zen as part of their SHADE mini grant program in 2023. The fifteen lead teachers, one in each of these classrooms completed a post–program survey, a 100% participation rate. When asked "How likely would you recommend the *One Love, One Heart Program* to another classroom or school?" 14 of the teachers responded, "extremely likely" (one teacher did not respond). And the same 14 reported they would want to have the program continue in all the classrooms at their school (the one teacher said 'maybe"). All the comments were enthusiastically positive except for the one teacher who suggested they should bring more instruments next time. Teachers reported that students liked the dancing, singing, playing instruments, and interacting with each other. And teachers reported what they liked the most were the exposure to different instruments, the breathing exercises, and the focus on learning to manage feelings. Finally, and most importantly, every one of the 15 teachers reported there were one or more parts of the curricula that they were continuing to use in their class. It appears the program was well received and that elements are being incorporated into the classes' ongoing activities.

4. Tomaro's C.H.A.N.G.E. (Creating Healing Answers, & Necessary Guidance for Excellence)

Tomaro's C.H.A.N.G.E. decided to continue their efforts with the support of Parent Information Center (PIC) to implement their project in year 2 since they were not able to get their project implemented in year 1.

Tomaro's CHANGE 2023 mini-grant program was a small group approach for providing holistic therapeutic care directly to youth and adolescents and indirectly to families, particularly those at risk or with special health care needs. This was accomplished through a multi-session YES to Mindfulness Program developed by Tomaro Pilgrim. The Program provided a holistic approach to aid elementary and middle school age youth in managing their emotions and behaviors utilizing meditation and mindfulness techniques. Mindfulness and meditation offer a valuable and empowering tool to improve youth and adolescents' psychosocial-mental wellbeing, physical health, cognitive ability, resilience, and school performance.

Yes to Mindfullness was originally planned to be a program addition for ongoing therapy clients of Tomaro's Change, but the timing and access proved not conducive to working with current clients. Consequently, the program was delayed and reformatted as a stand-alone 4-weekly sessions service for after school and evening youth at libraries and community centers. The new approach began in April 2023 with weekly sessions at the Route 9 New Castle County Library. Youth and adolescent participants attended the Yes to Mindfulness Program once a week for a series of four weekly 60–90-minute sessions, where they were taught basic techniques of mindfulness and meditation to help manage their emotions and behaviors. The short-term goal of the program is improved behavior and mental state, with a long-term goal of ultimately being more healthy and productive adults.

In 2023, Tomaro's Change provided services to six cohorts of youth: one in April-May, two in June, and one each in July, August, and September. A total of 50 youth participated with cohorts ranging in size from 6 to 11. Two-thirds of participants were female and one-third male; 23% were White and 77% Black. Although it was not explicitly asked, based on the center registration records and facilitator's observations, it is estimated that about 70% qualified for purchase of care and about 54% had special health care needs. Many were reported to be on ADHD medications. Having a medical home/physician was only asked of the first 3 cohorts, but in those 3, 86% of youth had a family physician or medical service. The Mini-grant program was delivered at the Claymont Community Center (1), the New Castle Public Library (1), and the Rte. 9 Library going into Wilmington (4).

Qualitative observations reported by the program deliverers reveal positive results, particularly from the parents and caregivers of the youth participants. Caregivers reported their youth looked forward to participating and to interacting with other youth in the activities. A particular case was a youth who had been diagnosed with suicidal ideation. The grandmother brings the child. The mother will not seek mental health assistance for the child, and the grandmother arranges to provide childcare so she can bring the child to the sessions, which the child enjoys and for which the grandmother is grateful. As to the students' reactions, they reported enjoying the mindfulness techniques, the group sharing activities, the safe space to talk, and the snack at the end of the session.

The 4 organizations that were awarded: Down Syndrome Association of Delaware, Children's Beach House, Teach Zen and the returning applicant Tomaro's CHANGE developed skills that will further sustain their projects after the funding has ended. These organizations enhanced their skills so that they can compete and apply for future grant opportunities to grow their efforts in serving CYSHCN. Below are tools that these organizations developed while working with CYSHCN:

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

The Parent Information Center will take the lessons learned from the second year of the mini-grant program and

enhance the program in year 3 (2024-2025) 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 the National Performance Measures (NPM) Medical Home. There will be a planned approach to engage family and community partnerships while executing health equity every step of the way through the process. Delaware will work in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health programs in the execution of the CYSHCN Blueprint for Change. 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 PIC team members executing the Family SHADE project, the CYSHCN Director, will review the NPMs below and align their data collection tools and their projects to mirror their projects initiatives with the Maternal Child Health Title V NPMs listed below:

- Performance Measure 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.

Parent Information Center (PIC) 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-test 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 (SHCN), and the number of times attended and if parent/guardian was present.

Parent Information Center (PIC) utilized 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 CYSHCN population. PIC was able to recruit 11 FLN members that served as collaborative leaders who contributed feedback on their experiences on service delivery to Parent Information Center (PIC) and to the 4 mini-grantees which served CYSHCN and their families. This network continued to consist of parents/guardians of children birth to age 26 that had a suspected or diagnosed disability. The network membership included trainings, monthly learning community sessions, support with Individual Education Plans (IEPs), and referrals. They attended Family SHADE Learning Communities and served as a resource, support, and mentor through their knowledge gained for other families that were navigating the system of care for CYSHCN. The FLN members shared their experiences with other families in navigating and understanding the Medical Home Model of Care through their Pediatrician/Primary Care Physician and other specialists. FLN members received a monthly stipend for attendance and participation as long as Parent Information Center (PIC) had the monetary resources available for this network.

The Family Leadership Network proved to be a challenge to organize in 2023. Plans called for Quarterly FLN meetings, and these usually occurred in conjunction with Learning Community Forums. This was done to have the Learning Community sessions serve as a training mechanism for the FLN members. The Target for the calendar

year 2023 was to recruit 15 active Family leaders from the community but only succeeded at recruiting 11 FLN members. The FLN members met quarterly throughout the calendar year. There were no Learning Community's held in January, instead in quarter 1 (Q1) the FLN group meeting was held on January 10th. Topics requested by FLN members were gathered during the meeting for planning the agenda for meetings throughout the year. The plans called for FLN training on the 1st Monday of the month and a scheduled Learning Community activity on the following Tuesday. This process was generally followed during the year with some time rescheduled for conflicts. On March 24, 2023 Transition Symposium was held in Dover DE on 3/24/2023 – Topic was Medical and Educational Transitions for Young People in Delaware, with an FLN component focused on Developmental Screening. Not counting PIC staff, there were 30 participants. This was the most widely attended FLN event of 2023. Parent Information Center team met with FLN members for the 2nd quarterly meeting (Q2) in April to discuss increasing FLN size, adding more training topics requested by FLN members, and shared survey results with FLN members. Also, they discussed ways to increase capacity of FLN members. On 4/11/2023 conducted a Learning Community around Medical Home and in conjunction with the Managed Care Organization Call/Zoom (MCO) meeting, provided support information with the Family Hope Coalition (formerly known as Mid-Atlantic Orphan Care Coalition (MAOCC)). All 8 FLN families involved reported gaining knowledge from the effort. Later in the year the New Castle County Police Department Mental Health Unit led a Learning Community meeting on 5/16/2023 in which 11 FLN families participated. On June 6, 2023 three FLN families participated with a focus on genetics issues and this was associated with the larger Learning Communities meeting on the same day with 18 participants. On August 7, 2023 the FLN Quarterly meeting conducted in association with the MCO meeting and Learning Community meetings the following day, 2 FLN families participated. This was the final FLN quarterly meeting for the year. On August 23, 2023 their was a Learning community where 14 participants attended on Mental and Behavioral Health Services for families for CYSHCN. Although the FLN did not reach their goal of 15 recruited FLN members they continue to try and engage families through recruitment activities such as attending health fairs and networking with other agencies serving CYSHCN.

Family SHADE Symposium:

The Family SHADE Project held quarterly symposiums which provided the CYSHCN community with the opportunity to engage in Maternal Child Health (MCH) Title V services provided to CYSHCN and their families. Some of the Symposium topics were revisited from the prior year. 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

The 2nd Annual Family SHADE Summit was postponed to calendar year 2024 due to not being able to secure a location in a timely manner. Parent Information Center will plan to hold the Summit in the Fall of 2024. The summit will provide the CYSHCN community with the opportunity to engage in Maternal Child Health (MCH) Title V services provided to CYSHCN and their families. The summit 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. There will also be a presentation by the mini-grantees that have been awarded in year two and three, 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.

It will also be an opportunity for the Family Leadership Network (FLN) 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.

- 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.

Managed Care Organization (MCO) Calls:
Maternal Child Health (MCH) supported the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish and English as these calls have continued to be a wanted resource. Parent Information Center (PIC) overseen the Family Voices program and they scheduled these forums where parents/caregivers asked questions and discussed issues they were having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). Common Issues discussed included: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations helped problem solve. These calls were beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they had for their children. Also, any organization, provider or state agency with questions could listen and learn. Family members can meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help. These meetings occurred approximately monthly with some months not meeting when other large annual meetings and symposia occurred. Seven meetings were conducted during Calendar Year 2023. Because of the nature of confidentiality promised to participants, it is not possible to report on specific questions covered monthly. However, the range of service areas present monthly and the length of the meetings give some sense of the breath of areas covered and accessible to parents and families.

Data on CYSHCN Families and State and community organizations attending the Zoom MCO Calls in calendar year 2023:

January 10, 2023: There were 19 named participants and 4 identifiable just by a phone number. The meeting lasted 91 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Nemours Health Services, Easter Seals, Autism Delaware, Delaware Family Voices, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

February 14, 2023: There were 20 named participants and 3 identifiable just by a phone number. The meeting lasted 61 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

March 14, 2023: There were 37 named participants and 4 identifiable just by a phone number. The meeting lasted

86 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Autism Delaware, Delaware Family Voices, Legal Aid, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

April 11, 2023: There were 19 named participants and 3 identifiable just by a phone number. The meeting lasted 72 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Autism Delaware, Delaware Family Voices, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

May 9, 2023: There were 18 named participants and 2 identifiable just by a phone number. The meeting lasted 41 minutes. Besides family participants, there was representation by PIC, Highmark, Ameri-Health, Delaware First Health, Legal Aid, Sunny Days, Division of Medicaid and Medical Assistance.

June 13, 2023: There were 15 named participants and 1 identifiable just by a phone number. The meeting lasted 31 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, Delaware Early Learning, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

August 8, 2023: There were 23 named participants and 1 identifiable just by a phone contact. The meeting lasted 69 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, Autism Delaware, Division of Medicaid and Medical Assistance, Maternal and Child Health Bureau, Division of Developmental Disability Services.

September 12, 2023: There were 22 named participants and 3 identifiable just by a phone contact. The meeting lasted 64 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, Delaware First Health, JEVS Human Services, Autism Delaware, Children's Charity, Center for Disability Studies, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

October 10, 2023: There were 18 named participants and 1 identifiable just by a phone contact. The meeting lasted 38 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, Legal Aid, JEVS Human Services, Children's Charity, A Better Chance for Our Children, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

November 14, 2023: There were 25 named participants. The meeting lasted 77 minutes. Besides family participants, there was representation by PIC, Highmark, AmeriHealth, Delaware Family Voices, JEVS Human Services, Autism Delaware, Delaware First Health, Maternal and Child Health Bureau, Division of Medicaid and Medical Assistance, Division of Developmental Disability Services.

To participate in the Managed Care Organization (MCO) calls/zoom meetings, registration can be done through the PIC website at www.picofdel.org/events or call the office at 302-999-7394.

Part C Birth to Three

The Delaware Department of Health and Social Services (DHSS) serves as the lead department for the Division of Public Health (DPH). The Part C of Individuals with Disabilities Education Act (IDEA) program and the Family Health Systems program falls under the Division of Public Health (DPH). Birth to Three Early Intervention program, holds the responsibility for assuring and implementing all components of the statewide system in compliance with policies under Part C IDEA. The Family Health System is where the Maternal Child Health Title V program and the Early

Hearing Detection and Intervention (EHDI) Program resides. Family Health System's EHDI program and Birth to Three program have worked closely together in serving infants ages 0-3 years of age providing statewide, comprehensive, coordinated, multidisciplinary, interagency system of care that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. Our EHDI program referred infants and toddlers' birth to three years of age who receive a diagnosis of Deaf or Hard of Hearing (D/HH) to the Birth to Three program once diagnosed with hearing loss at our Nemours Children's Hospital sole diagnostic audiology department in the state of Delaware. Our EHDI Coordinator, EHDI Follow-Up Coordinator and Children and Youth with/Special Health Care Needs (CYSHCN) Director has worked closely with Birth to Three Early Intervention and Nemours Children's Hospital. The EHDI team has refered infants' ages 0-3 years of age to the Birth to Three program, once their diagnosed. The process consisted of the Nemours Audiology team informing the family that the state of Delaware Division of Public Health EHDI program will be made aware of the diagnosis and the EHDI program will make a referral to the Birth to Three Part C program so that the family can have the option of receiving services for their newly diagnosed child. The family is also made aware that a referral will be sent to the Hands and Voices Guide by Your side Program and to the Statewide Programs for the Deaf/Hard of Hearing (D/HH), and Deaf-Blind Mentorship program. The EHDI Coordinator received quarterly excel reports from the Birth to Three coordinator for each county throughout the year which provides data on the families that accepted the early intervention services and the number of families that completed a signed Individualized Family Service Plan (IFSP) from the Birth to Three Program. Our EHDI Coordinator compiled the data and reported this data annually to the Centers for Disease Control (CDC) and Prevention, Hearing Screening & Follow-up Survey (HSFS). The most current data gathered is as follows:
In 2021 of the 11,050 total occurrent births, 10,780 infants were screened. Of those screened there were 10,540 infants that passed and a total of 240 did not pass. Of those that did not pass there were a total of 5 with no hearing loss and a total of 17 with Permanent hearing loss. Part C Birth to Three reported that all 17 referrals received enrolled in the Birth to Three program. Also, there were 11 families that signed their Individualized Family Service Plan (IFSP) after 6 months of age. These 17 families were referred to Hands & Voices Guide by Your Side where 8 out of the 17 D/HH diagnosed 0-3 infants accepted services. These families were also referred to the Statewide Programs for the Deaf, Harf of Hearing, and Deaf-Blind Mentorship program. Of the 17 diagnosed infants 5 families accepted services from the mentorship program.

The mission of Delaware's Birth to Three Early Intervention Program is to enhance the development of infants and toddlers with disabilities and/or developmental delays, and to enhance the capacity of their families to meet the special needs of these young children. This mission has been adopted by both the Interagency Coordinating Council (ICC) and DHSS.
Guiding principles include:

- Family-centered focus - Delaware is committed to strengthening and supporting families, sensitivity to the family's right to privacy, and respect for multicultural preferences. As the primary influence in the child's life, and the most valuable source of information about the needs of the child and family, family members are key participants in each step of early intervention design and delivery. A critical function of early intervention service providers should be to enhance and build the confidence and competency of the family so that the family can support their child's development throughout the day as natural learning opportunities occur.
- Integration of services - The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services and supports should be planned, using a collaborative, multidisciplinary, interagency approach. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.
- Universal application - Families of infants and toddlers with disabilities in all areas of

the state should receive comprehensive, multidisciplinary assessments of their young children, ages birth through two years, and have access to all necessary early intervention services and supports.
- Cost effectiveness - The system maximizes the use of third-party payment and avoids duplication of effort. Initial evaluation for eligibility and service coordination are provided at no cost to the family. Delaware has instituted a System of Payments policy to ensure financial sustainability of the program.
- High quality services - Service should be provided at the highest standards of quality with early intervention service providers being required to meet appropriate licensing and credentialing guidelines.

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

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

Department of Services for Children, Youth, and Their Families (DSCYF). Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the Division of Public Health (DPH). Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and aftercare. The Department of Services for Children, Youth, and Their Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with

the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training, and support to many daycare providers throughout the state, and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

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

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

Bureau of Oral Health and Dental Services and Family SHADE project:
Family SHADE promoted the Bureau of Oral Health and Dental Services (BOHDS) and expanded their reach to the CYSHCN population by putting the BOHDS information on the Division of Public Health Family SHADE website www.DEthrives.org . This afforded families easy access to Dentist that were able to serve CYSHCN. Having the BOHDS information on the Family SHADE website made it more convenient for families to access the dentist that best served CYSHCN and eliminated them from calling each dentist to ask if they can serve their child. It improved access to Dental Care for Delawareans with Disabilities and helped the dental workforce provide more effective and culturally competent care to patients with disabilities. Through outreach, information dissemination, and education made available to pediatricians and dental practitioners, this collaborative educated practitioners on best practices on serving the CYSHCN population. A Tool Kit is still an idea that we are working toward implementing through this collaborative initiative. Family SHADE Project will revisit the idea of a Tool Kit for Delaware's Dental Workforce. The implementation of a Toolkit for practitioners which would include a Tool Kit of resources such as a assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

COVID Response and Support:
In March of 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. Ms. Yvonne Bunch was hired to assure that a COVID response plan was in place with the mini-grantees that received awards in calendar year 2023. Ms. Bunch is a retired merit state of Delaware employee from the Department of Services for Children, Youth, and their Families (DSCYF) with specialty of working with vendors serving youth throughout the state of Delaware. Her expertise makes her a good match to providing oversight to the awardees of the mini-grants. She has provided on going education and technical assistance to the grantees. As we move forward, the 4 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.

In collaboration with the National Family to Family Network, Parent Information Center joined an alliance of Family-to-Family Health Information Centers to provide outreach, education and support to children and youth with special healthcare needs and their families. Our COVID Outreach Project provides information, education, and support about COVID vaccines to youth ages 12-15 and their families. The Covid Vaccine Outreach project can be accessed by contacting Ms. Jennifer Aaron, Outreach Coordinator, at 302-999-7394 or jaaron@picofdel.org

The Title V CYSHCN Director continues to work in collaboration with Delaware Family Voices in establishing a Collaborative Action Team Process: Diverse Family Engagement & Leadership. The State Collaborative Action Team Process included our Division of Public Health Maternal Child Health CYSHCN Director and Family Voices parent lead organization. We worked together to develop a plan to enhance diverse family engagement and family professional partnerships at the individual, program, and policy level. Through the technical support from the National Family Voices Leadership in Family and Professional Partnerships (LFPP) we established a draft Strategic Plan that included sustainability and the start of the collaborative. Family Voices has reconvened the Delaware Family to Family Health Information Center (F2F HIC) initiative. Delaware's Family Delegate Ms. Meedra Surratte is leading this initiative in promoting optimal health for children and youth with special health care needs (CYSHCN) and access to an effective health delivery system that is family centered. Our Family Delegate is actively working with the National Family Voices Network of Family to Family Health.

Delaware's Developmental Disabilities Council:
Delaware's Director of Children and Youth with Special Health Care Needs (CYSHCN) is a governor appointed member to the Delaware Developmental Disabilities Council (DDC). The CYSHCN director served as a Personnel Committee member and as an instrumental contributor to the Delaware Developmental Disabilities Council's 5 Year Strategic Plan 2022-2026. The Administration for Community Living (ACL) under the US Department of Health and Social Services approves our 5 Year Strategic Plan. 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).

The Developmental Disabilities Council began working in the Fall of 2023 on developing trainings for healthcare service providers to better serve persons with disabilities for whom English is not their first language, as well as the community to know their rights. Throughout the Fall of 2023 and going into the Spring of 2024, the Council has gathered information from individuals with disabilities and professionals in the community regarding barriers to individuals with disabilities who are unable to access health care services due to language barriers. This training program will highlight barriers identified and best practices moving forward to help remove barriers that are currently keeping some individuals from accessing services they so desperately need. It will also share resources, so individuals are aware of their rights to receiving home and community based services for all individuals with special health care needs.

Children with Special Health Care Needs - Application Year

Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 45,845. According to the 2021-2022 National Survey of Children's Health (NSCH), 40.2% of (Pop. Estimate 18,442) Delaware CYSHCN have a medical home in comparison to the (Pop. Estimate 5,933,047) nationwide CYSHCN average of 40.7%. This is data on CYSHCN between the ages of 0 through 17 with a medical home. 59.8% of CYSHCN (Pop. Estimate 27,403) in Delaware do not have a medical home in comparison to the (Pop. Estimate 8,650,282) nationwide CYSHCN average of 59.3%. Among the sub-group of children with special health care needs that have a medical home, 42.3% (Pop. Estimate 18,319) of Delaware CYSHCN were insured at the time of the NSCH survey in comparison to the nationwide to the (Pop. Estimate 5,773,784) nationwide CYSHCN average of 41.6%. Through the Maternal Child Health Title V Block Grant, Delaware will continue to actively work with partnering state and community contracted agencies to assure that all CYSHCN have a medical home and are adequately insured through statewide initiatives with grantees that serve CYSHCN.

Family SHADE

In FY 2024-2025 Delaware will continue to 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 Children and Youth with Special Health Care Needs (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. Parent Information Center (PIC) will capture data from the mini-grantees impact on the CYSHCN and their families to measure outcomes on medical home and CYSHCN adequately insured through the services rendered in the second year. PIC will work toward growing their Family Leadership Network (FLN) memberships. This network of parents/guardians of children birth to 26 that have a special health care need. The network membership will continue to provide 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. 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 (NPM) as well as topics addressing gaps in service and identify needs that are impacting families of CYSHCN. Through these initiatives, the Family SHADE project will contribute to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations, and a coalition located in one of our 3 counties (Sussex County), with a focus on innovative strategies and improving the Title V national performance measures and support the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC will continue to routinely take surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

Crosswalk of Maternal Child Health Block Grant 6 Core Indicators and the Blueprint for Change

The Director of CYSHCN along with the Parent Information Center -Family SHADE project team will begin to strategize with our MCH Title V team to make sure that we are touching on all 6 core indicators and health equity, quality of life and well-being, access to services and financing of services. We will align the current work and priorities that we are doing to serve CYSHCN and their families and improve where we would like to improve the system with and address the needs that have been identified in our needs assessment. This approach will allow us in measuring how well the state system is functioning based on the state data that we have received and how we compare to the national data. This approach will assist and guide our Title V programs in aligning current work and priorities with the Blueprint for Change: Guiding principles for a system of Services for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. This table below is a starting point for our state to identify where the state is and where we want to go in improving the system of services for CYSHCN. This approach will allow us to do a crosswalk in the Title V needs assessment and assist in reporting future Block Grant application related to Blueprint activities.

MCH Title V Block Grant Title V Delaware data and population in comparison to the national data and nationwide population. This information will provide the baseline and a starting point as we begin to move forward to develop our task and activities to implement our work, priorities, in alignment with the Blueprint for Change. This foundation will allow us to see where we are now in serving CYSHCN and where we want to move toward making a change across all domains within Delaware's Maternal Child Health Title V delivery of service.
Information below from: National Survey of Children's Health - Data Resource Center for Child and Adolescent Health (childhealthdata.org)

Measure	Delaware Data	Delaware Pop. Est.	National Data	Nationwide Pop. Est.
Well -Functioning System of Care	59.3% of CSHCN who received needed care coordination. 40.7% CSHCN Who did not receive needed care coordination.	35,707	55.6%CSHCN who received needed care coordination. 44.4% CSHCN who did not receive needed care coordination.	10,719,154
Family-centered care	83.6%CSHCN who receive family centered care 16.4% CSHCN who do not have family centered care	42,858	82.2 CSHCN Who have family centered care. 17.8% CSHCN who do not have family centered care	13,026,534
Medical Home (0-17)	44.2% Have a medical home 55.8% Do not have a medical home	206,169	46.1% Have a medical home 53.9% Do not have a medical home	72,882,036
Early and Continuous Screening	34.3% of children ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year. 65.7% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	25,117	33.7% of children ages 9 through 35 months, who received a developmental screening using a parent - completed screening tool in the past year. 66.3% of children ages 9 through 35 months who do not receive a developmental screening using a parent-completed screening tool in the past year.	8,270,177
Adequate & Continuous Insurance	44.7-52.4	70,540	28.1-39.9	24,796,006
Access to Community-Based Services	Data on access to community -based services was not captured on the NSCH Interactive Data Query 2022-present -Data Resource Center for Child And Adolescent Health. Delaware will begin to collect this data in calendar year 2025.			
Health Care Transition to adult health care, adolescents with special health care needs, age 12-17	CYSHCN Received services to prepare for transition 17.3% CYSHCN who did not receive services to prepare for transition 82.7%	22,956	CYSHCN who received services to prepare for transition 22.1% CYSHCN who did not receive services to prepare for transition 77.9%	6,918,810

Delaware will develop a crosswalk through our MCH Title V Block Grant and develop an alignment with the Blueprint for Change for CYSHCN. The 6 Core Indicators will be implemented throughout the domains and national performance measures in the delivery of service. Information from: https://downloads.aap.org/AAP/PDF/Blueprint_Crosswalk_FINAL_2023.pdf

and A Blueprint for Change: Guiding Principles for a System of Services for Children and Youth With Special Health Care Needs and Their Families | Pediatrics | American Academy of Pediatrics (aap.org)

	CORE INDICATOR#1 Children and youth are screened early and continuously	CORE INDICATOR#2 receive a medical home model of care that is patient-centered, coordinated, comprehensive, and ongoing	CORE INDICATOR#3 Community-based services are organized so families can use them easily	CORE INDICATOR#4 CYSHCN receive services necessary to make transitions to adult life, including healthcare	CORE INDICATOR#5 Families have adequate insurance and funding to pay for services they need	CORE INDICATOR#6 Families of CYSHCN Are partners in decision-making at all levels of care from direct care to the organizations that serve them
Health Equity	Healthy People 2030 defines healthy equity as "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Addressing poverty, damaging living conditions, and access to health and social services will mitigate adverse health effects. The principles and strategies will seamlessly acknowledge that poverty, discrimination, and their downstream consequences cause health inequities. Delaware will implement a crosswalk across our national performance measures which are: Well-women visit, Breastfeeding, Developmental Screening, Dental Visit (child/adolescent), physical activity (ages 12-17), Adolescent Well-visit, Adequate insurance, and workforce development.					
Quality of life & well-being	Historically, health care does not include a proactive focus on patient and family well-being and quality of life. Yet, studies have shown that parents and families of CYSHCN often experience disruptions to family life, social isolation, and chronic stress, and have significant and diverse psychosocial support needs. Data reveal that "CYSHCN and their families are at risk for adverse outcomes in economic, academic, and social emotional domains, in addition to physical health. Moreover, racial and ethnic disparities in access to opportunities and supports exacerbate the inequities that CYSHCN and their families experience.' Historically, the health system focused on measuring health outcomes, not necessarily metrics meaningful to families. These metrics should be developed in partnership with Families and can include the wellbeing and quality of life of the child from birth through adulthood, wellbeing of the family unit, and the ability to achieve dignity, autonomy and independence.					
Access to services	Access to services and supports is defined broadly and includes the 4 components of access to health care: coverage, services; timeliness; and a capable, qualified, and culturally competent workforce. This concept includes all social services necessary for CYSHCN and families to have full, thriving lives, including but not limited to education, early intervention, child welfare, foster care, health, and community-based supports. This critical area recognizes the educational system as an entry point and major deliverer of services for children and families. The ideal system is integrated across all sectors and anticipates families' needs. It aligns the delivery, payment, and administration of services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.					
Financing of service	Addressing health equity, well-being, quality of life, and access to care requires an adequately financed system of services. This includes both the overall systems of financing, including insurance design and organization of programs, as well as specific models and mechanisms for payment and eligibility. It supports models that improve quality and value, and recognize outcomes meaningful to stakeholders, including families, providers, and payers. Although the following principles and strategies focus on health care and related services, including care coordination, which is necessary in a system that is not fully integrated, CYSHCNC also may require an array of additional social services and educational supports.					

Family SHADE Mini-Grant program

In January of 2025 Parent Information Center (PIC) will review the data of the 3 mini-grantee awardees (Teach Zen, Children's Beach House and Down Syndrome Assoc. of Delaware). We will do a crosswalk of the National Performance Measures we impacted Their memorandum of understanding will end on November 30, 2024, and we will review the data and determine the impact cohort 2 of the Family SHADE mini-grants have made through these 3 community agencies. We will begin to implement phase 4 of implementing the third 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 pm & 6:00 pm	Required Zoom Information Session for Interested Applicants*
February 24, 2023, 5:00 pm	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 3 of the Family SHADE mini-grant program, PIC will plan to award a total of 1-4 organizations to implement the following services which align with the Maternal Child Health Title V National Performance Measures (NPMs) as well as align current work and priorities with the Blueprint for Change: Guiding Principles for a System of Services for Children and Youth with Special Health Care Needs (CYSHCN) and Their Families. The mini grantees which will be selected through a competitive request for proposal process. The mini-grantees from Cohort 2 -Down Syndrome Association of Delaware (DSADE), Children's Beach House (CBH) and Teach Zen will have an opportunity to compete for a second year if they choose too.

The 4 organizations that will be awarded will develop skills that will further sustain their projects after the funding has ended. These organizations will enhance their skills so that they can compete and apply for future grant opportunities to grow their efforts in serving CYSHCN. Below are tools that these organizations will develop while working with Parent Information Center Family SHADE Project serving CYSHCN:

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

The Parent Information Center will take the lessons learned from the second year of the mini-grant program and enhance the program in year 3 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 the National Performance Measures (NPM) Adequate Insurance and Medical Home. There will be a planned approach to engage family and community partnerships while executing health equity every step of the way through the process. Delaware will work in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health programs in the execution of the CYSHCN Blueprint for Change. 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 PIC team members executing the Family SHADE project, the CYSHCN Director, will review the NPMs below and align their data collection tools and their projects to mirror their projects initiatives with the Maternal Child Health Title V NPMs listed below:

- Performance Measure Developmental Screening
  Percent of children, ages 9 through 35 months, who received developmentally appropriate services in a well-coordinated early childhood system.
- Performance Measure Access to Medical Home
  Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
- Performance Measure 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 Adequate Insurance Percent of children, ages 0 through 17, who are continuously and adequately insured.

Parent Information Center (PIC) will continue to 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-test 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 (SHCN), and the number of times attended and if parent/guardian was present.

Parent Information Center (PIC) will continue to utilize the Family Leadership Network (FLN) members in collaboration with all of the mini-grantees to promote inclusion and receive feedback on where there are gaps in service delivery for CYSHCN population. PIC will work toward recruiting 15 FLN members that will serve as collaborative leaders who contribute feedback on their experiences on service delivery to Parent Information Center (PIC) and to the 4 mini-grantees which will serve CYSHCN and their families. This network will continue to consist of parents/guardians of children birth to age 26 that have a suspected or diagnosed disability. The FLN network membership includes trainings, monthly learning community sessions, support with Individual Education Plans (IEPs), and referrals. They will attend Family SHADE Learning Communities and serve as a resource, support, and mentor through their knowledge gained for other families that are navigating the system of care for CYSHCN. The FLN members will share their experiences with other families in navigating and understanding the Medical Home Model of Care through their Pediatrician/Primary Care Physician and other specialists. FLN members will receive a monthly stipend for attendance and participation as long as Parent Information Center (PIC) has the monetary resources available for this FLN network.

The quarterly FLN meetings, align in conjunction with Learning Community Forums. This will be done to have the Learning Community sessions serve as a training mechanism for the FLN members. The Target for the calendar year 2025 is to recruit 15 active Family leaders from the community but to date they have only succeeded at recruiting 11 FLN members. The FLN members will continue to meet quarterly throughout the calendar year.

Family SHADE Symposium:
The Family SHADE Project will hold quarterly symposiums which provide the CYSHCN community with the opportunity to engage in Maternal Child Health (MCH) Title V services provided to CYSHCN and their families. Some of the Symposium topics will be revisited from the prior year. 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

3rd Annual Family SHADE Summit
Parent Information Center will plan to hold the Summit in the Fall of 2025. The summit will provide the CYSHCN community with the opportunity to engage in Maternal Child Health (MCH) Title V services will be provided to CYSHCN and their families. The summit 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. There will also be a presentation by the mini-grantees that have been awarded in year two and three, which are: Down Syndrome Association, Children's Beach House, Teach Zen Inc. Tomaro's CHANGE.

It will also be an opportunity for the Family Leadership Network (FLN) to provide input on their life experiences to professionals serving CYSHCN. They will cover topics and services that align with the National Performance Measures Developmental Screening, Access to Medical Home, Transition to Adult Healthcare, Adequate Insurance.

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

Managed Care Organization (MCO) Calls:
Maternal Child Health (MCH) supported the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish

and English as these calls have continued to be a wanted resource. Parent Information Center (PIC) overseen the Family Voices program and they scheduled these forums where parents/caregivers asked questions and discussed issues they were having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). Common Issues discussed include: care coordination requests, In home care hours, Denials, Therapies, Private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations helped problem solve. These calls were beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they had for their children. Also, any organization, provider or state agency with questions could listen and learn. Family members can meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help. These meetings occurred approximately monthly with some months not meeting when other large annual meetings and symposia occurred. Seven meetings were conducted during Calendar Year 2023. Because of the nature of confidentiality promised to participants, it is not possible to report on specific questions covered monthly. However, the range of service areas present monthly and the length of the meetings give some sense of the breath of areas covered and accessible to parents and families. Also, any organization, provider or state agency with questions or calling to listen and learn. To participate in the MCO calls, registration can be done through the PIC website at www.picofdel.org/events or call the office at 302-999-7394.

Part C Birth to Three

The Delaware Department of Health and Social Services (DHSS) serves as the lead department for the Division of Public Health (DPH). The Part C of Individuals with Disabilities Education Act (IDEA) program and the Family Health Systems program falls under the Division of Public Health (DPH). Birth to Three Early Intervention program, holds the responsibility for assuring and implementing all components of the statewide system in compliance with policies under Part C IDEA. The Family Health System is where the Maternal Child Health Title V program and the Early Hearing Detection and Intervention (EHDI) Program resides. Family Health System's EHDI program and Birth to Three program have worked closely together in serving infants ages 0-3 years of age providing statewide, comprehensive, coordinated, multidisciplinary, interagency system of care that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. Our EHDI program refers infants and toddlers' birth to three years of age who receive a diagnosis of Deaf or Hard of Hearing (D/HH) to the Birth to Three program once diagnosed with hearing loss at our Nemours Children's Hospital sole diagnostic audiology department in the state of Delaware. Our EHDI Coordinator, EHDI Follow-Up Coordinator and Children and Youth with/Special Health Care Needs (CYSHCN) Director will continue to work closely with Birth to Three Early Intervention and Nemours Children's Hospital. The EHDI team will continue to refer infants' ages 0-3 years of age to the Birth to Three program, once their diagnosed. The process will continue to consist of the Nemours Audiology team informing the family that the state of Delaware Division of Public Health EHDI program will be made aware of the diagnosis and the EHDI program will make referrals to the Birth to Three Part C program so that the family can have the option of receiving services for their newly diagnosed child. The family will be made aware that a referral will be sent to the Hands and Voices Guide by Your side Program and to the Statewide Programs for the Deaf/Hard of Hearing (D/HH), and Deaf-Blind Mentorship program. The EHDI Coordinator will continue to receive quarterly excel reports from the Birth to Three coordinator for each county throughout the year which provides data on the families that accepted the early intervention services and the number of families that completed a signed Individualized Family Service Plan (IFSP) from the Birth to Three Program. Our EHDI Coordinator will continue to compile the data and report this data annually to the Centers for Disease Control (CDC) and Prevention, Hearing Screening & Follow-up Survey (HSFS).

Delaware's formerly known Child Development Watch has changed their name to Birth to Three. The mission of Delaware's Birth to Three Early Intervention Program is to enhance the development of infants and toddlers with disabilities and/or developmental delays, and to enhance the capacity of their families to meet the special needs of these young children. This mission has been adopted by both the Interagency Coordinating Council (ICC) and DHSS. The guiding principles include:

- Family-centered focus - Delaware is committed to strengthening and supporting families, sensitivity to the family's right to privacy, and respect for multicultural preferences. As the primary influence in the child's life, and the most valuable source of information about the needs of the child and family, family members are key participants in each step of early intervention design and delivery. A critical function of early intervention service providers should be to enhance and build the confidence and competency of the family so that the family can support their child's development throughout the day as natural learning opportunities occur.
- Integration of services - The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services and supports should be planned, using a collaborative, multidisciplinary, interagency approach. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.
- Universal application - Families of infants and toddlers with disabilities in all areas of the state should receive

comprehensive, multidisciplinary assessments of their young children, ages birth through two years, and have access to all necessary early intervention services and supports.

- Cost effectiveness - The system maximizes the use of third-party payment and avoids duplication of effort. Initial evaluation for eligibility and service coordination are provided at no cost to the family. Delaware has instituted a System of Payments policy to ensure financial sustainability of the program.
- High quality services - Service should be provided at the highest standards of quality with early intervention service providers being required to meet appropriate licensing and credentialing guidelines.

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

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

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

The Division of Public Health (DPH) has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Systems have participated on the vaccine committee, Early and Periodic Screening Diagnostic, and Treatment (EPSDT) implementation committee, and lead poisoning prevention committee. The AAP continues to be involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality. The Interagency Coordinating Council (ICC) continues to be active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide. In calendar year 2025, the ICC will continue to advise and assist the Department of Health and Social Services with implementation of the Birth to Three Early Intervention system and

other federal infants and toddlers' programs. Council members include parents, state agency personnel, private providers, insurance providers, legislators and professionals involved in personnel preparation. The ICC will continue to welcome parents of children birth to three to share their stories with the council. These partners will work on addressing the unmet needs in early childhood special education and early intervention programs for children with disabilities by assisting in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

Parent Information Center (PIC) implemented the Family Support Health Care DE Alliance (Family SHADE) project. Through the execution of the project, there is representation for Children and Youth w/Special Health Care Needs (CYSHCN) from the Family SHADE project who attends and serve as a member of the Sussex County Health Coalition. Through the Family SHADE project, PIC will maintain a partnership with organizations serving CYSHCN at the Sussex County Health Coalition. The Sussex County Health Coalition exists to engage the entire community in collaborative family-focused effort to improve the health of all children, youth and families in Sussex County, Delaware. They envision a community in which Delaware citizens and institutions (public, private, and not-for-profit) are actively engaged in community health promotion as a shared community good, and working together to create a cultural and physical environment which supports healthy lifestyles for our children and their families. Parent Information Center -Family SHADE project partners with Help Me Grow to identify ways to partner on early childhood, health and wellness, family outreach and community engagement activities.

Bureau of Oral Health and Dental Services and Family SHADE project:
Family SHADE promotes the Bureau of Oral Health and Dental Services (BOHDS) and will continue to expand their reach to the CYSHCN population by putting the BOHDS information on the Division of Public Health Family SHADE website www.DEthrives.org. This affords families easy access to Dentist that were able to serve CYSHCN. Having the BOHDS information on the Family SHADE website makes it more convenient for families to access the dentist that best serve CYSHCN and eliminates them from having to call each dentist to ask if they can serve their child with special needs. It will improve access to Dental Care for Delawareans with Disabilities and helped the dental workforce provide more effective and culturally competent care to patients with disabilities. Through outreach, information dissemination, and education made available to pediatricians and dental practitioners, this collaborative educated practitioners on best practices on serving the CYSHCN population. A Tool Kit is still an idea that we are working toward implementing through this collaborative initiative. Family SHADE Project will revisit the idea of a Tool Kit for Delaware's Dental Workforce. The implementation of a Toolkit for practitioners which would include a Tool Kit of resources such as an assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

COVID Response and Support:
Family SHADE plans to continue to employ the 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. Ms. Yvonne Bunch was hired to assure that a COVID response plan was in place with the mini-grantees that received awards in calendar year 2024. Ms. Bunch is a retired merit state of Delaware employee from the Department of Services for Children, Youth, and their Families (DSCYF) with specialty of working with vendors serving youth throughout the state of Delaware. Her expertise makes her a good match to providing oversight to the awardees of the mini-grants. She has provided on going education and technical assistance to the grantees. As we move forward, the 4 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. In 2025 we will reallocate the CYSHCN budget to fund the contractual full-time employee (FTE) to support the work that has been done in the prior 3 years with the Family SHADE Mini-grant project.

In collaboration with the National Family to Family Network, Parent Information Center joined an alliance of Family-to-Family Health Information Centers to provide outreach, education and support to children and youth with special healthcare needs and their families. Our COVID Outreach Project wil continue to provide information, education, and support about COVID vaccines to youth ages 12-15 and their families. The Covid Vaccine Outreach project can be accessed by contacting Ms. Jennifer Aaron, Outreach Coordinator, at 302-999-7394 or jaaron@picofdel.org

The Title V CYSHCN Director will continue to work in collaboration with Delaware Family Voices in establishing a Collaborative Action Team Process: Diverse Family Engagement & Leadership. The State Collaborative Action Team Process included our Division of Public Health Maternal Child Health CYSHCN Director and Family Voices parent lead organization. We will continue to work together to develop a plan to enhance diverse family engagement and family professional partnerships at the individual, program, and policy level. Through the technical support from the National Family Voices Leadership in Family and Professional Partnerships (LFPP) we will establish a draft

Strategic Plan that included sustainability and the start of the collaborative. Family Voices has reconvened the Delaware Family to Family Health Information Center (F2F HIC) initiative. Delaware's Family Delegate Ms. Meedra Surratte is leading this initiative in promoting optimal health for children and youth with special health care needs (CYSHCN) and access to an effective health delivery system that is family centered. Our Family Delegate continue to actively work with the National Family Voices Network of Family to Family Health. Ms. Surratte-Family Delegate will also attend the annual AMCHP conference and update the Memorandum of Understanding (MOU) that is in place with the Division of Public Health on an annual basis.

Delaware's Developmental Disabilities Council:
Delaware's Director of Children and Youth with Special Health Care Needs (CYSHCN) is a governor appointed member to the Delaware Developmental Disabilities Council (DDC). The CYSHCN director will continue to serve as a Personnel Committee member and as an instrumental contributor to the Delaware Developmental Disabilities Council's 5 Year Strategic Plan 2022-2026. The Administration for Community Living (ACL) under the US Department of Health and Social Services approves our 5 Year Strategic Plan. 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 -medical home, NPM - transition to adult health care for CYSHCN) and NPM -adequate insurance. The CYSHCN Director will discuss the Blueprint for Change for CYSHCN advisory board so that we are all executing the same message and addressing gaps in the delivery of service.

The Developmental Disabilities Council began working on developing trainings for healthcare service providers to better serve persons with disabilities for whom English is not their first language, as well as the community to know their rights. The Council has gathered information from individuals with disabilities and professionals in the community regarding barriers to individuals with disabilities who are unable to access health care services due to language barriers. This training program will highlight barriers identified and best practices moving forward to help remove barriers that are currently keeping some individuals from accessing services they so desperately need. It will also share resources, so individuals are aware of their rights to receiving home and community-based services for all individuals with special health care needs.

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	2023
Annual Objective			50	75	75
Annual Indicator		68	80	76	84
Numerator		17	20	19	21
Denominator		25	25	25	25
Data Source		FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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
Five-Year 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 Building - 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 2023 FHS Annual retreat, **"Stronger Through the Power of Connection**" – Power of Connection creates the feeling of value, support, involvement, and being an asset to each team member. A large portion of the day was planned outside and unfortunately a thunderstorm ended the day quite early. However, bringing everyone together to discuss our accomplishments and participate in instruction related to building connections was still a success.

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 staff that have joined since we last offered this course.

- **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 2024 FHS Annual Employee Retreat that always has a professional development component. The agenda for the day is still be finalized however, the theme is going to be around positive working relationships and boundaries while working remotely, leading to a more cohesive and productive team dynamic.

We have begun our Title V Needs Assessment process and we will be again assessing workforce internally and externally in our process. A Workforce Capacity was sent out in June 2024.

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 2024 Application/FY 22 Annual Report on our website, https://dethrives.com/title-v. Our DEThrives website is one that serves as the hub for information on many maternal and child health efforts in Delaware. The DEThrives website is available to everyone, including stakeholders, partners as well as the public.

As planned, MCH developed and delivered a series of comprehensive presentations highlighting our priorities. We have several advisory committees that meet regularly and provide ongoing input on MCH programs and priorities, including the Children with Medical Complexity Advisory Board, Help Me Grow and Home Visiting Advisory Board, the Birth Defects and Autism Registries Committee, Delaware Developmental Disabilities Council, Sussex County Health Coalition, and the Delaware Healthy Mothers and Infants Consortium (DHMIC). We have also attended meetings of Family SHADE, an alliance of organizations and families committed to working together to improve the quality of life for CYSHCN.

Our children and youth with special health care needs vendor, the Parent Information Center (PIC) implements our newly revitalized Family SHADE project. Delaware utilized Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making, to best serve our Children and Youth with Special Health Care Needs (CYSHCN) and their families. Family SHADE served as a learning network and respected resource for community organizations serving CYSHCN. Families were included in all levels of planning, implementation, and evaluation of CYSHCN programs and promoting positive systems change to best serve families of CYSHCN.

The PIC implemented the second year of the new approach to 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 has grown the Family Leadership Network (FLN) which is a network for parents/guardians of children birth to 26 that have a special health care need. The network membership included trainings, monthly learning community sessions, and support with Individual Educational Plans (IEPs), and referrals. FLN members received monthly stipends for attendance and participation. The Family SHADE Learning Communities provided families and organizations with the tools to build capacity as well as strategically advocate and serve CYSHCN through community-based organizations. PIC prioritized aligning the Learning Communities with the MCH national performance measures (NPM) as well as topics addressing gaps in service and identified needs that are impacting families of CYSHCN. Through these initiatives, the Family SHADE project contributed to building state and local capacity through testing small scale innovative strategies to improve the overall systems of care. PIC in partnership with community organizations focused on innovative strategies and improving the Title V NPMs and supported the implementation of the standards for systems of care for CYSHCN through measurable outcomes. PIC routinely took surveys to track and gather information and topics being requested by Family SHADE communities by taking pre, post, and overall evaluation surveys during focused learning communities.

The PIC will take the lessons learned from the second year of the mini-grant program and enhance the program in year 3 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 selected NPMs. There will be a planned approach to engage family and community partnerships while executing health equity every step of the way through the process. Delaware will work in alignment with our Early Hearing Detection and Intervention (EHDI) program and our Family to Family (F2F) initiative with Family Voices. Our Family Delegate, Family Leadership Network (FLN) members, and the Director of CYSHCN will work together along with the other Maternal Child Health community-based organizations serving underserved populations in soliciting recommendations from families and youth.

The Social Determinant of Health (SDOH) Committee of the DHMIC 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 on housing for pregnant and parenting women and a guaranteed basic income (GBI) demonstration program as a priority. The SDOH Committee's expertise and passion is to focus on the GBI project for pregnant women to address housing insecure pregnant women. Some basic program model components are:

- Guaranteed Basic Income 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 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

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.

Beginning in the fall of 2023, Delaware's Title V team continued to meet to prepare for the upcoming 2025-2030 Five-Year Needs Assessment. We identified the core members of our Internal Steering Committee, defined the roles and responsibilities of the team, and set expectations for each member. We approached our activities with an aggressive timeline, to ensure enough time was allotted for compiling the feedback and writing the Title V 2025 State Action Plan, along with the Title V 2026 Application Year/2024 Annual Report Block Grant.

To prepare for the 2025 Needs Assessment, our Internal Steering Committee has reviewed the Title V MCH Services Block Grant Guidance and have developed a timeline and work plan. We have also convened our Needs Assessment Capacity Assessment Steering Committee periodically for status awareness and input. Our team has also identified our guiding principles/framework and core values in addition to requesting access to national, state, and local data sources. Lastly, our Title V Internal Steering Committee has established a plan for community engagement and identified opportunities to raise awareness and share information about the assessment with partners.

Through our 2025 Needs Assessment process, MCH has created detailed and specialized health data sheets for each of the newly identified NPMs. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it relates to each measure. Information such as Delaware's goals, the significance of each measure, definitions, objectives, Delaware's current health status as it relates to each measure, and Delaware specific statistics related to each measure. MCH is currently in the process of assessing the health status of MCH populations and Delaware's State Program Capacity. We are in the conducting an environmental scan of MCH initiatives and data, as well as assessing the infrastructure of MCH programs. MCH is also assessing the partnerships and engagement within MCH programs, as well as assessing the MCH workforce capacity. We are soliciting the opinions of women, adolescents, and families in Delaware in addition to the input of local community-based organization.

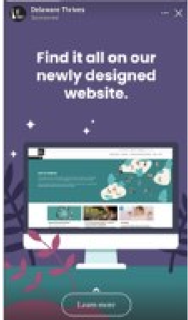
Other stakeholders are contacted by MCH for input and feedback through various meetings, conferences, surveys, and other community activities. MCH periodically reaches out to the public for feedback or updates regarding the MCH community. Such areas throughout this year included questions regarding the 2025 Needs Assessment, our Block Grant Application, the introduction of our MCH Performance Measure health data sheets, DHMIC updates, and more. Our stakeholder involvement and input has been taken into consideration as our team began to prepare for our 2025 Needs Assessment as well as the FY25 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.

Following the submission of the Title V 2024 Block Grant Application/2022 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 receives suggestions regarding changes to the Block Grant application.

As in years past, Title V supported the Family Voices Managed Care (MCO) Calls/Zoom meetings in Spanish and English as these calls have continued to be a wanted resource. The PIC oversees the Family Voices program and they scheduled these forums where parents/caregivers asked questions and discussed issues they were having with their Medicaid MCO (Highmark Health Options or Amerihealth Caritas). Common issues discussed included: care coordination requests, in home care hours, denials, therapies, private duty nursing, supplies, equipment and medication. During the calls MCO's and Medicaid representatives along with other partner organizations helped problem solve. These calls were beneficial to parents, caregivers of children with any special health care needs, mental health/behavioral or emotional needs with questions and concerns regarding the Medicaid insurance they

had for their children. Also, any organization, provider or state agency with questions could listen and learn. Family members can meet with state and community agencies for resources to answer questions and to point them toward services they need and may have been unaware about their existence or what was needed to qualify for help. These meetings occurred approximately monthly with some months not meeting when other large annual meetings and symposia occurred. Seven meetings were conducted during Calendar Year 2023. Because of the nature of confidentiality promised to participants, it is not possible to report on specific questions covered monthly. However, the range of service areas present monthly and the length of the meetings give some sense of the breath of areas covered and accessible to parents and families.

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 FY24 block grant application, Delaware's Five-Year State Action Plan, infographics on each of our NPMs, our State Action Plan Snapshot, the MCH Performance Measures data sheet, a framework of the Needs Assessment process, reports on our Focus Group studies, results of the Stakeholder Survey and more. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions.



The DEThrives.com site held a website campaign to promote awareness of the newly designed website. This campaign targeted Delawareans who were women of reproductive age, expectant parents, and parents of children aged 0-5 to help provide them with maternal and child health messaging. All social media ads had a feature that redirected the user to the DEThrives site once the ad was clicked. These ads ranged from organic (non-paid) and paid promotional posts on the DEThrives' Facebook and Instagram accounts that populated on newsfeeds and stories, streaming audio ads (latin and family genres were top performers), ads on gaming apps on mobile devices, an interactive quiz placed on website banners, and hardcopy materials such as flyers and posters were distributed to partner sites throughout the state. After the campaign, the DEThrives site earned 21K site visits from 14.8K users, over 55K clicks on the ads, 7.8 million impressions, and the average user browsed the DEThrives website for nearly 3 minutes. The audience type that viewed the ads the most (ranking from most to least) were parents of children aged 0-5, women, and then expectant parents.

Following the submission of our FY25 Block Grant application, we plan to post the application on our website. At that time, we will again solicit feedback and input into our Title V block grant application. Any major adjustments that are suggested will be documented for future consideration as the TVIS system will not be opened again after the submission of our application.

III.G. Technical Assistance

With an upcoming administration change in Delaware, key positions have begun to change including the Directors and Deputy Directors at the Division of Public Health, Division of Medicaid and Medicare Administration and a new Secretary was put in place earlier this year at the Department of Health and Social Services. It is possible that these positions will change again once a new Governor is elected and the appoint Secretaries for the various Departments in the State of Delaware.
Without knowing the background of the folks selected, we would like to begin to prepare information to educate on the purpose and design of Title V. We would like access to any materials/resources that are already developed that we can "steal" that could help us provide insight on the important role Title V place to the MCH population.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Signed WIC_DPH_DSS_DMMA_2018.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Delaware MCH Snapshot 1.pdf

Supporting Document #02 - DEThrives Social Media 1.pdf

Supporting Document #03 - Title V SSDI Projects 1.pdf

VI. Organizational Chart

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

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,126,787	
A. Preventive and Primary Care for Children	$ 673,445	(31.6%)
B. Children with Special Health Care Needs	$ 775,206	(36.4%)
C. Title V Administrative Costs	$ 204,299	(9.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,652,950	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,148,719	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,761,872	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,910,591	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 15,037,378	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 5,879,035	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,916,413	

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OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 217,887
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,274,693
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) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 152,725
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,067,298 (FY 23 Federal Award: $ 2,126,787)		$ 2,126,787	
A. Preventive and Primary Care for Children	$ 631,688	(30.6%)	$ 651,089	(30.6%)
B. Children with Special Health Care Needs	$ 866,345	(41.9%)	$ 890,554	(41.8%)
C. Title V Administrative Costs	$ 134,607	(6.5%)	$ 158,689	(7.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,632,640		$ 1,700,332	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,783,792		$ 9,783,792	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,580,255		$ 2,580,255	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,364,047		$ 12,364,047	
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)	$ 14,431,345		$ 14,490,834	
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)	$ 8,200,541		$ 5,849,820	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 22,631,886		$ 20,340,654	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,133,730	$ 1,133,730
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 174,703	$ 248,321
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,719,752	$ 3,684,909
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 139,652	$ 152,130
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	$ 262,897
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,040,612	$ 267,833

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Administrative costs were higher than originally projected.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Delaware

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 473,837	$ 426,455
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 673,445	$ 651,089
4. CSHCN	$ 775,206	$ 890,554
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,922,488	$ 1,968,098

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 5,270,344	$ 5,109,537
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 3,939,011	$ 3,778,203
4. CSHCN	$ 939,364	$ 858,960
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 10,148,719	$ 9,746,700
Federal State MCH Block Grant Partnership Total	$ 12,071,207	$ 11,714,798

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**

Field Note:
Infants are included in the 1-22 category.

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 25 Application Budgeted	FY 23 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	$ 964,770	$ 1,916,076
3. Public Health Services and Systems	$ 1,162,017	$ 210,711
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	$ 2,126,787	$ 2,126,787

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 1,344,512	$ 1,344,513
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,344,512	$ 1,344,513
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 5,756,670	$ 6,043,574
3. Public Health Services and Systems	$ 3,047,537	$ 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		$ 47,327
Direct Services Line 4 Expended Total		$ 1,344,513
Non-Federal Total	$ 10,148,719	$ 10,545,399

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: 11,785 **Data Source Year: 2023**

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	11,785 (100.0%)	1,206	34	34 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Delaware does not conduct long-term follow-up for newborn screening beyond ensuring the family is connected to recommended treatment services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Delaware

Annual Report Year 2023

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	289	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	11,785	37.1	0.0	60.4	2.0	0.5
3. Children 1 through 21 Years of Age	19,624	39.1	0.0	34.3	26.6	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	2,006	39.8	0.0	59.7	0.0	0.5
4. Others	1,178	0.0	0.0	100.0	0.0	0.0
Total	32,876					

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	10,816	Yes	10,816	100.0	10,816	289
2. Infants < 1 Year of Age	11,219	No	11,785	100.0	11,785	11,785
3. Children 1 through 21 Years of Age	248,550	Yes	248,550	100.0	248,550	19,624
3a. Children with Special Health Care Needs 0 through 21 years of age^	57,572	Yes	57,572	3.5	2,015	2,006
4. Others	759,061	Yes	759,061	100.0	759,061	1,178

^Represents a subset of all infants and children.

Form Notes for Form 5:

For Form 5B, item 4, the difference comes from direct and enabling in 5A vs Public Health Services in 5B which touch almost everyone in some form such as public health educational offerings or advertisements.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: 68 from MIECHV home visiting. 221 from state funded Home Visiting program. Health Women Health Babies serves pregnant women but no longer collects this information. Coverage 100% from federal grant funds and state funds, hence listing under "Other" for coverage.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: From Newborn Screening Program, same value as on Form 4. NBS has some non-resident counts, 2023 CY counts. Coverage is based on Health Statistic Center information Table C35 births by payment for CY 2021 (newer data not available). None is self-pay. Private/Other includes Other and Other Government.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Data source is Title V FPAR 1 to 24 yrs old, PEDS (12,091 unduplicated), CY 2023), CDW referrals (3490). MIECHV Home Visiting 1078 households - Home visiting assumes at least one child per household. Example: State funded Home Visiting 586 caregivers = 586 children at least. Total count does not include DPH EMR. PEDS total screens are 14,782.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Data source is Child Development Watch data and includes CDW Watch and CDW Part C clients, 2006 eligible.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**
	Field Note: 564 MIECHV female caregivers, 28 male caregivers gives 592 total adults, plus 586 caregivers from national system count, 1178 overall total. The number of preconception clients is not available from DPH databases. Coverage the same as item 1.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**

Field Note:
Difference in values is due to public health services affecting the entire population in Form 5b, while in Form 5a reflects direct services to women.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**

Field Note:
Differences likely due to counting differences reflecting edits by Health Statistics Center reflecting in state, resident births, versus non resident births.

3.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2023**

Field Note:
Value is from Health Statistics Center data.

4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
Count value is population in Delaware, estimated by Census. All have some "touch" with DPH through programs, service centers, public campaigns that use Title V funds.

5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
Population count value is estimate given by grant application,ages to 21. 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. Total % served based on CDW referrals 3490 divided by 57,572.

6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**

Field Note:
100% served comes from substance abuse education and programming which covers all genders and ages. Other programs that cover large percentage of population are safe sleep, breastfeeding materials, LARC 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 2023

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	5,388	2,988	2,080	62	623	16	0	61
Title V Served	11,218	5,388	2,988	2,080	62	623	16	0	61
Eligible for Title XIX	4,546	1,260	1,702	1,407	28	114	5	0	30
2. Total Infants in State	10,398	4,795	2,889	2,003	56	582	15	0	58
Title V Served	10,398	4,795	2,889	2,003	56	582	15	0	58
Eligible for Title XIX	4,456	1,243	1,663	1,376	28	112	5	0	29

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: CY 2022 data from annual report Table C22. Includes resident and non-resident births in DE.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: All infants born in DE get blood spot test which is under Title V.	
3.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: DE resident births. CY 2022 counts.	
4.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: All infants get blood spot test which is under Title V.	

Form 7
Title V Program Workforce

State: Delaware

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	13.85
1a. Total Number of FTEs (State Level)	13.85
1b. Total Number of FTEs (Local Level)	0
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	0
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	2
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	3

B. Training Needs (Optional)
No training needs were reported by the state.

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Delaware

1. Title V Maternal and Child Health (MCH) Director	
Name	Leah 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 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5747
Extension	
Email	isabel.rivera-green@delaware.gov

3. State Family Leader (Optional)	
Name	Meedra Surratte, M.ED.
Title	Executive Director of Parent Information Center of Delaware/Delaware Family Voices
Address 1	404 Larch Circle
Address 2	
City/State/Zip	Wilmington / DE / 19804
Telephone	(302) 999-7394
Extension	
Email	msurratte@picofdel.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Elizabeth R Orndorff
Title	SSDI Director
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5744
Extension	
Email	elizabeth.orndorff@delaware.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free "Hotline" Telephone Number	(800) 464-4357

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Delaware

Application Year 2025

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 - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	79.2 %	0.4 %	8,409	10,620
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 PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	84.2	9.2	85	10,093
2020	82.8	9.1	83	10,021
2019	67.0	8.2	68	10,152
2018	68.8	8.2	71	10,326
2017	55.2	7.3	58	10,515
2016	63.1	7.7	67	10,621

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	NR ⚑	NR ⚑	NR ⚑	NR ⚑
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 MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.0 %	0.3 %	976	10,809
2021	9.1 %	0.3 %	952	10,478
2020	8.9 %	0.3 %	928	10,385
2019	9.4 %	0.3 %	995	10,552
2018	8.9 %	0.3 %	948	10,614
2017	9.0 %	0.3 %	981	10,853
2016	8.9 %	0.3 %	982	10,984
2015	9.3 %	0.3 %	1,036	11,162
2014	8.3 %	0.3 %	908	10,970
2013	8.3 %	0.3 %	900	10,827
2012	8.3 %	0.3 %	913	11,018
2011	8.4 %	0.3 %	942	11,253
2010	8.9 %	0.3 %	1,016	11,357
2009	8.6 %	0.3 %	994	11,556

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	10.8 %	0.3 %	1,171	10,812
2021	11.0 %	0.3 %	1,151	10,480
2020	10.4 %	0.3 %	1,079	10,388
2019	10.7 %	0.3 %	1,130	10,560
2018	9.6 %	0.3 %	1,015	10,621
2017	10.2 %	0.3 %	1,108	10,846
2016	10.1 %	0.3 %	1,105	10,982
2015	9.9 %	0.3 %	1,101	11,153
2014	9.3 %	0.3 %	1,019	10,965
2013	9.4 %	0.3 %	1,022	10,818
2012	9.5 %	0.3 %	1,049	11,009
2011	9.3 %	0.3 %	1,051	11,247
2010	10.2 %	0.3 %	1,153	11,355
2009	10.0 %	0.3 %	1,160	11,543

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	30.2 %	0.4 %	3,270	10,812
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 ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022/Q1-2022/Q4	2.0 %			
2021/Q4-2022/Q3	2.0 %			
2021/Q3-2022/Q2	2.0 %			
2021/Q2-2022/Q1	2.0 %			
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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	1.0 %			
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 EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.6	0.7	48	10,502
2020	6.3	0.8	66	10,430
2019	7.2	0.8	76	10,600
2018	6.9	0.8	74	10,660
2017	6.4	0.8	70	10,888
2016	6.4	0.8	70	11,020
2015	9.2	0.9	103	11,202
2014	7.4	0.8	81	11,007
2013	6.8	0.8	74	10,863
2012	8.2	0.9	91	11,056
2011	8.8	0.9	99	11,291
2010	7.5	0.8	85	11,401
2009	6.6	0.8	77	11,584

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.8	0.7	50	10,482
2020	5.1	0.7	53	10,392
2019	6.4	0.8	68	10,562
2018	5.9	0.8	63	10,621
2017	6.3	0.8	68	10,855
2016	7.8	0.9	86	10,992
2015	9.1	0.9	102	11,166
2014	6.7	0.8	74	10,972
2013	6.4	0.8	69	10,831
2012	7.6	0.8	84	11,023
2011	8.9	0.9	100	11,257
2010	7.5	0.8	85	11,364
2009	8.0	0.8	92	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	3.0	0.5	31	10,482
2020	3.2	0.6	33	10,392
2019	4.4	0.6	46	10,562
2018	4.0	0.6	43	10,621
2017	4.1	0.6	45	10,855
2016	5.0	0.7	55	10,992
2015	7.2	0.8	80	11,166
2014	5.0	0.7	55	10,972
2013	4.4	0.6	48	10,831
2012	6.1	0.7	67	11,023
2011	6.5	0.8	73	11,257
2010	5.0	0.7	57	11,364
2009	5.8	0.7	67	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	1.8	0.4	19	10,482
2020	1.9	0.4	20	10,392
2019	2.1	0.4	22	10,562
2018	1.9	0.4	20	10,621
2017	2.1	0.4	23	10,855
2016	2.8	0.5	31	10,992
2015	2.0	0.4	22	11,166
2014	1.7	0.4	19	10,972
2013	1.9	0.4	21	10,831
2012	1.5	0.4	17	11,023
2011	2.4	0.5	27	11,257
2010	2.5	0.5	28	11,364
2009	2.2	0.4	25	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	181.3 ⚡	41.6 ⚡	19 ⚡	10,482 ⚡
2020	182.8 ⚡	42.0 ⚡	19 ⚡	10,392 ⚡
2019	284.0	51.9	30	10,562
2018	197.7	43.2	21	10,621
2017	230.3	46.1	25	10,855
2016	354.8	56.9	39	10,992
2015	456.7	64.1	51	11,166
2014	319.0	54.0	35	10,972
2013	295.4	52.3	32	10,831
2012	371.9	58.2	41	11,023
2011	426.4	61.7	48	11,257
2010	281.6	49.9	32	11,364
2009	346.1	54.8	40	11,559

Legends:

Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	104.1	31.4	11	10,562
2018	113.0	32.6	12	10,621
2017	101.3	30.6	11	10,855
2016	118.3	32.8	13	10,992
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	129.3	34.6	14	10,831
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	105.6	30.5	12	11,364
2009	121.1	32.4	14	11,559

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.5 %	0.8 %	548	9,963
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 DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	14.4	1.2	147	10,184
2020	20.9	1.5	212	10,126
2019	18.8	1.4	193	10,255
2018	23.3	1.5	242	10,392
2017	24.2	1.5	258	10,647
2016	26.8	1.6	288	10,731

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of 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) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	12.1 %	1.1 %	23,764	196,434
2020_2021	12.6 %	1.2 %	24,323	193,742
2019_2020	13.6 %	1.4 %	26,333	193,228
2018_2019	13.2 %	1.5 %	24,874	188,379
2017_2018	10.6 %	1.4 %	19,918	187,802
2016_2017	10.8 %	1.3 %	20,487	189,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	25.0	5.0	25	100,041
2021	13.9	3.7	14	100,513
2020	NR	NR	NR	NR
2019	24.9	5.0	25	100,413
2018	23.9	4.9	24	100,413
2017	14.9	3.9	15	100,707
2016	14.9	3.8	15	100,809
2015	15.8	4.0	16	101,233
2014	12.8	3.5	13	101,738
2013	18.6	4.3	19	101,932
2012	20.6	4.5	21	102,082
2011	18.8	4.3	19	100,869
2010	NR	NR	NR	NR
2009	16.8	4.1	17	101,227

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	38.1	5.6	47	123,426
2021	49.4	6.3	61	123,453
2020	37.1	5.6	44	118,596
2019	32.2	5.2	38	117,881
2018	39.8	5.8	47	118,017
2017	30.5	5.1	36	118,145
2016	34.0	5.4	40	117,766
2015	27.3	4.8	32	117,211
2014	31.6	5.2	37	117,122
2013	32.5	5.3	38	116,766
2012	37.1	5.6	44	118,726
2011	31.9	5.2	38	119,280
2010	35.4	5.4	43	121,431
2009	39.4	5.7	48	121,966

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	20.4	3.3	38	186,472
2019_2021	15.8	2.9	29	183,513
2018_2020	13.3	2.7	24	181,058
2017_2019	11.0	2.5	20	181,122
2016_2018	9.4 ϟ	2.3 ϟ	17 ϟ	181,393 ϟ
2015_2017	8.8 ϟ	2.2 ϟ	16 ϟ	181,147 ϟ
2014_2016	9.4 ϟ	2.3 ϟ	17 ϟ	180,556 ϟ
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

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	5.5	1.2	20	365,475
2019_2021	5.3 ⚡	1.2 ⚡	19 ⚡	359,930 ⚡
2018_2020	4.8 ⚡	1.2 ⚡	17 ⚡	354,494 ⚡
2017_2019	5.1 ⚡	1.2 ⚡	18 ⚡	354,043 ⚡
2016_2018	5.4 ⚡	1.2 ⚡	19 ⚡	353,928 ⚡
2015_2017	5.1 ⚡	1.2 ⚡	18 ⚡	353,122 ⚡
2014_2016	4.3 ⚡	1.1 ⚡	15 ⚡	352,099 ⚡
2013_2015	4.3 ⚡	1.1 ⚡	15 ⚡	351,099 ⚡
2012_2014	6.0	1.3	21	352,614
2011_2013	7.9	1.5	28	354,772
2010_2012	8.1	1.5	29	359,437
2009_2011	5.2 ⚡	1.2 ⚡	19 ⚡	362,677 ⚡

Legends:

🏴 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	22.2 %	1.4 %	45,845	206,314
2020_2021	21.2 %	1.4 %	43,315	203,874
2019_2020	21.4 %	1.5 %	43,421	202,474
2018_2019	21.1 %	1.5 %	42,838	202,747
2017_2018	20.2 %	1.6 %	41,131	203,545
2016_2017	20.9 %	1.4 %	42,438	203,529

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 CSHCN - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	13.4 %	2.1 %	6,121	45,845
2020_2021	12.1 %	2.0 %	5,254	43,315
2019_2020	10.6 %	1.7 %	4,610	43,421
2018_2019	15.3 %	2.4 %	6,555	42,838
2017_2018	19.3 %	3.3 %	7,958	41,131
2016_2017	19.8 %	3.0 %	8,423	42,438

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.7 %	0.6 %	6,359	173,496
2020_2021	2.9 %	0.6 %	4,927	172,115
2019_2020	4.0 %	0.9 %	6,949	172,204
2018_2019	3.7 %	0.9 %	6,224	167,190
2017_2018	3.5 %	0.8 %	5,845	167,032
2016_2017	3.6 %	0.8 %	6,237	172,389

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 ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	10.4 %	1.1 %	17,990	172,814
2020_2021	9.4 %	1.1 %	16,153	171,599
2019_2020	11.0 %	1.2 %	18,951	172,586
2018_2019	11.6 %	1.3 %	19,235	166,433
2017_2018	9.6 %	1.2 %	15,802	165,319
2016_2017	9.9 %	1.1 %	16,805	170,391

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 ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	53.1 %	4.6 %	13,267	24,976
2020_2021	45.1 %	5.1 %	10,521	23,304
2019_2020	48.8 % ϟ	5.7 % ϟ	12,454 ϟ	25,517 ϟ
2018_2019	54.0 % ϟ	5.7 % ϟ	13,496 ϟ	24,980 ϟ
2017_2018	54.5 % ϟ	5.6 % ϟ	12,720 ϟ	23,325 ϟ
2016_2017	63.4 %	5.1 %	14,831	23,387

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	89.8 %	1.2 %	184,943	206,060
2020_2021	89.4 %	1.2 %	182,163	203,709
2019_2020	88.9 %	1.4 %	179,718	202,058
2018_2019	89.6 %	1.4 %	181,112	202,227
2017_2018	90.0 %	1.4 %	183,076	203,376
2016_2017	90.5 %	1.2 %	183,956	203,320

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	18.5 %	0.6 %	855	4,610
2018	16.3 %	0.5 %	958	5,870
2016	16.2 %	0.4 %	1,116	6,906
2014	17.2 %	0.4 %	1,246	7,251
2012	16.9 %	0.4 %	1,292	7,642
2010	18.4 %	0.4 %	1,404	7,650
2008	17.3 %	0.5 %	1,097	6,328

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: 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
2021_2022	20.5 %	1.8 %	26,702	130,352
2020_2021	20.5 %	1.9 %	26,344	128,410
2019_2020	19.3 %	2.0 %	25,001	129,302
2018_2019	18.8 %	2.0 %	23,965	127,511
2017_2018	19.1 %	2.1 %	24,077	126,291
2016_2017	19.2 %	2.0 %	23,507	122,553

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.1 %	0.7 %	6,371	207,827
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 UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

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 VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	61.0 %	2.4 %	119,741	196,296
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 VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	84.2 %	2.8 %	50,778	60,307
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 VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	88.2 %	2.7 %	53,217	60,307
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 VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	89.3 %	2.7 %	53,828	60,307
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 VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	14.7	0.7	466	31,720
2021	13.5	0.7	425	31,410
2020	14.6	0.7	439	30,104
2019	14.9	0.7	444	29,792
2018	16.7	0.8	497	29,783
2017	18.5	0.8	552	29,906
2016	19.5	0.8	583	29,906
2015	18.1	0.8	540	29,829
2014	20.8	0.8	616	29,632
2013	24.4	0.9	728	29,860
2012	25.0	0.9	761	30,387
2011	29.0	1.0	900	31,023
2010	30.7	1.0	974	31,694
2009	33.5	1.0	1,081	32,283

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	10.4 %	1.1 %	1,024	9,830
2021	9.7 %	1.2 %	929	9,535
2020	10.6 %	1.2 %	992	9,401
2019	10.4 %	1.1 %	1,005	9,672
2018	13.1 %	1.2 %	1,262	9,616
2017	11.7 %	1.1 %	1,157	9,893
2016	10.5 %	1.0 %	1,057	10,051
2015	13.9 %	1.2 %	1,429	10,264
2014	13.4 %	1.2 %	1,367	10,223
2013	13.0 %	1.1 %	1,296	9,981
2012	13.8 %	1.1 %	1,385	10,061

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.6 %	0.8 %	7,466	205,812
2020_2021	2.9 %	0.7 %	5,908	203,371
2019_2020	2.9 %	0.7 %	5,817	201,434
2018_2019	2.3 %	0.6 %	4,622	201,338
2017_2018	2.7 %	0.7 %	5,500	203,063
2016_2017	3.1 %	0.8 %	6,391	203,262

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 FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Delaware

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		80	78	80.0	82
Annual Indicator	78.2	75.6	72.8	75.9	71.9
Numerator	127,950	124,769	117,625	125,530	116,483
Denominator	163,676	165,041	161,675	165,284	161,938
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	84.0	86.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80	80	81.5	83.0	84.5
Annual Indicator	78.5	79.7	82.4	83.6	76.1
Numerator	8,010	8,564	8,253	8,057	7,237
Denominator	10,209	10,741	10,019	9,637	9,513
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	84.5
Annual Indicator	88.1
Numerator	9,316
Denominator	10,573
Data Source	NVSS
Data Source Year	2022

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

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	20.5	24.0	24.5	25
Annual Indicator	19.8	23.6	28.2	25.0	21.9
Numerator	2,019	2,478	2,713	2,298	2,032
Denominator	10,187	10,493	9,615	9,184	9,264
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	25
Annual Indicator	22.4
Numerator	6,100
Denominator	27,226
Data Source	NSCH
Data Source Year	2021_2022

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

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	2020	2021	2022	2023
Annual Objective	32	27	30.0	32.0	34
Annual Indicator	25.5	30.3	29.1	32.1	34.3
Numerator	5,939	6,522	6,073	7,257	8,614
Denominator	23,289	21,559	20,867	22,604	25,117
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	2025
Annual Objective	36.0	38.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			20	22	22
Annual Indicator	25.1	25.1	25.1	21.6	21.6
Numerator	9,329	9,329	9,329	8,529	8,529
Denominator	37,230	37,230	37,230	39,459	39,459
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2017	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			20	21.0	22
Annual Indicator	11.6	13.0	14.9	16.0	14.8
Numerator	7,828	8,196	9,878	11,362	10,707
Denominator	67,249	62,967	66,257	70,996	72,524
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

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

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	2020	2021	2022	2023
Annual Objective			75	77	79
Annual Indicator	86.9	75.7	71.9	71.8	74.2
Numerator	62,537	47,654	48,388	51,420	53,987
Denominator	71,966	62,974	67,333	71,653	72,759
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	2025
Annual Objective	81.0	83.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.4	82.5	80	80.5	81
Annual Indicator	82.0	79.7	77.4	77.3	75.4
Numerator	154,827	149,645	148,645	149,188	147,612
Denominator	188,877	187,697	192,077	193,050	195,852
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

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

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	2020	2021	2022	2023
Annual Objective	81.2	72	70.0	72.0	74
Annual Indicator	70.9	68.6	67.2	68.8	70.7
Numerator	144,257	138,831	136,015	140,169	145,366
Denominator	203,436	202,281	202,319	203,715	205,678
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	2025
Annual Objective	76.0	77.0

Field Level Notes for Form 10 NPMs:

None

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

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

Field Level Notes for Form 10 NPMs:

None

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

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

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	44.2
Numerator	91,124
Denominator	206,169
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	40.2
Numerator	18,442
Denominator	45,845
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

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					
	2019	2020	2021	2022	2023
Annual Objective	52	30	28	27	26
Annual Indicator	44.7	45.8	45	42.8	42.8
Numerator					
Denominator					
Data Source	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2018	2019	2020	2021	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	25.0	24.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
2016-2018 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2019 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined. Not sure is an option that was included with our "I didn't want to be pregnant....", however CDC does not want states to include that option in their numbers now. Even with this change, Delaware numbers have still been decreasing since 2012.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Unfortunately, we had a delay in receiving PRAMS 2022 data. Therefore, we don’t have updated data to report on SPM 1 on untended pregnancy.

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

Annual Objectives

	2024	2025
Annual Objective	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.

4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Unfortunately, we were not able to obtain provisional 2023 Vital Statistics data, and therefore, numbers are the same for this reporting year.

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	2023
Annual Objective			50	75	75
Annual Indicator		68	80	76	84
Numerator		17	20	19	21
Denominator		25	25	25	25
Data Source		FHS Data	FHS Data	FHS Data	FHS Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives

	2024	2025
Annual Objective	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.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Counted staff that attended/participated in FHS Retreat and/or took courses through the All-Access Pass.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Delaware

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	15,700	17,000	17,250	8,500	9,000
Annual Indicator	16,672	8,488	8,015	8,109	9,937
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning	FPAR Title X/Family Planning Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Actual number served was 16,672 but field would not allow us to go over 16,500.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
50% drop due to COVID.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
This data includes all family planning clinic provider sites that report data to DPH that receive federal Title X funds or state Delaware Contraceptive Access Now DE State General Fund dollars.

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			90	86	88
Annual Indicator		88	84.2	86.1	89
Numerator				6,335	5,920
Denominator				7,354	6,655
Data Source		HWHB Program Data	HWHB Program Data	HWHB Program Data	HWHB Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	90.0	92.0

Field Level Notes for Form 10 ESMs:

None

ESM WWV.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	2023
Annual Objective			63	60	65
Annual Indicator		62	53.1	58.6	58.6
Numerator					
Denominator					
Data Source		Medicaid Claims Data	PRAMS data	PRAMS data	PRAMS data
Data Source Year		2019	2020	2021	2021
Provisional or Final ?		Final	Final	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	70.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
There was an issue with PRAMS data, and we are still awaiting this data.

ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Measure Status:	Active

State Provided Data

	2019	2020	2021	2022	2023
Annual Objective	65	58	60	62	64
Annual Indicator	54.9	47.9	57	55.3	48.2
Numerator					27
Denominator					56
Data Source	MIECHV program data	MIECHV program data	MIECHV program daa	MIECHV Program Data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2024	2025
Annual Objective	66.0	68.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:	Active

State Provided Data

	2019	2020	2021	2022	2023
Annual Objective			92	94	96
Annual Indicator	91.4	83.3	82.2	81	77
Numerator	433	398	412	439	412
Denominator	474	478	501	542	535
Data Source	MIECHV program data	MIECHV program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2024	2025
Annual Objective	98.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.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

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator		52.2
Numerator		1,167
Denominator		2,234
Data Source		MIECHV ASQ and OEL ASQ
Data Source Year		2023
Provisional or Final ?		Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) ASQ and Office of Early Learning (OEL) ASQ data is used as it is a complete data set and is representative statewide.

ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	14.3	21.4
Numerator	6	9
Denominator	42	42
Data Source	PANO MCH Program Data	PANO MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	12.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			25	75	75
Annual Indicator		29.2	76.2	74.2	66.7
Numerator		883	4,902	4,958	4,420
Denominator		3,027	6,429	6,678	6,631
Data Source		SBHC Program Data	SBHC Porgram Data	SBHC Program Data	SBHC Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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 AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	48.2	53.6
Numerator	4,530	3,413
Denominator	9,407	6,367
Data Source	SBHC Program Data	SBHC Program Data
Data Source Year	2021	2022
Provisional or Final ?	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2023**

   Column Name: **State Provided Data**

   Field Note:
   This represents data from the last half of CY2022 (July through December 2022).

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

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	0.1	0.2
Numerator	99	337
Denominator	140,263	141,729
Data Source	DOE Program Data	DOE Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	0.2	0.3

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			81	82	83
Annual Indicator	80.6	78.8	73.6	77.3	75.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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 PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	683	1,000
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	725.0	765.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Referrals for English were 912. Referrals for Spanish were 88. Total of 1,000.

ESM AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			90	92	94
Annual Indicator		90	89.1	91.5	90.6
Numerator		564	595	644	598
Denominator		627	668	704	660
Data Source		MIECHV Program data	MIECHV program data	MIECHV Program Data	MIECHV Program Data
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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.

3. **Field Name:** **2023**

   Column Name: **State Provided Data**

   Field Note:
   98% (602/615) of children had health insurance per the FY23 MIECHV program data.

ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	73.3	73.3
Numerator	11	11
Denominator	15	15
Data Source	Family SHADE/MCH Program Data	Family SHADE/MCH Program Data
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator		100
Numerator		
Denominator		
Data Source		CYSHCN Mini Grantee data
Data Source Year		2023
Provisional or Final ?		Final

Annual Objectives		
	2024	2025
Annual Objective	75.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
The number of children served by a Family SHADE mini-grantee was 609 (Numerator). The total children that can be served by a Family SHADE mini-grantee was 541 (Denominator). Our Annual Indicator was 113%, but this could not be entered into the EHB as it created an error. Also, Teach Zen did not identify a baseline of children to serve. Therefore, the number of children served by them was not factored into this count. For reference, Teach Zen saw 156 children but only 20% were CYSHCN which equals 30 CYSHCN served.

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 WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	Increase the number of women of reproductive age receiving family planning services.
Definition:	**Unit Type:** Count **Unit Number:** 20,000 **Numerator:** Total # of women of reproduction age that received family planning servicess **Denominator:**
Data Sources and Data Issues:	FPAR Title X/Family Planning Data
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 WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	Increase # of women served by the HWHBs program that were screened for pregnancy intention
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women that were screening for pregnancy intention **Denominator:** # of women served
Data Sources and Data Issues:	HWHB Program Data
Significance:	Asking the pregnancy intention question gives women an opportunity to discuss their future and offers providers to further discuss contraception option that are best for her based on her answer.

ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

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 BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants enrolled in home visiting receiving breast milk at 6 months of age **Denominator:** Number of infants enrolled in home visiting at 6 months of age
Data Sources and Data Issues:	MCH/MIECHV program data
Significance:	Our home visiting programs enroll the most vulnerable families that are of lower socio-economic status. Mothers in this population have lower rates of initiating breastfeeding as well as difficulty continuing to breastfeed through 6 months of age.

ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

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 DS.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 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

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 PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.
NPM – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent

Measure Status:	Active
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 AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	To increase the number of adolscents idenfitied in need of services (i.e. mental health; nutrition; reproduction health)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children receiving an assessment **Denominator:** # of unique children enrolled and receiving services at a SBHC
Data Sources and Data Issues:	SBHC program data
Significance:	Standardized assessment are important to ensure adolscents receive the services specific to their need.

ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues.
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	Ensure adolescents enrolled in SHBCs receive appropriate assessments and resources/services as needed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of mental health assessments completed within a SBHC **Denominator:** The number of students enrolled in a SBHC
Data Sources and Data Issues:	SBHC Program Data
Evidence-based/informed strategy:	Unfortunately, there is not much evidence behind School Based Wellness Centers based on the number of students enrolled and accessing services including mental health support, we know they are providing services that are needed for this population.
Significance:	Ensure adolescents receive services and treatment related to identified behavioral concerns that is accessible.

ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	Provide children enrolled in a Delaware school access to mental health services
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Raw # of unduplicated students receiving trauma specific mental health services from a provider chosen by student or parent. **Denominator:** Total # of students enrolled in DE schools.
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 PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Increase the percent of children enrolled in Medicaid, ages 1 through 17, who had a preventive dental visit in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children enrolled in Medicaid who received a preventative dental visit in the last year **Denominator:** Number of children who received a preventative dental visit in the last year
Data Sources and Data Issues:	National Survey for Children's Health
Significance:	Preventive dental visits ensures children have a bright and healthy smile. It also spares children the aches of tooth decay. We know the sooner families start regularizing their child's dental visits, the better their oral health will be throughout their lives.

ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

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 AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants
NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI

Measure Status:	Active
Goal:	To increase the number of primary caregivers and children with health insurance
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of primary caregivers and children (families) with health insurance **Denominator:** # of families enrolled
Data Sources and Data Issues:	MIECHV program data
Significance:	Health insurance covers essential health benefits critical to maintaining generalhealth, preventive care, treating illness and accidents

ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network.
NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI

Measure Status:	Active
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 AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.
NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI

Measure Status:	Active
Goal:	The goal is too serve as many families as each awardee has the capacity to serve.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children served by a Family SHADE mini-grantee **Denominator:** Total children that can be served by a Family SHADE mini-grantee.
Data Sources and Data Issues:	Family SHADE/MCH program data
Evidence-based/informed strategy:	Families and children with special healthcare needs have unique needs that requires additional support so by building capacity at the local level, we can increase the support available that is easily accessible to families and children.
Significance:	Building capacity at the local level to serve families with CYSHCN.

Form 11
Other State Data

State: Delaware

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Delaware

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	Quarterly	12		
2) Vital Records Death	Yes	No	Quarterly	24	Yes	
3) Medicaid	Yes	Yes	More often than monthly	0	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	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

Form 12
Part 2 – Products and Publications (Optional)

State: Delaware

Annual Report Year 2023

Form 12 Products And Publications