Maternal and Child Health Services Title V Block Grant

Delaware

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

July 15, 2016

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 2016 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 2017 Maternal and Child Health Services Title V Block Grant Application.

Please feel free to contact me at (302)744-4901 or via e-mail leah.woodall@state.de.us , if you have any questions or comments regarding the information presented in the application.

Sincerely,

Leah Jones Woodall, MPA
Chief, Family Health Systems
MCH Director

Family Health Systems
Delaware Division of Public Health
Jesse Cooper Building, Garden Level
417 Federal Street
Dover, DE 19901
(302) 744-4901

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Title V of the Social Security Act reflects our nation's commitment to improving the health and well-being of mothers, children, and their families, and is operationalized through a block grant. For an overview of the Title V Block Grant and the national health priorities it addresses, please visit http://mchb.hrsa.gov/blockgrant/.

In Delaware, the Title V Block Grant serves as the foundation for much of our Maternal & Child Health Program, and is administered by the Delaware Division of Public Health (DPH). DPH coordinates and collaborates with many organizations and other state agencies to implement activities that address grant goals and objectives.

As reflected throughout this application, partnerships are essential to our Title V Program, and collective impact is a philosophy that is foundational to our work. The scope of maternal and child health is broad and the needs are extensive. The Title V Program does not have the resources or capacity to be successful in addressing these needs without engaging many partners and aligning our work with that of others. Therefore, we consistently aim to identify goals that we share with our partners, and use those goals as a lens to guide our program and review emerging opportunities and needs.
This philosophy of partnership and collective impact is reflected in "DE Thrives," a social marketing theme shared by the Delaware Division of Public Health, the Delaware Healthy Mother and Infant Consortium, and partner organizations throughout the state. All share one common aim - that all of Delaware's babies and children have the same opportunity to thrive. And, all share one common belief - that we all have a part to play, and that when our babies and children thrive, we all are better off. Healthy women. Healthy babies. Healthy families. Healthy communities. That's DE Thrives. (www.dethrives.com)

The Title V Needs Assessment

Every 5 years, as a part of the federal Maternal and Child Health Title V Block Grant, states are required to complete a comprehensive assessment of the needs, desired outcomes, and system capacity for the maternal and child health population, including children and youth with special health care needs. The results of this assessment are then used to establish the priorities that will guide our Title V program for the next five years (2015-2020).

In September 2014, the Delaware Division of Public Health initiated its 2015 Title V Needs Assessment which was completed in May, 2015. This process included presentations to stakeholders, gathering of quantitative data, surveys of professionals and families, key informant interviews, and community focus groups. Our Steering Committee then conducted an analysis of this quantitative and qualitative data, and used it to inform the selection of priority needs. Many factors were considered in selecting priorities, including: size and seriousness of the health issue; disparities in outcomes; stakeholder support; importance to the community; and alignment with national and

state goals.

Following the Title V 2015 Needs Assessment, states were to prepare a Five-year State Action Plan and submit it as part of the first year Title V MCH Block Grant Application/Annual Report. The Five-year State Action Plan table is intended to serve as a working tool for states in developing an Action Plan that addresses the state and national MCH priorities identified through the Five-year Needs Assessment process.

Title V Action Planning

To address the build-out of the Five-year State Action Plan, a team of Domain Leaders was established along with a process by which all domain leaders would select their evidence based strategies. Each Domain Leader facilitated work groups that focused on the strategic planning process for each of the 8 national priorities selected. These work groups were a partnership comprised of state and community stakeholders. The work group purpose was to identify strategies and evidence-based/informed measures to address Delaware's Title V priorities.

Delaware worked with John Snow Inc., to review and research evidence based strategies provided by the new HRSA-funded initiative that supported states in their development of strategies to promote the health and well-being of maternal and child health populations in the US, . The Strengthen the Evidence Base for Maternal and Child Health (MCH) Programs initiative was undertaken by Johns Hopkins. Each domain workgroup received a list of identified and appropriate strategies for consideration and were encouraged to present additional strategies that they would like to have been considered.

In addition to the list of strategies, each workgroups was given a Strategy Grid to select strategies and evidence informed measures that would be used for the strategic planning process. The Strategy grids facilitated work groups in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool was particularly useful when agencies were limited in capacity and wanted to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing these challenges through a lens of diminished quality in services, the strategy grids provided a mechanism to take a thoughtful approach to achieving maximum results with limited resources.

After reviewing the strategies, the work groups began the categorization and prioritization process by placing competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. This process was guided by posing Feasibility and Need criteria questions to the group. The feasibility and need criteria were just a few criteria/questions for consideration. Each work group determined if the criteria made sense and if there were others that should be included. After completing the categorization and prioritization process using the Strategy Grid the work groups selected priority Evidence-based/informed measures that could be used to populate the Five-year Action Plan table.

Delaware's Title V Priorities and Plans

Delaware's Title V priorities and plans for the coming year are presented below by population domain, as defined by the federal Maternal and Child Health Bureau. These population domain "snapshots" convey a brief overview of our goals, progress, and plans for each health area. In some of the health areas, we are building on years of previous work and partnerships and have very detailed action plans forward. In others, we are forging into new territory and will be spending the coming year learning, building expertise, and establishing new relationships.

Please note that these plans represent the role that the Title V Program can play in improving the health of mothers and children, given our resources and capacity, and are not intended to be a comprehensive strategic plan to address each of the targeted health areas. Moving the needle on any of these health priority areas will require collective effort from many partners throughout the state. For more detail, please review Delaware's full Title V Maternal and Child Health Block Grant application.

Population Domain Snapshot: *Women's and Maternal Health*

Priority Health Need(s)	Objectives(s)	Strategies
National Performance Measure **Well-Woman Care** To increase the number of women who have **a preventive health visit** to optimize the health of women before, between and beyond pregnancies Decrease the percentage of women of reproductive age with an **unintended pregnancy**. (SPM)	By July 2020, increase the percentage of women with birth interval >18 months. By July 2020, reduce the unintended pregnancy rate by 10%.	**Defining the Need:** In 2013, 81% 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. 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. A national study revealed that among opioid-abusing women in the U.S., almost nine out of every 10 pregnancies were unintended. Delaware has one of the highest unintended pregnancy rates in the nation; 57% of pregnancies are unplanned. Approximately 48 percent of all Delaware births are paid for by Medicaid. **Accomplishments to Date:** Through partnership with the Delaware Healthy Mothers and Infants Consortium, there has been much work to educate our population about preconception health, in which preventive health visits play a key role. This work included social media outreach around the theme that "Health Begins Where You Live, Learn, Work & Play." Over the last year, preconception peer educators provided outreach to college students on topics ranging from preventive care, nutrition, physical activity, and reproductive life planning. We also continued to disseminate reproductive life planning tools to teens and adults to encourage them to establish and maintain healthy habits to support their life goals. While Delaware has seen gains in fewer infant deaths over the last decade for which there is much to celebrate, Delaware's unplanned pregnancy rate is one of the highest in the nation. The vision of the Delaware Plan to Reduce Unintended Pregnancies, now coined as Delaware Contraceptive Access Now (DE CAN), is that all children are born to parents who plan for them and want them. We envision a time when accidental pregnancies are increasingly a thing of the past. **Plans for the Coming Year:** Preventive health visits are an integral part of preconception care. In the coming year, we will continue our education and marketing campaign to encourage teens and women to develop reproductive life plans. We will also work to educate and counsel women of reproductive age (ages 14-44) about all contraceptive methods that are safe and appropriate for them, including long-acting reversible contraceptives (LARCs). Leveraging state funding, Delaware will continue to support the Healthy Women, Healthy Babies program, providing preconception, nutrition, prenatal and psychosocial "bundles" of care for women at the highest risk of poor birth outcomes. In addition, we will be implementing a plan to ensure that all women seeking health care are asked if they desire to become pregnant in the next year and, if not, provide same-day access to the full range of contraceptive methods, including long acting reversible methods, IUDs and implants. To accomplish this vision, all women of reproductive age will have access to free, effective contraception through their health care provider of choice, and providers will have both the training and supplies needed to offer all methods of contraception on the same day they are requested. Delaware has developed a plan to ensure that all women seeking health care, regardless of their health insurance status, are asked the One Key Question—if they desire to come pregnant in the next year and, if not, provide same-day access to the full range of contraceptive methods, including long acting reversible contraceptive (LARC) methods, IUDs and implants.
Are we moving the needle for women in Delaware?	With 81% of Delaware women accessing preventive health care, we are doing fairly well in this area. However, we are not doing so well on our rate of unplanned pregnancies, with Delaware ranked among the worst states in the nation. We hope to leverage preventive health visits as an opportunity to provide guidance on preconception health, reproductive life planning, and preconception in order to address this issue.	

Population Domain Snapshot: *Perinatal/Infant Health*

Priority Health Need(s)	Objectives(s)	Strategies
National Performance Measure **Breastfeeding** Improve rates of breastfeeding initiation and duration Reduce the disparity between African American women who initiate breastfeeding (SPM)	By July 2020, increase breastfeeding initiation rates in Delaware from 72.4% to 81.9%. By July 2020, increase the percent of women who breastfeed exclusively through 6 months from 13% to 25.5%.	**Defining the Need:** According to the 2011/2012 National Survey of Children's Health, 72.4% of Delaware babies were "ever breastfed or fed breast milk"; lower than the national estimate of 79.2%. Only 13% of infants are breastfed exclusively for 6 months. **Accomplishments in the Past Year:** Title V funding was used to support staff within DPH's home visiting program to earn and maintain the IBCLC (International Board Certified Lactation Consultant) credential. Leveraging additional sources of funding, DPH implemented a program called EPIC BEST (Educating Providers in the Community-Breastfeeding Education and Support Training) that provides onsite breastfeeding education and support training for ob-gyn and pediatric practices. To date, a total of 45 practices and over 400 healthcare employees have received training. In this second year of EPIC BEST, we attempted to reach practices that have a high number of impoverished and/or minority women and children in their practices and can now say that every Federally Qualified Health Center has received training. We continued to collaborate with the Breastfeeding Coalition of Delaware (BCD) and the Delaware Healthy Mothers and Infants Consortium (DHMIC) to share resources and increase the spread of posters, tip sheets, and educational materials that promote breastfeeding. Finally, our largest birthing facility in the state received Baby Friendly designation this past year. **Plans for the Coming Year:** We will continue to support home visitors to maintain the IBCLC credential, and we will also continue to implement EPIC BEST, spreading the training to more medical practices. We will also continue supporting birthing facilities with development and implementation of breastfeeding policies. In terms of marketing, we will disseminate existing messages and materials promoting breastfeeding. We will research the feasibility of launching the It's Only Natural social marketing campaign. We will collaborate with the BCD around provider education to support breastfeeding for Black women as part of their Generating Equity in our Mothers (GEM) project goal.
Are we moving the needle for infants in Delaware?	This is a new priority area for our Title V Program, and we will be tracking progress on the goals listed above. However, the percent of Delaware babies who were "ever breastfed or fed breast milk" remained stable between 2007 and 2011/12. During the same time period, the percent who were exclusively breastfed for their first six months increased from 10.6% to 13.0%. (National Survey of Children's Health, 2007 and 2011/12)	

Population Domain Snapshot: *Child Health*

Priority Health Need(s)	Objectives(s)	Strategies
Developmental Screening Improve rates of developmental screening in the healthcare setting	By July 2020, increase the percent of children, ages 9-71 months, receiving a developmental screening using a parent-completed screening tool.	**Defining the Need:** According to the National Survey of Children's Health, the percent of children receiving a developmental screening from their doctor increased from 10.9% in 2007 to 30.8% in 2011/12. **Accomplishments in the Past Year:** In May 2012, the Division of Public Health launched the PEDS portal, making it available free of charge to pediatricians and family practice physicians who sign up to implement the validated tool. PEDS Online is a web-based tool that allows parents to complete a developmental screening assessment, which is then transmitted to the provider for review at a well-child visit. Over the past two years, training and technical assistance were provided to pediatric and family practices to implement the PEDS tool. In 2015, 10,076 screens were completed for a total of approximately 30,000 screens to date. This makes up 7,866 unique children screened in 2015 – about 9% of children 0-8 years in the state. Practices implementing the tool increased by 3 in 2015 for a total of 36 community practices and 78 physicians trained to use the tool. To educate parents and promote awareness of developmental milestones, we created a developmental screening webpage (http://developmentalscreeningde.com/) as well as a You Tube video. **Plans for the Coming Year:** About one third of the practices that are currently enrolled to participate in Delaware's PEDS online are screening at very low rates. Over the coming year, we will continue to address several barriers that prevent optimal screening, including the need for site-specific data, the lack of awareness of where to refer at-risk children once screened, and lack of a feedback system with the referral sources to track progress of a given patient. We will expand screening via HMG/2-1-1 call center to increase the number of children receiving developmental screening in the state. We will also spread information and educational resources to physician's offices, state service centers, WIC offices, and other venues to empower parents to recognize signs of delay and to influence their pediatricians to provide screening.
Healthy Lifestyles Increase healthy lifestyle behaviors (healthy eating and physical activity)	By July 2020, increase the percent of children 6-11 years old who are physically active at least 60 min/day.	**Defining the Need:** The 2011 Delaware Survey of Children's Health (DSCH) estimates that 40% of children ages 2-17 are overweight or obese, with only 42.4% of children ages 6-11 achieving the recommended 60 minutes of physical activity per day. **Accomplishments in the Past Year:** The Title V program continued to partner with the PANO Program to spread their initiatives and materials through our Maternal and Child Health programs, services, and partner networks. For example, we supported "Motivate the First State" by sending flyers and information through our email networks, asking partners to post links to the initiative on their websites, and using our social media channels to spread the word. Our Home Visiting staff utilized our QT30 program guide to advise families on the benefits of physical activity and healthy eating. Our staff brought an awareness of developmentally appropriate activities for their children that included dance parties, frog leaps, and biking. With respect to healthy eating, our DPH staff includes fully licensed/certified nutritionists who provided consultation services for our families focused on healthy cooking. **Plans for the Coming Year:** While the Governor's Council on Health Promotion and Disease Prevention ended this year, we will continue to participate on committees of the State Health Improvement Plan and Healthy Neighborhood to align and support their plans to promote active living and healthy eating. To support these strategies we will work to create a marketing message similar to QT30 for children ages 6-11 that will highlight physical activities that will support our goal of increasing the percent of children who are physically active at least 60 minutes/day. This messaging strategy will also include suggestions for healthy cooking and eating options.
Are we moving the needle for children in Delaware?	A few years ago, Delaware was ranked 50th among states for the percent of children who received standardized developmental screening during health care visits. As of 2011/12 data, our screening rate is equal to the national rate. Although this is a substantial improvement, there is still much work to be done to ensure that all children are screened at appropriate ages with a validated tool, allowing for early identification of problems and connection to services. With respect to healthy lifestyles, data from the Delaware Survey of Children's Health show that from 2006 to 2011, there were trends in a positive direction for physical activity, increasing consumption of fruits and vegetables, and decreasing consumption of sugar-sweetened beverages. This is a new area of focus for Title V, and we will track progress on the goals listed above.	

Population Domain Snapshot: *Children and Youth with Special Health Care Needs (CYSHCN)*

Priority Health Need(s)	Objectives(s)	Strategies
Medical Home Increase the percent of children with and without special health care needs having a medical home	By July 2020, increase the percentage of pediatric clinicians in Delaware who have effective policies and procedures in place for effective care integration and cross-provider communication. By July 2020, improve access to care coordination within a medical home for families of CYSHCN. By July 2020, increase the percentage of primary pediatric practices reporting use of care plans for CYSHCN patients that have been developed and shared with families.	**Defining the Need:** According to the 2009/10 National Survey of Children with Special Health Care Needs, only 41.4% of CYSHCN received coordinated, ongoing, comprehensive care within a medical home, slightly below the national estimate of 43%. **Accomplishments in the Past Year:** An evaluation of the 2013 CYSHCN Medical Home Pilot project was completed. Of the three medical practices completing the post-project survey, all showed improvements in at least one of the domains defined for medical home. One of the trained parent partner guides who was placed in a pilot project practice was also transitioned to our Part C Program Child Development Watch. The positive results of this pilot project along with clear indication from parents through focus groups and surveys conducted in 2014 and 2015 and our key informant interviews conducted this year show a strong interest for care coordination within a family-centered medical home model. Work during this first year focused on increasing our collaboration with partners both within and external to state government. The purpose of this group was to serve a guiding committee for Title V/CYSHCN in order to both align our Title V goals for this population with the goals of multiple other state agencies and service providers as well as to identify mechanisms to advance the objectives of this grant. In order to reach providers and payors time and effort during the first year of this application focused on connecting with and providing input to the Delaware Center for Health Innovation (DCHI) State Innovation Model (SIM) initiative. Much effort went toward having the concerns of the CYSHCN community heard by the DCHI committees this year. Ann Phillips, Executive Director of Delaware Family Voices serves on the Patient/Consumer Advocacy Committee. Family SHADE representatives have attended meetings of every SIM Committee throughout the year. Through the active participation in and reporting from the DCHI meetings though out the year the issues important to the CYSHCN community were highlighted including the need for care coordination within medical homes and better payment models coverage for supports for this high needs population. **Plans for the Coming Year:** We will work with our partners including Family SHADE, Family Voices-DE chapter and our Guiding committee as well as families to identify a toolkit for both clinicians and families to help promote medical home and care coordination for CYSHCN. We will continue to use the Family SHADE Families Know Best survey to keep a pulse on how families are experiencing the level of care for their children. Questions will be included on a quarterly basis regarding the families' perspective on care coordination and the components of a medical home.
Are we moving the needle for CYSHCN in Delaware?	Medical home is a new priority area for our Title V Program, and we will be tracking progress on the goals listed above. In order to effectively measure progress in this area, we need to establish a baseline of the number of pediatric practices within the state that meet the criteria for a medical home for CYSHCN, whether or not they have been accredited. A survey to establish this baseline is planned for the coming year.	

Population Domain Snapshot: *Adolescent Health*

Priority Health Need(s)	Objectives(s)	Strategies
Bullying Decrease rates of bullying by promoting development of social and emotional wellness. **State Performance Measure** Decrease the percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.	By July 2020, decrease the number of Middle School students reporting they are being bullied based on the YRBS survey by 2%. By July 2020, decrease the number of children who report being bullied on school property at the high school level by 2%.	**Defining the Need:** According to the 2013 Youth Risk Behavioral Survey, approximately 30% of students in the United States have experienced being bullied, and many children (70-85%) experience bullying either as victims, perpetrators, bystanders, or a combination of roles. The percentage of students who reported feeling sad or hopeless for two or more weeks at a time in the past twelve months was 22% for Straight students, 42% for Gay/Lesbian students, and 60% for those who identified as bisexual with 12.8% who seriously considered attempting suicide. **Accomplishments in the Past Year:** In the past year our efforts were concentrated on gaining the "lay of the land" with regard to the services and programs available in Delaware for students who are bullied or who bully others. MCH participated in numerous training sessions, webinars, conferences, and workshops focusing on bullying prevention. As in past years, MCH partnered with the Injury Prevention Coalition to sponsor their annual Safe Kid Conference. The conference included presentations that focused on bullying and more specifically, the social and emotional competence of children to cope with bullies. In addition, MCH participated in workshops focused on LGBTQ and Transgender issues and how to become effective allies for these community members. As part of our efforts to understand the programs and services available to adolescents for addressing bullying, we became aware of the work being done to address the mental and emotional impacts of bullying. MCH participated in the AMCHP sponsored Bullying Workgroup where we were offered opportunities to collaborate with other States who have selected National Performance Measure 9 through conference calls, webinars, and workshops to explore and discuss evidence based strategies that could be implemented to offer assistance for bullying prevention activities and messaging. **Plans for the Coming Year**: Going forward, our focus on bullying prevention will turn to building partnerships and collaboration with our community partners to bring training and education resources to our grass roots organizations such the Sussex County Health Coalition. Additionally, MCH will launch a new Bullying Prevention webpage that will offer resources and information for parents, students, and professionals on how to address bullying for children with and without special health care needs. The decision to add a State Performance Measure linked to NPM 9 was made with the goal of focusing on the mental and emotional impacts on bullying and how those impacts can lead to suicidal ideation among adolescents. We will explore evidence based strategies that help define how the impacts of bullying can lead to serious, and possibly fatal, health outcomes in middle and high school aged children.
Are we moving the needle for adolescents in Delaware?	This is a new priority area for our Title V Program, and we will be tracking progress on the goals listed above. However, we feel we have made great strides in understanding the education resources available in Delaware that address bullying prevention, but there is more work to do. We will continue to assemble tools that address the mental, emotional and physical impacts of bullying in order to share and disseminate information to our community partners.	

Population Domain Snapshot: *Health Issues That Cut Across the Life Course*

Priority Health Need(s)	Objectives(s)	Strategies
Oral Health Improve oral health preventive care for pregnant women and children	By July 2020, increase the percentage of pregnant women who have a dental visit during pregnancy from 39% to 43%. By July 2020, increase the percent of Delaware children, ages 1 through 17, who have an annual preventive dental visit from 77% to 80%.	**Defining the Need:** According to the CDC Pregnancy Risk Assessment Monitoring System, the percentage of Delaware women who reported visiting a dentist or dental clinic during their most recent pregnancy rose between 2007 (36.0%) and 2011 (40.5%). The percent of children ages 1-17 who received one or more preventive dental care visits declined from 78.4% in survey year 2007 to 77.2% in survey year 2011/12 (National Survey of Children's Health). **Accomplishments in the Past Year:** Partnering with DPH's Bureau of Oral Health and Dental Services (BOHDS), Title V provided technical assistance in developing a website marketing message that highlighted the Oral Health Tool Kit, Tooth Troop, as well as offering a provider resource listing for parents of children with and without special health care needs. The website will be integrated with our MCH website, DEThrives.com by the summer of 2016. MCH has also collaborated with our community partner, Sussex County Health Coalition, to support and align our Title V priority needs and strategies with their strategic plan for Oral Health in Sussex County. BOHDS provided training for our MCH Home Visiting staff and we are in the planning stages of extending that training to additional community partners. **Plans for the Coming Year:** We will work to enhance the data available on this topic by gathering oral health data from 2-1-1 Help Me Grow and the PRAMS survey and sharing it with stakeholders. We will also develop a better understanding of the barriers that exist with regard to oral health services for pregnant women and young children by collaborating with the BOHDS and health professionals that promote preventive oral health services for these populations.
Adequate Insurance Coverage Increase the percent of children who are adequately insured	By July 2020, increase the percent of families reporting that their CYSHCN's insurance is adequate and affordable. By July 2020, increase the number of health plans whose member services staff are linked to relevant family organizations and programs to meet the needs of CYSHCNs.	**Defining the Need:** According to the 2011/12 National Survey of Children's Health, only 78% of Delaware children are adequately insured. **Accomplishments in the Past Year:** Over the past several years we have supported Delaware Family Voices in holding a monthly Medicaid Managed Care Call to address the concerns, questions and issues that parents of children with special health care needs may have with their Managed Care Organizations (MCO). These calls have been particularly productive during the last two years, as changes in the Medicaid MCO's resulted presented many challenges for families. Meetings between Title V Director and the Director of the Division of Medicaid and Medical Assistance over the first year have resulted in a commitment to update the Memorandum of Understanding between the two organizations. The Title V CYSHCN director met with Meg Comeau, Co-Principal Investigator at the Catalyst Center, who has agreed to work with Delaware as we develop the MOU to reflect the current needs of both programs. **Plans for the Coming Year:** Meetings throughout the year with key state Public Health constituents including Delaware's Part C programs, Child Development Watch, Home Visiting, Newborn Screening and Public Health Nurses showed that there was clear interest from all programs to be better educated around Delaware's Medicaid program, particularly around the Managed Care Organizations and plans. As members of each of these organizations interact with the public, and often CYSHCN and their families, they wanted better understanding of the Medicaid program in Delaware so that they could both directly answer questions and better direct their clients' questions. To address this need the Title V program working with the Division of Medicaid and Medical Assistance plans to establish a series of seminars tentatively titled "Medicaid 101" in years 2 and 3 of this cycle to provide clear understanding of the Medicaid Programs in Delaware.
Are we moving the needle for Delawareans?	Data presented above show that we have much more work to do to increase preventive oral health care for pregnant women and children. However, these data are from surveys conducted in 2010-2012, and we hope to see improvements as we work to gather more recent information. Adequate insurance coverage is a new priority area for our Title V Program, and we will be tracking progress on the goals listed above. We intend to focus our initial efforts on adequacy of insurance for children and youth with special health care needs, and hope that by addressing the issue for this vulnerable population, all children and families will benefit from processes developed, lessons learned, and information shared.	

II. Components of the Application/Annual Report

II.A. Overview of the State

Geography and Demographics

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 within two hours driving distance from New York City and Washington, D.C.

According to estimates from the U.S. Census Bureau, in 2014 the State of Delaware had about 935,614 residents, of which 71% were White and 22% were Black. The Hispanic population is steadily increasing, from 6.5% in 2007 to 8.7% in 2013. About 22% of Delawareans are children under the age of 18.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 552,778 residents or about 60% of the state's total population. New Castle County has a large population of African-American residents (nearly 25%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 53% of the city's population). New Castle County also has a large population of Hispanic residents, 9.2%. Kent County, home to the state's capital of Dover, has an estimated 171,987 residents (69% White and 25% Black). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2014 population was approximately 210,849 (83% White, 13% Black). Like New Castle, Sussex County also has a growing Hispanic population, estimated at 9.2% for 2013. Since 2010, the state's population has increased by approximately 4.2% (U.S. Census Bureau).

In 2014, statewide, it is estimated that there were about 179,010 women of childbearing age (15-44 years of age) and 254,362 infants, children and adolescents aged 0-21 years of age (Delaware Population Consortium). Annually in the state, about 11,500 babies are born. In 2015, 3,749 children received services through Child Development Watch, Delaware's Birth to Three Early Intervention System (Kids Count in Delaware, 2016). According to the 2011/12 National Survey of Children's Health, it is estimated that 22.4% of Delaware's children have special health care needs.

Economic Indicators

In Delaware, from 2013-2015, it is estimated that 20.1% of children, aged 0-17, were living in poverty, with the highest rates among those children aged 0-5 (20.4%). Children in Kent and Sussex County were more like likely to live in poverty than children in New Castle County (24.9% vs. 16.7%). During the same time period, 25.8% of Delaware's children lived in a household with underemployed parents (where no parent worked full-time, year round). Over forty percent (41.6%) of children from single-parent households in Delaware lived in poverty, compared to 10.0% of children living in two-parent households. The median income of two-parent households in Delaware from 2013-2015 was $85,088, compared to $24,897 for single-parent households and $22,573 for female-headed households. Of Delaware's children, 36.8% lived in a one-parent household in the 2013-2015 time periods. Almost half (47.6%) of births occurring in the five-year period 2009-2013 were to single mothers, with 71.8% of Black births, 64.1% of Hispanic births, and 40.4% of White births occurring among single mothers (Kids Count in Delaware, 2016). As of 2015, an average of 71,393 households per month received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP), and an average of 5258 households per month received cash assistance through the Temporary Assistance to Needy Families Program (TANF) (KIDS Count in Delaware, 2016).

Availability of Health Providers

Although the state is relatively small, disparities exist between the state's three counties, as well as between rural and urban areas, with regard to healthcare access. Many of the state's geographic service areas are federally

designated health provider shortage areas (HPSA), as outlined below.

- New Castle County
  - Four areas are a Primary Care HPSA
  - One area is a Dental HPSA
  - Three facilities are Mental Health Facility HPSAs
- Kent County
  - Medically Underserved Population – whole county
  - Primary Care Low Income Population HPSA – whole county
  - Dental Primary Care Low Income Population HPSA – whole county
  - Two facilities are Mental Health HPSAs
- Sussex County
  - Medically Underserved Area
  - Primary Care Low Income Population HPSA – whole county
  - Dental Primary Care Low Income Population HPSA – whole county
  - Mental Health Low Income Population HPSA – whole county
  - One facility is a Mental Health Facility HPSA

Context for Title V within the State

In Delaware, the executive branch of state government is headed by Governor Jack Markell. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency, and is led by Secretary Rita Landgraf. The Delaware Department of Health and Social Services (DHSS) consists of 12 divisions and the Delaware Healthcare Commission, with an overarching mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. The Delaware Division of Public Health (DPH), one of the largest divisions within DHSS, is the Title V agency responsible for planning, program development, administration and evaluation of maternal and child health (MCH) programs statewide. DPH is led by Karyl Rattay, MD, MS, FAAP, FACPM who serves as the Division Director. Because our state does not have county or local health departments, DPH administers both state and local public health programs. Within DPH, the Family Health and Systems Management (FHSM) 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 provisions 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. As such, our Title V Program works closely with the DHMIC to align our priorities and strategies as much as possible. There are also provisions in Title 16 for school-based health centers and the Newborn Hearing and Screening Program, which are not funded by Title V, but work in close coordination with the program.

Current Priorities of the Division of Public Health

Although many plans exist in Delaware that aim to improve the health of Delawareans, historically the state has not had a comprehensive plan or a single group to oversee how plans are being coordinated and monitored. For this reason, the Division of Public Health initiated a State Health Improvement Process in 2011. The purpose of the process was to assess the health status of Delawareans in a systematic, organized, and collaborative manner and increase coordination and communication across organizational “silos,” while addressing core issues identified for action by the community. The result was Delaware’s first State Health Improvement Plan (SHIP), which outlines specific actions to be taken to improve the health of Delawareans, and provides information to be incorporated into

partnering organizations' strategic plans. Two priority goals were selected for the focus of the SHIP – healthy lifestyles and access to mental health. The newly formed Delaware Public Health Institute is now managing the SHIP, and work continues on the implementation of the developed action plans to address the priority goals.

Closely aligned with the SHIP is the strategic plan for the Division of Public Health, which was put into place in the Fall of 2014. The plan outlines four priorities, including promoting healthy lifestyles, improving access to quality and safe healthcare, achieving health equity, and improving performance. Action plans are being developed for each priority, guided by an emphasis on population-based activities and strategies that strengthen the ability of communities and community-based programs to improve health. Simultaneously, the Division has been engaged in seeking accreditation from the Public Health Accreditation Board, and achieved this prestigious designation in 2016.

The findings, goals, and strategies that are part of both the Delaware SHIP and DPH's strategic plan were intentionally factored in to the Title V needs assessment process, with the goal of leveraging the results of these comprehensive planning efforts. Not surprisingly, the input gathered from professional MCH stakeholders, families, and community members through surveys, focus groups, and interviews reinforced the priorities of healthy lifestyles, mental health, health equity, and access to quality health care. Therefore, you will find these issues identified as priorities in our five-year Title V action plan in an attempt to achieve collective impact by aligning our maternal and child health program with these larger efforts.

Health Equity

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

- **Infant Mortality.** In the time period of 2009-2013, the African-American infant mortality rate was 13.4 while the rate infant mortality among Whites was 5.1.
- **Breastfeeding.** In 2011/12, the percent of Black infants who were ever given breast milk was 67.3%, compared with 75.1% of White infants and 75.3% of Hispanic infants. Black infants also had the lowest rate of breastfeeding through 6 months (2011/12 National Survey of Children's Health – NSCH).
- **Teen Births.** In the time period of 2009-2013, the rate of births to teens (ages 15-19), was 41.5 births/1000 same aged females in Sussex County, compared with 31.1 in Kent County and 27.1 in New Castle County (Kids Count in Delaware, 2016).
- **Overall Health.** In 2011/12, only 62.7% of Hispanic children were reported to be in very good/excellent health by their parent, compared with 83.6% of Black children, 77.8% of Multi-racial children, and 91.6% of White children. There was a similar disparity for income level, with only 61.9% of children in households under 100% of the Federal Poverty Limit (FPL) reported to be in very good/excellent health compared with 90.5% of children in the 200-399% FPL bracket (2011/12 NSCH).
- **Smoking.** In 2011, White mothers had the highest rate of smoking during pregnancy (15.8%) compared to Black (14.3%) and Hispanic (6.2%) mothers (2011 Pregnancy Risk Assessment Monitoring System [note: Black and Hispanic estimates are based on 39 and 8 responses respectively]).
- **Medical Home.** In 2009/10, 46.5% of White children with special health care needs had a medical home, as opposed to 37% of Black children and only 19.6% of Hispanic children. Similarly, children in households with incomes under 100% FPL had significantly lower access to medical homes than those in households with higher incomes (2009/10 National Survey of Children with Special Health Care Needs).

Additional health disparities are presented in more detail in our needs assessment summary. However, 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.

There is momentum building to address health disparities in our state. The Delaware Division of Public Health has established health equity as a strategic priority for the entire division. The Delaware Healthy Mothers and Infants Consortium continues to emphasize health equity and the social determinants of health, through highlighting the topic on conference agendas, bestowing health equity awards, and launching an online Health Equity Action Center (http://healthequityde.com/). Recognizing the importance of social determinants of health, a place-based, community approach has been established as a key component of the state's largest health reform effort – the State Healthcare Innovation Plan.

Health Care Reform Efforts in Delaware

The goal of improving population health by addressing health disparities and social determinants of health will be greatly influenced by a transformative effort in our state called the State Healthcare Innovation Plan. In 2013, catalyzed by the State Innovation Models (SIM) initiative, a national grant program administered by the Center for Medicare & Medicaid Innovation (CMMI), stakeholders from across Delaware came together to develop a State Health Care Innovation Plan. The goal of the plan was to achieve the Triple Aim - to improve population health, improve health care quality and patient experience, and reduce the growth in health care costs. Delaware was awarded a "design" grant in 2013, and then a "testing" grant of $139 million in 2015 to support the implementation of our plan.

The plan takes a comprehensive approach to health system transformation, consisting of four core elements:

1. Supporting local communities to work together to enable healthier living and better access to primary care;
2. Transforming primary care so that every Delawarean has access to a primary care provider and to better coordinated care for those patients with the greatest health needs;
3. Shifting to payment models that reward high quality and better management of costs, with a common scorecard across payers;
4. Developing the technology needed for providers to access better information about their performance and for consumers to engage in their own health (http://dhss.delaware.gov/dhss/dhcc/cmmi/files/cmmi_modeltestgrant.pdf).

The Delaware Center for Health Innovation (DCHI), a non-profit organization dedicated to the implementation of Delaware's plan, was established in early 2014 to work with the Health Care Commission and the Delaware Health Information Network (DHIN) to guide the State Innovation Models effort and track its progress. It is important to note that the 15-member DCHI board represents a diverse group of partners, including major health systems and payers in the state, independent providers, Delaware's largest federally qualified health center, educational institutions, the business community, and state government. Committees have been established for each of the core elements, and are meeting monthly to move the plan forward.

While all of this work has relevance to health of Delaware's maternal and child health population, the efforts of the "Healthy Neighborhoods" (strategy 1) committee will be especially important for addressing the social determinants of health that lead to so many of the disparities in MCH outcomes described above. We also see the work of the "Patient and Consumer Advocacy" (strategy 2) as essential to our Title V work related to enhancing access to medical homes, and the "Payment Model Monitoring" committee as critical to our work in ensuring adequate insurance coverage. To date, the committees have been focused primarily on adult care and management of chronic conditions, which tend to be the drivers of high health care costs. However, we hope to be able to advocate for the needs of children, including children with special health care needs, on these committees, and offer recommendations on how these key audiences should be included in plans moving forward.

Process to Determine Title V Priorities

As will be reflected throughout this application, collective impact is a philosophy that is foundational to our work, and underpins our process to review competing factors and determine priorities for the Title V Program. The scope of maternal and child health is broad and the needs are extensive, and we know that the Title V Program does not have the resources or capacity to be successful in addressing these needs without engaging many partners and aligning our work with that of others. Therefore, we consistently aim to identify goals that we share with our partners, and use those goals as a lens to review emerging opportunities and needs.

This approach is clear in our needs assessment methodology, where a significant amount of effort was invested in seeking input from a diverse group of professional stakeholders on what the needs of the maternal and child health population were, and where they felt the Title V program should focus its attention. We also reviewed the goals of existing statewide plans, such as the SHIP, and factored those into our prioritization process. Health needs that were aligned with statewide goals were assigned a higher score for that criterion than health needs that were not a focus of other efforts in the state.

Along with “alignment with national/state goals”, the prioritization process for the needs assessment included six additional criteria that are routinely examined by the Title V Program team as we weigh competing needs. These criteria include: size of the health issue; seriousness of the health issue; current level of intervention; community support, importance to our consumers; and disparities in outcomes. The Five-Year Needs Assessment Summary and State Selected Priorities sections of this application provide more detail on how these criteria were considered and applied in our prioritization process.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

To address the build-out of the Five-year State Action Plan, an Action Plan Steering Committee comprised of MCH Leaders was established along with a process by which all domain leaders would select their evidence based strategies. Each Domain Leader facilitated work groups that focused on the strategic planning process for each of the 8 national priorities selected. These work groups were a partnership comprised of state and community stakeholders. The work group purpose was to identify strategies and evidence-based/informed measures to address Delaware's Title V priorities.

Delaware worked with John Snow Inc., to review and research evidence based strategies provided by the new HRSA-funded initiative that supported states in their development of strategies to promote the health and well-being of maternal and child health populations in the US, The Strengthen the Evidence Base for Maternal and Child Health (MCH) Programs initiative was undertaken by Johns Hopkins. Each domain workgroup received a list of identified and appropriate strategies for consideration and were encouraged to present additional strategies that they would like to have been considered.

In addition to the list of strategies, each workgroups was given a Strategy Grid to select strategies and evidence informed measures that would be used for the strategic planning process. The Strategy grids facilitated work groups in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool was particularly useful when agencies were limited in capacity and wanted to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing these challenges through a lens of diminished quality in services, the strategy grids provided a mechanism to take a thoughtful approach to achieving maximum results with limited resources.

After reviewing the strategies, the work groups began the categorization and prioritization process by placing competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. This process was guided by posing Feasibility and Need criteria questions to the group. The feasibility and need criteria were just a few criteria/questions for consideration. Each work group determined if the criteria made sense and if there were others that should be included. After completing the categorization and prioritization process using the Strategy Grid the work groups selected priority Evidence-based/informed measures that could be used to populate the Five-year Action Plan table. In some cases, the strategies listed in the original Action Plan remained the same, but in some cases the strategies were modified or deleted based on the workgroup discussions and findings. As strategies were finalized, three of our workgroups were able to identify our State Performance strategies and measures. Discussion and evaluation of strategies netted SPMs for the Women/Maternal, Infant, and Child population domains.

A tracking tool was developed as way to record information on each of the strategies developed and coordinating ESMs. Information from our measures will be recorded annually if not quarterly. This information will then be transferred into a MCH data dashboard enabling us to show our stakeholders and communities the progress being made in our identified priority needs. This data dashboard will be visible on our DEThrives website.

MCH gathered community input and feedback by offering presentations on our Needs Assessment findings, updates on our action planning process, and by creating a comprehensive Title V marketing brochure. Upon completion of our MCH Block Grant Review, members of our MCH staff presented our Needs Assessment findings and State Action Plan to various community action groups as well as to our internal partners who contributed to the process. We are especially proud of our MCH Title V Overview brochure that was completed in time to be shared at the Annual Delaware Health Mothers and Infants Consortium Summit (DHMIC) which was held in April, 2016. This marketing tool was designed as a tri-fold brochure that provided a Needs Assessment overview and action planning

roadmap for our priorities and objectives for the next five years. Stakeholders such as Family Shade, DHMIC, The Sussex County Coalition, the Home Visiting Advisory Board, the Safe Kids Coalition, and the Help Me Group Advisory Community were just a few of the groups that were contacted for input and feedback.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Delaware's 2015 Title V needs assessment benefited from the commitment and engagement of its stakeholder (including families) community. Instead of relying solely upon data to drive the assessment and prioritization process, the Delaware Division of Public Health (DPH) employed multiple methods to engage partners and consumers, valuing their unique perspectives, contributions and assessment of the state of MCH in Delaware. Thus, following closely the ten steps of the State Title V Maternal and Child Health Needs Assessment Framework, the 2015 Strengths and Needs Assessment consisted of the following major tasks:

Establish Assessment Advisement Process. DPH established a MCH Strengths and Needs Assessment Steering Committee that was convened on a monthly basis for the purpose of reviewing the proposed assessment methodology, monitoring assessment progress, and reviewing draft primary data collection tools, and topic briefs as well as pilot testing the prioritization process.

Develop Plan for Public Input Process. Several methods were employed to gather public input including monthly 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 to be the stories behind the data. Stories help explain and animate what the numbers are saying, becoming another source of valuable data—qualitative data. The timing and sequence of gathering public input was iterative with each activity laying the ground work for subsequent activities.

Quarterly email updates: These email updates provided 700+ stakeholders an initial purpose and overview of the Title V strengths and needs assessment process, communicating what stakeholders can expect over the nine month assessment process. Subsequent email updates described assessment progress to date and next steps.

Community forums/listening sessions: Division staff attended coalition, program, and special initiative meetings across the state to discuss the assessment process and solicit input.

Focus Groups: Nine focus groups (three of which were in Spanish) were conducted statewide. Five to ten individuals participated in each focus group for a total of eighty-six participants. Three discussion guides were created for each set of focus groups and were translated into Spanish. Respondents received handouts for which they were asked to review and identify priorities for women's health and children and youth with special health care needs.

Surveys: A Professional Stakeholder Survey was developed and disseminated to providers of MCH service agencies, organizations, coalitions and programs for input on MCH population needs, system gaps and leverage points. The survey also provided stakeholders an opportunity to rank the fifteen national priority areas. The survey was disseminated electronically with a total of 247 completed surveys. In addition, a Families of Children and Youth with Special Health Care Needs Survey was conducted for the purpose of hearing the consumer voice about their experience in navigating the system of care, system strengths and opportunities for improvement. Electronic and hard copy surveys (available in English and in Spanish) were disseminated statewide with a total of 202 completed.

Key Informant Interviews: In order to learn more about system strengths and needs and to better understand the landscape of services and supports, DPH identified stakeholders to participate in key informant interviews. A total of twenty-two stakeholders were invited to participate in key informant interviews. All twenty-two stakeholders representing advocates, policy makers, insurers, hospitals, community based organizations and providers were interviewed via phone for 1.0-1.5 hour

conversations. Ten of the twenty-two stakeholders solely focused on children and youth with special health care needs.

Conduct Secondary Data Source Review and Collection. An inventory of relevant quantitative data (state and national) to be included in the assessment based on the MCH population domains and fifteen priority areas was conducted. Secondary data collected were used to inform the development of the fifteen topic briefs. Data sources accessed included the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (BRFSS), Birth Certificates 2006-2010 from Delaware Vital Statistics, Pregnancy Risk Assessment Monitoring System (PRAMS), National Survey of Children's Health 2011-2012, State hospital discharge data in the State Inpatient Databases (SID), Centers for Disease Control and Prevention (CDC) National Immunization Survey (NIS), Centers for Disease Control and Prevention, Primary Cesarean Delivery Rates, by State: Results from the Revised Birth Certificate, National Vital Statistics Report, and Linked birth certificate and hospital data on NICU levels from American Academy of Pediatrics (AAP).

Conduct Census of Services and Programs. A census of services and programs currently in place serving the MCH population was conducted. The census helped to identify system strengths and gaps.

Select Final Priorities and Performance Measures. The goals of the prioritization process were to 1.) Use a data-informed method to identify and prioritize Delaware's top health issues related to the health of women, infants, children and youth, including children and youth with special health care needs; and, 2.) Incorporate stakeholder and public input into finalizing the priority areas by population domain for action planning. The Steering Committee held a day-long review and prioritization meeting. Prior to this meeting members were provided a binder consisting of information sheets, survey findings as well as findings from the key informant interviews and focus groups. Members were asked to review these documents and complete their own independent prioritization process using the ranking worksheet (see Appendix A: Ranking Worksheet). The Steering Committee members then engaged in the following group prioritization process:

- **Review** information presented on each priority area based on quantitative data and summary of findings from stakeholder survey, consumer focus groups and key informant interviews.
- **Rate** each health issue on a scale of 1-5 against each of the specified criteria.
- **Discuss** individual ratings as a group, by health area, and make final adjustments to individual ratings as necessary.
- **Calculate Priority Scores** by tallying each committee members' sheets at the end of the review session. All ratings were be tallied by health area and then averaged by dividing the total by the number of committee members participating in the review.
- **Rank** the health problems – based on the average priority scores.

II.B.2. Findings

The following section presents key findings of Delaware's MCH population health status including CYSHCN, based on primary and secondary data collected through public health surveillance systems, surveys, key informant interviews and focus groups. The findings are organized by population domains and associated national performance measures. Considering MCHB's revised measurement framework for Title V, our 2015 needs assessment was designed to focus at the national performance measure level. A detailed presentation of surveillance data by each performance measure can be found in Appendix B: MCH Topic Briefs.

II.B.2.a. MCH Population Needs

i. Maternal/Women's Health

Well Woman Care (NPM 1)

Between 2011 and 2013, the percent of women in Delaware with a routine checkup within the last year declined slightly for women ages 18 or older from 82.6% to 81.0%[i],[ii],[iii]. This pattern is evident within different age groups, with the most significant decline for women between 25-34 years (from 80.5% to 72.3%). Women of Hispanic and Other non-Hispanic race experienced the most noted decline in routine check-up within the last year from 83.5% to 76.3% and 87.0% to 77.2% respectively. Black women had the highest rate of receiving a routine checkup compared to other races. Patterns of decline are also seen by income level. Women in mid-to low income levels experienced declines, whereas women in the lowest income category (less than $15,000) had increased and highest rate of routine checkup (86.7% in 2013).

Preventive care for women was seen as of high importance; ranked #5 among the 15 priority areas by respondents of the 2015 Stakeholder Survey. Key informants noted the increased messaging and initiatives in the state around prenatal and perinatal health as part of promoting well woman care contributed to the progress being made. Other efforts include raising awareness and messaging around diabetes and cancer. Key informants emphasized the importance of incorporating weight management, diabetes prevention/management in preconception and inter-conception care and highlighted the impact of these services have on lowering infant mortality rate in the state. Key informants also proposed reframing the idea of well woman care to transform it from being episodic to creating a continuum of care as a strategy for addressing women's health. This includes provider engagement and education around a "life course" approach to care.

Focus group findings highlight the lack of understanding, especially among low-income and minority women, of information they should ask their provider at health care visits. Participants reported that doctors were often too quick to provide medications and tests and women themselves did not have a clear understanding of their own preventive health care needs. While a high percent of women in Delaware receive routine checkups, multiple barriers still exist creating disparities in access. Lack of education, transportation, availability and affordability of services were barriers identified by focus group participants. Cultural beliefs about the importance of seeking preventive health care present the biggest challenge in certain communities. While there has been progress in the state in promoting awareness of preventive care in women of childbearing age, it is noted that there is not an equal distribution of these benefits. Disparities persist among minority and low-income women when systems in the community do not support the adoption of healthy behaviors.

Low-risk cesarean deliveries (NPM 2)

In Delaware, cesarean deliveries among low-risk first births increased from 2006 (23.5%) to 2010 (27.8%)[iv]. The five-year average over this time period was 24.4% (compared to the national average of 27.6% in 2010[v]) Between 2006 and 2010, Black, non-Hispanic (Black NH), women had the highest percentage of cesarean deliveries among low-risk first births (30.8%), followed by White, non-Hispanic (White NH) (27.5%), Other, non-Hispanic (Other NH) (26.1%), and Hispanic (23.4%).

Low risk cesarean deliveries was ranked #15 by stakeholders. There has been considerable effort in recent years to reduce the occurrence of non-medically indicated cesarean delivery on a national level. This is evident in Delaware with the March of Dimes "39 Week" campaign with the goal of decreasing the rate of elective deliveries less than 39 weeks. Hospital policies and other institutional quality improvement efforts to reduce and eliminate elective deliveries are also contributing to the steady decline in low-risk cesarean rates. However, disparities by race/ethnicity point to the continued work that needs to be done in this arena.

ii. Perinatal/Infant Health

Perinatal Regionalization (NPM 3)

In Delaware the only Level III certified NICU is at Christiana Care Hospital in Newark, DE. There is a Level II NICU at Kent General Hospital in Dover, DE but Level II NICUs generally do not have the capacity to handle life-threatening issues and often must transfer such cases to Level III facilities. Babies born with very low birth weight ("VLBW", or under 1,500 grams or 3.25 pounds) are at increased risk of dying within the first year of life.[vi] The percentage of VLBW babies accounted for only 1.8% births to mothers in Delaware between 2006 and 2010[vii]. This rate is slightly above the national (2007) benchmark of 1.5%.[viii] Between 2006-2010, the percent of VLBW births at a facility with a Level III NICU increased from 78.3% in 2006 to 81.7% in 2010[ix]. The average percent over that five year period was 79.0%. Between 2006 and 2010 (5-year combined), the highest percentage of VLBW infants born at a facility with a Level III NICU were Hispanic (82.1%), followed by White NH, (79.8%), Black NH (78.4%), and Other NH (78.1%).

Stakeholder survey respondents ranked perinatal regionalization #13 among the 15 areas. Delaware has made tremendous strides in perinatal regionalization through its quality improvement efforts shepherded by the Perinatal Cooperative. This Cooperative works to establish standards of care and policies around perinatal issues. Similar gains using quality improvement were noted for breastfeeding, also included in this domain. Strengthening the state's data systems will enable better use/application of quality improvement.

Breastfeeding (NPM 4)

According to the 2003, 2007, and 2011/12 National Survey of Children's Health (NSCH), the percent of children ages 0-5 in Delaware who were ever breastfed or fed breast milk increased from 62.1% in 2003 to 72.4% in 2011/12. This increase was reflected nationally (from 72.3% to 79.2%)[x],[xi],[xii] Between 2007 and 2011/12, the percent of children ages 0-5 who were ever breastfed or given breast milk increased for the race/ethnicity categories of White NH from 72.3% to 75.1% and for Black NH from 61.8% to 67.3%. The percent decreased for the race/ethnicity categories of Other NH from 92.7% to 69.5% and for Hispanic from 80.8% to 75.3%. Between survey years 2003 and 2011/12, the percent of children ages 0-5 who were ever breastfed or fed breast milk increased across all household income levels, with the greatest increase seen among children from the lowest income level (35.1% in 2003 to 62.9% in 2011/12).

In 2007 and 2011/12, the percent of children between the ages of 6 months and 5 years who were exclusively breastfed or given breast milk for their first six months increased in Delaware from 10.6% in 2007 to 13.0% in 2011/12, and from 12.4% to 16.0% nationally over the same time period[xiii],[xiv],[xv]. In the most recent survey, the national average (16.0%) was higher than Delaware (13.0%). Between 2007 and 2011/12, children who were exclusively breastfed for six months increased for White NH from 9.7% to 14.3% and Other NH from 12.8% to 20.9%, but decreased for Black NH from 11.1% to 8.7% and Hispanic from 13.1% to 11.0%. In survey year 2011/12, the race/ethnicity category of Other NH (20.9%) had the highest percentage, followed by White NH (14.3%), Hispanic (11.0%), and Black NH (8.7%).

Differences can be seen by income levels as well. Between 2007-2012, children exclusively breastfed for six months increased among higher income level households (from 9.6% to 13.1% for 200-399% FPL and from 9.3% to 20.7% for 400% FPL or higher) and decreased among lower income level households (from 10.6% to 4.3% for 100-199% FPL and from 15.4% to 9.9% for 0-99% FPL). This is in contrast to national estimates which increased across all household income levels between survey years 2007 and 2011/12.

Stakeholder survey respondents ranked breastfeeding #7 among the 15 priority areas. Key informants commented on the need for more hospitals to become breastfeeding friendly and focused outreach and education to African American communities. For the state, WIC continues to be a keystone in breastfeeding promotion efforts as the program, located in eleven service locations, supports women with infants to breastfeed. System initiatives include the state's Breastfeeding Coalition of Delaware's Baby Friendly Hospital Initiative that works closely with hospitals to obtain a "Baby Friendly Hospital" designation which means that the hospital is committed to providing information and instilling the confidence and skills needed to successfully

initiate and continue breastfeeding.

Safe Sleep (NPM 5)

The percentage of mothers in Delaware who reported most often laying their baby on his or her back to sleep slightly declined from 75.7% in 2007 to 73.7% in 2010[xvi]. National estimate data are not available for this survey as it is not administered in all fifty states.

Hispanic mothers saw the greatest change from 78.6% in 2007 to 70.3% in 2010. The percent of Other NH mothers also declined from 76.2% in 2007 to 74.2% in 2010 as did the percent for White NH mothers from 80.7% to 79.0%. The percent for Black NH mothers increased from 62.2% to 63.4%. In 2010, White NH mothers (79.0%) had the highest percent, followed by Other NH mothers (74.2%), Hispanic mothers (70.3%), and Black NH mothers (63.45%).

The percentage of mothers who reported most often laying their baby on his or her back to sleep appears to be correlated with income level between 2007 and 2010, as mothers at higher income levels had higher percentages than mothers at lower income levels. Between 2007 and 2010, the percentages declined for the income categories of less than $10,000 (66.3% to 63.4%), $10,000 to $24,999 (74.5% to 70.9%), and $25,000 to $49,999 (73.2% to 70.2%). The percent slightly increased for the income category of $50,000 or more from 82.6% to 83.1%.

Stakeholder survey respondents ranked safe sleep #12 among the 15 areas. Key informants commented that more works needs to be done on safe sleep. One observation shared was that safe sleep messaging appears to be competing with the breastfeeding message. One strategy suggested for rectifying this is by increasing community awareness and opportunities for parent education.

iii. Child Health

Developmental Screening (NPM 6)

The percent of children screened for being at risk for developmental, behavioral and social delays using a parent-reported standardized screening tool during a health care visit in Delaware increased from 10.9% in 2007 to 30.8% in 2011/12[xvii],[xviii]. In 2007, the rate for the state (10.9%) was lower than national estimates (19.5%). In 2011/12, they were equivalent (30.8%). Between 2007 and 2011/12, the percent of children screened increased among White NH (11.7% to 30.2%), Black NH (9.8% to 27.8%), and Hispanic children (16.6% to 38.3%). Survey year 2011/12, the percent screened was lower than national estimates within Black NH (27.8% & 31.7%) and within Other NH (28.7% & 31.2%). The percent screened in Delaware was higher than national estimates within White NH (30.2% & 29.9%) and Hispanic (38.2% & 32.4%). Between 2007 and 2011/12, the percent of children screened increased within all household income levels—from 9.2% to 20.5% in 0-99% FPL and from 12.2% to 31.1% in 400% FPL or higher.

Stakeholder survey results revealed developmental screening as ranked #1 among the 15 priority areas and also within the child health domain.

The state's commitment to and work on developmental screening resulted in significant progress however consumers and stakeholders alike recognize that there is still more work to be done. For example, expanded screening of families for depression and not just developmental delay in the child was one area for improvement identified. Others included improving access to the initial diagnosis of a child, ensuring adequate follow up (post diagnosis), and addressing geographic disparities (and barriers to services and care), specifically in Kent and Sussex counties. Some of the state's initiatives underway that will support further progress include Child Development Watch, Help Me Grow/2-1-1 and PEDS Developmental Screening. All three of these initiatives are statewide with Help Me Grow/2-1-1 and PEDS Developmental Screening focusing on increasing consumer awareness, knowledge and understanding of the importance of screening and directing families to resources,

support and services. Child Development Watch is an early intervention for children 0-3 years of age with a range of developmental delays.

Injury Prevention (NPM 7)

According to the Delaware Trauma System Registry, the rate of non-fatal injury hospitalizations per 100,000 children ages 19 and under increased from 2011 (592.8) to 2013 (623.2). Hospitalizations were higher among males compared to females, but rates increased for both males and females. Between 2011 and 2013, the rate of hospitalizations due to injury increased from 738.3 to 761.0 for males and from 441.7 to 477.4 for females. While rates of hospitalizations were highest among white children/adolescents (648.6), followed by Black (545.1), Hispanic (516.3) in 2013, these rates represent a decline only among white children/adolescents; Black and Hispanic hospitalization rates for non-fatal injuries increased from 2011-2013.

According to our stakeholder survey, childhood and adolescent injury prevention was ranked #8 among the 15 areas. With the increased attention to head injuries and concussion management, there has been a concerted effort in Delaware to increase awareness and educate school personnel, especially coaches on the rules regarding “back to play” policies. The focus has been more on sports related injuries with a workgroup consisting of Department of Education, physical therapists and Nemours holding a summit on concussions in Fall 2014.

Families of CYSHCN expressed concern about several injury related issues including bullying, accidental injury, safe transportation, and home safety. Counseling regarding home safety during child check-ups may be an opportunity for improvement.

iv. Adolescent Health

Physical Activity (NPM 8)

The growing trend that physical activity among adolescents compared to children declines is reflected in data from the Delaware Survey of Children’s Health (2008 and 2011). Data also shows differences by race/ethnicity. Increase in physical activity, as measured by percent of children meeting recommendation of engaging in moderate-to-vigorous physical activity for 60 minutes or more every day, were evident among white adolescents while declines were seen among Black and Hispanic adolescents between 2008 and 2011. Supplemental 2013 Youth Risk Behavior Survey (YRBS) data shows that 23.7% of Delaware high school students and 27.3% of middle school students report being physically active for at least 60 minutes per day on all 7 days[xix].

Physical activity in children and adolescents is a top priority in Delaware, ranked second out of the 15 priority areas according to the 2015 Stakeholder Survey. Key informants shared that there have been increased awareness and messaging from the state promoting active living. Combined with messaging, there have been efforts to increase environmental supports such as the availability of green space and bicycle trails. However, social factors such as income, education, neighborhood location has meant that not all communities have benefited or have access to these supports. Focus group participants pointed to the lack of programs in general, especially affordable options for summer camps as a place for children and adolescents to be physically active. The importance of nutrition and ensuring access to fresh fruits and vegetables was a noted strategy that is related to promoting physical activity. Parent education around nutrition as well as physical activity was emphasized. Schools have been traditionally seen as the natural environment to promote physical activity. Proponents have called for mandatory recess through middle and high school but have been challenged by the emphasis on academic achievement which often trumps the promotion of physical activity in schools.

Bullying (NPM 9)

The percent of high school students in Delaware reporting being bullied on school property in the last 12 months increased from 15.9% in 2009 to 16.5% in 2011 to 18.5% in 2013[xx]. In 2014, a greater proportion of middle

school students reporting being bullied (43.1%) than high school students (18.5%)[xxi]. Increases in reports of being bullied were evident among White (18.2% to 21.5%) and Black (10.5% to 15.3%) high school and middle school students in Delaware from 2009-2013, whereas a decrease was observed for Hispanic students (16.3% to 14.3%). All school districts in Delaware have incorporated bullying as part of school climate into their overall school wellness policies. Much of the progress in addressing bullying and ensuring a safe school environment has been through the advocacy for LGBT students. In-roads made by these groups need to be applied to the general population.

The stakeholder survey showed that Bullying ranked 10th among the 15 health priority areas, however our focus group discussion report showed that bullying was one of the most important issues with our parents, and especially with our families of children with special health care needs. The adequacy of resources to pay for evidence-based curricular and support ongoing professional development was underscored by key informants as a challenge in being able to address the issue. In particular, bullying impacts CYSHCN. Parents in focus groups expressed concern about their children's ability to cope with bulling and called for more training, education and awareness for teachers, daycare providers and para educators. In addition, key informants pointed to bullying as a symptom of larger systemic issues and called for a more comprehensive approach that includes self-esteem and character development at an early age, ensuring supportive mental health services, professionals being able to recognize depression and low self-esteem in adolescents and providing parent education about the use of social media.

Adolescent Well Visit (NPM 10)

The percent of children in Delaware ages 12-17 who received one or more preventive medical care visits within the last year increased from 81.0% in survey year 2003 to 86.6% in survey year 2011/12, and from 73.0% to 81.7% nationally over the same time period[xxii],[xxiii],[xxiv]. However, more recently, the percent declined from 89.4% in 2007 to 86.6% 2011/12 in Delaware and from 84.2% in 2007 to 81.7% nationally. In 2013, the percent in Delaware (86.6%) was greater than the national estimate (81.7%).

Adolescent well visit was ranked #4 of 15 priority areas and ranked #1 within the Adolescent Health Domain by respondents of the Stakeholder Survey. School based health centers and the role of the school nurse as part of the health care team is gaining importance in ensuring health of the adolescent population in Delaware. The state has a fairly robust network of school based health centers with 29 contracted to provide preventive health care services and linkages with primary care providers and other services and supports. State regulations require children to have a physical exam at the time of school entry, with a second appraisal at 9th grade. In addition to state mandate for a full time nurse to be stationed at every school (including charter schools), the Student Health Collaborative, a partnership between Nemours and neighboring school districts allows school nurses to have access to the EMR of students. Innovative strategies like these have been cited as evidence for progress in this arena. Ongoing challenges include the lack of medical home for adolescents where mental health needs can be coordinated, especially in Sussex County. Reproductive health services for adolescents in schools were also cited as an ongoing challenge in the face of rising unplanned pregnancies among adolescents in Delaware. While Title X partners have a statewide presence and include Planned Parenthood of DE, Children and Families First (ARC), DE State University (DSU students only), La Red Health Center, Westside Health; State Family Planning Clinics (6 sites), focus group participants also pointed to the need for translation services for Spanish speaking parents of adolescents to ensure access.

v. Children and Youth with Special Health Care Needs

Medical Home (NPM 11)

In 2011, 22.4% of children require special care, 41.4% of which in Delaware had a medical home, slightly below the national average of 43%, however disparities persist. For Black NH families, 37% had a medical home and

experiencing a much greater disparity, 19.6% of Hispanic families had a medical home. Economic disadvantage was also an indicator of families of CYSHCN less likely to have a medical home. 31.8% of families at 100-199% FPL reported having a medical home, compared to 55.4% of the high income level.[3]

According to our stakeholders, Medical Home was ranked #6 among the 15 areas. Survey and consumer focus group findings indicate that there is still work to be done around consumer education and awareness of what a Medical Home is and the services that it encompasses. Care coordination, for example, is not perceived as a standard of practice and families are unclear about what they can expect. Cultural competence and person-centered care were also noted as areas for improvement. And while consumers could identify and speak to their Medical Home none could identify a Dental Home which was noted as a system gap. These examples highlight overarching themes from survey, focus group and key informant interviews: 1.) Families are overwhelmed and have difficulty navigating the system of care to access needed services; and, 2.) There are opportunities for workforce development and enhancement given the shortage of providers who can care for CYSHCN and the need cultural competence training. However, Delaware has models from which to learn. The collaboration within the home visitation initiatives and Early Head Start were identified by stakeholders as successful as was the referral network for newborn hearing screening.

Transition (NPM 12)

In 2011, 22.4% of children require special health care in Delaware.[3] Survey results show that 38.4 % of CYSHCN received services necessary to make transition to adult health care. Significant racial disparity is observed with 16% of Hispanic CYSHCN received these services, compared to 53% of Non-Hispanic children.

As part of the 2015-2020 Title V Needs Assessment, maternal and child health stakeholders recently completed a survey to identify priority areas for addressing the health needs of Delaware's women, mothers, and children. With regard to transition services, the survey results revealed that transition (for children with and without special health care needs) was ranked #11 among the 15 areas.

Consumers and key informants were in agreement that there is room for improvement in comprehensive transitional services including employment, life skills, financial management, housing and job training. Families lack the knowledge, resources and support to navigate and facilitate transition for their YSHCN. Few families reported that their child's doctor had addressed transition with their child and many families would welcome a "roadmap" for transition as well as peer support groups. Transition system gaps appear most noticeable when the child is entering school and transition from high school. However, Delaware has a significant stakeholder base of individuals who collaborate well to continue to make progress in this area. There are excellent model programs and initiatives in the state such as the Transition Clinic at AI duPont Hospital for Children (Nemours), the Transition Task Force and the partnership work that is underway with the school system all of which are leverage points. Family SHADE - the Family Support and Health Care Alliance Delaware is another excellent resource. This alliance of organizations, agencies, families work to improve quality of life for CYSHNC by connecting families and providers to information, resources and services. Looking ahead, the state acknowledges that implementation of the Transition Plan may help to push progress even further.

vi. Cross-cutting/Life Course

Oral Health (NPM 13)

The percentage of women in Delaware who reported visiting a dentist or dental clinic during their most recent pregnancy rose slightly between 2007 (36.0%) and 2010 (39.0%)CDC [xxv]. While these rates are increasing for all racial groups, Hispanic women had the lowest rates of dental visit during pregnancy for all four survey years (22.3% compared to 45.9%. of white, 31.6% of black and 44.2% of other women in 2010.) Similarly, there are differences by income levels where 61.3% of women with a household income of $50,000 had a dental visit compared to only 21.2% of women with incomes of less than $10,000.

Based on data from the NSCH, 76.8% of children in Delaware received preventive dental visits in 2007 compared to the national average of 77.2%. In 2011/12, this percentage increased to 77.2%, equal to the national average. Delaware children experience disparities in preventive dental visits as well. While 83.3% of White NH children received a preventive dental visit for survey year 2011/12, 75.9% of Black NH and 65.5% of Hispanic children reported a preventive dental visit. For Hispanic children in particular, this percentage is well below the national average for this racial category (73.9%).

Access to preventive and specialty dental care has been an ongoing issue in Delaware. Over the last 8 years, an active Oral Health Coalition made up of providers, policy makes and other stakeholders have been advocating and supporting legislation in the state to increase access to dental care to both children and pregnant women. In particular, the coalition has been a strong advocate for Medicaid coverage for perinatal oral care. The coalition's "Tooth Troupe" program provides training to parents, teachers and child caregivers to promote oral hygiene and prevent early tooth decay. More recently, the coalition broadened its mission to reach disabled as well as older adults. Strategic partnerships with organizations that are embedded in the community like the Boys and Girls Club in Sussex County will ensure sustainability of Tooth Troupe educational efforts. Lastly, Delaware's five Dental Services Clinics is another key resource for the state, providing dental services to Medicaid eligible clients under 21.

Stakeholder survey results point to oral health as a relatively important issue (ranked #9 of 15). While insurance coverage is an ongoing impediment for children's access to preventive dental care, availability of dentists and orthodontists that have specialized equipment and space was expressed as a major challenge by families of CYSHCN. Other factors that impact persistent disparities in dental health outcomes include low literacy levels and poor access to transportation. There remain important opportunities for Delaware – in terms of partnerships, and education in communities, especially on the concept of a "dental home".

Household Smoking (NPM 14)

Delaware PRAMS data shows that the percent of mothers who smoked during the last three month of pregnancy increased between 2007 and 2009 from 12.6% to 16.6% and then declined from 2009 to 2010 from 16.6% to 12.8%[xxvi]. 2010 PRAMS data showed that White NH mothers had the highest rate of smoking during pregnancy (17.8%) compared to Black NH (9.3%) and Hispanic (2.4%). Smoking during pregnancy also appears to be negatively correlated with income level. NSCH data show that exposure to secondhand smoke among children 0-17 years declined in Delaware from 32.8% in 2003 to 23.5% in 2011/12. This is below the national average of 24.1% for 2011/12. This decline was seen among White, Black and Hispanic children between 2003 and 2011/12.

Survey respondents ranked smoking cessation/prevention at #14 out of 15 priority areas. This may be due to the perception that progress is being made in Delaware in relation to other priority areas. This progress can be attributed to a strong tobacco control program in Delaware that advocates a multi-prong approach targeting individual behavior as well as providing community supports such as mini-grants to communities, social marketing campaigns and enforcing clean indoor air policies. Delaware's Quitline and Maternal, Infant and Early Childhood Home Visiting programs are additional examples of population and individual based approaches also lending to the state's success. However, the perception of success has led to reduction in funding for smoking prevention/cessation programs. This presents challenges as new products such as e-cigarettes heavily promoted by the tobacco industry flood the market and is especially appealing to youth and young adults.

Adequate Insurance Coverage (NPM 15)

In 2007 and 2011/12 a higher percentage of children in Delaware were adequately insured (79.9% and 78.0%) compared to national estimates (76.5% for both survey years)[xxvii]. The slight decline in adequacy of insurance is also reflected when data is stratified by race and household income with the most significant decline among

Hispanic children (81.4% in 2007 to 77.5% in 2011/12). In Delaware income levels 200-399% FPL shows greatest decline in adequacy of insurance.

The 2015 stakeholder survey showed this issue was ranked #3 of 15 priority areas. Qualitative data collected as part of the needs assessment process point to the importance of this issue, particularly for families with CYSHCN. In focus groups, surveys and key informant interviews for the CYSHCN population, respondents pointed to the lack of or inadequate coverage for needed services for their children. Expenses ranged from respite care to medications and equipment. Financial strains due to out of pocket expenses and having to travel out of state for appropriate care was listed among the top challenges that CYSHCN families faced.

There remain opportunities in the state to address the adequacy of insurance coverage for all populations. Delaware Healthy Children Program provides one leverage point. This program offers low cost health insurance program for the state's uninsured children. New managed care requirements for CYSHCN families provide opportunities for education and outreach to families on how to access the coverage that they may already have. Critical to this is the strengthening of the information sharing infrastructure in the state. Without updated demographic and contact information of members, outreach is limited, especially to the most vulnerable populations in the state.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

In Delaware, the executive branch of state government is headed by Governor Jack Markell. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency, and is led by Secretary Rita Landgraf. The Delaware Department of Health and Social Services is the largest state agency, employing almost 5,000 individuals in a wide range of public service jobs. The department consists of 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long term care, visual impairment, aging and adults with physical disabilities, and Medicaid and medical assistance. The divisions are united by an overarching mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.

The Division of Public Health (DPH), one of the largest divisions within DHSS, serves as the Title V agency in Delaware. Under the direction of Karyl T. Rattay, MD, the mission of DPH 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. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. Each strand is comprised of a number of sections. The Title V Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs are part of the Family Health and Systems Section (FHS), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH, and Leah Woodall, MPA is the section chief for FHS.

The Family Health Systems Section is the home of many of the programs funded by Delaware's Title V federal-state partnership. As such, the section chief for FHS, Leah Woodall, MPA, also serves as the state MCH Director. The section is comprised of three units. The Bureau of Maternal & Child Health is led by the MCH Deputy Director, Linda Tholstrup, MS. The MCH Bureau is responsible for direct administration of the Title V Block Grant,

and also includes the following programs: Children and Youth with Special Health Care Needs; Newborn Screening (metabolic and hearing); Birth Defects and Autism Registries; Early Childhood Comprehensive Systems; State Systems Development Initiative; and Home Visiting. The Bureau of Adolescent and Reproductive Health, led by Gloria James, Ph.D. includes the Adolescent Health Program (School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program, the Healthy Women, Healthy Babies Program, and the Pregnancy Risk Assessment Monitoring System. (See Appendix C: Organization Chart).

II.B.2.b.ii. Agency Capacity

As the Title V agency, DPH operates a comprehensive array of programs and services to promote and protect the health of Delaware's mothers 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 above. However, the capacity to support the MCH population extends throughout all sections and strands of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers, and supports for tobacco cessation, to name a few. An overview of DPH's programs and services for the MCH population is summarized below by Title V population domains.

Women/Maternal Health: Programs, services and information are available to women in three broad categories - general health, sexual and reproductive health, and maternal health.

In the category of general health, DPH's Office of Women's Health offers education to the public regarding a variety of women's health issues via outreach and a monthly newsletter. In the area of sexual and reproductive health, the Title X program offers family planning, testing for sexually transmitted diseases, birth control supplies, pap smears, breast exams, and HIV testing and counselling. Finally, to support maternal health, DPH operates the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program which provides evidence-based home visiting for pregnant women, statewide. The WIC program is also available to low-income pregnant women and provides nutritious foods to supplement diets, information on healthy eating, and referrals to other services.

In Delaware, many programs, campaigns and services in the area of maternal health stem from the work of the Delaware Healthy Mother and Infant Consortium (DHMIC). The mission of the DHMIC is to provide statewide leadership and coordination of efforts to prevent infant mortality and to improve the health of women of childbearing age and infants throughout Delaware. The Family Health Systems Section of DPH is responsible the DHMIC and administration of related programs and initiatives. One such program is the Healthy Women, Healthy Babies program, which facilitates extra services for women who are pregnant, planning to become pregnant, or want to live healthier lives. These services include weight and stress management, mental health treatment, prenatal care, and more. The DHMIC also develops educational materials and tools to promote reproductive life planning and to monitor fetal kicks.

Perinatal/Infant Health: Much of our capacity to promote maternal health extends to the support of perinatal and infant health. For example, Delaware's Perinatal Cooperative falls under the DHMIC umbrella and works to enhance communication and collaboration across birth hospitals to improve delivery of care. Related to infant health and the prevention of infant mortality, the DHMIC develops educational messages to promote important practices like safe sleep environments and breastfeeding; similarly, WIC and the MIECHV reinforce these messages. DPH has internal capacity to offer home visiting services using the Healthy Families America model. We also contract with outside agencies to extend our capacity to support families. These agencies use the Nurse-Family Partnership and Parents as Teachers models.

DPH's Newborn Screening program offers both metabolic and hearing screening for every infant born in

Delaware. The program also provides follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services.

Child Health: To support healthy growth and development in both infants and children, Delaware has implemented the Help Me Grow model to improve early identification of developmental issues and timely connection to services. A key component of this effort is increasing our rates of developmental screening by providing physicians with online access to the Parents' Evaluation of Developmental Status (PEDS) validated screening tool. Another key feature is a centralized telephone access point for children and their families, in partnership with 2-1-1. Based on screening results, a physician can refer pregnant women and families with children to Delaware 2-1-1, which is part of United Way of Delaware. Help Me Grow call specialists provide families with connections to existing resources statewide. DPH also offers lead testing, physicals, and immunizations through child health clinics at state service centers across the state.

Children and Youth with Special Health Care Needs: For children identified as highest risk for developmental delays, physicians can refer directly to Child Development Watch (CDW), the statewide early intervention program under the Birth to Three Early Intervention System. CDW is a collaborative effort with staff from DPH, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children working together to provide early intervention to young children with special health care needs and their families.

Another source of support for this population is Family SHADE (Support and Healthcare Alliance of Delaware). 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 (CYSHCN) by connecting families and providers to information, resources and services.

DPH also supports two surveillance efforts related to CYSHCN. The Birth Defects Registry collects and analyzes data on children diagnosed with a birth defect under the age of five. The Autism Registry collects basic descriptive information on the individuals with autism, tracking changes in prevalence over time to inform planning of services and supports.

The Division for the Visually Impaired (DVI) works to strengthen the capacity of our agency, consumers, and community so that those who are blind and visually impaired may become and/or remain, employed, independent and self-sufficient. The Child Development Watch Program works with DVI to provide service coordination for children who are blind or visually impaired.

Adolescent Health: School-based health centers (SBHCs) are core to our capacity to support adolescent health. Delaware is fortunate to have a SBHC in 29 of our 32 high schools, each one operated by a multi-disciplinary team of health professionals who use a holistic approach to address a broad range of health and health-related needs of students. Fifteen of them also offer reproductive health services including oral contraceptives and condoms. The Title X program offers a range of reproductive health services and supplies at service locations throughout the state.

Delaware's Personal Responsibility Education Program (PREP) focuses on building capacity of teachers and volunteers to implement two evidence based pregnancy prevention and risk-reduction programs delivered at school and community sites.

Cross-Cutting/Life Course: Recognizing the importance of the social determinants of health across the lifespan, the Division of Public Health has established healthy equity as one of four strategic priorities. To advance work in this area, the Bureau of Health Equity was established and an action plan is being formulated. Also, an online health equity course has been developed and all DPH staff are strongly encouraged to complete the training to improve our capacity to understand and address issues around health equity.

Oral Health, also a life course issue, is addressed through the Bureau of Oral Health and Dental Services

(BOHDS). The BOHDS provides dental clinics throughout the state for Medicaid eligible clients under age 21. It also supports the Delaware Oral Health Coalition, whose mission is to provide leadership and advocacy so that the people of Delaware can access affordable, quality oral health care. Emphasis is placed on prevention and early diagnosis.

Smoking, another life course health issue, is addressed through DPH's Tobacco Prevention and Control Program. The Tobacco Program offers two programs to help smokers quit, conducts media campaigns, and funds youth-led campaigns and peer-education groups.

II.B.2.b.iii. MCH Workforce Development and Capacity

The total federal-state MCH partnership budget reported in this application includes Title V funds, state general funds, and appropriated special funds. The state portion of the MCH partnership is $9,390,789, which includes funds appropriated for state infant mortality reduction initiatives, and supports 58.1 FTEs (52.5 from general funds and 5.6 from appropriated special funds). The Title V federal allotment is estimated at $1,958,687 for FY 16.

In Delaware, the majority of Title V block grant funding is used to support approximately 22 positions (FTEs) across the division that are involved with MCH programs and services, including home visiting, Child Development Watch, 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, and families. The majority of these positions do not report directly to the Title V program, but rather to the administrator of the specific program or clinic that they work within. As we consider our needs assessment findings and develop our 5-year state plan, we will need to work with the managers of these positions to assess job responsibilities and ensure alignment with our new Title V priorities.

A smaller portion of block grant funding is available to support more targeted activities to advance our Title V priorities. 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 section II.B.2.c.

Although the MCH leadership team has a significant amount of professional experience, key members are relatively new in their current positions. Leah Woodall, MPA, the state MCH Director for Delaware and Section Chief for the Family Health Systems Section, is in her second year serving in these capacities, having previously served as the MCH Bureau Chief and Deputy Director. Linda Tholstrup, MS, MCHES, has served in the role of MCH Bureau Chief and Deputy Director since January 2014. Kate Tullis, PhD, was hired as the Children and Youth with Special Health Care Needs Director in October 2014. She previously served as the Newborn Screening and Genetics Program Administrator for DPH.

Delaware's MCH program does not include a dedicated staff member to focus on evaluation, data-analysis, or epidemiology. To fill this gap, we have a contractual relationship with John Snow, Inc. to support specific projects. We are on the recruitment list to host a CDC MCH Epidemiology assignee and hope to locate a candidate within the next year.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work however, with recent turnover in positions a number of staff have less than two years' experience in their current roles. As such, we have taken advantage of opportunities such as the AMCHP New Director Mentorship Program and AMCHP's MCH Navigator, and look forward to participating in additional professional development opportunities. Internal to 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 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.

II.B.2.c. Partnerships, Collaboration, and Coordination

One of the most impressive examples of collaboration is the Delaware Healthy Mothers and Infants Consortium (DHMIC). Formed in 2005 as a statewide vehicle to address infant mortality, the consortium includes approximately 150 members, including representatives from DPH, hospital systems, universities, the legislature, March of Dimes, and more. The consortium has five committees addressing standards of care, health equity, education and prevention, and data and science. 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 group is Family SHADE (Support and Healthcare Alliance Delaware), a collaborative alliance of family partners and organizations dedicated to supporting families of children with disabilities and chronic medical conditions. The 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 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 panel.

Additional key partnerships and collaborations include Delaware's statewide Early Childhood Council (ECC), the Safe Kids Coalition, the Family Coordinating Council, the Sussex County Health Promotion 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 are embarking on a new partnership with the Division of Prevention and Behavioral Health to co-lead Delaware's Project LAUNCH project, a 5-year award from the Substance Abuse and Mental Health Administration. We are also involved in the current Infant Mortality COIIN.

In terms of new partnerships, we are eager to become involved in Delaware's State Innovation Model (SIM) work, which is supported by an award from the Center for Medicare and Medicaid Innovation, and is aimed at improving the health of Delawareans, improving health care quality and patient experience, and controlling the growth in

health care costs.

In addition to the wide range of organizational collaborations listed above, we also value partnership with families and consumers. As part of our 5-year needs assessment process, we conducted 8 focus groups across our state with women, mothers, and family members (see Appendix D: Focus Group Report). The findings of the focus groups were instrumental in our needs assessment and directly informed one of the seven variables ("importance to consumer") that were used to prioritize our needs.

In support of planning for our CYSHCN program, a survey was also conducted with families of children with special health care needs. The survey included questions covering the seven system outcomes of the National Consensus Framework for Improving Quality Systems of Care for CYSHCN, and was fielded in both English and Spanish, electronic and hard copy. Results of the survey are being used to inform the direction of our work for this population.

Parents are also engaged through the Families Know Best Surveys administered by Family SHADE. Families Know Best is a voluntary parent advisory group. Participating families are asked to fill out monthly online or print surveys about the services they receive. Information gained through these surveys is shared with Family SHADE organizations, policy makers and agencies statewide.

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.

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.

For a complete list of references, see Appendix E: References.

II.C. State Selected Priorities

No.	Priority Need
1	To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.
2	Improve breastfeeding rates.
3	Improve rates of developmental screening in the healthcare setting using a validated screening tool.
4	Increase healthy lifestyle behaviors (healthy eating and physical activity).
5	Increase the percent of children with and without special health care needs having a medical home.
6	Decrease rates of bullying by promoting development of social and emotional wellness.
7	Improve the rate of Oral Health preventive care in pregnant women and children.
8	Increase the percent of children 0-17 who are adequately insured.

The selection of the State health priorities was completed as a result of a thorough examination of the findings from the state's Five-Year Needs Assessment. Based on the assessment process, Delaware has chosen the following eight priorities as the focus of our efforts in the coming 2015-2020 grant period:

1. To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.
2. Improve breastfeeding rates.
3. Improve rates of developmental screening in the healthcare setting using a validated screening tool.
4. Increase healthy lifestyle behaviors (healthy eating and physical activity).
5. Increase the percent of children with and without special health care needs having a medical home.
6. Address Bullying among middle and high school age children by focusing on ways to reduce the mental health impacts of bullying on children.
7. Improve the rate of Oral Health preventive care in pregnant women and children.
8. Increase the percent of children 0-17 who are adequately insured.

Delaware's 2015 Title V needs assessment and priority selection process benefited from the commitment and engagement of its committed and engaged stakeholder (including families) community. Instead of relying solely upon data to drive the assessment and prioritization process, the Steering Committee employed multiple methods to engage partners and consumers, valuing their unique perspectives, contributions and assessment of the state of MCH in Delaware. The goals of the prioritization process were to 1.) Use a data-informed method to identify and prioritize Delaware's top health issues related to the health of women, infants, children and youth, including children and youth with special health care needs; and, 2.) Incorporate stakeholder and public input into finalizing the priority areas by population domain for action planning.

The Needs Assessment Steering Committee was responsible for reviewing and understanding the data, and then assigning scores for each of the fifteen national health areas in order to rank them. A set of 7 variables were considered in this prioritization process, including size and seriousness of the health issue; disparities in outcomes; stakeholder support; importance to the community; and alignment with national and state goals. Once all individual rankings were completed, the findings were combined to determine the overall priority ranking. The final step was to

ensure that each of the 6 Title V population domains was represented in the priority health area selection, and that all rules outlined in the Title V guidance had been considered.

In addition to selecting priorities that aligned with the National Performance Measures, the Steering committee also took in to account additional suggestions from the stakeholders for priorities that were outside of the scope outlined in the guidance. Some of those health issues highlighted were nutrition, obesity, and mental health. Where possible, the Committee incorporated those suggestions as a feed to the National Performance Measures to ensure that the objectives and strategies focused not only on the stated measure, but also an additional perspective of the measure that was closely related. An example of such was the inclusion of a mental health component for addressing Bullying. The performance measure addresses the need to reduce the instances of bullying that is being reported, however we felt it was important to address bullying as a public health issue to include the mental health impacts on children being bullied and those who bullying others. Similarly, we received feedback from our stakeholders and community members regarding the importance of nutrition and obesity and therefore modified our objectives for physical activity to incorporate healthy lifestyles and healthy eating.

The continuation of our focus on priorities from the past five years includes areas that focus on improving rates of developmental screening and improving the rate of oral health care in children and pregnant women.

The feedback received from our stakeholder survey and key informant interviews highlighted our previous successes in developmental screening, however the data also showed that the need was high to continue to focus on this area. Stakeholder survey results revealed developmental screening as ranked #1 among the 15 priority areas as well as among the three priority areas within the children's health domain. Stakeholders' assessment of the state's capacity to improve developmental screening for children was very positive with about three-fourths indicating that there was a strong desire to address this issue and that evidence-based programs existed in this area. As a result of the state's commitment to and work on developmental screening, significant progress has been made however consumers and stakeholders alike recognize that there is still more work to be done. The objectives to continue the progression of success includes building on existing efforts to promote the adoption of PEDS screening tool by providing participating pediatric practices with technical assistance, practice-level data, and CQI tools to optimize their screening rates. We also feel it is important to educated parents about developmental milestones and the importance of developmental screening, empowering them to request that their pediatrician perform screening.

The last area of interest that will be continued from previous years will be the focus on oral health. In the past our focus was on the ensuring that oral health preventive services and treatment were available for children, including children with special health care needs. Great strides were made in the past year to advance the goal of ensuring oral health preventive services for children using various methods of outreach and community partnerships. There has been a significant increase in the utilization of the dental Medicaid program in Delaware can be directly correlated the program's coverage for children under age 21. Another program has been very successful in reaching high-risk children who do not have a dental home. Stakeholder survey results point to oral health as a relatively important issue but noted that there are not enough resources available to address the issue. There remain important opportunities for Delaware – in terms of partnerships, and education in communities, especially on the concept of a "dental home" and therefore our work will continue in this area for the next grant period.

Previously, Delaware focused on the health priority of obesity by addressing on children, adolescents, and women of childbearing age who were overweight or obese per the stated performance measure. While obesity continues to be an issue in Delaware, the new priority need will look at the 'whole picture' of obesity by addressing healthy lifestyle behaviors (healthy eating and physical activity). National Performance Measure 8 seeks to increase the percentage of children, ages 6-11, who are physically active at least 60 minutes per day and therefore we have replaced or "reframed" our objectives related to obesity by incorporating strategies that will not only address physical activity but also healthy eating as part of a complete plan to healthier lifestyles.

The remaining priority needs are new to the focus of our work in the coming years. The first of which addresses the need to increasing the number of pregnant women who receive preventive care services. The health priority need to increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies is a somewhat similar to our previous efforts however, not similar enough to be considered a continuation of those strategies. For those efforts, our stakeholders noted the increased messaging and initiatives in the state around prenatal and perinatal health as part of promoting well woman care contributed to the progress being made. Other strategies included engaging partnerships in community outreach activities included providing several women's health topics ranging from preventive care, nutrition, physical activity, and reproductive life planning.

Suggestions were made by our key informants that emphasized the importance of incorporating weight management, diabetes prevention/management in preconception and interconception care and highlighted the impact of these services have on lowering infant mortality rate in the state. Key informants also proposed reframing the idea of well woman care to transform it from being episodic to creating a continuum of care as a strategy for addressing women's' health. This includes provider engagement and education around a "life course" approach to care. Taking into consideration these and other feedback, it was decided to address National Performance #1 from a life course approach to addressing women's health before, between and beyond pregnancies versus addressing only women who receive a well woman visit in the past year.

Even though breastfeeding was not one of our ten priorities from 2010-2015, a significant amount of work has been done to address this issue, both through Title V funding and through partnerships with entities such as the DHMIC and the Breastfeeding Coalition of Delaware (BCD). 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. Stakeholders' assessment of the capacity of the Delaware Maternal and Child Health System to address improving breastfeeding for children indicated a strong desire to address this issue and that evidence based programs existed in this area. These and other suggestions from our stakeholder community make this a very important need for MCH to address for our mothers and children in Delaware.

Within the children with special health care needs community, it is widely known that in order to achieve optimal health outcomes, the system of care for children and youth with special health needs must have coordinated ongoing comprehensive care within a medical home. Our needs assessment survey and consumer focus group findings indicate that there is still work to be done around consumer education and awareness of what a Medical Home is and the services that it encompasses. Care coordination, for example, is not perceived as a standard of practice and families are unclear about what they can expect. Cultural competence and person-centered care (both elements of a medical home) were also noted as areas for improvement. These examples highlight overarching themes from survey, focus group and key informant interviews: 1.) Families are overwhelmed and have difficulty navigating the system of care to access needed services; and, 2.) There are opportunities for workforce development and enhancement given the shortage of providers who can care for CYSHCN and the need cultural competence training. However, Delaware has models from which to learn and will be working with proven methods used by programs within our bureau and division.

In Delaware as with other states in the nation, the issue of cyber bullying is also of growing concern. As a result of the various community outreach activities conducted during the needs assessment, MCH has learned of a significant gap in services related to bullying for adolescents aged 12-17. Historically, bullying awareness and prevention has been the responsibility of the Department of Education, however we now understand that bullying is quickly becoming a public health issue for young Delawareans, especially for those students who have resulting mental health issues. The adequacy of resources to pay for evidence-based curricular and support ongoing professional development was underscored by our key informants as a challenge in being able to address the issue. In particular, bullying impacts CYSHCN. Parents in focus groups expressed concern about their children's ability to cope with bulling and called for more training, education and awareness for teachers, daycare providers and para educators. In addition, key informants pointed to bullying as a symptom of larger systemic issues and called for a more comprehensive approach that includes self-esteem and character development at an early age, ensuring supportive mental health services, professionals being able to recognize depression and low self-esteem in adolescents and providing parent education about the use of social media.

Adequacy of insurance coverage is an issue of high importance among our survey respondents as well as key informants and consumers. The stakeholder survey showed this issue was ranked #3 of 15 priority areas and ranked #1 among the three issues within the Cross-cutting/Life Course Domain. Almost 80% of respondents agree/strongly agree that there is a strong desire in the state to address the issue and 48% indicated agreement that progress is being made. Qualitative data collected as part of the needs assessment process point to the importance of this issue, particularly for families with CYSHCN. In focus groups, surveys and key informant interviews for the CYSHCN population, respondents pointed to the lack of or inadequate coverage for needed services for their children. Expenses ranged from respite care to medications and equipment. Financial strains due to out of pocket expenses and having to travel out of state for appropriate care was listed among the top challenges that CYSHCN families faced. We feel there remain opportunities in the state to address the adequacy of insurance coverage for all

populations.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 15 - Percent of children ages 0 through 17 who are adequately insured

When embarking on the task of our Five-Year Needs Assessment, we determined that the best approach was to take in to consideration the National Performance Measure (NPM) for each of the fifteen priority health areas at the onset of the project to ensure we were able to gather information directly related to the NPMs. With this as the basis of the needs assessment, we set out to gather input and feedback from our stakeholders by presenting this information framed in a way that highlighted the national performance measures however our stakeholders were also asked to tell us of other areas they felt were important for us to focus on as well. This information was then synthesized and evaluated against our prioritization methodology to determine where ideas could align themselves with the national performance measures.

For the priority need that addresses women's health, our objective is to increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies. This objective is tied to the performance measure that seeks to increase the number of women who have a preventive medical visit. Preventive care for women in Delaware was seen as of high importance; ranked #5 among the 15 priority areas by respondents of the 2015 Stakeholder Survey. Forty-nine percent (49%) of respondents agreed/strongly agreed that progress was being made in Delaware, however only 32% agreed/strongly agreed that there were adequate resources available to address the issue. While a high percent of women in Delaware receive routine checkups, multiple barriers still exist creating disparities in access. Lack of education, transportation, availability and affordability of services were barriers identified by focus group participants. Cultural beliefs about the importance of seeking preventive health care present the biggest challenge in certain communities. While there has been progress in the state in promoting awareness of preventive care in women of childbearing age, it is noted that there is not an equal distribution of these benefits. These and other concerns from our stakeholder community were among the final determining factors evaluated for our priority selection.

In the perinatal/infant population domain our objective is to further improve the breastfeeding rates in Delaware. Specifically MCH intends to focus on the performance measure to increase the percentage of infants who are ever breastfed and increase the percentage of infants who are breastfed exclusively through 6 months of age. According to the 2011/2012 National Survey of Children's Health, 72.4% of babies were "ever breastfed or fed breast milk"; lower than the national estimate of 79.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding are lowest for Black, non-Hispanic infants, as well as infants in low-income households. These disparities are mirrored for infants who are exclusively breastfed for 6 months after birth, with the overall rate dropping to just 13%, with the rates for Black, non-Hispanic infants being much lower. 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 noted as the most

important national performance measure for our Title V program to address in the perinatal/infant domain, with 72% of stakeholders indicating that there was a strong desire to address the issue.

Our 2015 Needs Assessment showed that overall our community and professional partners are pleased with the progress being made in Delaware regarding developmental screening for children at an early age. In addition to our successes, we also found that there was additional work to be done and therefore we have chosen to address NPM 6 which seeks to increase the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.

Stakeholder survey results revealed developmental screening as ranked #1 among the 15 priority areas, overall, as well as among the three priority areas within the children's health domain. Stakeholders' assessment of the state's capacity to improve developmental screening for children was very positive with about three-fourths indicating that there was a strong desire to address this issue and that evidence-based programs existed in this area. Slightly less than half of stakeholders (48%) thought there were adequate resources available. However, nearly 60% of stakeholders thought progress is being made in this area. Based on this feedback, we feel that further collaboration with our professional partners will allow us to be even more successful in meeting the developmental screening needs of the children of Delaware.

In the child health population domain, we have chosen to select the performance measure that seeks to increase the percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day. The issue of physical activity in children and adolescents is a top priority in Delaware, ranked second out of the 15 priority areas according to the 2015 Stakeholder Survey. While the majority of stakeholders agreed that a strong desire is evident in the state to address this issue as well as evidence-based strategies being available, they also recognized the lack of resources available in the state which has delayed progress. Key informants shared that there has been increased awareness and messaging from the state promoting active living. Combined with messaging, there have been efforts to increase environmental supports such as the availability of green space and bicycle trails. However, social factors such as income, education, neighborhood location has meant that not all communities have benefited or have access to these supports.

The importance of nutrition and ensuring access to fresh fruits and vegetables was a noted strategy that is related to promoting physical activity. Parent education around nutrition as well as physical activity was emphasized. Schools have been traditionally seen as the natural environment to promote physical activity. Proponents have called for mandatory recess through middle and high school but have been challenged by the emphasis on academic achievement which often trumps the promotion of physical activity in schools. Addressing physical activity as a subset of healthy eating and healthy lifestyles will be our focus for this particular national performance measure.

New to public health is a focus on the issue of Bullying for our children with and without special health care needs. The NPM chosen for this health priority is described as reducing the percent of adolescents, ages 12 through 17, who are bullied or who bully others. Our needs assessment work on the issue of bullying has highlighted a significant gap in services related to bullying for adolescents aged 12-17, including our children with special health care needs. Historically, bullying awareness and prevention has been the responsibility of the Department of Education, however we now understand that bullying is quickly becoming a public health issue for young Delawareans, especially for those students who have resulting mental health issues. The NPM for this particular health area specifically includes not only children who are bullied, but also, those who bully others. Throughout the needs assessment effort, our stakeholders told us that the lack of mental health resources for their children remains one of their highest concerns.

We believe that addressing self-esteem and character development early in a child's education experience will increase our children's opportunities of becoming healthy and successful. The idea is that if children are exposed to positive personal image education at an early age, they will be better prepared to protect themselves, both physically and emotionally, from those who would bully them throughout their primary school years. Students who are bullied in middle and high school are most likely to suffer from low self-esteem, depression, substance abuse, and have poor

education outcomes. This holds true for not only the children who are being bullied, but also for those who bully others. Studies are also beginning to show that students who are involved in bulling (either receiving or bullying others) are likely to have issues that impact their ability to fully function as healthy adults.

The DPH priority in this area is to address bullying among middle and high school age children, including our children with special health care needs by focusing on ways to reduce the mental health impacts of bullying on students. The highest rate of bullying being reported in the YRBS survey is from our middle school students, where 43% of children surveyed reported being bullied while the number of high school students who report being bullied on school grounds last year was slightly more than 18% which is an increase over previous years. By shifting our focus slightly from the act of bullying or those who bully others and addressing this issue using a public health lens, we feel confident that we can decrease rates of bullying by promoting development of social and emotional wellness.

The 2015 Needs Assessment findings brought to light the issue of awareness and education on the concept of Medical Home for our children and youth with special health care needs (CYSHCN). Medical Home, which relates to NPM 11, was ranked #6 among the 15 areas according to our stakeholder survey findings. Medical Home was ranked #1 among the two (52% chose medical home, 44% chose transition to adult care) health priority areas related to CYSHCN. Stakeholders were asked to assess the capacity of the Delaware Maternal and Child Health System to address improving access to medical homes for children. Sixty-five percent thought there was a strong desire to address this issue. Fifty-seven percent thought evidence-based programs existed in this area. Only 38% thought there were adequate resources. And 41% thought progress was being made in this area.

Survey and consumer focus group findings indicate that there is still work to be done around consumer education and awareness of what a Medical Home is and the services that it encompasses. In our community focus group discussions, participants were asked to describe their medical home and were unable to do so until the facilitator explained what the term meant. Once they had the definition or understanding of the concept, they were more able to describe their version of medical home. An evaluation of the 2013 Medical Home Pilot project was completed with 3 of the 4 pediatric practices completing a post-project Medical Home Index Survey. Of the three practices completing the post-project survey all showed an increase in at least 4 of the 6 domains on the index, with one practice showing gains in each domain. The positive results of this pilot project along with clear indication from parents through focus groups and surveys conducted in 2014 and 2015 and our key informant interviews conducted this year, show a strong interest for care coordination within a family-centered medical home model. While the concept of transition also ranked high in importance for our parents, we feel by working to increase both public and professional awareness of all components of a medical home, including well planned transitions to adult healthcare, our program will continue to highlight the need for well-planned transition within the medical home.

From the Cross-Cutting domain, DPH has chosen to address NPM 13 which seeks to increase the percentage of women who had a dental visit during pregnancy along with increasing the percentage of children, ages 1 through 17, who had a preventive dental visit in the past year. The State of Delaware recognizes that oral health is a key indicator in the general health of children and adults. Untreated oral problems in children can lead to difficulty in eating, speaking, and sleeping. Pain associated with dental problems causes children to have trouble concentrating or even to be absent from school. Poor oral health also has significant implications for social development, affecting children’s self-esteem and relationships with others according to the U.S. Department of Health and Human Services.

Stakeholder survey results point to oral health as a relatively important issue (ranked #9 of 15) but noted that there are not enough resources available to address the issue. Survey respondents saw that stakeholders had a stronger desire to address children’s oral health compared to oral health for pregnant women. While adequate insurance coverage is an ongoing impediment for children’s access to preventive dental care, availability of dentists and orthodontists that have specialized equipment and space was expressed as a major challenge by families of CYSHCN. Other factors that impact persistent disparities in dental health outcomes include low literacy levels and

poor access to transportation. There remain important opportunities for Delaware – in terms of partnerships, and education in communities, especially on the concept of a “dental home”.

The last of the performance measures chosen is NPM 15; increase the percent of children ages 0 through 17, who are adequately insured. Adequacy of insurance coverage is an issue of high importance among survey respondents as well as key informants and consumers. The 2015 stakeholder survey showed this issue was ranked #3 of 15 priority areas and ranked #1 among the three issues within the Cross-cutting/Life Course Domain. Almost 80% of respondents agree/strongly agree that there is a strong desire in the state to address the issue and 48% indicated agreement that progress is being made due in large part to those who recently secured insurance coverage through the Affordable Care Act (ACA). Qualitative data collected as part of the needs assessment process point to the importance of this issue, particularly for families with CYSHCN. In focus groups, surveys and key informant interviews for the CYSHCN population, respondents pointed to the lack of or inadequate coverage for needed services for their children. Financial strains due to out of pocket expenses and having to travel out of state for appropriate care was listed among the top challenges that CYSHCN families faced. We understand that is not enough to merely be insured, but it is also critical that the adequacy of the insurance coverage be sufficient to ease the financial burden and logistical challenges that our citizens face while trying to secure health care for them and their families.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of Delaware women of reproductive age that had an unintended pregnancy
- SPM 2 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.
- SPM 3 - Percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

To address Delaware's unique MCH needs, three state performance measures were developed based on the findings of the Five-Year Needs Assessment. The rationale for why these measures were selected and links the selected SPMs with Delaware's identified priorities are described below.
Priority: To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies

SPM: To decrease the percent of women of reproductive age with an unintended pregnancy.

Preconception care and family planning are important aspects of preventive care for women. Delaware has one of the highest unintended pregnancy rates in the nation; 57% of pregnancies are unplanned. Approximately 48 percent of all Delaware births are paid for by Medicaid. 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. A national study revealed that among opioid-abusing women in the U.S., almost nine out of every 10 pregnancies were unintended.

Priority: Improve breastfeeding rates

SPM: To decrease the racial disparity between Black, non-Hispanic and White, non-Hispanic who initiate breastfeeding.

According to the 2011/2012 National Survey of Children's Health, 72.4% of babies were "ever breastfed or fed breast milk"; lower than the national estimate of 79.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding are lowest for Black, non-Hispanic infants, as well as infants in low-income households. In 2011/12, the percent of Black infants who were ever given breast milk was 67.3%, compared with 75.1% of White infants and 75.3% of Hispanic infants. These disparities are mirrored in the data for longer-term breastfeeding, with the overall rate dropping to just 13% of infants who are breastfed exclusively for 6 months; lower than the national average of 19%.

Priority: Decrease rates of bullying by promoting development of social and emotional wellness.

SPM: To decrease the percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

The decision to add a State Performance Measure linked to NPM 9 was made with the goal of focusing on the mental and emotional impacts on bullying and how those impacts can lead to mental health issues among adolescents. According to the 2015 YRBS, the percentage of high school students who reported feeling sad or hopeless for two or more weeks at a time in the past twelve months was 22% for Straight students, 42% for Gay/Lesbian students, and 60% for those who identified as bisexual. We will explore evidence based strategies that help define how the impacts of bullying can lead to serious, and possibly fatal, health outcomes in middle and high school aged children. Examples of poor mental health outcomes related to bullying include students who contemplate suicide in order to escape the anguish of being bullied. According to the 2015 YRBS, the percentage of high school students who seriously considered attempting suicide was 12.8%. Additionally, the percentage of high

schools students who actually made a suicide plan was 9.9%. While it is unreasonable to think that all suicides are a by-product of bullying, experts do know that bullying is linked to many negative outcomes including impacts on mental and emotional health, substance abuse, and self-inflicted violence.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The following action plan was developed based on a comprehensive needs assessment, and with input from many stakeholders. It defines an exciting path forward for our Title V efforts to support the health of Delaware's mothers, children – including children with special health care needs, and families.

This plan represents the role that Delaware's Title V Program can play in improving the health of mothers and children, given our resources and capacity. In some of the health areas, we are building on years of previous work and partnerships and have very detailed action plans forward. In others, we are forging into new territory and will be spending the coming year learning, building expertise, and establishing new relationships. As such, this plan is not intended to be a comprehensive strategic plan to address each of the targeted health areas. Rather, moving the needle on any of these health priority areas will require collective effort from many partners throughout the state.

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.

NPM

Percent of women with a past year preventive medical visit

Objectives

By July 2020, increase percentage of women with birth interval >18 months.

By July 2020, increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy

Strategies

In collaboration with the Delaware Healthy Mother and Infant Consortium's Education and Prevention Committee, develop social marketing campaign and social media messaging to increase awareness of the importance of preconception health and reproductive life planning.

Convene a workgroup of the DHMIC's Education and Prevention Committee 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 that are providing the Healthy Women Healthy Babies program services at 20 locations across the state.

# of women served by Title X programs/clinics that received a reproductive preconception health and/or other preventive services within the context of family planning visits.

ESMs

ESM 1.1 - # of social media messages promoting preventive health care and preconception health for women of reproductive age

ESM 1.2 - # of DHMIC Education and Prevention meetings held in past year

ESM 1.3 - # of women served by the HWHBs program that received Bundle A services/preconception care

ESM 1.4 - # of women served by Title X programs/clinics that received a reproductive preconception health and/or other preventive services within the context of family planning visits.

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.

SPM

Percent of Delaware women of reproductive age that had an unintended pregnancy

Objectives

Decrease the number of live births that were the result of an unintended pregnancy.

Strategies

Decrease the number of live births that were the result of an unintended pregnancy

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.8	82.6	83.4	84.2	85	85.8

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	69.1 %	2.4 %	111,261	161,007
2013	74.7 %	1.9 %	120,387	161,189
2012	80.9 %	1.6 %	129,685	160,358
2011	78.9 %	1.9 %	125,021	158,382
2010	74.5 %	2.3 %	116,904	156,834
2009	75.3 %	2.6 %	120,033	159,414

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - # of social media messages promoting preventive health care and preconception health for women of reproductive age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	50.0	50.0	50.0	50.0

ESM 1.2 - # of DHMIC Education and Prevention meetings held in past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

ESM 1.3 - # of women served by the HWHBs program that received Bundle A services/preconception care

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5,500.0	5,800.0	6,100.0	6,300.0	6,500.0

ESM 1.4 - # of women served by Title X programs/clinics that received a reproductive preconception health and/or other preventive services within the context of family planning visits.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12,000.0	12,300.0	12,600.0	12,800.0	13,000.0

Women/Maternal Health - Plan for the Application Year

In the domain of Maternal/Women's Health, we will 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 quality prenatal care for our mothers. In order to continue making progress in providing "whole health" care to our women and mothers, we will maintain and enhance our community partnerships by working together, leveraging talents and resources, and striving to find new ways to provide services.

In the coming year, a new Delaware Healthy Mothers and Infants Consortium (DHMIC) strategic plan will continue to be implemented spanning the next 3-5 years. 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.

Delaware will continue to support and provide the Healthy Women Healthy Babies (HWHB) program. By contract, seven health providers are providing HWHB services at 20 locations across the state. The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial "bundles" of care for women at the highest risk of poor birth outcomes.

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) with a new emphasis on substance abuse populations, Nurse Family Partnership, and Parents as Teachers. Recently, a significant state

investment was appropriated to the Division of Public Health to support the Nurse Family Partnership Program in the amount of $1.3M.

In Delaware, there are four different Health Ambassador programs, each striving to make a difference in the lives of Delaware's women and their families. Studies have shown that the use of community health workers has been documented as a method to enhance health education and promotion with high-risk, hard-to-engage, and underserved populations. As a complementary strategy to home visitation, promotoras serve as Health Ambassadors in the largely rural and Hispanic areas of southern Delaware while cultural brokers serve as Health Ambassadors in the urban communities in the City of Wilmington. Health Ambassadors use innovative, creative and culturally sensitive strategies to engage women and families. Health Ambassadors promote health education messaging on a range of maternal and child health topics: before, during and after pregnancy, birth spacing, reproductive life planning, as well as make a direct connection to Delaware 2-1-1 to link with a variety community based services including home visiting services as well as federally qualified health centers that can provide well women care.

For the past 30 years the Delaware wellness centers, located in 29 of the state's 33 high schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to support women's health. Twenty-nine School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public school setting. A bill was passed this year to stagger the implementation of the three SBHC in the remaining public high schools over the next three years. SBHCs provide at-risk assessment, diagnosis and treatment of minor illness/injury, mental health counseling, nutrition/ health counseling and diagnosis and treatment of STDs, HIV testing and counseling and reproductive health services (15/29 sites) with school district approval as well as health education. Given the level of sexual activity among high school students, persistent high rates of sexually transmitted infections (STIs) and the numbers of unintended pregnancies, reproductive health planning services are very important. In 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).

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. A national study revealed that among opioid-abusing women in the U.S., almost nine out of every 10 pregnancies were unintended. Delaware has one of the highest unintended pregnancy rates in the nation; 57% of pregnancies are unplanned. Approximately 48 percent of all Delaware births are paid for by Medicaid.

Launched earlier this year, Delaware Contraception Access Now (DE CAN) (www.upstream.org/delawarecan/) is a statewide plan that will increase access for all women to the full range of contraceptive methods, including the most effective, IUDs and implants. The overarching goal is to improve public health by creating an environment where the women of Delaware can achieve their goals and become pregnant only when they want to.

The DE CAN initiative is focused on increasing access to IUDs and implants, immediate post-partum. Delaware is a part of the Association of State Territorial Health Officials (ASTHO) LARC Immediate Post-Partum learning collaborative, which has been a great opportunity to learn from other states and has provided national expertise and support. Delaware is working with all birthing hospitals to consider implementing policies and an infrastructure to provide women with more options in postpartum contraception, and increase access to the most effective forms of birth control so she can start them when she wants to. Many women are sexually active before their 6 week postpartum visit, and many women do not return for their 6 week postpartum visit, which is why it is so important to

increase women's access to these methods, if she so desires. To date, Christiana Health Care Services (the largest birthing hospital in the State) is the only birth hospital that is providing LARCs immediate postpartum. From 3/2/2015 – 6/14/16, CCHS placed 500 immediate PP LARC devices, 377 devices were DE funded for women with Medicaid, and 123 devices were donated from the Ryan LARC Program for uninsured women. CCHS has also developed a set of policies, procedures and a protocol that can certainly be replicated to other birth hospitals.

In June 2016, an event was held to kick off the rigorous, independent evaluation of the impact of DE CAN initiative. The evaluation continues for five years: 2016 – 2021. All stakeholders, both in and outside of Delaware, will understand the impact of DE CAN on health outcomes and related cost savings. Some of the research evaluation questions include:

- How has the Delaware Plan affected the unintended pregnancy rate, birth rate, and abortion rate?
- How has the Plan affected the attitudes and beliefs about contraception, including the use of implants and IUDs in particular, among women of reproductive age and medical providers in Delaware?
- How has the uptake of contraception, including implants and IUDs in particular, changed over time as a result of the Plan? Have these changes occurred differentially among subgroups of interest (e.g., age, race, income-level, urban/rural, etc.)?
- What policy changes at the state-, health system-, and clinic-levels have occurred during the course of the Plan related to implants and IUDs?
- Have there been any cost-savings associated with the Plan in the short-, medium-, or long-terms?
- Has Delaware seen any cost-savings associated with Medicaid expenditures or other publicly funded programs such as Women, Infants, and Children (WIC), or Temporary Assistance for Needy Families (TANF)?
- Have Plan activities helped foster long-term sustainability?

Finally, this Fall 2016, a consumer-facing public awareness campaign will launch to increase awareness of contraceptive options and where low or no cost contraception can be obtained.

Women/Maternal Health - Annual Report

Beginning in the 1990s, Delaware's infant mortality rate was increasing while the national trend was decreasing. This trend prompted the Governor's Administration, at the time, to convene an Infant Mortality Task Force in June 2004. In May 2005 the Task Force's final report put forth a three-year plan with 20 recommendations to reduce the high infant mortality rate in Delaware. The plan called for the creation of the Delaware Healthy Mother & Infant Consortium (DHMIC), a Governor appointed body, to help ensure that the recommendations were put into effect. The DHMIC is structured into five subcommittees to monitor implementation of the Infant Mortality Task Force recommendations for the following critical areas: data and science, education and prevention, health equity, standards of care, and systems of care.

In addition, the Delaware Perinatal Cooperative was established in February 2011 as an action arm of the Delaware Healthy Mother & Infant Consortium. Through partnership with the March of Dimes, Delaware Chapter, and the Division of Public Health, a Perinatal Project Coordinator is dedicated to promoting the success of the Cooperative. In achieving its purpose, the Cooperative helps accomplish the mission of the Delaware Healthy Mother & Infant Consortium, which is to provide statewide leadership and coordination of efforts to prevent infant mortality and to improve the health of women of childbearing age and infants throughout Delaware. The DHMIC strategic plan is

focused on preconception care and well women care, and spans the next 3-5 years.

In partnership with a social marketing firm, Worldways, the Division of Public Health and several Maternal and Child Health partners developed a social media integration approach, whereby it is associated with its own blog, Twitter, Facebook, and YouTube, in which all MCH programs and initiatives participate. The branding tagline, Delaware Thrives, evolves around the theme that "Health Begins Where You Live, Learn, Work & Play". The goal is to coordinate and integrate our health promotion campaigns by first completing a website (www.DEThrives.com) that would be easy to grow, easy to maintain, and easy to navigate, and one that is search relevant. DHMIC and the Division of Public Health want to expand social media engagement around preconception topics beyond our current DE Thrives audiences. The goal is to cultivate new audience segments, those who are less typically the in-depth "health information seekers" that comprises much of our DE Thrives audience. The strategy entails creating new, simple content in a shareable format designed to quickly grab attention and increase social sharing of key content. This content will live in its own online environment associated with, but branded differently from DE Thrives. It will be pushed out through a range of social channels, as well as through "disruptive" social media ads.

Preconception peer educators continue to provide community outreach to increase infant mortality awareness with an emphasis on preconception and interconception health targeting the 18+ population. They primarily engage minority serving colleges and universities, and develop public/private partnerships. This work is based on the national Office of Minority Health's Preconception Peer Educator program model. The preconception peer educators provide education on several women's health topics ranging from preventive care, nutrition, physical activity, and reproductive life planning. Preconception peer educators are represented by Wesley College, Delaware Technical and Community College, University of Delaware, and Delaware State University.

Delaware followed the CDC's recommendation that everyone, both *female* and *male*, develop a *Reproductive Life Plan.*

- The Teen Plan "My Life. My Plan." Is a user-friendly guide that encourages teens to establish and maintain healthy habits and life-affirming goals. The plan was transformed from a paper booklet to an interactive digital site, and there are plans to add information and provide a forum for social networking, which will be located on www.DEThrives.com .
- The Adult Plan "Set Your Mind. Set Your Goals" is the cornerstone of a broad health education strategy for adult women that includes:
  - Preconception text messages
  - Web-based interactive education and support
  - Provider education on the Life Course Perspective

Health education through peer educators and health ambassadors "Set Your Mind. Set Your Goals" reproductive life plans help women assess their personal health concerns and set goals to help them achieve healthy pregnancies if or when desired. The plan was also transformed from a paper booklet to an interactive digital site on DEThrives.com. These allow women to explore their own goals and set themselves on a path toward enhancing their overall wellness. Prompted by local provider demand and inspiration from the recent release of the http://beforeandbeyond.org/toolkit for providers, a set of provider guidelines for Delaware's reproductive life plans are under development on how to use the reproductive life plans with patients and highlights key health messages (i.e. healthy weight, waiting 18 months before getting pregnant again, smoking cessation, etc.). Providers can use the RLPs in any educational setting including one on one, small, or large groups to help women understand that these are a resource and tool to help women consider IF and WHEN they want to have children, planning for pregnancy, or pregnancy prevention. Plus, it shares information about other factors and choices that may influence the impact of this decision.

Male Preconception Health Campaign ("Man Up, Plan Up") - As partners, men can play an important role as they encourage and support the health of women. The information is now available by visiting DEThrives.com, targeting males between 19 and 28 years of age, which uses a scrolling technique and allows items on the page to flow quickly and is easy to see on a Smart Phone. The site offers educational tools and links to resources and services with eye catching captions: Think About It, Way to Man Up, and Myth Busters.

A core team of DE Maternal and Child Health partners, including Delaware's Medicaid agency, assembled a small group of representatives to participate in the Infant Mortality CoIIN workto develop a plan to reduce infant mortality and improve maternal health with a goal to increase the percentage of planned pregnancies. While Delaware has seen gains in fewer infant deaths over the last decade for which there is much to celebrate, Delaware's unplanned pregnancy rate is one of the highest in the nation. The vision of the Delaware Plan to Reduce Unintended Pregnancies, now coined as Delaware Contraceptive Access Now (DE CAN), is that all children are born to parents who plan for them and want them. We envision a time when accidental pregnancies are increasingly a thing of the past. To accomplish this vision, all women of reproductive age will have access to free, effective contraception through their health care provider of choice, and providers will have both the training and supplies needed to offer all methods of contraception on the same day they are requested. By achieving this vision, Delaware will:

- Reduce the number of unintended pregnancies and births
- Reduce the number of pregnancies and births to teens
- Reduce the number of women who have pregnancies closer than 18 months apart
- Reduce the number of premature births
- Reduce Medicaid costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies

Delaware has developed a plan to ensure that all women seeking health care, regardless of their health insurance status, are asked the One Key Question--if they desire to become pregnant in the next year and, if not, provide same-day access to the full range of contraceptive methods, including long acting reversible contraceptive (LARC) methods, IUDs and implants.

Long acting reversible contraception (LARC) is the most effective contraceptive available today but there are barriers to access. LARCs require an upfront investment of several hundred dollars to have them available on the same day and medical and front line staff, including billing staff, may need to be trained. LARCs, comprised of implants inserted in the arm or IUDs inserted in the uterus, are the preferred method for women who desire access to the most effective, long term, and reversible contraception options. When family planning services are not used, women have an increased risk for an unintended pregnancy. Nearly half of women with an unintended pregnancy were using contraception. Research shows that pill, patch and ring users were 20 times more likely to have an unintended pregnancy compared to users of IUDs and implants after one year. LARCs are endorsed by the CDC, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics as the "first line and most effective" methods of contraception for all women.

Implementation of the DE CAN initiative has been successful to date due to the public/private partnership to improve birth intention, health outcomes for women and children, and access to the most modern, effective, reversible methods of contraception. The lead MCH partners include (1) the Division of Public Health; (2) Division of Medicaid and Medical Assistance (DMMA); (3) Upstream USA; and (4) the Delaware Healthy Mother and Infant Consortium (DHMIC), a governor-appointed body tasked with reducing infant mortality and improving the health of women of reproductive age. It should also be noted that the DE CAN initiative is fully supported and embraced by Governor

Jack Markell, and he personally wrote an Op-ed in the New York Times, “What States Can Do On Birth Control”, describing his commitment and support and why it makes sense on so many levels.

A DE CAN/LARCs workgroup has been assembled and meets on a monthly basis. Their charge and core purpose is to focus on:

- *Site recruitment:* help enlist health centers and private practices to participate in Upstream USA’s training and technical assistance program to build capacity among health care providers
- *Resolve issues:* help identify and find solutions to clinical and reimbursement barriers to providing same day access to the full range of methods
- *Spread the word:* share solutions and best practices within your organization and among your colleagues

In addition, a DE CAN/LARCs Advisory Committee has been established under the auspices of the Delaware Health Mother and Infant Consortium. This committee meets on a quarterly basis to work in concert with the workgroup and serves in an advisory capacity on Delaware’s Plan to lower the unintended pregnancy rate and improve preconception health and birth outcomes. Core areas of focus of the advisory committee include coverage and reimbursement, increased awareness through education, training, technical assistance, and professional development, fostering new and existing partnerships, and reviewing and disseminating research and data that will support the DE CAN initiative.

Upstream USA (www.upstream.org) is a non-profit organization that provides training and technical assistance to health centers and private practices around the country to increase their capacity to provide single visit access to contraception, particularly the most effective forms- the IUD and the implant. The Delaware Division of Public Health has partnered with Upstream USA to develop and implement a plan to reduce unintended pregnancy in the state of Delaware. The plan has four components:

- Providing training and technical assistance to all the publicly supported health centers and private providers to ensure all their female patients of reproductive age are offered the full range of contraceptive methods, including IUDs and implants, during their visits.
- Eliminating barriers to women receiving single visit access to all methods of birth control, at low or no-cost.
- Developing a public awareness campaign designed to increase awareness of the availability of low and no-cost birth control and its benefits.
- Creating a rigorous, independent evaluation of the short and long-term impact of the plan so that all stakeholders can see the benefits, including the impact on health outcomes, patient and provider experiences, and cost savings.

The first set of provider sites were trained by Upstream USA, beginning the week of February 22, 2016. To date, over 40 sites representing over 500 staff have been trained. There are other provider sites that are in discussion and are likely to schedule training dates throughout July and more will be added in the Fall of 2016. The goal is to recruit and train between 65-80 provider sites by the end of the two year initiative.

A number of 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 building on the fabric of our family planning and reproductive health service provider network.

Delaware is trying to remove system barriers as it relates to payment and reimbursement, which is very complex, and providers often lack the time and/or expertise to tackle these barriers (i.e. billing/coding). Upstream USA

provides training and technical assistance to all publicly funded healthcare providers and the 30–40 largest private healthcare providers in the state to ensure their patients are offered the full range of contraceptive methods, including IUDs and implants, in a single appointment. Coverage of LARCs within the current health care system is complicated, and with the Affordable Care Act changes are still unknown about exactly how this coverage will affect access. Under ACA, contraceptive coverage is included in the Women's Preventive Services Guidelines. Under this provision, women who are covered under new health insurance plans no longer have a co-pay or other cost sharing for all FDA approved contraceptives. There are some Grandfathered plans that don't have to follow the new preventive services coverage rules. Reimbursement can also be delayed (i.e. due to prior-authorization), creating cash flow problems for providers and clinics. Delaware is working 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. Already, the Delaware Division of Medicaid and Medicaid Assistance (DMMA) has revised its reimbursement policy

DMMA implemented a reimbursement policy on July 1, 2015, which allows for reimbursement of the LARC device through the Medicaid pharmacy benefit. Essentially, through a Federally Qualified Health Center (FQHC), a prescription is processed for a LARC device through a specialty pharmacy, and the pharmacy buys and bills Medicaid directly. The LARC is shipped directly to the "facility", in this case, the FQHC. The same scenario applies to the hospital for immediate postpartum, which promotes healthy birth spacing. Through private outpatient provider offices, the physician's office works with a specialty pharmacy/wholesaler/manufacturer, places the order, invoice is received (30-90 day billing) and the product is delivered to the physician office. The provider places the device, and then bills the payer – MCO or fee for service, and then receives payment.

The Delaware Division of Public Health has reallocated one-time repurposed funding to cover the cost of devices free of charge for women who do not have insurance. The funds will also cover the cost of devices to allow providers to have an initial stock, so that they can set up a system to replenish that stock through third party insurance. DPH is working with its State Pharmacy program to develop a mechanism to manage, track and distribute LARC devices to participating DE CAN providers. In addition, during the life of the DE CAN initiative, Upstream USA will provide devices free-of-charge for women who have no insurance.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Improve breastfeeding rates.

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

By July 2020, increase breastfeeding initiation rates in Delaware from 74% to 81.9%.

By July 2020, increase the percent of women who breastfeed exclusively through 6 months from 15.5% to 25.5%.

Strategies

Enhance capacity of ob-gyns and pediatricians to support women in breastfeeding.

Utilize social marketing techniques to influence women's decisions around infant feeding.

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.

ESMs

ESM 4.1 - # of provider practices that receive EPIC BEST training

ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials

ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants

ESM 4.4 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

ESM 4.5 - Increase the number of birthing facilities that receive baby friendly designation

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Improve breastfeeding rates.

SPM

Percent of Black, non-Hispanic mothers who initiate breastfeeding.

Objectives

Reduce the disparity between Black, non Hispanic mothers and White, non Hispanic mothers who initiate breastfeeding.

Strategies

Increase the percent of Black, non-Hispanic mothers who initiate breastfeeding.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	74.0	76.0	78.0	80.0	81.9	84.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	76.8 %	3.0 %	8,464	11,021
2011	65.7 %	3.8 %		
2010	69.1 %	3.6 %		
2009	69.7 %	3.0 %		
2008	73.8 %	2.4 %		
2007	69.8 %	2.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	15.5	18.0	20.5	23.0	25.5	27.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	19.7 %	2.8 %	2,091	10,615
2011	13.2 %	2.3 %		
2010	12.5 %	2.0 %		
2009	11.2 %	1.7 %		
2008	12.6 %	1.8 %		
2007	11.7 %	1.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - # of provider practices that receive EPIC BEST training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	62.0	64.0	65.0

ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	130.0	160.0	180.0	200.0

ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	7.0	9.0	11.0	12.0

ESM 4.4 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	18.0	20.0	23.0	25.0

ESM 4.5 - Increase the number of birthing facilities that receive baby friendly designation

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	5.0	5.0	6.0	6.0

Perinatal/Infant Health - Plan for the Application Year

In the domain of perinatal/infant health, Delaware's key priority since the 2010 needs assessment has been to reduce our infant mortality rate, along with the related factors of pre-term birth and low birth weight.

Considering MCHB's revised measurement framework for Title V, our 2015 needs assessment was designed to focus at the national performance measure level. Therefore, while reducing infant mortality remains an outcome of utmost importance for Delaware, a new, but related, priority emerged – breastfeeding. Progress and plans for both infant mortality reduction and breastfeeding promotion are described below.

Infant Mortality

Our work to address infant mortality is spearheaded by the Center for Family Health Research and Epidemiology, which is housed within the Family Health Systems Section, led by our Maternal Child Health Director. Therefore, while the following strategies do not appear in our 5-year action plan table, these efforts are very much a part of our Title V federal-state partnership, and continue to be supported by state funding allocated for prevention of infant mortality.

A primary program for addressing poor birth outcomes in our state is the Healthy Women Healthy Babies (HWHB) program. A recently completed outcome evaluation of the program strongly suggests the program is making an impact on the target population – women at the highest risk of poor birth outcomes in the state. The program has moved these women to the state average on several indicators including low-birth weight babies and infant mortality.

Our HWHB program providers along with Family Health Systems Section leadership are revisiting the screening and assessment tools to look for opportunities to build efficiency and give providers time to counsel patients and not just assess them. A new/revised preconception framework is being developed to guide this work. The framework is being driven by the recently released evidence-based preconception wellness measures. Delaware was fortunate enough to have Sarah Verbiest, Senior Advisor, National Preconception Health and Health Care Initiative speak at our DHMIC/MCH Summit in April 2016. Ms. Verbiest discussed the nine new clinical measures for preconception wellness and shared key national PCHHC resources. Current strategies for consumer engagement nationally and in Delaware were also discussed as well as acquiring a new understanding for integrating preconception health, life planning, life course theory, & reproductive equity. Delaware considered this presentation as our kick-off to integrating the new measures within our HWHB program.

Social marketing efforts to expand the reach of our HWHB program will continue but our messaging for

preconception wellbeing is being reevaluated to ensure consistent messaging across all of our programs within the Division of Public Health taking into consideration our LARC (DE CAN) initiative, Zika messaging and the new preconception measures. For example, provider guidelines are being developed to assist providers with discussing the importance of reproductive live planning with their patients. The guidelines call out specific questions such as the one-key question as well as how to start the conversation around setting healthy lifestyle goals.

Breastfeeding

According to the 2011/2012 National Survey of Children's Health, 72.4% of babies were "ever breastfed or fed breast milk"; lower than the national estimate of 79.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding 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 13% of infants who are breastfed exclusively for 6 months; lower than the national average of 19%.

This data clearly shows the need for improvements. 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.

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.

As reflected in our action plan for this domain, a core strategy will be to enhance the capacity of healthcare providers, including Ob-Gyns and pediatricians, to provide breastfeeding information and support to their patients. We know that healthcare providers have both the credibility and opportunity to influence and support women's decisions around infant-feeding. The EPIC BEST model provides physicians with the information, tools, and resources they need to maximize those opportunities. In the coming year, we plan to continue the work initiated in the previous two years to expand implementation of EPIC BEST, spreading the training to more practices and developing a larger cadre of trainers. Delaware DPH has also been awarded another ASTHO grant to further support this work.

Our five year plan includes a strategy to strengthen hospital efforts in supporting mothers/babies through comprehensive breastfeeding policies. The Breastfeeding Coalition of Delaware (BCD) is planning to work intimately with one of the two birthing facilities who have not yet received baby friendly designation. This particular facility is still in the discovery phase and has not yet committed to becoming designated as baby friendly. We are hopeful this facility will join the other four baby friendly birthing facilities with the support and encouragement from the BCD and DPH. Technical assistance will also be provided around developing infant feeding policies, staff training plans and data collection plans to the birthing facility once this commitment is made as well to those birthing facilities that have already received designation.

We will utilize social marketing techniques to influence women's decisions around infant feeding. Promoting messages and materials through our DE Thrives website is one strategy. In the coming year, we will also work with our partners to explore the feasibility of launching the "It's Only Natural" campaign, developed by the Office of Women's Health, in Delaware. This campaign would be ideal because it targets African American women, a population where we have a clear disparity in breastfeeding. Similarly, we will explore the possibility of promoting text4baby to increase utilization of this powerful tool in Delaware. We will partner with BCD around provider education to support breastfeeding in Black women in Delaware as part of their Generating Equity in our Mother's

(GEM) project goal. This project stems from a NACCHO grant they were awarded to specifically address reducing disparities in breastfeeding.

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

Perinatal/Infant Health - Annual Report

Infant Mortality

At 7.7 deaths per 1000 live births, Delaware's infant mortality rate remains inordinately high. From a high of 9.3 deaths per 1000 live births in 2006, we have now seen the infant mortality rate drop seven straight reporting periods. The 2009-2013 rate of 7.7 deaths per 1000 live births is the lowest yet. The racial disparity, however, remains a significant challenge. While the White rate has fallen to 5.1, the Black rate stands at 13.4, for disparity ratio of 2.6. The disparity ratio for the previous reporting period was 2.3.

The main drivers of our infant mortality remain unchanged – prematurity and low birth weight; others include congenital anomalies and sudden infant death syndrome. We have moved to address these drivers on a number of fronts. With the collaboration of our partners in the Delaware Perinatal Cooperative, we have achieved a 100 percent adherence to our 39-week initiative to improve birth outcomes. Under this initiative, all birthing institutions undertake to ensure that all births in their institutions occur at or after 39 weeks of gestation, unless a shorter term is medically indicated. Working with our Healthy Women Healthy Babies partners, we are aggressively addressing preconception health, psychosocial health, prenatal care and nutrition counseling.

The Perinatal Periods of Risk (PPOR) analysis completed in 2015 and made it quite clear that our best prospect for improving birth outcomes in Delaware are in addressing maternal health in the preconception period. In response to this finding, we engaged social media tools to expand the reach of the HWHB program. We have recruited an additional provider to serve some of the communities at highest risk in the northern part of the state. We have signed a contract for Medical Legal Partnership (MLP) services. Staff from all provider sites have been trained to identify patients who have social context issues and refer them to the MLP program. Through our partnership with the Delaware Healthy Mother and Infant Consortium, we are developing community engagement teams that will be working with selected communities to help build capacity in these communities to identify some of the social determinants that impact their health. One group specifically has identified three priorities: 1. Healthy lifestyles (physical activity), 2. Positive behavior, and 3. Finance management skills.

Our safe sleep campaign continues with education through providers and other care givers based on four simple messages:

- Babies should never sleep in a bed with anyone;
- Babies should always sleep on their back;
- There should be nothing in the crib with the baby; and
- Keep baby's environment smoke-free.

We have developed promotional materials, including onesies, with appropriate messaging to support the campaign. The Cribs for Kids program, partly funded by the Division of Public Health, provides cribs for families that cannot afford one.

Breastfeeding:

Even though breastfeeding was not one of our ten priorities from 2010-2015, a significant amount of work has been

done to address this issue, both through Title V funding and through partnerships with entities such as the DHMIC and the Breastfeeding Coalition of Delaware (BCD).

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 which received designation earlier this year. Title V funding was used to support staff within DPH's home visiting program to earn and maintain the IBCLC (International Board Certified Lactation Consultant) credential. We now have four home visitors throughout the state that hold the IBCLC credential, enabling them to better support their clients, as well as serve as a resource to other home visitors. Home visitors were also provided with supplies to support their breastfeeding clients, such as nipple shields.

In an effort to increase supports for breastfeeding women through their healthcare providers, DPH has made some exciting progress in implementing a program called EPIC BEST. EPIC BEST (Educating Providers in the Community-Breastfeeding Education and Support Training) is a program, developed in Pennsylvania that provides onsite breastfeeding education and support training for clinicians in community-based prenatal, family practice and pediatric practices. This effort was initiated with a small grant from the Association of State and Territorial Health Officers (ASTHO) to DPH, and has been implemented in partnership with the Medical Society of Delaware and the BCD. To date, a total of 45 practices and over 400 healthcare employees have received training. These employees include physicians, nurses, front line staff, and all employees of our from target practices (OB, Pediatric, and Family practices).

Lastly as far as the work with African American breastfeeding—in this second year of EPIC BEST we have really attempted to reach practices that have a high number of impoverished/minority women and children in their practices. We have trained every FQHC and have really targeted practices located in our high risk zip zones as well as all the Healthy Women/Healthy Baby providers.

DPH, the BCD, and the DHMIC formed a breastfeeding work group over the past year to identify opportunities to leverage each other's resources and expertise to promote breastfeeding. Posters, tip sheets, and educational materials that were developed by the BCD were uploaded to the resource page of the Delaware Thrives website, dethrives.com. This website serves as the electronic hub for DHMIC's education and social media efforts, and can significantly increase the dissemination and availability of these materials. In addition, key messages for women in the prenatal, immediate post-partum, and post-discharge stages were developed and will be added to the website to drive web traffic to the resources.

As more practices participate in the EPIC BEST training, we anticipated an increase in the demand for promotional and educational materials to be displayed and disseminated through physician's offices. To support this need, we worked with our social marketing vendor and the BCD to allow on-demand, free of charge online ordering of the BCD materials that were recently uploaded to the DE Thrives website. We will continue to advertise and promote the materials through ACOG, DHMIC and BCD.

Finally, Delaware joined a handful of states earlier this year that have "banned the bag" now that all maternity facilities have stopped distributing the gift bags that contained cans of formula, coupons, and other advertising. By distributing the formula gift bags, health care providers inadvertently appeared to implicitly promote formula over breastfeeding, the healthier choice. And, research has shown that the free bags increase formula sales and decrease the duration of breastfeeding. Delaware hospitals have been happy to work together to support the "ban the bag" campaign. Governor Jack Markell declared August as National Breastfeeding Month and the week of Aug. 1-7, 2015 as World Breastfeeding Week in Delaware. His signed proclamation urges "all Delawareans, including families, communities, child care, and health care and business sectors, to adopt policies and practices to

accommodate breastfeeding mothers as they strive to provide the best possible nutrition for their children”.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Improve rates of developmental screening in the healthcare setting using a validated screening tool.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By July 2020, increase the percent of children, ages 9-71 months, receiving a developmental screening using a parent-completed screening tool.

Strategies

Recruit new provider practices to adopt PEDS

Strengthen the referral feedback loops between pediatricians and the services they refer children to, based on screening results.

Expand developmental screening administration to include non-traditional screeners like Help Me Grow /2-1-1 Call center

Collaborate with partners/programs who have touch points with families (home visiting, hospitals, libraries, Text 4 Baby, etc).

Educate parents about developmental milestones and the importance of developmental screening, empowering them to request that their pediatrician perform screening.

ESMs

ESM 6.1 - # of new practices to adopt PEDs

ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices

ESM 6.3 - The percent of high risk screens referred to early intervention/Part C by pediatric practices

ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center

ESM 6.5 - # of new partnerships/collaborations

ESM 6.6 - # of YouTube views of educational video on developmental screening

NOMs

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

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Child Health - Entry 2

Priority Need

Increase healthy lifestyle behaviors (healthy eating and physical activity).

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

By July 2020, increase the percent of children 6-11 years old who are physically active at least 60 min/day.

Strategies

Participate on committees of the State Health Improvement Plan and Healthy Neighborhoods to align and support their plans to promote active living and healthy eating.

Review existing programs and services within the Maternal and Child Health Bureau of the Division of Public Health (DPH) and identify opportunities to infuse messaging and content related to healthy lifestyle behaviors.

ESMs

ESM 8.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

ESM 8.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

ESM 8.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

ESM 8.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	31.1	31.4	31.7	32	32.3	32.6

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.8 %	3.3 %	16,165	52,525
2007	10.9 %	1.8 %	5,727	52,752

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - # of new practices to adopt PEDs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	36.0	39.0	42.0	44.0	45.0

ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	125.0	150.0

ESM 6.3 - The percent of high risk screens referred to early intervention/Part C by pediatric practices

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	20.0	25.0	30.0	35.0

ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	150.0	200.0

ESM 6.5 - # of new partnerships/collaborations

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 6.6 - # of YouTube views of educational video on developmental screening

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	200.0	300.0	400.0	500.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	32.5	32.8	33.1	33.4	33.7	34

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.2 %	2.7 %	22,164	68,859
2007	41.5 %	2.8 %	26,563	64,016
2003	32.9 %	2.2 %	21,860	66,544

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	20.0	20.0	20.0	20.0

ESM 8.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

ESM 8.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0

ESM 8.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12.0	12.0	12.0	12.0	12.0

Child Health - Plan for the Application Year

Delaware's 2010 Title V needs assessment identified the following priorities in the domain of child health: reducing obesity; reducing unintentional injury; and increasing rates of developmental screening. Not surprisingly, our 2015 needs assessment showed that we continue to have needs in all three areas. However, after completing a systematic prioritization process, increasing healthy lifestyle behaviors (related to obesity prevention) and increasing developmental screening rose to the top as the Title V priorities in the child health domain for the next five years.

While injury prevention is not included as a stand-alone priority area in our action plan, elements of injury prevention will be addressed through our work in the adolescent domain around bullying. In addition, Delaware's continued work to prevent infant mortality will address aspects of injury prevention relevant to infancy, namely safe sleep. Please refer to the narrative for the infant and adolescent domains for more details on activities and plans in these health areas.

Progress and plans for our two child health priority areas – healthy lifestyles and developmental screening- are described below.

Healthy Lifestyles:

Childhood obesity rates remain high in Delaware, as in the nation. The 2015 Youth Risk Behavior Survey results for Delaware indicate that approximately 31.6% of youth are overweight or obese, while the 2011 Delaware Survey of Children's Health (DSCH) estimates that 40% of children ages 2-17 are overweight or obese. (The DSCH was conducted by Nemours in 2006 and 2011, and the results can be found at http://www.nemours.org/about/policy/encouragehealth/delaware-survey.html)

The statistics for related health behaviors, physical activity and healthy eating, provide more insight into the root of the problem, and also possible strategies to address it. According to the 2011 DSCH, only 42.4% of children ages

6-11 achieve the recommended 60 minutes of physical activity per day. However, this represents an increase from the 2006 survey results. The DSCH also revealed that from 2006 to 2011, there were trends in a positive direction in regard to increasing consumption of fruits and vegetables and decreasing consumption of sugar-sweetened beverages.

Although we have selected healthy lifestyles as a Title V priority within the child health domain, this is clearly an issue that spans the life course. Promotion of healthy lifestyles and prevention of obesity are statewide priorities, with clear leadership from entities such as the State Health Improvement Plan Strategic Planning Committees, the Healthy Neighborhoods initiative, the Health Promotion Bureau/PANO Program of DPH, Nemours Health & Prevention Services, and the Delaware Healthy Eating and Active Living Coalition. With this leadership and infrastructure firmly in place, our Title V program will play a role of collaborator, including advocacy for the unique needs and concerns of children, including those with special health care needs, related to healthy eating and physical activity.

Toward that end, we have assigned a staff member to begin participating in relevant sub-committees of the State Health Improvement Plan Strategic Planning, which plays a key role in implementation of the State Health Improvement Plan (SHIP). The two goals of the SHIP are to promote healthy lifestyle behaviors (healthy eating and active living) and to increase access to mental/behavioral health services. We will continue to work with Health Promotion Bureau/PANO Program to look for opportunities to (1) represent the unique needs of children, both with and without special health care needs and (2) utilize our capacity and resources to assist in moving the action plan forward.

Another strategy we employed to address healthy lifestyles was to examine existing MCH programs and services where we do play a lead role in order to identify opportunities to infuse messaging and content related to healthy lifestyle behaviors. For example, to support our work in raising parental awareness of development and milestones, we created a concept called “QT30.” Conveying the importance of spending 30 minutes of quality time with your child each day (QT30), this message is supported by a booklet full of ideas for activities that support children’s growth and development.

While the activities in the booklet have been aligned with Delaware’s Early Learning Foundations, there is a perfect opportunity to review the activities from the lens of physical activity and healthy eating. We plan to work our marketing resources to create a ‘QT30-Like’ pamphlet that infuses movement into a reading activity, or use of healthy foods instead of candy in a color sorting activity. Other examples will include incorporating messages about healthy eating and physical activity into our DE Thrives website and providing training and/or materials to home visitors to empower them to promote healthy lifestyles among their clients. We will continue reviewing our programs over the next year, and will implement at least one activity to infuse healthy lifestyles messaging. We fully anticipate that this will be an ongoing strategy.

In a similar vein, we will collaborate with DPH’s Health Promotion Bureau to take materials and initiatives created through their Preventive Health & Health Services Block Grant and disseminate them through MCH programs, services, and partner networks. One example for the coming year is promotion of “FitnessGram®.” This program is the most widely used youth physical fitness assessment, education and reporting tool in the world. This assessment is based not on athletic ability, but levels of fitness needed for good overall health. FitnessGram evaluates the five components of health-related fitness: Aerobic Capacity, Muscular Strength, Muscular Endurance, Flexibility, and Body Composition based on age and gender. The assessment is taken 2x per year in PE classes – once to perform a baseline (beginning of year), and the second (end of year) to show improvements made. DPH provides support to DOE for the “Fitnessgram” as the physical fitness assessment, education and reporting tool among Delaware school districts, and in return, DOE agrees to share the aggregate data with DPH. We feel that this data will help us get a broader understanding of the health and wellness of our school aged children.

Developmental Screening:

In April 2011, the Commonwealth Fund State Scorecard on Child Health Systems performance ranked Delaware 50th for the percent of children (ages 10 months -5 years) who received standardized developmental screening during visits. This data was based on the 2007 National Survey of Children's Health (NSCH), which reported Delaware's percent of children screened as 10.9% compared to the national percentage of 19.5%. Since that time, significant investments have been made in Delaware to support increased screening, including legislation in that mandated insurance coverage of developmental screening at 9, 18 and 36 months of age using validated instruments, and allocation of state funding to support a developmental screening initiative. As of the 2011/12 NSCH, Delaware's percent of children screened has risen to 30.8%. Although this is a substantial improvement, there is still much work to be done to ensure that all children are screened at appropriate ages with a validated tool, allowing for early identification of problems and connection to services.

Four years post the launch of the state's developmental screening initiative Delaware continues to make tremendous progress to advance early detection and connection to services for families of young children. Efforts have focused on obstacles that have prevented healthcare providers from administering developmental screenings. These efforts have spanned the facilitation of easy and free access to a preferred validated screening instrument, reimbursements for using validated screening tools and ensuring academic detailing to increase knowledge and change attitudes. Subsequently, knowledge about community resources and referrals to early intervention services have been strengthened, practice workflow enhanced with the use technological devices (iPads) and the feedback loop streamlined to assure families do not fall between the cracks.

We continue to investigate and address major bottlenecks that hinder effective implementation while embracing new approaches to improve the program. Our strategies for the coming year and beyond are to increase outreach efforts targeting parents and educating them about the value of having a developmental screen done for children. Education about developmental milestones and socio-emotional health of children empowers parents to advocate for their children and demand screening services from their health providers. To reach the goal of ensuring all eligible children receive developmental screens, we recognized the barriers faced if primary care was the sole delivery mechanism. Consideration for a non-traditional approach led to the expansion of screening by phone through the Help Me Grow/2-1-1 (HMG/2-1-1) call center. After receiving standard 2-1-1 service, parent callers of children birth to 8 years will be invited by the HMG/2-1-1 call staff to complete a questionnaire regarding their child's development. The tool of preference is the Parents' Evaluation of Developmental Status - (PEDS online).

Research shows that healthcare providers' knowledge of and referral patterns to early intervention services and other community services is quite low. For the coming year, we plan to increase knowledge through academic detailing and other onsite outreach efforts through the Parts B and C IDEA programs, Project LAUNCH, including the Help Me Grow/2-1-1 contact center. Specific attention will focus on ensuring that children identified at risk for developmental delays following a screen are actually linked with and receive the interventions recommended by the referring provider. A follow up to this effort will include enhancing the current system to close the feedback loop between providers making the referrals and the referring agencies. Two years into its existence, it is not consistently used by majority of pediatricians and family practitioners.

As a recipient of the recent Early Childhood Comprehensive Systems Impact grant (ECCS Impact), Delaware will enhance the developmental skills of young children over a 60-month period between August 2016 and July 2021. The project will be carried out in two place-based communities which consistently report higher levels of adverse outcomes. Delaware will educate, implement and sustain the Collaborative Innovation and Improvement Network (CoIIN) process for ECCS stakeholders at the state and local levels in each of the communities.

Child Health - Annual Report

Healthy Lifestyles:

Previous Year's Activities and Accomplishments:

Promotion of healthy lifestyles (active living and healthy eating) is a strategic priority for the Division of Public Health. Within DPH, work in this area is led by the Physical Activity, Nutrition, and Obesity (PANO) Program within the Health Promotion Bureau. The Title V program partners with the Health Promotion Bureau where appropriate. For example, the Chief of the Maternal and Child Health Bureau is a member of the Advisory Council for the Preventive Health and Health Services Block Grant, and the Chief of the Health Promotion Bureau actively participated on the Title V Needs Assessment and Action Planning Steering Committee.

A significant area of focus for DPH has been on enhancing the built environment to support healthy lifestyles for citizens of all ages. Over the past year, statewide health disparities and health risks related to community design, infrastructure, and built environment issues were identified and inventoried to produce a set of 15 GIS maps defining food deserts, as well as assessments of active mobility (walking/biking). This information was used to provide technical assistance in community planning and design, in order to incorporate health-related criteria. Based on this data, the City of Newark intends to create a "cycle track." A cycle track is an exclusive bike facility, physically separated from motor traffic and distinct for bicycles. Additionally, one contractor, the University of Delaware's Institutes for Public Administration (IPA), aided in the research and facilitation of two presentations delivered at the American Planning Association DE/MD Regional Conference: *Schools in the Complete Community*, which aims to integrate new and existing schools into the local bicycle and pedestrian networks; and, *Planning Healthy, Multigenerational Complete Communities (Perspectives from Delaware)*, which focused on healthy, livable communities that meet the needs of all residents regardless of age or ability level.

We are proud to report that Delaware continues to move up the ranks among Bicycle Friendly States, this year becoming 3rd in the nation. The League of American Bicyclists highlights Delaware's Bike and Pedestrian Improvements program, established by DelDOT, since the passage of Senate Concurrent Resolution #13, which dedicates state funding for cycling (and walking) in each of its annual capital budgets.

DPH's PANO program also continues to support a community-based participatory research effort with faith-based partners and Cooperative Extension agents from the University of Delaware. The goal of this effort, aligned with the goals of the Delaware Council on Health Promotion and Disease Prevention, is to build community capacity to make changes in their own environment to promote healthy lifestyles. Some yearly activities that have taken place for this project include:

- Completion of social and quality of life assessments, epidemiological assessments, behavioral and environmental assessments, and educational and ecological assessments of the Latino/Hispanic community in New Castle County, and the African-American community in Kent County.
- Initial conceptualization and development of a pilot program specifically tailored to each community.
- Establishment of a community advisory committee for each community to assist in and support on-going community health promotion activities.

Throughout the year, the PANO program has been working to promote the adoption of food service guidelines and nutrition standards, and the adoption of physical activity (or physical education) in priority settings such as schools, workplaces and early childcare education (ECE). With help from its partners, Nemours Health and Prevention Services and the Sussex County Health Promotion Coalition, and the University of Delaware, training and technical assistance has been offered to school districts, ECE providers and workplace leadership to create and support improved environments in nutrition and physical activity, improve awareness of nutritional standards and access to

PA opportunities, and promote healthy eating and physical activity in all three settings.

In addition, Public Health also launched Motivate the First State campaign that was developed with the Governor's Council on Health Promotion and Disease Prevention as part of its ongoing strategic efforts to improve health in DE. Through an interactive app, Delawareans can turn their activities into charitable contributions that help their community.

The PANO Program is responsible for managing the Preventive Health and Health Services Block Grant (PHHSBG). The goal of this block grant is to provide national grantees with flexible funding to address priority health needs. Delaware aligns this funding with the goals and objectives of the State Health Improvement Plan (SHIP), the Division of Public Health's Strategic Plan, and the recommendations given by the Governor's Council on Health Promotion and Disease Prevention, all of which have strategies specifically directed at improving the access to physical activity and healthy foods in priority populations. Funds from the block grant are used to implement or enhance evidence-based programming that ideally will result in better access to healthy eating and active living, a more educated public on the causes and risks of obesity, and long-term increases in the prevalence of healthy weight among our population. Currently, the block grant funds the following initiatives:

- Promoting a heathy beverage choice through point of sale marketing, the *One Less* social marketing intervention was implemented at DHSS Social Service Centers throughout Delaware.
- Encouraging population level increases in physical activity through the use of an online social platform, the Plus3Network. The *Motivate the First State* "clubhouse" within the Plus3Network was launched to promote increases in walking and biking among Delawareans.

Developmental Screening:

Previous Year's Activities and Accomplishments:
DPH's Maternal & Child Health Bureau is tasked with implementing the state's pediatric developmental screening initiative. Since the budget was first appropriated in 2012, funding has been used to facilitate the online access to the Parents Evaluation of Developmental Screening (PEDS), providing free access to the online portal to pediatricians and family practice physicians who sign up to implement the validated tool. PEDS Online is a web-based tool allowing parents to complete a developmental screening assessment, which is then securely transmitted to the provider. The tool is electronically scored and the results are available for the provider to review with the parent at the next well-child visit. This assessment can be done before the office visit, saving valuable time and resources.

A lot of ground was covered in 2015 through a contract with the DE Chapter of the American Academy of Pediatrics. Training and technical assistance was provided on multiple occasions to over 30 pediatric and family practices contemplating or already implementing the PEDS tool. The training addressed integrating the PEDS tool in practice workflow as well as using the PEDS toolkit as a resource. Furthermore, two workshops, drawing approximately sixty (60) health care providers, were organized across the state. In addition to providing an overview of the PEDS tool, this workshop focused on referrals, especially for behavioral and developmental concerns. This was in response to feedback received from the pediatric and family practice communities about their lack of knowledge regarding referrals for child mental health services.

Over the past year, our recruitment efforts yielded the on-boarding of Westside Family Health, a Federally Qualified Health Center (FQHC) with a mandate to provide healthcare for at risk populations. With four locations across the state, Westside has piloted the PEDS tool at one of their busy locations in Wilmington and is poised to expand to the other locations. Additionally, we were able to engage and provide training for another FQHC, La Red Health Center in the southern part (Sussex County) of the state with a majority Hispanic patient population.

A barrier we have faced since inception has been capturing the actual number of pediatric physicians operating in

the state. Knowledge of the denominator is essential to measuring the reach or performance of our recruitment efforts. Through the compilation of multiple mailing listings from different sources, we were finally able to arrive at a number to gauge our penetration efforts. A total of 78 physicians have been trained to use the PEDS instrument, making it a third of the target population. These physicians represent 36 practices across the state registered to use the tool.

10,076 screens were administered from January to December 2015 for a cumulative count of approximately 30,000 screens since launch. 7,866 unique children were screened out of the total screens in 2015 (10,076). This makes up about 9% of the total estimated children birth to 8 years in Delaware. Of the total screens administered in CY 2015, 4% were identified as high risk, 39% as medium risk while 57% were deemed low risk.

Studies and anecdotal statements we've heard from practices have stressed the different technology devices such as IPADS have made to practice workflow. Using funds from the Race to the Top Early Learning Challenge grant, we purchased 25 IPADs to be distributed to practices that request a need for them.

To educate parents and promote awareness of developmental milestones, we created two animated videos with Spanish versions to encourage parents to learn about the children's growth and also ask their providers about administering a screen for their child(ren). The video also promoted connection to community services through Help Me Grow/2-1-1 centralized call line. The video was posted on You Tube and distributed to physician practices and other state service programs for streaming in their waiting rooms.

For the first time and in partnership with the founder of PEDS Online, we were able to compile a report for all the practices currently using the PEDS instrument to provide a snapshot of their performance for CY 2015. The report shared highlights on how each practices' patients performed in terms of their risk levels including the number referred for early intervention and linked to other community resources. It also provided suggestions on how each can improve early detection and referral rates.

The Early Learning challenge grant also funded a continuous quality improvement (CQI) session with two of the practices implementing the PEDS instrument. The CQI focused on workflow for one and high risk referrals to early intervention, with the other. Recommendations will be disseminated to other practices.

Finally, we are pleased with our collaboration efforts this year. We have been successful in bringing together most of our developmental screening partners to the table to discuss how we can improve processes and work towards building a comprehensive developmental screening system statewide. This collaboration includes partners from the Office of Early Learning, that is focused on using the ASQ in the early childcare settings, Parts B and C early intervention programs and the Delaware Chapter of the American Academy of Pediatrics.

As a new ECCS impact grantee, we will continue to build on our developmental screening work with our collaborative partnership base as well as the Governor's Early Childhood Advisory Council.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Decrease rates of bullying by promoting development of social and emotional wellness.

NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

By July 2020, decrease the percent of Middle School students reporting they are being bullied based on the YRBS survey from 18.5% to 17.9%.

By July 2020, decrease the percent of children who report being bullied on school property at the high school level from 18.5% to 17.9%.

Strategies

Obtain data on the current bullying prevention efforts being implemented in schools.

Partner with coalitions such as Safe Kids Delaware to provide information and training on bullying to teachers, para educators, and child care operators.

Partner with School Based Health Centers to address bullying as a health issue, with particular focus on the mental health impact, for not only students who are being bullied but also students who bully others.

Create Anti-Bullying and Prevention webpage to be included in the Thriving Communities space on DEThrives.com

Strengthen DPH's internal capacity to address bullying as a public health issue by providing professional development on bullying and strategies to promote social and emotional wellness.

ESMs

ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment

ESM 9.2 - # of people who attend Safe Kids conference

ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying

ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Decrease rates of bullying by promoting development of social and emotional wellness.

SPM

Percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

Objectives

Decrease the percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

Strategies

Reduce the percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	18.5	18.3	18.1	18	17.9	17.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.6 %	2.2 %	10,087	69,185
2007	16.1 %	2.1 %	11,234	69,986

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.6 %	1.0 %	8,935	37,888

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 9.2 - # of people who attend Safe Kids conference

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	6.0	6.0	6.0	6.0

ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	25.0	25.0	25.0

Adolescent Health - Plan for the Application Year

In the domain of adolescent health, Delaware's key priority since 2010 needs assessment has been to address a multitude of health issues related to this population including, but not limited to, the teenage birthrate, the suicide rate among youths, obesity, and unintentional injury.

Our 2015 needs assessment was designed to focus on the health priority areas at the performance measure level, which has enabled us to shift our approach to serving adolescents from a more "whole health" perspective going

forward. Therefore, while teenage pregnancy and the other health concerns will remain important to our mission, our goal for the future is to approach the important issues facing adolescents with a focus on increasing healthy lifestyles and promoting the development of social and emotional wellness.

Bullying

In the past, our focus has been on unintentional injuries of children and youth. While this will remain an important focus for us, we intend to shift our approach slightly to addressing a different area of injury prevention by working on the impact and injury caused by the children who are bullied and who bully others. As a result of the various community outreach activities conducted during the Needs Assessment effort, MCH has learned of a significant gap in services related to bullying for adolescents aged 12-17. Historically, bullying awareness and prevention has been the responsibility of the Department of Education, however we now understand that bullying is quickly becoming a public health issue for young Delawareans, especially for those students who have resulting mental health issues.

The DPH priority in this area is to focus on bullying among middle and high school age children by focusing on ways to reduce the mental health impacts of bullying on children. MCH also understands that bullying behavior can be triggered at much earlier ages than middle school. Our Early Childhood Comprehensive Services program focuses on the ACEs study and is working with our community partners to further understand childhood and adolescent behaviors associated with adverse childhood experiences that may have contributed to their negative behavior issues. Students who are bullied in middle and high school are most likely to suffer from low self-esteem, depression, substance abuse, and have poor education outcomes. This holds true for not only the children who are being bullied, but also for those who bully others. Studies are also beginning to show that students who are involved in bulling (either receiving or bullying others) are likely to have issues that impact their ability to fully function as healthy adults.

Our plans for the upcoming year include partnering with our Department of Education (DOE) to gather data collected regarding bulling and learn about their bullying prevention efforts. In conjunction with working with our DOE partners, we will partner with School Based Health Centers to address bullying as a health issue, with particular focus on the mental health impact, for not only students who are being bullied but also students who bully others. Our data gathering efforts will include an evaluation of bullying and mental health related questions included in the latest YRBS survey. With regard to our marketing strategy, we will continue to enhance our Anti-Bullying and Prevention webpage to include additional resources for our consumers to support their need for mental health and emotional support services. Lastly, we will develop a workforce development plan to strengthen DPH's internal capacity to address bullying as a public health issue by providing professional development on bullying and strategies to promote social and emotional wellness.

While we feel we have made great strides this year in understanding the services and education available for bullying prevention, we also feel that we have merely scratched the surface of the offerings and opportunities for further education. Going forward, our focus on bullying prevention will turn to building partnerships and collaboration with our community partners to bring training and education resources to our grass roots organizations such the Sussex County Health Coalition and United Way of Delaware Pride Council. Where appropriate, we plan to pursue opportunities to join in the conversations and planning efforts to ensure our message of bullying as a public health issue is brought to the table and is considered in relevant strategic planning efforts. We will continue our partnership with Safe Kids Delaware as they continue to support our Title V National Priorities focused on Bullying prevention and Trauma Informed care for children with adverse childhood experiences.

Another strategy that will be of significant importance is to work with our CYSHCN partners, such as the University of Delaware Center for Disabilities Studies and Family SHADE, to understand their plans for developing consistent processes for reporting disparities in bulling between children with special health care needs and those without.

Feedback gathered from our community focus groups, key informant interviews, and stakeholder survey clearly indicate that CYHSCN are more likely to be bullied in school, on buses, and on playgrounds and our parents are often at a loss on where to turn for help. Our parents of children with special health care needs report that the process to have their child's bullying issues resolved is often inconsistent, fragmented, or even non-existent.

Adolescent Health - Annual Report

Bullying

In the past year our efforts were concentrated on gaining the "lay of the land" with regard to the services and programs available in Delaware for students who are bullied or who bully others. MCH participated in numerous training sessions, webinars, conferences, and workshops focusing on bullying prevention. Trainings such as "The ABC's of Being an LGBT Ally", "Transgender 101", and "Preventing Bullying Through Science, Policy, and Practice," were just a few of the informative and educational sessions participated in for 2015/16. In addition, a member of our MCH staff participated in the MCHB sponsored Public Health Department Workgroup which focused on NPM #9 and Bullying Prevention.

As in past years, MCH partnered with the Injury Prevention Coalition to sponsor their annual Safe Kid Conference. The conference included presentations that focused on bullying and more specifically, the social and emotional competence of children to cope with bullies. "Bullying in the 21st Century" and "The Road to Resilience" were presented to the conference attendees and served to educate on what is considered bullying and how we as teachers, mentors, and care coordinators can help to build and nurture children with high self-esteem and confidence to face the challenges of adolescents.

From a messaging perspective, we worked with our marketing resource to launch a new bullying prevention and information webpage (http://dethrives.com/thriving-communities/bullying) as part of our DEThrives.com webpage. Nestled in the Thriving Communities section of DEThrives, our Bullying page is broken down into three sections. We define the various types of bullying that can occur (verbal, physical, relational, etc), provide a valuable resource path for parents of children with disabilities and special health care needs, provide suggestions for what our consumers can do as parents, leaders and friends of those are being bullied, and offer a multitude of resources for our consumer to learn more about where to find help for bullying prevention.

Teen Birth Rate

Delaware's recent focus on reducing the teen pregnancy rate has shown steady improvement over the previous 5 year reporting periods. The 2008-2014 average teenage live birth rate declined to 16.2%, down from the previous reporting period of 2007-2011 rate of 18.2%, and 19.6% in the 2006-2010 reporting period. Each of the three counties in Delaware saw a decline in teenage live birth rates which indicates that efforts are being made across the state to address this issue.

Success in these rates can be directly attributed to the efforts of Delaware's School-Based Health Centers (SBHCs). All of the State's 29 SBHCs provide health services and education, and activities around reproductive life planning and education on contraception. Of those 29 SBHCs, 19 sites provide diagnosis, treatment and health education of or on sexually transmitted diseases reproductive health and family planning, and 7 provide diagnosis, treatment and health education of or on sexually transmitted diseases.

As a repeated theme from most program leadership, the challenges that will be faced in the coming year will be in continued funding. For example, in 2012, after the introduction of third-party billing in SBHCs, the registered dietitian hours were either cut or their positions eliminated due to non-reimbursement for those services although the nurse practitioners can address nutrition education. In addition, the number of services that the SBHCs can bill has substantially decreased due to Explanation of Benefits going home with the billing which often causes a student to avoid going to the SBHC for treatment for fear their parents will find out about their health problem.

Suicide Deaths among Youth

The suicide rate among youths aged 15 through 19 has been most recently reported at 6.7%. Each of the nineteen school districts in the State of Delaware has specific activities and strategies in place to address this health area. Of those school districts, six outline the details of their accomplishments from the past year. Overarching themes pertaining to depression, suicide and bullying were present across the school districts. Students were provided information, education and support from various resources within the schools to address suicidal ideation, depression, drug and alcohol prevention, wellness and healthy lifestyles, and anti-bullying.

Child and Adolescent Obesity

The MCH School Based Health Centers use an assessment tool to regularly screen adolescents on various topics relating to their health. Within the Risk Assessment for Adolescent Preventive services, students are asked questions relative to their diet and nutrition as well as their level of physical activity. Knowing that good eating habits should begin at an early age and in an effort to address children and adolescents who are overweight or obese, the DPH WIC program has engaged in activities to educate and train new mothers in ways they can make a positive impact on their children to ensure they start off with good nutrition and healthy eating.

In the past, WIC has provided cooking demonstrations for mothers and these demonstrations continue to show successes in educating mothers about healthy cooking. The WIC cooking demonstrations have now expanded to include 2 demonstration specialists and are offered throughout the state at each WIC site 2 times each month.

Unintentional Injuries among Children and Youth

Efforts to reduce unintentional injuries are carried out by several partners within the State of Delaware. MCH partners with the Safe Kids of Delaware coalition to sponsor their annual Safe Kid Conference. While the entire list of topics directly related to childhood and adolescent injury prevention, two workshops in particular specifically tied to our selected priorities for the work we will focus on for the next five year period. “Bullying in the 21st Century” and “The Road to Resilience” were presented to the conference attendees and served to define bullying and how we as teachers, mentors, and care coordinators can help to build and nurture children with high self-esteem and confidence to face the challenges of adolescents and avoid injury.

As is the case in many instances, our programs and services continue to face funding challenges from year to year which can make planning and implementation of new strategies and activities even more challenging for public health. A common theme as we move forward with executing our needs assessment action plan is to focus on the work that is being done through our community partners and find new ways to partner with those organizations. By joining forces with staffing, contracting connections, and the limited amount of funds available for new initiatives, we feel we can continue to make a difference in the outcomes of injury prevention, but it will take this joint effort and commitment from others to see successful progress in this area.

Teenage Smoking

In Delaware, the youth smoking rate is at the lowest point since the Youth Risk Behavior Survey began. In 2015, 9.9% of public high school students were current smokers (YRBS) which is down from 14.2% in 2013. Efforts to address teen age smoking rates are implemented through a contractual agreement between DPH and the American Lung Association. These coordinated activities include the Teens Against Tobacco Use (TATU), Delaware Kick Butts Generation (KBG), and the Not-On-Tobacco (NOT) programs. Last year in Delaware, the TATU program reach 12,642 youth, more than 6,200 participated in the KBG program and 26 individuals participated in the N-O-T program. However, what needs to monitored is electronic vaping among adolescents.

The TATU is a program that offers a curriculum that trains high school aged teens (as well as adult facilitators) on tobacco prevention. The trained teens then take the program to middle schools and other community settings to work with younger children. The program allows teens in Delaware to not only learn about presenting smoking cessation information and prevention to youth in their communities, but also develops future leaders for the communities in which they live by teaching them presentation, engagement, goal setting, and strategic planning skills.

In 1999, 13 teens received training in the TATU program and decided they wanted to do even more about tobacco prevention and control for the youth in Delaware. The KBG took shape and has been growing from an initial group of 13 teens to a current membership of 12,000 members. Delaware KBG is a program that empowers youth to develop and maintain groups in schools and communities to work on tobacco issues that are relevant to their environment. Their vision is for all Delaware youth to be tobacco and nicotine free. The group has developed a new website that provides a wealth of information on their goals, how teens can get involved, statistics on their successes, and a community calendar of events. http://kbgde.org/

Not On Tobacco (N-O-T) is the American Lung Association's voluntary smoking cessation program for teens aged 14-19. Participants engage in a 10-week program in which they develop skills and understanding to identify their reasons for smoking, healthy alternatives to tobacco use, and people who will support them in their efforts to quit. N-O-T is a structured approach to smoking cessation based on the social cognitive theory. Studies of 12,000 teens participating in the N-O-T program nationally found that approximately 90 percent of the teens enrolled in the N-O-T program either quit smoking or cut back.

Thousands of children, adults, and families throughout Delaware gain awareness on the importance of tobacco prevention thanks to the mini-grant program. The mini-grant program, a public-funded tobacco prevention initiative awarded to communities and organizations with a strong commitment to tobacco prevention and control programs, is made possible by DPH's Tobacco Prevention Community Contract. Funding for the program, which is managed by the American Lung Association in Delaware, is provided by the Delaware Health Fund. In 2015-2016, 30 agencies received an award. These included eight agencies in New Castle County, seven in Kent County, four in Sussex County, two serving both Kent and Sussex counties, and six statewide. A majority of the mini grants are for activities targeting adolescents. Organizations such as public schools, Boys and Girls clubs and Delaware Adolescent Program (DAPI) have received funding. Some of the recent challenges have been to continue to implement the same level of programming with reduced funding.

Each mini-grant recipient had to meet at least one of the goals for "A Tobacco-Free Delaware":

- Prevent the initiation of tobacco use among Delawareans
- Increase quitting and quit attempts among Delawareans who use tobacco products
- Reduce exposure to secondhand smoke
- Decrease the social acceptability of tobacco use

- Enhance Delaware's position of leadership in comprehensive tobacco prevention and control

Children with Special Health Care Needs

State Action Plan Table

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

Priority Need

Increase the percent of children with and without special health care needs having a medical home.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

By July 2020, increase the percentage of pediatric clinicians in Delaware who have effective policies and procedures in place for effective care integration and cross-provider communication.

By July 2020, improve access to Care Coordination within a Medical Home for families with CYSHCN.

By July 2020, Increase the percentage of primary pediatric practices reporting use of care plans for CYSHCN patients that have been developed and shared with families.

Strategies

Work with Family SHADE to continue to gather information from parents and network partners about needs related to the availability of medical homes.

Collaborate with partners to educate and support clinicians on effective care integration and cross-provider communication through training and access to tools and materials.

Collaborate with the Delaware Center for Health Innovation (DHCI) to ensure that care coordination in pediatric settings is addressed in DCHI projects.

Educate and support clinicians and families on the use of care plans.

ESMs

ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE

ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families

ESM 11.3 - Collaborate with Family Shade to ensure representation of CYSHCN partners at DCHI meetings and forums.

ESM 11.4 - Family Shade will work with their member organizations to develop recommendations and sign a letter to the DCHI regarding medical home and care coordination needs of this CYSHCN population.

ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

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

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.5	56	58.5	61	63.3	65.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	51.3 %	3.6 %	23,027	44,913
2007	48.4 %	3.3 %	22,691	46,922

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	57.2 %	2.0 %	87,697	153,270
2007	63.6 %	1.7 %	94,002	147,751

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

ESM 11.3 - Collaborate with Family Shade to ensure representation of CYSHCN partners at DCHI meetings and forums.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

ESM 11.4 - Family Shade will work with their member organizations to develop recommendations and sign a letter to the DCHI regarding medical home and care coordination needs of this CYSHCN population.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

Children with Special Health Care Needs - Plan for the Application Year

Work will continue around education of providers, families and family organizations around the need for and benefits of the medical home model for CYSHCN and their families. A key observation by our Title V CYSHCN Guiding Committee was that many of our public health professionals, both those providing direct services to families through our Home Visiting and Part C Early Intervention programs, as well as those providing indirect services to Delawareans with special health care needs, needed training around the Medical Home concept and care coordination. With increased knowledge of the subject the Public Health worker will be able to provide clear guidance to the family to aid in decision making and self-advocacy. The CYSHCN program will conduct educational workshops or presentations on Medical Home and care coordination to our public health professionals either in conjunction with staff meetings or trainings or separately. Our plan is to work with our Family Voices Chapter to develop and carry out these trainings using the validated materials developed by Family Voices.

Also continuing in Year 2 will be our work with the Delaware Center for Health Innovation (DCHI) State Innovation Model (SIM) initiative. Our Family SHADE leaders will continue to represent the needs of CYSHCN with respect to medical home and care coordination. Family SHADE will be working with its member organizations to develop a clear set of recommendations to the DCHI concerning the needs of CYSHCN and their families in Delaware. These recommendations will be submitted to the DCHI via a letter cosigned by Family SHADE and the member organizations. The strength of this effort lies in the unified voice of the CYSHCN community to affect system change in Delaware.

A new strategy for the Title V CYSHCN program this year will be to work with our Guiding Committee and community partners to identify a toolkit for both clinicians and families to help promote medical home and care coordination for

CYSHCN. We will work with our Family Voices Chapter that has conducted numerous workshops for families around care coordination and care plan notebooks and was involved in our D70 Medical Home Pilot project to identify materials useful to families and providers. With input from our guiding committee, community partners and families we will identify specific tools to promote medical home implementation and increase care coordination for CYSHCN in Delaware.

Throughout the year we will continue to use the Family SHADE Families Know Best survey to keep a pulse on how families are experiencing the level of care for their children. Questions will be included on a quarterly basis regarding the families' perspective on care coordination and the components of a medical home. Our measure for this strategy will be the number of responses and category of response to the survey question.

Children with Special Health Care Needs - Annual Report

In the domain of children with special health care needs, Delaware's key priority prior to the new guidance had been to enhance family support of Children and Youth with Special Health Care Needs through the support of Delaware Family SHADE, the Family Support and Healthcare Alliance of Delaware. Considering MCHB's revised measurement framework for Title V, our 2015 needs assessment was designed to focus at the national performance measure level. Therefore, while enhancing a system of family support for families of CYSHCN remains a statewide goal for Delaware, two new priorities for this population arose from our needs assessment work: medical home and adequate insurance coverage. Our needs assessment clearly showed that while some aspects of medical home were being met for our CYSHCN population a particular concern for respondents was the lack of care-coordination of the child's medical and community needs.

Work during this first year focused on increasing our collaboration with partners both within and external to state government. Our intent was to establish quarterly meetings of the key partners in the CYSHCN community that were brought together during our needs assessment process. The purpose of this group was to serve a guiding committee for Title V/CYSHCN in order to both align our Title V goals for this population with the goals of multiple other state agencies and service providers as well as to identify mechanisms to advance the objectives of this grant. Staffing reductions and other competing commitments allowed for a single in-person meeting of this group during Year 1. While quarterly meetings were not established the committee did stay in contact over the outcomes of the Needs Assessment for CYSHCN and is committed to implementing the quarterly meeting beginning in the Fall of 2016.

With agreement that the greatest need was for education around the medical home model and mechanisms to enhance care coordination focus during the first year was to identify ways to reach both providers and families. In order to reach providers and payors time and effort during the first year of this application focused on connecting with and providing input to the Delaware Center for Health Innovation (DCHI) State Innovation Model (SIM) initiative. Much effort went toward having the concerns of the CYSHCN community heard by the DCHI committees this year. Ann Phillips, Executive Director of Delaware Family Voices serves on the Patient/Consumer Advocacy Committee. Family SHADE representatives have attended meetings of every SIM Committee throughout the year. Through the active participation in and reporting from the DCHI meetings though out the year the issues important to the CYSHCN community were highlighted including the need for care coordination within medical homes and better payment models coverage for supports for this high needs population.

Likewise education around the medical home concept began within the community organizations that are members of Delaware's Family SHADE organization. A member survey was circulated and, as in our needs assessment, the greatest need for CYHCN families was the need for help with care coordination both within the medical system and between the medical system and community and educational services. Two meetings, one upstate and one

downstate, were held in conjunction with Family SHADE membership meetings to present the medical home model of care and aspects of care coordination.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Improve the rate of Oral Health preventive care in pregnant women and children.

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

By July 2020, increase the percentage of pregnant women who have a dental visit during pregnancy from 39% to 41%.

By July 2020, increase the percent of Delaware children, ages 1 through 17, who have an annual preventive dental visit from 77.2% to 81.2%.

Strategies

Improve data collection and reporting about dental visits and referrals.

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

Review existing programs and services within the Maternal and Child Health Bureau of the Division of Public Health (DPH) and identify opportunities to infuse messaging and content related to oral health.

ESMs

ESM 13.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data

ESM 13.2 - # of hits on BOHDS website

ESM 13.3 - # of presentations completed for partners & community members

ESM 13.4 - # of pediatric practices who are providing fluoride treatments

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

Increase the percent of children 0-17 who are adequately insured.

NPM

Percent of children ages 0 through 17 who are adequately insured

Objectives

By July 2020, increase the percent of families reporting that their CYSHCN's insurance is adequate and affordable.

By July 2020, 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 trainings for Title V staff and family organizations to ensure knowledge of insurance coverage.

Update the Title V Memorandum of Understanding (MOU) with Title XIX/Medicaid to reflect current needs.

ESMs

ESM 15.1 - # of staff of who attend trainings for Title V staff to ensure knowledge of insurance coverage

ESM 15.2 - MOU between Title V and Title XIX

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 21 - Percent of children without health insurance

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.4	39.8	40.2	40.6	41.0	41.4

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	40.8 %	1.6 %	4,148	10,157

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% and should be interpreted with caution

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.0	78.8	79.6	80.4	81.2	82.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.2 %	1.5 %	147,832	191,549
2007	76.8 %	1.4 %	143,473	186,797

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 13.2 - # of hits on BOHDS website

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30,000.0	40,000.0	40,000.0	55,000.0	60,000.0

ESM 13.3 - # of presentations completed for partners & community members

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	15.0	15.0	15.0	15.0

ESM 13.4 - # of pediatric practices who are providing fluoride treatments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	5.0	7.0	9.0	10.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.8	79.6	80.4	81.2	82	82.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	78.0 %	1.5 %	153,290	196,493
2007	79.9 %	1.2 %	150,990	188,996

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 15.1 - # of staff of who attend trainings for Title V staff to ensure knowledge of insurance coverage

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	25.0	0.0	25.0	0.0	25.0

ESM 15.2 - MOU between Title V and Title XIX

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

Cross-Cutting/Life Course - Plan for the Application Year

Oral Health

Based on information from 2015 Needs Assessment, DPH has chosen to address National Performance Measure 13 which seeks to increase the percentage of women who had a dental visit during pregnancy along with increasing the percentage of children, ages 1 through 17, who had a preventive dental visit in the past year. The specific objectives for this health priority will first seek to increase the percentage of women who have a dental visit during pregnancy from a reported rate of 40.5% to 43%.

Strategies for accomplishing this goal by July, 2020 include a collaboration effort between MCH and the BOHDS to collect data through PRAMS relating to pregnant women who have a dental visit during pregnancy. To move us

toward the 2021 goal, we will focus the first year on gathering this data from the latest version of the PRAMS survey. The latest version of the PRAMS survey includes two questions focused directly on this data and is expected to be in circulation by January, 2016. In addition, MCH will continue tracking oral health data from 2-1-1 Help Me Grow and share that data with BOHDS.

MCH will continue to review existing programs and services and identify opportunities messaging and content related to good oral health behaviors (ex. Breastfeeding, Home Visiting, DE Thrives website, etc.). It is through these efforts that the overall oral health literacy and understanding of our citizens can be enhanced and improved.

In addition, MCH feels it is extremely important to work with the BOHDS to discuss possible ways to provide training and technical assistance to providers that offer oral health services geared toward children and youth with special health care needs. It was through our Focus Group findings report from the CYHSCN discussions that we learned from parents the extent of the need for providers who not only serve this unique population but also have the necessary equipment in their offices that allow children with mobility issues to be seen for regular dental services. MCH will continue to support BOHDS in the promotion practice of early childhood medical providers who provide oral health screenings, fluoride varnish application, and dental referrals by age one.

Adequate Insurance Coverage

Delaware chose Adequate Insurance Coverage as a key priority area for the Cross-Cutting/Life Course Domain for this grant cycle. This issue was consistently ranked among the greatest concerns for our stakeholders throughout our needs assessment process. In the 2015 stakeholder survey adequate insurance coverage ranked 1st among the three issues directly linked to the Cross-Cutting/Life Course domain and 3rd when all 15 priorities were considered. In the more focused CYSHCN stakeholder survey 63% of the respondents were moderately or extremely concerned about the adequacy of their insurance and 59% ranked adequate insurance coverage among the “Top 2” health issues faced by their families. Key informant interviews also expressed a strong desire to address this issue within the state.

Although not formally designated to the CSHCN population domain the results of our needs assessment, key informant interviews and focus groups from CYSHNs stakeholders clearly showed adequate insurance coverage to be the greatest single concern for these families and our work plan focuses on this domain. Through addressing the adequacy of insurance for this particularly vulnerable population it is hoped that the Title V population in general will benefit from processes developed, lessons learned and information shared.

In Year 2 of this grant work on the Memorandum of Understanding between Title V and the Division of Medicaid and Medical Assistance will begin. Delaware is applying as a team for the August 2016 MCH Leadership Skills Institute to work directly on the Insurance Priorities for the Title V program. The Division of Medicaid and Managed Assistance has approved two senior staff to attend along with two Title V representatives, the CYCHCN Director and a Program Administrator that largely supportys the Title V Block grant, and serves MCH priorities as a special projects administrator. Along with working toward the completion of the MOU the group will work to delineate the educational needs of both state agencies and external partners around Medicaid coverage and access. The timing of the MCH Institute is fortuitous as it will allow the development of a clear plan for both Title V and DMMA to both work together and address the needs of internal and external partners. In the event that Delaware is unable to attend the Skills Institute it is anticipated that the identified team will work together in state to develop the MOU and educational materials and presentations. As represented in our ESMs for this Priority our progress will be measured by the completion of the MOU and the number of educational seminars “Medicaid 101s” held to both state agencies and external organizations.

Continuing throughout Year 2 Title V will support the monthly Managed Care Calls conducted by Delaware Family

Voices described above. Family SHADE, supported by Title V, will continue to develop their website's Roadmap to Services to include up to date information around insurance coverage for CYSHCN.

Cross-Cutting/Life Course - Annual Report

Oral Health

The Bureau of Oral Health and Dental Services (BOHDS) received a renewal grant from the DentaQuest Foundation for Oral Health 2015 Implementation Phase. The purpose of this grant was to continue to build on established partnerships and create new alliances to increase access to dental care and decrease the burden of oral disease for families in Delaware.

A significant increase in the utilization of the dental Medicaid program in Delaware can be directly correlated the program's coverage for children under age 21. DPH continues to engage in community outreach for prevention and increasing the utilization of dental services by directing children into a dental home. The DPH dental clinics provide services to children with a school-linked program where children are transported to the dental clinics. In the last year, 7,331 children have been seen in the DPH Dental Clinics.

The Seal-A-Smile program has been very successful in reaching high-risk children who do not have a dental home. The program targets schools that have a high percentage of low-income children to provide sealants for second-grade children who do not have a regular source of dental care. Children receive fluoride varnish and hygiene information in addition to the sealants and are given referrals for continuing care. During 2015-2016 school year, the Division of Public Health Seal-A-Smile Program visited 25 schools and screened 408 students with 74% receiving sealants. 43% of the students had untreated caries and 7% needed referrals for urgent care. With combined effort with DPH school linked program, Seal-A-Smile Program provided care to students at 48 out of 72 (64%) at-risk (F/R lunch rate >50%) schools.

In the past year, the BOHDS has worked on several marketing tools and messages to create a path to important resources and education materials for our providers and consumers. To augment their current State website, they have included a link to the new Delaware Oral Health Toolkit (http://www.dhss.delaware.gov/dhss/dph/hsm/tkhome.html). This toolkit offers easy-to-use materials that are customizable, web-based and available at no cost to our providers.

BOHDS partnered with MCH to create a marketing messaging campaign that was designed to be interactive and fun to use while providing valuable resources for our clients. The "Healthy Smiles, Healthy You!" website is scheduled to be up and running by the Fall of 2016 and will be added to our DETrhives.com website. This tool includes an interactive segment geared toward children and features animated characters that provide messaging and encouragement to children of all ages to brush their teeth twice per day, stay away from sugary drinks and understand how tooth decay can impact their smile and overall health. The remainder of the site focuses on highlighting positive oral health behavior for pregnant moms, children with and without special health care needs as well as provides information on where to get services. There is a Help Center included along with links to the Oral Health newsletter and opportunities for providers to get involved with the Tooth Troop.

The State of Delaware recognizes that oral health is a key indicator in the general health of children and adults. Untreated oral problems in children can lead to difficulty in eating, speaking, and sleeping. Pain associated with dental problems causes children to have trouble concentrating or even to be absent from school. Poor oral health also has significant implications for social development, affecting children's self-esteem and relationships with others (U.S. Department of Health and Human Services 2000).

Adequate Insurance Coverage

This priority was a new area for Delaware's Title V program and the first year was spent as an exploratory year for this priority focusing on building relationships across agencies within state government, external agencies and family organizations. Meetings throughout the year with key state Public Health constituents including Delaware's Part C programs, Child Development Watch, Home Visiting, Newborn Screening and Public Health Nurses showed that there was clear interest from all programs to be better educated around Delaware's Medicaid program, particularly around the Managed Care Organizations and plans. As members of each of these organizations interact with the public, and often CYSHCN and their families, they wanted better understanding of the Medicaid program in Delaware so that they could both directly answer questions and better direct their clients' questions. To address this need the Title V program is working with the Division of Medicaid and Medical Assistance plans to establish a series of seminars tentatively titled "Medicaid 101" in years 2 and 3 of this cycle to provide clear understanding of the Medicaid Programs in Delaware. These seminars will be held either independently or as part of regularly scheduled professional development trainings. Through educating the Public Health professionals that serve with those covered by Medicaid it is hoped that their clients will be provided with better direction and information on insurance coverage for CYSHCN and all children covered under the Managed Care Plans.

The theme of education also came through during meeting with our external partners including Family SHADE and Family Voices during Year 1. The importance of education of families around insurance coverage and benefits became a priority for this grant cycle. Both groups reported that families of children with special health care needs often do not understand their insurance plans and therefore do not take advantage of existing benefits.

Meetings between Title V Director and the Director of the Division of Medicaid and Medical Assistance over the first year have resulted in a commitment to update the Memorandum of Understanding between the two organizations. The Title V CYSHCN director met with Meg Comeau, Co-Principal Investigator at the Catalyst Center, who has agreed to work with Delaware as we develop the MOU to reflect the current needs of both programs.

Delaware Title V continues to support Delaware Family Voices in holding a monthly Medicaid Managed Care Call to address the concerns, questions and issues that parents of children with special health care needs may have with their Managed Care Organizations (MCO). Participants include representatives from Managed Care Organizations, Delaware Medical & Medicaid Assistance (DMMA), Disability Law Program, Division of Prevention and Behavioral Services, Division of Developmental Disabilities Services. During these calls families are able to ask questions regarding services and procedures specific to the MCOs.

Delaware Family SHADE implemented several strategies to educate families about insurance options and changes in Delaware. The Roadmap to Services on Family SHADE's website was expanded to include current information about insurance availability and both public and private options for CYSHCN.

Both Delaware Family Voices and Family SHADE have taken an active role in the Delaware Center for Health Innovation (DCHI) State Innovation Model (SIM) initiative this year. Ann Phillips, Executive Director of Delaware Family Voices serves on the Patient/Consumer Advocacy Committee. Family SHADE representatives have attended meetings of every SIM Committee though out the year. Through the active participation in and reporting from the DCHI meetings though out the year the issues important to the CYSHCN community were highlighted including the need for better payment models for care coordination and coverage for supports for this high needs population.

Other Programmatic Activities

Home Visiting

In Delaware, a significant portion of Title V federal grant funding has historically been used to support positions (FTEs) across the division that are involved with MCH programs and services. Many of these positions are part of

our home visiting program, which is a vehicle to address many aspects of infant health. Therefore, this investment in home visiting aligns with our priority on improving breastfeeding, but goes well beyond, serving as a core public health activity to support the needs of our MCH population.

This investment of our Title V resources is crucial for maintaining our statewide system of home visiting services, aimed at encouraging successful pregnancy outcomes and healthy growth and development of infants and children. The combination of Title V and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding supports a comprehensive continuum of three evidence-based home visiting programs designed to meet the various needs of mothers, infants, and children in our state. Data collected for the MIECHV program shows that Delaware has made progress on all six of the following benchmarks:

· **Maternal and Infant Health.** In the MIECHV evaluation, the percent of prenatally enrolled women who entered prenatal care in their first trimester increased from 82.5 percent in FY 2014 to 90.3 percent in FY 2015. Moreover, in FY 2015, almost all (96.2 percent) of postpartum women (between time of birth and 6 months after birth) served by home visitation were screened for postpartum depression. Finally, the percentage of children who were up-to-date on well-child visits increased from 63.9 percent in FY 2014 to 88.2 percent in FY 2015.

· **Injury Prevention.** In the MIECHV evaluation, the percent of clients served by the home visiting program who received information or training on injury prevention increased slightly from 94.5 percent in FY 2014 to 94.9 percent in FY 2015. This improvement and increased emphasis on injury prevention may have resulted in improvements in other measures. In particular, the percent of children served by the program that were reported as having a visit to the emergency room for any cause decreased from 25.6 percent in FY 2014 to 15.3 percent in FY 2015.. Likewise, the percent of mothers served by the program that reported a visit to the emergency room for any cause remained the same at 22.4 percent for FY14 and FY15.

· **School Readiness.** In the MIECHV evaluation, 479 Ages and Stages questionnaires (ASQ-3) were completed in FY 2015. Of these evaluations, 462 (96.4 percent) were above the cut-off (favorable outcome) in all categories assessed (communication and emergent learning, general cognitive skills, positive approaches to learning, and gross motor skills). In addition, 447 Ages and Stages Social-Emotional questionnaire were completed in FY 2015. Of these evaluations, 438 (97.9 percent) were below the cut-off (favorable outcome) for social and emotional development.

· **Domestic Violence.** In the MIECHV evaluation, 63 of the 124 (50.8 percent) families that screened positively for domestic violence in FY 2015 had documentation of receiving a referral to a relevant domestic violence service. Likewise, 63 of the 124 (50.8 percent) families that screened positively for domestic violence in FY 2015 had documentation of receiving a safety plan relevant to domestic violence. Although these results can be improved, it is worth noting that these figures are an improvement from FY 2014 in which the corresponding number of documented referrals was 5 of 15 (33.8 percent) and number of safety plan referrals was 5 of 15 (33.8 percent).

· **Referrals.** All 1,098 families had been screened by a home visitor for needs within two months of enrollment in home visitation. These needs include, but are not limited to, access to food stamps/TANF, educational and employment needs, child development services, and maternal and infant health needs (e.g., postpartum depression services). This demonstrates how MIECHV home visitors promptly help meet the essential needs of home visiting clients, which in turn, helps client retention and outcomes.

Infant Mortality COIIN

In July 2014, Delaware joined the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). As a participant in this initiative, we developed a “blueprint” that builds off of our statewide infant mortality reduction plan through the Delaware Healthy Mother and Infant Consortium and outlines our goals for the entire IM CoIIN project period (through July 2016). Delaware’s selected priorities include safe sleep, preconception/interconception care, and social determinants of health. Leah Woodall, who serves as the Maternal and Child Health Director, is leading and coordinating specific Delaware IM CoIIN activities with the aim of addressing infant mortality and disparities in

birth outcomes. Three learning networks have been established in Delaware linked to the three selected priorities to learn about evidence-based and promising practices (i.e. LARCs policy, practice change, and reimbursement strategies).

In addition, each learning network, designed driver diagrams and/or logic models, AIM statements and small tests of change/PDSA cycles for the three priorities:

1) Preconception/Interconception Care - Delaware developed a statewide plan for reducing the unintended pregnancy rate by increasing access to Long Acting Reversible Contraception for all women regardless of insurance coverage, with commitment from the Governor's office, DPH, Medicaid, FQHCs, Title X providers, as well as providers engaged in a preconception/interconception care program model, Healthy Women, Healthy Babies. We are conducting a CQI process to improve reporting of moderately or most effective methods with two HWHB program providers. For this project, we want to first focus on increasing the percentage of women using contraception. We will then looking at segmenting those women who are not planning on becoming pregnant (based on responses of the One Key Question).
2) Safe Sleep- Building on the safe sleep campaign developed through the DHMIC, we have partnered with WIC to provide safe sleep education to their clients. An evaluation is underway to determine the impact of the education module on behavior related to safe sleep practices. As part of our Cribs for Kids program parents are asked to complete a Safe Sleep questionnaire. The questionnaire asks 16 questions including information on smoking, sleep position, pacifier use, breastfeeding, etc. We have been collecting these since the inception of the program in 2009 with 1,570 pack n' plays being delivered. This data is used to monitor our safe sleep strategies implemented to show progress and work towards our IM COIIN learning network AIM statement.
3) Social Determinants of Health – Delaware selected Medical Legal Partnership as a strategy. The Medical-Legal Partnership (MLP) model serves as a method for legal and health care professionals to work together to improve the health and wellbeing of vulnerable populations. The MLP model integrates lawyers into the network of care providers in the health care setting. This intervention is premised on the idea that a high proportion of low-income individuals face serious legal challenges that adversely affect their social, emotional, and financial well-being. As part of ACA MIECHV Expansion Grant, the State of Delaware is working on integrating an MLP model with the state's home visiting program. In addition, Delaware is also integrating an MLP model with the state's Healthy Women Healthy Babies' preconception/interconception care program for high risk women. Assessment of mental health and well-being for these clients (in both home visiting and the Healthy Women, Healthy Babies Program) is done using the Mental Health Inventory, which is comprised of subscales that gauge anxiety, depression, emotional ties, positive affect, life satisfaction, and loss of behavioral/emotional control. As part of the COIIN work, Delaware plans to develop small tests of change of the MLP using the Mental Health Inventory.

Newborn Screening

Although not funded by Title V, Delaware's Newborn Screening Program continues to be an integral part of DPH's maternal and child health services, providing excellent follow up on both metabolic and hearing screening. We are excited to report that on July 1, 2015, new legislation was passed formalizing the program in Delaware Code, which had previously only been supported by regulation.

In October 2014, the program implemented a redesigned bloodspot card in order to capture the results of Critical Congenital Heart Defect screening via pulse oximetry. In June 2015, over 95% of the CCHD screens were recorded on the bloodspot cards. This percentage did not change in June 2016 and program staff will continue to work with birthing facilities to increase the rate of reporting.

Working with the Delaware Health Information Network (DHIN), much effort was focused on the preparation to both send and receive newborn screening results messages, both hearing and bloodspot, electronically via HL7 messaging. The program worked with our seven birth facilities to facilitate the electronic transmission of hearing screening results messages from the hospitals into our DPH newborn screening database. The program was able to

implement the electronic submission of hearing screening data from 4 of our birth facilities representing over 75% of the births. This has resulted in greater accuracy of data reporting as well as faster follow-up times for missed or failed hearing screens. The Newborn Hearing Screening Program will continue to work with the remaining two birth facilities not providing results electronically to DPH to identify obstacles and potential solutions in order to have all hearing screening results electronically submitted to DPH by the end of 2016. Our one and only children's hospital, A.I. DuPont is also transmitting diagnostic hearing results for any child receiving a diagnostic evaluation after receiving a failed screening result via DHIN. This has created a more streamlined process for referrals to early intervention for any child diagnosed with a hearing loss.

Last year, the Newborn Screening Program began the process to address the Association of Public Health Laboratories (APHL) newborn screening quality assurance measures. Dr. Bartoshesky, our medical genetics consultant, worked with both newborn screening follow-up and lab administrators to design and implement queries that addressed the 8 quality indicators recommended by APHL.

Specific to hearing screening, the program has continued their partnership with both Part C and Part B providers in the state in order to ensure that infants identified with hearing loss were referred to early intervention programs in a timely manner. A quarterly case review meeting was established with Part C and Part B providers as well as our contract audiologist from the state's sole children's hospital. These meetings allowed for rapid updates on infants and children 0-3 with hearing loss and facilitated the tracking of infants for the Early Hearing Detection and Intervention (EHDI) program. The EHDI program continues to work with Home Visiting and Delaware's Parents as Teachers Program to identify infants who have not received a passing hearing screen in order to reduce the loss-to-follow-up rate for the program.

In the past year, an evaluation of the Delaware Newborn Hearing Screening Program focusing on the experience and perception of families who have recently had a child diagnosed with hearing loss or who had a failed hearing screen was conducted. The results, shared with our EHDI Advisory Board, indicated general satisfaction of families with the services they received. Areas for improvement included better communication in writing to the parents at the time of referral and diagnosis; a standardized protocol for the number of outpatient rescreens performed before referral for diagnostic exam; increasing capacity for outpatient rescreening in Sussex County; and improving the knowledge and training of early interventionists in the area of hearing loss intervention options and resources.

The EHDI Advisory Board established a Quality Improvement/Quality Assurance subcommittee that worked with the Newborn Screening Coordinator and staff to identify and implement short term tests of change that may lead to a reduction in time to diagnosis and intervention, as well as loss to follow-up. The group used the results of the parent and family evaluation survey to identify practices that may help families progress through the hearing loss diagnostic process more quickly. The first project the sub-committee worked on was to revise the program letters that are sent to families and primary care providers regarding the results of the hearing screening. The group wanted to clearly convey the hearing screening program phases (screening, diagnosis and early intervention) to both families and primary care providers within the follow-up program letters. The letters were approved at the last EHDI Advisory Board meeting and will be implemented later this year.

Birth Defects and Autism Registry

Delaware uses Title V funds to support our Birth Defects and Autism Registries. These registries aid the Division of Public Health in assessing the prevalence of major birth defects and autism within the state and in planning for services for the affected populations. Both registries are legislatively mandated and have been awarded via a competitive RFP process to Christiana Care Health System, Center for Women's, Infants' and Children's Health Research. A multidisciplinary team conducts active surveillance statewide through collaborations with public health, public and private hospitals and providers.

Family SHADE

Delaware Title V funds have been used to support Family SHADE (the Family Support and Healthcare Alliance of Delaware), formed in 2010, an alliance of organizations, agencies, and families committed to working together to improve the quality of life of children and youth with special health care needs in Delaware. This organization has become a key partner with Public Health in organizing the numerous community partners delivering services and support to the CYSHCN population within the state. It has helped provide easier access to community-based service systems to Delawareans with CYSHCN. Delaware values this infrastructure development and maintenance for community organizations touching families and professionals who serve the CYSHCN population. Family SHADE serves as a conduit for bidirectional communication between Public Health and its members. It has provided Public Health with data from a bi-monthly survey of families on various topics which have allowed the Division to keep abreast on concerns and issues affecting this population. Family SHADE has been a key partner with Title V in bringing the concerns of the CYSHN population to the forefront of the State Innovation Model (SIM) grant ensuring that primary care pediatrics and the needs of a family-centered medical home for CYSHCN are brought forward in the DCHI strategic plan.

Special Needs Assistance Program (SNAP)

Title V funds were also used to support work within our Office of Preparedness to address the needs of the CYSHN population. Funding contributed salaries of staff working with state and local stakeholders to increase the preparedness levels of all vulnerable populations during all phases of disaster management. Specifically staff worked to develop preparedness and response strategies and capabilities that address the public health, mental/behavioral health, and medical needs of all vulnerable populations. Furthermore work was completed to improve the process to identify Children with Special Health Care Needs in the community and encourage their families to register with SNAP.

II.F.2 MCH Workforce Development and Capacity

The total federal-state MCH partnership budget reported in this application includes Title V funds, state general funds, and appropriated special funds. The state portion of the MCH partnership is $10,461,629, which includes funds appropriated for state infant mortality reduction initiatives, and supports 54.1 FTEs (48.5 from general funds and 5.6 from appropriated special funds). The Title V federal allotment is estimated at $1,961,019 for FY 17.

In Delaware, the majority of Title V block grant funding is used to support approximately 20 positions (FTEs) across the division that are involved with MCH programs and services, including home visiting, Child Development Watch, 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, and families. The majority of these positions do not report directly to the Title V program, but rather to the administrator of the specific program or clinic that they work within. As we considered our needs assessment findings and developed our 5-year state plan, we started to work with the managers of these positions to assess job responsibilities and ensure alignment with our new Title V priorities.

A smaller portion of block grant funding is available to support more targeted activities to advance our Title V priorities. 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 section II.B.2.c. of our 2015 needs assessment.

Although the MCH leadership team has a significant amount of professional experience, key members are relatively new in their current positions. Leah Woodall, MPA, the state MCH Director for Delaware and Section Chief for the Family Health Systems Section, is in her third year serving in these capacities, having previously served as the MCH Bureau Chief and Deputy Director. Crystal Sherman, BS, is our newest member and has served in the role of MCH Bureau Chief and Deputy Director since October 2015. She previously served as the Home Visiting Program Administrator overseeing implementation of the MIECHV program. Kate Tullis, PhD, was hired as the Children and Youth with Special Health Care Needs Director in October 2014. She previously served as the Newborn Screening and Genetics Program Administrator for DPH.

Delaware's MCH program does not include 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 share that we have recruited a CDC MCH Epidemiology assignee to DE. Khaleel Hussaini came aboard in May 2016. He brings a wealth of MCH experience primarily from his leadership roles at the Department of Health in Arizona.

Priorities/projects for the first year of the CDC epidemiologist's assignment have been identified and include:

- Complete an analysis of hospital discharge data to understand the impact of Neonatal Abstinence Syndrome (NAS) in Delaware.
- Support the State Innovations Model (SIM) Grant, awarded by CMMI, focused on Community Health through the Healthy Neighborhoods Initiative. Work with DOH to support activities in four priority areas: chronic disease, substance use/mental health, maternal and child health, and healthy lifestyles. Three neighborhood pilots are planned to launch this year addressing these areas.
- Support a DPH data systems inventory by advising on data linkage and categorizations.
- Join the DE state team in the CDC/ASTHO LARC Learning Community. Provide analytic and subject matter expert support.
- Assist with development of evidence-informed strategy measures for Title V Action plan. Provide specific support for "bullying" using YRBS data to analyze issues including cyber-bullying versus in-person bullying.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work however, with recent turnover in positions a number of staff have less than three years' experience in their current roles. As such, we have taken advantage of opportunities such as the AMCHP New Director Mentorship Program and AMCHP's MCH Navigator, and look forward to participating in additional professional development opportunities. Internal to 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. We recently developed a Delaware team consisting of two Medicaid staff, two MCH staff, and one family representative who submitted an application to attend the 2016 MCH Summer Skills Institute.

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 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 Health Equity Guide for Public Health Practitioners and Partners in June 2015. Training around the guide has been offered and the entire Family Health Systems section has received the training on the guide.

II.F.3. Family Consumer Partnership

One of the most impressive examples of collaboration is the Delaware Healthy Mothers and Infants Consortium (DHMIC). Formed in 2005 as a statewide vehicle to address infant mortality, the consortium includes approximately 150 members, including representatives from DPH, hospital systems, universities, the legislature, March of Dimes, and more. The consortium has five committees addressing standards of care, health equity, education and prevention, and data and science. 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 group is Family SHADE (Support and Healthcare Alliance Delaware), a collaborative alliance of family partners and organizations dedicated to supporting families of children with

disabilities and chronic medical conditions. The 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 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 panel.

Additional key partnerships and collaborations include Delaware's statewide Early Childhood Council (ECC), the Safe Kids Coalition, the Family Coordinating Council, the Sussex County Health Promotion Coalition, the Community Advisory Board for Home Visiting 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 are embarking on a new partnership with the Division of Prevention and Behavioral Health to co-lead Delaware's Project LAUNCH project, a 5-year award from the Substance Abuse and Mental Health Administration. We are also involved in the current Infant Mortality COIIN.

In terms of new partnerships, we are eager to become involved in Delaware's State Innovation Model (SIM) work, which is supported by an award from the Center for Medicare and Medicaid Innovation, and is aimed at improving the health of Delawareans, improving health care quality and patient experience, and controlling the growth in health care costs.

In the past year, MCH has cultivated a strong collaboration with our Oral Health counterparts here in DPH. We have become an active member of the Delaware Oral Health Coalition by participating in the Partnerships Action Group and have worked with the our marketing resource to enhance our website, DEThrives.com to include information on Oral Health programs, resources, and education for our consumers. MCH has worked with our community partner, the Sussex County Health Coalition, to align their strategic plan to our Title V National Priority needs which in turn, gives the Bureau of Oral Health and Dentals Services an additional portal for distributing education and training.

In addition to the wide range of organizational collaborations listed above, we also value partnership with families and consumers. As part of our 5-year needs assessment process, we conducted 8 focus groups across our state with women, mothers, and family members (see Appendix D: Focus Group Report). The findings of the focus groups were instrumental in our needs assessment and directly informed one of the seven variables ("importance to consumer") that were used to prioritize our needs.

In support of planning for our CYSHCN program, a survey was also conducted with families of children with special health care needs. The survey included questions covering the seven system outcomes of the National Consensus Framework for Improving Quality Systems of Care for CYSHCN, and was fielded in both English and Spanish, electronic and hard copy. Results of the survey are being used to inform the direction of our work for this population.

Parents are also engaged through the Families Know Best Surveys administered by Family SHADE. Families Know Best is a voluntary parent advisory group. Participating families are asked to fill out monthly online or print surveys about the services they receive. Information gained through these surveys is shared with Family SHADE organizations, policy makers and agencies statewide.

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.

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.

II.F.4. Health Reform

One of the most significant roles that our Maternal and Child Health program is playing 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 involves 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).

According to ACA requirements, health care plans must cover contraceptive methods and counseling for all women, as prescribed by a health care provider. In Delaware, momentum is building to leverage this requirement in order to address our exceptionally high rate of unplanned pregnancies. According to a report from the Guttmacher Institute, in 2010 approximately 57% of Delaware pregnancies were unplanned, the highest rate in the nation. This is a key concern for the Delaware Healthy Mothers and Infants Consortium, and partners working to improving infant health and reducing infant mortality. Increasing use of LARCs is seen as a promising approach to reducing unplanned pregnancies by offering women information and access to a long-term, effective method of contraception. We are working to provide information to women through messaging on our website, DeThrives.com, and we are planning to partner with the Department of Insurance to release a bulletin on LARCs. Work is also underway to implement a pilot that would support outpatient practices with training and technical assistance on insertion of LARCs. (For more details on our planned activities to promote LARCS, please see the action plan narrative for the domain of women's/maternal health).

On a broader scale, DPH and Title V Program staff are working to become more engaged in the largest health reform effort in our state, implementation of the State Health Care Innovation Plan. As described in section IIA, Delaware is poised to implement transformative changes in our health care system by 2019, guided by the State Health Care Innovation Plan. This plan, supported by a $139 million grant from the Center for Medicare & Medicaid Innovation, aims to improve population health, improve health care quality and patient experience, and reduces the growth in health care costs through the following core strategies:

1. Supporting local communities to work together to enable healthier living and better access to primary care;
2. Transforming primary care so that every Delawarean has access to a primary care provider and to better coordinated care for those patients with the greatest health needs;
3. Shifting to payment models that reward high quality and better management of costs, with a common scorecard across payers;
4. Developing the technology needed for providers to access better information about their performance and for consumers to engage in their own health.

The Delaware Center for Health Innovation (DCHI), a non-profit organization dedicated to the implementation of Delaware's plan, was established in early 2014 to work with the Health Care Commission and the Delaware Health Information Network (DHIN) to guide the State Innovation Models effort and track its progress. The 15-member DCHI board represents a diverse group of public and private partners, and includes Rita Landgraf, Secretary of the Department of Health and Social Services, of which DPH is a part.

Committees have been established for each of the core elements, and members of DPH leadership are making a concerted effort to attend committee meetings and be engaged in the development of plans. Dr. Karyl Rattay the Director of DPH, is an appointed member of the Healthy Neighborhoods committee, which is tasked with the strategy of supporting communities to enable healthier living and better access to primary care. Involvement and alignment with this committee will be especially important for addressing the social determinants of health that lead to so many of the disparities described in our needs assessment.

We also see the work of the “Patient and Consumer Advocacy” (strategy 2) as essential to our Title V work related to enhancing access to medical homes, and the “Payment Model Monitoring” committee as critical to our work in ensuring adequate insurance coverage. To date, the committees have been focused primarily on adult care and management of chronic conditions, which tend to be the drivers of high health care costs. A key strategy in our 5-year action plan is to engage with these committees in order to articulate the importance of maternal and child health to improving population health; to advocate for the needs of children, including children with special health care needs; and to offer recommendations on how these key audiences should be included in plans moving forward.

II.F.5. Emerging Issues

Zika Virus

Title V has been actively engaged in the rapidly evolving response to the potential birth defects caused by the Zika virus infection. The Division of Public Health has developed educational materials describing the Zika Virus, how it is transmitted and the potential for birth defects. These materials were disseminated to a variety of partners including the Delaware Healthy Mother Infant Consortium (DHMIC), ACOG, AAP, home visiting and Healthy Women Healthy Babies (HWHB) providers, a program that serves women at most risk of poor birth outcomes. A link to all of the materials including reporting tools and Public Health updates regarding Zika are also posted on the front page of our DEThrives website. We are exploring the feasibility of revising our Births Defects registry contract to include rapid population-based surveillance of microcephaly and other adverse infant outcomes, especially central nervous system defects linked to Zika virus infection during pregnancy. Our contracted provider has provided us with the number of infants diagnosed with microcephalus in DE from 2007-2012. Title V is also working with our Part C program partners to implement a long-term infant/child monitoring of all infants born to Zika positive mothers, based on CDC reporting guidelines.

Neonatal Abstinence Syndrome

Over the last few years, disturbing trends have emerged around prescription drug abuse in our state. Data show that more Delawareans die from drug overdoses than from any other cause of injury, including motor vehicle accidents. In a parallel trend, anecdotal data from MCH stakeholders and birth hospitals indicate that there is a rising incidence of Neonatal Abstinence Syndrome (NAS). While there is currently no system-wide surveillance of NAS in De, we are hoping to mandate reporting as a reportable disease in order to gain a better understanding of the magnitude of the problem. In the meantime, one way that DPH is working to address this issue is by partnering with programs such as home visiting, the DHMIC, and others to spread key prevention messages around this issue. The DHMIC has been able to obtain the number of NAS births from 2013-2015 from every birthing facility in the state, which is shared at the Perinatal Cooperative and Standards of Care committees. The numbers received are a good estimate but not exact as birthing facilities have different protocols for screening and testing for NAS. The numbers are steadily rising. In 2013, 247, in 2014, 301 and in 2015, 314 were reported. The messaging campaign targets both women of child-bearing age and medical practitioners serving this population. For the audience of women, the goal is to raise awareness of NAS, the impact that drug and alcohol use can have on babies prenatally, and the availability of recovery resources. The campaign targeting medical practitioners emphasizes universal screening, and structured screening built into the care of every pregnant woman.

Delaware’s Child Protection Accountability Commission, Substance-Exposed Infants/Medical Fragile Children Committee which several FHS section attend including the Title V Deputy Director, is applying for an In-Depth Technical Assistance for Substance Exposed Infants grant opportunity. Multiple letters of commitment from organizations were submitted along with application expressing their support including the Delaware Department of Services for Children, Youth and Their Families: Carla Benson-Green; Cabinet Secretary, Connections Community

Support Programs, Inc.: Catherine D. McKay, MC, CEO; Christiana Care Health System, Delaware Healthy Mother and Infant Consortium: Dr. David A. Paul, MD, FAAP; Beebe Healthcare: Bridget Buckaloo, MSN, RN; Delaware Health and Social Services, Division of Public Health/Child Development Watch: Dr. Karyl T. Rattay, M.D., MS; Delaware Health and Social Services, Office of the Secretary: Dr. Gerard Gallucci, MD, MHS; Delaware Child Death Review Commission: Anne Pedrick, MS; Fetal Alcohol Spectrum Disorder Task Force of Delaware: Emily Knearl; Co-Chair, March of Dimes: Aleks Casper, Reg. Director of Advocacy & Gov't Affairs; Children & Families First: Leslie Newman, CEO and the Office of the Child Advocate of Delaware: Tania Culley, Esq., Child Advocate. In preparation for the anticipated technical assistance the CPAC, SEI committee is developing a core leadership team and the Title V MCH Deputy Director will be a member of the team.

This past year, HB319 was introduced in Delaware's General Assembly. This is a non-punitive, public health-oriented bill that seeks to codify certain sections of the federal law known as the Child Abuse Prevention and Treatment Act ("CAPTA"). It also requires States to have policies and procedures in place to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder, including a requirement that healthcare providers involved in the delivery or care of such infants notify the child protective services system. Furthermore, CAPTA requires the development of a "plan of safe care" for these infants. Referrals to our home visiting programs are sited as being a requirement in the "plan of safe care". This bill clarifies and formalizes a uniform, collaborative response protocol in accordance with CAPTA that will require Delaware's child protection system partners to work together to ensure the safety of substance exposed infants and to provide support and services to the mothers and families of substance exposed infants. We will continue to monitor the status of this bill.

II.F.6. Public Input

Input Following Submission of FY16 Application

As a part of our comprehensive 5-year needs assessment, a significant amount of effort was invested in seeking input from professional and community stakeholders on the strengths and needs of our state related to maternal and child health.

In the previous year, we solicited input from professional stakeholders by posting our FY16 Title V application on our website, dethrives.com. The proposed Title V 5-Year Action Plan and selected priorities were also posted online for review on www.dethrives.com, a website that serves as the hub for information on many maternal and child health efforts in Delaware. The website is available stakeholders as well as the general public, and a button was placed on the home page of DEthrives.com to direct visitors to the Title V content. A survey link was provided on the website for individuals to provide comments and suggestions on the plan. An email was sent to a distribution list of 700+ stakeholders, describing the progress made on our needs assessment and directing them to the website to review the selected priorities and action plan.

Input to FY17 Application

Upon completion of our MCH Block Grant Review, members of our MCH staff presented our Needs Assessment findings and State Action Plan to various community action groups as well as to our internal partners who contributed to the process. MCH gathered community input and feedback by offering presentations on our Needs Assessment findings, updates on our action planning process, and by creating a comprehensive Title V marketing brochure.

We are especially proud of our MCH Title V Overview brochure that was completed in time to be shared at the Annual Delaware Health Mothers and Infants Consortium Summit (DHMIC) which was held in April, 2016. This marketing tool was designed as a tri-fold brochure that provided a Needs Assessment overview and action planning roadmap for our priorities and objectives for the next five years. Stakeholders such as Family Shade, DHMIC, The Sussex County Health Coalition, the Home Visiting Advisory Board, the Safe Kids Coalition, and the Help Me Grow

Advisory Board were just a few of the groups that were contacted for input and feedback.

Our stakeholder involvement and input was then gathered as we convened our Domain Work Groups and began the work of identifying our ESMs. Domain leads identified teams to develop and refine the Title V 5-Year Action Plan to include strategies and evidence based strategy measures. Domain team leads held team meetings from February through May of 2016 to review the selected priorities, and create the final set of strategies. The group provided valuable input into the feasibility and potential impact of the strategies, and suggested activities that would support implementation of the plan.

Following the submission of our final action plan and block grant application, we plan to post the documents on DEthrives.com, as well as on our Title V Program 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 made when the TVIS system is opened again after the review of our application.

II.F.7. Technical Assistance

Delaware anticipates the potential need for technical assistance in revising the Title V/Medicaid Interagency Agreement. Specifically, we need federal guidance on the requirements and restrictions for the agreement. An attempt was made to update Delaware's Memorandum of Understanding (MOU) between Title V and Title XIX in 2009, however it was never finalized. The MOU needs to be updated to address Delaware's new priorities and needs while taking into consideration the current environment of Delaware's healthcare services. It would also be helpful to see examples from states who recently updated their agreements.

Although the MCH leadership team has a significant amount of professional experience, key members are relatively new in their current positions. Our Leah Woodall, MPA, the state MCH Director for Delaware and Section Chief for the Family Health Systems Section, is in her third year serving in these capacities, having previously served as the MCH Bureau Chief and Deputy Director. Crystal Sherman, BS, is our newest member and has served in the role of MCH Bureau Chief and Deputy Director since October 2015. She previously served as the Home Visiting Program Administrator overseeing implementation of the MIECHV program. Kate Tullis, PhD, was hired as the Children and Youth with Special Health Care Needs Director in October 2014. She previously served as the Newborn Screening and Genetics Program Administrator for DPH. As such, we have taken advantage of opportunities such as the AMCHP New Director Mentorship Program and AMCHP's MCH Navigator, and look forward to participating in additional professional development opportunities. One skill that we feel still needs improvement is interpretation of MCH data as well as presenting data to stakeholders. Skills around making sense of the data and presenting in different ways depending on the audience is needed. MCH staff would appreciate the opportunity to attend training or receive support around telling a story with our data as a way to engage our stakeholders and communities.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,966,509	$1,966,509	$1,917,232	$1,935,927
Unobligated Balance	$400,000	$400,000	$344,648	$33,063
State Funds	$9,281,008	$9,281,008	$9,512,763	$9,512,763
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$1,440,000	$1,440,000	$1,368,000	$1,368,000
SubTotal	$13,087,517	$13,087,517	$13,142,643	$12,849,753
Other Federal Funds	$7,591,940	$7,591,940	$6,206,323	
Total	$20,679,457	$20,679,457	$19,348,966	$12,849,753

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,958,687	$1,605,272	$1,958,687	
Unobligated Balance	$445,373	$335,747	$298,794	
State Funds	$9,390,789	$9,390,789	$10,559,315	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$1,292,148	$1,292,148	$2,147,883	
SubTotal	$13,086,997	$12,623,956	$14,964,679	
Other Federal Funds	$10,411,186	$0	$10,406,559	
Total	$23,498,183	$12,623,956	$25,371,238	

	2017	
	Budgeted	Expended
Federal Allocation	$1,961,019	
Unobligated Balance	$256,511	
State Funds	$10,461,629	
Local Funds	$0	
Other Funds	$0	
Program Funds	$2,151,704	
SubTotal	$14,830,863	
Other Federal Funds	$8,446,184	
Total	$23,277,047	

III.A. 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 any 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.

III.B. 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 $14,830,863, 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 $23,277,047. Form 2 provides more detail on these other federal funds, which include the following grants: State Systems Development Initiative (SSDI); Early Hearing Detection and Intervention (EHDI); Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Early Childhood Comprehensive Systems (ECCS); Pregnancy Risk Assessment and Monitoring System (PRAMS); Title X; and Universal Newborn Hearing Screening.

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

FY16 Budget – Federal Title V Funds

Personnel Costs		**$1,619,484**
Salary, fringe, health insurance, indirects	$1,577,236	
Other employment costs (personnel, phone lines, DTI, network charges, postage, Fleet travel)	$42,248	

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.

In past years, our indirect rate has increased significantly, from 28.53% in 2014 to 2015's rate of 36.48%. The Division of Public Health is currently negotiating a new indirect rate with the US Department of Health and Social Services. As we await the final result of this process, we projected our FY17 budget using 25.60%, which is reflected in the budget amount above.

Contractual		**$334,755**
1) Support for activities described in action plan	$334,755	

Based on activities described in our 5-year action plan narrative, the following are budgeted amounts for each domain. 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.

Infant Health	$6,567
Pregnancy Health	$6,567
Child Health	$6,567
CYSHCN	315,054

Travel **$5,000**

Funding will support our staff to attend meetings and conferences for training and professional development (eg. AMCHP conference)

Supplies **$1,780**

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

FY 16 TOTAL BUDGET **$1,961,019**

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 $12,613,333 in state funds to the Maintenance of Effort agreement. This includes support for 52.5 FTEs from state general funds and 5.60 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 2017 meets the 30% requirement for CYSHCN. This requirement will be met through funding for staff who serve CYSHCN and their families, support for the Family SHADE network, operation of the birth defects and Autism registries, and initiatives to carry out the activities described in the action plan narrative for the CYSHCN domain.

Preventive and Primary Care for Children

The budget planned for FY 2017 meets the 30% requirement for preventive and primary care for children. This requirement will be met through funding for staff that provide services to infants and children 1-22, as well as population-level prevention efforts, as described in our action plan narrative for the infant and child health domains.

Administration

Less than 10% of our FY2017 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.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Delaware Title V-Title XIX Agreement_1993.pdf

V. Supporting Documents

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

Supporting Document #01 - APPENDIX A MCH Needs Assessment Ranking Worksheet.pdf

Supporting Document #02 - APPENDIX B Topic Briefs.pdf

Supporting Document #03 - APPENDIX C FHS Org Chart_0716.pdf

Supporting Document #04 - APPENDIX D Focus Group Reports.pdf

Supporting Document #05 - APPENDIX E References.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,961,019	
A. Preventive and Primary Care for Children	$ 645,281	(32.9%)
B. Children with Special Health Care Needs	$ 588,308	(30%)
C. Title V Administrative Costs	$ 196,000	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 256,511	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,461,629	
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)	$ 2,151,704	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,613,333	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 14,830,863	
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)	$ 8,446,184	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,277,047	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 133,040
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 6,586,617
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 139,153
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,102,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,958,687		$ 1,605,272	
A. Preventive and Primary Care for Children	$ 783,475	(40%)	$ 508,257	(31.7%)
B. Children with Special Health Care Needs	$ 783,475	(40%)	$ 346,076	(21.6%)
C. Title V Administrative Costs	$ 97,934	(5%)	$ 130,961	(8.2%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 445,373		$ 335,747	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,390,789		$ 9,390,789	
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)	$ 1,292,148		$ 1,292,148	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,682,937		$ 10,682,937	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 13,086,997		$ 12,623,956	
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)	$ 10,411,186		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,498,183		$ 12,623,956	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
No Other Federal Programs were provided by the State on Form 2 Line 9.	

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: The budgeted amount for this category was 40%, we are reporting actual amounts spent which is 31.7%. This is the reason for the variance.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: The budgeted amount for this category was 40%, we are reporting actual amounts spent which is 21.6%. This is the reason for the variance. The percent is 21.6% however once the remaining funds are spent by 9/30/16 the 30% CYSHCN's requirement will be met.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: The budgeted amount for this category was 5%, we are reporting actual amounts spent which is 8.2%. This is the reason for the variance.	
4.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: This represents the unobligated balance of FY15 award that is currently unspent as of 5/31/16, however these funds will be spent in full by 9/30/16.	
5.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: This total represents expenditures as of 5/31/16.The remaining funds will be spent in full by 9/30/16.	

Data Alerts:

1.	The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. Please add a field level note indicating the reason for the discrepancy.

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

State: Delaware

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 434,315	$ 548,582
2. Infants < 1 year	$ 0	$ 0
3. Children 1-22 years	$ 645,281	$ 508,257
4. CSHCN	$ 588,308	$ 346,076
5. All Others	$ 74,816	$ 71,397
Federal Total of Individuals Served	$ 1,742,720	$ 1,474,312

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 3,081,719	$ 3,255,270
2. Infants < 1 year	$ 3,120,153	$ 3,293,703
3. Children 1-22 years	$ 914,019	$ 1,726,747
4. CSHCN	$ 914,019	$ 2,153,122
5. All Others	$ 2,431,719	$ 2,658,155
Non Federal Total of Individuals Served	$ 10,461,629	$ 13,086,997
Federal State MCH Block Grant Partnership Total	$ 12,204,349	$ 14,561,309

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:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: We include this amount spent on infants in line 3 because TVIS requires line 3 o match Form 2 line 1A.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: We interpret the 30% requirement for Preventative and Primary Care for Children to include programs and services provided for both infants and children 1-22.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Delaware

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 1,306,700	$ 1,069,653
3. Public Health Services and Systems	$ 654,319	$ 535,619
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	$ 1,961,019	$ 1,605,272

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 3,127,828	$ 3,169,678
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 3,127,828	$ 3,169,678
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 5,639,354	$ 5,556,288
3. Public Health Services and Systems	$ 1,694,447	$ 1,956,971
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		$ 1,948,945
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 79,715
Durable Medical Equipment and Supplies		$ 367,749
Laboratory Services		$ 0
Other		
HWHB Support Activities		$ 773,269
Direct Services Line 4 Expended Total		$ 3,169,678
Non-Federal Total	$ 10,461,629	$ 10,682,937

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: 11,512

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	11,486 (99.8%)	403	53	53 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Screening	11,435 (99.3%)	138	14	14 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

We have no formal long term follow-up procedure in place. Every few years we select a few disorders for review of outcomes. Within past several years we have looked at outcomes of thyroid screening, hemoglobinopathies, bioitnidase, galactosemias, CAH, SCID and CF. These are done by record review at our state's only children's hospital and are done informally and when convenient for staff. Results are anonymized after collection so give us population rates of follow up, but not specific patient information nor specifics of treatment, simply rates of screen positive babies who are being followed by appropriate specialists. Results are presented to Advisory Board as they are completed.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Delaware

Reporting Year 2015

		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	4,049	49.3	0.0	13.0	37.7	0.0
2. Infants < 1 Year of Age	11,486	48.5	0.0	50.2	0.8	0.5
3. Children 1 to 22 Years of Age	273	100.0	0.0	0.0	0.0	0.0
4. Children with Special Health Care Needs	3,749	62.2	3.5	0.0	0.0	34.3
5. Others	5,700	41.0	0.0	16.9	37.2	4.9
Total	25,257					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2015**
	Field Note: 2015 HWHB Bundle C clients plus home visiting FY 2015	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2015**
	Field Note: 2015 Newborn Screening Program. Coverage Source estimate from Vital Statistics 2013 births.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2015**
	Field Note: Home visiting FY 2015	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: CY 2015 Child Development Watch children.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: CY 2015 HWHB preconception clients	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Delaware

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	4,426
2. Infants < 1 Year of Age	11,931
3. Children 1 to 22 Years of Age	10,073
4. Children with Special Health Care Needs	21,736
5. Others	17,700
Total	65,866

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2015**
	Field Note: CY 2015 HWHB prental clients; Home Visiting for FY 2015	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2015**
	Field Note: Newborn Screening and home visiting	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2015**
	Field Note: Title X to age 24 and home visiting	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: Child Development Watch; Developmental Screening	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: HWHB Preconception care; Title X 24+	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Delaware

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	11,202	7,507	3,024	29	553	3	0	86
Title V Served	11,202	7,507	3,024	29	553	3	0	86
Eligible for Title XIX	5,264	3,528	1,421	14	260	1	0	40
2. Total Infants in State	10,802	7,087	3,049	30	549	3	0	84
Title V Served	10,802	7,087	3,049	30	549	3	0	84
Eligible for Title XIX	5,077	3,331	1,433	14	258	1	0	40

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	9,857	1,345	0	11,202
Title V Served	9,857	1,345	0	11,202
Eligible for Title XIX	4,633	631	0	5,264
2. Total Infants in State	9,460	1,342	0	10,802
Title V Served	9,460	1,342	0	10,802
Eligible for Title XIX	4,446	631	0	5,077

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Delaware

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 464-4357	(800) 464-4357
2. State MCH Toll-Free "Hotline" Name	Helpline and 2-1-1 Help Me Grow	Helpline and 2-1-1 Help Me Grow
3. Name of Contact Person for State MCH "Hotline"	Donna Snyder-White	Donna Snyder-White
4. Contact Person's Telephone Number	(302) 255-1804	(302) 255-1804
5. Number of Calls Received on the State MCH "Hotline"		104,999

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.dhss.delaware.gov/dhss/dph/chca/dphmchhome.html	http://www.dhss.delaware.gov/dhss/dph/chca/dphmchhome.html
4. Number of Hits to the State Title V Program Website		2,167
5. State Title V Social Media Websites	www.dethrives.com	www.dethrives.com
6. Number of Hits to the State Title V Program Social Media Websites		85,147

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Delaware

1. Title V Maternal and Child Health (MCH) Director	
Name	Leah Woodall
Title	Section Chief, Family Health Systems
Address 1	417 Federal Street
Address 2	
City/State/Zip	Dover / DE / 19901
Telephone	(302) 744-4901
Extension	
Email	leah.woodall@state.de.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Kathryn Tullis
Title	Director, CYSCHN
Address 1	417 Federal Street
Address 2	
City/State/Zip	Dover / DE / 19901
Telephone	(302) 744-4906
Extension	
Email	kathryn.tullis@state.de.us

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Delaware

Application Year 2017

No.	Priority Need
1.	To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.
2.	Improve breastfeeding rates.
3.	Improve rates of developmental screening in the healthcare setting using a validated screening tool.
4.	Increase healthy lifestyle behaviors (healthy eating and physical activity).
5.	Increase the percent of children with and without special health care needs having a medical home.
6.	Decrease rates of bullying by promoting development of social and emotional wellness.
7.	Improve the rate of Oral Health preventive care in pregnant women and children.
8.	Increase the percent of children 0-17 who are adequately insured.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.	New	
2.	Improve breastfeeding rates.	New	
3.	Improve rates of developmental screening in the healthcare setting using a validated screening tool.	Continued	
4.	Increase healthy lifestyle behaviors (healthy eating and physical activity).	Replaced	
5.	Increase the percent of children with and without special health care needs having a medical home.	New	
6.	Decrease rates of bullying by promoting development of social and emotional wellness.	New	
7.	Improve the rate of Oral Health preventive care in pregnant women and children.	Continued	
8.	Increase the percent of children 0-17 who are adequately insured.	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Delaware

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	176.3
Numerator	182
Denominator	10,325
Data Source	Delaware Health Statistics Center
Data Source Year	2013

NOM 2 - Notes:

This is provisional data for 2013.

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	NR	NR	NR	NR
2009_2013	NR	NR	NR	NR
2008_2012	20.9	6.1 %	12	57,293
2007_2011	18.8	5.7 %	11	58,440

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	9.0 %	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%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.8 %	0.1 %	194	10,970
2013	1.7 %	0.1 %	181	10,827
2012	1.6 %	0.1 %	178	11,018
2011	1.8 %	0.1 %	206	11,253
2010	1.7 %	0.1 %	193	11,357
2009	1.9 %	0.1 %	214	11,556

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.5 %	0.2 %	714	10,970
2013	6.6 %	0.2 %	719	10,827
2012	6.7 %	0.2 %	735	11,018
2011	6.5 %	0.2 %	736	11,253
2010	7.3 %	0.2 %	823	11,357
2009	6.8 %	0.2 %	780	11,556

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.3 %	0.3 %	1,019	10,965
2013	9.5 %	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	10.1 %	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%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.0 %	0.2 %	330	10,965
2013	2.9 %	0.2 %	310	10,818
2012	3.0 %	0.2 %	332	11,009
2011	3.0 %	0.2 %	332	11,247
2010	3.2 %	0.2 %	361	11,355
2009	3.2 %	0.2 %	373	11,543

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.3 %	0.2 %	689	10,965
2013	6.6 %	0.2 %	712	10,818
2012	6.5 %	0.2 %	717	11,009
2011	6.4 %	0.2 %	719	11,247
2010	7.0 %	0.2 %	792	11,355
2009	6.8 %	0.2 %	787	11,543

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	6.7	0.8 %	77	11,584

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.4	0.8 %	69	10,831
2012	7.6	0.8 %	84	11,023
2011	8.9	0.9 %	100	11,257
2010	7.5	0.8 %	85	11,364
2009	8.0	0.8 %	92	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.4	0.6 %	48	10,831
2012	6.1	0.7 %	67	11,023
2011	6.5	0.8 %	73	11,257
2010	5.0	0.7 %	57	11,364
2009	5.8	0.7 %	67	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.9	0.4 %	21	10,831
2012	1.5	0.4 %	17	11,023
2011	2.4	0.5 %	27	11,257
2010	2.5	0.5 %	28	11,364
2009	2.2	0.4 %	25	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	295.5	52.3 %	32	10,831
2012	372.0	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 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	129.3	34.6 %	14	10,831
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	105.6	30.5 %	12	11,364
2009	121.1	32.4 %	14	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	22.8
Numerator	247
Denominator	10,827
Data Source	Hospitals
Data Source Year	2013

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.5 %	37,328	192,254

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.8	3.5 %	13	101,738
2013	18.6	4.3 %	19	101,932
2012	20.6	4.5 %	21	102,082
2011	18.8	4.3 %	19	100,869
2010	NR	NR	NR	NR
2009	16.8	4.1 %	17	101,227

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	31.6	5.2 %	37	117,122
2013	32.5	5.3 %	38	116,766
2012	37.1	5.6 %	44	118,726
2011	31.9	5.2 %	38	119,280
2010	35.4	5.4 %	43	121,431
2009	39.4	5.7 %	48	121,966

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	11.6	2.5 %	21	181,255
2011_2013	10.9	2.4 %	20	183,456
2010_2012	11.2	2.4 %	21	188,321
2009_2011	13.0	2.6 %	25	191,829
2008_2010	13.9	2.7 %	27	194,904
2007_2009	15.4	2.8 %	30	194,529

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	9.9	2.3 %	18	181,255
2011_2013	13.1	2.7 %	24	183,456
2010_2012	13.8	2.7 %	26	188,321
2009_2011	9.4	2.2 %	18	191,829
2008_2010	5.6	1.7 %	11	194,904
2007_2009	5.1	1.6 %	10	194,529

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.4 %	1.4 %	45,803	204,471
2007	23.9 %	1.3 %	48,067	201,362
2003	19.2 %	1.0 %	38,125	198,401

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.7 %	2.1 %	6,579	33,379

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.4 %	0.5 %	4,111	173,055
2007	0.9 %	0.3 %	1,451	167,279

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	11.0 %	1.2 %	19,057	173,014
2007	10.3 %	1.1 %	17,208	166,830

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	66.6 %	5.4 %	12,783	19,184
2007	77.0 %	4.8 %	14,978	19,452
2003	57.2 %	5.2 %	8,138	14,221

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	84.1 %	1.3 %	171,920	204,471
2007	84.5 %	1.2 %	170,122	201,362
2003	85.2 %	0.9 %	169,066	198,401

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.0 %	2.4 %	28,610	89,352
2007	33.2 %	2.1 %	28,826	86,933
2003	35.5 %	1.9 %	30,657	86,478

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	34.0 %	0.5 %	2,599	7,645

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	30.4 %	1.0 %	10,643	34,970
2011	29.1 %	1.4 %	9,932	34,173
2009	29.2 %	1.0 %	9,787	33,562
2007	30.5 %	1.2 %	10,162	33,287
2005	28.9 %	1.0 %	9,343	32,311

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	74.5 %	3.5 %	12,177	16,340
2013	71.8 %	3.4 %	11,875	16,545
2012	72.6 %	3.4 %	11,703	16,130
2011	63.5 %	3.6 %	10,788	16,984
2010	54.3 %	3.2 %	9,507	17,523
2009	38.9 %	3.6 %	6,730	17,292

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	67.6 %	4.7 %	18,921	27,992
2013	68.7 %	4.1 %	19,238	28,003
2012	67.2 %	5.0 %	18,743	27,882
2011	60.2 %	4.4 %	17,254	28,655
2010	63.9 %	4.4 %	17,878	27,983
2009	51.5 %	4.7 %	14,613	28,380

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	54.6 %	4.9 %	15,815	28,950
2013	37.1 %	4.3 %	10,786	29,053
2012	26.2 %	3.8 %	7,646	29,199
2011	11.6 %	2.6 %	3,484	29,938

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Delaware

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.8	82.6	83.4	84.2	85.0	85.8

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	69.1 %	2.4 %	111,261	161,007
2013	74.7 %	1.9 %	120,387	161,189
2012	80.9 %	1.6 %	129,685	160,358
2011	78.9 %	1.9 %	125,021	158,382
2010	74.5 %	2.3 %	116,904	156,834
2009	75.3 %	2.6 %	120,033	159,414

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	74.0	76.0	78.0	80.0	81.9	84.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	76.8 %	3.0 %	8,464	11,021
2011	65.7 %	3.8 %		
2010	69.1 %	3.6 %		
2009	69.7 %	3.0 %		
2008	73.8 %	2.4 %		
2007	69.8 %	2.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

Field Note:
PRAMS data (2011) indicates a higher percent that ever breastfeed, 80.2%

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	15.5	18.0	20.5	23.0	25.5	27.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	19.7 %	2.8 %	2,091	10,615
2011	13.2 %	2.3 %		
2010	12.5 %	2.0 %		
2009	11.2 %	1.7 %		
2008	12.6 %	1.8 %		
2007	11.7 %	1.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

Field Note:
PRAMS data (2011) indicates 51% still breastfeed at 8 weeks (2 months)

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	31.1	31.4	31.7	32.0	32.3	32.6

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.8 %	3.3 %	16,165	52,525
2007	10.9 %	1.8 %	5,727	52,752

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	32.5	32.8	33.1	33.4	33.7	34.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.2 %	2.7 %	22,164	68,859
2007	41.5 %	2.8 %	26,563	64,016
2003	32.9 %	2.2 %	21,860	66,544

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	18.5	18.3	18.1	18.0	17.9	17.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.6 %	2.2 %	10,087	69,185
2007	16.1 %	2.1 %	11,234	69,986

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.6 %	1.0 %	8,935	37,888

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.5	56.0	58.5	61.0	63.3	65.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	51.3 %	3.6 %	23,027	44,913
2007	48.4 %	3.3 %	22,691	46,922

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	57.2 %	2.0 %	87,697	153,270
2007	63.6 %	1.7 %	94,002	147,751

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.4	39.8	40.2	40.6	41.0	41.4

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	40.8 %	1.6 %	4,148	10,157

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% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.0	78.8	79.6	80.4	81.2	82.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.2 %	1.5 %	147,832	191,549
2007	76.8 %	1.4 %	143,473	186,797

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.8	79.6	80.4	81.2	82.0	82.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	78.0 %	1.5 %	153,290	196,493
2007	79.9 %	1.2 %	150,990	188,996

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Delaware

SPM 1 - Percent of Delaware women of reproductive age that had an unintended pregnancy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	57.0	56.0	52.0	50.0	47.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	67.0	68.0	69.0	70.0	71.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	24.0	22.0	21.0	20.0	19.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: Delaware

ESM 1.1 - # of social media messages promoting preventive health care and preconception health for women of reproductive age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - # of DHMIC Education and Prevention meetings held in past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.3 - # of women served by the HWHBs program that received Bundle A services/preconception care

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5,500.0	5,800.0	6,100.0	6,300.0	6,500.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - # of women served by Title X programs/clinics that received a reproductive preconception health and/or other preventive services within the context of family planning visits.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12,000.0	12,300.0	12,600.0	12,800.0	13,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - # of provider practices that receive EPIC BEST training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	60.0	62.0	64.0	65.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	130.0	160.0	180.0	200.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	7.0	9.0	11.0	12.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.4 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	18.0	20.0	23.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.5 - Increase the number of birthing facilities that receive baby friendly designation

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	5.0	5.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - # of new practices to adopt PEDs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	36.0	39.0	42.0	44.0	45.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	125.0	150.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.3 - The percent of high risk screens referred to early intervention/Part C by pediatric practices

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	150.0	200.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.5 - # of new partnerships/collaborations

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.6 - # of YouTube views of educational video on developmental screening

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	200.0	300.0	400.0	500.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 8.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12.0	12.0	12.0	12.0	12.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 9.2 - # of people who attend Safe Kids conference

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 11.3 - Collaborate with Family Shade to ensure representation of CYSHCN partners at DCHI meetings and forums.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.4 - Family Shade will work with their member organizations to develop recommendations and sign a letter to the DCHI regarding medical home and care coordination needs of this CYSHCN population.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 13.2 - # of hits on BOHDS website

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30,000.0	40,000.0	40,000.0	55,000.0	60,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.3 - # of presentations completed for partners & community members

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.4 - # of pediatric practices who are providing fluoride treatments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	5.0	7.0	9.0	10.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**

Field Note:
The indicators for this particular ESM are estimates as data from Medicaid was not received in time. This will indicator will be updated once TVIS is reopened.

ESM 15.1 - # of staff of who attend trainings for Title V staff to ensure knowledge of insurance coverage

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	0.0	25.0	0.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 15.2 - MOU between Title V and Title XIX

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Delaware

SPM 1 - Percent of Delaware women of reproductive age that had an unintended pregnancy
Population Domain(s) – Women/Maternal Health

Goal:	Decrease the number of live births that were the result of an unintended pregnancy
Definition:	**Numerator:** Number of mothers reporting that their pregnancy was unintended **Denominator:** Number of live births in Delaware **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Health statistics
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 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.
Population Domain(s) – Perinatal/Infant Health

Goal:	Reduce the disparity between Black, non Hispanic mothers and White, non Hispanic mothers who initiate breastfeeding
Definition:	**Numerator:** Number of Black, non Hispanc women who report breastfeeding initiation **Denominator:** Number of live births in Delaware **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Health Statistics
Significance:	Benefits of breastfeeding have been well documented in recent years, including risk reduction for allergies/asthma, increased antibodies to fight off viruses and bacteria, lower risk of SIDS, and much more. Additionally, breastfed babies and mothers have been shown to be at less risk for obesity and developing various chronic diseases. Breastfeeding initiation is considered an early indicator of breastfeeding fidelity throughout the first year of life. In 2011/12, the percent of Black infants who were ever given breast milk was 67.3%, compared with 75.1% of White infants and 75.3% of Hispanic infants. (2011/12 National Survey of Children's Health)

SPM 3 - Percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.
Population Domain(s) – Adolescent Health

Goal:	To decrease the percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.
Definition:	**Numerator:** Number of students reporting feeling hopeless for two or more weeks at a time in the past 12 months. **Denominator:** Number of students completing YRBS **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Youth Risk Behavior Survey (YRBS)
Significance:	The decision to add a State Performance Measure linked to NPM 9 was made with the goal of focusing on the mental and emotional impacts on bullying and how those impacts can lead to mental health issues among adolescents. Examples of poor mental health outcomes related to bullying include students to contemplate suicide in order to escape the anguish of being bullied. While it is unreasonable to think that all suicides are a by-product of bullying, experts do know that bullying is linked to many negative outcomes including impacts on mental and emotional health, substance abuse, and self-inflicted violence.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Delaware

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: Delaware

ESM 1.1 - # of social media messages promoting preventive health care and preconception health for women of reproductive age
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Increase the number of social media messages (tweets and facebook posts) promoting preventive health care and preconception health
Definition:	**Numerator:** Total number of social media messages **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Google analytics data, for those that visit the preconception page on DEThrives.com
Significance:	The use of social media messages can help bring public awareness to the issue and emphasize the importance of preventive health care for women as well as to specific preventive care and preconception health (i.e. management of chronic health conditions, tobacco avoidance, healthy weight, preconception multivitamin with folic acid use, absence of sexually transmitted infections, etc.). Social media and other emerging communication forums online have the potential to reach large and diverse populations. When messages are developed using science-based health messaging, social media can be a communication medium that can educate and influence health decision making.

ESM 1.2 - # of DHMIC Education and Prevention meetings held in past year
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Development of a framework for optimizing the health and well-being of women of reproductive age.
Definition:	**Numerator:** Number of meetings held **Denominator:** N/A **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	Meeting agendas/meeting minutes documented
Significance:	The DHMIC's Education and Prevention Committee meets on a quarterly basis with ADHOC work groups also convening in between. This committee focuses on education and messaging that optimizes the health and well-being of women before, during and in between pregnancies.

ESM 1.3 - # of women served by the HWHBs program that received Bundle A services/preconception care
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Increase the number of women served by the HWHB program who receive Bundle A services.
Definition:	**Numerator:** Number of women who receive Bundle A services/preconception services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 6,500
Data Sources and Data Issues:	Healthy Women Healthy Babies Program data
Significance:	The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial “bundles” of care for women at the highest risk of poor birth outcomes.

ESM 1.4 - # of women served by Title X programs/clinics that received a reproductive preconception health and/or other preventive services within the context of family planning visits.
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Increase the number of women of reproductive age receiving family planning services.
Definition:	**Numerator:** Total # of women of reproduction age that received family planning servicess **Denominator:** N/A **Unit Type:** Count **Unit Number:** 13,000
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 4.1 - # of provider practices that receive EPIC BEST training
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the number of provider practices that receive EPIC BEST training.
Definition:	<table><tr><td>**Numerator:**</td><td>Number of provider practices that receive EPIC BEST training</td></tr><tr><td>**Denominator:**</td><td>N/A</td></tr><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>65</td></tr></table>
Data Sources and Data Issues:	MCH program data-BCD data
Significance:	The EPIC Breastfeeding Program offers peer-to-peer breastfeeding education to physician's offices, hospitals and residency programs. The goal is to educate physicians and their staff on breastfeeding and inform them as to why they play a critical role in a woman's decision to breastfeed and to continue breastfeeding. Information is provided on evidence-based standards of how to encourage, promote and support breastfeeding. Information on how to access lactation and support services in the community and free resources for patient education is also provided.

ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the hits to the web page and the number of downloads of the materials.
Definition:	**Numerator:** Total number of breastfeeding material downloads **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Google analytics data, for those that visit the web pages regarding breastfeeding on DEThrives.com
Significance:	The use of social media messages can help bring public awareness to the issue and emphasize the importance of breastfeeding and the support available for breastfeeding women. Posters, tip sheets, and educational materials that were developed by the Breast Coalition of Delaware (BCD) were uploaded to the resource page of the Delaware Thrives website, dethrives.com. This website serves as the electronic hub for DHMIC's education and social media efforts, and can significantly increase the dissemination and availability of these materials. In addition, key messages for women in the prenatal, immediate post-partum, and post-discharge stages were added to the website to drive web traffic to the resources.

ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the number of MIECHV home visitors who become certified.
Definition:	**Numerator:** Number of MIECHV home visitors who become certified **Denominator:** N/A **Unit Type:** Count **Unit Number:** 12
Data Sources and Data Issues:	MIECHV program data
Significance:	The MIECHV program serves high risk pregnant women and/or women who have recently given birth. Home visitors are trusted by their clients and are in a prime position to provide breastfeeding support, encouragement and linkages to additional resources such as support groups.

ESM 4.4 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk
Definition:	**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 **Unit Type:** Percentage **Unit Number:** 100
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 4.5 - Increase the number of birthing facilities that receive baby friendly designation
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	All birthing facilities in the state of Delaware to receive baby friendly designation
Definition:	**Numerator:** Number of birthing facilities that received baby friendly designation **Denominator:** N/A **Unit Type:** Count **Unit Number:** 6
Data Sources and Data Issues:	MCH and BCD program data
Significance:	Birthing facilities that receive baby friendly designation have proven to provide optimal level of care for infant feeding and mother/baby bonding. Baby Friendly hospitals give all mothers the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feeding formula safely.

ESM 6.1 - # of new practices to adopt PEDs

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase the number of pediatric practices who sign up to use the PEDS tool and receive training and TA.
Definition:	**Numerator:** The number of practices that sign up and receive subsequent training and TA. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 45
Data Sources and Data Issues:	DE APP
Significance:	In order to increase developmental screening, additional providers need to screen using a validated tool within the new recommended AAP guidelines. It is important for Delaware to continue to recruit new practices to receive training and offer ongoing TA to utilize the PEDs tool enhancing early detection and intervention.

ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To increase provider referrals to HMG/2-1-1.
Definition:	**Numerator:** The number of referrals to HMG/2-1-1 from pediatric practices **Denominator:** N/A **Unit Type:** Count **Unit Number:** 150
Data Sources and Data Issues:	HMG/211 data on Practice Referrals
Significance:	To reach the goal of ensuring all eligible children receive developmental screens, we recognized the barriers faced if primary care was the sole delivery mechanism. Consideration for a non-traditional approach led to the expansion of screening by phone through the Help Me Grow/2-1-1 (HMG/2-1-1) call center. After receiving standard 2-1-1 service, parent callers of children birth to 8 years will be invited by the HMG/2-1-1 call staff to complete a questionnaire regarding their child's development. The tool of preference is the Parents' Evaluation of Developmental Status - (PEDS online). Indicator that families are actually receiving the appropriate services they need.

ESM 6.3 - The percent of high risk screens referred to early intervention/Part C by pediatric practices
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	That 100% of high risk screens are referred to an early intervention program and our documented.
Definition:	**Numerator:** Percentage ofl high risk screens referred to early intervention/Part C. **Denominator:** N/A **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Child Development Watch (CDW), Delaware's birth-3 early intervention program data on practice referrals
Significance:	Research shows that healthcare providers' knowledge of and referral patterns to early intervention services and other community services is quite low. It is important that we increase knowledge through academic detailing and other onsite outreach efforts through the Parts B and C IDEA programs, Project LAUNCH, including the Help Me Grow/2-1-1 contact center. Specific attention will focus on ensuring that children identified at risk for developmental delays following a screen are actually linked with and receive the interventions recommended by the referring provider.

ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase screening through other non-health providers.
Definition:	**Numerator:** Number of screens after PEDS/HMG intergration **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	PEDS Online data and HMG/2-1-1 Data
Significance:	Will indicate screens can also be administered by sources other than health providers.

ESM 6.5 - # of new partnerships/collaborations

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To foster systems collaboration to maximize resources.
Definition:	**Numerator:** Number of new partnerships made **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	ECCS/HMG/DEAAP Outreach data
Significance:	We have been successful in bringing together most of our developmental screening partners to the table to discuss how we can improve processes and work towards building a comprehensive developmental screening system statewide. Continuing to foster and strengthen our partnerships will prevent duplications, silos and maximize financial and human resources.

ESM 6.6 - # of YouTube views of educational video on developmental screening
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase the number of views of educational video on developmental screening
Definition:	**Numerator:** Total number of views to the YouTube videos **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Google analytics data, for those that view the video
Significance:	The use of social media messages can help bring public awareness to the issue and emphasize the importance of develomentaly screening as well as indicate parent engagement on the topic of developmental screening

ESM 8.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Increase the number of MCH materials that include healthy eating and physical activity messages
Definition:	**Numerator:** Number of MCH materials that include incorporation healthy lifestyle messages for children **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	MCH program data
Significance:	The use of social media, websites, blogs as well as brochures can help bring public awareness of the benefits of healthy lifestyles. Social media and other emerging communication technologies have the potential to reach large and diverse populations and help reach individuals when, where and how they want to receive health messages.

ESM 8.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To create a marketing message to address healthy lifestyles and active living for children ages 6-11.
Definition:	**Numerator:** Marketing message developed **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	MCH program data
Significance:	By infusing our messaging and content related to healthy lifestyle behaviors with existing programs and services within the Maternal and Child Health and Bureau of Health Promotion will ensure a consistent message from DPH to our communities.

ESM 8.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To distribute Healthy Lifestyles brochures to agencies providing services to children ages 6-11 as well as families.
Definition:	**Numerator:** # of brochures disseminated **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	MCH Program Data
Significance:	The brochures reach to birth to age 8...prevention targeting young children

ESM 8.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	For MCH and/or Bureau of Health Promotion to participate and stay engaged in the State Health Improvement Plan and Healthy Neighborhoods committee meetings.
Definition:	**Numerator:** Number of meetings attended by MCH and/or Bureau of Health Promotion **Denominator:** N/A **Unit Type:** Count **Unit Number:** 12
Data Sources and Data Issues:	State Health Improvement Plan (SHIP) and Healthy Neighborhood committee meeting minutes
Significance:	The two goals of the SHIP, a statewide improvement plan are to promote healthy lifestyle behaviors (healthy eating and active living) and to increase access to mental/behavioral health services. DPH including Title V and the Bureau of Health Promotion values the opportunity to be actively involved in this statewide planning process to ensure the needs of our target populations are taking into consideration into this statewide initiative.

ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Obtain data on the current bullying prevention efforts being implemented in schools and to align MCH messages
Definition:	**Numerator:** Environmental scan of DOE and MCH messages **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	MCH and Worldways (Social Marketing contractor) data
Significance:	Bullying is a new priority for MCH and with limited resources, it is important to align any bullying prevention messages developed with current activities and messages being promoted. Collaborating with partners such as DOE will allow for consistent messages around bullying prevention and the importance of emotional well-being to reach communities, schools and providers and have the biggest impact for school aged children.

ESM 9.2 - # of people who attend Safe Kids conference

NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Maintain stakeholder engagement at Safe Kids Conference
Definition:	**Numerator:** Number of people in attendance **Denominator:** N/A **Unit Type:** Count **Unit Number:** 75
Data Sources and Data Issues:	Safe Kids Conference Planning Committee (MCH represented)
Significance:	SAFE KIDS Delaware Coalition is a non-profit organization established in 1989, comprised of volunteers dedicated to reducing unintentional childhood injury in children from birth to age 14. The Delaware Division of Public Health serves as the lead agency.The coalition provides leadership to their communities in the effort to reduce unintentional childhood injury. They identify and target the injury problems most prevalent in their local areas. Then, by calling on the combined resources of their diverse membership, they plan and implement strategies to address those problems. MCH has been a proud sponsor of the statewide Childhood Injury Prevention Conference. This one day conference provides valuable injury prevention and safety information to an audience made up of teachers, para educators, day care providers, nurses, first responders, and members of our MCH staff. Our primary focus is to ensure that MCH priorities align with priorities identified by the Coalition where appropriate.

ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	To strengthen DPH's internal capacity to address bullying as a public health issue.
Definition:	**Numerator:** # of trainings/learning sessions offered **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	MCH program data
Significance:	Bullying is a new a priority for DPH and it is important to provide professional development opportunities to our MCH workforce on bullying and strategies to promote social and emotional wellness.

ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Strengthen the partnership between SBHC and MCH staff to address bullying prevention efforts.
Definition:	**Numerator:** Number of meetings attended by both MCH and SBHC staff **Denominator:** N/A **Unit Type:** Count **Unit Number:** 6
Data Sources and Data Issues:	SBHC and MCH meeting agendas and minutes
Significance:	Delaware has School Based Health Center (SBHC) in almost all of our public high schools. SBHC provide multitude of services including mental health. We will partner with School Based Health Centers to address bullying as a health issue, with particular focus on the mental health impact, for not only students who are being bullied but also students who bully others.

ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	To provide professional development opportunities to our stakeholders providing services to adolescents 12-17 years of age.
Definition:	**Numerator:** # of partners who attend DPH/MCH hosted sessions **Denominator:** N/A **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	MCH program data
Significance:	Delaware MCH knows that we have to take a collective impact approach to this effort and we all working towards the same goal using similar strategies. With the 24/7 nature of bullying, it is important for our workforce as well as stakeholders to have skills and tools to address bullying and all of the negative health outcomes that go along with it.

ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To gather information from parents and network partners about needs related to the availability of medical homes.
Definition:	**Numerator:** Survey disseminated and contains questions regarding medical home **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Family SHADE data
Significance:	We need to understand families, family organizations as well as providers perspectives on medical home and its components and what the priorities are. This information will continue to guide our work to ensure our priorities are aligned.

ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families

NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To promote use of the recommended care coordination toolkit
Definition:	**Numerator:** Identification of a toolkit **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	MCH program data
Significance:	Identification of a toolkit for both clinicians and families will help promote medical home and increase care coordination for CYSHCN. We will work with our Family Voices Chapter that has conducted numerous workshops for families around care coordination and care plan notebooks.

ESM 11.3 - Collaborate with Family Shade to ensure representation of CYSHCN partners at DCHI meetings and forums.
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To have representation of our CYSHCN partners at every DCHI meeting/forum
Definition:	**Numerator:** The number of meetings attended by Family Shade partners **Denominator:** The total number of DCHI meetings **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	DCHI Meeting Minutes
Significance:	This will ensure that concerns of CYSHCN are vocalized at these meetings where MCH services as well as insurance topics are discussed to develop statewide policies. Guaranteeing primary care pediatrics and the needs of a family-centered medical home for CYSHCN are brought forward.

ESM 11.4 - Family Shade will work with their member organizations to develop recommendations and sign a letter to the DCHI regarding medical home and care coordination needs of this CYSHCN population.
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Is to have all member organizations co-sign the letter to DCHI.
Definition:	**Numerator:** Signed letter delivered to DCHI **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	DHCI Meeting minutes
Significance:	This presents a unified voice from our Family Shade member organizations which include Autism DE, Down Syndrome Association of DE, Hands and Voices DE as well as several others organizations to this important policy making body in the state of DE.

ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Educate public health professionals who interact and/or provide services to CYSHCN.
Definition:	**Numerator:** Number of educational sessions **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	MCH program data
Significance:	A key observation by our Title V CYSHCN Guiding Committee was that many of our public health professionals, both those providing direct services to families though our Home Visiting and Part C Early Intervention programs, as well as those providing indirect services to Delawareans with special health care needs, needed training around the Medical Home concept and care coordination. With increased knowledge of the subject the Public Health worker will be able to provide clear guidance to the family to aid in decision making and self-advocacy.

ESM 13.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Develop an annual report that provides information regarding referrals to dental services, dental services received at a DPH clinic along with information received from our PRAMS data collection efforts.
Definition:	**Numerator:** Development of an annual Oral Health report **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	DPH program data
Significance:	This will improve data collection and reporting around dental visits and referrals to give Delaware's oral health program a clearer picture of what is working and any barriers/gaps that exist.

ESM 13.2 - # of hits on BOHDS website

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Promote BOHDS new website which includes community member materials as well as the Oral Health Tool Kit.
Definition:	**Numerator:** # of hits on BOHDS website **Denominator:** N/A **Unit Type:** Count **Unit Number:** 60,000
Data Sources and Data Issues:	Worldways (social marketing contractor) monthly reports
Significance:	The use of a website can assist with public awareness to the importance of oral health for pregnant women and children. Content regarding resources, when to go to the dentist, how often and when your child should have their first dental visit are all topics addressed.

ESM 13.3 - # of presentations completed for partners & community members
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Provide presentation regarding the importance of Oral Health, available resources and new initiatives to MCH partners and community members.
Definition:	**Numerator:** # of presentations completed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 15
Data Sources and Data Issues:	BOHDS program data
Significance:	Presentations are one way to reach our targeted audience to bring awareness to Oral Health any why it is an Title V MCH priority. This allows for partners and community members to have personal interaction with our Oral Health program as the discuss the importance of oral health, resources in the community and how to access them.

ESM 13.4 - # of pediatric practices who are providing fluoride treatments
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Increase the number of pediatric practices who are providing fluoride treatments
Definition:	**Numerator:** Number of pediatric practices who are providing fluoride treatments **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Medicaid
Significance:	Fluoride is a key oral prevention method to prevent tooth decay by making the tooth more resistant to acid attacks from plaque bacteria and sugars in the mouth. It also reverses early decay. In children under 6 years of age, fluoride becomes incorporated into the development of permanent teeth, making it difficult for acids to demineralize the teeth.

ESM 15.1 - # of staff of who attend trainings for Title V staff to ensure knowledge of insurance coverage
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Goal:	Increase the knowledge of the services Medicaid provides as well as the types of insurance plans Medicaid provides to Public Health professionals and family centered organizations.
Definition:	**Numerator:** The number of staff trained **Denominator:** N/A **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	MCH program data
Significance:	Training to increase knowledge around insurance coverage and Medicaid plans within our state are important as insurance plans can be difficult for families to understand as well as the staff from public health and family organizations. By convening trainings which we are calling Medicaid 101s, we will increase Public Health and family organizations staff knowledge of Medicaid as well as strengthen the relationship between Medicaid and family organizations.

ESM 15.2 - MOU between Title V and Title XIX

NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Goal:	Update the Title V memorandum of understanding (MOU) with Medicaid to reflect current needs.
Definition:	**Numerator:** Signed MOU **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	MCH Program Data
Significance:	Medicaid and Title V serve many low-income women and children, including children with special health care needs. Title V provides support for comprehensive services to women and children with limited access to health care services. Successful coordination of Title V with Medicaid programs assists in maximizing funding to meet the health care needs of low-income women and children including CYSHCN.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Delaware

Form Notes for Form 10d NPMs and SPMs

Due to changes in the both the wording of the items between the 2007 and 2011/2012 versions of the National Survey of Children's Health and the definitions used to track Children with Special Needs, this measure cannot be reported. On a couple of the measures (Children's Overall Health, Access to Medical Homes and Access to a Specialist, there appears to be movement in the right direction (a general closing of the gap between CSHCN and children without special health care needs), however these differences were not significant. This measure will need to dropped and replaced with a more timely and accessible indicator.

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	61	44	25	35	43
Denominator	61	44	25	35	43
Data Source	Newborn Screening Program	Newborn Screening	Newborn Screening	Newborn Screening Program	Newborn Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Calendar year 2013. Includes hearing loss. Newer data not available.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data. Based on Delaware Disorder List from Newborn Screening. Does not include hearing.	
3.	**Field Name:**	**2011**
	Field Note: 2011 Newborn Screening Data	

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	65.0	72.7	73.4	74.2	74.9
Annual Indicator	72.0	72.0	72.0	72.0	72.0
Numerator					
Denominator					
Data Source	National Survey of CSHCN, 2009-2010	National Survey of CSHCN, 2009-2010	National Survey 2009 - 2010	National Survey 2009 - 2010	National Survey 2009 - 2010
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	50.0	41.8	42.2	42.6	43.1
Annual Indicator	41.4	41.4	41.4	41.4	41.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN, 2009-2010	National Survey of CSHCN, 2009-2010	National Survey 2009-2010	National Survey 2009-2010	National Survey 2009-2010
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	65.0	70.6	71.3	72.0	72.7
Annual Indicator	69.9	69.9	69.9	69.9	69.9
Numerator					
Denominator					
Data Source	National Survey of CSHCN, 2009-2010	National Survey of CSHCN, 2009-2010	National Survey	National Survey	National Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generatethe NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generatethe NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generatethe NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	92.0	69.7	70.4	71.1	71.8
Annual Indicator	69.0	69.0	69.0	69.0	69.0
Numerator					
Denominator					
Data Source	National Survey of CSHCN, 2009-2010	National Survey of CSHCN, 2009-2010	National Survey 2009-2010	National Survey 2009-2010	National Survey 2009-2010
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	45.0	38.8	39.2	39.6	39.9
Annual Indicator	38.4	38.4	38.4	38.4	38.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN, 2009-2010	National Survey of CSHCN, 2009-2010	National Survey CSHCN 2009-2010 2	National Survey CSHCN 2009-2010 2	National Survey CSHCN 2009-2010 2
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	70.0	72.9	73.6	78.0	78.0
Annual Indicator	72.1	77.0	77.0	79.3	76.1
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey 2013	National Immunization Survey 2014, via Kids Count
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: from National Immunization Survey 2014. 2015 data will be available late 2016.	
2.	**Field Name:**	**2014**
	Field Note: from National Immunization Survey 2013. 2014 data will be available late 2015.	
3.	**Field Name:**	**2013**
	Field Note: Estimated. It is for 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, and 1 or more doses of any MMR vaccine, plus 3 or more doses of Hib vaccine of any type, 3 or more doses of HepB vaccine, and 1 or more doses of varicella vaccine. Pertussis is not included, and not part of NIS data. 4:3:1:1:3:3:1 2013 data does not come out until September 2014	
4.	**Field Name:**	**2012**
	Field Note: Estimated Vaccination Coverage with 4:3:1:3:3:1 Amoung Children 19-35 Months of Age by Race/Ethnicity, U.S. National Immunization survey, July 2011 - June 2012. Confidence Intervals +/- 7.0%. Method of Target Setting: 10% improvement over next 10 years. 5/20/2014 Revised from last year, increased to 77.	
5.	**Field Name:**	**2011**

Field Note:
Estimated Vaccination Coverage with 4:3:1:3:3:1 Amoung Children 19-35 Months of Age by Race/Ethnicity, U.S. National Immunization survey, July 2010 - June 2011. Confidence Intervals +/- 6.4%.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	20.0	17.6	15.8	14.6	14.4
Annual Indicator	14.6	14.6	14.6	11.6	11.7
Numerator	248	248	248	197	199
Denominator	16,994	16,994	16,994	16,957	16,954
Data Source	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center	Delaware Health Statistics Center, DPC	Delaware Health Statistics, DPC
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Delaware health Statistics Center, 2012 report. 199 births Delaware Population Consortium, DPC, est pop 15 - 17: 16,954	
2.	**Field Name:**	**2014**
	Field Note: Delaware health Statistics Center, 2012 report. 197 births Delaware Population Consortium, DPC, est pop 15 - 17: 16,957	
3.	**Field Name:**	**2013**
	Field Note: Delaware Health Statistcis Center, 2011 data as estimate. 2011 Single year value numerator: 248 DPC Esitmated denominator: 17166 >> 14.4	
4.	**Field Name:**	**2012**
	Field Note: 2012 data are not available. Estimate is based on 2011. Single year value.	
5.	**Field Name:**	**2011**

Field Note:
2011 data from Health Statistics. Single year value.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	35.0	34.7	71.5	72.2	72.9
Annual Indicator	34.0	70.8	54.0	54.0	54.0
Numerator		391			
Denominator		552			
Data Source	Delaware Dental Survey	Delaware Oral Health Program	Delaware Dental Survey	Delaware Smiles report	Delaware Smiles report
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Indicator is based on a 2013 statewide survey of third grade children - Delaware Smiles report. New report expected in 2016. FY 2014-15 program data shows 64 schools participated (of 97) and 1547 children had sealants put on. This is an increase from 2013-2014 of 45 schools and 1300 children.	
2.	**Field Name:**	**2014**
	Field Note: Indicator is based on a 2013 statewide survey of third grade children - Delaware Smiles report. New report expected in 2016.	
3.	**Field Name:**	**2013**
	Field Note: The 2013 indicator is based on a 2013 statewide survey of third grade children - Delaware Smiles report.	
4.	**Field Name:**	**2011**
	Field Note: The 2011 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	3.4	3.1	2.3	3.3	3.2
Annual Indicator	3.4	3.4	3.4	1.7	0.6
Numerator	6	6	6	3	1
Denominator	175,391	175,391	175,391	175,391	173,943
Data Source	Delaware Vital Statistics, DE Pop Consortium	Delaware Vital Stats, DE Pop Consortium	Delware Vital Stats, DE Pop Consortium	Delaware Trauma Registry, DE Pop Consortium	Delaware Trauma Registry, DE Population Consortium
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: From calendar 2015 from Trauma Registry. Values may differ from Vital Statistics. Denominator estimate from 2015 Delaware Population Consortium projections.	
2.	**Field Name:**	**2014**
	Field Note: From calendar 2013 from Trauma Registry. Values may differ from Vital Statistics.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data are not available. This indicator is estimate from 2011.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data are final. Denominator is 1 year population estimate. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	44.0	49.4	37.4	53.0	54.0
Annual Indicator	48.4	50.8	52.3	51.9	51.9
Numerator					
Denominator					
Data Source	Delaware PRAMS Data	2009 Delaware PRAMS Data	Delaware PRAMS 2010	Delaware PRAMS 2011	Delaware PRAMS 2011
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: PRAMS 2011. Indicator of whether mother was still breastfeeding 8 weeks after delivery.	
2.	**Field Name:**	**2014**
	Field Note: PRAMS 2011. Indicator of whether mother was still breastfeeding 8 weeks after delivery.	
3.	**Field Name:**	**2013**
	Field Note: Delaware PRAMS 2010. Indicator still breasfeeding at 8 weeks after delivery. Revised future goals to start at 52 percent, 10% improvement over five years.	
4.	**Field Name:**	**2012**
	Field Note: 2009 Delaware PRAMS Data - Still breastfeeding at time of interview.	
5.	**Field Name:**	**2011**
	Field Note: 2008 Delaware PRAMS Data. Percent of women who are still breastfeeding at time of interview. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	99.7	98.4	98.4	96.4	98.4
Numerator	11,587	11,261	11,261	11,018	11,252
Denominator	11,627	11,449	11,449	11,426	11,435
Data Source	Delaware Newborn Screening Program	Delaware Newborn Screening Program	Delaware Newborn Screening Program	Delaware Newborn Screening Program	Delaware Newborn Screening Program
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data from calendar year 2013. Newer data not available. Denominator may include out of state residents.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data not available, estimate from previous year.	
3.	**Field Name:**	**2012**
	Field Note: 2012 Newborn Hearing Screening Program Data. Birth count form Newborn Screening.	

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	8.0	7.9	7.0	7.0	6.9
Annual Indicator	8.0	7.1	7.5	6.9	6.7
Numerator					
Denominator					
Data Source	2012 Kids Count	2013 Kids Count	Kids Count Delaware	Kids Count Delaware	Kids Count Delaware
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 3 year average, 2013 - 2015, Kids Count Delaware 2016 report	
2.	**Field Name:**	**2014**
	Field Note: 3 year average, 2012 - 2014, Kids Count Delaware 2015 report	
3.	**Field Name:**	**2013**
	Field Note: 2011 - 2013 Three year average, Kids Count Delaware	
4.	**Field Name:**	**2012**
	Field Note: 2010-2012 three year average as reported in 2013 KIDS COUNT. Method of Target Setting: 10% improvement over next 10 years.	
5.	**Field Name:**	**2011**
	Field Note: 2009-2011 three year average as reported in 2012 KIDS COUNT. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	20.4	21.1	20.6	20.2	19.8
Annual Indicator	21.5	20.7	27.9	26.1	28.0
Numerator	2,704	2,611	3,661	4,482	3,089
Denominator	12,593	12,592	13,133	17,184	11,041
Data Source	Delaware WIC Program	Delaware WIC	Delaware WIC	Delaware WIC	Delaware WIC
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Non-rounded value is 29.79% For 2014, DE WIC reported 26.5% (3120/11746). These maybe revised from previous values.	
2.	**Field Name:**	**2014**
	Field Note: For calendar year 2014, from Delaware WIC.	
3.	**Field Name:**	**2013**
	Field Note: Data from WIC, calendar year 2013.	
4.	**Field Name:**	**2012**
	Field Note: Calendar Year 2012 WIC Data Method of Target Setting: 10% improvement over next 10 years.	
5.	**Field Name:**	**2011**
	Field Note: 2011 Delaware WIC Program Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	9.4	10.2	12.2	12.0	12.0
Annual Indicator	12.4	12.2	12.8	13.6	13.6
Numerator	1,394	1,394			
Denominator	11,227	11,449			
Data Source	Delaware Vital Stats	Delaware Vital Statistics	DE PRAMS 2010	Delaware PRAMS 2011	Delaware PRAMS 2011
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Delaware PRAMS, 2011.	
2.	**Field Name:**	**2014**
	Field Note: Delaware PRAMS, 2011.	
3.	**Field Name:**	**2013**
	Field Note: Indicator from Delaware PRAMS 2010 data from CPonder.	
4.	**Field Name:**	**2012**
	Field Note: Method of Target Setting: 10% improvement over next 10 years. 2012 Data are not available at this time. Births from Newborn Screening. Numerator estimate from previous.	
5.	**Field Name:**	**2011**
	Field Note: Method of Target Setting: 10% improvement over next 10 years. 2011 births from Healths Statistics. Numerator estimated.	

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	3.2	5.5	5.5	5.4	5.4
Annual Indicator	6.0	6.0	5.0	15.0	6.7
Numerator	11	11	3	9	4
Denominator	182,666	182,666	59,480	60,116	59,680
Data Source	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center, DPC	Delaware Health Statistics, DPC
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Delaware Health Statistics Center, 2013 report. Delaware Population Consortium, Oct 2015 estimate.	
2.	**Field Name:**	**2014**
	Field Note: Delaware Health Statistics Center, 2012 report. Delaware Population Consortium, Oct 2014 estimate.	
3.	**Field Name:**	**2013**
	Field Note: 2011 data, single year value from Vital Statistics.	
4.	**Field Name:**	**2012**
	Field Note: 2008-2010 Delaware Vital Statistics Data. Due to low numbers, indicator is reported as a three year moving average. Method of Target Setting: 10% improvement over next 10 years.	
5.	**Field Name:**	**2011**

Field Note:
2008-2010 Delaware Vital Statistics Data.
Due to low numbers, indicator is reported as a three year moving average.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	78.0	79.5	83.0	83.7	84.5
Annual Indicator	84.0	84.0	84.0	81.3	79.3
Numerator	178	178	178	148	149
Denominator	212	212	212	182	188
Data Source	2011 Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Office	Delaware Health Statistics Office
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data from calendar year 2012. Newer data not available.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data not available.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data are not available at this time.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data from Vital Statistics. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	73.0	79.5	80.3	81.1	81.8
Annual Indicator	74.3	74.3	74.3	73.3	74.8
Numerator	8,338	8,338	8,338	8,054	8,079
Denominator	11,227	11,227	11,227	10,982	10,802
Data Source	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center	2013 Delaware Health Statistics
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Delaware Health Statistics Center, 2012 report.	
2.	**Field Name:**	**2013**
	Field Note: 2013 data not available. Estimate from 2011 data. Delaware PRAMS 2010 estimate is 80.4.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data are not available at this time. Estimate from 2011 data.	
4.	**Field Name:**	**2011**
	Field Note: Method of Target Setting: 10% improvement over next 10 years. 2011 data from Vital Statistics. 2010 PRAMS data indicate 80.4% got care in first trimester.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Delaware

SPM 1 - The rate of infant deaths between birth and 1 year of life.

	2011	2012	2013	2014	2015
Annual Objective	7.8	7.9	7.8	7.8	7.7
Annual Indicator	8.7	8.6	8.6	8.1	7.7
Numerator	98	98	98		
Denominator	11,227	11,449	11,449		
Data Source	Delaware Vital Stats	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center	Delaware Health Statistics Center
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 7.7 per 1,000. 5 year average, 2008 - 2012. 2013 not available yet.	
2.	**Field Name:**	**2014**
	Field Note: 8.1 per 1,000. 5 year average, 2007 - 2011. 2012 not available yet.	
3.	**Field Name:**	**2013**
	Field Note: 2013 data not available. Numerator and denominator are estimates.	
4.	**Field Name:**	**2012**
	Field Note: 2012 data not available. 2012 denominator and numerator are estimates from Newborn Screening.	
5.	**Field Name:**	**2011**
	Field Note: Source is vital statistics annual report for 2011. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

SPM 2 - The rate of live births at 32 to 36 weeks of gestation(preterm birth).

	2011	2012	2013	2014	2015
Annual Objective	106.0	101.3	100.3	99.2	98.2
Annual Indicator	86.9	85.2	85.2	96.9	96.6
Numerator	976	976	976	1,064	1,043
Denominator	11,227	11,449	11,449	10,982	10,802
Data Source	Delaware Vital Stats	Delaware Vital Stats	Delaware Vital Statistics	Delaware Health Statistics Center	Delaware Health Statistics Center
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Delaware Health Statistics Center. 2012 report.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 not available. Values are provisional.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data are not available. Data reported for 2012 are provisional. Method of Target Setting: 10% improvement over next 10 years.	
4.	**Field Name:**	**2011**
	Field Note: Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

SPM 3 - The rate of low birth weight and very low birth weight deliveries.

	2011	2012	2013	2014	2015
Annual Objective	84.0	103.6	89.0	88.1	87.2
Annual Indicator	84.2	82.5	82.5	82.9	17.4
Numerator	945	945	945	910	188
Denominator	11,227	11,449	11,449	10,982	10,802
Data Source	Delaware Vital Stats	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center	Delaware Health Statistics Center
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Delaware Health Statistics Center, 2012 report. Five year, 2008 - 2012, average is 86.	
2.	**Field Name:**	**2013**
	Field Note: Current data not available.	
3.	**Field Name:**	**2012**
	Field Note: 2012 data are not available. Data reported for 2012 are provisional. Method of Target Setting: 10% improvement over next 10 years.	
4.	**Field Name:**	**2011**
	Field Note: 2011 data from Vital Statistics. Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

SPM 4 - The percent of children and adolescents who are overweight or obese.

	2011	2012	2013	2014	2015
Annual Objective	33.0	28.5	27.9	27.4	26.8
Annual Indicator	29.1	29.1	30.5	30.5	31.6
Numerator					
Denominator					
Data Source	2011 Delaware High School YRBS	2011 Delaware YRBS	Delaware High School YRBS	Delaware High School YRBS 2013	Delaware High School YRBS 2015
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
From Delaware High School YRBS 2015. Covers ages 14 -18 years old.
15.8% obese in 2015. 15.8% overweight in 2015.

2. **Field Name:** **2014**

Field Note:
From Delaware High School YRBS 2013. Covers ages 14 -18 years old. 2015 data will be available in late 2015

3. **Field Name:** **2013**

Field Note:
2013 Delaware High School YRBS. YRBS done in odd numbered years.

Other information:
Percentage of children and adolescents who are overweight or obese.
2012
32.0%

Delaware children age 10-17.

Source: National Survey of Children's Health, Delaware sample.

4. **Field Name:** **2012**

Field Note:
2011 Delaware High School YRBS. YRBS survey done in odd numbered years.

5. **Field Name:** **2011**

Field Note:
2011 Delaware High School YRBS. Overweight 16.9% CI (14.9-19.0); Obese 12.2% CI (10.8-13.8).

Method of Target Setting: 20% improvement over next 10 years.

Data Alerts: None

SPM 5 - The percent of women of childbearing age (15-44) who are obese (BMI 30 or higher).

	2011	2012	2013	2014	2015
Annual Objective	25.0	14.4	26.3	26.0	25.8
Annual Indicator	28.2	24.1	26.4	26.8	26.6
Numerator	206	193			
Denominator	731	801			
Data Source	2011 Delaware BRFSS	2012 Delaware BRFSS	2013 Delaware BRFSS	2014 Delaware BRFSS	2015 Delaware BRFSS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: For calendar 2015 from BRFSS. Age range is 18 - 44 years old. Data for age range 15 - 18 comes from YRBS, which has 13.3% of female high school students were obese in 2015. (final)	
2.	**Field Name:**	**2014**
	Field Note: For calendar 2014 from BRFSS. Age range is 18 - 44 years old. Data for age range 15 - 17 comes from YRBS which does not have new information this year.	
3.	**Field Name:**	**2013**
	Field Note: 2013 weighted percentage. Delaware women, 18 - 44. Additional information: About 11% of public high school female students (ages 15-18) were obese in 2013 (YRBS).	
4.	**Field Name:**	**2012**
	Field Note: 2012 Delaware BRFSS, Women, 18-44. Method of Target Setting: 10% reduction over the next 10 years. 2012 Annual Indicator not reweighted. 24.2% is weighted value. Numerator revised from previous value of 213.	
5.	**Field Name:**	**2011**

Field Note:
2011 Delaware BRFSS, Women, 18-44

Data Alerts: None

SPM 6 - The mortality rate among children and youth (0-21 years) due to unintentional injuries.

	2011	2012	2013	2014	2015
Annual Objective	12.6	15.2	15.1	14.9	14.8
Annual Indicator	9.6	9.6	9.6	7.8	10.3
Numerator	19	19	19	18	24
Denominator	197,057	197,057	197,057	230,092	233,966
Data Source	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Health Statistics Center, DPC	Delaware Health Statistics, DPC
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2014 data not available. Delaware Health Statistics Center, 2013 report. Age 0 - 19. DPC Population estimate 0 - 19 Oct 2015, 233,966.	
2.	**Field Name:**	**2014**
	Field Note: 2014 data not available. Delaware Health Statistics Center, 2012 report. Age 0 - 19. DPC Population estimate 0 - 19 Oct 2014, 230,092.	
3.	**Field Name:**	**2013**
	Field Note: 2013 data are not available. Data reported are provisional.	
4.	**Field Name:**	**2012**
	Field Note: 2012 data are not available. Data reported are provisional. Method of Target Setting: 10% improvement over next 10 years.	
5.	**Field Name:**	**2011**

Field Note:
2011 data, numerator from Vital Statistics, denominator from Population Consortium.

Age range 0 - 19 years old.

Method of Target Setting: 10% improvement over next 10 years.

Data Alerts: None

SPM 7 - The percent of Delaware public high school students who currently smoke.

	2011	2012	2013	2014	2015
Annual Objective	18.8	18.1	17.9	17.8	17.6
Annual Indicator	18.3	18.3	14.2	14.2	9.9
Numerator					
Denominator					
Data Source	2011 Delaware High School YRBS	2011 Delaware High School YRBS	2013 Delware High School YRBS	2013 Delaware High School YRBS	2015 Delaware High School YRBS
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Percentage from 2013 Delware High School YRBS. 2015 data will be available in late 2015.	
2.	**Field Name:**	**2013**
	Field Note: Percentage from 2013 Delware High School YRBS.	
3.	**Field Name:**	**2012**
	Field Note: 2011 Delaware YRBS. YRBS survey done in odd numbered years.	
4.	**Field Name:**	**2011**
	Field Note: 2011 Delaware High School YRBS, Smoked cigarettes on at least 1 day in the last 30 days. 18.3%, CI (16.2-20.5). Method of Target Setting: 10% improvement over next 10 years.	

Data Alerts: None

SPM 8 - The percent of benchmark measures completed for implementation of a formal umbrella structure for organizations serving families with children with special health care needs in Delaware.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	80.0	100.0	100.0	100.0	100.0
Numerator	4	5	5	5	5
Denominator	5	5	5	5	5
Data Source	State Title V Program	State Title V Program	State Title V Program	State Title V Program	State Title V Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: Goals have been met. Will create new ones with new needs assessment in future.	
2.	**Field Name:**	**2012**
	Field Note: See Form 16, SPM 8 "Detail Sheet" for how this measure is determined.	
3.	**Field Name:**	**2011**
	Field Note: See Form 16, SPM 8 "Detail Sheet" for how this measure is determined.	

Data Alerts: None

SPM 9 - The percentage of children aged 4 months to 5 years with no or low risk for developmental, behavioral or social delays.

	2011	2012	2013	2014	2015
Annual Objective	78.0	74.7	75.5	76.2	77.0
Annual Indicator	72.4	72.4	72.4	72.4	72.4
Numerator					
Denominator					
Data Source	NSCH 2011-2012	NSCH 2011-2012	NSCH 2011-2012	NSCH 2011-2012	NSCH 2011-2012
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: 2011-2012 National Survey of Children's Health	
2.	**Field Name:**	**2012**
	Field Note: 2011-2012 National Survey of Children's Health	
3.	**Field Name:**	**2011**
	Field Note: 2011-2012 National Survey of Children's Health Method of Target Setting: 10% improvement over next ten years.	

Data Alerts: None

SPM 10 - The percent of health indicators that improve across four domains (child health, mental health, health care access and quality, and family health) for children with special health care needs.

	2011	2012	2013	2014	2015
Annual Objective	20.0	20.0	30.0	30.0	30.0
Annual Indicator			0.0	0.0	0.0
Numerator			0	0	0
Denominator			8	8	8
Data Source			NSCH, although this particular data is no longer available (see note)	NSCH, although this particular data is no longer available (see note)	NSCH, although this particular data is no longer available (see note)
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

Field Note:
Due to changes in the both the wording of the items between the 2007 and 2011/2012 versions of the National Survey of Children's Health and the definitions used to track Children with Special Needs, this measure cannot be reported. On a couple of the meaures (Children's Overall Health, Access to Medical Homes and Access to a Specialist, there appears to be movement in the right direction (a general closing of the gap between CSHCN and children without special health care needs), however these differences were not signficant. This measure will need to dropped and replaced with a more timely and accessible indicator.

2. **Field Name:** **2012**

Field Note:
Due to changes in the both the wording of the items between the 2007 and 2011/2012 versions of the National Survey of Children's Health and the definitions used to track Children with Special Needs, this measure cannot be reported. On a couple of the meaures (Children's Overall Health, Access to Medical Homes and Access to a Specialist, there appears to be movement in the right direction (a general closing of the gap between CSHCN and children without special health care needs), however these differences were not signficant. This measure will need to dropped and replaced with a more timely and accessible indicator.

3. **Field Name:** **2011**

Field Note:
The indictors for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparties between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

See Form 16, SPM 10 "Detail Sheet" for how this measure will be determined.

Method of target setting: 50% improvement over next five years.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 SPM 10. Please review your data to ensure this is correct
2.	A value of zero has been entered for the numerator for year 2014 SPM 10. Please review your data to ensure this is correct.

Form 11
Other State Data

State: Delaware

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Delaware

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: Delaware

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2 ESM 1.3 ESM 1.4	
To increase the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies.			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Improve breastfeeding rates.	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2 ESM 4.3 ESM 4.4 ESM 4.5	
Improve breastfeeding rates.			SPM 2

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Improve rates of developmental screening in the healthcare setting using a validated screening tool.	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2 ESM 6.3 ESM 6.4 ESM 6.5 ESM 6.6	
Increase healthy lifestyle behaviors (healthy eating and physical activity).	NPM 8 - Physical Activity	ESM 8.1 ESM 8.2 ESM 8.3 ESM 8.4	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Decrease rates of bullying by promoting development of social and emotional wellness.	NPM 9 - Bullying	ESM 9.1 ESM 9.2 ESM 9.3 ESM 9.4 ESM 9.5	
Decrease rates of bullying by promoting development of social and emotional wellness.			SPM 3

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase the percent of children with and without special health care needs having a medical home.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 ESM 11.3 ESM 11.4 ESM 11.5	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Improve the rate of Oral Health preventive care in pregnant women and children.	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2 ESM 13.3 ESM 13.4	
Increase the percent of children 0-17 who are adequately insured.	NPM 15 - Adequate Insurance	ESM 15.1 ESM 15.2	