Maternal and Child Health Services Title V Block Grant

Delaware

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FY 2019 Application/ FY 2017 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, 2018

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 2019 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 2019Maternal 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 F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

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 time over the course of the five year grant cycle 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.

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

Priority Health Need(s)	Objectives(s)	Strategies
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 2017, 80.3% 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. Beyond pregnancy, ongoing preventive care and family planning are important, as is interconception care to address the risks of women who experienced adverse pregnancy outcomes. 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 includes social media outreach around the theme that "Health Begins Where You Live, Learn, Work & Play." Over the last year, we disseminated reproductive life planning tools to teens and adults to encourage them to establish and maintain healthy habits to support their life goals, and developed life plan toolkits with scripted lesson plans, learning objectives and handouts for educators to use one on one or in groups. The Delaware Healthy Mother and Infant Consortium

		(DHMIC) and the Division of Public Health (DPH) launched a State-wide optimal birth spacing awareness campaign to 1) Increase the number of women who receive education on waiting at least 18 months after delivering a baby to conceiving another pregnancy; and 2) Increase the number of women who receive a timely postpartum visit (from 2 to 6 weeks). We also worked on content updates to the DEthrives.com website and launched digital ads using a life course framework. This year, Delaware leveraged funding through one of four cooperative agreements awarded by the U.S. Department of Health and Human Services' Health Resources and Services Administration Maternal and Child Health Bureau (HRSA MCHB) to a national coalition supported by UNC Center for Maternal & Infant Health (UNC CMIH) and the National Preconception Health and Health Care Initiative (PCHHC). Funding is administered through UNC School of Social Work. DE is one of four states participating in this CoIIN grant (i.e. OK, NC, CA, DE). This Preconception CoIIN will develop, implement, and disseminate a woman-centered, clinician-engaged, community-involved approach to the well woman visit to improve the preconception health status of women of reproductive age, particularly low-income women and women of color. Through the Healthy Women Healthy Babies program, Delaware women with a previous adverse birth outcome are identified, assessing their risks, and then provided an enhanced care coordination approach. 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; http://www.upstream.org/delawarecan/), 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. The early evidence of Delaware CAN's outcomes among Delaware healthcare providers is very promising, as Child Trends released a research brief estimating that following Upstream's partnership with the state of Delaware, there was an estimated decrease of 15 percent in unplanned pregnancies among Title X patients in the state from 2014-2016.

		Plans for the Coming Year: Preventive health visits are an integral part of preconception care. In the coming year, we will work on the Preconception CoIIN grant in collaboration with the core CoIIN team and clinic partners, hold community engagement events called "Chat n Chews", and will develop an adaptable model to effectively integrate preconception care (PCC) into the well woman visit. We will also 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). In FY19, the General Assembly approved state funding to sustain DE CAN to ensure that a system is in place to support uninsured and underinsured women of reproductive age seeking health care continue to get access to the full range of contraceptive methods, including the most effective, long acting reversible methods, IUDs and implants. 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. Over the next year, in collaboration with MCH stakeholders across the state and a consulting firm, Third Sector Capital Partners, DPH plans to revisit the HWHBs program model and framework to ensure outcomes are achieved and contracts with providers are performance based.
Oral Health Improve oral health preventive care for mothers during pregnancy	By July 2020, increase the percentage of pregnant women who have a dental visit during pregnancy from 39% to 43%.	**Defining the Need:** According to PRAMS, the percentage of Delaware women who reported visiting a dentist or dental clinic during their most recent pregnancy rose between 2007 (36.0%) and 2015 (44.4%). While this information shows a positive trend for women in Delaware, we continue to lag behind the national average of 53% in 2015. **Accomplishments to Date:** Our CDC Epidemiologist has also prepared a data brief that focuses on Oral Health in Mothers and Children. The data brief provides select indicators on oral health among pregnant women from Pregnancy Risk Assessment Monitoring Survey (PRAMS) data from 2012-2015. Our Healthy Women, Healthy Babies program provides support dental services for Healthy Women, Healthy Babies patients through two Federally Qualified Health Centers FQHCs

		(including one in Sussex County) to help promote access to oral health. Poor oral health has been identified as a risk factor for poor birth outcomes yet dental care is not readily available, especially in Southern Delaware. In collaboration with the FQHCs and the DPH's Bureau of Oral Health and Dental Services Program, more women of childbearing age will have access to dental care. We are happy to report that our sister agency, Delaware Medicaid and Medicare Assistance (DMMA) recently negotiated with one of their Managed Care Organizations (MCO) to include Medicaid coverage for adults over the age of 21 for one preventive oral health visit and one set of laboratory dental x-rays per year. This is exciting new progress for Medicaid and MCH will continue to work with DMMA to expand coverage in the future for problem and urgent dental care coverage. We anticipate that the expansion of coverage for preventive oral health care will show tending successes in the coming years. **Plans for the Coming Year:** Our Healthy Women, Healthy Babies support of oral health for pregnant mothers will continue as we work toward the next reporting year. A multi-partner collaboration effort will be presented to prenatal mothers in Sussex County in late July, 2018. "Dental Care Is Prenatal Care" will be presented to 15-20 prenatal mothers and will set out to provide women with the knowledge and skills necessary to achieve optimal oral health for themselves and their infants, and will understand the link between oral health and adverse pregnancy outcomes. 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.).
Are we moving the needle for women in Delaware?	With 80% 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 interconception care to prevent repeated adverse birth outcomes in order to address this issue. At the onset of this grant cycle, we set specific objectives for this health priority and we sought to increase the percentage of women who have a dental visit during pregnancy from a reported rate of 40.5% to 43%. We have achieved our goal of increasing the rate to 43%, but we intend to continue our efforts so that we move closer to achieving the national average of 53%.	

Population Domain Snapshot: *Perinatal/Infant Health*

Priority Health Need(s)	Objectives(s)	Strategies
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. We brought the Milk Mob training to Delaware to further increase the expertise of service providers on breastfeeding. The Milk Mob provided Outpatient Breastfeeding Champion training, which is conducted by International Board Certified Lactation Consultants (IBCLC). Leveraging additional sources of funding, DPH concluded a program called EPIC BEST (Educating Providers in the Community-Breastfeeding Education and Support Training) that provided onsite breastfeeding education and support training for ob-gyn and pediatric practices. A total of 63 primary care practices trained and over 700 healthcare employees received training. In this last year of EPIC BEST, we again 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, we are tracking the number of birthing facilities in the state who receive Baby Friendly designation this past year. As of now, we have four facilities that achieved this designation and the Breastfeeding Coalition of Delaware continues to support the remaining two birthing facilities with the designation process.

		Plans for the Coming Year: We will continue to support home visitors to maintain the IBCLC credential. 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 also be targeting the dangers of substance use while pregnant or breastfeeding. Currently, we are targeted the dangers of marijuana use while breastfeeding as well as the promotion of breastfeeding while on MAT.
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:** The advent of the Early Childhood Comprehensive Systems Impact grant has changed the landscape and scope of developmental screening for MCH and the state. Emphasis on collaborations with community groups has integrated developmental screening efforts that was occurring at the same time within the early childcare setting. . It has led to a more comprehensive approach in addressing developmental screening across the state. In addition to ensuring developmental promotion at the local level it has also integrated the efforts that had been established with the early child care and education arenas. Through efforts of the two placed based community teams (PBCs) in New Castle County and Sussex County there's been an increased focus in developmental health monitoring, screening and follow-up. Delaware's PBCs focused on improving the administration, tracking and referral of the Ages and Stages Questionnaire (ASQ) in the early child care and education sector. Feedback from surveys conducted during the 2017 grant year indicated a number of child care centers within the PBC catchment areas lacked the training to administer, analyze and make referrals using the screening instrument. This led to the hiring of a consultant to support the training efforts of the PBCs within the child care centers and the eventual change in the training curriculum and the application of credit hours as an incentive for early child care providers to early QRIS credits. The teams also developed and agreed on consent forms to be used in the child cares for ASQ screens, developed an ASQ referral matrix following the screening which is based on the process that exists in

		the health care settings; improved the pathway for getting referrals to either early intervention or Help Me Grow/2-1-1 including streamlining the workflow for referrals at physician practices. Similarly, in the health care setting, Delaware worked with its ECCS Impact team members and Delaware Chapter of the American Academy of Pediatrics to improve and streamline screening and referral system for physician practices implementing the PEDS tool. Over 14,900 screens were administered in the 2017 calendar year, exceeding the estimated 10,500 screens projected each year. The ongoing partnership with the Delaware Chapter of the American Academy of Pediatrics also led to the development of webinar series on developmental screening; community resources and the use of the PEDS online screening instrument. The webinar will provide continuous medical credits (CME) for physicians and nurses who decide to take the training. Overall, the state has increased its efforts on developmental screening and was successful in persuading a hospital in Sussex County, in the southern part of the state to include developmental screening information in the discharge documents for the labor and delivery unit. We continue to update screening information on the developmental screening webpagehttp://developmentalscreeningde.com/) by providing resource and services information and also providing a description of the early intervention programs - (Parts B and C). This is in response to concerns from physicians regarding the differences between the two services. **Plans for the Coming Year:** Through the partnership with the ECCS Impact place-based communities, we will continue to foster family and community engagement to increase awareness and knowledge about developmental milestones and the importance of early detection. We will leverage our partnerships with the Division of Libraries; Learn the Signs Act Early and Division of Social Services to reach out to their target populations. We will also continue to reach out to school districts to encourage them to transition from the DIAL screener to the ASQ screener for the kids 4 year and older. We will continue streamline processes and

		measures for the two preferred screening instruments in the state – PEDS tool and Ages and States (ASQ) assessment tool. Delaware uses the ASQ in the early learning setting while the PEDS tool is used in the health care setting. We plan to establish a Care Coordination Learning Collaborative based on the Connecticut Model to determine the best approach to ensure families who are screened are assisted from the time a screen is administered through to when family determines their needs have been met. This effort will convene stakeholders together to address issues and concerns on developmental screening and other early childhood concerns. The learning collaborative will develop inter-agency solutions to common problems towards a streamlined early childhood system, through the sharing of ideas, learning from one another and identifying needs and gaps in service delivery to improve access for children and their families. Continuous Quality Improvement methods will be applied to improve those gaps in the system. We will also continue to increase promotion by targeting physician practices for Lunch and Learns while taking advantage of outreach opportunities within local areas to increase awareness.
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 2017 Youth Risk Behavior Survey results for Delaware indicate that approximately 16.6% of youth are overweight, which represents an increase from the 2015 YRBS of 15.8%. According to the 2016 National Survey of Children's Health, 29.8% of Delaware's children ages 6-11 engage in vigorous physical activity every day. For children ages 12-17, that number declines to 15.5%.s saw increases as well with 15.4% in 2017 as compared to 14.4% in 2015. **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. We completed work on our Health Eating/Physical Activity (HEPA) booklet and to date have distributed more than 2,000 booklets to community partners. Booklets will be distributed by our community health educators at Kids Day at the Delaware State Fair.

		Marketing efforts from the PANO group have also incorporated our messaging and have provided a consistency between both groups. In May, 2018 PANO distributed 5,500 Healthy Eating/Active Living materials (activity books, lunch boxes with messaging on it; bottled water with "5-2-1 Almost None" messaging) at the School Day Wilmington Blue Rocks baseball game. Additionally during National Nutrition Month in April, PANO visited three school districts and distributed the same materials to 1,500 K-5 graders. **Plans for the Coming Year:** We will continue our work with our marketing resources and the PANO group to complete and distribute the HEPA booklet. There will be continued support of the State Health Improvement Needs Assessment and the goals of promoting health lifestyle behaviors. We plan to leverage FitnessGram® data from DOE to inform the creation marketing messages and materials that focus on healthy eating and active living. MCH will partner with PANO on the Policy, Systems, and Environment professional training to the participating teams by creating Memorandums of Understanding (MOUs. We will work with our community partners who provide after school care services to children (school districts, early childcare centers, after-school programs) ages 6-11 to connect them to this training opportunity. The deliverable for the MOU will be for the team to present details and measure to show that they have implemented a strategy the supports 60 minutes of activity for children each day.
Oral Health Improve oral health preventive care for children	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 latest National Survey of Children's Health, the percent of children ages 1-17 who received one or more preventive dental care visits increased from 77.2% in 2011/12 to 79.9% in 2016 which is slightly higher than the national average of 78.7%. Additionally, 22,000 children (11.7%) had tooth decay in Delaware in the past year. **Accomplishments in the Past Year:** Delaware's Oral health national priority work focuses on not only national data, but also feedback gained from local professional development trainings. Evaluations are given to participants and those are reviewed for enhancements and opportunities for improvement in the training curriculum. Over the last year, feedback on professional

		development trainings have offered us the opportunity to hear from childhood day care providers, school nurses, and organizations who work with our families with children with special health care needs. The State Dental Director along with the Director of the Health, Family SHADE and Wellness unit in the Center for the Disabilities Studies presented an open panel discussion focused on families with children with special health care needs. The message provided was centered around helping the community understand the roles of dentists, pediatricians, and educators along with advice and counseling from family representative organizations who offered insight to navigating insurance issues that families face when getting their children oral health care. Community partnership efforts remained strong with Oral Health education opportunities also being presented at community dinners and conferences held statewide. Our social media marketing efforts remain strong and show success through postings and video viewings of messages related to the importance of health care as it relates to health care. **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 ensure that barriers to oral health services for our families of children with special health care needs are incorporated into work done within the newly formed Title V/Title XIX Cross-Agency Coordination Committee. This committee is being developed to support the recently signed Memorandum of Understanding between Title V and Title XIX – Medicaid.
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.	

	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 2016 National Survey of Children's Health, 29.8% of Delaware's children ages 6-11 engage in vigorous physical activity every day. For children ages 12-17, that number declines to 15.5%. According to the 2011/12 National Survey of Children's Health, 5.5% of children ages 6-11 and 13.9% of children engaged in vigorous physical activity, however in this survey, "vigorous activity" was defined as physical activity for at least 20 minutes that made them sweat and breathe hard. In the 2016 survey, vigorous activity included duration of 60 minutes and the question asked the number of children who exercised at least 60 per day for all seven days of the week therefore it is not possible to compare the two surveys for trend analysis. Going forward, our efforts will use the 2016 survey results as our baseline for measuring progress. Data presented above show that we have shown success in moving the needle in supporting increased education and outreach to stress the importance of oral health care for children beginning at age 1. Our community and inter-agency partnerships remain a critical piece of our success and continued cultivation of those partnerships will lead us to meeting our Title V goals in this area.

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 2016 National Survey of Children's Health, only 57.4% of CYSHCN in Delaware reported that their care met the medical home criteria, which is above the national estimate of 43.2%. **Accomplishments in the Past Year:** Delaware has worked to address the issue of medical home with our families with children with special health care needs by utilizing resources supported by the Universal Newborn Hearing Screening and Intervention Program funded by the Health and Resources System Administration. Under this program, we have established Learning Community structures which are led by two (2) parent lead organizations who work with families of infants who are Deaf or Hard of Hearing (D/HH). Work continued around education of providers, families and family organizations around the need for and benefits of the medical home model for CYSHCN and their families. We partnered with our Birth to Three program to provide on-site education at pediatric provider's offices on developmental screening, referrals to early intervention and other resources in the community. This Pilot Project to provided outreach and education to our pediatric care providers in Sussex County around Part C services, care coordination and community services continued and outcomes including knowledge of community services and referral processes to Part C and Part B were measured. **Plans for the Coming 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. Our Family SHADE leaders will continue to represent the needs of CYSHCN with respect to medical home and care coordination working with the Delaware Center for Health Innovation (DCHI) State Innovation Model (SIM) initiative. 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. We will be partnering with our Part C Birth to Three partners on marketing campaign as well as updating our materials. We are also considering including some video testimonials from parents who received early intervention services through our program.
<u>Adequate Insurance Coverage</u> 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 2016 National Survey of Children's Health, only 67.9% of Delaware children are adequately insured. This represents a drop from 78% in 2011/2012 NSCH. **Accomplishments in the Past Year:** Work on the Memorandum of Understanding between Title V and the Division of Medicaid and Medical Assistance (DMMA) was completed in June, 2018. The Delaware team that attended the 2016 MCHB Leadership Skills Institute worked to complete a very meaningful MOU that addresses the multiple populations covered by both Medicaid and Title V. Title V continued 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). These calls are also presented in Spanish two times each year. DMMA established a workgroup and MCH was asked to join the Children with Medical Complexity (CMC) Steering Committee to develop a comprehensive plan for managing health care needs of Delaware's children with medical complexity. In developing the plan, the workgroup sought input from health care providers, hospitals, health systems, payers, managed care organizations, social service agencies, consumer advocacy organizations representing children with medical complexity, and parent advocates. MCH participated in the workgroup sessions during the first quarter of 2018 and the final plan was submitted in May, 2018. **Plans for the Coming Year:** Our plan for the coming year is to work on the establishment of the Cross-Agency Coordination Committee. Delaware is once again sending a team to

		the 2018 MCHB Skills Institute in Tempe, Arizona and the team will be comprised of two MCH staff and two DMMA staff. Our challenge will be to leverage skills and tools offered during the Skills Institute to design, define, and document the vision, mission, and charge of the Cross-Agency Coordination Committee. As described in our MOU this committee will work to establish a multi-disciplinary coordination committee. The committee will be responsible for working together on training, messaging, case management, and procedures. The training of public health professionals on insurance coverage and issues families may encounter with access to services will be a priority for the coming year. Support of the Family Voices Managed Care Calls in Spanish and English will continue.
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 increase knowledge of the components of Medical Home among parents, providers and public health professionals. Through educational efforts listed above we will bring medical home and care coordination to the forefront increasing the demand for the services by families while giving providers more information to be better positioned to meet the families' needs. Adequate insurance coverage remains a 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.	

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:** Data from the Delaware 2017 survey for High School students tell us that the percent of children, 12-17 years old, who report being bullied on school property, was 14.1% which is down from 16.4% in 2015. The percent of children 15-18 years old who report being cyberbullied stands at 10.1% according to the 2017 YRBS, which is down from 11.7% in 2015. Middle school aged children, 12-14 who report being bullied on school property is at 38.6% according to the 2017 Middle School YRBS, which is down from 41.1% in 2015. The percentage of middle school students who reported being cyberbullied is 16.6% according to the 2017 Middle School YRBS, which is down from 18.2% in 2015. High school students reported feeling "sad or hopeless almost every day for 2 weeks or more in a row during the 12 months prior to the survey" has increased from 24.2% in 2015 to 27.6% in 2017. Both females and males reported an increase with females rising from 32.5% (2015) to 36.9% (2017) and males increasing from 15.3% (2015 to 18.4% (2017). **Accomplishments in the Past Year:** As a follow on to our initial strategy of getting the lay of the land regarding prevention efforts within DOE, MCH has been asked to become a contributing partner on the Positive Behavior Support Project State Advisory Committee. This work offers us greater, and timelier, access to valuable DOE information such as the Delaware School Climate Survey data results and the DOE Bullying Reports in Delaware Public School Districts and Charters annual report. MCH has worked to increase the number of partners we collaborate with to help spread the word about current legislation, trainings, education opportunities, as well as sharing information on emerging issues regarding bullying. We continued our partnership with our support of the 2018 Safe Kids Conference by contributing funds, served as part of the conference planning committee and was instrumental in bringing topics to the conference that addressed cultural competency for vulnerable youth and a panel discussion on the impact on youth affected by family trauma resulting from substance abuse. In relation to our State Performance Measure that focuses on the social and emotional health of our students, MCH maintains a strong connection with local

		advocacy groups to offer Public Health perspective and support where possible when addressing non-discrimination and cultural competency issues that impact the students in Delaware. **Plans for the Coming Year**: We plan to pursue opportunities to join in the conversations and planning efforts to ensure our message of bullying prevention as a public health issue is brought to the table and is considered in relevant strategic planning efforts. We plan to remain active in community efforts to find ways to offer professional development training in the areas of transgender cultural competency for our school districts to ensure that transgender students feel welcome in their education environments. We look forward to our continued work with the PBS State Advisory committee and would very much like to assist the Department of Education in their efforts to expand The No Bully System to include at least 10 schools in Delaware and to support the implantation of the Botvin LifeSkills training into middle school health curriculum. We hope to utilize the Anti-Bullying Self-Assessment tool to develop a plan internally to begin an assessment of Public Health's capacity to support social and emotional wellness projects for youth in Delaware.
Are we moving the needle for adolescents in Delaware?	Overall, we find that the latest data shows a declining trend in reported instances of bullying for middle and high school students. Increased use of evidence-based, and practice-based, strategies, along with increase social media marketing appears to be making an impact in reducing bullying. However, we are seeing a rising trend in the mental health of middle and high schools students which tells us that there is more work to be done to focus on the social and emotional well-being of our students. While in the middle of our five year grant cycle, we feel this remains 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.	

III.A.2. How Title V Funds Support State MCH Efforts

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

Title V funding also supports our efforts to improve health outcomes, support policies that foster state health department transformation to lead the way towards innovative, community-based solutions. The evolution of our health care system has necessitated that public health agencies make the transformation from safety-net medical direct service providers to more innovative, community-based models which include programs for universal developmental screenings, care coordination, and home visiting. Using a population health framework allows Delaware to implement upstream, data-driven strategies to respond to broad community health needs and evaluate and monitor emerging population health trends.

III.A.3. MCH Success Story

Although Delaware has many successes to celebrate, having a newly signed formal memorandum of understanding (MOU) in place with Medicaid is a huge success. Our previous MOU with Medicaid was signed in 1993. Our CYSHCN Director and Title V Coordinator worked with Medicaid team members for the last two years on this new MOU. The purpose of the MOU is to improve the maternal and child health public health service delivery and public health outcomes for underserved populations throughout the State of Delaware. In particular, the implementation of the MOU seeks to:

- Provide coordination between the DMMA and the DPH for programs impacting women, infants and children.
- Provide coordination in the administration of programs that are designed to improve the health of children (particularly CYSHCN) and families in the State of Delaware.
- Maintain a process that allows for joint access to critical data without duplication of effort.

The MOU will enable the us and Medicaid to further define the roles of staff in each agency, clarify expectations, provide guidelines for case referral and case management and organize mechanisms for information sharing and problem resolution.
The MOU was just finalized in June 2018 and we look forward to working closely with Medicaid team members to making the objectives in the MOU a reality. In fact, DE will be participating in another Title V Skills Institute this summer sending two Title V staff members and two Medicaid staff members.

III.B. Overview of the State

Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. Geographically, the state's area encompasses only 1,982 square miles, ranking Delaware 49th in size among all states. Delaware is bordered by New Jersey, Pennsylvania and Maryland, as well as the Delaware River, Delaware Bay, and Atlantic Ocean. Centrally located between four major cities, Wilmington, the state's largest urban center, is within an hour's drive to Baltimore, MD and Philadelphia, PA, and within two hours driving distance from New York City and Washington, D.C.

According to estimates from the U.S. Census Bureau, in 2017 the State of Delaware had about 961,939 residents, of which approximately 70% were White and 23% were Black. The Hispanic population is steadily increasing, from 8.7% in 2013 to 9.3% in 2017. About 21.3% of Delawareans are children under the age of 18 and 5.7% were under the age of 5.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 559,793 residents or about 58% of the state's total population. New Castle County has a large population of African-American residents (nearly 26%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 58% of the city's population). New Castle County also has a large population of Hispanic residents, 10%. Kent County, home to the state's capital of Dover, has an estimated 176,824 residents (67% White and 26% Black). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2017 population was approximately 225,322 (83% White, 13% Black). Like New Castle, Sussex County also has a growing Hispanic population, estimated at 9.4% for 2017.

In 2016, statewide, it is estimated that there were about 176,235 women of childbearing age (15-44 years of age) (Delaware Vital Statistics) and 259,903 infants, children and adolescents aged 0-21 years of age (Kids Count in Delaware, 2018). Annually in the state, about 11,500 babies are born. In 2017, 4,398 children received services through Child Development Watch, Delaware's Birth to Three Early Intervention System (Kids Count in Delaware, 2018). According to the 2016 National Survey of Children's Health, it is estimated that 22.9% of Delaware's children have special health care needs.

Economic Indicators

In Delaware, from 2014-2016, it is estimated that 18.5% of children, aged 0-17, were living in poverty, with the highest rates among those children aged 0-5 (19.3%). Children in Kent and Sussex County were more like likely to live in poverty than children in New Castle County (24.3% vs. 18.5%). According to Kids Count in Delaware, 2018, from 2015-2017, 22.3% of Delaware's children lived in a household with underemployed parents (where no parent worked full-time, year round). Almost forty percent (39.1%) of children from single-parent households in Delaware lived in poverty, compared to 9.5% of children living in two-parent households. The median income of two-parent households in Delaware from 2015-2017 was $95,890, compared to $34,708 for single-parent households.

Of Delaware's children, 36.1% lived in a one-parent household in the 2015-2017 time periods. Almost half (47.4%) of births occurring in the five-year period 2010-2014 were to single mothers, with 71.4% of Black births, 63.1% of Hispanic births, and 40.0% of White births occurring among single mothers (Kids Count in Delaware, 2017). As of 2017, an average of 71,109 households per month received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP), and an average of 4,763 households per month received cash assistance through the Temporary Assistance to Needy Families Program (TANF) (KIDS Count in Delaware, 2018).

Availability of Health Providers

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

New Castle County:

- 4 Primary Care HPSAs
- 1 Dental HPSA

Kent County *in its entirety* is a:

- Medically Underserved Population
- Primary Care HPSA

- Dental HPSA

Sussex County *in its entirety* is a:

- Medically Underserved Area
- Primary Care HPSA
- Dental HPSA
- Mental Health HPSA

Services for CYSHCN

In Delaware, Children and Youth with Special Health Care Needs (CYSCHN) are served by the Birth to Three Program for infants and toddlers aged 0-3 and by evidence based home visiting program services. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. The CDW program provides developmental assessments of children birth to 3 years of age and service coordination for developmental services and therapies. CDW is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children (the only children's hospital in Delaware) working together to provide early intervention to young children with special health care needs and their families.

The Children and Youth with Special Health Care Needs Director (CYSHCN) sits in the Division of Public Health's Maternal and Child Health Bureau in the Family Health Systems Section. This position is essential as it functions to bolster and cultivate family and professional partnerships by working closely with families and family-led organizations. Delaware's Birth to Three system works in coordination with the CYSHCN Director through Family SHADE, a large network of partners that work to improve the system of care of services and develop family-centered care, which has become part of the culture for DPH in addressing the needs of families of young children with special needs.

Context for Title V within the State

In Delaware, the executive branch of state government is headed by Governor John Carney. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency, and is led by Secretary Kara Odom-Walker. 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.

In May 2014, Governor Markell signed House Bill 214, requiring Down syndrome education material and information support be offered to health care professionals and parents. Specifically, this bill requires that hospitals, physicians and other health professionals, who provide a prenatal or postnatal diagnosis of Down syndrome have access to resources and information that is up-to-date and evidence-based for distribution to parents and caregivers.

The goal is for parents to receive timely and accurate information about Down syndrome to help them seek resources and have the best knowledge-base when caring for their child. The Division of Public Health, in partnership with the Down Syndrome Association of Delaware, provides access to up-to-date information in two booklets available to health professionals online. The first pamphlet entitled "Delivering a Down Syndrome Diagnosis" is for health professionals and contains additional websites and reference materials. The second is a booklet to share with parents entitled "Understanding a Down Syndrome Diagnosis" available in English and Spanish.

The pamphlets are available free of charge by request from the website: www.Lettercase.org . Additional information is available for Delaware health professionals and parents on the Down Syndrome Association of Delaware website: www.dsadelaware.org . The Division of Public Health offers additional resources for health professionals and for parents at: www.DEThrives.com.

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 original focus of the SHIP – healthy lifestyles and access to mental health. The newly formed Delaware Public Health Institute is working closely with DPH to manage the SHIP, and work continues on the implementation of the developed action plans to address the priority goals.

The Delaware Division of Public Health (DPH) is currently seeking input from Delawareans on a draft version of a statewide assessment identifying the primary health needs of First State residents. DPH worked with a broad range of non-profit and medical partners, and community-based and government agencies to create the draft Statewide Health Assessment (SHA) document. The SHA is an examination of the health of our population. Data gathering for a needs assessment to develop this document began in 2016. The data, pulled from a variety of sources including focus groups, were used to identify local and statewide trends for the identification and prioritization of strategies. The ultimate goal of a SHA is to develop strategies to address critical health needs and identify challenges and assets in the state in a comprehensive way. All results were compiled and analyzed collectively to paint a collective picture of Delaware's health. This comprehensive process yielded the following four top-level priority areas of focus:

1. **Chronic Disease**: specifically -heart disease, diabetes, and asthma

2. **Maternal and Child Health**: specifically - teen pregnancy, premature births, and low birth weight

3. **Substance Use/Misuse**: specifically -the opioid epidemic, accidental overdose, and smoking/e-cigarette use

4. **Mental Health**: specifically - mental health diagnoses (especially in youth), suicide/suicidal ideations, and impact of trauma.

The plan is posted at http://www.dhss.delaware.gov/dhss/dph/files/shna.pdf. The deadline for submissions is Tuesday, July 31, 2018. This public input process is an opportunity to provide feedback about the information presented in the draft SHA. After receiving public comments, DPH will organize partners again to develop strategies and goals to address Delaware's major health needs.

Simultaneously, the Division engaged in maintaining its accreditation status by the Public Health Accreditation Board (PHAB). The Division of Public Health achieved this prestigious designation as an accredited health department in 2016. This is an ongoing effort to maintain our designation over the next five years, which will need to be monitored. Reports are submitted annually to demonstrate that we continue to meet the PHAB standards.

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.

The Division of Public Health established a Strategic Leadership Group and developed an annual review of the DPH 2014-2017 Strategic Plan. The DPH Strategic Leadership Group's mission is to lead and oversee the development, implementation, and progress of the division's strategic plan. As such, it engages in monthly meetings to report on the plan strategic priority progress. The DPH Strategic Leadership Group, which the Title V MCH Director/Section Chief of Family Health Systems is a member, continues to meet monthly to review progress of strategic plan priorities using a performance management and reporting dashboard system. The DPH's Office of Performance Management has offered additional trainings for team members throughout the year to get more managers on board with development of strategic goals and priorities for each of their sections. Family Health Systems Section is

ahead of the game, as a strategic plan was developed and finalized in 2018. The final draft of the 2018-2023 DPH strategic plan is in the edit process and was recently shared with the Division for input and feedback. At the same time Dr. Karyl Rattay, Director of DPH, will take it to a Department of Health and Social Services leadership team meeting for feedback. Dr. Rattay will be doing town halls later in 2018 to discuss the strategic plan and strategic priorities.

In 2017 and through the first half of 2018, DPH took responsibility for developing a comprehensive response to the opioid epidemic for the Delaware Department of Health and Social Services. This includes addressing the non-medical use of drugs, changing prescribing behavior, use of naloxone, encouraging alternative pain management, referral to substance use disorder treatment and support, and medication-assisted treatment. In May 2018, the director of DPH called together members of the Division of Substance Abuse and Mental Health and other divisions throughout the Department of Health and Social Services to review and provide input on a draft strategy to prevent and manage substance use disorder. Recently, other agencies have also been invited to weigh in on the strategic approach, including the Department of Corrections, the Department of Services for Children, Youth and Their Families, Department of Public Safety, to name a few. Using the strategy map and balanced scorecard approach, the vision is a coordinated and comprehensive approach to prevent, identify, effectively treat and support those impacted by substance use disorder.

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 2010-2016, the infant mortality rate for African Americans averaged 12.5 while the rate for infant mortality among Whites was 5.1. For the same 5-year period the average infant mortality rate for all races was 7.5 which is higher than the national average of 5.9.
- **Breastfeeding.** In 2016, the percent of Black infants who were ever given breast milk was 65.7%,compared with 80.8% of White infants (NSCH 2016. According to the NSCH 2011/12 data, Black infants had the lowest rate of breastfeeding through 6 months. The most available data for Hispanic infants that were ever given breast milk was 75.3% *(NSCH 2011/12).
- **Teen Births.** The 5-yr average teen birth rate in the U.S. and in Delaware declined. The 5 yr average teen birth rates in the U.S. declined by 43 percent from 43.3 per 1000 women in 2000-2004 to 24.5 per 1000 in 2012-2016. During the same time-frame Delaware saw a 51 percent decline in five-year average teen birth rates from 45.7 per 1000 women in 2000-2004 to 22.6 per 1000 in 2012-2016. Despite the decline in the teen birth rates disparities persist with Black teen birth rate 33.8 per 1000 women in 2012-2016 as compared to White teen birth rates at 20.1 per 1000 women in 2012-2016. The disparity ratio in the teen birth rates was 1.7 times for Blacks to that of Whites. Despite the racial disparities, Delaware made great strides in five-year average rates among white and black teen birth rates through several population based health interventions.
- **Overall Health.** In 2016 NSCH*, 88.3% (62.07%) of Hispanic children were reported to be in very good/excellent health by their parent, compared with 87.8% (83.6%) of Black children, 94.7% (78.2%) of Multi-racial children, and 92.7% (91.6%) of White children. There was a similar disparity for income level, with only 91.9% (61.9%) of children in households under 100% of the Federal Poverty Limit (FPL) reported to be in very good/excellent health compared with 88.4% (90.5%) of children in the 200-399% FPL bracket (percentages in parenthesis came from the 2011/12 NSCH)*.
- **Smoking.** From 2012-2015, compared to Black (22.7%) and Hispanics (10.2%), a significantly higher percentage of White (29%) mothers stated they had smoked in the 3 months before pregnancy. When asked whether or not they smoked in the last 3 months of their pregnancy, the percentage responding "Yes", was 11% for Black, 3.8% for Hispanic, and 15% for White women. (DE PRAMS 2012-2015)
- **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. Every person deserves equal access to safe communities that foster opportunities to achieve optimal health and well-being. The Delaware Healthy Mothers and Infants Consortium continues to emphasize health equity and the social determinants of health, through highlighting the topic on Annual MCH Summit agendas, bestowing health equity awards to individuals and organizations to recognize efforts, 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 as well as a laser focus of the Delaware Healthy Mother and Infant Consortium's efforts as it aims to reduce the infant mortality rate.

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 (SIMs) effort and track its progress. This past year began with very big shift in state leadership and a transition, resulting in a number of changes and new directions. The year ended with the launch of several new programs. This past year's plan was centered on Healthy Neighborhoods, payment reform, behavioral health integration, and others –all supported by Health IT—and continue the state's efforts to transform health and health care for all Delawareans.

Payment reform and related activities have been a major focus of the SIMs work this past year and will continue through the last year of the grant. All eyes are on payment reform as value based payment is the buzz word, particularly for Medicaid MCO contracts and most recently the Division of Public Health's Healthy Women Healthy Babies program will explore value based payment and performance based contracts as a pilot program for transitioning the Department of Health and Social Service contracts in this direction. DHSS Cabinet Secretary Kara Walker introduced the Division of Public Health to Third Sector Capital Partners to provide expertise and technical assistance on this topic.

The Health Care Commission (HCC) will continue to support the Department of Health and Social Services in their efforts to construct and launch a health care benchmark plan for the state focused on total cost of expenditures in the state (Choosehealthde.com). Health care costs consume 30% of Delaware's budget. Delaware health care costs are, per capita, the third highest in the nation — more than 27% above the U.S. average. Delaware's health care costs are expected to more than double by 2025. The benchmark plan is essentially a target for health care spending growth. By increasing transparency and the dialogue about total health care spending, we can identify opportunities for cost and quality improvement. Benchmark reporting will be at the system level and may look at large organizations, such as accountable care organizations, but not at small, individual practices. New models for payment will be developed in collaboration with Delaware payers, providers, and consumers. The HCC and its vendors will also continue to focus on transparency and quality efforts through payment reforms on many fronts—linking with DHIN and the practice transformation efforts under SIM.

Behavioral health integration is also a very important aspect of Delaware's practice transformation work. Founded on the plan developed in year three of the SIMs work, the HCC plans to work with practices across the state to improve their capacity to address behavioral health needs alongside primary care. The HCC will also continue to support other practice transformation activities, and seek ways to support provider engagement in Delaware's Health Information Network (DHIN). Behavioral health is also a core priority of our maternal and child health work, as we work on preserving the psychosocial bundled service through the Healthy Women Healthy Babies program, mitigating adverse childhood experiences (ACES), NPM decrease rates of bullying by promotion social and emotional wellness, as well as support adolescent health through the 32 school based health centers that we monitor, whereby mental health visits make up 40% of all visits.

The Healthy Neighborhoods (HN) initiative, which was launched in the fall of 2017, will propel population health efforts through the three county-based HN councils. Grants were recently distributed through the HCC to develop a mini-grant program that allows these local councils to implement critical, evidence-based programs to improve population health.

Legislation was also introduced this year and passed both the House and Senate, Senate Bill 227, and now is ready for the Governor's signature. The bill will 1) require the Health Care Commission to collaborate with the Primary Care Reform Collaborative to develop annual recommendations to strengthen the primary care system in Delaware 2) Require all health insurance providers to participate in the Delaware Health Care Claims Database. 3. Require individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate for the next 3 years. The scope of the Primary Care Reform Collaborative long-term recommendations would include payment reform, value based care, workforce and recruitment, directing resources to support and expand primary care access, increasing integrated care (including for women and behavioral health), and evaluating system-wide investments into primary care using claims data.

Finally, Health IT and health information exchange and transparency underpin the success and sustainability of all of these SIMs efforts. Without data, payment reforms can be lop-sided, practice transformation can be stymied, and local communities cannot target high-need issues and populations. Therefore, legislation was passed at the end of June 2018 to support DHIN and invest in our HIT efforts to essentially create an all claims database (which, could take years to develop and implement)—in concert with several other initiatives.

While all of this work has relevance to health of Delaware's maternal and child health population, the efforts of the "Healthy

Neighborhoods" work will be especially important for addressing the social determinants of health that lead to so many of the disparities in MCH outcomes described throughout this application. The Healthy Neighborhoods initiative targets four critical health priorities that align with our Title V MCH priorities, including healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease prevention and management.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

With regard to our on-going Needs Assessment efforts, our team has several avenues from which we continue to gather information and feedback on how our strategies are meeting the needs of the MCH population. We continue to leverage the availability of the latest national and local data sets for on-going evaluation and to monitor key measures that support our action plan. Reports such as the latest YRBS and BRFSS allow us to revisit our strategies and measures for continued relevance for our children and youth strategies. The recent release of the 2016 National Survey of Children's Health has allowed us to gain perspective and establish new baselines for our measures. Major differences between the 2011/2012 survey and 2016 have required us to revisit certain measures and determine if changes to the baseline measures are necessary. The good news is that with the coming release of the 2017 data this fall, we anticipate being able to begin our analysis on trends that can support our on-going efforts.

The benefit of having a CDC Epidemiologist on site has been a tremendous one as we enter into the third year of the CDC contract. Dr. Hussaini's work focusing on Neonatal Abstinence Syndrome has provided us with rich data from which informed decisions when we developed our strategy map for substance use disorders. His work this year on neonatal abstinence syndrome, maternal mortality and morbidity, perinatal cooperative quality indicators, and oral health has proven invaluable as we work with our partners on a plan of action to help support mothers and children. Our plan it to continue to leverage his skills and expertise to perform evaluation and trend analysis on the latest data being released both nationally and locally.

As we move into year four of the MCH Block Grant cycle, we plan to use existing and newly available data, such as the 2016 National Survey of Children's Health data, as the basis for the work to be done in the next assessment cycle. One such data source is the survey findings from our 2018 MCH Block Grant Stakeholder Survey that was distributed to our stakeholder network of more than 700 recipients. In this survey, we reviewed the work being done with the eight national priorities and asked our stakeholders to let us know how they felt we were doing in addressing these areas. We offered ample opportunity for comments and suggestions and the results were documented in a findings report that we then circulated back out to the stakeholders for them to review and respond as they felt necessary.

This year we reconvened our 2015 Needs Assessment team to review of trends and analysis being done on the data relating to our national and state priorities. In these meetings, we reviewed the priorities, strategies and measures. We explained the changes that were being made to the Block Grant application with regard to pairing down the number of health priority areas if necessary. We allowed our NA Team to give us their thoughts on whether we should 'stay the course' with our strategies and measures or change based on what they know to be happening in their particular areas. Findings from the stakeholder survey were also part of the discussion with our 2015 Needs Assessment team. We asked each team member to review the findings and provide us with their thoughts on the effectiveness of our strategies and offered them the opportunity to suggest modifications or changes to the current strategies. We also took the opportunity to let our team know that we would be kicking off the next Needs Assessment effort in 2019.

Below are a few examples of how we are leveraging various sources of information for feedback and communications from our community partners.

NPM 1 – Well Woman Care

DHMIC Education and Prevention Committee – this group meets on a quarterly basis, and provides feedback on social marketing efforts, including specific updates to DEThrives.com. Specifically, we have been focused on

content updates to the website and formatting messaging for Blog/Facebook posts, Tweets, and website updates. We also monitor google analytics data on traffic to the DEThrives website, and specific pages, to measure reach to target populations, women of reproductive age, and priority messaging (shares/likes, etc.). The Committee also assembled an editorial workgroup comprised of women's health education experts and clinicians to review website content for accuracy and evidence based information to support tips and preconception health messaging shared with consumers.

Title X/Family planning – two sub-recipient provider meetings are held each year to provide family planning service updates. We are also monitoring the annual FPAR data on number of women of reproductive age with a family planning visit as well as track the use of moderate to effective methods of birth control by method type.

CMS Maternal and Infant Health Initiative grant – A very exciting development is the use of the CMS MIH grant to support the Behavioral Risk Factor Surveillance System (BRFSS). The Delaware Division of Public Health put the additional funds into an existing contract with Abt Associates, the current contractor for Behavioral Risk Factor Surveillance System (BRFSS) data collection in Delaware, to provide professional services for administering the BRFSS questionnaire. Delaware is supporting the addition of questions from "Module 19: Preconception Health/Family Planning" to the 2017 survey questionnaire to track the use of moderate to effective methods of birth control and LARCs. The cost involved covering an increase in the overall sample size of the 2017 BRFSS questionnaire. This increase will be necessary to ensure an adequate sample of adult women of reproductive age (ages 18-44) responding to the survey. It is paramount that we increase the proportion of cell phone vs. landline respondents to make sure that we reach the younger population, ages 18-24. We are currently analyzing the data collected from Module 19 collected in the 2017 BRFSS questionnaire.

NPM 6 Child Health – Developmental Screening

The Early Childhood Comprehensive Systems Impact grant award has significantly changed the landscape and scope of developmental screening in the Maternal and Child Health Bureau. Through efforts of the two placed based community teams (PBCs) in New Castle County and Sussex County there's been an increased focus in developmental health monitoring, screening and follow-up. Delaware's PBCs focused on improving the administration, tracking and referral of the Ages and Stages Questionnaire (ASQ) in the early child care and education sector. Feedback from surveys conducted during the 2017 grant year indicated a number of child care centers within the PBC catchment areas lacked the training to administer, analyze and make referrals using the screening instrument. Additional sources of feedback included those from child care providers to establish a core group of parent champions who will be leaders in their communities and serve as advocates and mentors to other parents in their communities.

NPM 9 - Bullying

In the Adolescent Health domain our efforts to support anti-bullying and bullying prevention efforts is supported by our many community partners who share in the same commitment to provide students with a safe and accepting environment in which to learn and thrive. MCH has presented several overviews and updates to our youth serving organizations and have garnered rich feedback from discussion and follow up meetings with our local partners. MCH has contributed to the wider community efforts by participating in the HRSA sponsored Implementation Work Group (IWG). This work group meets quarterly and consists of all the states who have chosen bullying prevention as a performance measure under their federal Child and Maternal Health Block Grant and it allows us to gather information about strategies being implemented in other states. The IWG also uses an online learning collaborative to share information and engage in discussion. Through this work, MCH has offered to share success stories for the programs being implemented in our schools by submitting a blog article to stopbulying.gov that was to coincide with National Disabilities Awareness Day in July, 2017. The process to get the blog posted to stopbullying.gov was tied

up in review with SAMHSA for several months after submission, so while we did not make publication in time for National Disabilities Awareness Day, we are happy to report that the blog was finally published on March 26, 2018 and can be found at the following link: https://www.stopbullying.gov/blog/2018/03/26/when-students-disabilities-become-bullying-targets.html.

Suggestions and comments from our stakeholder survey highlighted that bullying remains a serious concern for our partners and families, especially for our vulnerable youth – children with special health care needs and those who identify as LGBTQ.

NPM 11 – CYSHCN – Medical Home

Delaware has worked to address the issue of medical home with our families with children with special health care needs by utilizing resources supported by the Universal Newborn Hearing Screening and Intervention Program funded by the Health and Resources System Administration. Under this program, we have established Learning Community structures which are led by two (2) parent lead organizations who work with families of infants who are Deaf or Hard of Hearing (D/HH). Delaware kicked off our first Learning Community on May 15, 2018. There were parents, audiologist, otolaryngologist, neonatal nurse, neonatologist, physicians, early intervention providers, and teachers of children with hearing loss. As a result of the survey which was shared with these individuals; the parents and the professionals that participated in this meeting collectively to determine which topics could best address the needs of both parents and professionals who serve infants who are Deaf or Hard of Hearing (D/HH) in Delaware.

As a result of this exercise, several additional events are scheduled in the coming months that will offer workshops that provide valuable information to our community stakeholders. The Learning Community schedule with workshop topics have been distributed to parents and professionals serving infants who are D/HH. These topics include: Medical Home and the Care Notebook, Joint Committee on Infant Hearing (JCIH) Recommendations: What 1-3-6 means to you. The workshops are being offered in New Castle, Kent and Sussex County during the day and in the evening. Parents and professionals schedules were taken into consideration when the schedule was made. We look forward to gathering feedback from families and professionals as a result of these programs and will use this information as we move forward with our work to address medical homes for families with children with special health care needs.

NPM 13.1 & 13.2 – Oral Health – Children and Pregnant Moms

Our oral health national priority work focuses on not only national data, but also feedback gained form local professional development trainings. Evaluations are given to participants and those are reviewed for enhancements and opportunities for improvement in the training curriculum. Over the last year, feedback on professional development trainings have offered us the opportunity to hear from childhood day care providers, school nurses, and organizations who work with our families with children with special health care needs. Through our work with the Sussex County Health Coalitions, we have heard from local hospitals who wish to partner with MCH and our Bureau of Oral Health and Dental Services to provide specialized training to expectant mothers as well as nursing teams who work with mothers on pre-natal care as it relates to good oral hygiene. Our stakeholder survey suggestions and comments shows us that there is a need for additional marketing and education on the oral health care coverage for both children and pregnant mothers. Another pressing need as shown in the survey findings, is the need for adult oral health care coverage from Medicaid. Currently, health care coverage for Medicaid recipients ends at age 21, therefore our expectant mothers who are older than age 21 are not covered by Medicaid for basic oral health services or urgent oral health care needs.

Our CDC Epidemiologist prepared a data brief that focuses on Oral Health in Mothers and Children. The data brief provides an overview of oral health status among Delaware children 17 and younger using the NSCH 2016 data and provides select indicators on oral health among pregnant women from PRAMS data from 2012-2015. We are using

the information contained in this data brief to determine possible modifications and enhancement to our strategies for providing further education on the importance of oral health preventive care for pregnant moms and children. The goal is to have mothers understand how good oral health contributes to positive birth outcomes as well as better overall health.

NPM 15 – Adequate Insurance

Our stakeholder survey provided proof that the need for adequate health care coverage for our children with special health care needs remains a priority for our families and community partners once again. Comments and suggestions by survey participants included the need for further education on what health care options are for families who may not qualify for Medicaid, expanded coverage for special equipment needs, additional funding for home therapy and respite care, and access to care in general.

Recent State Budget Epilogue language (Section 141) provided an appropriation to the Division of Medicaid and Medical Assistance (DMMA) to address the needs not easily bet for children with medical complexity through the existing health care model. DMMA established a workgroup and MCH was asked to join the Children with Medical Complexity (CMC) Steering Committee to develop a comprehensive plan for managing health care needs of Delaware's children with medical complexity. In developing the plan, the workgroup sought input from health care providers, hospitals, health systems, payers, managed care organizations, social service agencies, consumer advocacy organizations representing children with medical complexity, and parent advocates. MCH participated in the workgroup sessions during the first quarter of 2018 and the final plan was submitted in May, 2018. A link to the plan is provided: https://news.delaware.gov/2018/05/30/dhss-releases-delawares-plan-managing-health-care-needs-children-medical-complexity/

II.B. Five Year Needs Assessment Summary and Updates
FY 2018 Application/FY 2016 Annual Report Update

With regard to our on-going Needs Assessment efforts, our team has several avenues from which we continue to gather information and feedback on how our strategies are meeting the needs of the MCH population. We plan to use available national and local data sets for on-going evaluation and monitor of key measures that support our action plan. Reports such as the latest YRBS and BRFSS will help inform our strategies and measures for our children and youth strategies. The coming release of the National Survey of Children's Health will also be a focus of evaluation as we get into the fall of 2017. On the local level, we plan to leverage the latest School Climate and Discipline Survey, vital statistics data, and state health improvement assessment findings and updated goals and strategies. Another important data source will be the Medicaid claims data. We believe that the claims data will give us the opportunity to align ourselves with trends that will inform our work on the next version of our Title V/Title XIX MOU by showing where duplications may be occurring and how we can eliminate the redundancies.

The benefit of having a CDC Epidemiologist on site has been a tremendous one during this first year of the CDC contract. We plan to leverage his skills and expertise to perform evaluation and trend analysis on the latest data being released both nationally and locally. His work this year on neonatal abstinence syndrome has proven invaluable as we work with our partners on a plan of action to help support mothers and children who have fallen victim to substance abuse.

As we move into year three of the MCH Block Grant cycle, we plan to use available data as the basis for the work to be done in the next assessment cycle. During the next year, we plan to re-convene our 2015 Needs Assessment Steering Committee to begin a review of trends and analysis being done on the data relating to our national and state priorities. During that time, we hope to gather additional information and insight from our Needs Assessment partners to better understand the impact of our work at the grass roots level. We also hope to gain a clear understanding on where we could improve our efforts for even greater successful outcomes.

Below are a few examples, by performance measure, of how we are leveraging various sources of information for feedback and communications from our community partners.

Focusing on the Women/Maternal Health Domain, there are several avenues in which we are gathering feedback and monitoring community response to the work being done to support NPM 1 and State Performance Measure 1. The LARC/DE CAN Workgroup group is an informal body that provides feedback and support on implementation of DE CAN. We hold bi-monthly meetings, and document discussions in meeting minutes with identified action and items and identify who is accountable for follow through.

DHMIC Education and Prevention Committee – this group meets on a quarterly basis, and provides feedback on social marketing efforts, including specific updates to DEThrives.com. Specifically, we have been focused on content updates to the website and formatting messaging for Blog/Facebook posts, Tweets, and website updates. We also monitor google analytics data on traffic to the DEThrives website, and specific pages, to measure reach to target populations, women of reproductive age, and priority messaging (shares/likes, etc.). The Committee also assembled an editorial workgroup comprised of women's health education experts and clinicians to review website content for accuracy and evidence based information to support tips and preconception health messaging shared with consumers.

Title X/Family planning – two sub-recipient provider meetings are held each year to provide family planning service updates. We are also monitoring the annual FPAR data on number of women of reproductive age with a family planning visit as well as track the use of moderate to effective methods of birth control by method type.

CMS Maternal and Infant Health Initiative grant – A very exciting development is the use of the CMS MIH grant to support the Behavioral Risk Factor Surveillance System (BRFSS). The Delaware Division of Public Health will put the additional funds into an existing contract with Abt Associates, the current contractor for Behavioral Risk Factor Surveillance System (BRFSS) data collection in Delaware, to provide professional services for administering the BRFSS questionnaire. Delaware is supporting the addition of questions from "Module 19: Preconception Health/Family Planning" to the 2017 survey questionnaire to track the use of moderate to effective methods of birth control and LARCs. The costs will involve covering an increase in the overall sample size of the 2017 BRFSS questionnaire. This increase will be necessary to ensure an adequate sample of adult women of reproductive age (ages 18-44) responding to the survey. It will ensure that we get good proportions from all age and demographic groups. It is paramount that we increase the proportion of cell phone vs. landline respondents to make sure that we reach the younger population, ages 18-24. The Delaware BRFSS sample currently is 60% cellphone and 40% landline. This proportion will move to 65% or 70% cellphone as

funding permits. The contractor and state coordinator have calculated that, in addition to the increase in cell phone sample, the total sample will need to increase from ~4,000 per year to 5,000 plus in order to obtain an adequate sample of women in the reproductive age group. This will also support the strategies identified to show progress on NPM 1.

NPM 4 (a & b) Perinatal/Infant domain

NPM 6 Child Health – Developmental Screening

NPM 8 – Child Health – Physical Activity

In the Adolescent Health domain our efforts to support anti-bullying and bullying prevention efforts is supported by our many community partners who share in the same commitment to provide students with a safe and accepting environment in which to learn and thrive. MCH has presented several overviews and updates to our youth serving organizations and have garnered rich feedback from discussion and follow up meetings with our local partners. We have cross-pollinated our presentations to include organizations that support our children with special health care needs as well as those who focus on the support and well-being of our LGBT youth. MCH has contributed to the wider community efforts by participating in the HRSA sponsored Implementation Work Group (IWG). This work group meets quarterly and consists of all the states who have chosen bullying prevention as a performance measure under their federal Child and Maternal Health Block Grant and it allows us to gather information about strategies being implemented in other states. The IWG also uses an online learning collaborative to share information and engage in discussion. Through this work, MCH has offered to share success stories for the programs being implemented in our schools by submitting a blog article to stopbulying.gov to coincide with National Disabilities Awareness Day in July, 2017. We look forward to our blog posting on stopbullying.gov and will use posted comments as a method to evaluate new ways to address this topic for children with disabilities.

Our oral health national priority work focuses on not only national data, but also feedback gained form local professional development trainings. Evaluations are given to participants and those are reviewed for enhancements and opportunities for improvement in the training curriculum. In addition, our MCH team has participated in the HRSA sponsored peer-to-peer community of learning to support states addressing Title V/Maternal and Child Health (MCH) state action plan national performance measure (NPM) 13—Dental Visit. This community of learning, which was supported by MCHB, was designed to provide a forum to share activities and strategies to increase access to oral health care for pregnant women and children and adolescents ages 1–17. This community of learning was leveraged by our team to participate in conference calls to discuss challenges, share resources and best practices, and learn about training opportunities that might help us reach our goals. While the community of learning was only scheduled to exist through June, 2017, we hope that the learning collaborative continues to function for years to come. We also plan to continue working with our Oral Health Coalition partners to help gather information and insight from our dental providers state-wide.

FY 2017 Application/FY 2015 Annual Report Update

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.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,958,687	$1,605,272	$1,958,687	$1,958,861
State Funds	$9,390,789	$9,390,789	$10,559,315	$10,559,315
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$1,292,148	$1,292,148	$2,147,883	$2,147,883
SubTotal	$12,641,624	$12,623,956	$14,665,885	$14,666,059
Other Federal Funds	$10,411,186	$0	$10,406,559	$10,406,559
Total	$23,052,810	$12,623,956	$25,072,444	$25,072,618

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,961,019	$1,913,137	$1,961,019	
State Funds	$10,461,629	$10,461,629	$10,437,817	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$2,151,704	$3,294,852	$2,385,566	
SubTotal	$14,574,352	$15,669,618	$14,784,402	
Other Federal Funds	$8,446,184	$8,446,184	$6,823,020	
Total	$23,020,536	$24,115,802	$21,607,422	

	2019	
	Budgeted	Expended
Federal Allocation	$1,913,137	
State Funds	$9,782,274	
Local Funds	$0	
Other Funds	$0	
Program Funds	$3,294,852	
SubTotal	$14,990,263	
Other Federal Funds	$7,715,622	
Total	$22,705,885	

III.D.1. 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.D.2. 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 $14,990,263 which includes our block grant award and state Maintenance of Effort funds, as indicated on Form 2.

When additional federal grants are included, the state MCH budget totals $22,705,885 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.

FY18 Budget – Federal Title V Funds

Personnel Costs		**$1,534,645**
Salary, fringe, health insurance, indirect	$1,497,121	
Other employment costs (personnel, phone lines, DTI, network charges, postage, Fleet travel)	$37,524	

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.

Our indirect rate has decreased from 21.47% to the same as last year at the rate of 12.13%.

Contractual $367,466

Support for activities described in action plan $406,297 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 $20,000

Pregnancy Health $35,000

Child Health $35,000

Preconception $35,000

CYSHCN $242,466

Travel $8,000

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

Supplies $3,026

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

FY 17 TOTAL BUDGET $1,913,137.00

Spending Requirements

Maintenance of Effort

In FY89, the Delaware Division of Public Health allocated $5,679,728 in general fund dollars to Maternal and Child Health, including programs for Children with Special Health Care Needs. This figure serves as the base for determining our required maintenance of effort. For the current application, the state is allocating $13,077,126 in state funds to the Maintenance of Effort agreement. This includes support for 46.9 FTEs from state general funds and 6 FTEs from state appropriated special funds, as well as the appropriated special funds for infant mortality initiatives, developmental screening, and Nurse Family Partnership home visiting.

CYSHCN

The budget planned for FY 2019 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 2019 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 FY2019 budget is allocated for administrative costs. This category primarily includes funding for staff (salaries, indirects) who work to administer the Title V Block Grant (fiscal analyst, administrative assistant, etc), as opposed to staff who are implementing programs or delivering services. Small amounts for travel and supplies are also included.

III.E. Five-Year State Action Plan

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

State: Delaware

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The Division of Public Health, 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. Within DPH, the Family Health and Systems section has direct oversight of Title V, as well as a number of other MCH programs including the Children and Youth with Special Health Care Needs, the Early Childhood Comprehensive Systems (ECCS) initiative, Newborn Screening (Metabolic and Hearing) Program, Birth Defects Registry, the State Systems Development Initiative, Adolescent Health and School Based Health Centers, the Infant Mortality Elimination program, the Center for Family Health and Epidemiology, the Title X/Family Planning, DE MIECHV, as well as others that require partnerships, coalition building and leadership.

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

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

Data driven decision making. Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core public health functions and address specific health priorities. The aim is to have DPH working at the "bottom of the public health pyramid on population based and infrastructure building services. The most recent DPH strategic plan (2018-2023), has identified the following priorities:

- Promote healthy lifestyles
- Improve population health and reduce health care costs
- Achieve health equity
- Reduce substance use disorder and overdose deaths

These priorities are addressed in part through the relevant partnerships between the Division of Public Health/Title V MCH and external partners, using innovative and evidence-based or informed approaches and data is used to drive decision making.

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

planning priorities.

Access to care. Mentioned throughout the application, the Healthy Women Healthy Babies program promotes access to care, by providing an evidence based framework to improve women's health, mental health, and nutrition before, during and after pregnancy. The framework uses a Life Course perspective model that conceptualizes birth outcomes as the end product of the entire life course of the mother leading up to the pregnancy – not simply only the 9 months of pregnancy.

Education and prevention. "Delaware Thrives" is the branding theme and umbrella for all maternal and child health social marketing programming, developed in partnership with the Delaware Healthy Mother and Infant Consortium, which the state funds along with other federal funding sources, such as Title V, and DPH Family Health System staff support.

Title V MCH has led several successful social marketing campaigns to help educate, inform and promote healthy behaviors. For example, of the infant deaths in Delaware between 2006 and 2010, 37 percent were associated with unsafe sleep environments, including co-sleeping and sleeping on soft surfaces. The Long Live Dreams, safe sleep campaign, launched in 2013 and still going strong, was designed to impact the SIDS rate and unsafe infant sleep practices. The messages were developed to reach new parents with simple safe sleep messages. In addition, other key examples of DHMIC and DPH evidence based social marketing include Adverse Childhood Experiences (ACES) messaging in collaboration with the Governor's Family Services Cabinet Council and preconception health messaging through the promotion of reproductive life planning. The CDC recommends that every man and woman have a reproductive life plan, as one strategy to promote lifelong wellness. Both women and men, as well as teens can develop a set of personal goals about having or not having children based on values and a plan to achieve those goals. Many of our campaigns have a strong emphasis on peer to peer outreach through DPH's home visitors, health ambassadors, and preconception peer educators, through family to family support by providing shareable tools and social media content, and enable provider to patient promotion to achieve multiple dosing and reinforcement. The promotion efforts seek to influence choice, peer support, family norms, culture and policy consistent with best practices and data/evidence.

Supporting coordinated, comprehensive and family-centered systems of care. In Delaware, there has been a large focus over the last five years on building a coordinated, comprehensive and family centered early childhood system of care. The state leveraged large multi-million dollar Early Learning Challenge grants from the federal government, and two Delaware Governor administrations have focused on state investments, even during challenging economic times. The Governor's Early Childhood Advisory Council established a Child Health Committee, which DPH's Maternal and Child Health Deputy provides lead staff support, as well as membership and participation from the Early Childhood Comprehensive Systems Administrator. Developmental screening, Help Me Grow, the ECCS CoIIn impact grant, DE Maternal Infant and Early Childhood Home Visiting, as well as SAMHSA's Project Launch grant goals and deliverables are discussed to align key efforts and maximize resources. The Title V MCH team, specifically the ECCS Administrator, helps co-lead the Project LAUNCH grant to promote child wellness by strengthening linkages between children's health and mental health.

Family SHADE has continued to grow and thrive over the past few years, as a network of providers and family members striving to improve the system of services for children and youth with special health care needs (CYSHCN). The group has worked to expand membership, enhance and promote their website, practical tools and technical assistance for family-led organizations, and support partners in implementing activities related to the core outcomes and indicators for CYSHCN, as well as outreach to families to connect them to resources and services. Family SHADE has played a significant role in addressing the Title V MCH performance measures related to CYSHCN, as well as our state priorities, and details of the organization's accomplishments can be found throughout

the narrative and broader application.

Title V as a leader and convener. Partnerships are a unique and a fantastic asset in Delaware, as Title V MCH is a leader and convener of a broad spectrum of partners to address the needs of women, infants and children. Delaware prides itself in building and maintain partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. In working to improve the lives of women, children and families, leadership is an essential role for maternal and child health (MCH) programs. Leaders must have a vision, take initiative, influence people, solve problems, and take responsibility in order to make things happen. And, regardless of your title and level in the organization, everyone at every level on the DPH Title V MCH team is engaged in the process of leadership. We conduct our work and our interactions with others using the 10 Principles of Leadership (LeadQuest) and these values as guideposts for our personal behavior, professional practice, and public health decisions. The Division of Public Health has been focused on creating a culture of leadership over the last 8-10 years, using this framework. Title V MCH has a proven track record of creating unity, build trusting relationships to help achieve success by working with others rather than stepping on or over people. We work on bringing people together, to establish a common vision and set of values along with programmatic systems and operations, such as planning, goal setting, communications and quality improvement. Examples of our role as Title V leaders and conveners are discussed throughout the application, including the Delaware Healthy Mother and Infant Consortium, Help Me Grow and early childhood comprehensive and coordinated systems work. Through the power of partnerships, we continue to integrate our programs where it makes sense, find the connections to make sure we are not duplicating work, focus on doing the right things and doing things right. Public Health success will depend on health leaders working closely with both the private and public sectors, and over the next year, we are making a concerted effort to tap new and non-traditional partners (i.e. business community, transportation, housing, planning, including faith based organizations, etc.), particularly as we address social context issues impacting the health of women, infants and children.

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

III.E.2.b. Supportive Administrative Systems and Processes

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

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 $9,666,040, which includes funds appropriated for state infant mortality reduction initiatives, and supports 53.1 FTEs (46.5 from general funds and 6.6 from appropriated special funds). The Title V federal allotment is estimated at $1,913,137 for FY18.

In Delaware, the majority of Title V block grant funding is used to support approximately 17.65 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 continue to evaluate our progress as it relates to our needs assessment findings and execute our 5-year state plan, we work with the managers of these positions to assess job responsibilities and ensure alignment with our new Title V priorities.

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 fourth 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. Crystal is also temporarily filling the roll of Children and Youth with Special Health Care Needs Director as that position became vacant in January 2018. Crystal previously served as the Home Visiting Program Administrator overseeing implementation of the MIECHV program.

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 MCH Summer Skills Institute, 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

Delaware's MCH program does not include parents or family members who fill staff positions in our department. In addition, Delaware 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 have a CDC MCH Epidemiology assignee, Khaleel Hussaini who 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 Khaleel Hussaini, CDC epidemiologist have been identified and include:

Project Title	Description of Activities
Title V annual data reports Needs assessment	1) Access, review, and develop data and measures specific to report Title V that includes: a) Evidence-based strategy measures b) Explore and assess the feasibility of Hospital Discharge Data (HDD) and Birth Certificate data link to examine data quality as well as develop quality measures specific to Title V MCH priorities. c) Coordinate with Delaware Vital Statistics Manager to explore and assess the feasibility of linking Medicaid claims data to birth certificate as well as develop quality measures specific to Title V MCH priorities. d) Utilize BRFSS, PRAMS, YRBS, and Delaware Household Survey data for fact sheets and research briefs, community profiles specific to women of childbearing age and pediatric population e) Complete a women of child-bearing age report
Develop, present, and complete Neonatal Abstinence Syndrome (NAS) research report	1) Utilize Hospital Discharge Data to develop NAS research report 2) Create Mother-child dyads to develop a prospective cohort to monitor and examine long-term impacts of NAS 3) Present NAS findings from DHMIC group. 4) Explore, assess, and recommend the feasibility of developing a surveillance system for NAS using syndromic surveillance database specific to Admission Discharge and Transfers (ADT measures), and/or Delaware Health Information Network (DHIN) and/or develop Clinic Decision Support Systems (CDSS) in EHRs (test case Christiana's Cerner System).
School-based Health Centers (SBHC)	1) Assess and explore the feasibility of utilizing SBHC database for reporting performance measures and continuous quality improvement related to performance measures 2) Provide technical and scientific advice on data collection for SBHC performance measures as well as database development and maintenance 3) Develop a process and outcome evaluation plan for SBHC 4) Attend relevant joint-council meetings 5) Participate on the SBHC RFP Review and Selection Committee, to support data surveillance, evaluation and quality improvement planning efforts
Medicaid Claims Analyses	1) Attend Truven Healthcare Analytics Data Suite training and any on-going group meetings 2) Explore and assess the feasibility of linking Medicaid claims data to birth certificate 3) Develop research briefs specific to mental health among maternal and child health population using claims data

Project Title	Description of Activities
	4) Develop and assist in CQI measures specific to ASTHO Long Acting Reversible Contraceptives (LARC) initiatives for Center for Medicaid and Medicare Systems (CMS) Maternal and Infant Health Initiative grant.
MCH Data Inventory	1) Assess and explore the feasibility of documenting existing MCH data inventory systems for standardization. 2) Support data extraction, transaction, and loading (ETL) and standardization capabilities using informatics principles Continual support for LARC, SBHC, Healthy Women and Healthy Babies, MIECHV, Newborn Screening initiatives.
Infant mortality CoIIN	1) Attend quarterly meetings of DHIMC and relevant subcommittee meetings 2) Provide technical assistance and any relevant data analyses support to guide CoIIN efforts in Delaware 3) Provide input and feedback to the development of CoIIN related reports and communication. 4) Assist in Delaware Vital Statistics Center in meeting quarterly data to CoIIN 5) Utilize Death Certificate data to complete Infant Mortality briefs, causes of death briefs for women of childbearing age, and pediatric population.
Community Profiles Dashboard	Provide as needed technical and scientific advice on developing community profiles for State Innovation Model Grant (SIM) in areas of chronic disease, substance use/mental health, MCH, and healthy life-styles
Maternal Infant Early Childhood Home Visiting (MIECHV)	Provide technical advice and/or data support for any evaluation related activities for MIECHV
Epidemiology, Health Data and Informatics Section (EHDIS)	Participate and provide as needed technical advice for EHDIS strategic goals that includes translational public health research
Other tasks and emerging MCH priorities	Provide as needed technical advice and data support for any emerging MCH priorities
Healthy Women Healthy Babies	Participate and provide scientific and technical support for the program in conjunction with DHIMC efforts
Upstream LARC/Title X DE CAN initiative	Participate and provide scientific and technical support for the program in conjunction with DPH efforts

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

One of the most impressive examples of collaboration is the Delaware Healthy Mothers and Infants Consortium (DHMIC). Formed in 2005 as a statewide vehicle to address infant mortality, the consortium includes approximately 150 members, including representatives from DPH, hospital systems, universities, the legislature, March of Dimes, and more. The consortium has 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 Coalition, and the Breastfeeding Coalition of Delaware.

As outlined in our organizational structure, our Title V program is intimately connected with federal investments, such as the State Systems Development Initiative (SSDI), Maternal and Infant Early Childhood Home Visiting (MIECHV), Early Childhood Comprehensive Systems (ECCS), and Personal Responsibility Education Program (PREP) Partners by virtue of the location of these grant programs within the same section - Family Health Systems. In addition, we have been actively work 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 now involved in a Preconception CoIIN grant.

Over the past three years, 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 Dental Services an additional portal for distributing education and training. In 2017, MCH was recognized by the Sussex County Health Coalition as their "Community Partner of the Year".

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. 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.

Delaware recently created a new committee bringing together the Division of Public Health, Division of Family Services and the Division of Substance Abuse and Mental Health. The group is made up key leadership including all three Division Directors, two Deputy Directors and senior program directors including both the Title V Director and Deputy Director. The group decided to work on three key goals, a MOU, training for direct service staff and education. The purpose of the MOU stems from both The Department of Health and Social Services and The Department of Services for Children, Youth and Their Families recognizing that each has an important role to improve the lives of families impacted by substance use disorders. The MOU states that each agency agrees to establish a multi-disciplinary coordination committee. The purposes of the Committee will focus on training, messaging, case management of procedures for referrals.

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.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The Delaware State Systems Development Initiative (SSDI) is a key component of our Title V program. The program's initiatives ensure the Maternal and Child Health (MCH) programs have access to relevant information and data. The Division of Public Health (DPH) recognizes that a structured surveillance system to enable analysis of risk factors, behaviors, practices, and experiences before, during and after pregnancy would provide valuable statistics to support existing MCH programs and a basis for applications for new MCH funding allocations for intervention programs. DPH promotes interoperability within our data systems and encourages enhancing current systems versus building new systems.

The purpose of the SSDI program has always focused on access to data and data linkages of key data elements to support the Title V program. Delaware's SSDI program has made tremendous progress towards gaining access to Vital Statistics, Newborn Screening, Oral Health and Medicaid data, as well as, executing data linkages as needed. The SSDI program will continue to support the Title V program by improving access to data by expanding or enhancing current data systems. The SSDI program supports the continued work on projects that increase our ability to receive more "real time" data.

Resources deployed by the SSDI program include not only financial, but also project management and epidemiological resources. Funds used to support evaluation and analysis of MCH data allows us to ensure that data relevant to Title V programs and priorities is made available in a timely manner. Throughout the current 5 year SSDI grant cycle, the SSDI Program Manager will provide valuable support to the on-going needs assessment effort, as well as program management for at least three of the Title V national performance measure population cohorts. The SSDI Program Manager is slated to lead the next Title V 5-year Needs Assessment beginning in 2019. The SSDI program is instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee to Delaware, Dr. Khaleel Hussaini. Additional contractual dollars are allocated to working with John Snow, Inc. (JSI) to support projects that provide evaluation services for Title V Stakeholder surveys.

Khaleel S. Hussaini is a Centers for Disease Control and Prevention (CDC) Maternal and Child Health Epidemiologist (MCH) assignee to the Delaware Division of Public Health. In addition to his routine analyses of quantitative and qualitative population health data available at DPH to support MCH Block Grant, and other program initiatives and evaluation, Dr. Hussaini provides scientific and technical assistance to Division staff and stakeholders in the areas of maternal and child health outcomes, development of surveillance databases, and integration of technologies. As part of his initial work with DPH, he completed research that examined Neonatal Abstinence Syndrome and its implications on maternal and neonate health (see: http://dethrives.com/wp-content/uploads/2013/06/11.14.17-Neonatal-abstinence-syndrome-Delaware-2010-2015_final_update-dss-110817- w-Priv-Bd-comments_KH_111417_approved.pdf). Dr. Hussaini is also working on initiatives specific to social determinants and life-course with a focus on women's mental health and its impact on child health. In the area of School-Based Health Centers (SBHCs), Dr. Hussaini is building internal capacity for evaluation. Currently he is undertaking the evaluation for our Healthy Women, Healthy Babies program building on a summative evaluation completed last year. His work focuses on population health through application of health informatics principles. The financial support of Dr. Hussaini's contract emphasizes the value provided to assuring we have the richest data to inform our Title V decisions.

To date there has been three comprehensive reports: 1) Women of Childbearing Age – State of the State (see: http://dethrives.com/wp-content/uploads/2018/01/CHILD_BEARING2016_STATEofSTATE_approved1.compressed.pdf), 2) School-Based Health Centers; 3) PRAMS Consolidated Report (2012-2015, in review). Dr. Hussaini is also working on Data Brief documents that highlight where Delaware stands in comparison to other states on critical areas of importance for the

health and well-being of mothers and children in our state. Data Briefs have been completed for Maternal Morbidity, Perinatal Quality Indicators, and Oral Health in Mothers and Children to date. The completed Data Briefs have been added as a .zip file attachment and can be found in the appendix section of our application.

Work is also being done to begin researching and evaluating the feasibilities of making valuable connection to outside data sources in order to enrich our work in Title V. In 2017 linkages were created between Medicaid claims data and our oral health pediatric provider data. It was here that we were able to ascertain the status and progress in the number of Pediatric Primary Care providers who are now offering oral health screenings, fluoride varnish application and referrals for children during their pediatric well-visit. Through the collaboration between our MCH program communications efforts and DPH's Bureau of Oral Health and Dental Services education awareness and training, the number of Pediatric providers who complete this service for our children rose from 10 in 2015 to 29 in 2016. Identification of oral health service billing and diagnosis codes from our EMR database and then linked to our Medicaid claims data, provided us with this very important outcome finding. It is through data sharing and linkages like this that we can improve on our MCH Title V strategies and measures for the MCH Block Grant.

Hospital Discharge Data (HDD) has been linked to Vital Statistics Birth Certificate data to monitor Neonatal Abstinence Syndrome (NAS). In addition, most recently this linked data was also linked to Birth Defects Registry Data, as well as PRAMS data. While Medicaid claims data are routinely linked to vital statistics birth certificate data by the Delaware Health Statistics Center and are not under Title V purview, Medicaid data are also being linked where feasible to HDD, and other Title V program data. One such linkage that is currently underway is linkage between Medicaid data and School-Based Health Center data for evaluating health outcomes, which was completed and presented to the stakeholders (the report is available upon request as it is anticipated that several peer-review articles will be produced). Statewide, Delaware is working towards reducing the number of babies born exposed to opioids and other harmful substances. While we have just scratched the surface of understanding the full impact of the issue on our mothers and babies, having the expertise of our CDC MCH Assignee provides us with significant advantages in our efforts to establish data linkages with hospital discharge data. Our CDC MCH Assignee has already produced findings in this area that have informed our strategies and measures to continue our work in reducing the number of children diagnosed with Neonatal Abstinence Syndrome (NAS). This linkage allows us to not only determine if mothers received prenatal care, but also allows us to understand the impact to the length of time that a child remains in the hospital post-birth.

Additional evaluation activities supported by the SSDI program include an effort lead by the SSDI Program Director in working with John Snow, Inc. (JSI) this spring that allowed us to circulate a "mid-cycle" Title V MCH Stakeholder survey. JSI worked with MCH to craft the survey, collect survey responses and provide a findings summary that detailed information provided by our stakeholders when asked how we are doing in the support of our Title V national priority health areas. The findings informed our decision making efforts on whether or not to change the strategies and/or activities in our State Action Plan. Details of the project are listed in the Public Input section of our application and the findings presentation has been included as attachment Appendix A.

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

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

One of the most significant roles that our Maternal and Child Health program plays is supporting the implementation of the Affordable Care Act as it relates to preventive health services for women. Most recently, all eyes have been on the pending repeal and replacement of ACA, changes to Medicaid and proposed cuts to public health prevention funds and what it means for women, infants, children and families.
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). For more details on our accomplishments and planned activities to promote LARCS, please see the narrative for the domain of Women/Maternal Health. Medicaid continues to be a strong partner in this work including changing reimbursement policy and processes regarding immediate postpartum LARC access.

In fact, Medicaid is a strong partner in many of our MCH programs including the Healthy Women Healthy Babies program, School Based Wellness Centers and Home Visiting. Medicaid is currently working with our Home Visiting Program Administrators on reimbursement strategies. We believe two out of the four evidence based home visiting programs are eligible for reimbursement under the current state plan and only minor changes are needed to current policy and program manuals. Our Home Visiting program manager is working directly with a Medicaid staff member on these programmatic as well as possibly service coding changes (ICD 10 codes). As of June 15, 2018, Title V and Title XIX have an updated current MOU (please see section titled Title V-Medicaid IAA/MOU).

On a broader scale, DPH and Title V Program staff are engaged in the largest health reform effort in our state, implementation of the State Health Care Innovation Plan. 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:

- Supporting local communities to work together to enable healthier living and better access to primary care;
- 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;
- Shifting to payment models that reward high quality and better management of costs, with a common scorecard across payers;
- Developing the technology needed for providers to access better information about their performance and for consumers to engage in their own health.

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 is especially important for addressing the social determinants of health that lead to so many of the disparities described in our needs assessment.

In June, 2018 Dr. Rattay kicked off the first Delaware Healthy Communities Sustainability Workshop. This opportunity brought together a broad stakeholder community that is committed to population health in Delaware, in addition the workshop was an opportunity to help form a public-private sustainability model for Healthy Neighborhoods as well as key initiatives that address social determinants of health and aligned to improve population health in Delaware for the foreseeable future. A draft proposed infrastructure was announced and

attendees were given opportunity to provide feedback including areas of strengths and areas of concern. The framework had a strong emphasis on community input and included a Community Investment Council, a Guidance Committee and a Backbone Organization with core functions described for all.

In support of a movement to transform how health care is delivered and paid for in the state, Delaware was one of eight states chosen to participate in a National Governors Association initiative to harness data systems to inform health policymaking. Joining Arkansas, Colorado, Indiana, Iowa, Minnesota, Vermont and Washington, Delaware's team will receive guidance in creating a strategic plan for data analytics in support of policy and decision-making in its Medicaid program.

Over the course of the 16-month project, Delaware's team will receive technical assistance and engage in cross-state learning to help advance its capacity to use and analyze data in the Medicaid program within the Department of Health and Social Services (DHSS). About 230,000 Delawareans are served by Medicaid, the shared state and federal health insurance program for people from low-income households, seniors eligible for long-term care and individuals with disabilities. In January, DHSS' Division of Medicaid and Medical Assistance (DMMA) signed value-based purchasing contracts with its two managed care organizations (MCOs) – Highmark Health Options Blue Cross Blue Shield Delaware and AmeriHealth Caritas Delaware.

Medicaid data also will be an important component of Delaware's work on health care spending and quality benchmarks. In February, Governor Carney signed Executive Order 19 creating a 13-member Advisory Group to make recommendations to DHSS Secretary Dr. Kara Odom Walker on health care cost and quality benchmarks across Delaware's health care system, including employer-based coverage, Medicare and Medicaid. Secretary Walker will provide her formal recommendations to the Governor this summer. Beginning in 2019, Delaware will measure the total cost of health care, the first step in increasing transparency in how health care dollars are spent.

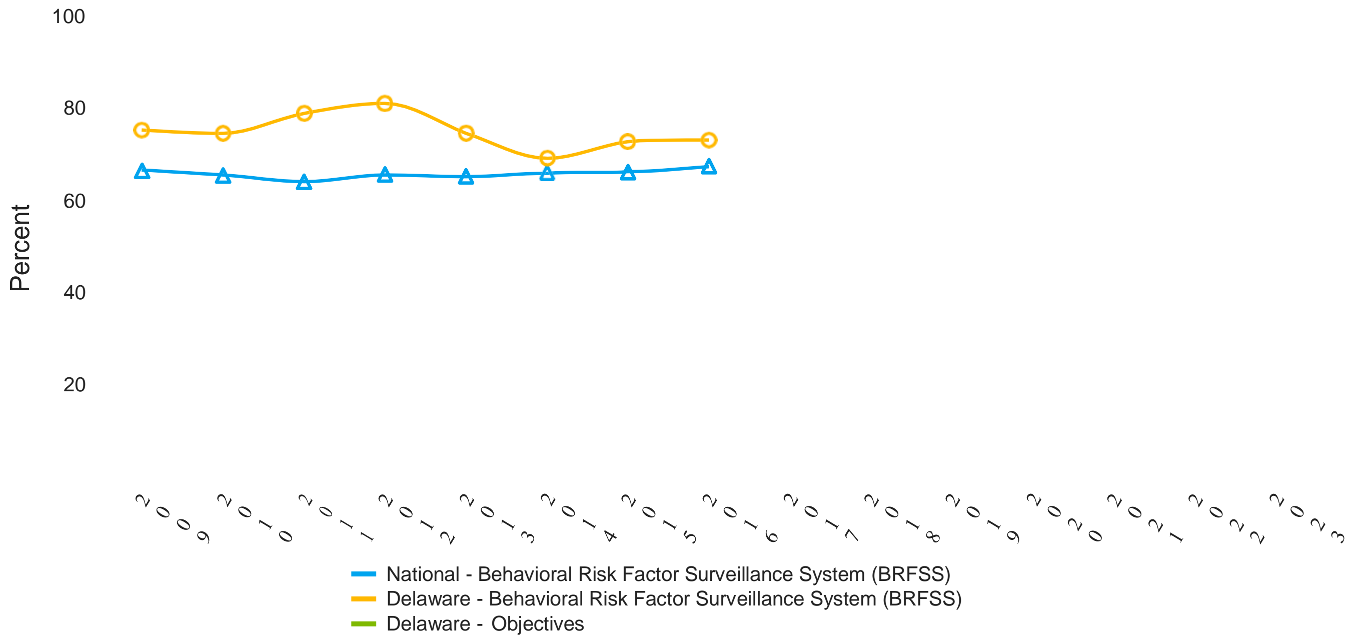
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.9 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.1 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	24.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	9.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	9.1	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	7.2	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.0	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	456.7	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.1 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	11.7 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	91.1 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	19.5	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	13.9 %	NPM 1

National Performance Measures



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	81.8	82.6
Annual Indicator	72.8	73.0
Numerator	118,008	118,081
Denominator	162,112	161,778
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	83.4	84.2	85.0	85.8	86.6	87.4

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - # of MCH social marketing public awareness messages (i.e. brochures, blogs, Facebook posts, website content, etc.) that promote preventive health care and preconception health for women of reproductive age.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	111
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	110.0	121.0	133.0	146.0	150.0

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

Measure Status:	Inactive - This measure is being deactivated due to the fact that these are now standing meetings within the DHMIC yearly calendar and will no longer be tracked.

State Provided Data		
	2016	**2017**
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	meeting agendas/minutes	meeting agendas/minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		8,300
Annual Indicator	8,146	8,819
Numerator		
Denominator		
Data Source	Healthy Women Health Babies Program data	Healthy Women Health Babies Program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

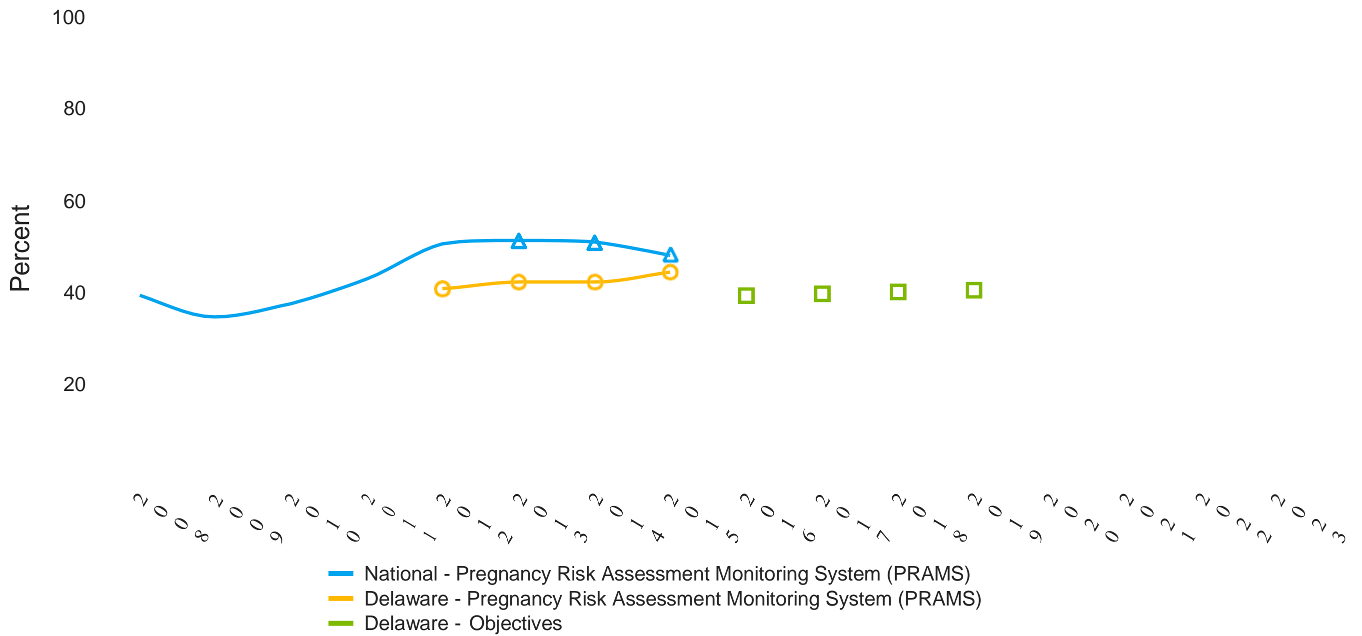
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8,500.0	8,700.0	8,900.0	9,000.0	9,100.0	9,200.0

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15,000
Annual Indicator	14,998	15,891
Numerator		
Denominator		
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15,500.0	15,700.0	15,900.0	16,200.0	16,500.0	16,500.0



Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	39.4	39.8
Annual Indicator	42.2	44.4
Numerator	4,224	4,562
Denominator	10,020	10,267
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	40.2	40.6	41.0	41.4	41.8	42.2

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Increase the number of hits on BOHDS website by working to include a social marketing campaign that drives traffic to the site.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		5,000
Annual Indicator	3,989	5,530
Numerator		
Denominator		
Data Source	DPH Google Analytics	DPH Google Analytics
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10,000.0	15,000.0	20,000.0	25,000.0	30,000.0	30,000.0

ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	50.0	100.0	150.0	200.0

ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	3.0	4.0	5.0	5.0

State Performance Measures

SPM 1 - Percent of Delaware women of reproductive age that had an unintended pregnancy

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		57
Annual Indicator	57	57
Numerator		
Denominator		
Data Source	Health Statistics	Health Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	56.0	52.0	50.0	47.0	45.0	43.0

State Action Plan Table

State Action Plan Table (Delaware) - 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

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

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	Status
ESM 1.1 - # of MCH social marketing public awareness messages (i.e. brochures, blogs, Facebook posts, website content, etc.) that promote preventive health care and preconception health for women of reproductive age.	Active
ESM 1.2 - # of DHMIC Education and Prevention meetings held in past year	Inactive
ESM 1.3 - # of women served by the HWHBs program that received Bundle A services/preconception care	Active
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.	Active

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

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

Priority Need

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

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

By July 2020, increase the percentage of pregnant women who have a dental visit during pregnancy from 39% to 43%.

Strategies

Work with Bureau of Oral Health and Dental Services (BOHDS) to create a social marketing campaign to raise awareness that oral health is an important part of prenatal health.

Collaborate with community partners to increase education within the OB/GYN practices that focuses on counseling pregnant women on the importance of getting a dental exam during pregnancy.

Ensure Home Visitors and Health Ambassadors are made aware of the expanded oral health care coverage for adult Delawareans who are enrolled in AmeriHealth Caritas Delaware.

ESMs	Status
ESM 13.1.1 - Increase the number of hits on BOHDS website by working to include a social marketing campaign that drives traffic to the site.	Active
ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.	Active
ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.	Active

NOMs

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

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

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

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

SPM 1 - 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

Work with Inter-agency and community partners to improve messaging regarding birth spacing and reducing unintended pregnancy.

Women/Maternal Health - Annual Report

Well Woman Care - Annual Report

In the domain of Maternal/Women's Health, we focused 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 continued to bolster and nurture our community partnerships by working together, leveraging talents and resources, and striving to find new ways to provide services.
Over the last year, we continue to monitor the Delaware Healthy Mothers and Infants Consortium's (DHMIC) strategic plan which covers a 3-5 year timeframe. 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. Beginning in the 1990s, Delaware's infant mortality rate was increasing while the national trend was decreasing. Prompted by a list of 20 recommendations, developed by an Infant Mortality Task Force in 2005, 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. Staff in the Division of Public Health's Family Health Systems Section largely provide staff support to the committees and help carry out and execute strategies to support the DHMIC's strategic plan.

Education and prevention is a cornerstone of the DHMIC work, utilizing the latest social media platforms. In partnership with a social marketing firm, Worldways, the Division of Public Health and several Maternal and Child Health partners we continued to develop update and launch messaging through the use of social media, whereby we continue to post messages via blogs, Twitter, Facebook, 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". This year has focused on updating existing content and adding new content on the website (www.DEThrives.com) that is easy to grow, easy to maintain, and easy to navigate, and one that is search relevant. A small core workgroup continues to meet to look at the content and develop messaging for blogs, tweets and posts on preconception health topics for men and women.

It's been several months since the spring and we are still riding high from the incredible success of the 2018 Annual DHMIC Maternal and Child Health Summit, held in April. The Delaware Healthy Mothers and Infants Consortium (DHMIC) and the Department of Health and Social Services (DHSS), Division of Public Health (DPH) organize this event. This was the 13th DHMIC summit. The summit brings together leaders in the area of family health to discuss new approaches to enhance the health of women, children and families of all ages. The theme this year was "Creating a Healthy Future: What Would it Take?" The audience was comprised of primarily health care providers and community representatives interested in promoting maternal and child health, the pursuit of health equity, and the expansion of community engagement in addressing the social determinants of health. Approximately 350 people attended the summit. Governor John Carney, Lieutenant Governor Bethany Hall-Long, Department of Health and Social Services Cabinet Secretary Dr. Kara Odum-Walker, DPH Division Director, Dr. Karyl Rattay, Attorney General Matthew Denn, were among the lead dignitaries that spoke and shared their support of maternal and child health work. DPH and partners were grateful to have Kenn Harris, Vice President for Community Engagement, overseeing the Healthy Start program in New Haven, CT and all community engagement work participate as the Keynote Speaker. Mr. Harris inspired deep reflection and thoughtful consideration of our next steps as a state; to be better listeners, align with community partners including non-traditional partners, and to do a more thorough job of recognizing and addressing the social determinants of health including extreme poverty and all of its confounding

factors. Erika Clark Jones, Executive Director of Celebrate One in Columbus, OH was also a lead speaker and talked about the value of local government engagement in aligning multi-sector collaboratives to address social determinants of health. Finally, Dr. Kathryn Edin, co-author of $2 a Day: The Rise of Extreme Poverty in America, shared stories from individuals interviewed for the book demonstrating the magnitude, causes, and consequences of extreme poverty among families with children. This year's program left us feeling energized and excited for the future of Delaware. Our planning team was so excited in our post conference debriefing that we already started to brainstorming for next year's summit.

The Delaware Healthy Mother and Infant Consortium (DHMIC) embraced the focus and framework of a preconception health approach, to optimize the health of women before, between and beyond pregnancies. Among the top issues and priorities for interconception care approved last year, which was suggested by committee members include: Birth spacing; weight management; social determinants of health; chronic disease management; increased access to birth control and the most effective methods; nutrition and physical activity; smoking cessation; substance abuse; and stress management.

This year, Delaware launched an Optimal Birth Spacing campaign, which educates women and families on waiting at least 18 months from the time a baby is born to the time a woman gets pregnant again. Shortened interpregnancy interval occurs more often when pregnancies are unintended and in women less than 18 years of age at the time of conception. In Delaware, this is impacting not only our youth but also women from 18-34 years of age. Helping women plan and space their pregnancies is an important strategy to support healthy outcomes for mothers and babies. DHMIC partnered with Worldways Social Marketing to create a Birth Spacing Implementation Toolkit for providers. The toolkit includes a provider letter, implementation letter, reproductive life plan, brochure/poster, worksheet, and checklist flyer (in English and Spanish). Signed by the DPH director, the DHMIC chair, and the Perinatal Cooperative's medical director, the provider letter explains the research behind the birth spacing initiative and encourages the provider community to champion the statewide campaign. The implementation letter explains how to use the remaining materials with patients to spread the birth spacing message.

All toolkit items can be found by visiting http://dethrives.com/order-materials/browse. The reproductive life plan booklet and birth spacing worksheet are available for order and download under the website's "My Life, My Plan: Woman" section. The remaining items are available for order and download under the "Birth Spacing Materials" section. The Perinatal Education Coordinator is supporting implementation by providing on-site education. The research, reasoning, and roll-out instructions are presented via PowerPoint presentation to select provider groups working with women of reproductive age. On-site education started with the Healthy Women Healthy Babies provider locations statewide. Obstetricians, birthing hospitals, home visitors, substance use partners, and various community groups were also identified and received on-site education. A webinar of the presentation was developed this year and launched in early July and is available on dethrives.com for provider training.

This year, planning has begun to revisit the vision and framework of the Healthy Women Healthy Babies (HWHB) program, now in its 8th year of operations. DPH contracts with seven health providers to deliver the HWHB services at 20 locations across the state. The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial "bundles" of care for women at the highest risk of poor birth outcomes. DPH is working in collaboration with the DHMIC and several MCH partners to review a recent release of a comprehensive evaluation of the program and specific birth outcomes to help inform plans for improving program quality (2011-2015). Overall 11,844 unique women in the HWHB program from 2011 through 2015 were linked to Delaware Vital Statistics Data sets (linked birth mortality files and fetal death files). Birth outcomes were also compared to county-level outcomes reported in the Delaware Vital Statistics Report. The prevalence of very low birth weight and low birth weight babies born to African-American mothers were lower among patients of the HWHBs practices than for New Castle County or Sussex County. For most HWHBs

practices, the fetal death rate was also lower, although infant mortality was not. Overall, results for the program were more mixed – not as clear as the results were for African-American participants.

To compliment the work of the Healthy Women Healthy Babies program as well as strategic initiatives of the DHMIC, Delaware leveraged funding this year through one of four cooperative agreements awarded by the U.S. Department of Health and Human Services' Health Resources and Services Administration Maternal and Child Health Bureau (HRSA MCHB) to a national coalition supported by UNC Center for Maternal & Infant Health (UNC CMIH) and the National Preconception Health and Health Care Initiative (PCHHC). Funding is administered through UNC School of Social Work. DE is one of four states participating in this CoIIN grant (i.e. OK, NC, CA, DE). This Preconception CoIIN will develop, implement, and disseminate a woman-centered, clinician-engaged, community-involved approach to the well woman visit to improve the preconception health status of women of reproductive age, particularly low-income women and women of color.

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. This year, DPH formed a small workgroup with the Delaware Division of Medicaid and Medical Assistance to explore Medicaid reimbursement for evidence based home visiting programs. To date, we have learned that there are a variety of approaches and mechanisms for reimbursement through Medicaid. We are fortunate that we will be able to leverage a technical assistance opportunity through the Heising Simmons Foundation on this issue, which is one of several home visiting policy and advocacy projects funded through this foundation.

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, and also serves as a compliment to home visiting services. This past year, new contracts were negotiated for delivering Health Ambassador Services, in response to an RFP released in June 2017. 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 31, soon to be 32 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. School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public school setting. A bill was passed in 2016 to stagger the implementation of the three additional SBHCs in the remaining public high schools over FY17, FY18, and FY19, provided that funding is appropriated to support implementation. 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 (27/32 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). Three different school district school board's voted and approved to add Nexplanon as a birth control method in 2017, which were implemented this Fall/Spring and offered at the school based health center sites (for a total of 7 sites). This is a major accomplishment being that each school district's elected school board members vote on and approve what services can be offered at each SBHC site.

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

Launched in 2016, Delaware Contraception Access Now (DE CAN) (www.upstream.org/delawarecan/) improves access for all women to the full range of contraceptive methods, including the most effective, IUDs and implants. This initiative furthers the Division of Public Health's priority to sustain providing low cost access of long acting reversible contraceptives (LARCS) to low income women across the state, including customized, CME/CEU-accredited, on-site technical assistance and training by Upstream USA, so that providers can offer the best contraceptive care to their clients. Upstream USA's training is based on a "Team Approach" that includes everyone from front line staff, financial staff and clinical staff. They bring in the latest teaching tools and learning technology including the Virta Med Pelvic Simulator, e-learning, the CDC medical eligibility criteria application and the full functionality of bedsider.org.

Improving birth outcomes is both a public health and a budgetary priority for Medicaid. The Division of Public Health's team, along with Upstream, USA worked closely with Medicaid and several MCH stakeholders to ensure that there are no policy barriers to all women getting same-day access to all methods of birth control, at low or no cost. The Delaware Division of Medicaid and Medical Assistance (DMMA) revised its reimbursement policy for hospitals providing labor and delivery services, so that they can offer their patients placement of IUDs and implants immediately post-delivery if patients request them. This change in policy promotes optimal birth spacing and increases access to this birth control method. Currently the largest hospital system in the state, Christiana Health Care Systems IPP LARCs, as well as Nanticoke Health Systems and Bayhealth Medical Centers. Beebe Medical Center is currently in training and will be implementing these services later this year. Upstream, USA and Division of Public Health continue to work with hospitals statewide on training and implementing these new processes and procedures. Furthermore, Delaware's Division of Medicaid and Medical Assistance also implemented a reimbursement policy change approved by the Centers for Medicare and Medicaid Services (CMS) allowing the cost of long acting reversible contraception (LARC) to be carved out of the federally qualified health center (FQHC) prospective payment system (PPS) rate.

In March 2018, the Pregnancy Intention Screening Questions (PISQ) an important door opener to discuss preconception health with a woman's health provider was implemented into the Division of Public Health's Electronic Medical Records System. This was no small feat, especially for a state agency such as DPH, as other DE CAN providers have been struggling with enhancing their EMRs to add a PISQ in their system. DPH Family Health Systems considers this a huge win! This question encourages providers to ask women of childbearing age "Would you like to become pregnant in the next year?" Women who answer "yes" receive counseling and screening to ensure optimal health in preparation for a pregnancy. Women who answer "no" or "not sure" have meaningful conversations covering all options for contraception and family planning, to ensure that each woman makes an

optimal decision based on her individual circumstances. The Pregnancy Intension Screening Question has the potential to reduce disparities in care and outcomes, especially for groups with higher rates of unintended pregnancy and adverse birth outcomes.

A consumer-facing public awareness campaign for Delaware CAN, BeYourOwnBaby.com, was launched in May 2017, and the digital/google analytics data is impressive, as the campaign aims to increase awareness of contraceptive options and where low or no cost contraception can be obtained. The campaign is aimed at 18–29 year olds, and the centerpiece is a funny, empowering and celebratory online video, an “anti-PSA” PSA about choosing yourself first. It features diverse women in colorful, fun settings and scenarios. The creative messaging is based on empowerment and focused on “free” in all meanings of the word – free in cost, free to be yourself, free to choose what’s best for you. The video doesn’t focus on any one method of birth control. It includes a wide range of methods. The campaign is predominantly digital, and advertises across Google Search, digital display advertising networks, Facebook, Instagram, Pandora, YouTube, and Gmail. Upstream USA has been closely monitoring the efficacy of the digital marketing tactics, and has made adjustments based on which tactics are most successfully motivating women to seek birth control. The campaign directs consumers to a website where they can watch the feature-length video, learn more about birth control options, book a birth control appointment, and even schedule free transportation to and from health centers. Consumers are able to enter their zip code and insurance status to yield locations that fit their needs.

The campaign focuses on empowering and positive messaging to bring consumers from awareness to action. After the visit, a patient is given a rebate card, and they can collect the rebate by using the interactive website or mail-in option. There are a number of women who requested the rebate card to cover out of pocket expenses for birth control. Upstream USA, leading the DE CAN implementation, pursued a partnership with Walmart/Walgreens whereby a birth control code is entered and the patient cost is paid by Upstream USA. As part of the campaign, multiple transportation options were put into place, including Uber, Lyft, bus, or taxi and the cost to or from the woman’s birth control visit is reimbursed. Early evidence of the campaign efforts show that the campaign is inspiring women of reproductive age to seek out reproductive health services at participating DE CAN provider sites, and there is early evidence that it is also helping improve access to family planning services. It was recently announced that the campaign will be funded through September 30, 2018 and after that date Upstream, USA will be slowly transitioning several aspects of DE CAN out of the state (i.e. State of Washington and Massachusetts).

The early evidence of Delaware CAN’s outcomes among Delaware healthcare providers is very promising, as Child Trends released a research brief estimating that following Upstream’s partnership with the state of Delaware, there was an estimated decrease of 15 percent in unplanned pregnancies among Title X patients in the state from 2014-2016, compared to 1.3% nationally in just two years (Berman et al., 2018). Delaware CAN includes health centers that serve nearly 80% of women of reproductive age in the state. Nearly 2,000 women in Delaware have taken advantage of the "All Methods Free" program. Finally, 112 trainings, 41 partners representing 182 sites, 2465 clinicians and support staff have been trained as of this writing by Upstream USA. The 41 partners serve nearly 125,000 women of Delaware’s approximately 190,000 women of reproductive age. To assess DE CAN’s long-term impact, the University of Maryland in partnership with the University of Delaware, is conducting a rigorous and independent evaluation of the intervention. The evaluation includes both a process and impact study and assesses outcomes such as contraceptive use, LARC utilization, Medicaid costs, and unplanned pregnancies resulting in unplanned births.

Oral Health for Pregnant Moms – Annual Report

At the onset of this grant cycle, we set specific objectives for this health priority and we sought to increase the

percentage of women who have a dental visit during pregnancy from a reported rate of 40.5% to 43%. We have achieved our goal of increasing the rate to 43%, but we intend to continue our efforts so that we move closer to achieving the national average of 53%. According to PRAMS, the percentage of Delaware women who reported visiting a dentist or dental clinic during their most recent pregnancy rose between 2007 (36.0%) and 2015 (44.4%). While this information shows a positive trend for women in Delaware, we continue to lag behind the national average of 53% in 2015.

Delaware's Oral health national priority work focuses on not only national data, but also feedback gained from local professional development trainings. According to findings from our 2018 Stakeholder Survey, there is a high desire to address this health priority, but partners feel there is little progress being made thanks, in part, to inadequate resources. The respondents believe there are evidence-based strategies available to help move the needle in this area, but not enough "boots on the ground" to make it happen. The findings actually tell us that the oral health for pregnant woman and oral health for children is our weakest area of success and respondents advised us to stay the course with seeking to improve oral health rates for both of these domains.

The comments and suggestions from the survey overwhelmingly point out that Medicaid coverage for adults over the age of 21 remains the single biggest barrier to pregnant women getting an oral health checkup during pregnancy. While Medicaid coverage for adult oral health preventive services are making advances, coverage for emergencies and restorative care remain non-existent.

Our CDC Epidemiologist has prepared a data brief that focuses on Oral Health in Mothers and Children (See Appendix D). The data brief provides select indicators on oral health among pregnant women from Pregnancy Risk Assessment Monitoring Survey (PRAMS) data from 2012-2015. Our Healthy Women, Healthy Babies program provides support dental services for Healthy Women, Healthy Babies patients through two Federally Qualified Health Centers FQHCs (including one in Sussex County) to help promote access to oral health. Poor oral health has been identified as a risk factor for poor birth outcomes yet dental care is not readily available, especially in Southern Delaware. In collaboration with the FQHCs and the DPH's Bureau of Oral Health and Dental Services Program, more women of childbearing age will have access to dental care. We are happy to report that our sister agency, Delaware Medicaid and Medicare Assistance (DMMA) recently negotiated with one of their Managed Care Organizations (MCO) to include Medicaid coverage for adults over the age of 21 for one preventive oral health visit and one set of laboratory dental x-rays per year. This is exciting new progress for Medicaid and MCH will continue to work with DMMA to expand coverage in the future for problem and urgent dental care coverage. We anticipate that the expansion of coverage for preventive oral health care will show trending successes in the coming years.

Women/Maternal Health - Application Year

Well-Woman Care – Plan for the Coming Year

In May 2005, the IMTF issued a report that included 20 recommendations to reduce the number of Delaware babies who die before their first birthday (rate of infant mortality) and to eliminate the racial disparity in the rate at which these babies die. The infant mortality rate is generally regarded as proxy for the overall health of a community. The infant mortality rate (IMR) for black babies is consistently 2.5 times that of white babies in Delaware. Maternal age, chronic illness (asthma, hypertension, diabetes), nutrition, infection (STI, HIV), stress, unwanted pregnancy, smoking, and other drug use and lack of prenatal care are all factors that increase the risk of adverse pregnancy outcomes and maternal complications. Therefore, as a result of the IMTF in Delaware and the research that they put into their report, along with their 20 recommendations, one of their recommendations was to create the Delaware Healthy Mother Infant Consortium, a governor appointed consortium comprised of 15 citizens in Delaware who would oversee the IMTF recommendations. In turn, the DHMIC established the Healthy Women Healthy Babies (HWHBs) program in July 2009. A significant amount of state funds, approximately $4.2M, is invested in several infant mortality reduction initiatives. DPH is pleased to report that budget cuts to Infant Mortality funding in FY18 were partly restored in FY19 year (as of July 1, 2018). As a result of the restored funding cuts and prevailing wisdom and commitment to improving maternal and infant health, there are some promising new initiatives and enhancements to existing ones that address the social determinants of health that DPH is working on in the coming year along with our DHMIC partners and maternal and child health stakeholders.

For long, the fundamental principal and focus in public health circles around the nation was that early entry into prenatal care was the panacea for infant mortality. Twelve years ago, a careful examination of the factors behind the inordinately high infant mortality rate in the state revealed that the major driver was maternal health in the preconception period. The DPH consequently put together an intervention focused on improving preconception health of the women at the highest risk of poor birth outcomes. The Delaware Healthy Women, Healthy Babies (HWHBs) program aims to reduce the occurrence of adverse birth outcomes, infant mortality and low birth weight babies by providing support and services to high risk women during preconception and prenatal care for women who are at risk for poor outcomes.   The goal is to provide assistive services to encourage the woman to maintain a healthy weight, nutritious diet, receive appropriate amounts of folic acid, manage chronic disease, address environmental risk factors such as smoking, substance abuse or other stress-inducing circumstances, as well as the development of a personalized reproductive life plan (for all women and men). The DPH HWHB program reimburses providers on 4 bundled service options (Bundle A- Preconception Care; Bundle B -Psychosocial Care - Mental health screening, diagnosis and treatment, social work services and support; Bundle C- Enhanced Prenatal Care, and Bundle D Nutrition Care – healthy weight and physical activity). The HWHB bundles align with current best and recommended practice as outlined by the AAP (American Academy of Pediatrics), ACOG (American Congress of Obstetricians and Gynecologists), CDC (Center for Disease Control) and USPSTF (United States Preventive Services Task Force). The HWHB program has been nationally recognized by the National Association of Maternal and Child Health Programs for providing evidence-based preventive services beyond the scope of routine prenatal care.

Leading up to its 8th year of program operations, a series of HWHBs evaluations have been completed, prompting the DPH and DHMIC members and stakeholders to take another look at the vision and framework for the program, consider quality improvements to the program based on evidence and promising practices and with public input, initiate a ***HWHB 2.0.*** The HWHB program is housed under the Division of Public Health, and will be working over the next several months to design, plan, and execute a day-long Forum (TBD: “Innovation for Impact” on 10/24/18) of stakeholders who will brainstorm emerging and innovative medical model strategies to improve preconception, prenatal, and birth outcomes of Delaware women, particularly those at increased risk. The Forum is intended to be

both informative and participative thus gaining insights and ideas that may shape the future direction of the State funded, contracted provider Healthy Women Healthy Babies program. DPH is working on following through with some identified leads of potential public and private sector, Delaware, regional, and out of state speakers. To date, the draft agenda for a 9am-2pm forum on October 24, 2018, is inclusive of lunch and breakout sessions, and plans to address the following minimum core topics; Value/Performance Based Contracting, Metrics & Measurements, Social Determinants of Health, Role of Community Health Workers/Case Managers, and Innovation. Furthermore, as MCH leaders, we recognize the importance of identifying a champion (s) or "Ambassador" role to support the evolution of the HWHB program at, and subsequent to, the Forum. Therefore, both the Director of the Delaware Division of Public Health, Dr. Karyl Rattay, and the Medical Director for the Division of Medicaid and Medical Assistance, Dr. Elizabeth Brown, will serve as Ambassadors to support this transformative effort. This partnership between these two sister agencies, one of several over the last year, is truly a reflection of the Title V MCH and Title XIX MOU and embodies its purpose.

The HWHB Program was developed using a lifecourse framework to explain health and disease patterns, particularly health disparities, across populations and over time. Health is interconnected or a series of inter-dependent stages over the course of one's life. The lifecourse framework recognizes the interaction of behavioral, biological, environmental, psychological and social factors that contribute to the health and well-being throughout an individual's life. The available research is clear that the path to more significant and sustained improvement in the statewide maternal and infant mortality rate and in eliminating the persistent racial disparity lies in addressing the social determinants of health -the social context factors that compromise the health of families which then makes them susceptible poor outcomes. Over the next year, DPH in collaboration with DHMIC partners plan to compliment the changes to the Healthy Women Healthy Babies program, a medical intervention, by developing a focused strategy via a Request for Proposal (RFP) process to implement community based interventions that address some of the underlying environmental, economic and social structures that impact resources needed for health, such as poverty, lack of stable housing, access to healthy foods, access to early childhood education, medical legal partnership, financial literacy, etc.

The 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 response to the opioid epidemic, a large part of the last two years has involved monitoring the increases of Neonatal Abstinence Syndrome (NAS) voluntarily reported by hospitals. The Cooperative also implemented a standard definition of NAS in September 2016 so that all hospitals were identifying babies that met this criteria. In addition, Dr. Khaleel S. Hussaini, Delaware's CDC Maternal and Child Health epidemiologist is beginning to compile and present data related to Perinatal Quality Indicators (PQI's) using birth certificate data, looking at Delaware resident births by hospital. The data hopes to explore opportunities and examine the challenges for monitoring, preventing, and reducing complications during pregnancy, improve care and improve accuracy and timeliness of birth certificate data; and provide individual hospital reports on select PQI's. Other states use this data to drive public health initiatives and Delaware is excited to be on this data driven path as well. Perinatal Cooperative grant. In September of 2017, Delaware successfully leveraged a CDC Perinatal Cooperative grant. The grant is little more than half way through first year. In April a quarterly report was submitted which was the reapplication for continuing the grant. As a condition of the grant, the Perinatal Cooperative identified OB Hemorrhage Protocol as their priority quality improvement project. Delaware reports 20 OB Hemorrhages in the state; to decrease that number by 25%, which may be aggressive and quite challenging. A physician champion who is a member of the Perinatal Cooperative reached out to the six birthing hospitals in Delaware to inquire about their protocols for maternal hemorrhage. Of the six, only four institutions responded and one of those four admitted to having no protocols. Six questions were asked:

1. What hemorrhage risk assessment tool do you use and when is it used?
2. Do you have a hemorrhage cart/ bag and what is in it?

3. Do you have formal postpartum hemorrhage protocol, guideline?
4. How do you escalate a hemorrhage within the institution?
5. Is there blood bank policy for postpartum hemorrhage, separate from the above protocols, or are they are part of one of the protocols.
6. Do you have an early warning alert system and what is it?

Responses to these questions were provided by physicians. OB hemorrhaging is a national problem due to the increase in occurrences in this country, and in Delaware, in part due to previous c-sections, advanced maternal age, co-morbid conditions, multiple gestations, diabetes and hypertension. There is vacant full-time Masters Prepared Nurse position that is being recruited to support the program who will go to birthing institutions and coordinate to get the necessary data from the birthing facilities. A data system will also be developed and the data needs will be inputted into the system so that it can be extracted for reporting purposes.

Preconception peer educators will 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.

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. A set of community provider guidelines for Delaware's reproductive life plans have been completed and assembled into a toolkit 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. In the coming year, DPH plans to work with partners to update content on male health and father engagement on DEThrives.com, targeting males between 19 and 28 years of age. 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 small workgroup will be assembled as a subset of the DHMIC's Education and Prevention Committee to tackle the content updates and other male health initiatives. Furthermore, the DHMIC Annual MCH Summit planning committee has selected male preconception health and father engagement as a key topic for the 2019 (14th) DHMIC Annual Summit.

Preconception CoIIN. DE was selected as a state CoIIN team for the National Preconception Health and Health Care Initiative's application for the Collaborative Improvement and Innovation Network on Infant Mortality (IM CoIIN) HRSA-17-105 funding opportunity. DE, along with CA, OK, and NC are working with the University of North Carolina, Chapel Hill, Center for Maternal & Infant Health, the parent agency of the grant. DE is working with two Healthy Women Healthy Babies providers, Westside Family Health Care and Christiana Health Care and a State team has been asked to support and guide the work. National technical assistance webinars on several preconception topics are also available to our state team partners.

Over the next year, we will work on incorporating preconception health education into the clinic based setting. This is

an excellent opportunity to align with the efforts to transform the HWHBs 2.0 program. Milestones by the end of September include finalizing feedback from an iterative survey of the clinic provider sites and gathering information on different clinic based settings, implementing preconception health education in practice based setting, development of education materials and social marketing messaging via DEThrives Facebook, Twitter, and blogs for patients, practice workflow, and prioritizing preconception screening of patients and identify what tools can be incorporated. By the end of September, we plan to narrow down and define the scope of the CQI projects for each site.

Simultaneously, we are also planning 3-4 Consumer engagement events that will engage women of reproductive age, holding one in each county across the state. The "Chat n Chew" events will be engaging, inviting and recruiting women of reproductive age to gather information on the knowledge, behavior, and attitudes on preconception health for the purpose of identifying any gaps in information for resources. This will help inform the clinic based education and CQI activities. We are looking at holding the consumer engagement events in high risk zip code areas identified through our Delaware Maternal Infant and Early Childhood Home Visiting grant Needs Assessment.

DE CAN Sustainability. DE CAN has paved the way for improving access to all methods of contraception, including LARCs. The statewide initiative has improved clinical counseling techniques based on best practices, increased same day access to birth control, increased number of patients screened for pregnancy intention, improved training of staff and clinicians, and increased patient awareness of family planning services. 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 CAN is in the third year of the statewide initiative, and both DPH and Upstream USA are working on sustainability plans to slowly transition key components of the initiative to DPH, and allow for Upstream USA to transition out of the state to replicate the initiative to other states (i.e. State of Washington and Massachusetts).

DPH developed a sustainability proposal to leverage FY19 State General Funds to support the sustainability and ongoing programmatic costs of Delaware Contraceptive Access Now (DE CAN). DPH envisions that in-kind support will continue through DPH and DMMA, a contractual MCH Epidemiologist (.15 FTE) as well as the State Pharmacy as a mechanism to track, store and distribute LARC devices to participating Title X network providers to support the ongoing sustainability, infrastructure and ongoing operational costs. In addition, DPH requires two (2) new state funded full-time FTEs to sustain limited program operations. At a minimum, the proposal ensures that health care providers (through the Title X network) who serve low-income uninsured women, are equipped to provide the most effective long acting reversible contraceptive methods. Furthermore, DPH plans to sustain limited training and technical assistance as designed by Upstream, in consultation with the Delaware Divisions of Public Health, to support the 39 community health centers[1] through attrition and staff turnover who serve the majority of low-income women. As of this writing, DPH is waiting to learn whether the budget proposal was approved by the General Assembly for FY19. These funds will ensure that a system is in place to sustain access to the most effective methods of contraception, LARCs (IUDs and implants), to Delaware's uninsured and under-insured women of reproductive age.

In 2018, Upstream is focused on achieving DE CAN goals and objectives through data driven quality improvement activities and sustainability at each DE CAN partner site. The actual "end date" will be determined when DE CAN partners:

- Have achieved their goals related to this project
- Have the tools and resources needed to ensure continued success

- Have the appropriate systems, workflows, policies, procedures in place

The five main components of Upstream's sustainability package include:

1. **Sustainability Readiness** – a robust assessment that Upstream will use to ensure sites are ready to move to "maintenance mode". The assessment addresses issues related to: Billing/Coding, training and precepting plans, stocking supplies, policies/procedures, documentation, Pregnancy Intention Screening Question integration and mechanisms for quality improvement.
2. **Partner Resources**: an invite-only website with dozens of resources including training videos, guides, competency checklists, protocols/procedures, EMR templates etc.
3. **Train-the-Trainer:** customized technical assistance to equip trainers to utilize available resources and ensure new staff are trained on contraceptive care.
4. **eLearning**: Upstream will offer two eLearning courses including Contraceptive Counseling and Care and Billing and Coding for Contraceptive Care
5. **Communications**: regular e-mail newsletter with up to date issues related to contraceptive care e.g. updates on billing/coding, updates related to changes in medical guidelines, training and QI tips, etc.

The DE CAN/LARCs Advisory Committee that has been established under the auspices of the Delaware Health Mother and Infant Consortium will continue to meet on a quarterly basis and will serve 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, reviewing and disseminating research and data that will support the DE CAN initiative, and sustainability plans.

Delaware has worked hard and will continue 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 training and technical assistance continues, but is winding down through the end of 2018 to all publicly funded healthcare providers 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. Delaware took the matter into its own hands and passed a bill (Senate Bill 151) to continue the protections under ACA. Access to birth control provides health benefits for women and children, improves women's ability to control IF and WHEN they have a child, and fosters women's ability to participate in education and the workforce. However, the cost of birth control, particularly the higher up-front costs of the more effective, longer-acting birth control methods, is often a barrier to women accessing the birth control they need. This bill codifies the current federal requirement that health insurance plans include coverage for contraceptives and applies this requirement to individual, group, State employee, and public assistance plans. Furthermore, the bill retains the current ability for religious employers to exclude coverage for the insertion and removal and medically necessary examination associated with the use of FDA-approved drugs or devices. The bill is now waiting to be signed by Delaware Governor John Carney.

Medicaid also implemented a policy that excludes Long Acting Reversible Contraceptives (LARCs) from the Federally Qualified Health Centers (FQHC) encounter rate. The DMMA, and the Managed Care Organizations that currently participate in the Diamond State Health Plan programs, currently reimburse the FQHC at an 'Encounter' rate. The encounter rate is fully inclusive of all services provided at the clinic. DMMA has modified the State Plan to exclude LARCs from the encounter rate. LARCs are defined as either being intra-uterine devises or hormonal implants.

Oral Health for Pregnant Women – Plan for the Coming Year

Our Healthy Women, Healthy Babies support of oral health for pregnant mothers will continue as we work toward the next reporting year. A multi-partner collaboration effort will be presented to prenatal mothers in Sussex County in late July, 2018. “Dental Care Is Prenatal Care” will be presented to 15-20 prenatal mothers and will set out to provide women with the knowledge and skills necessary to achieve optimal oral health for themselves and their infants, and will understand the link between oral health and adverse pregnancy outcomes.

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.). We also hope to continue the expansion of our social media reach by working with our marketing partners as well as with the Bureau of Oral Health and Dental Services. In the past year, our Facebook posts have increased by nearly 350 posts and our YouTube videos viewership has shown a steady rise as well. We intend to continue to leverage these media outlets to help spread the word about the importance of an oral health checkup during pregnancy. Our DPH Dental Director is also working with our marketing company to produce a video on the importance of oral health treatment and the dangers of prescription pain medication post-surgery. Along those same lines, and in line with the re-engineering of our flagship website, dethrives.com, we intend to support our BOHDS partners in launching a marketing campaign that will drive visitors to the Healthy Smiles, Healthy You page. In 2017, this page saw a dramatic decline in website traffic and we would like to turn that trend around with a fresh new campaign.

We will work with BOHDS and our HMG 2-1-1 partners to create an Oral Health Dashboard as listed in our State Action Plan. Preliminary designs were started in 2017, however competing priorities with the on-boarding of the new Dental Director pushed this activity to the side for 2017. We will incorporate data compiled by our CDC Assignee to include his recent research and findings and work to establish a dashboard that reaches across MCH into Dental health in order to present a final product that shows that dental health is part of overall good health.

We will work with our DPH staff, contractors and community partners to create an awareness campaign to explain recent changes to the Medicaid MCO benefits around oral health care for adults ages 21 and over. It is important that our pregnant mothers over the age of 20 understand that AmeriHealth Caritas Delaware is the managed care organization under contract with Delaware Medicaid to provide one annual oral health exam and one set of oral health lab x-rays per year. By doing this, we hope to increase the number of pregnant women over the age of 20 who receive an oral health exam during pregnancy.

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[1] In CY2016, Title X had a total number of 39 provider sites, including SBHCs that provide reproductive health services.

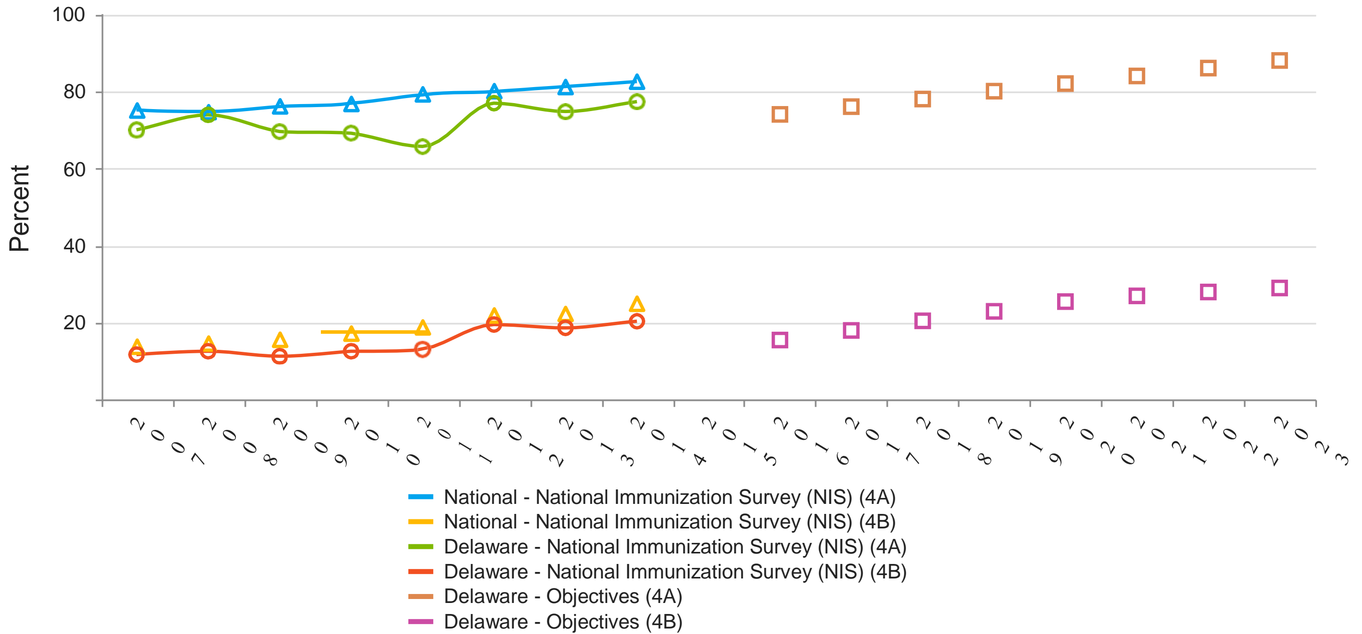
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	9.1	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.0	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	Not Reportable	NPM 4

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	74	76
Annual Indicator	74.6	77.2
Numerator	7,709	7,684
Denominator	10,340	9,953
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	15.5	18
Annual Indicator	18.9	20.5
Numerator	1,847	1,966
Denominator	9,794	9,570
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	20.5	23.0	25.5	27.0	28.0	29.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		65
Annual Indicator	58	63
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		100
Annual Indicator	98	0
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	130.0	150.0	170.0	190.0	200.0	200.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	4	5
Numerator		
Denominator		
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	9.0	11.0	12.0	12.0	12.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	17.2	60.3
Numerator		
Denominator		
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	61.0	65.0	65.0	68.0	70.0	72.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	5.0	6.0	6.0	6.0	6.0

State Performance Measures

SPM 2 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		67
Annual Indicator	67	66
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

State Action Plan Table

State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 1

Priority Need

Improve breastfeeding rates.

NPM

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

Objectives

By July 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	Status
ESM 4.1 - # of provider practices that receive EPIC BEST training	Inactive
ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials	Active
ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants	Active
ESM 4.4 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting	Active
ESM 4.5 - Increase the number of birthing facilities that receive baby friendly designation	Active

NOMs

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

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

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

State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 2

Priority Need

Improve breastfeeding rates.

SPM

SPM 2 - 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.

Perinatal/Infant Health - Annual Report

Infant Mortality – Annual Report

In 2011-2015, Delaware's infant mortality rate (IMR) was 7.7 infant deaths per 1,000 live births, resulting in a total decline of 17.2 percent from 2000-2004 rate of 9.3 infant deaths per 1,000 live births. At 5.9 infant deaths per 1,000 live births, the U.S. rate remained lower than the Delaware rate. Black infants experienced significantly higher mortality rates than white infants, but the gap is decreasing. In 2011-2015 the black IMR of 12.3 infant deaths per 1,000 live births was more than two times higher than the white IMR rate of 5.3 infant deaths per 1,000 live births, whereas in 1990-1994 the black IMR was three times higher than the white IMR.

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 mission of the Delaware Healthy Mother & Infant Consortium (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 2018 Annual Summit brings together community leaders, health care providers and elected officials to work together on bold, statewide health goals. Learn firsthand about the progress that is being made, the challenges yet to be overcome and to interact with national thought leaders and local action takers. See who wins the 2018 Dr. Kitty Esterley Community Health Champion Awards.

The full-day Annual Summit is an opportunity for partners to be a part of helping women, infants and families in Delaware to thrive. This year, our Summit welcomed 250 community and health professional participants to connect and collaborate. The Summit this past year aimed at engaging more unconventional partners with presentations focused on health in all policy and how community leaders can help address social determinants of health. Presentations for the 2018 Annual Summit included:

- Aligning for Impact: Saving Babies in Columbus, Ohio –Erika Clark Jones
- Looking Back, Leaping Forward: Recognition and Innovation-Kevin Harris
- Creating a Healthy Future: What Will It Take?-Dr. David Paul
- These presentations along with the others can be found at http://dethrives.com/dhmicsummit/program

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. Delaware's selected priorities included safe sleep, preconception/interconception care, and social determinants of health. Leah Woodall, who serves as the Maternal and Child Health Director, lead and coordinated specific Delaware IM CoIIN activities with the aim of addressing infant mortality and disparities in birth outcomes. Three learning networks were established in Delaware linked to the three selected priorities (Preconception/Interconception, Safe Sleep, Social Determinants of Health) to learn about evidence-based and promising practices (i.e. LARCs policy, practice change, and reimbursement strategies).

Our safe sleep campaign continued 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.

However, this past year we started to focus our safe sleep messages towards families struggling with substance use disorders. A video featuring women in recovery with their newborns discussing safe sleep was created and through this process a fifth message was developed. The fifth message is around having a safe person especially when you are prone to nodding off, for example when methadone dosage is still being regulated. 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. This program is being expanded to include agencies serving families with substance use disorders.

Our MIECHV program also focused on a Safe Sleep CQI project this past year as the reported performance data around safe sleep position, co-sleeping, and infant safe sleep was low. The local implementing agencies were encourage to report on knowledge and attitudes involving safe sleep behaviors among clients who were either prenatally enrolled or had an infant at or less than age 6 months. Data and qualitative feedback on safe sleep behaviors was reported on the enrollment forms for prenatally enrolled clients as well as the Age 1 month and age 3 month forms. Clients were tracked on these forms up to the age 6 months form.

The programs were instructed on how to monitor and assess progress on a timely basis using the data collected in their respective data systems. For example, for safe sleep, programs were shown how to track reported safe sleep practices at Age 1 Months, Age 3 Months, and Age 6 Months in order to ensure proper safe sleep practices were practiced at these time intervals, and if not, the reasons why these practices were not carried out and ideas to improve upon safe sleep practices.

Home visiting clients enrolled in our MIECHV programs have recently been informing our home visitors on what messages resonate on increasing breastfeeding rates and safe sleep practices. In particular, the home visiting clients who have initiated breastfeeding by Age 3 Months and/or safe sleep practices by Age 6 Months have been asked what supports assisted these clients to engage in these health-affirming practices. In addition, the clients who have not initiated breastfeeding by Age 3 Months and/or clients who have not engaged in safe sleep practices for their infant by Age 6 Months (these are typically clients who enroll in our home visiting programs postpartum) have also informed our home visitors on the reasons why they have not engaged in these practices and potential suggestions for how to improve upon these behaviors among other clients enrolled in these home visiting programs.

For more information on our work related to infant mortality, please see our annual report in the Well-Woman Care section. Activities completed this past year include new training materials on birth spacing. Comprehensive evaluation of our HWHB program.

Breastfeeding – Annual Report

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.

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. EPIC BEST concluded this year with a total of 63 primary care practices trained and 712 employees of those practices training. As far as the work with African American breastfeeding—in this third year of EPIC BEST we continued to target 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.

We continued to support our home visiting program to ensure that home visitors have the expertise and supplies they need to support women in breastfeeding. This included helping a core set of staff, spread geographically across the state, to earn and maintain the IBCLC credential. We offered the Milk Mob Outpatient Breastfeeding Champion training last year to further increase the expertise of service providers on breastfeeding. Over 40 people attended both days of training to become certified as Outpatient Breastfeeding Champions. Seven (7) IBCLCs attended the third day of training that will enable Delaware to have its own cadre of instructors. Plans are underway to offer the training again. The Milk Mob provides Outpatient Breastfeeding Champion training, which is conducted by International Board Certified Lactation Consultants (IBCLC). This program incorporates the highest level of scientific and evidence-based information to support lactation. This intense training provides clinical information at a higher level, which is more meaningful and appropriate for healthcare providers. It has been successfully utilized by other states and is an intervention recommended by the federally funded United States Breastfeeding Committee. State employed home visitors (such as DPH Smart Start), contracted home visitors (such as Children & Families First and PAT) and community primary care providers will be encouraged to attend the first two days of training. Instruction is provided on how to answer the most common breastfeeding questions that a

breastfeeding mother and her family have throughout the course of lactation, into toddlerhood and beyond. The instructors will also provide a course on the third day to enable Delaware to have its own cadre of instructors, thereby giving our state the capacity to extend the breastfeeding knowledge of our providers and home visitors. The trainers enlisted to attend the instruct-the-instructor will consist of Public Health employees, IBCLCs employed by partners, and IBCLCs that work with community physicians. One of our IBCLCs who will be participating in the Instruct-the-Instructor course has already planned a training for February 2018.

On Saturday June 2, 2018 the BCD and the Division of Public Health sponsored a statewide conference entitled: "Tethered Oral Tissues: A comprehensive common sense guide to the examination, assessment, diagnosis, laser treatment and post-surgical care of tethered oral tissues for the breastfeeding dyad". 49 professionals (including dentists, dental hygienists, pediatricians, IBCLCs, and nurses) attended.

Perinatal/Infant Health - 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 – Application Year

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. However, most of the work described below, can be found under the Well-Woman domain sections.

A primary program for addressing poor birth outcomes in our state is the Healthy Women Healthy Babies (HWHB) program. We are in the process of the reviewing the release of a comprehensive evaluation of the program and specific birth outcomes to help inform plans for improving program quality. A revamped version of this program (HWHB 2.0) is being considered and public forum will be conducted later this year by our Public Health Division Director, Dr. Rattay and Medicaid Medical Director, Dr. Brow,

DE was selected as a state CoIIN team for the National Preconception Health and Health Care Initiative's application for the Collaborative Improvement and Innovation Network on Infant Mortality (IM CoIIN) HRSA-17-105 funding opportunity. DE, along with CA, OK, and NC are working with the University of North Carolina, Chapel Hill, and Center for Maternal & Infant Health, the parent agency of the grant. DE is working with two Healthy Women Healthy Babies providers, Westside Family Health Care and Christiana Health Care and a State team has been asked to support and guide the work. National technical assistance webinars on several preconception topics are also available to our state team partners.

Over the next year, we will work on incorporating preconception health education into the clinic based setting. This is an excellent opportunity to align with the efforts to transform the HWHBs 2.0 program. Milestones by the end of September include finalizing feedback from an iterative survey of the clinic provider sites and gathering information on different clinic based settings, implementing preconception health education in practice based setting, development of education materials and social marketing messaging via DEThrives Facebook, Twitter, and blogs for patients, practice workflow, and prioritizing preconception screening of patients and identify what tools can be incorporated. By the end of September, we plan to narrow down and define the scope of the CQI projects for each site.

Social marketing efforts to expand the reach of our HWHB program will continue but our messaging for preconception wellbeing will continue to evaluated 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 will be considered for development to assist providers with discussing the importance of reproductive live planning with their patients. We plan to develop guidelines that include specific questions such as a pregnancy intention question as well as how to start the conversation around setting healthy lifestyle goals, using our MyLifeMy Plan or another vetted tool. Our MyLifeMyPlan booklet will be receiving a makeover as well and content is

currently being reviewed.

For more information on our work related to infant mortality, please see our plans for the coming year in the Well-Woman Care section. Plans include an upgrade of our current model for HWHB, referred to HWHB 2.0 which will may include value based payments and a RFP that will address social determinants of health.

Breastfeeding – Application Year

According to the 2017 Breastfeeding Report Card, 77.2 % of babies born in Delaware were “ever breastfed or fed breast milk”; lower than the national estimate of 82.5%. 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 20.5% of infants who are breastfed exclusively for 6 months; lower than the national average of 24.9%.

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

According to the Ripples Group findings in April 2018, WIC WOW Data System:

- Breastfeeding Initiation rates in the WIC population remains steady at 52%
- Duration at 3 months increased in all clinics, with an average of 32%
- Duration at 6 months averaged 23% in all counties
- Exclusivity rates increased in 2 counties with an average rate of 31%

The Delaware WIC Program continues to contract throughout the State with Bayhealth Foundation, Christiana Health Care Systems, The Latin American Community Center, St. Francis Hospital, Nemours Pediatrics, and Westside Family Health Care to take breastfeeding peer counseling services into the heart of the community. It is 88% more likely that a participant will be breastfeeding at 3 months duration when contacted by a peer counselor. Mothers contacted by a peer counselor is 59% more likely to be breastfeeding at 6 months. Exclusivity rates among WIC mothers that are contacted is 4% higher than mothers not contacted.

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. Our final hospital is also now starting to make some efforts towards Baby Friendly. The BCD is working with this facility to provide a “Baby Friendly” presentation to their board to work towards buy in from leadership.

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. One of our WIC Breastfeeding Coordinators is planning to attend the ROSE Conference (Reaching Our Sisters Everywhere) in Atlanta Georgia. We are hoping to obtain materials that can be useful in the Delaware WIC Program to decrease disparities in this at risk population.

This past year, with assistance from the Association of State and Territorial Health Officials (ASTHO) funding, the BCD has surveyed the Delaware lactation support community to establish a lactation support resource list as well as to determine where there were gaps in support. As a result of the survey, it was determined that Delaware lacks diversity within peer and professional breastfeeding support. Plans are now underway to create scholarships to a more racially and ethnically diverse candidate pool to help us broaden our reach within peer and professional support.

Additionally the BCD was able to use a contractor to survey the existing workplace support programs, and use these programs to create a plan for implementing a wide-scale workplace support program. Thus far we have developed a business “sell sheet” that summarizes the reasons that businesses should support breastfeeding in Delaware; a workplace support in Delaware presentation that outlines the laws and facts about businesses supporting breastfeeding in Delaware; a template letter for women to give to their employers when wanting to return to work while breastfeeding; a list of key stakeholders for workplace support outreach; and social medial messages for support outreach.

Delaware’s WIC office will be hosting their annual World Breastfeeding event in August 2018. Marie Biancuzzo, RN MS CCL IBCLC, Breastfeeding Outlook will be this years guest speaker. Marie Biancuzzo, Breastfeeding Outlook’s Director of Education, has more than 30 years’ experience as a clinical nurse specialist in all areas of maternal-child health. A recognized expert in childbearing and breastfeeding, Marie’s current work focuses on helping mothers and babies get the care they need—primarily by training health professionals in evidence-based practices.
Presentations throughout the day will include:

- The Myths and Facts on Breastfeeding
- Breastfeeding Awareness and Advocacy in Daycare Setting
- Communication of Hospital Policies
- Personal and Professional Development.

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).

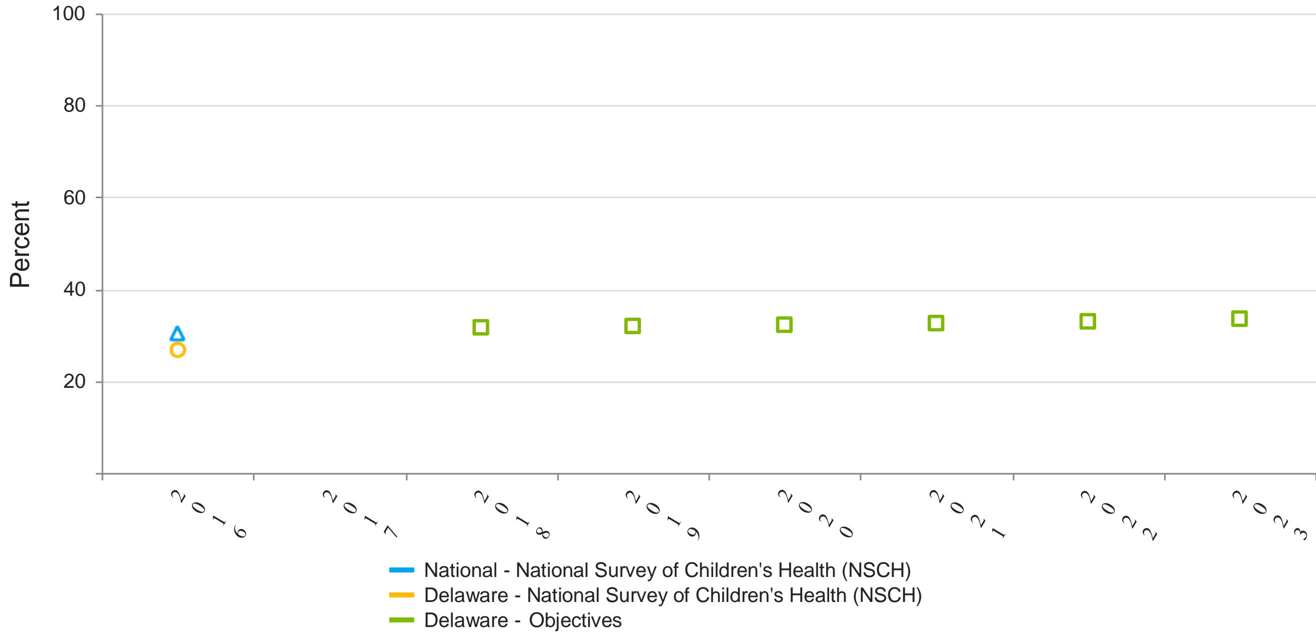
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	11.7 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	91.1 %	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	16.8 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	17.2 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	15.8 %	NPM 8.1

National Performance Measures

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



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		26.9
Numerator		5,997
Denominator		22,305
Data Source		NSCH
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	31.7	32.0	32.3	32.6	33.0	33.6

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - # of new practices to adopt PEDs

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		36
Annual Indicator	34	37
Numerator		
Denominator		
Data Source	DE AAP	DE APP
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	39.0	42.0	44.0	45.0	45.0	45.0

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

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		45
Annual Indicator	32	10
Numerator		
Denominator		
Data Source	HMG 2-1-1	HMG 2-1-1
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	65.0	85.0	105.0	125.0	145.0	150.0

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

Measure Status:	Active

State Provided Data		
	2016	**2017**
Annual Objective		15
Annual Indicator	15	100
Numerator		
Denominator		
Data Source	CDW program data	CDW program data
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

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

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		50
Annual Indicator	20	18
Numerator		
Denominator		
Data Source	HMG 2-1-1	HMG 2-1-1
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	100.0	125.0	150.0	200.0	200.0

ESM 6.5 - # of new partnerships/collaborations

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	10	10
Numerator		
Denominator		
Data Source	ECCS Program Data	ECCS Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

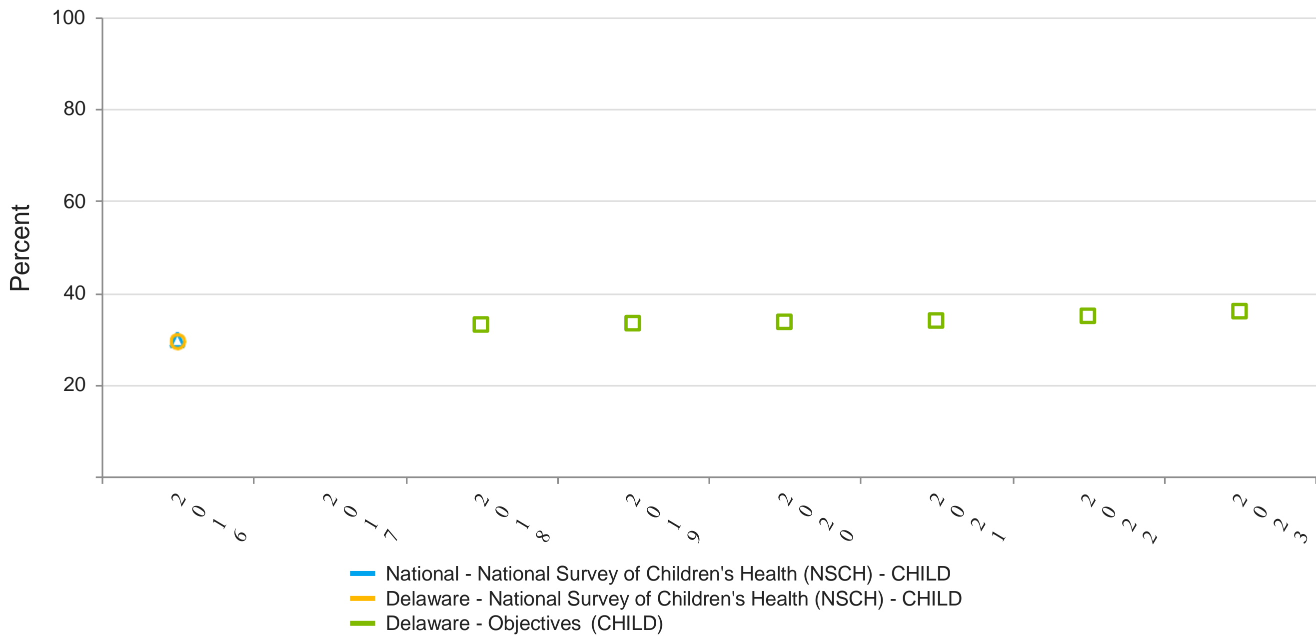
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	10.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		100
Annual Indicator	41	163
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	150.0	200.0	250.0	300.0	350.0	400.0



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		29.5
Numerator		17,762
Denominator		60,210
Data Source		NSCH-CHILD
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	33.1	33.4	33.7	34.0	35.0	36.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	0	20
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

ESM 8.1.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		1,000
Annual Indicator	877	1,000
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

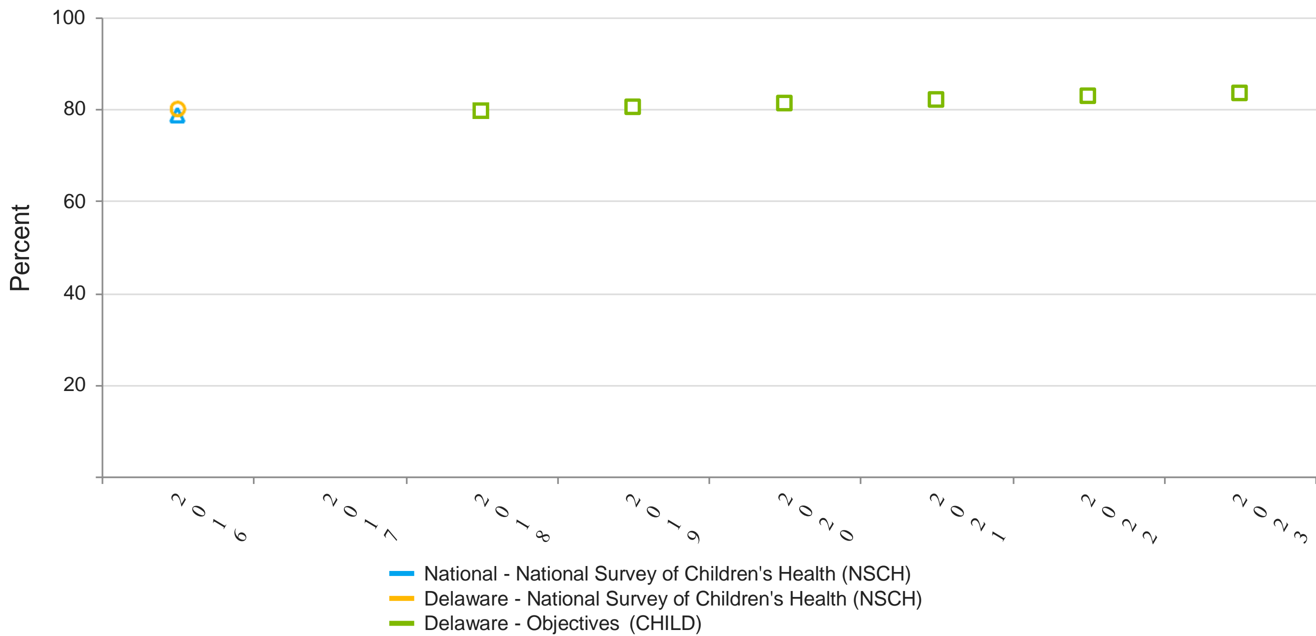
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0

ESM 8.1.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		12
Annual Indicator	12	12
Numerator		
Denominator		
Data Source	SHIP and Health Neighborhoods committee minutes	SHIP and Health Neighborhoods committee minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	12.0	12.0	12.0	12.0	0.0



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		79.9
Numerator		152,949
Denominator		191,522
Data Source		NSCH
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.6	80.4	81.2	82.0	82.8	83.4

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 13.2.2 - # of presentations completed for partners & community members

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	6	7
Numerator		
Denominator		
Data Source	BOHDS program data	BOHDS program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

ESM 13.2.3 - # of pediatric practices who are providing fluoride treatments

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	21	17
Numerator		
Denominator		
Data Source	Medicaid	Medicaid
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

By July 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	Status
ESM 6.1 - # of new practices to adopt PEDs	Active
ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices	Active
ESM 6.3 - The number of potential high risk screens referred to early intervention/Part C by pediatric practices	Active
ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center	Active
ESM 6.5 - # of new partnerships/collaborations	Active
ESM 6.6 - # of YouTube views of educational video on developmental screening	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

NPM

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

Objectives

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	Status
ESM 13.2.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data	Active
ESM 13.2.2 - # of presentations completed for partners & community members	Active
ESM 13.2.3 - # of pediatric practices who are providing fluoride treatments	Active

NOMs

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

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

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

Priority Need

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

NPM

NPM 8.1 - Percent of children, ages 6 through 11, 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	Status
ESM 8.1.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children	Active
ESM 8.1.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11	Active
ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed	Active
ESM 8.1.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating	Active

NOMs

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

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

Child Health - Annual Report

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 of these 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. The Title V priority focused on increasing oral health checkups for children ages 0-17 was also identified in our 2015 Needs Assessment efforts. Originally assigned to the Cross-Cutting Population Domain, our Oral Health for children has been moved to the Child Health Domain due to the change in population domains described in the latest version of the Block Grant Guidance. Similarly, our report for Oral Health for Pregnant Mothers has been moved to the Women's Health Domain.

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.

Developmental Screening – Annual Report:

The Early Childhood Comprehensive Systems Impact grant award has significantly changed the landscape and scope of developmental screening in our Maternal and Child Health Bureau. It has led to a more comprehensive approach in addressing developmental screening across the state. In addition to ensuring developmental promotion at the local level it has also integrated the efforts that had been established with the early child care and education arenas. Through efforts of the two placed based community teams (PBCs) in New Castle County and Sussex County there has been an increased focus in developmental health monitoring, screening and follow-up. Delaware's PBCs focused on improving the administration, tracking and referral of the Ages and Stages Questionnaire (ASQ) in the early child care and education sector.

Feedback from surveys conducted during the 2017 grant year indicated a number of child care centers within the PBC catchment areas lacked the training to administer, analyze and make referrals using the screening instrument. In October 2017, Walko Educational Services received a contract to support the training efforts of the PBCs within the child care centers. The original ASQ training format of (4 hours) was reformatted into two-part series of 2 hours each, to reduce the burden and time away from child care centers. The first part focused on how to administer the tool while the second part addressed the interpretation and referral process. Since this was a new and improved curriculum, approval for certification was also sought from the Delaware Institute for Educational Excellence. This approval was necessary to ensure child care centers participating in the Quality Rating and Improvement System (QRIS) under Delaware Stars program earned credits towards the Stars levels. More than 40 child care providers including some PBC community members have been trained so far. In order to be prepared for any occurrences due the anticipated uptake in the demand for screens, the Help Me Grow Call center staff also made sure they were trained to provide ASQ screens. Training was offered on using the ASQ-SE, versions 2 and 3, as well.

Delaware's ECCS teams increased their partnership with other state and non-profit partners this grant year. A partnership with the Division of Libraries will strengthen the partnership to promote developmental screening among library patrons through presentations such as the Books, Blocks and Balls activities. Parents of young children who visit the libraries will also be targeted for developmental screening opportunities while exposing them to presentations on the importance of developmental screening and tracking milestones. The partnership with state libraries also led to another collaboration with the Division of Social Services (DSS). We will take advantage of a separate partnership between the Division of Social Services and the Division of Libraries, which provides on-site social workers to provide assistance for library patrons to

receive services such as TANF or SNAP. In this collaboration, the DSS has agreed to work with ECCS Impact partners to ensure developmental screening services are offered to the library patrons who show up for social services. DSS staffers will ask whether or not parents with children birth to eight have had a developmental screen administered in the last 6 months. Parents who indicate no screens administered in the last 6 months will be invited to speak to an on-site ECCS PBC member for a screen. In the event an ECCS PBC team member is not available, the on-site social worker will ask the question and make a referral to Help Me Grow/2-1-1 call center, should the parent indicate a screen was not administered in the last six months.

As an activity the ECCS impact grantee teams focused on establishing a “Speakers Bureau” which included professionals from Child Development Watch (Part C IDEA), American Academy of Pediatrics; DPH/MCH, Help Me Grow/2-1-1; Child Find and child mental health providers as subject matter experts to provide ongoing training and technical assistance on a range of early childhood health and education topics to providers and parents/families. To date, nearly 10 requests have been made by programs across the state asking for presentations and education on brain science, developmental screening, parenting and fatherhood, among others.

We also collaborated with Delaware’s Learn the Signs Act Early Ambassador to promote developmental screening. The ECCS Impact team will collaborate with the Act Early Ambassador to determine how to customize Act Early promotional materials including coming up with a dissemination plan.

In the Southern part of the state, the PBC in Sussex County, Sussex County Health Coalition (SCHC) are also collaborating with Read Aloud Delaware to provide nine “Parent Empowerment” classes to reach residents in the catchment area. The program will cover “language and literacy”; “reading readiness” and “from scribbling to writing”. Measures will be identified to establish successful outcomes. They also collaborated with other public and private partners to sponsor the Sussex County Early Educator’s conference which brought together over 130 early educators. The keynote was delivered by author Eric Litwin, also known as Pete the Cat. The Sussex team continues to expand their engagement with the hospitals in their area to distribute ‘Mom Bags” for new moms, as well as addressing developmental screening in the discharge paperwork. As part of the evaluation for those who received the “Mom Bags” post cards will be sent to them to track the utility and effectiveness of the strategy. The eventual plan will be to scale it up and spread to the northern part of the state in New Castle County, where the majority of babies in the state are born.

The Sussex County PBC team has also been successful in partnering with the University of Delaware’s Cooperative Extension event on healthy eating which brings together families to learn how to cook healthy meals. The event will have a developmental screening component including a component where younger children up to age 8 are involved in interactive play.
Other accomplishments include using previous feedback from child care providers to establish a core group of parent champions who will be leaders in their communities and serve as advocates and mentors to other parents in their communities.

Delaware’s ECCS teams were also effective in developing promotional materials on developmental screening and milestones. Materials include a developmental screening brochure, milestone wheel and a pocket guide on screening in the state. These materials have been disseminated statewide at numerous events, and also made available on Delaware Thrives, the Family Health systems’ website for the public to order. Some of the materials are also available in Spanish.

Delaware’s ECCS Impact team have also been successful in creating processes for the delivery of screens in the health and early child care settings, including during outreach. For this period, the teams collectively developed and agreed on consent forms to be used in the child cares for ASQ screens, developed an ASQ referral matrix following the screening which is based on the process that exists in the health care settings; improved the pathway for getting referrals to either early intervention or Help Me Grow/2-1-1 including streamlining the workflow for referrals at physician practices. The ongoing

partnership with the Delaware Chapter of the American Academy of Pediatrics also led to the development of webinar series on developmental screening; community resources and the use of the PEDS online screening instrument. The webinar will provide continuous medical credits (CME) for physicians and nurses who decide to take the training.

Delaware's colonial PBC team has been very effective in engaging the school districts to transition from using the DIAL to the Ages and Stages Questionnaire the screening instrument used at the Kindergarten level. Though this effort may not specifically target the ECCS Impact grant target population of children birth to three, it prepares and encourages providers who cater to the birth to three population to consider using the ASQ tool for a smooth transition as those children in their care transition out to Kindergarten. The Colonial PBC team has been very effective in not only changing their school system to adopt the ASQ tool but has persuaded two other school districts who are currently piloting the tool. They have gone across the state and presented to groups such as Head Start programs; Part B Coordinators, school Superintendents and secretaries.

The advent of the ECCS Impact grant has led to an integrated approach between the healthcare and early child care and education settings in addressing efforts related to developmental screening and early intervention. For the upcoming year (FY19), the ECCS Impact grant will steer early childhood providers and health providers to focus on the following drivers to move the needle to achieving the aim for next fiscal year.

D1: Family partnership grounded in supportive, trusting relationships and mutual respect:

To promote family partnership that is supportive and based on trusting relationships, the ECCS team will increase the recruitment of parent champions to build their capacity and leadership to advocate for children in their communities. They will also be encouraged to organize parent-led groups which can be a resource to early childhood community and will ensure that decisions and activities are informed by parents.
The ECCS Impact teams and their place-based community teams will continue as done in previous years to increase outreach within the community. They will to organize events targeting parents to increase their knowledge about developmental screening through events such as health fairs, parent conferences, Kindergarten enrollment events, block parties, etc. At each of these events will be opportunities to disseminate promotional materials that will increase parent awareness

D2: Universal developmental promotion

Under this driver the ECCS Place-based community groups will work in their catchment areas to promote and increase awareness of early brain development and developmental milestones and screening among community groups. They will also work with the Learn the Signs Act Early Ambassador to disseminate educational materials and families.

Additionally, the teams will be working with the Division of Libraries to organize a Books, Balls and Blocks event to promote developmental screening and increase access to families who do not have access to developmental screens. The event will include interactive play stations where children can interact with books, balls or blocks. The activities will be designed to increase brain development. Parents who participate will be offered the opportunity to do a developmental screen.
The Mount Pleasant Place-based community group will also be partnering with programs that provide services to expectant mothers or families in their catchment area to provide education on brain development, parenting and developmental screening information. Entitled "Preparedness on Parenting" (POP), the event will target young families and will be modeled after a baby shower.

D4: Coordinated systems for Developmental promotion

Care Coordination is proposed as way to determine the best approach to ensure families who are screened are assisted from the time a screen is administered through to when family determines their needs have been met. To accomplish this the ECCS program will lead and organize a Care Coordination learning Collaborative to create a forum where stakeholders can meet to address issues and concerns on developmental screening. The learning collaborative will develop inter-agency solutions to common problems towards a streamlined early childhood system, through the sharing of ideas, learning from one another and identifying needs and gaps in service delivery to improve access for children and their families. Continuous Quality Improvement methods will be applied to improve those gaps in the system.

Healthy Lifestyles – Annual Report:

Childhood obesity rates remain high in Delaware, as in the nation. The 2017 Youth Risk Behavior Survey results for Delaware indicate that approximately 16.6% of youth are overweight, which represents an increase from the 2015 YRBS of 15.8%. When broken down by gender, both females and males saw an increase in percentages with 17.8% of females was considered overweight in 2017. This represents an increase from 2015 where 17.3% of females were overweight. Males saw increases as well with 15.4% in 2017 as compared to 14.4% in 2015. The most recent results from the Delaware Survey of Children's Health (DSCH) estimates that 36% of children ages 2-17 are overweight or obese. Nemours conducted the Delaware Survey of Children's Health (DSCH) in 2006, 2008, 2011, and most recently in 2014. The 2014 DSCH was conducted from July 2014 to May 2015 by telephone, including cell phones. The survey results can be found at https://www.nemours.org/about/policy/delawaresurveychildren.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 2016 National Survey of Children's Health, 29.8% of Delaware's children ages 6-11 engage in vigorous physical activity every day. For children ages 12-17, that number declines to 15.5%. According to the 2011/12 National Survey of Children's Health, 5.5% of children ages 6-11 and 13.9% of children engaged in vigorous physical activity, however in this survey, "vigorous activity" was defined as physical activity for at least 20 minutes that made them sweat and breathe hard. In the 2016 survey, vigorous activity included duration of 60 minutes and the question asked the number of children who exercised at least 60 per day for all seven days of the week therefore it is not possible to compare the two surveys for trend analysis. Going forward, our efforts will use the 2016 survey results as our baseline for measuring progress.

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 continues to collaborate, including advocating for the unique needs and concerns of children, including those with special health care needs, related to healthy eating and physical activity.

As stated in last year's plan for the coming year, a Public Health staff member was assigned to participate in the State Health Improvement Plan – Revision Committee. Delaware Public Health Institute convenes the SHIP Revision Committee, during which stakeholders will use findings from the State Health Needs Assessment to identify and prioritize strategic issues, and develop updated Public Health goals and strategies. Previously, the two goals of the SHIP included the promotion of healthy lifestyle behaviors (healthy eating and active living) and to increase access to mental/behavioral health services. We have continued our 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. The Revision Committee is in the final phase of their work and these

meetings ended in December, 2017. Final assessment reports will be generated and new priorities will be selected for the State Health Improvement Plan. MCH will remain tightly aligned to these priorities as in the past.

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, we were able to leverage a perfect opportunity to review the activities from the lens of physical activity and healthy eating.

Our DPH partner from the Health Promotions/Disease Prevention Bureau - Physical Activity, Nutrition, and Obesity (PANO) has been instrumental in supporting our MCH priority for increased physical activity for children ages 6-11. Utilizing our marketing resources and in partnership with the PANO Program, we have finalized the print version of our Health Eating & Physical Activity (HEPA) booklet and have been circulating booklet to our community partners. The HEPA booklet infuses movement into a reading activity, or use of healthy foods instead of candy in a color sorting activity. In addition we have incorporated 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. This year 1,000 HEPA booklets have been distributed to our community health educators and will be given out during the Delaware State Fair’s Annual “Kids Day” activities. Community partners can place their own orders for these booklets, free of charge, from the Materials page of dethrives.com and to date 1,600 HEPA booklets have been order through this channel. To support increased marketing messages for healthy eating and physical, we have increased our social media message posts from 48 in 2016-2017 to 65 in 2017-2018. Marketing efforts from the PANO group have also incorporated our messaging and have provided a consistency between both groups. In May, 2018 PANO distributed 5,500 Healthy Eating/Active Living materials (activity books, lunch boxes with messaging on it; bottled water with “5-2-1 Almost None” messaging) at the School Day Wilmington Blue Rocks baseball game. Additionally during National Nutrition Month in April, PANO visited three school districts and distributed the same materials to 1,500 K-5 graders.

In support of our Title V strategies and goals, the PANO program promoted events aimed at getting the children to increase their physical activity. In May, 2018 PANO participated in the North Dover Elementary Super Science Day to teach kids the importance of 60 minutes of physical activity every day by conducting an experiment on the outcomes engaging in just 10 minutes of moderate to vigorous physical activity on memory for academic achievement. Approximately 60 children engaged in this event. PANO participated in the grant submission of the 1807 by the DOE. Strategy objectives and outcomes align with increasing the number of children participating in 60 minutes of PA/PE per day.

We continued our work with PANO in its 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. As stated in last year’s block grant, we planned to collaborate with PANO to gain access to their “FitnessGram®” data. At the time of this application, that data has not been made available as teachers had until the end of the school year to finish collecting their data. Once collected it then had to be populated in a database

for analysis. PANO estimates that analysis will be completed this summer; therefore we will move this activity to our next grant reporting cycle. Related to the collection of this data, PANO conducted three professional development events focused on the presidential youth fitness program for Health & Physical Activity teachers of Delaware and four professional development presentations for FitnessGram® statewide to increase the capacity for teachers to implement nationally recommended standards in the school setting.

To recap statements made in our Needs Assessment update, the goal of increasing the number of students who get 60 minutes of physical activity each day is proving to be more challenging than expected. The on-going needs assessment for this priority was informed largely by the comments and suggestions from our stakeholder survey. These findings tell us that most students are getting a minimum amount of physical activity throughout their school age years, with most of the scheduled activity coming in the form of recess for children in elementary schools. As children progress to middle and high school, fewer requirements exist for schedule physical activity (outside of organized sports) as requirements for time spent preparing for statewide testing competes for students' and staff time. Our survey participants tell us that more resources are needed for parent awareness, school-based focus on physical activity and nutrition, and adaptive PE changes are sorely needed in our schools for children with special health care needs. We also heard that more energy is needed to focus on walkable parks and greens spaces that invite families to engage in outdoor activities.

Oral Health for Children – Annual Report:

MCH work centered on improved oral health outcomes for children relies heavily on our partnership with our sister DPH agency, the Bureau of Oral Health and Dental Services (BOHDS). Our Home Visitors and contracted Health Ambassadors are offered professional development training and service education throughout the year and take care in sharing that information with the families being served in Delaware. This includes training and education that encourage families to have their children seen by a dentist starting at age 1.

Based on information from 2015 Needs Assessment, DPH has chosen to address National Performance Measure 13.1 and 13.2 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. According to the latest National Survey of Children's Health, the percent of children ages 1-17 who received one or more preventive dental care visits increased from 77.2% in 2011/12 to 79.9% in 2016 which is slightly higher than the national average of 78.7%. Additionally, 22,000 children (11.7%) had tooth decay in Delaware in the past year.

Delaware's Oral health national priority work focuses on not only national data, but also feedback gained from local professional development trainings. Evaluations are given to participants and those are reviewed for enhancements and opportunities for improvement in the training curriculum. Over the last year, feedback on professional development trainings have offered us the opportunity to hear from childhood day care providers, school nurses, and organizations who work with our families with children with special health care needs.

Our stakeholder survey suggestions and comments show us that there is a need for additional marketing and education on the oral health care coverage for both children and pregnant mothers. Another pressing need as shown in the survey findings is the need for adult oral health care coverage from Medicaid. Currently, health care coverage for Medicaid recipients ends at age 21; therefore our expectant mothers who are older than age 21 are not covered by Medicaid for basic oral health services or urgent oral health care needs.

To address our community outreach and education efforts, MCH maintains strong ties to various committees and agencies that support overall children's health, including oral health. Our BOHDS staff and leadership participated in

the 2018 Safe Kids Conference where they were offering educational materials to attendees representing school nurses, nurses, and early childcare providers. Some attendees made inquiries for possible professional development trainings and the BOHDS team is working to schedule those trainings.

MCH also worked with BOHDS to cross-pollinate education opportunities by supporting an open panel discussion focused on families with children with special health care needs. The event was coordinated by Family SHADE, which receives funding from Title V, and included a four member panel representing oral health professionals, pediatricians, the education community – Delaware Technical Community College adjunct professor, and a family representative. The event was attended by partner organizations that support the children with special health care needs community and families. The message provided was centered around helping the community understand the roles of dentists, pediatricians, and educators along with advice and counseling from family representative organizations who offered insight to navigating insurance issues that families face when getting their children oral health care.

Our DPH Dental Director, Dr. Conte maintained his connection with the community partners in Sussex County by working with MCH and the Sussex County Health Coalition to provide educational presentations at two “Dollar Dinners”. These dinners an opportunity for families to enjoy a health family dinner for $1 per person and are held in varying locations in Sussex County. Events such as these attract families from many cultures and socio-economic status. Dr. Conte works hard to tailor his message to the audience and these dinners provide ample opportunity for him to educate the entire family unit, including grandparents (many of whom are caring for their grandchildren), on the importance of oral health.

MCH team continues our participation in the HRSA sponsored peer-to-peer community of learning to support states addressing Title V/Maternal and Child Health (MCH) state action plan national performance measure (NPM) 13—Dental Visit. This community of learning was leveraged by our team to participate in conference calls to discuss challenges, share resources and best practices, and learn about training opportunities that might help us reach our goals.

Our social media messaging efforts for the past year reflect varying results from the different sources. The number of hits on our Healthy Smiles, Healthy You webpage on dethrives.com has seen a dramatic drop in traffic. Hits for the July, 2017-May, 2018 were 434, compared to traffic during July, 2016-May 2017 which was 9,615. Partial explanation for this drop is that the Healthy Smiles, Healthy You webpage went live in the fall of 2016 and a major marketing campaign was done to kick off the webpage. The number of hits to the Bureau of Oral Health and Dental Service, Division of Public Health webpage was steady from previous years and stood at 5,530 for the same timeframe. Our video views from this webpage are up from zero to 45 for the same time periods as above. The number of views for videos and messages on Facebook that pertain to oral health for children and pregnant mothers is up to 345. The number of social media posts on Facebook was 20, which was up from the previous year by 20%.

To address the promotion the practice of early childhood medical practitioners providing oral health screenings, fluoride varnish application, anticipatory guidance, and dental referrals by age one, MCH supported BOHDS in their education and promotion efforts through marketing materials and broad dissemination of their newsletter to our community partners. While our Medicaid claims data illustrated a dramatic uptick in these services being provided in the FY17 annual reporting year, this year the data shows a decrease in the number of physicians who billed for fluoride varnish application has been reduced to 17. The drop from 29 in 2016 to 17 in 2017 is attributed to a number of individual pediatricians moving to the large health system networks of Nemours and Christiana Care Health Services and are billing under those entities. Nonetheless, we continue be encouraged that many of our pediatric providers are taking an active role in offering limited oral health services to children in Delaware.

Child Health - Application Year

Child Health Application Year
Developmental Screening – Plan for the Application Year:

Through the partnership with the ECCS Impact place-based communities, we will continue to foster family and community engagement to increase awareness and knowledge about developmental milestones and the importance of early detection.

We will leverage our partnerships with the Division of Libraries; Learn the Signs Act Early and Division of Social Services to reach out to their target populations. We will also continue to reach out to school districts to encourage them to transition from the DIAL screener to the ASQ screener for the kids 4 year and older.

We will continue streamline processes and measures for the two preferred screening instruments in the state – PEDS tool and Ages and States (ASQ) assessment tool. Delaware uses the ASQ in the early learning setting while the PEDS tool is used in the health care setting.

We plan to establish a Care Coordination Learning Collaborative based on the Connecticut Model to determine the best approach to ensure families who are screened are assisted from the time a screen is administered through to when family determines their needs have been met. This effort will convene stakeholders together to address issues and concerns on developmental screening and other early childhood concerns. The learning collaborative will develop inter-agency solutions to common problems towards a streamlined early childhood system, through the sharing of ideas, learning from one another and identifying needs and gaps in service delivery to improve access for children and their families. Continuous Quality Improvement methods will be applied to improve those gaps in the system.

We will also continue to increase promotion by targeting physician practices for Lunch and Learns while taking advantage of outreach opportunities within local areas to increase awareness.

Healthy Lifestyles – Plan for the Application Year:

In support of the State Health Improvement Needs Assessment, we will continue to provide a staff member to participate 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.

We plan to continue our work with our marketing resources to market and distribute our HEPA booklet to community partners. As our flagship website dethrives.com undergoes a redesign, we will work to expand our messaging about healthy eating and physical activity for children with and without special health care needs and their families. We plan to provide 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 will work to increase social media messaging by 10% in the coming year and will work closely with PANO to ensure our messaging for Healthy Lifestyles remain consistent with their marketing efforts. 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. We look forward to working with the Health Promotion Bureau in its evaluation of the first year of "FitnessGram®" data. Information gathered from this analysis will help to information our strategy for expanding our health lifestyles messaging.

PANO, in collaboration with the state's Land Grant University Cooperative Extension Programs, hosted a policy, systems and environment (PSE) professional training collaborative, "Systems Approaches to Healthy Communities." The curriculum was developed by the University of Minnesota's Cooperative Extension and consists of five on-line modules. Delaware's collaborative incorporated a Coaches Training which was a two-day, in-depth learning of the web-based professional development program that promotes the integration of policy, systems, and environmental (PSE) interventions with educational strategies, a review of the Coaches guide, and expectations & requirements for participation in Delaware's Learning Collaborative. Participant take-aways included:

- Basic terminology and examples of systems-thinking including the Social-Ecological Model, Spectrum of Prevention, and PSE concepts.
- Skills to expand their own programs across multiple levels to impact policies, systems, and environments.
- Strategies and tools for strengthening engagement, communicating with partners, and understanding community context.

Following the Coaches training, each participant was responsible for building a team within his/her organization that could develop and implement PSE strategies to be integrated and promoted within his/her own organizations and/or communities. Coaches and Team members are ideally decision makers, leadership team members, supervisors of health educators/nutrition assistants, those who are responsible for developing processes and procedure within an organization and might also be those who are responsible for providing technical assistance to smaller organizations or coalitions. The Preventive Health and Health Services Block Grant funding was used to purchase the curriculum for Delaware, and up to 200 people will be granted access for its use.

In keeping with this work being done by PANO, MCH will partner on this initiative to expand this program to add 2 new teams to participate in this training. We will work with our community partners who provide after school care services to children (school districts, early childcare centers, after-school programs) ages 6-11 to connect them to this training opportunity. The PSE teams will be made up of administrators, teachers, and/or decision makers at the program and policy level. PANO will conduct a 5-module training with each team, either through face-to-face or web-based training, and be presented in a way to satisfy the PSE requirement for Professional Development. PANO will provide technical assistance to work with each team to develop a PSE change strategy for enhancing or adopting Health Eating/Physical Activity standards. MCH will work with PANO to present this to the participating teams by creating Memorandums of Understanding (MOUs) in exchange for this no-cost professional development and technical assistance. The deliverable for the MOU will be for the team to present details and measure to show that they have implemented a strategy the supports 60 minutes of activity for children each day.

Oral Health for Children – Plan for the Application Year:

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 2022 goal, we will continue to focus on gathering this data from the latest version of the PRAMS survey. The latest version of the PRAMS survey included two questions focused directly on this data and was in circulation in 2016 however data results will not be available until the fall of 2018. 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 additional 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 stakeholder survey findings report 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. We feel the need for education and outreach to this community remains high and therefore our efforts to create new opportunities and education curriculum to address these needs is imperative. We plan to leverage our work in the Title V/Title XIX Cross-Agency Communication Committee to ensure that families with children with special health care needs are sufficiently represented on the services and programs offered by Medicaid and the Medicaid Managed Care Organizations.

Our stakeholder survey suggestions and comments show us that there is a need for additional marketing and education on the oral health care coverage for both children and pregnant mothers. Another pressing need as shown in the survey findings is the need for adult oral health care coverage from Medicaid. Currently, health care coverage for Medicaid recipients ends at age 21; therefore our expectant mothers who are older than age 21 are not covered by Medicaid for basic oral health services or urgent oral health care needs.

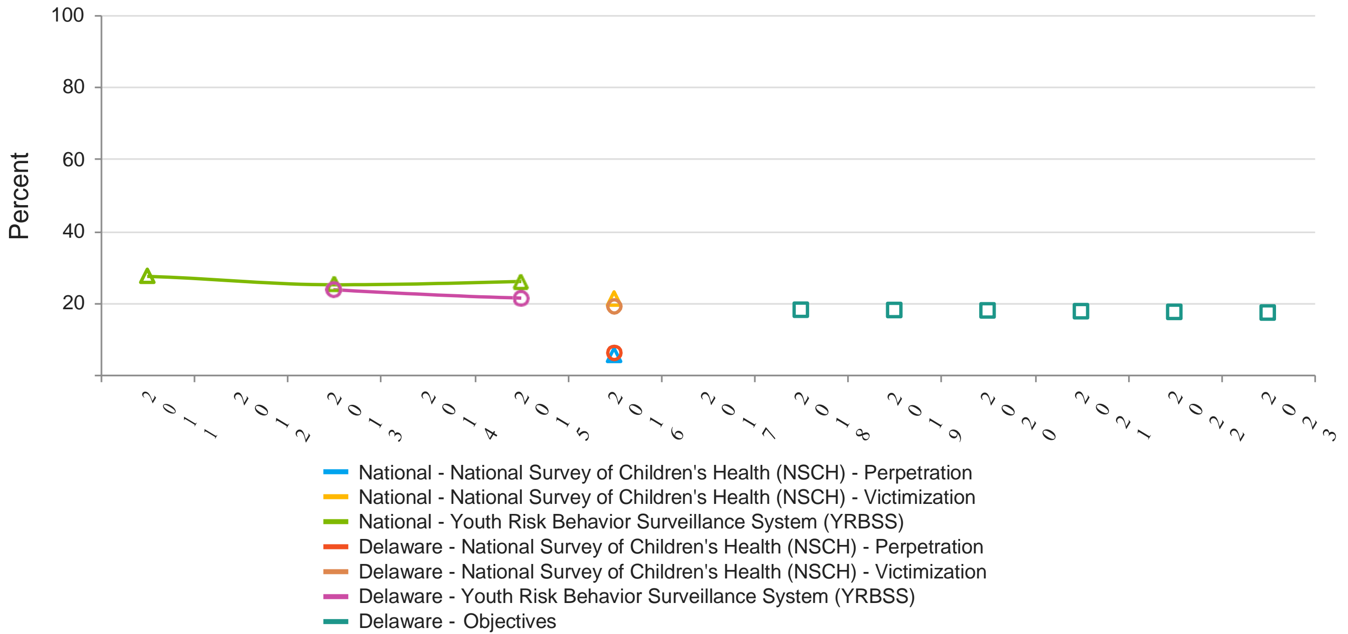
Our current plan is to also support the expansion of professional development training to early childcare providers in Kent and New Castle counties to replicate the success that was seen in the trainings that were held in Sussex County. While previous trainings were very successful the full curriculum is not yet recognized by the Delaware Stars Program as accepted professional development training. Delaware Stars for Early Success is a Quality Rating and Improvement System (QRIS). A QRIS is used to assess, improve and communicate the level of quality in early care and education and school-age settings. Participation in Delaware Stars is voluntary and demonstrates a program's commitment to continuous quality improvement. In order to obtain favorable ratings in the Delaware Stars for Early Success Program, early childhood education centers participate in professional development trainings and earn continued education units. The training offered by BOHDS has not yet been approved for CUE's for their training by Delaware Stars and MCH is committed to supporting the efforts needed to achieve that designation.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	34.0	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	6.7	NPM 9

National Performance Measures



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	18.5	18.3
Annual Indicator	21.2	21.2
Numerator	8,235	8,235
Denominator	38,923	38,923
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	6.3
Numerator	4,514
Denominator	71,720
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	18.9
Numerator	13,561
Denominator	71,592
Data Source	NSCHV
Data Source Year	2016

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	18.1	18.0	17.9	17.7	17.5	17.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	MCH and Worldways	MCH and Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 9.2 - # of people who attend Safe Kids conference

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	75
Numerator		
Denominator		
Data Source	Safe Kids Conference Planning Committee	Safe Kids Conference Planning Committee
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	0.0	75.0	0.0	75.0	0.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	5	1
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		3
Annual Indicator	3	3
Numerator		
Denominator		
Data Source	SBHC and MCH meeting minutes	SBHC and MCH meeting minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		150
Annual Indicator	166	159
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	150.0	150.0	150.0	150.0	150.0	150.0

State Performance Measures

SPM 3 - Percentage of high school students reporting feeling hopeless for two or more weeks at a time in the past 12 months.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		22
Annual Indicator	22	27.6
Numerator		
Denominator		
Data Source	YRBS	YRBS
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	22.0	21.0	20.0	19.0	18.0	17.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 9 - 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	Status
ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment	Active
ESM 9.2 - # of people who attend Safe Kids conference	Active
ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying	Active
ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying	Active
ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.	Active

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 (Delaware) - Adolescent Health - Entry 2

Priority Need

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

SPM

SPM 3 - 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

Identify collaboration opportunities to work with non-traditional community partners on projects that focus on creating positive social and emotional skill sets for pre-teens and teens.

Bullying - Annual Report

As a result of the various community outreach activities conducted during our on-going needs assessment effort, MCH has learned of significant gaps 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. Gaps in services and programs often can be attributed to inconsistency in policies and procedures between school districts. The State of Delaware is unique in that our school districts are divided into 19 separate entities and each district is responsible for addressing bullying and bullying prevention for their respective district. Differences in interpretation of legislation, regulation, and policy suggestions result in administrators handling these occurrences in different ways. While everyone's goal is to being concise and clear in addressing reports of bullying, variations in resolutions are inevitable.

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. Fortunately, our Early Childhood Comprehensive Services efforts are strongly focused on supporting projects that focus on Adverse Childhood Experiences (ACEs) and can therefore carry the message to those projects. 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 this reporting year included furthering our partnership with our Department of Education (DOE) in order to gather data collected regarding bullying and learn more about their bullying prevention efforts. As a follow on to our first strategy of getting the lay of the land regarding prevention efforts within DOE, MCH has been asked to become a contributing partner on the Positive Behavior Support Project State Advisory Committee. This work offers us greater, and timelier, access to valuable DOE information such as the Delaware School Climate Survey data results and the DOE Bullying Reports in Delaware Public School Districts and Charters annual report. Our participation in this advisory committee allows us to communicate our MCH priority relating to bullying prevention and offer insight and suggestions to programs that will support the social and emotional well-being of school-aged children. The current efforts of the Advisory Committee include an effort to build our state-wide asset map and update information related to tiered behavior and Social-Emotional Learning focused initiatives. The committee meets quarterly to provide partner updates, identify gaps in strategies, and discuss potential areas for growth and integration. Meeting agendas include opportunities to share upcoming events and activity updates. We have worked with our partners at DOE to explore various Trauma Informed Education evidence-based approaches and options and hope to influence future curriculum changes to include these program options.

Regarding Bullying Prevention programming within the state of Delaware, three programs have been either implemented or piloted in a number of school districts and have shown to be extremely successful. Details of two of these programs were outlined by our team in a July, 2017 anti-bullying blog article that was recently posted to stopbullying.gov (https://www.stopbullying.gov/blog/2018/03/26/when-students-disabilities-become-bullying-targets.html). The PEERS (Program for the Education and Enrichment of Relational Skills) was designed for teens with disabilities and aims to empower students to address bullying and build positive peer relationships. In addition to PEERS, some Delaware schools have been able to pilot The No Bully System® to prevent bullying and provide effective student support-based interventions when bullying is occurring.

It was our hope that we could partner with DOE to support the implementation of the No Bully System® in 10 additional

school districts this year, however a shift in approach was adopted to help tie into the efforts of addressing the opioid epidemic in our school, by implementing a pilot program for incorporating Botvin LifeSkills into middle schools health curriculum. Further details of that effort are discussed below. School districts that have not implemented either of these programs are required to have policies and procedures in place to address bullying reports and are to ensure that administrators, faculty, staff, students and parents are aware of these policies and procedures.

A third program, Botvin LifeSkills, was piloted in a select number of Middle Schools in Sussex County during the last year. The Office of Public Health Nursing and Child Development Watch team worked with eight middle schools in Sussex County to incorporate Botvin LifeSkills program into the middle school health curriculum. The evidence based program promotes social-emotional learning through a combination of life skills and drug resistant skills that provide a powerful formula for bullying prevention. Our plan for the coming year will offer support to further the implementation of this program in the middle school curriculum. To learn more about Botvin LifeSkills, please see their website - https://www.lifeskillstraining.com/.

The importance of strong community and inter-agency partnerships cannot be understated when addressing the impacts of bullying in our students. MCH has worked to increase the number of partners we collaborate with to help spread the word about current legislation, trainings, education opportunities, as well as sharing information on emerging issues regarding bullying. We have continued our strong connection to the Sussex County Health Coalition and have become members of the Youth Servicing and Engagement Committee (YESO), in addition to our participation in the Health Committee. YESO is a proactive Committee that works to engage, empower and educate youth engagement and youth serving organizations and the community they serve, to improve or impact the health needs of children living in Sussex County. MCH has presented information to this community on the Title V priorities focused on the social and emotional wellness of our youth and has actively recruited other community organizations to provide education and program information to the committee. We have also presented in formation on the No Bully System as well as provided legislation documentation for the committee members.

Another very strong partnership has been established with the HRSA sponsored Implementation Work Group (IWG). This work group consists of all the states that have chosen bullying prevention as a performance measure under their federal Child and Maternal Health Block Grant. IWG uses an online learning collaborative to share information and engage in discussion and it meets quarterly. MCH participated in IWG meetings at the annual AMCHP Conference. Through participation in the workgroup, MCH has recently established a connection for potential partnership with Detective Joey Melvin of the Delaware State Police/Georgetown Police Department. Detective Melvin is an instructor for the National Association of School Resource Officers and a Detective/School Resource Officer with the Georgetown Police Department in Delaware. MCH is in the early stages of establishing a collaboration effort to explore future opportunities that will be introduce the possibility of implementing evidence-based strategies into the work being done by the Office of School Resource Officers that focus on social-emotional supports for children who are being bullied at school, or through cyberbullying, as well as those who are suffering from trauma in their family lives as a result of substance use disorders. This is just another example of the important role the IWG is playing in our efforts to address the impacts of bullying on our youth in Delaware.

Another of our strategies targeted for the last year was to partner with School Based Health Centers (SBHC) 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. This also includes children with special health care needs and those with disabilities. 2017/18 proved to be a challenging year for our Bureau of Adolescent Health and Reproductive Services as they were unexpectedly faced with a significant shift in data collection arrangements for their SBHC's. Much of the last year has been focused on wrapping up data collection efforts with their previously contracted resources and shifting to data collection from each of the hospitals that provide staffing resources to our SBHC's. While those arrangements were being negotiated and solidified, the bureau was successful in implementing data collection efforts that identify ICD10 codes

related to bullying behaviors and assessments coming from our SBHC's. It is expected that this information will provide rich information in the coming year that will begin to shed light on the number of students being seen at our SBHC's who are impacted by bullyingbehaviors.

In relation to our State Performance Measure that focuses on the social and emotional health of our students, MCH maintains a strong connection with local advocacy groups to offer Public Health perspective and support where possible when addressing non-discrimination and cultural competency issues that impact the students in Delaware. Most recently, we have been watching closely to a Governor directive that required DOE to develop an anti-discrimination policy that protected all students from being discriminated against based on sexual identity. A diverse committee was formed and this committee released their initial draft of the regulation in November, 2017 for public comment. At this time, DPH has not been asked to provide feedback on the regulation. Focus groups and open meetings were held statewide to gather feedback and input from the community. The results of that effort evolved into a second draft of the regulation which is currently out for additional public comment until July 6, 2018. Details of Regulation 225 can be found at https://www.doe.k12.de.us/antidiscrimination . MCH brings information that impacts children to our community partners so that they are aware and can comment as they see fit. We feel it is important the community partners who support children with and without special health care needs be made aware of changes that could impact or change the behavior of the children they serve. MCH will maintain a connection with grass roots efforts to understand challenges and offer support from Public Health.

We are very proud of our success in expanding our bullying message across multiple population domains this year. While our main focus was adolescents ages 12-17, we have worked with our counterparts in the Office of Emergency Management Services, Delaware Health and Social Services to support the 2018 Safe Kids Conference. This is a conference that is presented every two years and invites participants that include nurses, school nurses, daycare providers, and emergency medical services personnel to discuss various topics focused on physical, social, and emotional safety of children. MCH has been a long-standing supporter of this event and this year was a Platinum Sponsor of the event that attracted just under 100 attendees in June, 2018. Financial support was provided and our Title V Coordinator/SSDI Project Director served as a member of the planning committee for the conference. In exchange for our support, the conference two of the four presentations offered tied directly into our MCH priorities. "Bullying and Vulnerable Youth: Considerations and Responses" was presented to the attendees and offered two primary objectives. Attendees learned how to identify biases which may impact their ability to respond to bullying incidents and they also learned to verbalize three critical steps to respond safely to bullying incidents. Steps included knowing how to maintaining control of emotions, communicating effectively nonverbally, and de-escalating the discussion. This presentation was an overwhelming success based on feedback received throughout the rest of the day from attendees.

The second presentation that supported our MCH work was "The Impact of Addiction: Helping the Helper Care for Students, Families, and Themselves". This presentation was also a byproduct of our strong partnership with the Sussex County Health Coalition. Three licensed mental health professionals from various backgrounds and expertise held a panel discussion with the group that included a high level overview of several aspects of trauma-related impacts on children as a result of family member substance abuse. Topics included:

- ADDICTION AND ITS IMPACT ON THE CHILD
- TRAUMA MANIFESTATION ON THE CHILD
- LONG TERM HEALTH IMPACT
- FAMILY & YOUTH ADDICTION SIGNS AND SYMPTOMS
- SCHOOLS RESPONSE-HOW TO ENGAGE
- COMMUNITY SUPPORTS-WHERE TO GO
- YOUR ROLE
- SELF CARE

Again, responses from the attendees were positive and many said how much they appreciated that the discussion also included ways to practice self-care, which is not always considered in the work that they, do day in and day out. The Safe Kids Conference is held every two years and MCH is very proud of the collaboration successes we share with this agency.

This year MCH partnered with Family SHADE, the Parent Information Center of Delaware (PIC), and the University of Delaware Center for Disabilities Studies to create a community presentations for families and community partners who serve children with disabilities. The first presentation was offered in October, 2017. "Using Social Skills to Address Bullying" was presented as a workshop and focused helping CSHCN (and their families) develop the tools and skills to deal with bullying behaviors that are directed toward them. This presentation was in line with the strategies contained in the PEERS program. A Family SHADE workshop "Bullying" was held in March, 2018 and was presented at their quarterly membership meeting. This workshop was intended to build on the message presented in the Fall, 2017, but added another component for community organizations to understand methods to encourage the families they serve to learn the same tools and skills. Both presentations were a success and Family SHADE hopes to develop additional presentations in the future.

Our data gathering efforts included an evaluation of bullying and mental health related questions included in the latest YRBS survey. Data from the Delaware 2017 survey for High School students tell us that the percent of children, 12-17 years old, who report being bullied on school property, was 14.1% which is down from 16.4% in 2015. A breakdown by gender shows a decrease in the number of females who reported being bullied from 18.6% in 2015 to 17.1% in 2017 and a decrease in the number of males who reported being bullied from 13.6% in 2015 to 11.2% in 2017.

The percent of children 15-18 years old who report being cyberbullied stands at 10.1% according to the 2017 YRBS, which is down from 11.7% in 2015. A breakdown by gender shows the percentage of females who reported being cyberbullied was 12.4% in 2017 which represents a decline from 16% in 2015. High School males who reported being cyberbullied increased slightly from 7.3% in 2015 to 7.6% in 2017.

Middle school aged children, 12-14 who report being bullied on school property is at 38.6% according to the 2017 Middle School YRBS, which is down from 41.1% in 2015. The breakdown by gender shows a decrease in females reported being bullied from 47.1% in 2015 to 44.8% in 2017. For males the breakdown also shows a decrease from 47.1% in 2015 to 32.6% in 2017.

The percentage of middle school students who reported being cyberbullied is 16.6% according to the 2017 Middle School YRBS, which is down from 18.2% in 2015. The gender breakdown for students who reported being cyberbullied is 23.8% for females, down from 26.4% in 2015, and 10% for males in 2017, which represents a slight decrease from 10.3% in 2015.

Our State Performance Measure aims to decrease the number of students who reported feeling helpless or sad in the past twelve months. Using the latest High School YRBS data we can see that high school students reported feeling "sad or hopeless almost every day for 2 weeks or more in a row during the 12 months prior to the survey" has increased from 24.2% in 2015 to 27.6% in 2017. Both females and males reported an increase with females rising from 32.5% (2015) to 36.9% (2017) and males increasing from 15.3% (2015 to 18.4% (2017).

Overall, this and other supporting data show a declining trend in reported instances of bullying for middle and high school students. Increased use of evidence-based, and practice-based, strategies, along with increase social media marketing appears to be making an impact in reducing bullying. However, we are seeing a rising trend in the mental health of middle and high schools students which tells us that there is more work to be done to focus on the social and emotional well-being

of our students.

With regard to our marketing strategy, we can report that our Bullying website has seen a slow increase in traffic and plans are underway to research and consider how we can drive up the traffic for members of our community. Social media outreach effort have doubled in the past year and the plans are to increase the social media messaging for the coming year. Our flagship website, dethrives.com is in a 'next generation' design upgrade and we intend to work with our marketing resources to upgrade the bullying prevention page as well.

Our plans for the last year that involved implementing an Anti-Bullying Self-Assessment for programs and service in the Division of Public Health were not met for this year; therefore we hope to address this in the coming year. We were, however, successful in meeting our professional development goal for our FHS by presenting information on Cultural Competency and Bullying Prevention. "Bullying in the 21st Century was presented to staff during a quarterly section meeting and staff was heard from Janice Selekman, a professor at the University of Delaware. Dr. Selekman presented facts and information on how the face of bullying has changed over the course of time. Staff was engaged in robust conversation about what constitutes bullying and how to address bullying in the workplace. We intended to host a second workshop with our FHS staff to understand more about cyberbullying and the tools and techniques being used through social marketing and text messaging, however, no such offerings where found here in Delaware, so we will add this to our list for the coming year.

Finally, to align information gathered from our mid-cycle stakeholder survey results, we have found that our efforts to support anti-bullying and bullying prevention efforts is supported by our many community partners who share in the same commitment to provide students with a safe and accepting environment in which to learn and thrive. It is through our many presentations that we have garnered rich feedback from discussion and follow up meetings with our local partners. We have cross-pollinated our presentations to include organizations that support our children with special health care needs as well as those who focus on the support and well-being of our LGBTQ youth. Suggestions and comments from our stakeholder survey highlighted that bullying remains a serious concern for our partners and families, especially for our vulnerable youth – children with special health care needs and those who identify as LGBTQ.

Adolescent Health - Application Year

Bullying - Application Year

Going forward, our focus on bullying prevention will continue with 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 Family SHADE Where appropriate, we plan to pursue opportunities to join in the conversations and planning efforts to ensure our message of bullying prevention as a public health issue is brought to the table and is considered in relevant strategic planning efforts. One such conversation that we would like to become a partner in is the School-Based Mental Health Collaborative Task Force that is facilitated by the Sussex County Health Coalition. This is a model program that has proven to be extremely successful in increasing the amount of mental health care providers available to students in four Sussex County schools and has reduced wait times for triage appointments from 2.5 months to two weeks.

We look forward to establishing and cultivating a partnership with Detective Melvin and the Delaware State Police to address ways to support children who are experiencing family-related trauma that ultimately impacts their performance at school. We feel this falls under the category of an aspect of social determinants of health by collaborated with our state police to help find solutions for our children.

We look forward to our continued work with the PBS State Advisory committee and would very much like to assist the Department of Education in their efforts to expand The No Bully System to include at least 10 schools in Delaware. This support may come in the form of financial support to sponsor training for school district staff and administration or in the form of messaging support by offering to education community organizations on the benefits and successes of the No Bully System in our local schools. Along those same lines, we plan to partner with our Office of Public Health Nursing and Child Development Watch, DOE, and local school districts to implement the Botvin LifeSkills training in more Delaware middle schools.

We will work to develop a plan internally to utilize the Anti-Bullying Self-Assessment tool created by Abt Associates for the benefit of its Bullying Prevention IWG group to begin an assessment of Public Health's capacity to support social and emotional wellness projects for youth in Delaware.

The coming year will provide an important opportunity to infuse cultural competency training for our School Based Wellness staff with an additional focus on the emotional well-being of transgendered youth. Providing welcoming and safe spaces in schools, supportive staff, and importance of health peer to peer relationships will enhance our strategy to improve the social and emotional wellness of our students. In working with our SBHC's, we also hope to leverage data that will shed light on the number of students who visit the centers and make reports of bullying. We will maintain a connection with DOE and our community partners to understand the impacts of Regulation 225 and how the school districts implement the regulation. We will work closely with our SBHC as well to understand impacts from their perspective as SBHC provide more mental health services than any other service.

With regard to our marketing strategy, as our flagship website, dethrives.com, undergoes a redesign, we plan to introduce a new version of our bullying page to incorporate additional resources for our families and community partners. We also plan to boost our social media presence by offering more education and information to readers on Facebook, Twitter, and Instagram.

Lastly, we plan to host at least one professional development training for our Family Health Systems staff as part of a quarterly staff meeting that focuses on the importance of building resiliency in our youth through the use of evidence-based programs that promote social and emotional wellness. We will also continue our search for a professional development opportunity that will provide our staff with education on the various social media outlets used by teens that end up being

weapons of emotional destruction for our most vulnerable youth. We feel it is an important opportunity to teach our staff, which can then pass the information along to our families, of the ways parent can monitor their child's social media habits and contacts.

As in the past, we feel we have made great strides this year in understanding the services and education available for bullying prevention. We have also gained valuable knowledge about the climate of social engagement in schools that will ultimately serve to inform our opportunities to improve emotional and whole-health outcomes for our youth.

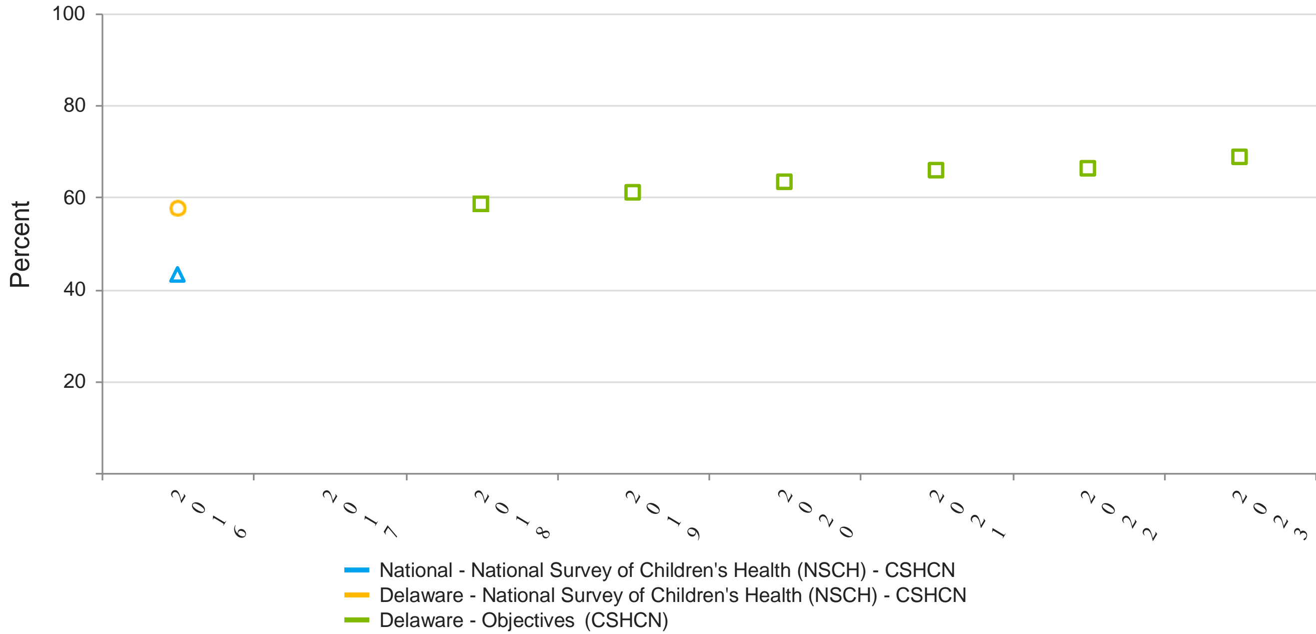
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	18.5 %	NPM 11 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	69.5 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	91.1 %	NPM 11 NPM 15
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)	NIS-2016	78.1 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	65.4 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	78.3 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	63.3 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	87.5 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	87.3 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	2.6 %	NPM 11 NPM 15

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		57.4
Numerator		26,743
Denominator		46,594
Data Source		NSCH-CSHCN
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	58.5	61.0	63.3	65.8	66.2	68.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	Family Shade data	Family Shade data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		No
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		100
Annual Indicator	83.3	66.7
Numerator	25	20
Denominator	30	30
Data Source	DCHI Meeting Minutes	DCHI Meeting Minutes
Data Source Year	2017	2018
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	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.

Measure Status:	Inactive - Completed

State Provided Data		
	2016	**2017**
Annual Objective		No
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	DCHI Meeting Minutes	DCHI Meeting Minutes
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

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

Measure Status:	Active

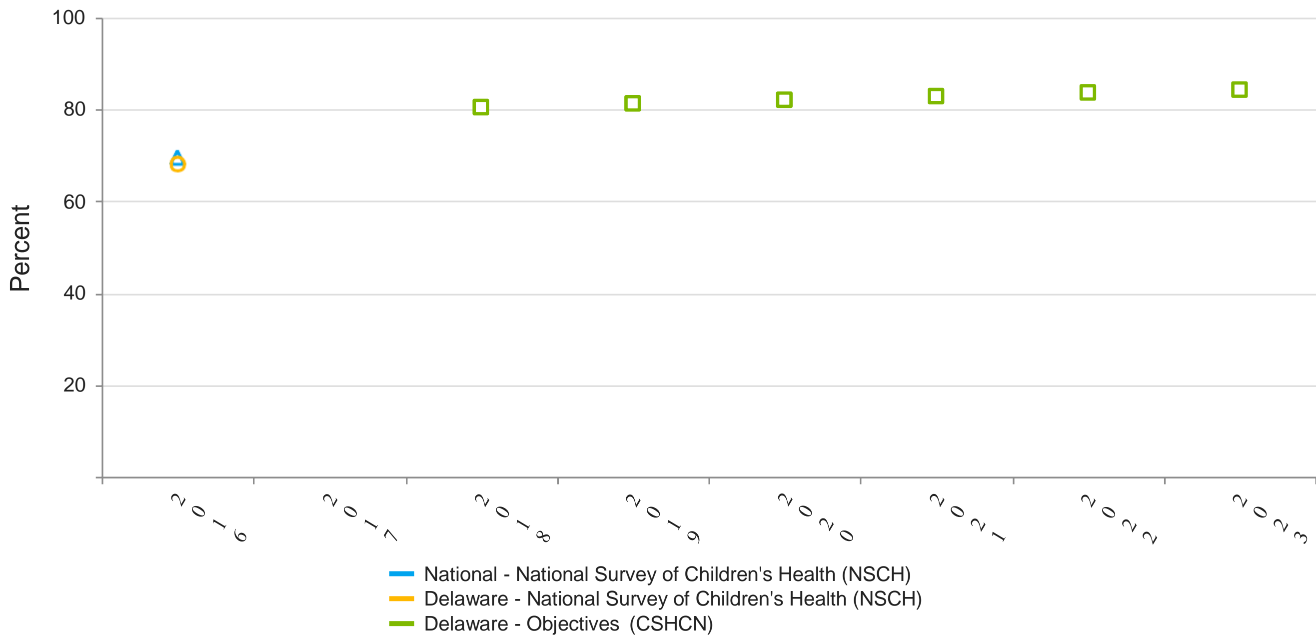
State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	2	2
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes



NPM 15 - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2017
Annual Objective	
Annual Indicator	67.9
Numerator	137,974
Denominator	203,264
Data Source	NSCH
Data Source Year	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.4	81.2	82.0	82.8	83.6	84.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	0.0	25.0	0.0	25.0	0.0	25.0

ESM 15.2 - MOU between Title V and Title XIX

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		No
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	MCH Program Data	Final MOU
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 15.3 - Establishment of Cross-Agency Coordination Committee

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

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

Priority Need

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

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have 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.

Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

ESMs	Status
ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE	Active
ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families	Active
ESM 11.3 - Collaborate with Family Shade to ensure representation of CYSHCN partners at DCHI meetings and forums.	Active
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.	Inactive
ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.	Active
ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Priority Need

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

NPM

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

Design, establish and implement the Cross-Agency Coordination Committee that will support the execution of the Title V/Title XIX Memorandum of Understanding.

ESMs	Status
ESM 15.1 - # of staff of who attend trainings for Title V staff to ensure knowledge of insurance coverage	Active
ESM 15.2 - MOU between Title V and Title XIX	Inactive
ESM 15.3 - Establishment of Cross-Agency Coordination Committee	Active

NOMs

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 22.1 - Percent of children, 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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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

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

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

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Medical Home – Annual Report

According to the 2016 National Survey of Children's Health, 57.4% of CYSHCN in Delaware reported that their care met the medical home criteria, which is above the national estimate of 43.2%.

This past year, Delaware has worked to address the issue of medical home with our families with children with special health care needs by utilizing resources supported by the Universal Newborn Hearing Screening and Intervention Program funded by the Health and Resources System Administration. Under this program, we have established Learning Community structures which are led by two (2) parent lead organizations (Family Voices and Hands and Voices) who work with families of infants who are Deaf or Hard of Hearing (D/HH). Delaware kicked off our first Learning Community on May 15, 2018. There were parents, audiologist, otolaryngologist, neonatal nurse, neonatologist, physicians, early intervention providers, and teachers of children with hearing loss. A survey was shared with these individuals; the parents and the professionals that participated in this meeting collectively to determine which topics could best address the needs of both parents and professionals who serve infants who are Deaf or Hard of Hearing (D/HH) in Delaware.

As a result of this exercise, several additional events are schedule in the coming months that will offer workshops that provide valuable information to our community stakeholders. The Learning Community schedule with workshop topics have been distributed to parents and professionals serving infants who are D/HH. These topics include: Medical Home and the Care Notebook, Joint Committee on Infant Hearing (JCIH) Recommendations: What 1-3-6 means to you. The workshops are being offered in New Castle, Kent and Sussex County during the day and in the evening. Parents and professionals schedules were taken into consideration when the schedule was made. We look forward to gathering feedback from families and professionals as a result of these programs and will use this information as we move forward with our work to address medical homes for families with children with special health care needs.

Child Development Watch (CDW), Delaware's Birth to Three program is using a statewide, cohesive approach to engaging children, families, and Primary Care Providers (PCP) in Delaware's Early Intervention programming. As Primary Care Providers guide efforts of comprehensive pediatric care in our state, Child Development Watch initiated a Kent and Sussex county pilot to educate providers and perform program evaluation amongst CDW and PCP offices. This outreach reviewed and analyzed the effectiveness of CDW operations, PCP knowledge and perceptions of Early Intervention.

Outreach pilot began in July 2017 and targeted pediatric primary care providers and staff in Kent and Sussex counties. The outreach effort reached over 125 providers and staff and 20 practices were provided and educational training. The goals of this pilot were:

- To educate providers and staff in Kent and Sussex counties
- Evaluate the effectiveness of CDW referrals and services
- To further support Delaware's Medical Home initiatives by providing and supporting comprehensive, coordinated, compassionate, and culturally effective care coordination
- To develop and sustain ongoing efforts of community engagement to align in building, managing and sustaining comprehensive pediatric service delivery.

The outreach evaluation tasks included:

1. Tracked monthly compliance on use of new referral form
2. Trended qualitative data feedback on provider office visits
3. Trended responses from PCP survey
4. Mined data and analyzed CDW referral data for 2017

Provider Outreach increases the opportunity for a more streamlined, efficient way for families to access timely and appropriate care at the time of referral. Timely and effective service has a greater likelihood of engaging families from the beginning. Families participating in Early Intervention may be more likely to follow through with interventions for their child and communicate their wants and needs with their healthcare providers as we these strengthen relationships. Healthcare providers will be better equipped to provide and utilize the community supports that Delaware has to offer.

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.

On January 1, 2018, Delaware's Newborn Metabolic Screening program was outsourced to a third party. After many discussions with partners and birthing facilities about fee increases, we committed to exploring alternatives including posting a RFP for the program where vendors could bid on just the lab portion, the follow-up portion or both. We entered into a contract with Nemours/Alfred I. duPont Hospital for Children (N/AIDHC) to assume the responsibility for the Newborn Screening Program for the State of Delaware as a result of that process. Nemours selected PerkinElmer as the provider of laboratory services because of their strong reputation in diagnostics and successful newborn screening programs throughout the United States and globally.

We expected the transition of the program from Delaware's Division of Public Health to Nemours to be smooth as they had already been partnering with the State in providing medical consulting and short-term follow-up services for the Newborn Screening Program since 2013. Nemours also maintained relationships with birthing hospitals statewide and a referral network of pediatric specialists for children diagnosed or identified as at-risk through newborn screening. The transition as in fact been smooth with only a few minor issues that were resolved quickly. The MCH program oversees this contract and will continue to monitor operations.

Adequate Insurance Coverage – Annual Report

Delaware chose Adequate Insurance Coverage as a key priority area based on the 2015 Needs Assessment final rankings. 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.

According to the 2016 National Survey of Children's Health, only 67.9% of Delaware children are adequately insured. This represents a drop from 78% in 2011/2012 NSCH. Our 2018 Title V Stakeholder Survey provided proof that the need for adequate health care coverage for our children with special health care needs remains a priority for our families and community partners once again. Comments and suggestions by survey participants included the need for further education on what health care options are for families who may not qualify for Medicaid, expanded coverage for special equipment needs, additional funding for home therapy and respite care, and access to care in general.

Recent State Budget Epilogue language (Section 141) provided an appropriation to the Division of Medicaid and Medical Assistance (DMMA) to address the needs not easily bet for children with medical complexity through the existing health care model. DMMA established a workgroup and MCH was asked to join the Children with Medical Complexity (CMC) Steering Committee to develop a comprehensive plan for managing health care needs of Delaware's children with medical complexity. In developing the plan, the workgroup sought input from health care providers, hospitals, health systems, payers, managed care organizations, social service agencies, consumer advocacy organizations representing children with medical complexity, and parent advocates. In fact, at the meeting of every meeting a parent provided a presentation on her families day-to-day life with a child with complex medical needs along with explaining how they utilize the care notebook developed by Family Voices. MCH participated in the workgroup sessions during the first quarter of 2018 and the final plan was submitted in May, 2018. A link to the plan is provided: https://news.delaware.gov/2018/05/30/dhss-releases-delawares-plan-managing-health-care-needs-children-medical-complexity/

As in years past, Title V supported the monthly Managed Care Calls conducted by Delaware Family Voices. Family SHADE, supported by Title V, continued to develop their website's Roadmap to Services to include up to date information around insurance coverage for CYSHCN. The traffic to this page increased dramatically from September, 2017 – May, 2018 with 623 page views; an increase of 184%. Family SHADE continued to use the Families Know Best surveys to take a pulse on how families of CYSHCN are experiencing insurance coverage for their special needs child. These surveys have proven to shed light on areas where targeted education on insurance coverage is needed such as addressing the dually eligible children who qualify for both Medicaid and Medicare.

Medical Home – Plan for the Coming Year

The Division of Public Health and Birth to Three will be meeting with a social marketing vendor this summer to establish a campaign on available early intervention services and to how to access services. We will also be developing messaging on what a medical home is and the importance of a medical home. Work will also continue on identifying and/or developing materials for a toolkit for both clinicians and families to help promote medical home and care coordination for CYSHCN. Specifically through contracts with Delaware's Family Voices and Hands & Voices Chapters a care coordination handbook for families with children who are deaf or hard of hearing will be developed. Likewise, through collaborations with the Delaware Building Bridges Project, Autism Delaware and Family Voices care coordination for families with children diagnosed with Autism Spectrum Disorder will be developed.

Along with the condition-specific materials the CYSHCN Director will work with Family SHADE, Delaware Family Voices and the Part C State Systemic Improvement Plan Implementation Team to select care coordination and medical home materials for families with CYSHCN and their service providers. Continuing in Year 4 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. Having submitted the letter of recommendations on behalf of multiple organizations serving CYSHCN in Year 2 Family SHADE members will continue to advocate for their adoption in any outcomes, recommendations or decisions of the DCHI. The strength of this effort lies in the unified voice of the CYSHCN community to affect system change in Delaware. Measures for this effort include the number of meetings attended by Family SHADE and the inclusion of Family SHADE's recommendations in any decisions or recommendations by the DCHI.

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.
Continuing in Year 3 will be the Pilot Project to provide outreach and education to our primary care providers in Sussex County around Part C services, care coordination and community services. Through the personal contact of the Advanced Practice Nurse, with knowledge of the community, Part C and services, with the key personnel within the Primary Care Practices we hope to be able to track measurable outcomes including: knowledge of community services and referral processes to Part C and Part B. The increased knowledge within the practice should lead to an increase in the number of all families responding positively to questions around medical home in the bi-annual children's survey.

The work plan for 2018-2019 Family SHADE/Title V partnership consists of the following:

- Continue to support the development of the Family SHADE organization and its mission of improving the quality of life for CYSHCN by connecting families and providers to information, resources and services.
  - Increase cultural awareness/competency of member organizations to better serve diverse populations.
    - Coordinate at least one cultural competency training for Family SHADE members.
    - Explore having a language line and/or interpreter services available for Family SHADE and member organizations.
  - Increase Family SHADE outreach and promotion efforts.
    - Increase Family SHADE outreach to underrepresented and non-English speaking families and service providers in Delaware.
    - Expand marketing to include hospitals, state health clinics, schools, and Delaware's Division of

Social Services Community Partner Support Units.

- Continue to assist Delaware MCHB in addressing cross-cutting priorities which also meet the needs of CYSHCN and their families.
    - Coordinate bullying workshop, webinar or presentation in Southern Delaware.
    - Represent Family SHADE at meetings of the Nemours Health Equity Consortium, Help Me Grow Advisory Board and Sussex County Health Coalition Health Committee.

- Enhance the role of the Family SHADE program to include educating governmental entities and others regarding recognized gaps in services and family support to CYSCN and their families.
    - Provide information to policy makers via letters and/or meetings from Family SHADE Advisory and/or members regarding issues of concern to families of CYSHCN.

Adequate Insurance Coverage – Plan for the Coming Year

Now that our Title V/Title XIX Memorandum of Understanding has been completed and is now in place, our plan for the coming year is to work on the establishment of the Cross-Agency Coordination Committee. Delaware is once again sending a team to the 2018 MCHB Skills Institute in Tempe, Arizona and the team will be comprised of two MCH staff and two DMMA staff. Our challenge will be to leverage skills and tools offered during the Skills Institute to design, define, and document the vision, mission, and charge of the Cross-Agency Coordination Committee. As described in our MOU this committee will work to establish a multi-disciplinary coordination committee. The committee will be responsible for working together on training, messaging, case management, and procedures.

The training of public health professionals on insurance coverage and issues families may encounter with access to services will be a priority for the coming year. Support of the Family Voices Managed Care Calls in Spanish and English will continue.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Input Following Submission of FY18 Application

In 2017, we solicited input from professional stakeholders by posting our FY17 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 to stakeholders as well as the general public.

As planned, MCH developed and delivered a series of comprehensive presentations highlighting our priorities. We have several advisory committees that meet regularly and provide ongoing input on MCH programs and priorities, including the Help Me Grow and Home Visiting Advisory Board, the Birth Defects and Autism Registries Committee, Sussex County Health Coalition and the Delaware Healthy Mothers and Infants Consortium (DHMIC). We have also attended meetings of Family SHADE, an alliance of organizations and families committed to working together to improve the quality of life for CYSHCN. Family SHADE conducts bi-monthly Families Know Best surveys, which gather feedback from families of CYSHCN on topics related to resources and services available to them. Most of these committees have aligned their priorities to our Title V priorities and are either working on initiatives at the local level or developing statewide policies. Family SHADE also holds monthly Networking Breakfasts with partners and families alternating locations to provide statewide coverage. Members of our MCH team make a point of attending these sessions to ensure participation in the discussion and to communicate updates in our Title V action plan.

Input to FY18 Application

In preparation for completing the FY19 Title V Block Grant, the MCH Bureau disseminated a short survey to more than 750 stakeholders, community partners, and state agency colleagues asking for their feedback on the work we have done in addressing our National and State Performance Measures. The survey was open from May 1 - May 15th. Stakeholders received the following message from the Title V team:
"Every five years the Delaware Division of Public Health conducts a statewide needs assessment and our last needs assessment was completed in 2015. The assessment seeks to identify priority areas for the state of Delaware to improve the health and well-being of Delaware's women, mothers, children – including children with special health care needs, and families. As we are now in the middle of our 5 year State Action Plan cycle, we believe it is important to check in with our stakeholders to get feedback on how you feel we are doing in addressing our national health priorities as identified in the 2015 needs assessment.

By completing the survey, you will help to inform the Division of Public Health's on-going Maternal and Child Health strategic planning process and Block Grant Application. Please click on the following link to access this brief survey and ***complete before May 15, 2018*** so that this information can be incorporated into Delaware's FY19 Title V Block Grant application."

At the close of the survey, we have received more than 100 responses to the survey. Once the survey closed, John Snow, Inc. compiled the results and provided MCH with a summary of the findings. Meetings were held with the 2015 Needs Assessment team as well as with our internal domain leaders to discuss the findings and make changes to strategies, as necessary. The findings were distributed to the same stakeholder community that received the request to complete the survey. The final power point presentation has been posted to www.dethrives.com and has been added to this application as an attachment (Appendix A)

The overall message garnered from this activity was for our program to stay the course with our strategies and activities. Our stakeholders provided robust commentary for suggestions and comments on what should remain a priority for the Title V program. Overwhelmingly our partners tell us that marketing and messaging are crucial in

getting the word out to families of the programs and services that are available for them. Many times, we receive comments such as “more education need for mental health and available resources”, “need more information on early screening and referral for services”, or “need more school-based focus & parent awareness” (physical activity priority), just to quote a few.

As in years past, 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 contacted for input and feedback through various meetings, conferences and other community activities. Our stakeholder involvement and input has been taken into consideration as our team began to prepare for the FY19 application. Our Domain leads have made it a practice to keep in mind our Title V strategies as they take on new projects and activities with their partners, ensuring alignment where possible.

As we move into year three of the MCH Block Grant cycle, our plan is to continue using available data as the basis for the work to be done in the next assessment cycle. As planned, we re-convened our 2015 Needs Assessment Steering Committee to begin the review of trends and analysis being done on the data relating to our national and state priorities. Our team reviewed trends pertaining to their area of expertise and shared their suggestions for strengthening our strategies where necessary. As with the survey findings, our NA Team recommended that we maintain the current priorities and offered suggestions for possible new activities for year three of the action plan. One such suggestion seeks to create a partnership with the Department of Education, the Delaware State Police and Public Health to pilot the “Handle with Care” program in one or more of our middle schools. This program is designed to focus on the social and emotional wellness of children who are impacted by family struggles as a byproduct of the opioid crisis and domestic violence. Details of this strategy are highlighted in our Plan for the Coming Year for NPM 9.

Our FY19 application will incorporate information contained in the release of the 2016 National Survey of Children’s Health to hopefully celebrate all the progress we have made as well as identify areas we would like to see improved. We also look forward to the development of trend data as the 2017 National Survey of Children’s Health is released in the Fall of 2018.

Following the submission of our 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.

III.G. Technical Assistance

Delaware is once again excited to field a team to participate in the 2018 MCHB Summer Skills Institute. This training opportunity will bring a critical set of skills to our MCH staff that will be, applied to current and upcoming initiatives that enhance the lives of mothers, children and families in Delaware. Examples of such initiatives include the Delaware CAN sustainability effort, the rededication of our Healthy Women, Healthy Babies programs, our Perinatal Cooperative CoIIN work, and most recently, the execution of our Title V/Title XIX Memorandum of Understanding (MOU) between the Division of Public Health (DPH) and the Division of Medicaid and Medical Assistance (DMMA). DPH will benefit from this training opportunity independently as well as in our partnership with various community partners, such as DMMA. Delaware's Title V MCH program has forged a renewed partnership with Medicaid to identify needs and gaps in coverage for women of reproductive age, pregnant women, infants, and children with and without special health care needs. The learning opportunities being offered at this session will address this and all eight of the MCH Title V National Priority needs out lined in our 2015 Needs Assessment.

Now that our Title V/Title XIX MOU has been fully executed, our team would like to explore tools and strategies that will help us define, develop and launch our new Cross-Agency Coordination team. This team will be responsible for defining each aspect of the committee – including training, messaging, case management, and procedures for tasks such as data sharing. It will be imperative that each agency feel as if their needs and boundaries are being considered and that each group will provide regular participation in committee activities. Clear communication will be the key to our success. We need to know how to effectively describe work being done by both agencies and explore the details around Medicaid reimbursement and reducing duplicative service delivery. A mapping of services being offered that includes clear definition will be required. We will need to understand and sell the benefits of delivering evidence-based services and make a case for reimbursement. Common understanding of referrals will also need to be defined.

Additional technical assistance is also requested to assist with the on-boarding of our new Children with Special Health Care Needs Director. Interviews for this position will be conducted during the months of July and August with an anticipated start time of mid-September. To assist with the learning curve, it would be helpful to know of MCHB training opportunities that are available for new Directors in this area of Maternal and Child Health.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - APPENDIX A   TitleVSurvey2018_FINAL_6.05.18.pdf

Supporting Document #02 - APPENDIX B Data Brief_SMM.pdf

Supporting Document #03 - APPENDIX C Data Brief_PQCC.pdf

Supporting Document #04 - APPENDIX D Data Brief_OralHealth.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FHS Org Chart_2018.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,913,137	
A. Preventive and Primary Care for Children	$ 611,279	(31.9%)
B. Children with Special Health Care Needs	$ 584,959	(30.5%)
C. Title V Administrative Costs	$ 147,671	(7.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,343,909	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,782,274	
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)	$ 3,294,852	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,077,126	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 14,990,263	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,715,622	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 22,705,885	

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OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 447,640
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,665,161
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,529,980
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 145,870
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,440,843
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 136,128

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,961,019		$ 1,913,137	
A. Preventive and Primary Care for Children	$ 645,281	(32.9%)	$ 625,470	(32.6%)
B. Children with Special Health Care Needs	$ 588,308	(30%)	$ 632,532	(33%)
C. Title V Administrative Costs	$ 196,000	(10%)	$ 109,388	(5.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,429,589		$ 1,367,390	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,461,629		$ 10,461,629	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,151,704		$ 3,294,852	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 12,613,333		$ 13,756,481	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,679,728				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 14,574,352		$ 15,669,618	
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		$ 8,446,184	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 23,020,536		$ 24,115,802	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 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	$ 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	$ 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	$ 140,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 139,153	$ 139,153
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,102,000	$ 1,102,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 250,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted 10% variance resulted from Expenditures only equaling 5.8% which was less than Administrative Expenditures Budgeted	
2.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted Program Income was lower than actual Income collected because there was a fee increase per test resulting in additional program income.	

Data Alerts: None

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

State: Delaware

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 391,201	$ 377,936
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 611,279	$ 625,470
4. CSHCN	$ 584,959	$ 632,532
5. All Others	$ 178,027	$ 167,811
Federal Total of Individuals Served	$ 1,765,466	$ 1,803,749

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 2,805,012	$ 3,081,719
2. Infants < 1 year	$ 2,839,612	$ 3,120,153
3. Children 1 through 21 Years	$ 958,819	$ 914,019
4. CSHCN	$ 958,819	$ 914,019
5. All Others	$ 2,220,012	$ 2,431,719
Non-Federal Total of Individuals Served	$ 9,782,274	$ 10,461,629
Federal State MCH Block Grant Partnership Total	$ 11,547,740	$ 12,265,378

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:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: We include the amounts expended on Infants in Line 3 because TVIS requires Line 3 to match to Form 2 Line 1A- Infants are considered children on form 3A	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: State of Delaware interprets the 30% requirement for Preventative & Primary Care for Children to include programs and services provided to infants through children 1-22 and report as such.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Delaware

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 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	$ 1,234,859	$ 1,358,327
3. Public Health Services and Systems	$ 678,278	$ 554,810
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	$ 1,913,137	$ 1,913,137

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 2,682,290	$ 3,127,828
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,682,290	$ 3,127,828
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 5,733,667	$ 6,685,836
3. Public Health Services and Systems	$ 1,366,317	$ 2,799,669
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 2,286,442
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 294,016
Durable Medical Equipment and Supplies		$ 225,204
Laboratory Services		$ 0
Other		
HWHB Support Activities		$ 322,166
Direct Services Line 4 Expended Total		$ 3,127,828
Non-Federal Total	$ 9,782,274	$ 12,613,333

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: 11,405 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,383 (99.8%)	471	36	36 (100.0%)

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

2. Other Newborn Screening Tests

None

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 in the 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 it gives us population rates of follow-up, but not specific patients information nor specifics of treatment; simply rates of babies who screen positive and are being followed by appropriate specialists. Results are presented to our Advisory Board as the reviews are completed.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: Delaware

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX%	(C) Title XXI%	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,345	55.6	0.0	13.1	30.6	0.7
2. Infants < 1 Year of Age	11,628	47.5	0.0	51.0	1.2	0.3
3. Children 1 through 21 Years of Age	1,616	39.1	0.0	34.3	26.6	0.0
3a. Children with Special Health Care Needs	1,511	39.8	0.0	59.7	0.0	0.5
4. Others	7,819	45.3	0.0	21.0	31.5	2.2
Total	24,408					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: Notes: Unduplicated clients. Title XIX is Medicaid (DPH EMR data includes 'Amerihealth' 'Amerihealth Caritas Delaware' 'Amerihealth Caritas Medicaid MCO' 'Amerihealth Caritas Medicaid MCO Plus' 'Delaware Physicians Care' 'Medicaid' 'Medicaid - Amerihealth Caritas' 'Medicaid - Delaware Physicians Care Inc' 'Medicaid - Fee For Service' 'Medicaid - Highmark' 'Medicaid - United Healthcare Community Plan' 'United Health Care MCO' 'United Health Care Plus MCO' 'United Healthcare Community Plan' 'Unitedhealthone') 1. Data source is Healthy Women Healthy Babies (HWHB) Bundle C clients (CY17).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: 2. Data source is Newborn Screening (NBS) data (CY17) occurrence and DPH EMR Home Visiting Smart Start/HFA <1 years of age (i.e., 11,405 + 223) (CY17)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: 3. Data source is DPH EMR data sorted by program. Smart Start/HFA is our Home Visiting program. Children ages 1-22. Wide swings in data attributed to fluctuations in staff vacancies in FY16 (273 children served) & FY17 (50 children served). Of the 1616 reported in this field, 105 are children without special health care needs and the Primary Source of Coverage information is for these 105 children only.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: 3a. Data Source is Child Development Watch EMR Data and includes CDW-Watch and CDW PART C clients (CY17)	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: 4. Data Source is Healthy Women Healthy Babies Preconception Health Clients (CY17)	

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Delaware

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	6
2. Infants < 1 Year of Age	21
3. Children 1 through 21 Years of Age	19
3a. Children with Special Health Care Needs	22
4. Others	32

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: 1. Data source is HWHB Bundle C (CY17) plus DPH EMR Home Visiting Clients (CY17).	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: 2. Data source is Newborn Screening (CY17) plus DPH EMR Home Visiting clients (CY17).	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: 3. Data source is Title X clients to age 24 (FPAR) plus DPH EMR clients (CY17).	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: 3a. Data source is CDW EMR for CDW and CDW PART C clients (CY17) plus Developmental Screenings (CY17).	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: 4. Data source is HWHB Preconception clients (CY17) plus Title X clients age 25+ (FPAR).	

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

State: Delaware

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	11,415	6,257	2,870	1,547	23	649	4	0	65
Title V Served	11,415	6,257	2,870	1,547	23	649	4	0	65
Eligible for Title XIX	4,965	1,823	1,829	1,137	11	128	1	0	36
2. Total Infants in State	10,966	5,786	2,895	1,542	20	638	4	0	81
Title V Served	10,966	5,786	2,895	1,542	20	638	4	0	81
Eligible for Title XIX	4,925	1,789	1,817	1,138	11	128	1	0	41

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	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 464-4357	(800) 464-4357
2. State MCH Toll-Free "Hotline" Name	Helpline and 2-1-1 Help Me Grow	Helpline and 2-1-1 Help Me Grow
3. Name of Contact Person for State MCH "Hotline"	Donna Snyder-White	Donna Snyder-White
4. Contact Person's Telephone Number	(302) 255-1804	(302) 255-1804
5. Number of Calls Received on the State MCH "Hotline"		1,405

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.dhss.delaware.gov/dph/chca/dphmchhome.html	http://dhss.delaware.gov/dph/chca/dphmchhome.html
4. Number of Hits to the State Title V Program Website		2,187
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		103,572

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	Crystal Sherman
Title	MCH Bureau Chief
Address 1	417 Federal Street
Address 2	
City/State/Zip	Dover / DE / 19901
Telephone	(302) 744-4779
Extension	
Email	crystal.sherman@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 2019

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
2016	78.8 %	0.4 %	8,534	10,829
2015	78.6 %	0.4 %	8,666	11,022
2014	78.7 %	0.4 %	8,510	10,814
2013	76.8 %	0.4 %	8,144	10,602
2012	74.7 %	0.4 %	8,026	10,745
2011	75.7 %	0.4 %	8,297	10,954
2010	75.0 %	0.4 %	8,403	11,210
2009	74.7 %	0.4 %	8,089	10,824

Legends:

☐ Indicator has a numerator <10 and is not reportable

☐ Indicator has a numerator <20, a confidence interval width >20%, 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	
	2017
Annual Indicator	156.0
Numerator	156
Denominator	10,000
Data Source	Health Statistics/Hospital Discharge/Vital Records
Data Source Year	2014

NOM 2 - Notes:

95% Confidence Intervals for Severe Maternal Morbidity Rates for 2010-2014. For the 5-year period 2010-2014, the rate is 137.1 per 10,000 delivery hospitalizations.

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
2012_2016	NR	NR	NR	NR
2011_2015	NR	NR	NR	NR
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 - 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
2016	8.9 %	0.3 %	982	10,984
2015	9.3 %	0.3 %	1,036	11,162
2014	8.3 %	0.3 %	908	10,970
2013	8.3 %	0.3 %	900	10,827
2012	8.3 %	0.3 %	913	11,018
2011	8.4 %	0.3 %	942	11,253
2010	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 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.1 %	0.3 %	1,105	10,982
2015	9.9 %	0.3 %	1,101	11,153
2014	9.3 %	0.3 %	1,019	10,965
2013	9.5 %	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 - 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
2016	24.1 %	0.4 %	2,649	10,982
2015	25.0 %	0.4 %	2,792	11,153
2014	24.4 %	0.4 %	2,676	10,965
2013	22.7 %	0.4 %	2,454	10,818
2012	22.5 %	0.4 %	2,473	11,009
2011	22.7 %	0.4 %	2,550	11,247
2010	24.2 %	0.4 %	2,752	11,355
2009	23.8 %	0.4 %	2,749	11,543

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	1.0 %			
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
2015	9.2	0.9	103	11,202
2014	7.4	0.8	81	11,007
2013	6.8	0.8	74	10,863
2012	8.2	0.9	91	11,056
2011	8.8	0.9	99	11,291
2010	7.5	0.8	85	11,401
2009	6.7	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
2015	9.1	0.9	102	11,166
2014	6.7	0.8	74	10,972
2013	6.4	0.8	69	10,831
2012	7.6	0.8	84	11,023
2011	8.9	0.9	100	11,257
2010	7.5	0.8	85	11,364
2009	8.0	0.8	92	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.2	0.8	80	11,166
2014	5.0	0.7	55	10,972
2013	4.4	0.6	48	10,831
2012	6.1	0.7	67	11,023
2011	6.5	0.8	73	11,257
2010	5.0	0.7	57	11,364
2009	5.8	0.7	67	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.0	0.4	22	11,166
2014	1.7 □	0.4 □	19 □	10,972 □
2013	1.9	0.4	21	10,831
2012	1.5 □	0.4 □	17 □	11,023 □
2011	2.4	0.5	27	11,257
2010	2.5	0.5	28	11,364
2009	2.2	0.4	25	11,559

Legends:

□ Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	456.7	64.1	51	11,166
2014	319.0	54.0	35	10,972
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
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	129.3	34.6	14	10,831
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	105.6	30.5	12	11,364
2009	121.1	32.4	14	11,559

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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
2015	8.1 %	0.9 %	839	10,319
2014	6.3 %	0.8 %	639	10,225
2013	7.7 %	0.9 %	766	10,018
2012	6.0 %	0.8 %	612	10,186
2011	6.3 %	0.7 %	657	10,418
2010	7.3 %	0.8 %	755	10,402
2009	9.4 %	0.9 %	1,004	10,696
2008	7.0 %	0.7 %	778	11,166
2007	5.9 %	0.9 %	438	7,454

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or 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 hospital births

FAD Not Available for this measure.

State Provided Data	
	2017
Annual Indicator	23.0
Numerator	23
Denominator	1,000
Data Source	Health Statistics/Hospital Discharge/Vital Records
Data Source Year	2015

NOM 11 - Notes:

During 2010 to 2015 in Delaware, 1,172 cases of NAS were identified with an incidence of 18.6 cases per 1,000 births. The incidence of NAS increased 94 percent, from 11.9 cases per 1,000 births in 2010 to 23.0 cases per 1,000 births in 2015.

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.7 %	1.7 %	22,451	191,338

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.9	3.8	15	100,809
2015	15.8	4.0	16	101,233
2014	12.8	3.5	13	101,738
2013	18.6	4.3	19	101,932
2012	20.6	4.5	21	102,082
2011	18.8	4.3	19	100,869
2010	NR	NR	NR	NR
2009	16.8	4.1	17	101,227

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	34.0	5.4	40	117,766
2015	27.3	4.8	32	117,211
2014	31.6	5.2	37	117,122
2013	32.5	5.3	38	116,766
2012	37.1	5.6	44	118,726
2011	31.9	5.2	38	119,280
2010	35.4	5.4	43	121,431
2009	39.4	5.7	48	121,966

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	9.4	2.3	17	180,556
2013_2015	12.2	2.6	22	179,785
2012_2014	11.6	2.5	21	181,255
2011_2013	10.9	2.4	20	183,456
2010_2012	11.2	2.4	21	188,321
2009_2011	13.0	2.6	25	191,829
2008_2010	13.9	2.7	27	194,904
2007_2009	15.4	2.8	30	194,529

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	6.7	1.9	12	180,556
2013_2015	6.7	1.9	12	179,785
2012_2014	9.9	2.3	18	181,255
2011_2013	13.1	2.7	24	183,456
2010_2012	13.8	2.7	26	188,321
2009_2011	9.4	2.2	18	191,829
2008_2010	5.6	1.7	11	194,904
2007_2009	5.1	1.6	10	194,529

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	22.9 %	1.8 %	46,594	203,511

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.5 %	3.1 %	8,616	46,594

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.1 %	0.9 %	5,355	174,664

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.0 %	1.7 %	20,659	172,211

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	69.5 %	6.0 %	16,759	24,128

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	91.1 %	1.4 %	185,058	203,190

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	17.2 %	0.4 %	1,246	7,251
2012	16.9 %	0.4 %	1,292	7,642
2010	18.4 %	0.4 %	1,404	7,650
2008	17.3 %	0.5 %	1,097	6,328

Legends:

Indicator has a denominator <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
2015	15.8 %	0.9 %		
2013	14.2 %	0.7 %		
2011	12.2 %	0.8 %		
2009	13.5 %	0.8 %		
2007	13.2 %	0.8 %		
2005	14.0 %	0.7 %		

Legends:

Indicator has an unweighted denominator <100 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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	16.8 %	2.6 %	14,304	85,051

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.7 %	0.7 %	7,474	204,214
2015	2.8 %	0.7 %	5,730	204,356
2014	5.0 %	1.0 %	10,145	204,238
2013	5.1 %	1.0 %	10,294	203,729
2012	3.6 %	0.7 %	7,271	204,974
2011	3.5 %	0.6 %	7,089	204,528
2010	5.6 %	0.9 %	11,456	205,695
2009	5.7 %	0.9 %	11,823	206,826

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width 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
2016	78.1 %	3.2 %	12,109	15,498
2015	79.3 %	3.1 %	12,458	15,717
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	65.4 %	2.3 %	125,447	191,903
2015_2016	69.2 %	2.7 %	132,417	191,243
2014_2015	66.2 %	2.2 %	127,154	192,133
2013_2014	66.7 %	1.9 %	128,042	192,065
2012_2013	67.4 %	3.2 %	129,839	192,518
2011_2012	55.1 %	3.1 %	107,291	194,657
2010_2011	52.1 %	4.3 %	101,548	194,909
2009_2010	46.8 %	2.7 %	84,412	180,367

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 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) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	78.3 %	3.6 %	22,196	28,342
2015	67.6 %	4.3 %	19,077	28,225
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	63.3 %	4.2 %	18,680	29,511
2015	62.9 %	3.9 %	18,426	29,280
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	87.5 %	2.0 %	50,644	57,853
2015	88.7 %	1.9 %	51,004	57,505
2014	90.5 %	1.9 %	51,554	56,943
2013	84.4 %	2.3 %	48,139	57,056
2012	77.8 %	3.0 %	44,397	57,081
2011	80.7 %	2.3 %	47,258	58,593
2010	65.5 %	3.0 %	37,427	57,165
2009	53.4 %	3.3 %	31,064	58,209

Legends:

□ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	87.3 %	2.2 %	50,523	57,853
2015	87.5 %	2.1 %	50,332	57,505
2014	86.7 %	2.4 %	49,345	56,943
2013	81.8 %	2.6 %	46,657	57,056
2012	78.0 %	3.2 %	44,507	57,081
2011	78.2 %	2.5 %	45,835	58,593
2010	71.2 %	3.0 %	40,719	57,165
2009	58.4 %	3.3 %	33,991	58,209

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.5	0.8	583	29,906
2015	18.1	0.8	540	29,829
2014	20.8	0.8	616	29,632
2013	24.4	0.9	728	29,860
2012	25.0	0.9	761	30,387
2011	29.0	1.0	900	31,023
2010	30.7	1.0	974	31,694
2009	33.5	1.0	1,081	32,283

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	13.9 %	1.2 %	1,429	10,264
2014	13.4 %	1.2 %	1,367	10,223
2013	13.0 %	1.1 %	1,296	9,981
2012	13.8 %	1.1 %	1,385	10,061

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.6 %	0.9 %	5,326	203,101

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Delaware

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	81.8	82.6
Annual Indicator	72.8	73.0
Numerator	118,008	118,081
Denominator	162,112	161,778
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	83.4	84.2	85.0	85.8	86.6	87.4

Field Level Notes for Form 10a NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	74	76
Annual Indicator	74.6	77.2
Numerator	7,709	7,684
Denominator	10,340	9,953
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	15.5	18
Annual Indicator	18.9	20.5
Numerator	1,847	1,966
Denominator	9,794	9,570
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	20.5	23.0	25.5	27.0	28.0	29.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		26.9
Numerator		5,997
Denominator		22,305
Data Source		NSCH
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	31.7	32.0	32.3	32.6	33.0	33.6

Field Level Notes for Form 10a NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		29.5
Numerator		17,762
Denominator		60,210
Data Source		NSCH-CHILD
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	33.1	33.4	33.7	34.0	35.0	36.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	18.5	18.3
Annual Indicator	21.2	21.2
Numerator	8,235	8,235
Denominator	38,923	38,923
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	6.3
Numerator	4,514
Denominator	71,720
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	18.9
Numerator	13,561
Denominator	71,592
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	18.1	18.0	17.9	17.7	17.5	17.3

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		57.4
Numerator		26,743
Denominator		46,594
Data Source		NSCH-CSHCN
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	58.5	61.0	63.3	65.8	66.2	68.7

Field Level Notes for Form 10a NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	39.4	39.8
Annual Indicator	42.2	44.4
Numerator	4,224	4,562
Denominator	10,020	10,267
Data Source	PRAMS	PRAMS
Data Source Year	2013	2015

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	40.2	40.6	41.0	41.4	41.8	42.2

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		79.9
Numerator		152,949
Denominator		191,522
Data Source		NSCH
Data Source Year		2016

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	79.6	80.4	81.2	82.0	82.8	83.4

Field Level Notes for Form 10a NPMs:

None

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2017
Annual Objective	
Annual Indicator	67.9
Numerator	137,974
Denominator	203,264
Data Source	NSCH
Data Source Year	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.4	81.2	82.0	82.8	83.6	84.2

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		57
Annual Indicator	57	57
Numerator		
Denominator		
Data Source	Health Statistics	Health Statistics
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	56.0	52.0	50.0	47.0	45.0	43.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		67
Annual Indicator	67	66
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		22
Annual Indicator	22	27.6
Numerator		
Denominator		
Data Source	YRBS	YRBS
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	22.0	21.0	20.0	19.0	18.0	17.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Delaware

ESM 1.1 - # of MCH social marketing public awareness messages (i.e. brochures, blogs, Facebook posts, website content, etc.) that promote preventive health care and preconception health for women of reproductive age.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	111
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	110.0	121.0	133.0	146.0	150.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - This measure is being deactivated due to the fact that these are now standing meetings within the DHMIC yearly calendar and will no longer be tracked.

State Provided Data		
	2016	**2017**
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	meeting agendas/minutes	meeting agendas/minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		8,300
Annual Indicator	8,146	8,819
Numerator		
Denominator		
Data Source	Healthy Women Health Babies Program data	Healthy Women Health Babies Program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8,500.0	8,700.0	8,900.0	9,000.0	9,100.0	9,200.0

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15,000
Annual Indicator	14,998	15,891
Numerator		
Denominator		
Data Source	FPAR Title X/Family Planning Data	FPAR Title X/Family Planning Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15,500.0	15,700.0	15,900.0	16,200.0	16,500.0	16,500.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
ESM 1.4 - 2023 measure should be 16,800 but TVIS will only allow measure to be 16,500

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

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		65
Annual Indicator	58	63
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This is the last year of funding for EPIC BEST so this measure maybe removed next year unless alternate funding is identified to continue these training efforts.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		100
Annual Indicator	98	0
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	130.0	150.0	170.0	190.0	200.0	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

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		5
Annual Indicator	4	5
Numerator		
Denominator		
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	9.0	11.0	12.0	12.0	12.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Less home visitors than anticipated were interested in becoming IBLC certified than expected even thought we offered to provide funding. We will continue to promote and offer our support for home visitors who would to receive this certification. If we do not see an increase in participation

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
We added one more certified home visitor this year, bringing our total to 5.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	17.2	60.3
Numerator		
Denominator		
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	61.0	65.0	65.0	68.0	70.0	72.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	5.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - # of new practices to adopt PEDs

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		36
Annual Indicator	34	37
Numerator		
Denominator		
Data Source	DE AAP	DE APP
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	39.0	42.0	44.0	45.0	45.0	45.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45
Annual Indicator	32	10
Numerator		
Denominator		
Data Source	HMG 2-1-1	HMG 2-1-1
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	65.0	85.0	105.0	125.0	145.0	150.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	15	100
Numerator		
Denominator		
Data Source	CDW program data	CDW program data
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This indicator should be 274 but TVIS will not allow me to change the Annual Indicator.

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

Measure Status:	Active

State Provided Data

	2016	2017
Annual Objective		50
Annual Indicator	20	18
Numerator		
Denominator		
Data Source	HMG 2-1-1	HMG 2-1-1
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	100.0	125.0	150.0	200.0	200.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   Our FY18 objective for this measure was an over-estimation based on our assumption that the HMG/2-1-1 call staff would be proactive and invite callers to take a screen over the phone.

ESM 6.5 - # of new partnerships/collaborations

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	10	10
Numerator		
Denominator		
Data Source	ECCS Program Data	ECCS Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	10.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The indicator for this ESM should be 18 but TVIS will only allow up to 10. There has been a dramatic increase in this ESM due to our new focus on community partnerships and collective impact.

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

Measure Status:	Active

State Provided Data		
	2016	**2017**
Annual Objective		100
Annual Indicator	41	163
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	150.0	200.0	250.0	300.0	350.0	400.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	0	20
Numerator		
Denominator		
Data Source	google analytics data/Worldways	google analytics data/Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Column Name: **State Provided Data**

Field Note:
ESM 8.1 - Annual Indicator should be 65 but TVIS will only allow indicator to be 20

ESM 8.1.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		1,000
Annual Indicator	877	1,000
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		12
Annual Indicator	12	12
Numerator		
Denominator		
Data Source	SHIP and Health Neighborhoods committee minutes	SHIP and Health Neighborhoods committee minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	12.0	12.0	12.0	12.0	0.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	MCH and Worldways	MCH and Worldways
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 9.2 - # of people who attend Safe Kids conference

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	75
Numerator		
Denominator		
Data Source	Safe Kids Conference Planning Committee	Safe Kids Conference Planning Committee
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	0.0	75.0	0.0	75.0	0.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Actual number of attendees was 96 but TVIS will only allow a number between 0-75.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	5	1
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		3
Annual Indicator	3	3
Numerator		
Denominator		
Data Source	SBHC and MCH meeting minutes	SBHC and MCH meeting minutes
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		150
Annual Indicator	166	159
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	150.0	150.0	150.0	150.0	150.0	150.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This number includes presentations given to community partners focused on CSHCN as well.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	Family Shade data	Family Shade data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Questions around the availability of medical homes were included in the Family Shade "Families Know Best" surveys in 2017.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		No
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		100
Annual Indicator	83.3	66.7
Numerator	25	20
Denominator	30	30
Data Source	DCHI Meeting Minutes	DCHI Meeting Minutes
Data Source Year	2017	2018
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	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.

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		No
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	DCHI Meeting Minutes	DCHI Meeting Minutes
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	2	2
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 13.1.1 - Increase the number of hits on BOHDS website by working to include a social marketing campaign that drives traffic to the site.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		5,000
Annual Indicator	3,989	5,530
Numerator		
Denominator		
Data Source	DPH Google Analytics	DPH Google Analytics
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10,000.0	15,000.0	20,000.0	25,000.0	30,000.0	30,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	50.0	100.0	150.0	200.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	3.0	4.0	5.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The prototype has been created and work is on-going.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This ESM remains a work in progress, however the Oral Health Data Brief has been added to this application as Appendix D to support this ESM.	

ESM 13.2.2 - # of presentations completed for partners & community members

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	6	7
Numerator		
Denominator		
Data Source	BOHDS program data	BOHDS program data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This ESM indicator falls below the objective due in part to on-boarding time and training for the new DPH Dental Director.

ESM 13.2.3 - # of pediatric practices who are providing fluoride treatments

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	21	17
Numerator		
Denominator		
Data Source	Medicaid	Medicaid
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This ESM indicator falls below the objective due to a number of pediatric providers being consolidated into the major hospital systems and out of private practice.

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	MCH Program Data	MCH Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	0.0	25.0	0.0	25.0	0.0	25.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: A contract with Delaware Family Voices to provide Medicaid-specific training to Title V/Public Health staff was delayed due to other priorities for Delaware Family Voices.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: A contract with Delaware Family Voices was signed in early 2018 just prior to the departure of our CSHCN Director; that coupled with other priorities for Delaware Family Voices resulted in no training being completed for FY18.	

ESM 15.2 - MOU between Title V and Title XIX

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		No
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	MCH Program Data	Final MOU
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 15.3 - Establishment of Cross-Agency Coordination Committee

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	Yes	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

Measure Status:	Active
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

Measure Status:	Active
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

Measure Status:	Active
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 Measures (ESM) Detail Sheets

State: Delaware

ESM 1.1 - # of MCH social marketing public awareness messages (i.e. brochures, blogs, Facebook posts, website content, etc.) that promote preventive health care and preconception health for women of reproductive age.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of 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:** 150
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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - This measure is being deactivated due to the fact that these are now standing meetings within the DHMIC yearly calendar and will no longer be tracked.
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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
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:** 10,000
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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of women of reproductive age receiving family planning services.
Definition:	**Numerator:** Total # of women of reproduction age that received family planning servicess **Denominator:** N/A **Unit Type:** Count **Unit Number:** 16,500
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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Completed
Goal:	Increase the number of provider practices that receive EPIC BEST training.
Definition:	**Numerator:** Number of provider practices that receive EPIC BEST training **Denominator:** N/A **Unit Type:** Count **Unit Number:** 65
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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk
Definition:	**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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the 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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
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 theyneed.

ESM 6.3 - The number of potential high risk screens referred to early intervention/Part C by pediatric practices NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To foster systems collaboration to maximize resources.
Definition:	**Numerator:** Number of new partnerships made **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the 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 8.1.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
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 8.1.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
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 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
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 8.1.4 - # of SHIP and/or Healthy Neighborhoods meetings and events attended that align with statewide initiatives for active living and healthy eating
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
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

Measure Status:	Active
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

Measure Status:	Active
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

Measure Status:	Active
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:** 5
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

Measure Status:	Active
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

Measure Status:	Active
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:** 200
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, ages 0 through 17, who have a medical home

Measure Status:	Active
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, ages 0 through 17, who have a medical home

Measure Status:	Active
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, ages 0 through 17, who have a medical home

Measure Status:	Active
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, ages 0 through 17, who have a medical home

Measure Status:	Inactive - Completed
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, ages 0 through 17, who have a medical home

Measure Status:	Active
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 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.
Definition:	**Numerator:** 0 **Denominator:** 0 **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	MCH Program Data
Significance:	During the last year, we conducted a pilot that included outreach to primary care providers to provide education on how to refer and when to refer, etc. We have received feedback from these providers as well as partners and community members that our materials are outdated and the services provided by the program are not visible enough. DPH along with Birth to Three will meeting a our social marketing vendor to start the process to develop campaign that will not only high early intervention services and how to access them but also the importance of a medical home.

ESM 13.1.1 - Increase the number of hits on BOHDS website by working to include a social marketing campaign that drives traffic to the site.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
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 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Increase awareness of the importance of good oral health while pregnant and the relationship to positive birth outcomes by working with BOHDS to create a social marketing campaign.
Definition:	**Numerator:** Social Marketing campaign presented on dethrives.com **Denominator:** n/a **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Worldways marketing campaign and google analytics for number of hits on dethrives.com.
Significance:	Survey findings tell us that most mothers are not aware of the impact that poor oral health care has on birth outcomes. There are those that also believe that it is dangerous to their unborn babies health to have an oral health check up during pregnancy. We intend to debunk the myths and spread awareness that will show that oral health is a critical piece of prenatal health.

ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Work with DPH staff, contractors, and community partners to ensure pregnant mothers who have AmeriHealth Caratias Delaware MCO coverage know of the oral health benefits available to them during their pregnancy.
Definition:	**Numerator:** # of community presentations completed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	Total count of presentations made by DPH staff, contractors and community partners that support education and awareness of expanded Medicaid MCO oral health care coverage for adults.
Significance:	Expanded oral health care coverage in Delaware for adults ages 21 and over has been non-existent in the past. The recent contract negotiations between Delaware Medicaid and Managed Care Organization, AmeriHealth Caritas Delaware has established coverage for adults aged 21 and over that includes one annual exam and one set of oral x-rays per year. It is crucial that we ensure that pregnant mothers over the age of 20 are aware of these benefits and make an appointment for an oral health check-up during their pregnancy.

ESM 13.2.1 - Development of an annual report that includes HMG 2-1-1 referrals, PRAMS data and DPH dental clinic service utilization data
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
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 13.2.2 - # of presentations completed for partners & community members
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	All Children 0 through 17
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 13.2.3 - # of pediatric practices who are providing fluoride treatments
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the 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:** 40
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 continuously and adequately insured

Measure Status:	Active
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 continuously and adequately insured

Measure Status:	Inactive - Completed
ESM Subgroup(s):	CSHCN
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.

ESM 15.3 - Establishment of Cross-Agency Coordination Committee
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Work with Medicaid partners to develop the structure, process, and policy that will support the creation of the Cross-Agency Coordination Committee (CACC).
Definition:	**Numerator:** Structure and schedule for CACC **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	CACC meeting minutes.
Significance:	As described in our recently signed MOU, the CACC will work to establish a multi-disciplinary coordination committee who will be responsible for working together on training, messaging, case management, and procedures. The overarching goals of this committee is to ensure that the mothers and families in Delaware who are eligible for services are given a clear understanding of where and how they can obtain those services. This group will address any redundant services and activities between agencies as well as filling any gaps in services that exist.

Form 11
Other State Data

State: Delaware

The Form 11 data are available for review via the link below.

Form 11 Data