

**Maternal and Child
Health Services Title V
Block Grant**

Delaware

**FY 2022 Application/
FY 2020 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

September 1, 2021

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 2021 Maternal and Child Health Services
Title V Block Grant Program**

With this letter of transmittal, please find the Application Face Sheet (standard Form 424) for the State of Delaware's Federal Fiscal Year 2020 Maternal and Child Health Services Title V Block Grant Application.

Please feel free to contact me at (302) 608-5754 or via e-mail leah.woodall@delaware.gov, if you have any questions or comments regarding the information presented in the application.

Sincerely,

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

Family Health Systems
Delaware Division of Public Health
Jesse Cooper Building, Garden Level
417 Federal Street
Dover, DE 19901
(302) 608-5754

I.B. Face Sheet

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

I.C. Assurances and Certifications

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the “*Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms*,” OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Delaware's Title V priorities and plans for the coming year are presented below by population domain, as defined by the MCHB. In some of the health areas, we are building on years of previous work and partnerships and have very detailed action plans forward. In others, we are forging into new territory and will be spending the time over the course of the five-year grant building expertise and establishing new relationships.

Population Domain: Women's and Maternal Health

Defining the Need: The priority need is to increase the number of women who have access to and receive coordinated, comprehensive services before, during and beyond pregnancy, decrease the percent of Delaware women of reproductive age with an unintended pregnancy and to reduce the disparity in infant mortality rates. In 2019, 75.5% of Delaware women, ages 18-44, received a routine check-up within the last year (Behavioral Risk Factor Surveillance System), while 89.6% of Delaware women, ages 45 and older received the same check-up. Access to preventive health care is critical to identify health issues early, prevent the onset of disease, and prepare women for healthy pregnancies.

Accomplishments to Date: We continue to focus on increasing the number of women who have a preventive visit to optimize the health of women before, between and beyond pregnancies. In order to continue making progress in providing "whole health" care to our women and mothers, we continue to bolster and nurture our community partnerships by working together focused on addressing the social determinants of health, leveraging talents and resources, and striving to find new ways to provide services. Over the last year, we continue to monitor the Delaware Healthy Mothers and Infants Consortium's (DHMIC) strategic plan which covers a 3-5 year timeframe. Through a partnership with DHMIC, there has been much work to educate our population about preconception health, in which preventive health visits play a key role. All priorities and interventions will be carried out through the lens of improving health equity, the use of the life course approach, enhancing data collection and use of quality improvement to achieve stated goals. Through the Healthy Women Healthy Babies 2.0 program, Delaware women with a previous adverse birth outcome are identified, assessing their risks, and then provided an enhanced care coordination approach. Delaware previously implemented 6 Healthy Women Healthy Babies Zones community-based interventions to address the SDOH.

Plans for the Coming Year: Over the next year, DPH in collaboration with DHMIC partners, plan to further track and analyze benchmark data and the performance based approach to the the Healthy Women Healthy Babies program, a medical intervention, by simultaneously supporting the 8 community based interventions in high risk zones implemented across the state that address some of the underlying environmental, economic and social structures that impact resources needed for health, such as poverty, lack of stable housing, access to healthy foods, access to early childhood education, medical legal partnership, financial literacy, etc. Preconception peer educators (PPE) will continue to provide community outreach to increase infant mortality awareness with an emphasis on preconception and interconception health targeting the 18+ population. In the coming year, we will also continue to develop the patient education materials that incorporate what we have learned as a CQIN over the past couple of years. Delaware will help identify clinicians, largely representing our Healthy Women Healthy Babies program providers and other interested MCH partners to help create some initial materials this fall, as well as those who are willing to review materials and test them with patients.

Population Domain: Perinatal/Infant Health

Defining the Need:

The priority is to improve breastfeeding rates and duration. According to the Pregnancy Risk Assessment Monitoring System (PRAMS), Delaware infants who are ever breastfed in 2019 was at 87.3%. This is compared to 86.6% in 2018 and 87.1% in 2017. When you view the percent of Delaware infants who are breastfed exclusively through six months, the number are significantly lower. In 2016, 19.8% of infants were exclusively breastfed through

six months, compared to 23.6% in 2017 and 28.2% in 2018. The data clearly shows the need for improvements in overall breastfeeding initiation but also the need to address disparities that exist in Delaware. In addition, the input gathered through the 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 health domain.

Accomplishments in the Past Year:

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

According to the Ripples Group findings in the Final Quarter Report of 2020, WIC WOW Data System:

- Breastfeeding Initiation rates in the WIC population increased to 57% versus 53% in 2019
- Duration at 3 months increased in all clinics, with an average of 42% versus 33% in 2019
- Duration at 6 months averaged 32% in all counties versus 25% in 2019
- Exclusivity rates decreased to an average rate of 23.5% versus 28% in 2019

According to Ripples findings in the final quarter report of October 2020 a participant contacted by a peer counselor is 81% more likely to be breastfeeding at 3 months and 88% more likely to be breastfeeding at 6 months. Exclusivity rates among WIC mothers remains 5% higher when mothers are contacted by a peer counselor.

WIC offices closed March 2020 and remain closed to date due to Covid-19 precautions. Participants are contacted by phone for scheduling appointments certifications and recertifications. WIC benefits are loaded remotely and the WIC no show rate because of the WIC waiver for Physical Presence remains at an all-time low of 11%.

Plans for the Coming Year:

The Breastfeeding Coalition of Delaware was selected as one of the HWHB mini-grant awardees. Their goal is to improve breastfeeding rates for women of color to the HWHB high-risk zones of Wilmington, Claymont, and Seaford by providing access to community resources, education and peer support. The project, Delaware Breastfeeding Village is offering accessible support, engaging groups, text check-ins, access to variable levels of lactation support, and incentives for participation. In addition, the Breastfeeding Coalition of Delaware hired three diverse breastfeeding peer counselors (BPC) and one lactation consultant to provide breastfeeding support to women. WIC and Medicaid eligible mothers can participate in a 6-month program where they receive support from a breastfeeding peer counselor and a lactation consultant if needed. Mothers receive incentives to participate in groups and have monthly motivational text from peer counselors. Mothers who complete the program will be invited to a baby shower to celebrate completion. The goal is to decrease isolation among mothers, to increase breastfeeding duration and to decrease barriers to breastfeeding support. Earlier this year, 60 women were enrolled in the program and we are looking forward to reviewing the data to determine if this is an initiative that can be scaled to increase breastfeeding rates statewide.

Population Domain: Child Health

Defining the Need: The priority is for children to receive developmentally appropriate services in a well-coordinated early childhood system. Only 30.3% of Delaware children, ages 9-35 months, received a developmental screening in the past year.

In addition, Delaware aims to increase access to comprehensive oral health care for children most at risk for oral disease. When left untreated, tooth decay can harm a child's quality of life and impair academic performance.

According to the 2018/2019 National Survey of Children's Health (NSCH), 20.3% of Delaware children, ages 0 through 17, have not had a preventive dental visit in the past year.

Accomplishments in the Past Year: There was a total of 13,420 PEDS Online screens completed on children 0-59 months between 7/1/20 and 6/30/21, which corresponds to an estimated 8,316 unique children or 61.97% of the total screens completed that were unduplicated. This compares to 13,106 PEDS Online screens completed on children 0-59 months between 7/1/19 and 6/30/20 and an estimated 8,318 unique children or 63.46% of total screens completed were unique. This equates to a 2.40% increase in total screens completed while the number of unique (i.e., unduplicated) children stayed relatively the same.

From 03/20 to 02/21 when program access was restricted, toothbrushes, toothpaste, dental floss, and oral health education was delivered to 6,320 children ages to 0 - 8 years of age to childcare facilities, day camps, urgent care, lactation counselors and pediatricians that included a business card with a new dental help line number. The dental helpline is staffed by the dental team to help address oral health concerns and connect the public to a dental provider that is accepting patients. From 11/20-06/21, 1,742 calls were received from the public looking for a dentist or having a dental problem.

Plans for the Coming Year: Delaware's developmental screening goals will focus on continuous improvement to streamline the developmental screening processes and build in efficiencies that enhance community awareness; improve referrals to early intervention and anticipates the potential uptake in screens. Efforts will continue to enhance the tracking of intake and referrals for children at higher risk for developmental delays. We will also continue to provide technical assistance and training to pediatricians and family practices that are using the PEDS instrument, as well as potential recruits. In addition, partnerships with the Office of Early Learning will continue to improve the delivery of developmental screening services within Delaware's school districts. Outreach efforts such as Books, Balls, and Blocks (BBB) will continue in collaboration with multiple community stakeholders.

BOHDS will continue working on completing oral health educational videos, resources, and online enrollment for oral health programs and education. Delaware will continue the Delaware Smile Check Program (DSCHP) by partnering to add online enrollment, consent, and screening forms in addition to flyers and a satisfaction survey to our DEThrives website for portable dental operations. The portable program includes dental screenings and prevention programs onsite that include fluoride application, oral health education, and case management. Delaware's dental team will continue to develop collaborations and conversations with the National Federation for the Blind, Autism Delaware, Family Shade, CYSHCN, DOE, Child Development Watch, and families that have a child with a disability.

Population Domain: Adolescent Health

Defining the Need: The priority need is to increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being. The NSCH shows that the percentage of Delaware adolescents who have had a preventive medical visit in the past year declined from 2017 to 2018 but is on the rise again in 2019.

In addition, Delaware strives to increase the number of adolescents who are physically active. According to the 2018/2019 NSCH, Delaware is among the lowest of its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day.

Accomplishments in the Past Year: Many SBHC's implemented telehealth in which students were able to access care via this method. Upon availability of the vaccine to adolescents 12 and older, SBHC's have coordinated efforts for the COVID-19 vaccine with medical vendors in the latter months of the school year. This year, DPH, Family Health Systems, Adolescent Health also completed an intense, virtual, strategic planning process in which 13 goals were established to produce a synchronized organization of SBHC's across the state of Delaware. DPH has also signed multi-year MOUs with various school districts in an effort to support and build resilient children and improve the social and emotional wellness of children and adolescents.

Delaware's DPH has provided support to the Delaware Cancer Consortium, Cancer Risk Reduction Committee, Healthy Lifestyles Subcommittee (HLSC). The HLSC presented health and wellness policy recommendations to the Office of the Governor, which included policy recommendations for children and youth, and adolescents. Delaware also released a Request for Proposals (RFP) for Advancing Healthy Lifestyles: Chronic Disease, Health Equity & COVID-19 (AHL). One objective of the AHL initiative is to support the next phase of implementation and planning for these policy recommendations.

Plan for the Coming Year: DPH, in collaboration with several key stakeholders, convened this past year to create a Delaware School-Based Health Center (SBHC) Strategic Plan. The planning process was utilized to develop a model for expansion of SBHCs that was both financially sustainable and anchored in best practices. Our next steps include publishing our Strategic Plan and Implementation & Evaluation Plan. In addition, DPH plans to begin interim governance and implementation as well as setting up a longer-term governance and accountability model to oversee

implementation of our plan and continued success of Delaware's SBHC.

Delaware will also continue our partnership with the Cooperative Extension, University of Delaware (UD), Health & Wellness Ambassadors for the upcoming grant cycle as well as again working with the UD 4-H Department to sponsor another poster contest that promotes teens to seek emotional and mental health treatment, when needed. Through Delaware's Program's Advancing Healthy Lifestyles (AHL): Chronic Disease, Health Equity & COVID-19 initiative, we will continue to support youth health through AHL: Coordinated School Health and Wellness activities. We will also partner with other state agencies and community organizations to sustain Community Capacity Building and engage community partners who are primarily serving disparate or targeted communities, to develop strategies that address physical activity related activities. We will continue to collaborate with the Delaware Department of Education (DOE) on Coordinated School Health and Wellness initiatives as well as explore efforts to ensure students with special needs are included in the physical fitness assessment resources, and that adaptive resources are available for Delaware students.

Population Domain: CYSHCN

Defining the Need: The priority is to increase the percent of children with and without special health care needs who are adequately insured. According to the 2018-2019 NSCH, 69.6% of Delaware children are adequately insured in comparison to the national average of 62.1%. Access to high quality health care was chosen as the most important thing that women, children and families need to live their fullest lives by our stakeholders.

Accomplishments in Past Year: Family SHADE utilizes the Family Knows Best Surveys (FKBS) for families of CYSHCN on a quarterly basis to get a pulse on what were the needs of the families caring for their CYSHCN between the ages of 0-21. Recent State Budget Epilogue language provided an appropriation to the Division of Medicaid and Medical Assistance (DMMA) to address the needs not easily met 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. As a result of the Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity, several workgroups were put in place to continue progress. Additionally, as in years past, Title V supported a very important activity, the Managed Care Organization health calls facilitated by Delaware Family Voices.

Plans for the Coming Year: Delaware's Title V/Title XIX Memorandum of Understanding (MOU) will continue to establish the Cross-Agency Coordination Committee with our Medicaid partners. Delaware will utilize Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making to best serve our Children and Youth with Special Health Care Needs (CYSHCN). In addition, Delaware utilized the Needs Assessment results to revitalize the approach in executing the Family SHADE program. In preparation to the contract ending, a competitive Request for Proposal (RFP) was created and administered in our state. The RFP was developed in alignment with the three NPMs that are specific to our CYSHCN population, who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (See Program Overview attachment for a complete overview)

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

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

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

In the past few years, we have allocated funds to address social determinants of health including the integration of the medical legal partnership model within our home visiting programs and our Healthy Women Healthy Babies (HWB) providers offices. More recently, funding has been allocated to key community organizations to address community needs with a range of services and/or programs that will propel Delaware forward in two areas, systems of care for children with the special health care needs and infant mortality. Over a year ago, we released a new RFP for our HWB Zones work which includes mini-grant awards to local communities to address the disparity in our infant mortality rates. We just closed out a similar RFP to award mini grants to improve systems and standards of care for children with special healthcare needs.

School Based Health Centers are being expanded in elementary schools in high need areas providing direct services to enrolled children but also wrap around support for family members such as referrals to needed services.

III.A.3. MCH Success Story

Throughout 2020 and 2021, Delaware continued to quickly pivot in the way that health care was delivered to our MCH population through the COVID-19 pandemic. Shifting to virtual services, rather than in-person, allowed for benefits such as, reducing virus exposure to mothers and children and expanding access to services.

An example of MCH virtual innovation is how we continue our outreach efforts to educate parents on the importance of developmental screening through the Books Balls and Blocks (BBB) events. Unfortunately, a series of face-to-face BBB events planned were foiled by the pandemic. To show our resilience, the Early Childhood Comprehensive System (ECCS) teams and the family engagement partners pivoted to virtual sessions. This was no easy task as it meant looking for a facilitator who could engage 1–3-year old's (virtually), an individual who could develop a curriculum based on the issues/milestones of focus, etc. The first virtual BBB occurred in the summer of 2020 and have held more than 10 virtual events. Our virtual events encourage adults to play with children in directed age-appropriate play. By participating with your child – fine motor, communication and problem-solving skills are increased. We have learned through this challenge that we can innovate once we put our minds to it. With more than 10 virtual sessions held, we are confident to embed this in the infrastructure and have been bold to plan for other cultural populations such as the Hispanic population while introducing participating parents to topics such as early literacy and early intervention services.

Another example of Delaware's virtual services to our partners was our Annual Delaware Healthy Mother & Infant Consortium (DHMIC) Summit. The theme of this year's summit was *The Power of You, the Power of Community: Shaping the Narrative to Build Healthy Generations*. For the 14 years prior, the DHMIC has made good on its promise to provide statewide leadership and coordination of efforts to prevent infant mortality and improve the health of women of childbearing age and infants throughout Delaware. And the 15th year proved to be no different – pandemic or not. The annual DHMIC Summit focused multiple sessions on galvanizing the community to end health disparities for black mothers, infants, and families. The DHMIC Summit integrated a full agenda of educational, advocacy, networking, and story-sharing opportunities to mobilize participants to better understand the reasons why, and the ways how, they can leverage their professional, personal, and community service resources to decrease racial disparities in maternal and infant health. The Summit reached 450 attendees this year, including health care professionals, community influencers, policymakers, faith community leaders, and concerned citizens to be empowered on critical topics by leadership from DHMIC, Delaware Thrives, and the Delaware Division of Public Health, along with local and national experts from various fields who are committed to ending racial and ethnic health disparities.

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.

Delaware's population as of April 1, 2020, was 989,948, according to the Census.

Delaware's population increased by 10.2% from 2010 to 2020. Population growth slowed over the past five years of the decade compared with its first five years.

The First State was above the national growth rate of 7.4%, ranking 12th among all states in population growth rate from 2010 to 2020 and first among Northeast and Mid-Atlantic states. According to estimates from the U.S. Census Bureau, in 2019, 69% of Delaware residents were White and 23% were Black. The Hispanic population is steadily increasing, from 8.7% in 2013 to 9.6% in 2019. About 20.9% of Delawareans are children under the age of 18 and 5.6% were under the age of five.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 558,753 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 180,786 residents (66% White and 27% Black). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2019 population was approximately 234,225 (83% White, 12% Black). Like New Castle, Sussex County also has a growing Hispanic population, estimated at 9.3% for 2019.

In 2019, statewide, it is estimated that there were about 181,705 women of childbearing age and 247,017 children and adolescents aged 0-21 years of age (Census). Preliminary data shows 10,457 births for 2020. According to 2018-2019 combined years of data 21.5% or 43,524 (National Survey of Children's Health/NOM 17.1) have special healthcare needs.

Economic Indicators

In Delaware, 17.5 percent of children lived in poverty in 2015-2019, which remained stable with 17.4 percent in 2010-2014. The highest rates are among those children aged 0-5 at 19.2% or 1 in 5 young children. According to Kids Count in Delaware, 2021, from 2015-2019, 26.1% of Delaware households were families with female head and children under 18. The median income of two-parent households with children under the age of 18 in Delaware from 2015-2019 was \$106,395, compared to \$31,235 for single female headed households and \$48,642 for male headed households.

Almost half (46.6%) of births occurring in the five-year period 2014-2018 were to single mothers, with 70.5% of Black births, 61.5% of Hispanic births, and 34.9% of White births occurring among single mothers (Kids Count in Delaware, 2019). As of 2020, an average of 60,101 households per month received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP). (KIDS Count in Delaware, 2020).

Availability of Health Providers

Although Delaware is a relatively small state, disparities exist between its three counties regarding healthcare access. Access to health care services poses an issue for many uninsured, underserved and otherwise at-risk populations in

Delaware. A myriad of factors affect access to health care, including lack of health insurance, lack of providers, an overall mal distribution of providers, etc. The Health Resources and Services Administration/Bureau of Health Workforce designated the following as Health Professional Shortages Areas (HPSAs). Regardless of their location, Federally Qualified Health Centers (FQHCs) are also automatically designated as HPSAs. In addition, many of the state correctional facilities are designated as HPSAs.

New Castle County:

- 4 Primary Care HPSAs
- 1 Dental HPSA

Kent County *in its entirety* is a:

- Medically Underserved Population
- Primary Care HPSA
- Dental HPSA

Sussex County *in its entirety* is a:

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

Services for CYSHCN

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

The Children and Youth with Special Health Care Needs Director (CYSHCN) sits in the Division of Public Health's Maternal and Child Health Bureau in the Family Health Systems Section. This position is essential as it functions to bolster and cultivate family and professional partnerships by working closely with families and family-led organizations. Delaware's Birth to Three system works in coordination with the CYSHCN Director who oversees the Newborn Metabolic and Hearing Screening programs to ensure policies and procedures are in place for appropriate and timely receipt of needed intervention services. Delaware's Family SHADE is a collaborative alliance of family partners and organizations committed to improving the quality of life for children and youth with special health care needs, and their caregivers, by connecting families and providers to information, resources and services; advocating for solutions to recognized gaps in services; and supporting its member organizations. Later this year, Family SHADE will be developing a process to award mini grants to community organizations to implement small place-based interventions to drive innovation and if proven effective brought to scale.

Context for Title V within the State

Governor John Carney took office as Delaware's 74th Governor in January 2017. Governor Carey heads the Executive Branch of state government in Delaware. Within the Executive Branch, the Delaware Department of

Health and Social Services (DHSS) is a cabinet-level agency and is led by Secretary Molly Magarik. The Delaware Department of Health and Social Services is one of the largest agencies in state government. DHSS has 11 divisions and employs more than 4,000 individuals in a wide range of public service jobs. In one way or another DHSS affects almost every citizen in our great state. Our divisions provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance. The Department includes three long-term care facilities and the state's only public psychiatric hospital, the Delaware Psychiatric Center.

The Division of Public Health (DPH) is one of the largest divisions within DHSS and home to Title V, the agency is responsible for planning, program development, administration and evaluation of maternal and child health (MCH) programs statewide. DPH is led by Karyl T. Rattay, MD, MS, FAAP. FACP who serves as the Division Director. DPH remains steadfast to its mission, which is to protect and promote the health of all people in Delaware. Because Delaware does not have county or local health departments, DPH administers both state and local public health programs. Within DPH, the Family Health Systems (FHS) section has direct oversight of Title V, including the Children and Youth with Special Health Care Needs (CYSHCN) program.

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

As of January 1, 2021, DPH was charging the birth facilities and midwives \$135.00 per newborn for the newborn metabolic screening including lab and follow up services. THE DPH contracts with A.I. duPont Children's Hospital to administer the statewide program which includes both the program and laboratory services. A.I. duPont Children's Hospital currently sub-contracts with Perkin Elmer to provide the laboratory services. Since outsourcing the program in 2018, the program has not increased the \$135 fee. The Delaware Newborn Screening Advisory Committee meets at least three times a year and is a governor appointed body. The Advisory Committee members, DPH and AI. duPont spent quite a bit of time discussing the last few years discussing and voting on necessary changes including the elimination of the mandated second screen, how long blood spots should be stored and expanding the newborn screening panel. All these items, eliminating the second screen, timeline for specimen collection and the length of time bloodspot cards are stored were approved by the Advisory Committee and all birthing facilities were included in the process. The Advisory Committee also voted on and provided a recommendation to the DPH Division Director to add four additional conditions, Pompe Disease, Mucopolysaccharidosis Type I (MPS I), X-Linked Adrenoleukodystrophy (X-ALD) and Spinal Muscular Atrophy (SMA) to Delaware's screening panel. With Dr. Rattay's approval, the additional conditions were added to the panel January 1, 2020. The program drafted the revisions needed to update the regulations to reflect the changes approved by the Board to change the timeline for storage of the specimens and collection of the specimens, the updated regulations were approved. The program

also drafted changes to revise the legislative code which was approved during this most recent legislative session.

Current Priorities of the Division of Public Health

The Division of Public Health 2019-2023 Strategic Plan provides a clear and proven path for the division to continue to lead the state's public health system. DPH is embarking on the Public Health 3.0 approach. Public Health 3.0 refers to a new era of enhanced and broadened public health practice that goes beyond traditional public health department functions and programs. Cross-sectoral collaboration is inherent to the Public Health 3.0 vision. We are collaborating across multiple sectors and leveraging data and resources to address policies as well as social, environmental, and economic conditions that affect health and health equity. We spent the better part of eight months re searching and analyzing our existing goals, strategies, and data; examined current national and local public health challenges; and considered future public health challenges. As a result, we have identified five strategic priorities, of which our new strategic plan is based: Promote Healthy Lifestyles; Improve Population Health and Reduce Health Care Costs; Achieve Health Equity; Reduce Substance Use Disorder and Overdose Deaths. The DPH is doubling its efforts to work collaboratively alongside Delaware state agencies and external stakeholders to address the immediate and long-term health consequences of substance use disorder and violence in communities. To tackle these complicated issues, DPH sees its role as providing prevention expertise, as well as technical assistance related to evidence based population health practices.

DPH staff will actively implement this strategic plan by improving our services, participating in robust workforce development activities, and practicing the LeadQuest 10 Principles of Personal Leadership.

Public Health has a unique lens. Our guiding principles call upon us to engage in population-based activities to strengthen community-based public health. Research continues to tell us that while 95 percent of our health care dollars are spent on acute care, these dollars account for only 10 percent of improvements to our health status. For sustainable results, our future efforts must include collaborating with communities to improve their ability to identify the most important determinants of health, to develop strategies to address them, and to implement those strategies. This strategic plan is evidence of our commitment to working strategically with our partners to achieve our vision of healthy people in healthy communities. Final updates were made and the *DPH Division Director formally adopted the DPH 2019-2023 Strategic Plan* on January 1, 2019. We expected that strategies to address these priorities as well as other priorities surfacing would be impacted by our necessary COVID-19 response efforts and these response efforts are continuing.

Simultaneously, the Division is engaged in maintaining its accreditation status by the Public Health Accreditation Board (PHAB). As an accredited public health agency, over the last four years we have made continuous progress. We report on that progress in annual reports to the PHAB. The Division of Public Health officially begun the journey to become reaccredited in January 2020 and we were able to acquire an extension on our submission deadline due to COVID. Once again, we have assembled DPH PHAB Domain Teams and have begun organizing to develop and collect required reaccreditation documents. Like our first accreditation run, we are comparing the 12 PHAB Domains national public health service standards with public health services we provide in Delaware. These PHAB standards are based on the long-standing 10 Essential Public Health Services. The DPH Domain Teams have met to develop narratives and capture documents describing how we implement public health services in Delaware in preparation for our submission later this year.

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

Health Equity

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

- **Infant Mortality.** The annual infant mortality rate for 2019 was 6.6 per 1,000 live births as compared to 5.6 for the U.S. The 2019 annual rate for DE was 6.6 per 1,000 live births. The five-year infant mortality rate (2015-2019) was 7.2 (12.5 for non-Hispanic blacks, 8.0 for Hispanics, and 4.2 for non-Hispanic whites). The annual black infant mortality increased from 11.5 per in 2018 (32 infant deaths) to 12.3 per 1,000 live births (35 infant deaths) in 2019. The five-year Black to White disparity ratio was about 3 times.
- **Breastfeeding.** As per the PRAMS 2019 data the percent overall prevalence of ever breastfed among those who delivered was 87.3% and currently breastfeeding/at the time of survey was 59.0%. As per the PRAMS data, the 2019 prevalence of ever breastfed among non-Hispanic black was 86.0% as compared to 85.3% among non-Hispanic white, and 91.1% among Hispanics. Similarly, the 2019 prevalence of currently breastfeeding (or at the time of survey) among non-Hispanic blacks was 44.7% as compared with 62.7% among non-Hispanic whites, and 62.9% among Hispanics.
- **Teen Births.** The 5-year average teen birth rate in the U.S. in 2002-2006 was 41.0 (21.2 for non-Hispanic white and 59.3 for non-Hispanic blacks) and the 5-year average teen birth rate in Delaware was 41.1 (25.0 for non-Hispanic whites, and 68.9 for non-Hispanic blacks). The 5-year average in teen birth rate in Delaware declined by (~56%) from a high of 41.1 to 18.2 in 2015-2019 with declines ~57% among non-Hispanic white from 25.0 in 2002-2006 to 10.7 in 2015-2019 and ~59% declines in non-Hispanic blacks from 68.9 in 2002-2006 to 28.4 in 2015-2019. The disparity ratio in the teen birth rates was 2.7 times for Black teens to White teens. 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.** Overall, in 2018-2019, 89.5% of Delaware children reported to be in excellent/very good health (Hispanic, 78.1%; White, 94.9%; Black, 84.3%; Other, 94.4%) as compared with 90.3% (Hispanic, 87.4%; White, 93.0%; Black, 85.3%; Other 90.4%) in the U.S. Health status varied by income status in Delaware similar to the U.S. Health status improved with increased household incomes. For instance, in Delaware, 85.1 % of children in household 0-199% FPL indicated "Excellent/very good health" as compared to 88.7% in 200-299%FPL, 89.3% in 300-399% FPL, and 95.5% in 400% or greater FPL categories.
- **Overall Health women of childbearing age.** According to 2016-2019 BRFSS data women of childbearing ages (18-44 years) had poor health based low SES. Health status improved with increase in levels of education and income. Among women of childbearing ages with less than high school, the percentage of women with excellent/very good health was 73%, 81% for high school graduates, 85% for those who attended technical school/or some college, and 95% for those who had a college degree. Similarly, 71% of women of childbearing ages whose income was <\$20,000 indicated they had excellent/very good health as compared to 83% in income category of \$20,000-\$49,999 and 94% in \$50,000 or more income category. With regards to race and ethnicity, 88% of White (non-Hispanic) women reported excellent/very good health as compared to 84% Black (non-Hispanic) women, 76% Hispanic women, and 86% other races.
- **Smoking.** Cigarette use during pregnancy declined ~30% from 12.3% in 2010 to 8.6% in 2019 as per birth certificate data. The 2019 smoking rate among White (non-Hispanic) was 12.1% (15.0% in 2010) as compared to 8.0% in Black (non-Hispanic) (11.8% in 2010) and 2.7% in Hispanics (2.9% in 2010). According the PRAMS 2012-2019 data, the prevalence of smoking in last 3-months of pregnancy in 2012 was 13.3% and the prevalence declined in 2019 to 10.1% ~ 3 percentage points (or 24%).
- **Medical Home.** In 2018-2019, 44.8% of white children with special health care needs had a medical home (U.S. 47.0%) as compared with 32.9% of black children (U.S. 40.6%) and 43.9% of other children (U.S. 40.1%). The 2018-2019 estimate for Hispanic was unavailable due to low sample size. Source: 2018/19 National Survey of Children with Special Health Care Needs.

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 and released the second version of the [Healthy Equity Guide for Public Health Practitioners and Partners](#). The Delaware Division of Public Health (DPH), the University of Delaware's School of Public Policy & Administration, and other partners created the guide to help Delawareans better understand tools and strategies that promote health equity and support upstream population health approaches. The document is designed to assist all sectors which can include but are not limited to government, education, workplaces, private sector, nonprofit agencies, faith-based institutions, and health care settings address underlying causes of health inequities in communities and promote optimal health for all in Delaware. Every person deserves equal access to safe communities that foster opportunities to achieve optimal health and well-being. The Delaware Healthy Mothers and Infants Consortium continues to emphasize health equity and the social determinants of health, through highlighting the topic at Annual MCH Summit agendas, bestowing health equity awards to individuals and organizations to recognize efforts and launching an online [Health Equity Action Center](#).

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

Health Care Reform Efforts in Delaware

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

After receiving federal grant monies through the Centers for Medicare and Medicaid's State Innovation Model (SIM) project, Delaware has made a significant investment in transitioning to value-based payment models. Value based payment models enable collaboration between providers and health systems in addition to allowing a greater focus on keeping people healthy through improving primary care. This is vastly different from the traditional Fee for Service

model that aligns payment for services with volume, regardless of patient outcomes and whether the overall population of the state is getting healthier. The State has supported these changes from a policy perspective by setting the expectation for Medicaid Managed Care Organizations (MCOs) and State Employee/Retiree Third-party administrators to offer and promote the adoption of value-based models.

In 2017, House Joint Resolution 7 authorizes the Department of Health and Social Services to establish a health care spending benchmark linked to growth in the overall economy. In 2018, the Department of Health and Social Services (DHSS), the Delaware Health Care Commission (DHCC) and the Delaware Economic and Financial Advisory Council (DEFAC) worked together to establish the spending and quality benchmarks. Insurers reported initial calendar year 2018 baseline data in 2019, giving them and the Department experience in collecting and reporting data, which is essential to the benchmarks and improving the process moving forward. Governor Carney established health care spending and quality benchmarks in Executive Order 25, issued in November 2018. The spending benchmark is set on a calendar year by the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee. DEFAC set the benchmark at 3.5% for calendar year 2020, with the rate transitioning down to 3.0% for calendar years 2022 and 2023. In December 2020, the Delaware Health Care Commission revised the existing quality benchmarks, as required by Executive Order 25. The results of the review will establish Quality Benchmarks for 2022-2024. The revised/new Quality Benchmarks will be announced in 2021. While we are still addressing the health care, humanitarian and fiscal crisis created by COVID-19, our essential purpose in driving change to make health care better for all Delawareans through our “Road to Value” remains vitally important. We need to support our health care system to rebound from the global pandemic with value-based goals so it can be stronger going forward. Now, more than ever, our vision to improve transparency and public awareness of spending and quality in our State through the adoption of spending and quality benchmarks will assist in these efforts.

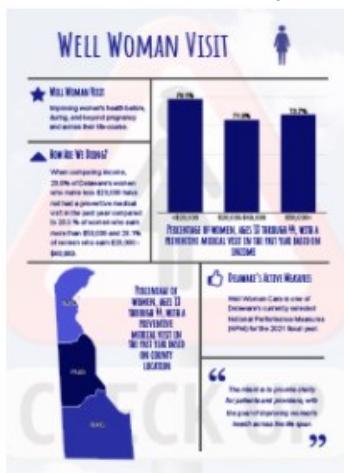
III.C. Needs Assessment

FY 2022 Application/FY 2020 Annual Report Update

This year we reconvened our Title V team to prepare for the likelihood of emerging and shifting priorities due to the impacts of the COVID-19 pandemic on Delaware's maternal and child health population. We had just finished our Five-Year Needs Assessment, but the COVID-19 pandemic had impacted our MCH population, and we felt the need to keep it on our radar. Our Title V team knew that we would need to assist our partners and help address their needs. The first goal of our Title V team was to use a data-informed method to identify and prioritize Delaware's top health issues as a result of the pandemic, related to the health of women, infants, children and youth, including children and youth with special health care needs. Additionally, keeping the pandemic in mind our team aimed to incorporate stakeholder and public input into finalizing any modifications to the priority areas by population domain for action planning. The Needs Assessment Steering Committee was responsible for reviewing and understanding the data, canvassing and surveying our MCH team for emerging issues and concerns they are observing from the data, and identifying priority areas of concern from the national health areas.

Our Title V team reviewed state and national data that was specific to Delaware's MCH populations. Our team used the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); and Delaware Health Statistics (birth records, death records, hospital discharge data).

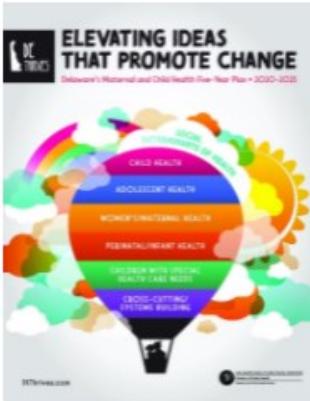
Through our 2020 Needs Assessment process, MCH created detailed and specialized Health Infographics for each of the 15 National Performance Measures. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it related to each measure. Information such as Delaware's goals and objectives, Delaware's baseline data, how Delaware compares to our neighboring states as well as nationally, and more. This year, MCH amended these Health Infographics once the 2019 and 2018/2019 NSCH data was released. Below is a picture of one of our Health Infographics. All of our Title V and Needs Assessment information, including our health Infographics, is found in one central location, our DEThrives website (<https://dethrives.com/title-v>). We encourage all of our stakeholders and partners to check back often for updated information and resources.



As part of the Title V Maternal and Child Health (MCH) Block Grant, Delaware has developed another graphic for our partners to use as an additional resource. This colorful snapshot is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. Our Plan is organized by the six reporting domains, which includes five MCH population domains (Women/Maternal Health, Perinatal/Infant Health, Child Health, Children and Youth with Special Health Care Needs (CYSHCN), and Adolescent Health). The sixth domain addresses state-specific Cross-

cutting/Systems Building needs.

This State Action Plan offers an at-a-glance snapshot for the public, our partners, and our stakeholders to better understand our five-year plan. This report identifies the priority needs within each of the six domains, the program objectives, key strategies and relevant national and state performance measures for addressing each objective. Provided below is a picture of our colorful State Action Plan that can be utilized by our partners.



Our team met throughout the year and was originally strategizing the various ways to gain a pulse of Delaware's women, adolescents, and children, including children and youth with special health care needs. Originally, our goal was to include data relevant to the MCH population on the State Action Plan Snapshot. Our intentions were for our partners and stakeholders to be able to view Delaware's data in one document. Unfortunately, we were not able to see this through during this past year as obtaining certain data has been a challenge. Additionally, our team would need to work through various hurdles that arose, such as: repetitive display of data, partner agencies not allowing us to use the data publicly, and obtaining the perfect conduit for partners accessing the data. For example, Delaware would like to pursue an app for our Title V information. We feel that our partners, stakeholders and the public will be in favor of having Delaware's data readily available via an application on their phone. We believe finding all maternal and child health resources in one place would be beneficial to their work. Our plan is to begin, though, with obtaining and displaying the data on our colorful State Action Plan Snapshot first, and then we will pursue the app.

Our Title V team set out to get a pulse of where our community needs may have shifted, the impacts of COVID-19 on our maternal and child health population, how we can address each need and the possibility of tweaking our priorities and strategies because of the emerging needs and trends. We were looking to find out what data to pull to begin our review, what issues should we be paying attention to, what key items to obtain a pulse on, what key questions to include when surveying our partners, what partners should we be talking to, what are items that we need to ensure we don't miss, and more.

After reviewing the available data and convening as a team, the areas that rose to the top for our Title V team were women of childbearing age and adolescent health. As both of these domains were already part of our Title V priority areas, our Title V team determined the best course of action would be to survey our partners for input in their specialized maternal and child health population domain. We wanted our partners to know that Title V is committed to improving our ability to support programs continuing to address the MCH population during the pandemic. We aimed to better understand how our stakeholders were adapting to the ongoing challenges of the pandemic and we wanted to be more informed of the ways that our partner's programs were adjusting to address COVID-19 related response needs. In addition, we felt that we should be closely looking into the impacts of COVID on service delivery and the modifications our partners have made due to the pandemic in their particular fields. We were hopeful to find out what options have been the most impactful.

Additional evaluation activities included an effort led by the SSDI Project Director in working with Forward Consultants for this ongoing Title V Mini Needs Assessment process. MCH intensely worked with Forward Consultants to modify our 2020 Needs Assessment Professional Stakeholder Survey. Our finalized objectives for our Mini Needs Assessment were:

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

Our team knew that we wouldn't be removing any priorities previously selected as a result of the 2020 Needs Assessment and new five-year grant cycle. Rather, we would be addressing additional priorities that rose to the top. Therefore, we chose to keep our original Professional Stakeholder Survey that was utilized during the 2020 Five-Year Needs Assessment and modify it to include questions pertaining to the COVID-19 pandemic. Additionally, we selected to utilize the previous survey in an effort to compare data from one survey to the next. We included questions about services, staff, clients, sustainability, and the utilization of telehealth as a result of the pandemic. When we surveyed our stakeholders regarding the 15 National Performance Measures (NPM), we focused on each NPM given the current pandemic climate. We already understood which priorities were most important for Delaware after the 2020 Needs Assessment. By focusing our questions surrounding the pandemic, we were looking for our stakeholders to identify the priorities that are most important given our current health crisis.

Part of this survey included additional questions for our Title V Partners of the various ways Title V is able to provide technical assistance. The Division of Public Health (DPH) coordinates and collaborates with many organizations and other state agencies to implement activities that address grant goals and objectives. Title V was concerned about how we can better support our partners. We asked for various ways Title V could provide technical assistance to our partners to be better responsive to their needs. We listed the different ways Title V could provide technical assistance and requested they rank their most pressing needs. We supplied examples such as:

- Provide data
- Assist with data to apply for resources
- Strategic planning
- Disseminate information via social media outlets
- Guide a grant writing process

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

Our Professional Stakeholder Survey for our Mini Needs Assessment was ultimately distributed to more than 950 partners and stakeholders of MCH service agencies, organizations, coalitions and programs for input on MCH population needs, the impact of the COVID-19 pandemic, and technical assistance needs. The survey also provided stakeholders an opportunity to rank the fifteen national priority areas as a result of the pandemic on their

organization. Unfortunately, because our partners continue to work through the pandemic, responses were not as robust as we had originally hoped. Even after repeat requests, only a fraction of responses were received.

When MCH conducted our Title V Five-Year Needs Assessment Professional Stakeholder Survey in March 2020, it was at the very beginning of the COVID-19 pandemic and only 109 usable surveys were completed. Although this Mini Needs Assessment was still a good mix of responses, we had hoped for more than the 85 responses received. Potential survey respondents were instructed to complete the survey by July 23, 2021; however, late responses were allowed until July 30, 2021 given the summer vacation season and to allow for more entries to increase the number of survey respondents that could be included for analysis.

Forward Consultants completed an analysis of the survey and our Title V team recently met to review the information to determine if any new objectives or Evidence-Based Strategy Measures (ESM) emerged because of the pandemic. As a result of the analysis, our Title V team learned that about three-quarters of survey respondents ranked Well-Woman Visit within their top five NPMs for being the most important to address. In addition, it was noted that the majority of respondents stated that their organization did not change any staff during the COVID-19 pandemic. Approximately half of respondents claimed that they did not reduce services due to the pandemic. However, almost one-third of respondents said that their organization reduced some of their services.

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

Our Title V team requested Forward Consultants complete an in-depth analysis of the results of this Mini Needs Assessment and compare to the results of the Five-Year Needs Assessment results. Our team was specifically interested in understanding any differences or likenesses that resulted when comparing the stakeholder responses in selecting important National Performance Measures pre-COVID and post pandemic. Specifically, we asked if anything stood out that would lead us to deviate from our current course and wanted to justify any changes. Interestingly, there were not any major differences in NPM-related responses in either survey.

In the original Title V Needs Assessment Professional Stakeholder Survey, respondents ranked (1) adequate insurance, (2) developmental screening, (3) well-woman visit, (4) risk-appropriate perinatal care, and (5) physical activity (children, adolescents) as the most important NPMs in terms of what they thought would be important to address. This is fairly comparable to the updated survey in which respondents ranked (1) well-woman visit, (2) risk-appropriate perinatal care, (3) adequate insurance coverage, (4) breastfeeding, and (5) low-risk cesarean delivery as the top NPMs to address.

As provided in our last Title V Application, although our stakeholders ranked Risk-Appropriate Perinatal Care as an important National Performance Measure, it was not selected as one of Delaware's priority areas. This is because there is no political will behind this measure. In addition, neither MCH or DPH has influence over a physician referring their higher risk mothers to deliver at a hospital with a level III or higher Neonatal Intensive Care Unit that can provide the proper care the newborn requires. Instead, the Title V team is focused on areas where we can align our collaboration and resources to make an impact on the maternal and child health population.

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

incorporate mental health in addition to physical activity.

We learned that our Title V funded partners ranked “provide data” as either the first or second choice by 60% of Title V partners. Conversely, assistance with strategic planning was considered to be the first or second most important need to be addressed by only 20% of Title V partners. Therefore, during this upcoming year, our SSDI Project Director will work with our CDC Epidemiologist to continue with a previous goal identified prior to the pandemic. We will pursue including data relevant to the MCH population on the State Action Plan Snapshot created last year. Our intentions will be for our partners and stakeholders to be able to view Delaware’s data in one document. This will also include previous year’s data, so our partners can track the information from year to year. We understand that we may face additional challenges that might rise, such as repetitive display of data, partner agencies not allowing us to use the data publicly, and obtaining the perfect conduit for partners accessing the data. In the future, Title V may pursue an app for our Title V information. We feel that our partners, stakeholders and the public will be in favor of having Delaware’s data readily available via an application on their phone. We believe finding all maternal and child health resources in one place would be beneficial to their work. Our plan will be to begin with obtaining and displaying the data on our colorful State Action Plan Snapshot first, and then we will research pursuit of an app.

As the Title V agency, DPH operates a comprehensive array of programs and services to promote and protect the health of Delaware’s mothers and children, including children and youth with special health care needs. Within, DPH, the Family Health Systems section houses many of these programs, as described within the application. However, the capacity to support the MCH population extends throughout all sections of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers and supports for healthy lifestyles (physical activity, nutrition, tobacco cessation), to name a few. An overview of DPH’s partnerships, collaborations and coordination surrounding our programs and services for the MCH population is summarized below.

The Delaware Title V MCH program can meet the needs of women, mothers, infants, children, CYSHCN and adolescents through partnership, collaboration and coordination with other entities. Delaware has many advisory boards, councils and coalitions that our MCH program works with to extend the reach of Title V, guide our work and expand on the overall capacity to support mothers, children and families. Two of the largest groups of partners coming together around MCH issues in Delaware are the DHMIC and Family SHADE.

MCH’s finest collaboration is the Delaware Healthy Mother & Infant Consortium (DHMIC). The DHMIC pursues the health of women, infants and families through a life course approach. The DHMIC approach includes planning with the community, thinking holistically about women’s health and addressing inter-generational health. The DHMIC supports a continuum of services promoting optimal health from birth throughout the lifespan, from one generation to the next. Formed as a statewide vehicle to address infant mortality, the consortium includes approximately 20 Executive Committee members, including two representatives from the House of Representatives, a representative from the Governor’s office, a representative from the Department of Services for Children, Youth and their Families (DSCYF), the Secretary of the Department of Health and Social Services, and fifteen additional members approved by the Governor who represents the medical, social service and professional communities as well as the general public. These additional representatives come from the State Senate, DPH, hospital systems, universities, faith-based communities, and more. The DHMIC invites over 150 partners and stakeholders to the quarterly meetings.

In December 2018, the consortium developed a three-year strategic plan with one- and three-year objectives. One of the goals was to create three workgroup committees: Well-Woman, Social Determinants of Health, and Maternal Infant Morbidity and Mortality. Delaware’s Perinatal Quality 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. For more information on the DHMIC, please visit this website, <https://dethrives.com/dhmic>

This past April 2021, the DHMIC hosted our 15th Annual Delaware Healthy Mother & Infant Consortium Summit. The theme of this year's summit was *The Power of You, the Power of Community: Shaping the Narrative to Build Healthy Generations*. The annual DHMIC Summit focuses multiple sessions on galvanizing the community to end health disparities for black mothers, infants and families. The DHMIC Summit integrated a full agenda of educational, advocacy, networking, and story-sharing opportunities to mobilize participants to better understand the reasons why, and the ways how, they can leverage their professional, personal, and community service resources to decrease racial disparities in maternal and infant health. The Summit reached 450 attendees this year, including health care professionals, community influencers, policymakers, faith community leaders, and concerned citizens to be empowered on critical topics by leadership from DHMIC, Delaware Thrives, and the Delaware Division of Public Health, along with local and national experts from various fields who are committed to ending racial and ethnic health disparities.

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

Family SHADE holds monthly membership meetings where members meet and collaborate with others who are living and working with children with disabilities or chronic health care condition. In addition, Family SHADE sponsors relevant trainings, seminars and virtual workshops that were selected by our partnering organizations and families of CYSHCN. These topics were all coordinated with the input of organizations that serve the CYSHCN population and families that needed to participate in trainings on these topics so that they could enhance their quality of life for their CYSHCN overall wellbeing.

The DHMIC and Family SHADE represent two of the largest groups of partners coming together around MCH issues, but there are many other advisory boards, councils, and coalitions that our MCH program works with to extend the reach of Title V, guide our work, and expand the overall capacity to support mothers, children, and families. For example, the Help Me Grow Advisory Committee, convened by DPH, consists of representatives from organizations across the state. Similarly, the Home Visiting Community Advisory Board pull together home visiting and partnering programs from across the state to ensure a coordinated continuum of home visiting services. In addition, the Governor's appointed Early Hearing Detection and Intervention (EHDI) Board 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 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 have partnered with Project LAUNCH and the Division of Substance Abuse and Mental Health in combating the opioid epidemic. The State of Delaware created a committee bringing together the Division of Public Health, Division of Family Services, and the Division of Substance Abuse and Mental Health. The group is made up of key leadership including all three Division Directors, two Deputy Directors and senior program directors including both the Title V Director and Deputy Director/MIECHV Project Director. The group decided to work on three key goals, a MOU, training for direct service staff and education.

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

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

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

Home visiting supervisors, treatment providers, Division of Family Services administrators, supervisors, and caseworkers have come together to form the Delaware Multisystem Healthy Action Committees (MSHAC) in each county. The initial kick off was held in September 2016 and quarterly meetings in each of our three counties continue to collaborate. The charge of MSHAC is to plan how to serve families with substance use disorder better through a multi-agency approach.

Agenda topics for these meetings have included sharing resources and educational materials, Neonatal abstinence syndrome (NAS) hands on soothing techniques training, updates from local treatment providers, coordination of services and referrals, tips for using DFS hotline reporting, related state legislation, and even walking through substance abuse specific cases in each agency. Supervisors and agency representatives are asked to refer information back to their staff of professionals who work directly with substance abuse clients and families. Guest speakers have been invited quarterly and continue to enrich the knowledge of the committee.

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

Parents continue to be engaged through 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 to discuss and 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.

Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Delaware's 2020 Title V Needs Assessment benefited from the commitment and engagement of its stakeholder community. Our Title V MCH workforce realized the need to approach the process with a holistic and comprehensive strategy. Instead of relying solely upon data to drive the assessment and prioritization process, the Delaware Division of Public Health employed multiple methods to engage partners and consumers, valuing their unique perspectives, contributions and assessment of the state of MCH in Delaware. Through the Needs Assessment process, Title V was looking to determine Delaware's population health status, Title V's program capacity (organizational structure, agency capacity and MCH workforce capacity), as well assess Delaware's partnerships and ability to collaborate and coordinate efforts. The Needs Assessment helped Title V establish priority needs 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.

The Title V team recognized the need for Delaware to seek and obtain a broad spectrum of input and obtained many voices throughout the process – men, women, families, stakeholders, MCH workforce, partners, health experts, advisory boards, and more. Delaware partnered with John Snow Inc. (JSI) to conduct the Title V Needs Assessment closely following the steps of the State Title V MCH Needs Assessment Conceptual Framework which consisted of the following major tasks:

Establish Assessment Advisement Process. DPH established a MCH 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.

Develop Plan for Public Input Process. Several methods were used to gather public input including regular email updates to stakeholders, surveys, community forums/listening sessions, key informant interviews and focus groups. Qualitative data such as focus groups and key informant interviews can be considered to be the stories behind the data. The timing and sequence of gathering public input was iterative with each activity laying the groundwork for subsequent activities.

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. The Title V team also worked with Aloysius Butler & Clark (AB&C) to conduct 12 consumer Focus Groups regarding several MCH issues related health care and their community. A total of 92 women and men participated. Four maternal health groups focused on questions related to women's health. Three groups were conducted in English and one group was in Spanish. Four groups focused on mothers and children and youth with special health care needs. Two of those groups were in English and two were conducted in Spanish. Two father/partner groups were conducted. And lastly, two preconception groups were held with African American women without children. Discussion guides were created for each set of focus groups and were translated in Spanish. Participants received handouts for which they were asked to review and identify priorities for women's health, a father's role in their child's live and children and youth with special health care needs.

Surveys. MCH worked with JSI to craft a Professional Stakeholder Survey that was distributed to more than 800 stakeholders 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. Unfortunately, because the COVID-19 pandemic occurred, responses were not as robust as we had originally hoped. The Stakeholder Survey, for example, was distributed to more than 800 stakeholders, but after many repeat requests, only 109 usable surveys were obtained. Although this was still a good mix of responses, we had hoped for more. Many internal and external partners were unavailable as they were addressing other critical needs within the maternal and child health community related to Delaware's response to COVID-19. The findings informed our decision-making efforts to select our National Performance Measures, State Performance Measures and Evidence-Based Strategy Measures.

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. Thirteen Key Informant Interviews were conducted with partners representing every population domain and a Workforce Capacity Analysis was completed by 15 MCH leaders currently in the workforce.

Conduct Inventory of Relevant Quantitative Data for Review. Our Title V team reviewed state and national data that was specific to Delaware's MCH populations. The team used the following data sources:

Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior System (YRBS); National Immunization Survey; National Survey of Children's Health (NSCH); Pregnancy Risk Assessment Monitoring Systems (PRAMS); Delaware Health Statistics (birth records, death records, hospital discharge data). The Title V team used the data to create detailed and specialized Health Infographics for each of the 15 National Performance Measures. The aim was to provide our stakeholders and partners with a snapshot of Delaware's health status as it related to each measure. Information such as Delaware's goals and objectives, Delaware's baseline data, how Delaware compares to our neighboring states as well as nationally, and more.

Select Final Priorities and Performance Measures. The MCH Title V team carefully selected and assembled fellow DPH peers to be members of our Steering Committee where an intense review and scrutiny was conducted on our Five-Year Needs Assessment data collection. The Steering Committee reviewed each Infographic, the Focus Group Study, our Stakeholder Survey Report as well as the Key Informant Interview Analysis. In addition, our group was diverse with field expertise, a robust discussion developed after each National Performance Measure was presented.

Upon conclusion of our Steering Committee Summit, in order to assess the needs of our MCH population, we tasked our members to prioritize and rank each National Performance Measure based on:

- Size of the Health Issue;
- Seriousness of the Health Issue;
- Disparities in Outcomes;
- Current Level of Intervention;
- Community Support;
- Political Will;
- Importance to Consumer; and
- Alignment with National/State Goals.

All our Needs Assessment information is found in one central location, our DEThrives website, <https://dethrives.com/title-v>. Here MCH has all the detailed Title V information, including infographics on each of our 15 National Performance Measures, a framework of the Needs Assessment process, reports on our Focus Group studies, results of the Stakeholder Survey and more. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions. During the month of March alone, our Title V page on DEThrives received 275 pageviews.

Fortunately, our Title V program is housed in the same section as our MIECHV program within the Division of Public Health. We were able to easily coordinate efforts, sharing data analysis and consumer feedback. In completing our 2020 MIECHV Needs Assessment, we chose to adopt an independent method for identifying communities at risk. Making use of diverse and highly vetted data sources, several indicator measures were developed for the State of Delaware. The indicators chosen for this report tended to center slightly more on socioeconomic wellbeing and less on health status since more timely data was available on the former than on the latter and due to the state's vested interest in focusing on the social determinants of health. Using these indicators, an analysis was then conducted on aggregated zip codes – or “zones” – as the geographic unit of interest. The indicator results at the zone level were compared across zones and the top five zones for each indicator were highlighted. The zones most frequently highlighted among the top five indicators were classified as “at-risk” communities.

Relatively recent zip code level data was available for the following indicators, were ultimately used to determine the at-risk zones:

- Adults with No Dental Visit in Past Year
- Adults who Binge Drink
- Adults who Smoke
- Age-Adjusted Mortality Rate

- *Chronic Conditions (3 Sub-Indicators)*
 - *Adults with Diabetes*
 - *Adults with High Blood Pressure*
 - *Adult Obesity*
- *Educational Attainment (Less Than High School Graduate)*
- *Health Insurance (No Coverage)*
- *Limited Access to Health Care*
 - *Adults Delaying/Not Seeking Care*
 - *Adults with No Usual Source of Care*
- *Limited English Proficiency*
- *Low Birth Weight*
- *Poverty (Below 100% FPL)*
- *Unemployment*

The zones identified during our MIECHV Needs Assessment process closely align with the high-risk zones identified in when determining areas of need for our HWHB Zones program. The HWHB Zones program is discussed in detail under the Women/Maternal Health Domain reports. These areas will be considered as we implement programs to address our identified Title V priorities.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

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. As mentioned, the infographics provide a summary of all the 16 national performance measures and 3 additional priorities evaluated for each population domain. This infographics can be found, <https://dethrives.com/title-v>.

Maternal Health/Women's Health:

In 2015, only 72.6% of Delaware women, ages 18-44, had a preventive medical visit each year. The percentage rose slightly through the years and in 2018, 78.3% of women had the preventive medical visit according to the NSCH. Black women had the highest rate of receiving a preventative well visit compared to other races. Patterns of decline are seen by income level.

Our infant mortality rates have been improving over the years, however the disparity as persistent and our stakeholders selected reducing black infant mortality as a priority for the next 5 years. The annual infant mortality rate for 2018 was 5.9 per 1,000 as compared to 5.7 for the U.S. The provisional 2019 annual rate for DE was 6.4 per 1,000. The five-year infant mortality rate (2014-2018) was 7.3 (12.2 for non-Hispanic blacks, 8.4 for Hispanics, and 4.5 for non-Hispanic whites). The provisional 2015-2019 five-year infant mortality rate was 7.2 (12.3 for non-Hispanic blacks, 8.0 for Hispanics, and 4.3 for non-Hispanic whites). The annual black infant mortality saw a 15% (19% if provisional data are included) decline in annual rates. For instance, the annual non-Hispanic IMR has been declining from a high of 13.5 per 1,000 live births to 11.5 and 2018 and 10.9 in 2019 (provisional data).

Women receiving an annual preventative well-visit was seen as of high importance; ranked #3 among the 15 priority areas by our stakeholders. Our Focus Group Study results stressed that women collectively understood that providers played a key role in their lives and had a deep desire for conversation and encouragement on "how to" health conditions and concerns. Participants described a variety of clinical encounters (positive and negative) in which the clinician is directive – do this, do that, read this; the interaction is didactic in nature. On the one hand, this is acknowledged as indicative of competent advocacy, but in many instances, there are a whole host of issues that go unspoken because the interaction is not conversational in nature. These issues are slightly "off topic" but highly related to the topic: for example, referrals may

prompt worry over the severity of illness; anti-depressant/antianxiety medications may prompt worry over a parent finding out about it. This phenomenon is very apparent for informational material, such as for nutrition and physical activity. Handouts are informative in a general way but prompts deeper questions about HOW to implement the guidance in their own lives, which are not discussed – patients are just sent home with the information. This issue may also be related to the Insurance Theme; patients come in for brief problem-focused issues, not an annual preventive care exam, during which there could be more time to talk. This issue may be amplified when providers are residents/medical students. Not being able to converse is very important for mental health, nutrition/exercise, and (exceptionally important) for family planning. This feedback during the focus groups validated our decision to incorporate community health workers to work with providers to ensure better communication.

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. According to PRAMs data, between 2012-2015 34.5% of women either wanted to become pregnant later or didn't want to be pregnant then or at any time in the future. PRAMs data between 2016-2018 indicates unintended pregnancies are decreasing in Delaware with 27.5% of women either wanted to become pregnant later or didn't want to pregnant then or in the future. In working with or stakeholders, we are going to continue to prioritize decreasing unintended pregnancies even with the decreases. Based on the consumer feedback, we clearly have more work to do to promote a better relationship with women among providers and to address issues such as implicit bias with our providers.

Perinatal/Infant Health:

According to the National Immunization Survey, Delaware infants who are ever breastfed in 2018 was at 77.4% compared to 77.2%. When you view the percent of Delaware infants who are breastfed exclusively through six months, the numbers are significantly lower. In 2016, 18.9% of infants were exclusively breastfed through six months, compared to 20.5% in 2017 and 23.6% in 2018.

Our Stakeholder Survey ranked Breastfeeding the eighth highest of Most Important NPMs, overall. In addition, Breastfeeding was ranked second in terms of Community Awareness, Desire to Address and Progress has Been Made on the Issue.

While Stakeholders ranked Risk-Appropriate Perinatal Care as the fourth highest Most Important National Performance Measure, it was not selected as one of Delaware's priority areas. This is because there was no political will behind this measure. In addition, neither MCH or DPH has influence over a physician referring their higher risk mothers to deliver at a hospital with a level III or higher Neonatal Intensive Care Unit that can provide the proper care the newborn requires. Instead, the Title V team is focused on areas where we can align our collaboration and resources to make an impact on the maternal and child health population.

Based on available data, the percentage of Delaware infants placed to sleep on their backs was generally increasing from 77.2% in 2012 to 81.9% in 2017. In 2018, it took a dip, though, to 79.8%. The percentage of Delaware infants who sleep alone on an approved surface has increased from 36.0% in 2016 to 38.7% in 2018. Our Stakeholders ranked Safe Sleep as first among the percent who Agree Progress has Been Made on the Issue.

Delaware historically has a high infant mortality rate and significant racial disparities exist as well. While the state experienced a 22% reduction in infant mortality between 2000 and 2017, Delaware's infant mortality rate of 7.3 deaths per 1,000 live births in 2013-2017 is still significantly higher than the national rate of 5.9 deaths per 1,000 live births in 2013-2017.

The leading cause of infant mortality is premature birth, and such births have both short-term and long-term negative impacts, and disproportionately impact women of color. Black infants in Delaware are more than twice as likely as white infants to die before their first birthday. Factors such as obesity, diabetes, hypertension, chronic disease, smoking, stress, race and racism, genetics, infection, and maternal age, along with multiple social determinants, all contribute to premature death and infant mortality.

In Delaware, black women have an infant mortality rate of 12.5 deaths per 1,000, which is approximately two and a half times that of white women, for which the infant mortality rate is 5.1 deaths per 1,000 live births.

As a result of our Steering Committee Summit, the Title V team selected Breastfeeding as the top priority for Delaware to address in the coming five years for the Perinatal/Infant Health Domain.

Child Health:

Based on available data, Delaware is among the lowest of its surrounding states when comparing children, ages 9-35 months, who received a developmental screening in the past year, where only 25.5% of these children received the screening. Delaware is also below the national average of 33.5% of children with the screening. Developmental Screening was selected as the Most Important NPM in the Child Health Domain as a result of our Stakeholder Survey. In addition, it was ranked as the second highest priority overall.

The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders. Ranking second is this population domain and tenth overall. Our stakeholders recognize that dental health equals overall health and the Title V team has identified that MCH is able to align our collaborations and resources to make an impact. According to the 2017/2018 National Survey of Children's Health (NSCH), 18.0% of Delaware children, ages 0 through 17, have not had a preventive dental visit in the past year. The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders.

As a result of our Steering Committee Summit, the Title V team selected Developmental Screening and Preventive Dental Visit as top priorities for Delaware to address in the coming five years for the Child Health Domain.

Delaware's stakeholders ranked Injury Hospitalization as the lowest priority when ranking overall priorities and ranked it the lowest among all priorities in the Child Health Domain. Similarly, the other National Performance Measures in the Child Health Domain did not score high.

Adolescent Health:

The percentage of adolescents who have had a preventive medical visit in the past year has been declining in Delaware. In 2016, the percentage was 89.5%, while in 2017 the percentage declined to 84.2% and in 2018, Delaware's percentage of adolescents who have had a preventive medical visit in the past year fell to 70.2%.

As with the Child Health Domain, Injury Hospitalization was the lowest priority when ranking overall.

Based on available data, Delaware is among the lowest of its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day. 15.3% of Delaware's adolescents are physically active zero days per week. Additionally, Delaware is also the lowest of its surrounding states when it comes to those adolescents being physically active every day, at only 11.6%.

The Adolescent Well-Visit ranked the Most Important National Performance Measure within the Adolescent Health Domain and the seventh priority overall. As a result of our Steering Committee Summit, the Title V team selected Physical Activity and Adolescent Well-Visit as top priorities for Delaware to address in the coming five years for the Adolescent Health Domain.

Our Title V team selected the Adolescent Well-Visit because of the versatility of the measure. The team selecting this measure with the goal of incorporating other Adolescent Health Domain priorities within the well-visit measure. Priorities like bullying, mental health, smoking, healthy lifestyles, transition and trauma could all be bundled within this measure.

Children with Special Health Care Needs:

According to the 2017/2018 National Survey of Children's Health, only 70.0% of Delaware's children, ages 0 through 17, with special health care needs are adequately and continuously insured. Access to high quality health care, including having adequate health insurance that reduced barriers to primary and specialty care was chosen as the Most Important thing that women, children and families need to live their fullest lives by our stakeholders. In addition to the Most Important, Adequate Insurance was also selected by our stakeholders as the Most Unmet need of women, children, and families in Delaware communities.

According to the 2017/2018 National Survey of Children's Health, only 46.0% of Delaware children with special health care needs have a medical home. Additionally, 77.6% of Delaware adolescents, ages 12 through 17, with special health care needs, have not received services necessary to make transitions to adult health care.

The Focus Group Study results showed that parents are concerned that their children with special health care needs are uncomfortable changing providers and may not accept care easily from a new doctor. Parents stressed the importance of transitioning to an adult world and that it is a process of teaching the child behavioral rules all over again, where there is one set of rules for children and one set for adults.

However, transition ranked relatively low among our Stakeholders as the Most Important performance measures to address. The team felt to focus more on areas where we can align our collaboration and resources to make an impact on children with and without special health care needs. For example, with the selection of adolescent well-visit, we plan to address

transition with our SBHC and providers.

As a result of our Steering Committee Summit, our Title V team selected Adequate Insurance as a top priority for Delaware to address in the coming five years for the Children and Youth with Special Health Care Needs Health Domain.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

In Delaware, the executive branch of state government is headed by Governor John Carney who took office as Delaware's 74th Governor in January 2017. Within the executive branch, the Delaware Department of Health and Social Services (DHSS) is a cabinet-level agency and is led by Secretary Molly Magarik. The Delaware Department of Health and Social Services is the largest state agency employing more than 4,000 individuals in a wide range of public service jobs. The Department consists of 11 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, state service centers, management services, financial coaching, and Medicaid and medical assistance. The divisions are united by an overarching mission, which is simple yet profound: to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.

The Division of Public Health (DPH) is one of the largest divisions within DHSS, serves as the Title V agency in Delaware. Under the direction of Karyl T. Rattay, MD, MS, 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 multitude of sections. HI&S is led by Cassandra Codes-Johnson, MPA, and the Family Health Systems (FHS) section falls within HI&S. The Section Chief of FHS is Leah Woodall, MPA. The Title V Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs are part of FHS, within the HI&S strand.

The Family Health Systems Section is the home of many of the programs funded by Delaware's Title V federal-state partnership. As such, the section chief for FHS, Leah Woodall, MPA, also serves as the state Title V MCH Director. The section is comprised of three units. The Bureau of Maternal & Child Health is led by the MCH Deputy Director, Crystal Sherman, BS. The MCH Bureau is responsible for direct administration of the Title V Block Grant, and includes the following programs: Children and Youth with Special Health Care Needs; Newborn Screening (metabolic and hearing); Birth Defects and Autism Registries; Early Childhood Comprehensive Systems Impact; State Systems Development Initiative; and Home Visiting (MIECHV and state funded). The Bureau of Adolescent and Reproductive Health, led by Gloria James, Ph.D. includes the Adolescent Health Program (School-Based Health 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 Section VI. Organizational Chart for reference).

III.C.2.b.ii.b. 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 of the Division, including services such as the WIC program, immunizations and lead testing through State Service Centers and supports for healthy lifestyles (physical activity, nutrition, tobacco cessation), to name a few. An overview of DPH's programs and services for the MCH population is summarized below by the Title V MCH 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 (OWH) offers education to the public regarding a variety of women's health issues via outreach. The OWH's focus spans the lifetime of a woman, from adolescents through postmenopausal stages. 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 for the DHMIC and administration of related programs and initiatives. One such program is the Healthy Women, Healthy Babies 2.0 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, breastfeeding and the dangers of substance use while pregnant.

Perinatal/Infant Health: Much of our capacity to promote maternal health extends to the support of perinatal and infant health. For example, Delaware's Perinatal Quality Cooperative (DPQC) falls under the DHMIC umbrella and works to enhance communication and collaboration across birth hospitals to improve delivery of care. Related to infant health and the prevention of infant mortality, the DHMIC develops educational messages to promote important practices like breastfeeding and safe sleep environments; similarly, WIC and the MIECHV reinforce these messages. With state funding, we have been able to contract with outside agencies to expand evidence-based home visiting giving Delaware a continuum with the ability serve families prenatally through a child's fifth birthday.

DPH's Newborn Screening program offers both metabolic and hearing screening for every infant born in Delaware. The program also provides follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services. Delaware screens for all the disorders recommended by the Uniform Screening Panel.

Child Health: To support healthy growth and development in both infants and children, Delaware continues to implement the Help Me Grow model to improve early identification of developmental issues and timely connection to services. Help Me Grow is a partnership of many organizations throughout the state and has four key areas of activity: Central 2-1-1 Telephone Access, Physician Outreach, Community Outreach and System Improvement. Help Me Grow call specialists provide families with connections to existing resources statewide as well as providing a developmental screening utilized the validate tool, ASQ.

A component of our effort to increase developmental screening is providing physicians with online access to the Parents' Evaluation of Developmental Status (PEDS) validated screening tool. Delaware's Early Childhood Comprehensive Systems program (ECCS) shares the vision of the State's early childhood community to support a coordinated, comprehensive and sustainable early childhood framework. For that reason, the ECCS program collaborates with its place-based community partners and stakeholders to improve outcomes in population-based children's developmental health and family well-being. This approach entails closer relationship and integration of early childhood and education settings and health sector. DPH also offers lead testing, physicals, and immunizations through child health clinics at state service centers across the state.

Adolescent Health: School Based Health Centers (SBHCs) are core to our capacity to support adolescent health. For the past 30 years, Delaware School Based Health Centers, located in 32 public high schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to support women's overall physical and mental health. SBHCs provide at-risk 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.

In addition, Delaware's SBHCs provide important access to mental health services and help eliminate barriers to accessing mental health care among adolescents. Over the last couple of years, school boards voted and approved to add Nexplanon as a birth control method, and 14 sites now offer at their health center.

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 middle and high schools in addition to community sites throughout the state. Alliance for Adolescent Pregnancy Prevention also offer evidence-based curricula and implementation of programs that assist in reducing the instances of teenage pregnancy and sexually transmitted diseases throughout the state, targeted to middle and high school aged adolescents.

Children and Youth with Special Health Care Needs Health: 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 (Part B) 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 uses active surveillance to collect and analyze data on children diagnosed with a birth defect under the age of five. A data committee under the DHMIC reviews the data and determines any prevention strategies that could be deployed. The Autism Registry is a passive surveillance registry that 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.

III.C.2.b.ii.c. MCH Workforce Capacity

The total federal-state MCH partnership budget reported in this application includes Title V funds, state general funds, and appropriated special funds. The state portion of the MCH partnership is \$10,128,656.00, which includes funds appropriated for state infant mortality reduction initiatives and supports 53.0 FTEs (46.4 from general funds and 6.6 from appropriated special funds). The Title V federal allotment is estimated at \$2,027,826.00 for FY 20.

In Delaware, the majority of Title V block grant funding is used to support approximately 18.75 positions (FTEs) across the division that are involved with MCH programs and services, including Child Development Watch, adolescent health, child health, health education, and primary care. In this way, Title V funding has historically been leveraged to bolster the capacity of many DPH programs that serve mothers, children, and families. Most of these positions do not report directly to the Title V program, but rather to the Administrator of the specific program or clinic that they work within. As we consider our recent Five-Year Needs Assessment findings and develop our 5-year State Action Plan, we will need to work with the Program Managers of these positions to assess job responsibilities and ensure alignment with our new Title V priorities.

Family Health Systems Section Chief: Leah Woodall, MPA, was appointed as the Section Chief of the Family Health Systems Section in 2013 and serves as the state's Title V Director. Leah has worked for DPH since April 2010, serving as the Title V/MCH Deputy her first three years, and served three years in the MCH area as the MCH Bureau Chief and Deputy

Director.

Maternal and Child Health Bureau Chief/Title V MCH Deputy Director: Crystal Sherman, BS, has served in the role of MCH Bureau Chief and Deputy Director since October 2015. Before this promotion, Crystal was also in the MCH unit and served as the Home Visiting Program Administrator.

Director of Children & Youth with Special Health Care Needs: Isabel Rivera-Green, MSW, has been serving as the Director of Children & Youth with Special Health Care Needs since September 2018. Before this role, Isabel served as the Early Hearing Detection Intervention (EHDI) Coordinator from October 2015 until she was hired as the CYSHCN Director.

Title V Block Grant Coordinator, Project Director of State Systems Development Initiative: Elizabeth Orndorff is new starting in DPH and MCH in August 2018 as the Title V Coordinator and the SSDI Director. She is also responsible for coordinating the 2020 Title V Five-Year Needs Assessment.

Maternal and Child Health Epidemiologist, Centers for Disease Control and Prevention Assignee: Khaleel S. Hussaini, PhD. 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.

Having a well-prepared work force is critical to meet the maternal and child health needs of the people of Delaware. Having a committed, empowered workforce, with a wide-range of expertise, is necessary to create a resilience-oriented, trauma-informed system of care. As part of our Five-Year Needs Assessment, MCH conducted a Workforce Capacity Analysis where the objective was to identify Delaware's Title V program capacity.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work however the dedicated team recognizes the need for continuous professional development. They recognize a need to learn how: to balance the needs of diverse stakeholders, to find evidence, to learn quality improvement methods, and to understand health disparities. Regarding specialized cultural and linguistic competency training, DPH offers internal training opportunities. In addition, DPH offers training opportunities through a collaborative agreement with Johns Hopkins Bloomberg School of Public Health/Med-Atlantic Public Health Training Center.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The Delaware Title V MCH program can meet the needs of women, mothers, infants, children, CYSHCN and adolescents through partnership, collaboration and coordination with other entities. Delaware has many advisory boards, councils and coalitions that our MCH program works with to extend the reach of Title V, guide our work and expand on the overall capacity to support mothers, children and families. Two of the largest groups of partners coming together around MCH issues in Delaware are the DHMIC and Family SHADE.

MCH's finest collaboration, the Delaware Healthy Mother & Infant Consortium (DHMIC). The DHMIC pursues the health of women, infants and families through a life course approach. The DHMIC approach includes planning with the community, thinking holistically about women's health and addressing inter-generational health. The DHMIC supports a continuum of services promoting optimal health from birth throughout the lifespan, from one generation to the next.

Formed as a statewide vehicle to address infant mortality, the consortium includes approximately 19 Executive Committee members, including representatives from the House of Representatives, State Senate, DPH, hospital systems, universities, faith-based communities, and more. The DHMIC invites over 150 partners and stakeholders to the quarterly meetings. In December 2018, the consortium developed a three-year strategic plan with one- and three-year objectives. One of the goals was to create three workgroup committees: Well-Woman, Social Determinants of Health, and Maternal Infant Morbidity and Mortality. Delaware's Perinatal Quality 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. For more information on the DHMIC, please visit this website, <https://dethrives.com/dhmic>.

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 committed 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 pull together home visiting and partnering programs from across the state to ensure a coordinated continuum of home visiting services. In addition, the Governor's appointed Early Hearing Detection and Intervention (EHDI) Board 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 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 have partnered with Project LAUNCH and the Division of Substance Abuse and Mental Health in combating the opioid epidemic. The State of Delaware created a committee bringing together the Division of Public Health, Division of Family Services, and the Division of Substance Abuse and Mental Health. The group is made up key leadership including all three Division Directors, two Deputy Directors and senior program directors including both the Title V Director and Deputy Director/MIECHV Project Director. The group decided to work on three key goals, a MOU, training for direct service staff and education.

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

- To work as a team on shared client cases to attain the most positive outcome;
- To provide each client with the most comprehensive care; and
- To prevent duplication of activities.

The MOU states that each agency agrees to establish a multi-disciplinary coordination committee. The focus for the committee was training, messaging, case management, and the development of procedures. Since the development of this MOU, it has been decided that each of Delaware's counties will have a committee focused on the above-mentioned items. Home visiting supervisors, treatment providers, Division of Family Services administrators, supervisors, and caseworkers have come together to form the Delaware Multisystem Healthy Action Committees (MSHAC) in each county. The initial kick off was held in September 2016 and quarterly meetings in each of our three counties continue to collaborate. The charge of MSHAC is to plan how to serve families with substance use disorder better through a multi-agency approach.

Agenda topics for these meetings have included sharing resources and educational materials, updates from local treatment providers, coordination of services and referrals, tips for using DFS hotline reporting, related state legislation, and even walking through substance abuse specific cases in each agency. Supervisors and agency representatives are asked to refer information back to their staff of professionals who work directly with substance abuse clients and families. Guest speakers have been invited quarterly and continue to enrich the knowledge of the committee. Topics and speakers relevant to this work are listed in Table 13.

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

Parents continue to be engaged through 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.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The selection of the State health priorities was completed as a result of a thorough examination of the findings from the state's Five-Year Needs Assessment. Based on the assessment process, Delaware has chosen the following seven priorities as the focus of our efforts in the coming 2020-2025 grant period:

1. Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancies.
2. Improve breastfeeding rates.
3. Children receive developmentally appropriate services in a well-coordinated early childhood system.
4. Empower adolescents to adopt healthy behaviors (healthy eating and physical activity).
5. Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.
6. Increase the percent of children 0-17 with and without special health care needs who are adequately insured.
7. Improve the rate of Oral Health preventive care in children.

Delaware's 2020 Title V needs assessment and priority selection process benefited from the commitment and engagement of its committed and engaged stakeholder (including families) community. Instead of relying solely upon data to drive the assessment and prioritization process, the Steering Committee employed multiple methods to engage partners and consumers, valuing their unique perspectives, contributions and assessment of the state of MCH in Delaware. The goals of the prioritization process were to 1.) Use a data-informed method to identify and prioritize Delaware's top health issues related to the health of women, infants, children and youth, including children and youth with special health care needs; and, 2.) Incorporate stakeholder and public input into finalizing the priority areas by population domain for action planning. The Needs Assessment Steering Committee was responsible for reviewing and understanding the data, and then assigning scores for each of the sixteen national health areas in order to rank them.

A set of 7 variables were considered in this prioritization process, including size and seriousness of the health issue; disparities in outcomes; stakeholder support; importance to the community; and alignment with national and state goals. Once all individual rankings were completed, the findings were combined to determine the overall priority ranking. The final step was to ensure that each of the 6 Title V population domains was represented in the priority health area selection, and that all rules outlined in the Title V guidance had been considered. In addition to selecting priorities that aligned with the National Performance Measures, the Steering committee also took in to account additional suggestions from the stakeholders for priorities that were outside of the scope outlined in the guidance. Some of those health issues highlighted were infant mortality, social determinants of health and mental health. Where possible, the Committee incorporated those suggestions as a feed to the National Performance Measures to ensure that the objectives and strategies focused not only on the stated measure, but also an additional perspective of the measure that was closely related. An example of such was the inclusion of a mental health component for addressing well woman and adolescent well-visit where a mental health services are provided (HWB 2.0 and SBHCs). The performance measure addresses the need to for adolescents to receive a preventative well-visit annually to support their social, emotional well-being. Similarly, we received feedback from our stakeholders and community members regarding the importance of nutrition and obesity and therefore modified our objectives for physical activity to incorporate healthy lifestyles and healthy eating.

The continuation of our focus on priorities from the past five years includes areas that focus on increasing the number who

have a preventative well-woman visit, improving breastfeeding rates, improving rates of developmental screening, improving the rate of oral health care in children and increasing the percent of children with and without special health care needs who are adequately insured.

The need to increase the number of women who receive preventive care services remained a priority among stakeholders and consumers. The health priority need for women to have access to and receive coordinated, comprehensive services before, during and beyond pregnancy is considered a continuation of the strategies we have developed over the last 5 years including new programming within the last year. For those efforts, our stakeholders noted the increased messaging and initiatives in the state around promoting well woman care contributed to the progress being made. Other strategies included engaging partnerships in community such as the HWB Zones project and the implementation of mini grants. Suggestions were made by our key informants that emphasized the importance of incorporating weight management, diabetes prevention/management in preconception and interconception care and highlighted the impact of these services have on lowering infant mortality rate in the state. Key informants also proposed reframing the idea of well woman care to transform it from being episodic to creating a continuum of care as a strategy for addressing women's health. Taking into consideration these and other feedback, it was decided to address National Performance #1 from a life course approach to addressing women's health before, between and beyond pregnancies versus addressing only women who receive a well woman visit in the past year.

The input gathered through our needs assessment process showed support from partners to continue to address breastfeeding rates. Through a survey of MCH stakeholders, breastfeeding was ranked as the number nine national performance measure for our Title V program to address in the perinatal/infant domain, and over 50% indicated that there was a strong desire among stakeholders to address the issue. Stakeholders' assessment of the capacity of the Delaware Maternal and Child Health System to address improving breastfeeding for children indicated a strong desire to address this issue and that evidence-based programs existed in this area. It was also noted the need to reduce the disparity that exists for black women. These and other suggestions from our stakeholder community make this a very important need for MCH to address for our mothers and children in Delaware.

The feedback received from our stakeholder survey and key informant interviews highlighted our previous successes in developmental screening, however the data also showed that the need was high to continue to focus on this area. Stakeholder survey results revealed developmental screening as ranked #3 among the 15 priority areas and ranked #1 among the three priority areas within the children's health domain. Stakeholders' assessment of the state's capacity to improve developmental screening for children was very positive with about three-fourths indicating that there was a strong desire to address this issue and that evidence-based programs existed in this area. As a result of the state's commitment to and work on developmental screening, significant progress has been made however consumers and stakeholders alike recognize that there is still more work to be done. The objectives to continue the progression of success includes building on existing efforts to promote the adoption of PEDS screening tool by providing participating pediatric practices with technical assistance, practice-level data, and CQI tools to optimize their screening rates. We also feel it is important to educate parents about developmental milestones and the importance of developmental screening, empowering them to request that their pediatrician perform screening. Improving developmental screening and coordination of care is also a priority for the statewide Early Childhood Council per the draft strategic plan which will be unveiled this Fall.

In the past our focus was on the ensuring that oral health preventive services and treatment were available for children, including children with special health care needs. Great strides were made in the past year to advance the goal of ensuring oral health preventive services for children using various methods of outreach and community partnerships. There has been a significant increase in the utilization of the dental Medicaid program in Delaware can be directly correlated to the program's coverage for children under age 21. Stakeholder survey results point to oral health as a relatively important issue but noted that there are limited resources available to address the issue. There remain important opportunities for Delaware – in terms of partnerships, and education in communities, especially on the concept of a "dental home" and therefore our work will continue in this area for the next grant period.

The last area of interest that will be continued from previous years will be the focus on Adequacy of insurance coverage is an issue of high importance among our survey respondents as well as key informants and consumers. The stakeholder survey showed this issue was ranked #2 of 15 priority areas and ranked #1 among the CYSHCN domain. Almost 80% of

respondents agree/strongly agree that there is a strong desire in the state to address the issue and 48% indicated agreement that progress is being made. Qualitative data collected as part of the needs assessment process point to the importance of this issue, particularly for families with CYSHCN. In focus groups, surveys and key informant interviews for the CYSHCN population, respondents pointed to the lack of or inadequate coverage for needed services for their children. Expenses ranged from respite care to medications and equipment. Financial strains due to out of pocket expenses and having to travel out of state for appropriate care was listed among the top challenges that CYSHCN families faced. We feel there remain opportunities in the state to address the adequacy of insurance coverage for all populations.

The remaining priority needs are new to the focus of our work in the coming years both fall under the Adolescent Domain, NPM 8.2 and NPM 10.

According to the 2017/2018 National Survey of Children's Health (NSCH), Delaware is among the lowest of its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day. 15.3% of Delaware's adolescents are physically active zero days per week. Our stakeholders selected increasing physical activity among this population as the number one priority for this population domain and was ranked 5th overall. The National Survey for Children's Health (NSCH) shows that the percentage of Delaware adolescents who have had a preventive medical visit in the past year has been declining. In 2016, the percentage was 89.5%, while in 2017 the percentage declined to 84.2% and in 2018, Delaware's percentage of adolescents who have had a preventive medical visit in the past year fell to 70.2%. The survey also revealed that 24.0% of Hispanic adolescents and 23.7% Black adolescents did not have a preventive medical visit in the last year. This is significantly higher compared to 13.4% of White adolescents who did not have a preventive medical visit in the last year. Our stakeholders identified the adolescent well visit as the number two priority for this population domain and was ranked 7th overall.

National Performance Measure 8 seeks to increase the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day and therefore we have replaced or "reframed" our objectives related to obesity by incorporating strategies that will not only address physical activity but also healthy eating as part of a complete plan to healthier lifestyles. Disparities exist in both measures with the percentage of black adolescents being physical active lower than their white peers.

Working with our School Based Health Centers will be a key strategy to addressing the number of adolescents that receive comprehensive and coordinated services addressing their social, emotional and physical well-being. Addressing SODH will be an overall strategy for Delaware in addressing every priority selected in the next five years. Responses were a clear call to address social determinants of health (SDOH); in our stakeholder survey, with 88 respondents noting one or more aspects of SDOH.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,961,019	\$1,993,981	\$1,913,137	\$1,992,794
State Funds	\$10,437,817	\$10,437,817	\$9,782,274	\$9,782,274
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$2,385,566	\$2,385,566	\$3,294,852	\$3,294,852
SubTotal	\$14,784,402	\$14,817,364	\$14,990,263	\$15,069,920
Other Federal Funds	\$6,823,020	\$6,823,020	\$7,715,622	\$7,715,262
Total	\$21,607,422	\$21,640,384	\$22,705,885	\$22,785,182
2020		2021		
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,993,981	\$2,027,826	\$2,027,826	
State Funds	\$10,287,704	\$10,287,704	\$10,128,656	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$2,973,146	\$2,973,146	\$2,957,897	
SubTotal	\$15,254,831	\$15,288,676	\$15,114,379	
Other Federal Funds	\$6,162,044	\$6,162,064	\$6,890,346	
Total	\$21,416,875	\$21,450,740	\$22,004,725	

	2022	
	Budgeted	Expended
Federal Allocation	\$2,042,781	
State Funds	\$9,957,273	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$2,053,906	
SubTotal	\$14,053,960	
Other Federal Funds	\$9,974,592	
Total	\$24,028,552	

III.D.1. Expenditures

Expenditures

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

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

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

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

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

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

III.D.2. Budget

Budget

Federal Block Grant and non-federal MCH Partnership budgets are reported separately on Forms 2 and 3. The total budget for our federal-state MCH partnership is \$15,114,379 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 \$10,401,192. 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.

FY21 Budget – Federal Title V Funds

Personnel Costs	\$1,551,888
Salary, fringe, health insurance, indirect	\$1,538,492
Other employment costs (personnel, phone lines, DTI, network charges)	\$13,396

Title V Maternal and Child Health Block Grant Funding has historically funded staff positions within the Division of Public Health's MCH services and programs, including the Smart Start/Healthy Families America home visiting program, Child Development Watch, Adolescent Health, and Reproductive Health. As a result, most of the federal allocation of each year's MCH Block Grant award is budgeted for staff salaries, other employment costs (OEC), and indirect costs.

Contractual \$219,874

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

Travel \$0

Due to COVID, we do not anticipate traveling this coming budget year.

Supplies \$3,260

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

FY 21 TOTAL BUDGET \$2,042,781

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 \$13,086,553 in state funds to the Maintenance of Effort agreement. This includes support for 46.4 FTEs from state general funds and 6.6 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 2021 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 registry, 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 2021 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 FY2021 budget is allocated for administrative costs. This category primarily includes funding for staff (salaries, indirects) who work to administer the Title V Block Grant (fiscal analyst, administrative assistant, etc), as opposed to staff who are implementing programs or delivering services. Small amounts for travel and supplies are also included.

III.E. Five-Year State Action Plan

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

State: Delaware

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

Delaware's Division of Public Health (DPH) is the largest division within the Department of Health & Social Services (DHSS). The Title V Team is part of the Bureau of Maternal & Child Health (MCH), which is situated within the Family Health Systems & Management (FHS) unit. Title V is responsible for planning, program development, administration, and evaluation of maternal and child health programs statewide. Within DPH, the Family Health Systems & Management section has direct oversight of Title V, as well as a number of other MCH programs including Children and Youth with Special Health Care Needs (CYSHCN), the Early Childhood Comprehensive Systems (ECCS) initiative, Newborn Screening (Metabolic and Hearing), Birth Defects Registry, State Systems Development Initiative (SSDI), Adolescent Health and School Based Health Centers, Infant Mortality Elimination program, Center for Family Health and Epidemiology, Title X/Family Planning, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, as well as others that require partnerships, coalition building and leadership.

The Life Course Perspective continues to be the lens through which we view our MCH work. Delaware's Title V MCH work focuses on ways to increase these protective factors and decrease risk factors. The Life Course Perspective suggests that a complex interaction of protective 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.

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

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 nine months of

pregnancy. The goal is to provide assistive services to encourage the woman to maintain a healthy weight, nutritious diet, receive appropriate amounts of folic acid, manage chronic disease, address environmental risk factors such as smoking, substance abuse or other stress-inducing circumstances, as well as the development of a personalized reproductive life plan (for all women and men). The model is a value/performance based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health, and incorporates the role of community health workers to further support outcomes.

Looking ahead, a Well Woman Initiative related type content is in the development phases and will be placed on the DEThrives site to inform women of childbearing age (15-44 years old) the issues around maternal health in Delaware. This content will focus more on the consumer than the provider providing evidence-based education about annual well woman visits for example and will provide call to action messaging to help encourage women to play an active role in their maternal health.

To bring more attention to the Community Health Workers and to showcase how a woman can learn ways to live a healthier lifestyle, a paid Facebook newsfeed video ad ran for the entire month of March in 2021. The ad targeted women aged 15-44 years old, who lived in the top four high risk zone zip code regions in Wilmington. It displayed a way for women to contact a community health care worker to learn ways of living a healthier lifestyle. The one minute and 20-second-long video reached 100,896 impressions which is the total number of times a user saw the ad, 731 clicks (number of times a user clicked on the ad), and users spent an average of about 29 seconds on the DEThrives site with the help of this video ad alone.

DEThrives and community partners will come together in observance for Black Breastfeeding Week (August 25th to August 31st) to provide information on the benefits of breastfeeding a black or brown babies to improve Black infant mortality rates and improve black maternal health. Some ways this content will be promoted on DEThrives is the organic and paid posts on the DEThrives channels, posting related black breastfeeding community partner events all week long, there will be an op-ed press release submitted to the News Journal (a local Delaware newspaper), a Spokesperson Advisory document will be used to cover public relations related content, and the Lt. Governor will promote a DEThrives' post on their personal social media platforms to help spread the word.

30 Minutes of Quality Time or QT30, is launching an app and is being finalized at the moment, which is planned to launch before the end of 2021. There are a total of about 159 videos that have been created (of actual Delawareans) demonstrating the activities listed on the QT30 webpage on the DEThrives site. There are indoor and outdoor activities that are organized into age groups (0-3 years old and 4-8 years old). This app is to help encourage parents and caregivers to see the importance of providing that one-on-one undivided quality time with their child for at least thirty minutes a day. To help ensure this time is well spent with their child a timer was added on the app as a friendly reminder to complete an activity in its full duration. By providing this quality time to a child it helps prepare them for school and ultimately will help them perform better in school as well.

Education and prevention.

"Delaware Thrives" (DEThrives) is the branding theme and umbrella for all maternal and child health social marketing programming, developed in partnership with the Delaware Healthy Mother and Infant Consortium (DHMIC), which the state funds along with other federal funding sources, such as Title V, and DPH Family Health System staff support. We are excited to report that DEThrives has recently become more robust with social media posts, messaging, programs, partnerships and much more. DEThrives utilizes Facebook, Twitter, Instagram and blog posts to educate, inform, and provide resources, services and links to the Delaware maternal and child health population and our partners. MCH is using this strategy to engage and inform our population with up to date information pertaining to various needs and topics.

Title V MCH has led several successful social marketing campaigns to help educate, inform and promote healthy behaviors over the years. Most recently, DEThrives highlighted a March of Dimes Spotlight paper. March of Dimes Spotlight paper In mid to late October 2020, DEThrives submitted a “Spotlight on State Progress” short report to the March of Dimes representing the progress the state of Delaware has accomplished in the past year in terms of improving birth outcomes and the steps the State of Delaware’s DPH is doing to improve maternal and child health. With data and efforts made by the DHMIC, the Healthy Women Healthy Baby (HWHB) Program 2.0, HWHB Zones mini grants, multiple MCH stakeholders, and medical intervention, the infant mortality rates in Delaware decreased from 9.3 deaths per 1,000 live births to 7.5. Unfortunately, there is more work that needs to be done as the Black infant mortality rate is still 2.7 times higher than the White infant mortality rate. Evidence-based findings discovered that two of the biggest factors that are affecting the infant mortality rate in Delaware are preterm births and low birthweight births where socioeconomic status and racial disparity are contributing factors in these poor health outcomes. Local and statewide interventions have been set in place based on the HWHB Zones (zones are based upon zip codes and census tracts) throughout the state to spread evidence-based and place-based strategies to address these disparities, bring awareness to programs, better address, educate, and care for women of childbearing age (15-44 years old) and their babies that are considered high risk for poor birth outcomes, and help assist Black maternal health grassroots organizations to share their messages statewide. This work also compliments the medical intervention, HWHBs 2.0.

Each HWHB Zones mini grantee was awarded funding (the latest two or three mini grantees were provided second cycle funding on January 1, 2021) for local communities/organizations to share their strategies aiming to improve health outcomes for women of childbearing age and their babies to address the root causes of infant mortality across Delaware. This funding for existing mini grantees will continue their HWHB zone programs through June 2022.

DPH also used the DEThrives platform to launch Hotlines – Hugging: Domestic Violence, a promotion ad than ran from September 16th through October 18th 2020. DEThrives ran a single-image newsfeed ad for the Community Health Advocates program. The ad was shown on Facebook, Instagram and other audience networks that featured instructions on what to do in an event of an unhealthy relationship. The ad targeted females aged 15-44 years old, Black/African American or Latina/Hispanic, women who were pregnant, a new parent, and/or of reproductive age, living in high-risk zone zip codes based on the Healthy Women Healthy Baby (HWHB) Zones. During the time the ad was running, the ad helped gain roughly 282,000 impressions which is the total number of times a user saw the ad, over 16,000 unique users to the DEThrives site, and reached about 16,000 women an average of 17 times. In the end, the Delaware Coalition Against Domestic Violence (DCADV) Healthy Women Healthy Babies mini grantee did see an increase in referrals after the ad aired.

Additionally, DEThrives started posting short seven day promotional ads on a monthly basis which started in late February 2021. These ads were posted on the DEThrives Facebook and Instagram pages to increase the awareness of the post's content, increase engagement on the DEThrives social platforms, help drive traffic to the DEThrives website, and to assist consumers and partners to become familiar with the DEThrives name, message, and overall mission. From April 1, 2020 to June 30, 2021 alone, two short promotional ads reached about 96,000 users in the target audience and earned 100,000 impressions with the DEThrives ad content (HWB in April and Developmental Milestones info in May).

Between July 1, 2020 and June 30, 2021 organic searches, meaning users who searched for “DEThrives.com” within the Google or Bing search engine continue to rank as the number one way the DEThrives site receives traffic from consumers. Based on analytical data the typical user that visits the DEThrives site is described to be female, views the site on a desktop followed by a mobile device, and predominately resides in the cities of Wilmington and

Dover. Between June 2020 and June 2021, the DEThrives social channels which consist of Facebook, Instagram, and Twitter saw an increase of a total of 104 fans (or followers), a 148,541 impression (number of times a post has been displayed) increase, and a 1,498 increase in the number of engagements (any action a consumer takes with the content). The DEThrives Instagram followers increased by 159 in one year out all three social media platforms. In terms of website traffic, the DEThrives site has been able to maintain at least a 3,400 new user visit to the site during every quarter. The blog and summit sections are the top two sections that have received the most pageviews in one year. The most popular searched for blog post within the past year is titled “The Importance of Developmental Screening for Children”.

Supporting coordinated, comprehensive and family-centered systems of care.

Early identification and intervention for developmental delays to improve birth outcomes for children birth to 8 years continue to be the north star for the Early Childhood Comprehensive Systems (ECCS) Impact grant. The purpose of the program is to improve outcomes in population-based children’s developmental health and family well-being.

Over the past five years, Delaware has leveraged multiple funding sources from state and federal programs such as ECCS, Title V, Maternal Infant Early Childhood Home Visiting (MIECHV) and the Preschool Development grants to drive its efforts to improve these developmental health outcomes and family well-being.

With a long-term goal of progression toward universal developmental surveillance and screening, Delaware’s EC community emphasizes a coordinated, comprehensive and holistic approach which takes into account the impact of the social determinants of health of the child and his/her family. This entails focusing on the integration of a host of multi-sector programs in the health and early learning and education settings. To this end, the developmental screening effort places emphasis on collective impact with a goal toward shared measurement and agenda, in addition to the use of continuous quality improvement methods to address the gaps identified within the system.

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 you 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 utilized the feedback from the board members and partners throughout the state to provide technical assistance and workshops for organizations serving CYSHCN, so that they are better equipped to serve CYSHCN in Delaware. One highlighted experience last year was the opportunity to offer their partners with a grant writing workshop. This workshop better positioned their organizations to compete for grant funding opportunities by providing grant writing workshops to their board members who managed large and small grassroot organizations. The workshops were such a success that additional workshops were scheduled virtually from August 2020 to October 2020. Throughout the year, Family SHADE provided virtual workshops that were selected by our partnering organizations and families of CYSHCN:

- Delaware Assistive Technology Initiative (DATI). They help families find and try tools that support learning, communication, personal care, employment, and leisure. DATI raises awareness of assistive technology.
- Family SHADE also offered a Workshop on Delaware Readiness: Parent and Family Voices: Delaware Education and COVID-19. This served as a platform for Q&A for families that had questions specific to the pandemic.
- A workshop was held on How Community Health Workers Can Support Individuals with Complex Needs amid COVID-19 through the utilization of Better Care Playbook.
- Through Facebook and other social platforms, COVID-19 Related Stories for Schools – Autism Little Learners were implemented for the families.

- Through their partnership with Parent Information Center (PIC) of Delaware, virtual events were shared on Family SHADE's website. Topics on Early Childhood: Ideas for Home Learning, Coronavirus and Delaware Education Updates. These events were offered in both English and Spanish language.
- Family SHADE promoted DE Hands and Voices Learning Community, Topic: Stephanie Olson presented on fostering effective collaboration between parents and professionals across philosophies and communication methods. This training empowered families of Deaf/Hard of Hearing children to become advocates for their children and develop a partnership with their medical homes. This is one of several trainings that were promoted by Family SHADE.
- Easterseals provides workshops on respite services at the Family SHADE Networking virtual Breakfast meetings.
- Family SHADE created a series of Social Justice trainings in February of 2021. They were coordinated at the request of their partnering organizations and families. The Social Justice trainings came about due to the climate of the environment and the racial tensions in the United States.
- Diversity, Equity & Inclusion workshops were provided to partnering organizations and families that wanted to talk and express what they were feeling. Family SHADE coordinated a series of three workshops in the months of March and April of 2021.
- Childcare was an issue due to the pandemic. Family SHADE partnered with Childcare providers in the state and provided a Childcare workshop series in the month of June 2021. The topics were specific to CYSHCN.

Title V as a leader and convener.

Partnerships are a unique and a fantastic asset in Delaware and our Title V MCH is a leader and convener of a broad spectrum of partners to address the needs of women, infants, children, adolescents, and children with special health care needs. Delaware prides itself in building and maintaining partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. In working to improve the lives of women, children and families, leadership is an essential role for maternal and child health (MCH) programs. Leaders must have a vision, take initiative, influence people, solve problems, and take responsibility in order to make change happen.

In addition, regardless of your title and level in the organization, everyone at every level on the DPH Title V MCH team is engaged in the process of leadership. We conduct our work and our interactions with others using the 10 Principles of Leadership (LeadQuest) and these values as guideposts for our personal behavior, professional practice, and public health decisions. DPH has been focused on creating a culture of leadership for over 10 years, using this framework. Title V MCH has a proven track record of creating unity, building trusting relationships to help achieve success by working with others rather than stepping on or over people. We work on bringing people together, to establish a common vision and set of values along with programmatic systems and operations, such as planning, goal setting, communications and quality improvement. Examples of our role as Title V leaders and conveners are discussed throughout the application, including the Delaware Healthy Mother and Infant Consortium, Help Me Grow and Early Childhood Comprehensive Systems work.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. However, with recent turnover in positions, a number of staff have less than three years' experience in their current roles. As such, we have recently taken advantage of the *FranklinCoveys 7 Habits of Highly Effective People*.

Previously, in October 2018, 30 staff members from administrative to leadership roles, participated in a two-day training on *FranklinCoveys 7 Habits of Highly Effective People*. Our workforce gained hands on experience,

applying timeless principles that yielded greater productivity, improved communication, strengthened relationships, increased influence, and laser-like focus on critical priorities. The course also included over 30 award-winning videos. The training was very interactive and involved role playing so participants could put what they were learning into practice. In follow-up to the 7-habits, we also participated in the FranklinCoveys 5 Choices to Extraordinary Productivity training. The 5 Choices to Extraordinary Productivity empowers people with clear discernment to avoid distractions and to accomplish the goals that matter most in their professional and personal lives.

In an ongoing effort to promote our Cross-Cutting/Systems Building priority domain, we have again partnered with *FranklinCovey* to create some leadership development training. The MCH leadership team wanted the new trainings to be a fun and engaging experience, so we incorporated them into our annual Team Building Event. *FranklinCovey* established a set of on-line Leadership Development trainings for all Family Health Systems (FHS) members. These courses touched on development training topics such as: Be Proactive, Get Better: Carry Your Own Weather, Take Stock of Your Emotional Bank Account, Think We, Not Me, Wear Glasses that Work, The Change Model, and more.

Through the power of partnerships, we continue to integrate our programs where it makes sense, find the connections to make sure we are not duplicating work, focus on doing things right. Public Health success will depend on health leaders working closely with both the private and public sectors, and over the next year, we are making a concerted effort to tap new and non-traditional partners (i.e. business community, transportation, housing, planning, including faith based organizations, etc.), particularly as we address social context issues impacting the health of women, infants and children.

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

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

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

In Delaware, the majority of Title V block grant funding is used to support approximately 18.75 positions (FTEs) across the division that are involved with MCH programs and services, including Child Development Watch, adolescent health, home visiting, health education, and primary care. In this way, Title V funding has historically been leveraged to bolster the capacity of many DPH programs that serve mothers, children, adolescents, children and youth with special health care needs and their families. The majority of these positions do not report directly to the Title V program, but rather to the administrator of the specific program or clinic that they work within. We will 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.

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 the Needs Assessment Summary section, III.C.2.b.ii. of our FY21 application.

Although the MCH leadership team has a significant amount of professional experience, a couple of our key members of our unit are relatively new in their current positions. Elizabeth Orndorff was recently hired in August 2019 as our new Title V Block Grant Coordinator. Elizabeth also serves as our State Systems Development Initiative (SSDI) Project Director. Isabel Rivera-Green, MSW, has been serving as the Director of Children & Youth with Special Health Care Needs since September 2018. Before this role, Isabel was also in the MCH unit as the Early Hearing Detection Intervention (EHDI) Coordinator from October 2015 until she was hired as the CYSHCN Director. In addition, Leah Woodall, MPA, the state MCH Director for Delaware and Section Chief for the Family Health Systems Section, is in her eighth year serving in these capacities, having previously served as the MCH Bureau Chief and Deputy Director for three years. Crystal Sherman has served in the role of MCH Bureau Chief and Title V Deputy Director since October 2015.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. However, professional development is an ongoing process to ensure staff have the tools needed to perform all job functions with the highest level of execution. We have utilized a variety of training platforms for professional development including the MCH Navigator, *FranklinCovey* and our internal DPH training office.

All MCH staff are encouraged to utilize the MCH Self-Assessment tool as a guide to develop their professional development goals annually. Supervisors are tasked with reviewing and coaching staff on the development of their goals and ensuring time is allotted for professional development. Leadership meets regularly to discuss strengths of the staff to ensure we continue to recruit team members that have the skills that are needed as well as complement the unit.

In October 2018, 30 staff members from administrative to leadership roles, participated in a two-day training on *FranklinCovey 7 Habits of Highly Effective People*. Our workforce gained hands on experience, applying timeless principles that yielded greater productivity, improved communication, strengthened relationships, increased influence, and laser-like focus on critical priorities.

The training was very interactive and involved role playing so participants could put what they were learning into practice. The 7 Habits Objectives during this training included habits like:

- Paradigms and Principles of Effectiveness
- Be Proactive
- Begin with the End in Mind
- Put First Things First
- Private Victory to Public Victory

- Think Win-Win
- Seek First to Understand, Then to Be Understood
- Synergize
- Sharpen the Saw
- Living the 7 Habits

All MCH have access to an All Access Pass to the entire *FranklinCovey* Library which provides a refresher of all the habits along with several other topics important to leadership. The All Access Pass was designed to help organizations achieve strategic initiatives, develop leaders, and build skills and capabilities across the organization in a completely nimble and flexible way that helps them overcome those challenges - all at the very best value. With access to *FranklinCovey* courses, assessments, videos, tools, and digital assets, we can utilize the content in a wide variety of ways and across multiple delivery modalities to best meet the needs of our organization. The All Access Pass includes courses such as: The 4 Essential Roles of Leadership; Managing Millennials; Presentation Advantage; Find Out WHY: The Key to Successful Innovation, and more. All courses are offered in formats that are convenient to participants and on a schedule that is most convenient to them.

Most recently, we provided an opportunity to participate in the following *FranklinCovey* resources :

- The 5 Choices – Course Summary: Learn a process which will dramatically increase their ability to achieve life's most important outcomes. Backed by science and years of experience, this course will make you more productive and give you an inner sense of fulfillment and accomplishment. This time and life management workshop will help you make the right choices as you plan your day, week, and life, by aligning tasks with your most important goals. You will move from being buried alive to being extraordinarily productive!
- Implicit Bias – Course Summary: Bias is a natural part of the human condition—of how the brain works. And it affects how we make decisions, engage with others, and respond to various situations and circumstances, often limiting potential. There is nothing more fundamental to performance than how we see and treat each other as human beings.
- Change Management Model – Course Summary: Although we all can change our behavior, we rarely ever do. As you understand the change model, you can help people work through short-term turbulence so they can get to longer-term benefits of the change.

We are currently pursuing a section wide training for Family Health later this year, titled 6 Principles of Leadership which will be offered to all mid-level managers and above. The 6 Critical Practices for Leading a Team is a special collection of curated content from proven *FranklinCovey* offerings. The repurposed mindsets, skillsets, and toolsets provide first-level leaders with relevant and practical resources to help them excel in this tough and demanding role.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.

It's important to note that not all learning occurs in a classroom or on an electronic device. Learning can be as simple as a supervisor observing an employee performing a task and offering suggestions on how to improve that performance (i.e. on-the-job training). It can occur during staff, one-on-one, and, performance feedback meetings, or by reading an article in a professional periodical and putting the concepts to work on the job. All supervisors at the DPH are encouraged to and can facilitate learning by adding a Professional Development section to employees' Performance Plans. Working together on this will help employees focus on his/her training goals and establish a more productive working relationship. To keep track of this, employees can use the [DPH Personal/Professional Development Plan](#), as a tool to help them and their supervisors, develop goals and document uniquely tailored training needs and experiential learning exercises to expand their knowledge, skills

and abilities to provide the best service possible to the citizens of Delaware.

Additionally, internal DPH workforce development opportunities include our Office of Performance Management, which has created a comprehensive workforce development plan outlining DPH training goals and objectives, as well as resources, roles and responsibilities related to the plan's implementation. With regard to specialized cultural and linguistic competency training, DPH offers in-house training opportunities. In addition, DPH offers training opportunities through a collaborative agreement with Johns Hopkins Bloomberg School of Public Health/Mid-Atlantic Public Health Training Center.

As part of the Governor's Trauma-Informed Care initiative, DHSS required every employee complete the online course titled: DHSS Trauma Informed Awareness Training. This training is also part of the New employee/supervisor curricula for future new hires. DHSS Trauma Informed Awareness Training examines the pervasive effects trauma has on individuals, families and organizations. Trauma results from many experiences such as an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects. Many DPH programs are considered trauma informed, some sections have no idea about the impacts of trauma on our clients, patients and co-workers, therefore, the Governor's initiative is that we all become trauma aware.

DPH staff are also afforded the opportunity to advance their skills through the DE TRAIN Learning Network. DE TRAIN is an affiliate of the TRAIN national learning network that provides quality-training opportunities for professionals who protect and improve Delaware's public health. This is a free service funded by Delaware Public Health's Emergency Medical Services and Preparedness Section (EMSPS) in partnership with the Public Health Foundation Training.

DPH Policy Memorandum Number 65 outlines the Health Equity and Cultural Competency Policy for the Division of Public Health. The purpose of the policy states that DPH's policies, processes, programs, services, interventions, and materials will be provided in a manner that considers the social and cultural and linguistic characteristics of the population we serve and strive to improve health equity as outlined in Title VI of the Civil Rights Act of 1964. The policy gives direction to when all DPH employees must complete health equity and cultural competency training courses.

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

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

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

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

One of the most impressive examples of collaboration is the Delaware Healthy Mothers and Infants Consortium (DHMIC). Formed in 2005 as a statewide vehicle to address infant mortality, the consortium includes approximately 150 members, including representatives from DPH, hospital systems, universities, the legislature, March of Dimes, and more. The consortium has several committees addressing standards of care, health equity, education and prevention, and data and quality improvement. The Delaware Perinatal Quality Collaborative (DPQC) was initially established in 2011 as a subcommittee of the Delaware Healthy Mother and Infant Consortium (DHMIC). In 2019 the DPQC was memorialized in state code as a freestanding organization. The DPQC is now constituted as an independent public instrumentality. All seven birthing institutions in Delaware are members of the DPQC. The Collaborative is comprised of voting members appointed by member organizations. Each member organization has one representative. Delaware's Perinatal Cooperative is a subcommittee of the consortium. Staff from the Family Health Systems Section of DPH staff these committees and support the partners in advancing shared work. Collectively, the DHMIC follows a life course model. (For more information, visit www.dethrives.com)

In the domain of CYSHCN, a key partnership 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 screening panel.

Additional key partnerships and collaborations include Delaware's statewide Early Childhood Council (ECC), the Home Visiting Community Advisory Board, the Developmental Disabilities 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 Impact (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 also worked actively with the Division of Prevention and Behavioral Health and the Division of Substance Abuse and Mental Health Administration on various boards and councils.

Champions for Young Children is a partnership of the Delaware Division of Public Health's (DPH) Maternal Child Health Bureau (MCHB), Christina Cultural Arts Center, and Public Allies Delaware that seeks to engage community members in advocating for health, education, and well-being of children birth to age 8 years and their families. This partnership has helped parents within the community enhance their leadership skills and learn how to advocate for the health, education, and wellbeing of young children and their families. Over two dozen parents have completed this training through the course of the ECCS program.

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. The surveys are disseminated quarterly and focus on various topics such as medical home, adequate insurance and oral health.

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 to share their concerns, and as a result many families get a better understanding of how the system works and the providers and policymakers hear how a family is impacted by rules and regulations.

The Department of Services for Children Youth and their Families (DSCYF) and the Department of Health and Social Services (DHSS) recognize that each Department has an important role to improve the lives of families impacted by substance abuse. For this reason, the agencies entered into a Memorandum of Understanding in 2016 developed for the agencies:

- To work as a team on shared client cases to attain the most positive outcome
- To provide each client with the most comprehensive care
- To prevent duplication of activities

The Multi-Sector Health Action Committee (MSHAC) was established as result of the MOU by DSCYF and DHSS jointly to serve as a multi-disciplinary coordination committee focused on 1) training 2) messaging/communication 3) case management and 4) to develop and maintain procedures that assure appropriate coordination between agencies and related partners. The charge of MSHAC is to plan how to serve families with substance abuse better through a multi-agency approach. The county-based MSHAC committees emerged following a "Call to Action" forum in September 2016, when state agencies, treatment providers and the Annie Casey Foundation came together to address the opioid epidemic and the impact on frontline staff.. An MSHAC planning subcommittee was formed and a statewide training for DFS frontline staff, home visiting professionals and treatment providers will take place on June 24, 2019 at Dover Downs, Dover, DE. This event including a panel with a Mother, her child welfare case worker and home visitor to discuss her experiences with addiction, services received and how she was ultimately connected to system of care. She presented openly and honestly on her frustrations, success and most importantly how she felt as a Mom when her child for example was deemed to be developing normally after completing validated screening tools.

Maternal, Infant, Early Childhood Home Visiting (MIECHV) continues target families with Substance Use Disorder (SUD) and substance exposed infants (SEI). Families with SUD and/or a substance exposed infant need the support and benefits that home visiting programs provide as these infants can experience symptoms of withdraw that could include body shakes, fussiness, excessive crying or have a high-pitched cry, have breathing and feeding problems. Delaware has developed NAS recommendations, which include referring any baby that had a positive drug screen and/or diagnosis of NAS prior to discharge. Home Visiting programs have established relationships with hospitals and the child welfare office. With the introduction of the Comprehensive Addiction and Recovery Act (CARA) legislation, Delaware passed similar legislation in June 2018. This legislation requires reporting all incidents of all infants born with substance exposure including not only opioids but also marijuana and alcohol. Once child welfare receives the notification, discharge planning begins with the development of a plan of safe care. A referral to home visiting services is completed as soon as possible so that is possible that first home visit is conducted prior to discharge or the home visitor is at least part of the discharge plan/meeting. Individuals with substance abuse issues are being targeted by many programs with most of them being members of the Home Visiting Community Advisory Board and are struggling with engagement. Strategies to engage these families are discussed at meetings and the

acceptance rate for this population is monitored. Our MIECHV Innovation grant revolved around working with the SUD population and as part of the project trainings were developed to support home visitors were developed.

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

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

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

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

Delaware has two dedicated Full Time Equivalents (FTE) epidemiologists in our MCH section, Khaleel S. Hussaini and George Yocher. By ensuring access to MCH data, Delaware's epidemiologists are able to analyze and present information which programs can then use to make data informed decisions. Funds used to support evaluation and analysis of MCH data allows us to ensure that data relevant to Title V programs and priorities is made available in a timely manner.

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

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

Dr. Hussaini's research has focused on immigrant adaptation specifically those relating to acculturation, assimilation, and global identities and intersection of civil society and its implications on maternal and child health and well-being. Methodological interests relate to application of quasi-experimental designs for evaluating public health interventions, with special focus on propensity score analyses, regression discontinuity designs, and regression point-displacement designs.

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

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

Delaware's MCH epidemiologists have direct, consistent, electronic, and timely access to:

- Behavioral Risk Factor Surveillance System (BRFSS)

- Child Fatality Review
- Delaware Birth Defects Registry
- Delaware School Survey (DSS)
- Evidence-Based Home Visiting
- High School Youth Risk Behavior Surveillance (YRBS)
- Hospital Discharge Data (HDD)
- Middle School Youth Risk Behavior Surveillance (YRBS)
- Neonatal Abstinence Syndrome Surveillance (Based on HDD)
- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Syndromic Surveillance Data (ESSENCE)
- Vital Records Birth
- Vital Records Birth-Death Linked
- Vital Records Death
- Vital Records Fetal Death
- Youth Risk Behavior Surveillance System (YRBSS)
- FHS program-specific data
 - HWHB
 - FPAR TITLE X Family Planning data
 - School-based health centers data
- Delaware Perinatal Quality Collaborative (DPQC) (specific to quality indicators)

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

Dr. Hussaini has continued to assist in Delaware's COVID-19 efforts contact tracing and epi investigation activities at State Health Operations Center (SHOC) especially during early genesis of the pandemic due to capacity issues. These efforts just recently ended in late April of this year with creating lab reports. He has also coordinated local and state efforts to provide regular updates to the CDC on Delaware's efforts for COVID-19 and assignee's involvement specific to women of childbearing ages (15-44 years) and children. He continues to work on informing the Delaware Perinatal Quality Collaborative (DPQC) on COVID-19 providing scientific and technical assistance.

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.

The MCH program relies on our epidemiologists, who assist in developing process and outcome measures to measure the impact of the Action Plan on the health of the MCH population. Progress is monitored on each measure by MCH program staff and other stakeholders periodically throughout the year and during our Steering Committee meetings. Based on measurement performance, MCH program staff and stakeholders revise our strategies and objectives as needed to improve health impact.

MCH program staff and epidemiologists completed our Five-Year Needs Assessment review, which provided data on the MCH population. MCH staff, stakeholders and our Steering Committee then used this data to select priorities for the upcoming grant cycle. Once the priorities were chosen an action plan was developed to impact each priority.

Access to MCH data allows for program development and progress monitoring of the MCH Block grant Action Plan. During this past year, our MCH team and epidemiologists reconvened to again review the available data for our Mini Needs Assessment due to the impacts of COVID-19 on our maternal and child health populations. We executed a stakeholder survey to gauge the effects of the pandemic on our partners and to determine if additional priorities have emerged or shifted as a result. In addition, we were specific to seek additional input from our Title V funded partners on any technical assistance Title V can provide. Title V was concerned about how we can be more intentional with supporting our partners. We were asking our partners for ways we could be responsive to their needs. We asked our partner to rank their pressing needs, which included: providing data, assist with data to apply for resources, strategic planning, disseminate information via social media outlets and guide a grant writing process.

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

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

Our epidemiologists have areas of interest for training and development. Developing small area estimates from National/State level survey data, training on creation of weight using iterative proportional fitting (IPF or raking). Dr. Hussaini is also interested in using SAS to produce prevalence ratios when other software such as SAS/Callable SUDAAN, STATA, or other software are not available for survey data. Training specific to machine learning using SAS for big data analytics. Extracting and using social media (i.e., twitter, facebook, instagram etc.) data to create structured datasets. Natural language processing (NLP) to create structured data from EMR. Training on EPIC, AllScripts, and CERNER EMR systems to assist hospitals and facilities to extract EMR data. George is also specifically interested in program evaluation and software use.

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

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

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

The purpose of the SSDI program has always focused on access to data and data linkages of key data elements to support the Title V program. Delaware's SSDI program has made tremendous progress towards gaining access to Middle and High School Surveys, Vital Statistics, Newborn Screening, Oral Health and Medicaid data, as well as, executing data linkages as needed. The SSDI program will continue to support 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.

By promoting MCH data infrastructure, our community stakeholders and partners have MCH data collection and analysis capacity. They are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. This in turn facilitates the creation of effective programs, which leads to health improvements in the MCH population.

Resources deployed by the SSDI program include not only financial, but also project management and epidemiological resources. Funds used to support evaluation and analysis of MCH data allows us to ensure that data relevant to Title V programs and priorities is made available in a timely manner. Throughout the current 5-year SSDI grant cycle, the SSDI Program Manager 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 led the Title V 2020 5-year Needs Assessment as well as our ongoing Mini Needs Assessment due to the impacts of the COVID-19 pandemic on our maternal and child health population.

The SSDI program is instrumental in providing data support by funding a portion of the contractual costs for our CDC MCH Assignee to Delaware, Dr. Khaleel Hussaini. Additional contractual dollars are allocated to working with Forward Consultants to support projects that provide evaluation services such as the Title V Mini Needs Assessment survey and analysis.

Khaleel S. Hussaini, PhD, is a Centers for Disease Control and Prevention (CDC) Maternal and Child Health Epidemiologist (MCH) assignee to the Delaware Division of Public Health. 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.

Besides developing data and research briefs for Title V, Dr. Hussaini has continued to assist in Delaware's COVID-19 efforts contact tracing and epi investigation activities at our State Health Operations (SHOC) especially during early genesis of the pandemic due to capacity issues. These efforts just recently ended in late April of this year with creating lab reports. He has also coordinated local and state efforts to provide regular updates to the CDC on Delaware's efforts for COVID-19 and assignee's involvement specific to women of childbearing ages (15-44 years) and children. He continues to work on informing the Delaware Perinatal Quality Collaborative (DPQC) on COVID-19, providing scientific and technical assistance.

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

He also provided technical feedback and worked with our Title V Needs Assessment Coordinator for Delaware's 2021 Title V Mini Needs Assessment to ensure timely completion of the needs assessment process despite competing COVID-19 priorities.

He continues to serve as a local resource for Delaware Maternal Mortality Review Committee under the auspices of Child Death Review Commission (CDRC), and Delaware Medicaid and Medical Assistance (DMMA), severe maternal mortality and morbidity (SMM) to assist in Center for Medicaid and Medicare Services (CMS) learning collaborative on SMM. Dr. Hussaini has continued to work with DMMA to advocate for proper utilization of SMM claim codes as part of an ongoing learning collaborative funded by CMS.

Dr. Hussaini has continued to assist with Center for Family Health and Epidemiology team members within Family Health Systems in Delaware to assist with data collection and tracking for Healthy Women Healthy Babies (HWB) program version 2.0. In addition, he recommended and utilized Drug Enforcement Agency (DEA) census data to develop gap analysis for Delaware Perinatal Quality Collaborative (DPQC) Opioid Quality Improvement Initiative (CDC Grant) for identification of potential trainees.

Dr. Hussaini also assisted and helped complete the Title V Needs Assessment Data Analysis 2020 MCH Block Grant for National Performance Measures (NPMs) and State Performance Measures (SPMs). He has been working to develop new National Performance Measures (NPMs) and State Performance Measures (SPMs) using PRAMS national dataset. The financial support of Dr. Hussaini's contract emphasizes the value provided to assuring we have the richest data to inform our Title V decisions.

Dr. Hussaini is updating and completing a 100+ page report using PRAMS data for 2012-2019 that provide prevalence estimates for a variety of indicators before, during, and after pregnancy. The anticipation release date is August 2021. These indicators are stratified by age, SES, and race and place to highlight health disparities. Dr. Hussaini is also expected to complete the severe maternal mortality (SMM) data brief from 2010-2014. The delay in the update has been specifically due to lack of consensus on measurement of obstetric hemorrhage that is a major driver for SMM and mortality at the national level. Dr. Hussaini developed an alternative algorithm using revenue

codes to serve as a proxy for blood transfusions. The updated report is expected to be completed beginning of the new federal fiscal year. During the report Dr. Hussaini submitted three manuscripts for CDC clearance and are currently at various stages of peer review process. One of the manuscripts is a multistate collaborative effort to examine preterm births before and during the COVID-19 pandemic. The second one is a research letter that examines a variety of perinatal quality indicators and specifically increase in cesarean deliveries pre-lockdown and post-lockdown in Delaware during COVID-19. The third manuscript is based on linked birth certificate, hospital discharge, and PRAMS data that examines the impact of adverse maternal experiences and NAS. There is one manuscript that is currently under CDC clearance that examines postpartum contraceptive use among NAS and non-NAS deliveries.

As of last year, we had significant developments in achieving our goal of accessing data and data linkages of key data elements to support the Title V program. We were able to obtain data from state-wide school surveys that we typically haven't had access to in the past. We worked with the University of Delaware, Center for Drug and Health Studies (CDHS) to obtain access to the Delaware School Survey as well as the Middle School Youth Risk Behavior Survey (YRBS).

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

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

Timely access to 2019/2020 record-level data for vital statistics (i.e., birth and death data) was one that has been a challenge due to the pandemic as well as issues specific to a facility. However, monthly birth certificate aggregate data used for monitoring perinatal quality indicators was readily available. These data were used to examine multistate preterm births. COVID-19 data specific to women of childbearing ages, and pediatric population for surveillance has not been available, which has led to a local knowledge gap about the changing epidemiology of COVID-19 in the Title V MCH population. This past year's school YRBS survey data was available as well as local Delaware School Survey data. However, because the YRBS did not meet the response rates of CDC, the data was not usable for analysis.

Additional evaluation activities supported by the SSDI program include an effort lead by the SSDI Project Director in working with Forward Consultants for our ongoing Title V Mini Needs Assessment process. MCH worked with Forward Consultants to modify our 2020 Needs Assessment Stakeholder Survey, which was distributed to more than 950 partners and stakeholders. Our objectives for our Mini Needs Assessment were:

- Gauge the impacts of the pandemic on our partners within each health domain
- Learn how our partners were adapting to the ongoing challenges of the pandemic
- Be more informed of the ways each program is adjusting
- Support programs that continue to address the MCH population

- Identify ways MCH can better support our Title V funded partners with technical assistance

Forward Consultants completed an analysis of the survey and our Title V team recently met to review the analysis to determine if any new objectives or Evidence-Based Strategy Measures (ESM) emerged because of the pandemic. Our Title V team determined that Well-Woman Visit and Adolescent Well Visit are top priorities for MCH to focus on as a result of the pandemic. Through the priority of Adolescent Well Visit, we will continue to incorporate mental health in addition to physical activity.

We were also concerned about how we can better support our Title V funded partners. We asked for ways we could provide technical assistance to them and be responsive to their needs. We canvased our Title V funded partners to learn if they have pressing needs where Title V could assist. We supplied examples such as:

- Provide data
- Assist with data to apply for resources
- Strategic planning
- Disseminate information via social media outlets
- Guide a grant writing process

We learned that our Title V funded partners ranked “Provide data” as either the first or second choice by 60% of Title V partners. Conversely, assistance with strategic planning was considered to be the first or second most important need to be addressed by only 20% of Title V partners.

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

Delaware would also like to report recent progress with emphasis on the contributions of the SSDI grant in building and supporting accessible, timely and linked MCH data systems. Vital statistics data (i.e., birth and death) data are routinely matched to Hospital Discharge Data (HDD). The data from Birth Defects Registry Data, PRAMS data, Medicaid data, program specific data such as Healthy Women Healthy Babies, School-Based Health Centers, Title X Family Planning data are matched as needed for program evaluation and monitoring purposes. As noted previously, there has been a significant knowledge gap with regards to the impact of COVID-19 on the Title V MCH population as these data are not easily accessible for surveillance purposes and/or linkage to enhance the epidemiological knowledge base.

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

Delaware's MCH Block Grant is complimented by other funding sources within the Family Health Systems (FHS) that increase our data capacity efforts, which support up to date MCH data and information systems. This ensures our program managers, epidemiologists, partners, and stakeholders have MCH data collection and analysis capacity. They are then able to leverage this capacity to make data informed decisions, particularly regarding program planning. For example, access to MCH data allows for population assessment, program development, and progress monitoring of the MCH Block grant State Action Plan. This in turn, facilitates the creation of effective programs, which leads to health improvements in the MCH population.

The mission of the Division of Public Health is to protect and enhance the health of the people of Delaware. The Division accomplishes its mission by:

- working together with others;
- addressing issues that affect the health of Delawareans;
- keeping track of the State's health;
- promoting positive lifestyles;
- responding to critical health issues and disasters;
- promoting the availability of health services.

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

In addition to our State Systems Development Initiative (SSDI) grant, other key components of our MCH epidemiological and data enhancement activities support our Title V program and activities. Family Health Systems (FHS) is committed to contracting consistent, high-quality support in research, epidemiology and program evaluation for our section and its associated programs.

Forward Consultants is our epidemiology, research, and evaluation (ERE) contractor and FHS is confident they have the experience and capacity to carry out all required activities with assistance and guidance from the DPH, FHS section.

Our ERE contracting services maintain and improve existing methods of information collection for FHS MCH statistical analysis. Examples include linked infant birth and death records, poor birth outcomes registry, and birth certificate data analysis.

The contract covers developing new methods to collect key information for decision-making and research. This can include merging existing sources of information (e.g., population-based information, surveillance systems, survey information and program/service utilization information). Project examples include data collections methods to assess the impact of nurse home visiting, data collection methods to assess the impact of preconception care and enhanced prenatal care services, and literature review of provider cultural competence and health equity.

Our Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Needs Assessment was also facilitated by our ERE contracting services. MCH leveraged and aligned the activities of our MIECHV Needs Assessment as well as our Title V Five-Year Needs Assessment. Combining efforts to gather the information and data required for both needs assessments helped leverage staff and fiscal resources across the two programs and aligned the data

collected by each to better meet the needs of women, infants, and children in the state of Delaware. Coordinating the two needs assessments, helped avoid duplication of effort and strengthened a statewide approach to addressing the needs of young children and their families.

Our ERE contracting services also aims to improve access to and use of information in addition to translating information into an easily understandable form to inform the public and key stakeholders. Project examples include data analysis and presentation of data for the annual Delaware Healthy Mother & Infant Consortium (DHMIC) report, birth defects registry analysis, and social distal factors report.

Forward Consultants also designs and implements research studies to assess program impact. This includes natural experiments, prospective studies, case control studies, and/or cross-sectional studies. Research studies may rely on quantitative methods, qualitative methods, or a mix of the two. Some project examples include one research study proposed by Data/Science Committee of the DHMIC, and a study to assess the impact of nurse home visiting.

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

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

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

The following are examples of programs that require ERE services:

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

In 2019, DPH launched a data portal allowing Delawareans to assess the overall health of their communities. The

My Healthy Community data portal delivers neighborhood-focused population health, environmental and social determinant of health data to the public. The innovative technological showpiece allows users to navigate the data at the smallest geographical area available, to understand and explore data about the factors that influence health.

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

Delaware residents are able to explore a variety of data indicators in the following categories: community characteristics, the environment, chronic disease, and mental health and substance use. Air quality data, asthma incidence data, public and private drinking water results, drug overdose and death data, community safety, maternal and child health, healthy lifestyles, health services utilization, infectious diseases, education, socioeconomic influencers, lead poisoning, suicide and homicide, and populations vulnerable to climate change are all currently available.

DPH believes that our health and the environment in which we live are inherently connected and the My Healthy Community portal will allow communities, governments and stakeholders to better understand the issues that impact our health, determine priorities and track progress. Communities can use the data to initiate community-based approaches, support and facilitate discussions that describe and define population health priorities and educate residents about their community's health and the environment in which they live.

Residents can search health indicators by street address, ZIP code, census tract, neighborhood, town/city, county and state. In addition, they can compare their community's health measures with other Delaware communities, their county, and the state, as well as view data trends over time. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), not all data can be made available at the community level therefore, the system is designed to provide data for the smallest geographic area possible.

The Division of Public Health is convinced that access to data is a key factor in making progress toward a stronger and healthier Delaware. The ability to easily access such crucial information like substance use and overdose data by zip code enables Delawareans to compare it to larger areas and examine trends. For the first time, Emergency Department non-fatal drug overdose data from DPH, and Prescription Monitoring Program (PMP) data will be available thanks to a partnership with the Division of Professional Regulation.

Addiction, air quality, chronic disease and drinking water quality impact every one of us and when communities become aware of the level at which these issues are occurring in their neighborhoods, it can spur action that can improve the quality of life for current and future generations.

My Healthy Community had been years in the making through a partnership among several DPH programs, the Department of Natural Resources and Environmental Control (DNREC), the Division of Substance Use and Mental Health (DSAMH), and the Delaware Health Care Commission (HCC). DPH's contractor for this project was Green River of Brattleboro, Vermont.

Health and environmental agencies have a long history of separately tracking trends, when, in fact, environmental conditions and health outcomes are often closely related. This public-access portal brings health and environmental data together and puts this information at the fingertips of all Delawareans, including healthcare and environmental professionals.

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

My Healthy Community encompasses the Delaware Environmental Public Health Tracking Network (EPHTN), and benefits from participation in an Environmental Public Health Tracking Peer-to-Peer Fellowship program through the Association of State and Territorial Health Officials (ASTHO), with the Kentucky Department of Health as Delaware's EPHTN mentor. [State of Delaware – My Healthy Community](#)

MCH collaborates with the Division of Public Health's Bureau of Chronic Disease Prevention. The Chronic Disease Prevention Bureau, in the Division's Health Promotion and Disease Prevention Section, manages programs to prevent and control these chronic illnesses. The programs work closely with the Bureau of Health Promotion, whose programs address the major risk factors for the leading causes of death, such as tobacco use, physical inactivity, poor nutrition, and obesity.

Over the last three decades, scientific evidence has clearly demonstrated how personal behaviors affect development of diseases. Smoking, physical inactivity, poor eating habits, obesity, alcohol abuse, and other risk factors can lead to a variety of chronic health problems-like heart disease, cancer, type 2 diabetes, or lung diseases. Lifestyle behaviors increase the risk of communicable diseases such as AIDS, sexually transmitted diseases, and vaccine-preventable diseases. Injuries from violence and accidents also may be caused by behavioral risks.

As a result of this evidence, public health professionals are focusing on ways to help people change their behaviors to reduce risks and prevent illness or premature death. To accomplish this, public health researchers need to gather information about health risks. How many people are at risk? What populations are most affected? Are there new or emerging health concerns which need to be addressed? Health agencies use this information to plan, implement and evaluate health education and disease prevention programs for the public.

The Behavioral Risk Factor Survey (BRFS) is an annual survey of Delaware's adult population about behaviors which increase the risk of disease, premature death, and disability. The Behavioral Risk Factor Surveillance System (BRFSS) is a cooperative effort of the Delaware Division of Public Health and the U.S. Centers for Disease Control and Prevention (CDC), and is primarily funded by CDC.

These data are gathered through the Behavioral Risk Factor Surveillance System (BRFSS). In the early 1980s, the Centers for Disease Control and Prevention (CDC) worked with several states, including Delaware, to create the BRFSS and address these behavioral health risks. This unique, state-based surveillance system is the largest continuously conducted telephone health survey in the world. The BRFSS includes all 50 states, the District of Columbia, and three territories. The sample is randomized by state, producing more accurate data for state planning. The state-based system allows states to add questions of local interest.

Delaware has been collecting behavioral risk factor data continuously since 1990. Interviewing is conducted every month of every year, and data are analyzed on a calendar-year basis. The BRFS made methodological improvements in 2011 to address social and technical changes in telephone usage. The annual sample in Delaware is about 4,000 adults age 18 and older.

The random-sample telephone survey is conducted for the Division of Public Health by Abt Associates, Inc. Data from the survey are used by both public and private health providers to plan health programs and to track progress toward the state's health goals.

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

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

The document has been tailored for the use of the Family Health Systems (FHS) section using *the Federal Emergency Management Agency (FEMA) Continuity of Operations (COOP) Plan Template, State of Alaska Division of Homeland Security and Emergency Management and Virginia Department of Emergency Management COOP SOG*.

This COOP SOG was prepared by the Section Chief of FHS/Title V Director, to develop, implement and maintain a viable COOP capability. This plan complies with applicable internal Department of Technology & Information (DTI) policy, Executive Order 38 and supports recommendations provided in FEMA's Continuity Guidance Circular 1 (CGC 1) and Continuity Guidance Circular 2 (CGC 2). This COOP SOG has been distributed internally to appropriate personnel within DPH and with external organizations that might be affected by its implementation.

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

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

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

The DHSS/DPH has also developed the State Health Operations Center (SHOC) which provides command and control for all public health and medical response and recovery functions, Emergency Support Function (ESF) 8, in a statewide or local emergency or disaster. The SHOC oversees and coordinates health and medical response operations including the operation of Points of Dispensing (PODs), Alternate Care Sites, Shelter Medical Stations, and hospital coordination. Organizational Structure: The organization and structure of the SHOC follows the Incident Command System (ICS) and is National Incident Management System (NIMS) compliant. The State Health Officer (SHO) serves as the Incident Commander (IC) for whom the members of the Command staff work to provide legal and policy support as well as maintain communications with the media and the public. Four Section Chiefs report to

the IC during a SHOC: The Finance & Administration Section handles human resources, procurement, and other administrative services. Planning Section gathers and analyzes information and helps to formulate the Incident Action Plan (IAP). Operations Section implements the IAP and manages the SHOC's tactical response to the event. Logistics Section maintains all supply, transportation, communications, and other such support to SHOC operations. SHOC can be activated at one of three levels, depending on the type and complexity of the event. The DPH Director or their designee determines the level of SHOC activation.

- SHOC Level 1 activation indicates heightened assessment and is used for events such as a mass public gathering requiring the deployment of DPH resources, or the presentation of a suspicious substance associated with a credible threat.
- SHOC Level 2 activation is the result of a localized event with a potential statewide impact, such as a severe weather warning, or a confirmed regional or Delaware case of a disease with potentially urgent public health implications and/or widespread impact.
- SHOC Level 3 is activated during a statewide emergency, such as a pandemic disease or illness or a credible threat of or an actual terrorist attack in the state or region

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

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

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

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

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

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

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

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

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

Healthy Communities Delaware (HCD) involves business, community, and organizational participants, and is managed as a collaboration among DPH, the University of Delaware Partnership for Healthy Communities, and the Delaware Community Foundation. HCD works in partnership with communities to address resident priorities around the social determinants of health - conditions in which we are born, live, learn, work and age. The Division of Public Health (DPH) and the Healthy Communities Delaware (HCD) initiative announced collaborations with several communities throughout Delaware that have been significantly impacted by COVID-19 in 2020. Many Delawareans lack the basic resources for health and well-being - safe and healthy homes, a quality education, meaningful employment, a healthy environment, access to healthy foods, financial stability and reliable transportation. Many of these inequities are a result of and perpetuated by structural racism and discrimination and are exacerbated by the COVID-19 pandemic.

Working with 12 community-based lead organizations, Healthy Communities Delaware is providing more than \$720,000 in funding to nine communities across the state to reduce the impact of COVID-19 on Delaware's most vulnerable populations. Descriptions on the can be viewed using the following link,

<https://healthycommunitiesde.org/community-partners>. This funding will help communities address important fundamental needs by creating neighborhood hubs to serve as food pantries and provide prevention care and resources; hiring bilingual resource navigators; and replacing deteriorating buildings with affordable rental units. Projects will engage residents in identifying the needs of their communities, building trust, and directly providing food, education, and care resources. These collaborative efforts will support nine communities working with 12 community-based organizations to navigate such challenges as food security, resource navigation, housing, job creation and workforce development. Healthy Communities Delaware is collaborating with 8 organizations in New Castle County, 1 organization in Kent County and 3 in Sussex County.

Senate Bill 227 and Executive Order 25 was passed/issued in 2018 which 1) requires the Delaware Health Care Commission to collaborate with the Primary Care Reform Collaborative to develop annual recommendations to

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

The Primary Care Reform Collaborative released their annual report in May 2020 and highlighted how the landscape of our health care delivery and life in general has been drastically altered since the last report. The necessary measures to ensure recovery from the health pandemic that has swept the globe has also paralyzed the normal rhythm and function of every aspect of life. For health care, it has starkly highlighted deficiencies, gaps and disparities but it has also accelerated innovation, partnerships and collaboration, which hopefully will drive the development of successful solutions for the former.

The crisis in primary care, which prompted the passage of SB 227, still exists in the shadow of the overall pandemic. While SB227 has provided a fragile stability for some aspects of primary care, there needs to be much more significant change in how primary care is delivered, including investments to help current practices thrive; enhancements for our existing and future workforce and bending the cost curve with alternative payment models. The expansion of the Primary Care Reform Collaborative invested all stakeholders in what it means for primary care to be foundational to health care delivery in Delaware. Aligning the stakeholders, including payors, providers, employers and the State on how to build primary care beyond survival and through sustainability into a successful “cornerstone” of health care delivery in Delaware will continue to be the bulwark of the Collaborative. The development of the Office of Value Based Health Care Delivery provides an essential framework for data collection, analysis and policy research that is crucial to the development of an overarching primary care policy. How these proceeds in Delaware, post-pandemic, with concerns regarding funding, potential increases in loss of access and the general effect on overall health outcomes is difficult to determine. However, even though the momentum of work has lagged with the pandemic, the stakeholders in the Collaborative are committed to developing and implementing policy recommendations that will improve the delivery of primary care and provide Delaware with adequate, quality access at lower costs.

Department of Health and Social Services (DHSS) Secretary Molly Magarik presented the state's first Benchmark Trend Report at today's Delaware Health Care Commission (DHCC) meeting, summarizing health care spending and quality data collected for calendar year 2019. The report is the latest step in the state's effort to reduce health care spending and improve quality of care for Delawareans. The Benchmark Trend Report details total health care spending for 2019 and compares it to baseline data collected for 2018. The first spending benchmark went into effect on Jan. 1, 2019, and was set at 3.8%, with the target expected to decrease gradually to 3% over the following three years. For calendar year 2019, the report found overall health care spending in Delaware totaled \$8.2 billion vs. \$7.6 billion for 2018. The per-capita cost increased from \$7,814 in 2018 to \$8,424 in 2019, or 7.8% – more than twice as high as the 3.8% target. Spending in 2019 increased across all spending categories, including the five largest:

- Hospital inpatient: \$1.8 billion (up from \$1.6 billion in 2018)
- Hospital outpatient: \$1.6 billion (up from \$1.4 billion in 2018)
- Physician: \$1.3 billion (up from \$1.2 billion in 2018)
- Pharmacy: \$1.2 billion (up from \$1.1 billion in 2018)
- Long-term care: \$1.1 billion (up from \$1 billion in 2018)

The release of the 2019 spending and quality data is another step along the state's "Road to Value" initiative to improve access to affordable, quality health care for all Delawareans. That effort remains critically important even as Delaware responds to the COVID-19 crisis, Secretary Magarik said.

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

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

- Provide coordination between the Division of Medicaid and Medical Assistance (DMMA) and the Division of Public Health for programs impacting women, infants and children.
- Provide coordination in the administration of programs that are designed to improve the health of children (particularly Children with Special Health Care Needs) and families in the State of Delaware.
- Maintain a process that allows for joint access to critical data without duplication of effort.

Further, the MOU enables the agencies to:

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

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

The DMMA hired a Maternal and Child Health Quality Assurance Administrator recently, and DPH sees this as a fantastic opportunity to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies. The DMMA Medical Director, Dr. Liz Brown is a close partner as a DPQC member as well as a previous member of the Preconception CoIN. Currently, key MCH leadership including the Title V Director meet monthly with both of these DMMA staff members along with other DMMA policy staff members.

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

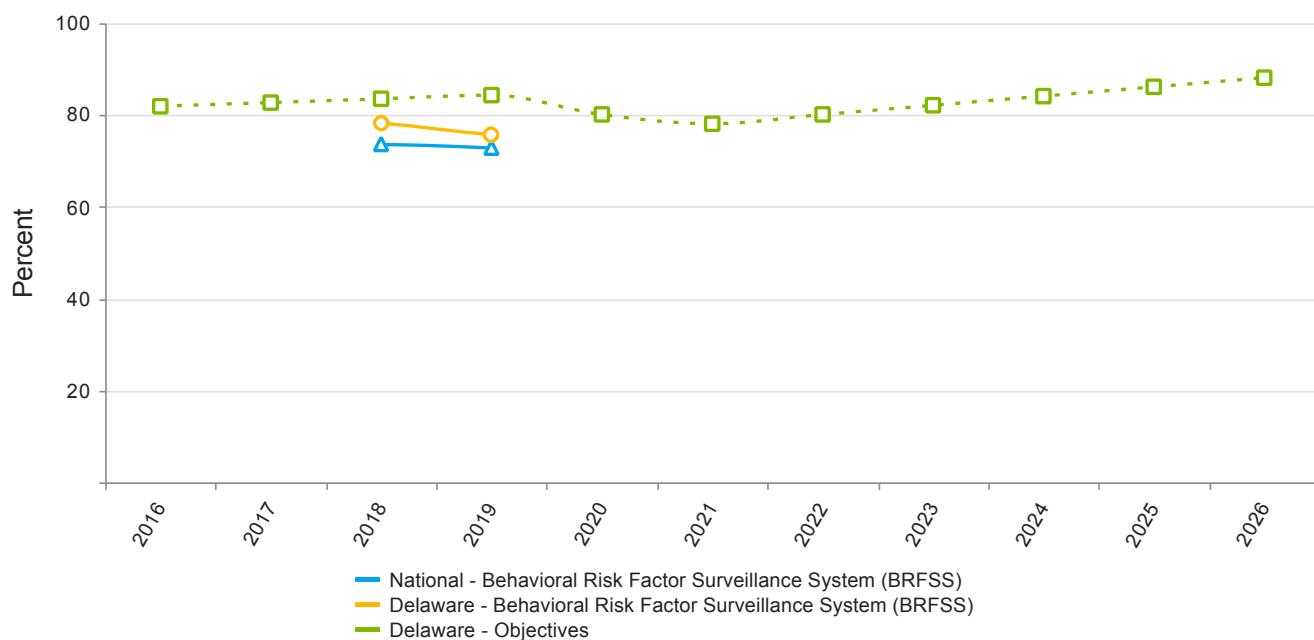
Women/Maternal Health

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-2018	68.8	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.4 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.7 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	29.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.9	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.0	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	197.7	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	6.8 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	23.3	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	13.3 %	NPM 13.1
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-2018_2019	15.7 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.5 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	14.9	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	10.4 %	NPM 1

National Performance Measures

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



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017	2018	2019	2020
Annual Objective					80
Annual Indicator				78.2	75.6
Numerator				127,950	124,769
Denominator				163,676	165,041
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

ⓘ Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15,000	15,500	15,700	17,000
Annual Indicator	14,998	15,891	16,386	16,672	8,488
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	17,250.0	17,500.0	17,750.0	18,000.0	18,250.0	18,250.0

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		88
Numerator		
Denominator		
Data Source		HWHB Program Data
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	92.0	94.0	96.0	98.0	100.0

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		62
Numerator		
Denominator		
Data Source		Medicaid Claims Data
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	65.0	67.0	69.0	70.0	72.0

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	2018	2019	2020
Annual Objective		57	56	52	30
Annual Indicator	57	45.5	43	27.5	28.7
Numerator					
Denominator					
Data Source	Health Statistics	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2015	2016	2017	2016-2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	25.0	24.0	23.0

SPM 2 - Reduce the disparity in infant mortality rates

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		4.6
Numerator		
Denominator		
Data Source	HWHB Program Data and Vital Statistics Data	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Delaware) - Women/Maternal Health - Entry 1	
Priority Need	Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By July 2025, increase percentage of women with birth interval > 18 months. Increase the number of HWHBs Zone Mini-grantees focused on MCH Priority High Risk Areas engaged in MCH funded activities from 6 to 8 in 2020 to 8 to 10 in 2025. By 2025, increase the number of women receiving a timely postpartum visit.	
Strategies	
Convene the Well Woman Workgroup with expertise in women's health and preconception health to develop a framework for optimizing the health and well-being of women of reproductive age. Work with DPH's seven contractual health providers using a performance and outcomes based approach to deliver the Healthy Women Healthy Babies program services across the state. Work with 6 HWHBs Zones Mini-Grantees focused on MCH Priority High Risk areas engaged in MCH funded activities. Patient Reminders-Support providers in disseminating reminders and education materials (e.g., postcard, text, email, phone) to women about the importance of scheduling annual preventative visits In collaboration with the Delaware Healthy Mother and Infant Consortium's Well Woman Workgroup, develop a Media Campaign-Utilize media outlets to increase awareness of the importance of preconception health and reproductive life planning as well as promote preventive well woman medical visits. Patient-Navigators-Adopt protocols where clinic staff and Community Health Workers (e.g., WIC, HWHBs providers) assist with referrals to make preventative visits Collaborate with the Delaware Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes for women and babies. Provider Education-Host a webinar series for providers about annual preventive visits and strategies to address missed opportunities Support the development and implementation of the housing pilot for pregnant women in collaboration with the DHMIC's Social Determinants of Health workgroup. Ensure the data reports produced by Title V describe relevant disparities and discuss potential root causes, implications, and recommendations for moving towards equity and improved health outcomes for women and babies.	

ESMs	Status
ESM 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics	Active
ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention	Active
ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method	Active
NOMs	
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	
NOM 3 - Maternal mortality rate per 100,000 live births	
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	
NOM 5 - Percent of preterm births (<37 weeks)	
NOM 6 - Percent of early term births (37, 38 weeks)	
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.2 - Neonatal mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	

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

Priority Need

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

SPM

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

Objectives

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

Strategies

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

Promote routine pregnancy intention screening

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

Priority Need

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

SPM

SPM 2 - Reduce the disparity in infant mortality rates

Objectives

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

Strategies

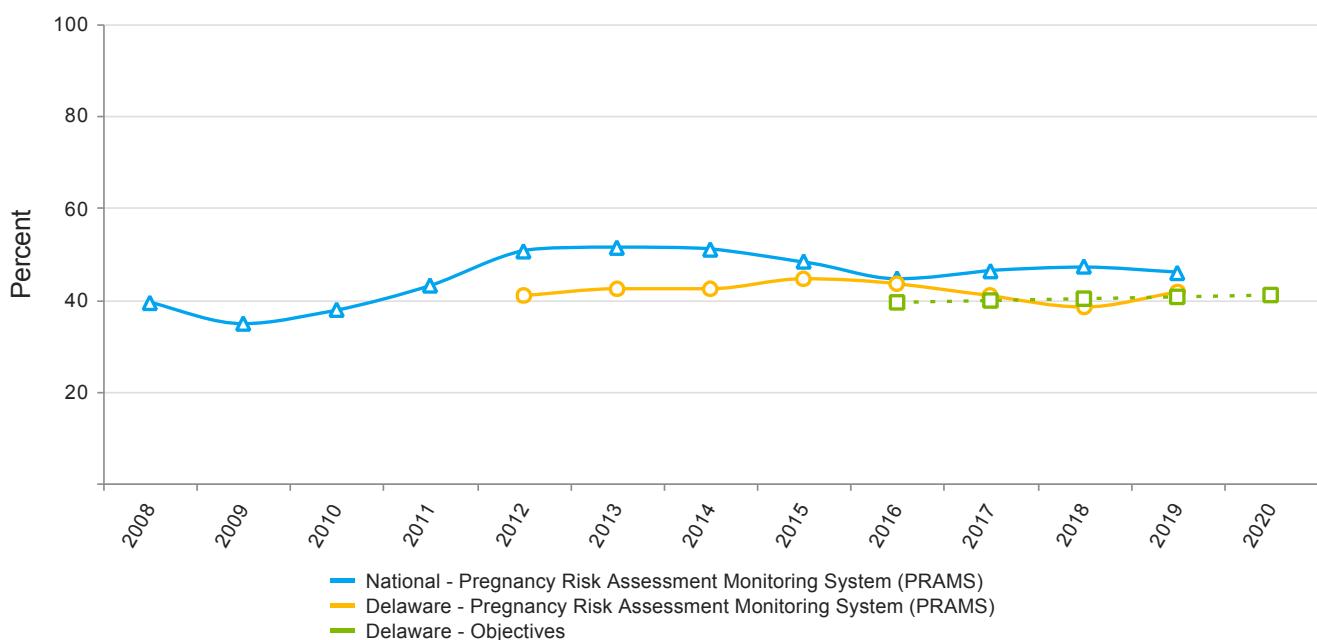
Ensure the data reports produced by Title V describe relevant disparities and discuss potential root causes, implications, and recommendations for moving towards equity and improved health outcomes for women and babies.

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

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

2016-2020: National Performance Measures

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	2017	2018	2019	2020
Annual Objective	39.4	39.8	40.2	40.6	41
Annual Indicator	42.2	44.4	43.5	38.5	41.8
Numerator	4,224	4,562	4,461	3,777	4,101
Denominator	10,020	10,267	10,261	9,807	9,807
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2016	2018	2019

2016-2020: Evidence-Based or -Informed Strategy Measures

2016-2020: 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	2018	2019	2020
Annual Objective		5,000	10,000	5,000	5,000
Annual Indicator	3,989	5,530	1,101	989	1,184
Numerator					
Denominator					
Data Source	DPH Google Analytics				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.

Measure Status:		Active			
State Provided Data					
	2017	2018	2019	2020	
Annual Objective			25	50	
Annual Indicator			0	4	
Numerator					
Denominator					
Data Source			MCH Program Data	MCH Program Data	
Data Source Year			2019	2020	
Provisional or Final ?			Final	Final	

2016-2020: ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			2	3
Annual Indicator			2	0
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Women/Maternal Health - Annual Report

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

Over the last year, 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 currently undergoing a review of its current infrastructure and revisiting its bylaws and committee structure to monitor implementation of the Infant Mortality Task Force recommendations. Staff in the Division of Public Health's Family Health Systems Section largely provide staff support to the committees and help carry out and execute strategies to support the DHMIC's strategic plan. The new framework and structure of the DHMIC is designed to focus more intensively on the strategic goals and priorities. The Committees include:

1. Well Woman/Black Maternal Health Committee - The focus of this committee is on a comprehensive, evidence-based approach to reproductive health and the health of women before, during, and after pregnancy - one that is woman-centered and clinician-engaged. The group functions to meet the diverse and often complex needs of reproductive-age women, particularly from more vulnerable populations, and works to foster leadership and information sharing, solicit voices of the consumer, encourage innovation, build awareness, and promote reproductive life planning.
 - a. The Black Maternal Health Workgroup (BMHW) sits under and reports to the Well Woman Committee. The purpose of the BMHW is to address the disproportionately high and unacceptable rates of maternal mortality and morbidity in Black and Indigenous People of Color (BIPOC) communities in Delaware. The BMHWG will work to ensure all women of reproductive age in Delaware will be healthy and have access to safe, respectful, culturally appropriate maternal care before, during and beyond pregnancy.
2. The Social Determinant of Health Committee which seeks to understand where people live, work, play and pray can help create actionable engagement strategies to improve health outcomes by addressing barriers rooted in structural racism. This group works to collaborate with the community, offer space for shared learning with providers, review policies and programs to identify opportunities for change, evaluate best practices, identify health needs, and engage the faith-based community. The SDOH Committee decided to focus on housing for pregnant and parenting women as a priority. In reviewing literature and recent studies, SDOH Committee Co-chairs Rita Landgraf and Rep. Minor Brown proposed exploring the feasibility of a pilot in Delaware similar to the Healthy Beginnings at Home pilot in Columbus, Ohio.
 - a. The Housing Pilot Workgroup. This group was recently established over the last year to report directly to the SDOH Committee. While we don't yet know the full extent, the unique health and social vulnerabilities faced by pregnant women who experience homelessness or are housing insecure have no doubt increased during the COVID-19 pandemic. To respond to this crisis, the workgroup is exploring interventions to provide these women with housing and wrap around social supports. In doing so, programs such as the Healthy Beginnings at Home Pilot in Columbus, Ohio, are under

review, which demonstrated a decrease in emergency hospital stays and negative birth outcomes, like the number of pre-term births, infant mortality, and decrease the number of days baby is in the NICU.

Health Management Associates (HMA) was hired contractually by the Division of Public Health to analyze conditions in Delaware that would inform this pilot, such as housing availability, enrollment size and criteria, funding availability, and evaluation needs. As part of this, HMA also engaged childbearing women who are or who have been housing insecure to help in the design of the pilot. The findings should help the DHMIC's housing advisory workgroup and the SDOH Committee make recommendations to the broader DHMIC on how to create a pilot for pregnant, housing insecure women.

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

Education and prevention are a cornerstone of the DHMIC work, utilizing the latest social media platforms. In partnership with a social marketing firm, Aloysius Butler and Clark (AB&C), the Division of Public Health and several Maternal and Child Health partners we continued to develop, update and launch messaging through the use of social media, whereby we continue to post messages via blogs, Twitter, Facebook, YouTube, and most recently added Instagram, in which all MCH programs and initiatives participate. The branding tagline, Delaware Thrives, evolves around the theme that "Health Begins Where You Live, Learn, Work & Play". This year we continued to focus 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 is hard to believe that the DEThrives social media and website was launched in 2013, and now is due for a refresh and update. DEThrives is currently undergoing a comprehensive update.

Due to the COVID-19 pandemic, we held our 2021 Annual DHMIC Maternal and Child Health Summit virtually on the platform Socio, on April 13, 2021. For 15 remarkable years, DHMIC has been making good on its promise to provide statewide leadership coordination of efforts to prevent infant mortality and improve the health of women of childbearing age and infants throughout Delaware. 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. 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. Developed around the theme "The Power of You, The Power of Community: Shaping the Narrative to Build Healthy Generations," the DHMIC summit integrates a full agenda of educational, advocacy, networking, and story-sharing opportunities to mobilize participants to better understand the reasons why - and the ways how - they can leverage their professional, personal, and community service resources to decrease racial disparities in maternal and infant health.

The Summit reached 450 attendees this year, including health care professionals, community influencers, policymakers, faith community leaders, and concerned citizens to be empowered on critical topics by leadership from DHMIC, Delaware Thrives, and the Delaware Division of Public Health (DPH), along with local and national experts from various fields who are committed to ending racial and ethnic health disparities. A summary of the agenda follows:

Keynote presentations

- "Leadership for the Next Decade: Recovery, Resilience, and Respect." Kay A. Johnson, Johnson Group

Consulting, Inc.

- “Reframing and Reclaiming Community Through Our Stories.” An interactive workshop led by Sonny Eugene Kelly, PhD
- “The SACRED Birth Study: Advancing Cultural Rigor in Hospital Births and Perinatal Quality Improvement.” Dr. Karen, MD, MPH, FACOG, Reproductive Justice
- “Building the Capacity of Communities to Advance Health Equity.” Edward P. Ehlinger, MD, MSPH, Public Health Metaphysician

Special Remarks and Presentations

- John Carney, Governor, State of Delaware, and Lt. Governor Bethany Hall-Long
- Karyl Rattay, MD, MS. FAAP, Director, Delaware Division of Public Health
- Dr. David Paul, Chair, DHMIC
- DHMIC Health Equity Awards presentation
- Black Maternal Health Awareness video presentation
- Health Equity Awards presentation

As in the past, we put out a call for the Summit looking for bold ideas, bold new programs, or a bold new approach to improving the health of women, men, infants, and families, calling them Virtual Innovation Stations. Innovation Stations participants were encouraged to submit a 1-2-minute video recording detailing their organization and/or program. The following topics were covered:

- Delaware Doula Effort
- Black Maternal Health and Advocacy
- Understanding the Impact of Health Inequity, Disparities and Implicit Bias on the Care of Women Before, During, and After Pregnancy
- Why Health Matters Before Pregnancy
- Teen Scene: Programs and Services for Adolescents
- Breast is Best
- The 4th Trimester: An Underutilized Opportunity for Prevention
- It's A Man's World
- Community Outreach and Engagement of Special Populations
- Supporting Mother/Baby Dyads through Opioid and Substance Use Treatment and Recovery Services
- Addressing the Social Determinants of Health in the Care of Women, Infants, and Families
- Financial Empowerment

Not only are the organizations/programs featured during the DHMIC 2021 Summit rich with content, featuring the Innovation Stations also establish the foundation for consistent dialogue around these organizations/programs as DHMIC partners and ultimately result in greater awareness of and support for the DHMIC mission.

The DHMIC also awarded its Health Champions awards during its April 13 Summit. Shane Darby received the individual Champion in Health award for founding the statewide non-profit organization, Black Mothers in Power. The non-profit empowers black mothers to advocate for legislation to address racial inequity, to understand the impact of implicit bias in health care services, to improve health access and response for black families, and to promote Doula care before, during, and post-partum.

The Community Legal Aid Society (CLASI) received the group Champion in Health award. Executive Director Dan Atkins accepted the award on behalf of CLASI. CLASI provides free legal services to vulnerable populations to help

them address the social determinants of their health. CLASI works on issues to improve housing conditions, prevent homelessness, and obtain protective orders for survivors of domestic abuse. CLASI helps immigrants obtain permanent residency and ensures that low income families have food and income benefits. Much of CLASI's work – housing, public benefits, domestic violence – affects health. Delawareans cannot be their healthiest without a safe home, food on the table, and safety net benefits.

Delaware Division of Public Health Director Dr. Karyl Rattay was also honored as the longest-serving state public health official in the United States. Governor John Carney surprised Dr. Rattay with an award on April 13 during the Delaware Healthy Mother and Infant Consortium's Summit. Under Dr. Rattay's 12 years of leadership, DPH achieved national accreditation in 2016, completed Delaware's first State Health Improvement Plan, and distributed guidance to improve health equity in Delaware. Dr. Rattay directs DPH's response to public health emergencies, including the current COVID-19 pandemic as well as past events including the 2009 H1N1 Pandemic, Superstorm Sandy, Ebola virus, Zika virus and Tuberculosis (TB) outbreaks. Since 2012, she also has helped to guide Delaware's response to the opioid epidemic. Dr. Rattay is a staunch supporter of the state's healthy mothers and babies initiative, partners with communities to improve health, and promotes healthy lifestyles and the availability of health services such as cancer screenings and immunizations. She also strongly believes in statewide health partnerships to improve population health and health equity. To view the video of Dr. Rattay receiving her award from Governor Carney, visit <https://youtu.be/2956WFsgZew>.

All speaker presentations and VIS have been repurposed on <https://dethrives.com/summit-2021>and social media channels, including Facebook and Twitter.

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

All eyes are on the first year and accomplishments resulting from implementing 6 Healthy Women Healthy Baby (HWB) Zones community-informed strategies that aim to increase awareness, educate, better serve women of reproductive age and amplify the voice of black maternal health grass roots organizations. The primary focus is innovation and to spread evidence-based programs and place-based strategies to improve the social determinants of health and equity in maternal and infant health outcomes, as a complement to our medical intervention, HWBs 2.0. The first-ever mini grants support the shared initiative to narrow the wide variance in birth outcomes between black women and white women by building state and local capacity and testing small-scale innovative strategies. DPH worked with Health Management Associates (HMA) to develop a mini-grant process to fund local communities/organizations to implement interventions to address social determinants of health in priority communities throughout Delaware. The six mini grantees awarded included Delaware Adolescent Program, Inc. (DAP), Delaware Coalition Against Domestic Violence (DCADV), Delaware Multicultural and Civic Organization (DEMCO), Hispanic American Association of Delaware (HAAD), Kingswood Community Center, and Rosehill Community Center. A short description of the awarded community-based interventions are described below.

- Delaware Adolescent Program, Inc.: serves teen mothers and their partners providing mentoring services and Support for social and emotional well-being and support in navigating the health and social services system.
- Delaware Coalition Against Domestic Violence: This organization provides support to victims of domestic violence and administers flexible Health Access Funds to support the safety and health of the participants. DCADV also trains health care providers on best practices for domestic violence assessment and response.
- Delaware Multicultural and Civic Organization (DEMCO): Provides life skills supports and job training education to young women of childbearing age, including those who are pregnant and parenting
- Hispanic American Association of Delaware: This organization provides pregnancy and postpartum support in Spanish to women ages 15-44 who live in ZIP code 19720 in New Castle County.
- Rose Hill Community Center: Provides fitness, nutrition counseling and self-improvement classes to women at no cost.

New awardees were added through a competitive mini grant award cycle and process, and include:

- Parent Information Center (PIC): Train six doulas, who will provide nonclinical emotional, physical, and informational support before, during, and after labor and birth. In partnership with community organizations, the program will also provide virtual training on childbirth education, breastfeeding initiation, prenatal nutrition, healthy family relationships, and community supports; empower women to be their own self-advocates; provide one-on-one coaching calls with pregnant women (prenatal and postpartum) starting six weeks before due date and continuing six weeks postpartum; offer postpartum support groups with other new parents as well as breakout sessions on breastfeeding, sexuality, mental health, and infant development; and create an awareness campaign focused on prenatal and postpartum support.
- Rosehill Community Center: This organization will use its new cycle of additional grant funding to address toxic stress - as they feel that stress during the pandemic has led to fear and anxiety, and has caused residents in their service area to be overwhelmed and have feelings of isolation and loneliness. Rose Hill's funded program will work to serve women ages 15 to 44 in New Castle (ZIP code 19720) and Wilmington (ZIP code 19801) by providing free mental health workshops with psychologists and psychiatrists twice a month, covering the following topics: feelings of isolation, depression, self-care, setting boundaries, stress, and knowing your triggers, etc. Rose Hill will provide lessons on reducing stress, breathing sessions, mindfulness training, and journaling. They will also provide massage therapy and stretching techniques (three times per client), as well as yoga lessons once a week.
- Wilmington Urban League (MWUL) will be serving as a fiscal agent for Black Mothers in Power (BMIP), a grassroots organization focusing on Black mothers in the community and underserved populations. The Metropolitan Urban League will use grant money to provide and sponsor a doula program to train 10 black women to become certified doulas through the National Black Doula Association. The organization will be training five doulas in New Castle County and Kent County, and will be focusing on engaging at-risk pregnant women who live in high-risk zones. Each doula will help women during the critical times of pregnancy, birth and postpartum, and early parenting.
- Breastfeeding Coalition of Delaware will provide breastfeeding support groups to the HWHB high-risk zones of Wilmington, Claymont, and Seaford. It will offer accessible support, engaging groups, text check-ins, access to variable levels of lactation support, and incentives for participation. In addition, the Breastfeeding Coalition of Delaware will hire three diverse breastfeeding peer counselors (BPC) and one lactation consultant to provide breastfeeding support to women. At the completion of the program, the Breastfeeding Coalition of Delaware will host a baby shower for participants, where they will provide needed baby supplies, education, and support to pregnant and postpartum women.

The first full year Evaluation report was released in June 2021. Some of the preliminary findings from the

participants demonstrate progress and a positive impact as it relates to the overall NPM1 Well Woman:

- Demographic data: 482 women and girls served; majority of participants from Zip codes 19702, 19720, 19801, 19804, 19805, 19901, 19904; 605 of participants were black, 35% were white, 6% identified as “multi-racial/other”; 105 participants said Spanish was their primary language; About ½ have a high school diploma or GED.
- Most common expressed needs by the women screened and engaged in the mini grantee interventions were referred to resources for stable housing, utility assistance, help reading health materials (health literacy), and access to food. Nearly half struggle with childcare, transportation, social support or access to medical care.
- 72% of participants have either been pregnant, are parenting, or is currently pregnant.
- Participants were screened for pregnancy intention and referrals were made as appropriate to local family planning provider sites and Healthy Women Healthy Babies providers. The majority of participants are not intending to become pregnant in the next year.
- Of the DEMCO participants, on average 82% of participants felt that they had improved their professional skills and increased confidence to prepare for employment.
- Of the DCADV participants, 96% of flex fund recipients reported that the funds "Significantly" or "Completely" reduced their financial stress.
- Of the Rosehill participants, 59% of participants lost weight. On average, participants lost 3lbs over the course of the program.
- Of those that participated in the DAPI intervention, they were asked “To what extent did the program increase resilience to relationship pressure and intention to apply refusal skills?” 75% of students reported confidence applying refusal skills (“I would feel comfortable saying no to my partner when I don't feel like having sex”).
- Participants showing statistically significant improvements in depression, anxiety and stress.
- Adapted wrap around services and support during Covid-19 included “flex funds”, computers and internet needs. Flex funds were most commonly used to meet basic needs such as food, diapers, winter coats, and feminine hygiene products, to support needs of children, to pay utility bills, to meet physical needs, and to buy essential furnishings.

One key component of the HWHB Zones initiative is the provision of coaching and technical assistance (TA) to the mini-grantees (and one unfunded organization) throughout the life of the initiative to build capacity and ensure sustainability of the interventions, as well as focus on continuous quality improvement. In Grant Cycle 1, the TA consisted of two learning collaborative meetings (one in person in December and one virtual in May), as well as individual coaching and TA. Each mini grantee has a coach from HMA with whom they meet regularly. The frequency and length of coaching and TA calls and meetings over the last year were developed by each coach and mini grantee in collaboration.

Coaches reported a variety of strengths and weaknesses across the HWHBs Zones mini-grantees prior to participating in the HWHBs Zones initiative and, therefore, the TA needs that were identified vary widely across the mini-grantees. Common needs included:

- programmatic challenges (i.e., unexpected challenges related to implementing the proposed program).
- fiscal challenges (i.e., challenges with submitting invoices or receipts).
- data challenges (such as challenges collecting data, recording data, or submitting data); and/or
- infrastructure challenges (i.e., not having enough staff).

Importantly, the emergence and impacts of COVID-19 and the killing of George Floyd followed by growing national attention to racial inequities have had a significant impact on mini-grantees and the communities they serve. The HMA coaches supported the mini grantees in their efforts to be responsive to the changing and emerging needs of

the people they serve. Mini grantee needs for technical assistance during these crises have included:

- how to transition services to virtual rather than in person.
- how to respond to changing and emergent needs of the people served by the mini-grantees, such as technological needs to be able to continue to participate in services, urgent needs for “flex funds” to pay for necessities in the face of sudden unemployment, needs for additional social support and behavioral health support;
- how to conduct consent for enrollment in the evaluation online.
- how to collect data online.
- how to support individuals and communities experiencing trauma; and
- how to collect information from participants about emerging needs, about how well virtual services are meeting their needs, and barriers to participation in virtual services.

The DHMIC embraced the focus and framework of a preconception health approach, to optimize the health of women before, between and beyond pregnancies. Delaware developed the Women’s Wellness initiative, *Every Woman Every Time Delaware: Reimagining the Preventive Medical Visit*, which at its core seeks to strengthen the dynamic interplay between a woman and her health care provider(s) by encouraging honest and open communication about her reproductive and general health care needs. The initiative focuses on four broad areas including 1) Pregnancy intention screening; 2) Assessment of health risk behaviors, and prevention and education tools 3) management of chronic health conditions 4) identification of social determinants of health with linkage to services. DHMIC, through DPH has a contractual support position, a Women’s, Infants, and Families Nurse Consultant that devotes time and expertise to lead the Women’s Wellness initiative. This year, the WIF Nurse Consultant wrote a very strong Op-ed piece, “Well Woman Care: Why your yearly visit is important”^[1], published in the Delaware News Journal that described the Every Women Every Time DE initiative directed to consumers and the broader public. Some of her core responsibilities include:

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

One of the WIF Nurse Consultant’s projects is to focus on educating young women of reproductive health age on reproductive life planning, working with the Warehouse. The Warehouse concept arose from the need for quality afterschool programs for youth in one of Wilmington’s higher crime areas. Unlike a traditional community center, the Warehouse employs a collaborative teen engagement structure involving a network of youth-serving nonprofits that will operate within the Warehouse framework and deliver programs under a shared roof. The mission of the Warehouse is to create a collaborative culture to revolutionize teen engagement in Wilmington with the vision of supporting confident, competent and courageous young adults ready to take the next step in their lives. The Warehouse also creates a physical safe space and network of support for Wilmington teens while nurturing a culture of opportunity that stands in opposition to a culture of poverty and violence. To support the REACH Riverside community revitalization effort, The Warehouse became part of the holistic Community Health and Wellness effort underway in Riverside. To create alignment with the REACH model, The Warehouse is also guided by five pillars of success: Recreation, Education, Arts, Career, & Health. The WIF Nurse Consultant is involved in the Health pillar

and offers maternal and child health education on the DHMIC reproductive life planning.

The WIF Nurse Consultant is also promoting the Preconception Peer Education Program and encouraging new colleges and universities to adopt and operationalize the program. The PPE program was implemented in May 2007 by the Office of Minority Health (OMH) of the Department of Health and Human Services, supported by DPH and the DHMIC for replication. This national program was launched as part of its initiatives to eliminate health disparities among racial and ethnic minorities in the U.S. The Preconception Peer Educators (PPE) Program was developed to raise awareness among college students about being well before, during, and beyond pregnancy. The overarching goals of the PPE program are to reach college-aged populations with targeted messages stressing the importance of preconception health and health care, train college students, particularly minority students as peer educators, and provide them with the tools necessary to educate other students of reproductive age (15-44) on their respective campus about the importance of receiving preventive care, education, and counseling before deciding to create a baby. While the program initially was going strong at the University of Delaware, there are some changes in leadership that are making its sustainability a little rocky. Over the next year, plans include providing technical assistance and support to the University of Delaware to ensure sustainability and engaging Delaware State University as a partner to establish a new PPE chapter. DPH and the Division of Medicaid and Medical Assistance (DMMA) under the auspices of the DHMIC have begun having conversations with community stakeholders (including birthing hospitals) about the support doulas can provide to women prenatally, during labor and delivery and postpartum and what would be needed to move towards credentialing and Medicaid reimbursement. The DHMIC established a Doula Adhoc Committee, which is led by DHMIC member and legislator, Representative Mimi Minor Brown, to continue to address doula policy and reimbursement opportunities. While many of the services provided by doulas are nonmedical, there is evidence of the benefits of doulas to address health disparities and improve maternal and infant outcomes. There are barriers to designing a reimbursement structure and process for seeking Medicaid reimbursement. Some of these barriers include establishing minimum requirements for certification & training, reasonable reimbursement rates for both Doulas and Medicaid, and billing coverage if doulas enroll as independent providers. Also, because many doulas see themselves as rooted in their communities and not necessarily the formal healthcare system, there is currently no single national doula network or credentialing association and we do not know how many doulas there are in the state/people interested in offering doula services. There are two organizations now, including Black Mothers in Power (serving Wilmington) and Parent Information Center (serving Sussex), who have received a DPH/DHMIC Healthy Women Healthy Babies mini grant to work on a small scale pilot to develop a network of doulas, provide training and increase capacity in the state, which will be monitored closely for lessons learned.

Healthy Women Healthy Babies (HWB) program 2.0, rolled out operations based on the new vision and framework focused on performance-based outcomes. DPH contracts with seven health providers to deliver the HWB services at 20 locations across the state. The Healthy Women Healthy Babies program provides preconception, nutrition, prenatal and psychosocial care for women at the highest risk of poor birth outcomes. DPH worked tirelessly in collaboration with the DHMIC and several MCH partners to review a recent release of a comprehensive evaluation of the program and specific birth outcomes to help inform plans for improving program quality (2011-2015). Overall, results for the program were more mixed - not as clear as the results were for African American participants, making the case that it was time to revisit the program model to further enhance outcomes.

The HWBs 2.0 program uses an outcomes-orientation and learning collaborative approach throughout the contracting process and ongoing service delivery relationship. By focusing on outcomes, the program takes an equity-driven approach that deepens funder-provider-participant mutual accountability in designing and delivering services focused on reaching a core set and minimum of 6 benchmark indicators (i.e. screening for pregnancy intention; increase women who have a well woman visit; screen for substance misuse; increase the proportion of

HWHB participants that abstain from tobacco use; depression screening and referral; social determinants of health screening, etc.).

Data collection and analysis is central to this new HWHBS 2.0 model as well as continuous quality improvement (CQI) for ongoing learning and improvement. This means that tracking, assessing, and improving outcomes for the HWHB program require a deliberate CQI plan and effort by providers which emphasizes quality improvement. Another important component to the program, providers are required to coordinate and collaborate with a Community Health Worker (CHW), Health Ambassador, Lay Health Advisor (LHA), or Promotora, defined as an individual who is indigenous to his or her community and consents to be a link between community members and the service delivery system, to further enhance outcomes for women and babies. Resources supporting community health workers are limited, and to demonstrate the value added, Delaware DPH invested in a small Community Health Worker pilot this year focused on engaging women of reproductive age and connecting women to the Healthy Women Healthy Babies providers and other community services and supports in high risk areas in the City of Wilmington. This year, we are exploring additional funding streams to support expansion into high risk zones in Kent/Sussex Counties.

There is strong evidence that home visiting supports good maternal and women's health outcomes. Since 2010, Delaware has competitively applied for and has been awarded the Maternal Infant Early Childhood Home Visiting Grant (MIECHV) funding through the Affordable Care Act. Funding is used to support evidence-based home visiting programs through increased enrollment and retention of families served in high risk communities. Delaware grant funds are also used to sustain and build upon the existing home visiting continuum within Delaware, which includes three programs including Healthy Families America (known programmatically as Smart Start) Nurse Family Partnership, and Parents as Teachers. This year, additional funding (approximately \$345K) was awarded through the American Rescue Plan to support MIECHV. We will be working with our current MIECHV training and TA vendor to provide related trainings on emergency preparedness and response planning for families as well as any other topics identified by LIAs related to the pandemic. For example, conducting virtual home visits, conducting intimate partner violence and depression screenings virtually. We will also work with our health ambassadors to provide an emergency preparedness workshop for families.

The Child Death Review Commission formed a small home visiting workgroup in 2019 which continues to meet including the Delaware Division of Medicaid and Medical Assistance (DMMA) to explore Medicaid reimbursement for evidence-based home visiting programs. While we have learned that there are a variety of approaches and mechanisms for reimbursement through Medicaid, movement on solidifying reimbursement for home visiting services is finally getting some traction. DMMA has secured TA support from Mercer to work with DPH to explore financing models.

In Delaware, there are two different Health Ambassador programs, each striving to make a difference in the lives of Delaware's women and their families and 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, promotors 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. Health Ambassadors have been critically vital during this unprecedented year, to keeping families engaged in home visiting during the COVID-19 crisis. The promotors were able to perform contactless drop-off to home visiting

families when local stores ran out of essential items such as food, diapers, and wipes. In addition, health ambassador programs quickly transitioned to "Virtual" chat-n-chews and baby showers to create a safe space for women in the community to share their concerns around pregnancy.

School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public school setting, and also contribute to better outcomes related to NPM 1 Well Woman Care. There is a growing interest for expansion to elementary, middle and additional high schools. School Based Health Centers are going through a paradigm shift, and there is a lot of stakeholder interest and commitment to understand national and in state innovations in practices and policies, and explore options moving forward to enhance SBHCs in Delaware within the local healthcare, education, and community landscape. Delaware currently defines SBHCs as health centers, located in or near a school, which use a holistic approach to address a broad range of health and health-related needs of students. Services may also include preventative care, behavioral healthcare, sexual and reproductive healthcare, nutritional health services, screenings and referrals, health promotion and education, and supportive services. SBHCs are operated by multi-disciplinary health professionals, which includes a nurse practitioner overseen by a primary care physician, licensed behavioral health provider, licensed nutritionist, and/or dental hygienist. SBHCs are separate from, but interact with, other school health professionals, including school nurses and school psychologists and counselors. SBHCs also operate alongside and interact with outside health care professionals and systems.

The Delaware Division of Public Health (DPH), in collaboration with several key stakeholders, just completed a year long process to create a Delaware School-Based Health Center (SBHC) Strategic Plan. The planning helped DE develop a model for expansion of SBHCs that is both financially sustainable and anchored in best practices. The goal is to ensure that SBHCs are responsive to the individual needs of Delaware's children - who, for a variety of reasons, may not otherwise have access to the health care system for critical health and wellness services. The final plan was released in June 2021 and is available for viewing at DEThrives.com/sbhc.

For the past 30 years, Delaware School Based Health Centers, located in 32 public high schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to support women's overall physical and mental health. Eventually, these young women and men will be our health consumers, so it is essential to support health and wellness during this critical period and coming of age. SBHCs provide at-risk assessment, diagnosis and treatment of minor illness/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). Over the last couple of years, school district school boards voted and approved to add Nexplanon as a birth control method and offered at the school-based health center sites and as of this writing total 14 sites). This is a major accomplishment being that each school district's elected school board members vote on and approve what services can be offered at each SBHC site. Offering the most effective birth control methods as an option, gives more young women informed choices so that they can decide when/if to get pregnant and ultimately reduce unplanned pregnancies.

Unplanned pregnancies are expensive and cost women, families, government, and society. Extensive data show that unplanned pregnancies have been linked to increased health problems in women and their infants, lower educational attainment, higher poverty rates, and increased health care and societal costs. And, unplanned pregnancies significantly increase Medicaid expenses. By reducing unintended pregnancy, we can reduce costs for pregnancy related services,

particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.

Launched in 2016, Delaware Contraception Access Now (DE CAN) (www.upstream.org/delawarecan/) improves access for all women to the full range of contraceptive methods, including the most effective, IUDs and implants. By implementing Upstream USA's whole healthcare practice transformation approach, DE CAN created a long-term system change for contraceptive access across Delaware. It includes three critical components to help break down barriers for all women accessing contraceptive care. First, it enables health centers to make reproductive care a routine part of primary care by implementing a Pregnancy Intention Screening Question (PISQ) – a variation of the question, "do you want to become pregnant in the next year?" – at every healthcare appointment. Second, if they do not want to become pregnant, DE CAN trains health centers to counsel patients on the full range of contraceptives available to them. DE CAN enables health centers to be able to provide patients with their choice of contraception at that visit – the same day – by training administrative staff on business processes such as billing, coding and stocking devices. Third, DE CAN created consumer demand for contraception by developing consumer-marketing campaigns to educate women about their options for care.

Delaware CAN includes health centers that serve nearly 80% of women of reproductive age in the state. Nearly 2,000 women in Delaware have taken advantage of the "All Methods Free" program during the intensive intervention. Upstream hosted 130 trainings, trained nearly 3000 clinicians and staff from 41 partners representing 185 sites across DE. A key component of the model is quality improvement and implementation coaching that follows each training. During the quality improvement phase of the initiative, Upstream and health centers work together to remove barriers, implement patient centered contraceptive counseling, integrate pregnancy intention screening into the EHR and set up data collection to assess impact. The 41 partners serve nearly 125,000 women of Delaware's approximately 190,000 women of reproductive age. The Division of Public Health's team, along with Upstream, USA worked closely with Medicaid and several MCH stakeholders to ensure that there are no policy barriers to all women getting same-day access to all methods of birth control, at low or no cost. The Delaware Division of Medicaid and Medical Assistance (DMMA) revised its reimbursement policy for hospitals providing labor and delivery services, so that they can offer their patients placement of IUDs and implants immediately post-delivery if patients request them. This change in policy promotes optimal birth spacing and increases access to this birth control method.

DPH has successfully integrated the nationally recognized Delaware Contraceptive Access Now (DECAN) initiative into the Family Planning Program, which sits in the Family Health Systems Section in DPH, where Title V MCH also resides organizationally. Since FY20, the program receives a consistent state GF investment in the amount of \$1.5M and furthers the DPH's priority to sustain providing low cost access of all methods of birth control, including the most effective LARCS to low income women across the state. This initiative continues to improve public health by empowering women to become pregnant only if and when they want to by training staff on best practices in patient-centered care and shared decision-making, that will increases their knowledge of all contraceptive methods including mechanism of action, efficacy, risks, side effects and benefits.

The Division of Public Health's team, is working with five of the six Delaware birthing hospitals to ensure that all patients can receive the contraceptive method of their choice immediately after giving birth, including immediate post-partum LARCS. This change in policy will promote healthy birth spacing and give women more access to all methods of birth control. Currently the largest hospital system in the state, Christiana Health Systems offers these services, as well as Nanticoke Health Systems and Bayhealth Medical Centers. Beebe Medical Center has trained their providers and have implemented this service in the past year. The Division of Public Health continues to work with all hospitals statewide on training and technical assistance with these new processes and procedures.

Furthermore, Delaware's Division of Medicaid and Medical Assistance also implemented a reimbursement policy

change approved by the Centers for Medicare and Medicaid Services (CMS) allowing the cost of long acting reversible contraception (LARC) to be carved out of the federally qualified health center (FQHC) prospective payment system (PPS) rate.

The Pregnancy Intention Screening Questions (PISQ) is an important door opener to discuss preconception health with a woman's health provider and 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, which will continue to be a source of data to monitor. 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. DPH requires that all Healthy Women Healthy Babies providers also include a PISQ benchmark measure for consistency and alignment with the DE CAN program.

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

The Delaware Family Planning program completed two full in-person training sessions on September 18, 2019 and January 22, 2020. These trainings included interactive conversations and games that cover topics such as the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling, and hands-on clinical Nexplanon and IUD training for clinicians. The April 29, 2020, July 22, 2020, October 21, 2020 and January 13, 2021 trainings were cancelled due to COVID-19 pandemic. Due to the Covid-19 restrictions the DECAN program was switched to a virtual training platform where 28 people have been trained virtually. The clinical training portion was temporarily put on hold but was resumed on March 30, 2021. In order to make up for the in-person clinical trainings the DECAN program has secured and scheduled trainings for the following dates: June 30, 2021, August 25, 2021, September 22, 2021, October 20, 2021 and November 17, 2021.

The DPH Family Planning team has been working with the Department of Corrections (DOC) since the beginning of the initiative to be able to provide access to all methods of birth control to incarcerated women that are transitioning back into the general population and are seeking such methods. Starting November 1, 2020, a policy and procedure was finally approved and these services are available to all incarcerated women in Delaware. All birth control methods provided through this formal relationship with DOC are provided by DE CAN state funds and are managed through the State Pharmacy. The Family Planning Trainer Educator provides training to all women's corrections staff on all methods of contraception, techniques for patient-centered /shared decision making along with training on bias and coercion. This is to ensure that services are offered in a voluntary manner.

Since the DPH Family Planning team took on the responsibility of DECAN training in the Fall of 2019, 59 staff members have been trained on the DECAN initiative, all methods of contraception, bias and coercion, patient-centered/shared decision making, patient centered contraceptive counseling. There have been 22 clinicians trained in Nexplanon insertions/removals and 12 clinicians trained on IUD insertion/removals. A total of 9 provider sites have taken part in the DECAN trainings including staff and providers from Westside Family Healthcare, Connections, Department of Corrections, LaRed Health Center, Sussex Central High School, Indian River High School, Sussex

Tech High School, Rosa Health Center, and Nemours.

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. Child Trends issued a report using available contraceptive data from 2014 to 2017 in Delaware among Delaware Title X family planning clients ages 20–39. The observed movement from moderately effective contraception to highly effective Long Acting Reversible Contraception (LARCs), paired with a small decrease in no method, was linked to a substantial simulated decrease (24.2 percent) in the unintended pregnancy rate among this population. The complete report, including methodology and limitations, was commissioned by Upstream and can be found at ChildTrends.org.

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

- We find increases in LARC use for Title X adult patients
- We find increases in postpartum LARC use for Medicaid and non-Medicaid women
- We find increases in LARC insertion for teens enrolled in Medicaid, age 15-18. We do not find statistically significant results for LARC insertion for adult non-postpartum women in Medicaid, age 19-44.

Oral Health for Pregnant Mothers

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.

According to findings from our 2020 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 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 domains. However, during the Needs Assessment process oral health in the Women/Maternal Health Domain did not rank in the top 10 overall.

So, although not selected as a priority, we will continue to work with the Bureau of Oral Health and Dental services on ensuring our partners serving women have resources to educate women on the importance oral health and making referrals to dental services when needed. 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. 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.

[1] <https://www.delawareonline.com/story/opinion/2021/05/28/well-woman-care-why-your-yearly-visit-important/7457494002/>

Women/Maternal Health - Application Year

In May 2005, the Infant Mortality Task Force at the time issued a report that included 20 recommendations to reduce the number of Delaware babies who die before their first birthday (rate of infant mortality) and to eliminate the racial disparity in the rate at which these babies die. The infant mortality rate is generally regarded as proxy for the overall health of a community. The infant mortality rate (IMR) for black babies is 2.7 times that of white babies in Delaware. Maternal age, chronic illness (asthma, hypertension, diabetes), nutrition, infection (STI, HIV), stress, unwanted pregnancy, smoking, and other drug use and lack of prenatal care are all factors that increase the risk of adverse pregnancy outcomes and maternal complications. 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 (DHMIC), 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 as well as improved health outcomes for women and babies. The primary focus of the IMTF/HWMB funding has been to reduce the number of Delaware babies who die before their first birthday. The strategy has been to identify women at the highest risk of poor birth outcomes and to address any underlying medical conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk. The success of this effort lies in the fact that since its inception, our infant mortality rate had dropped by 25% over the last decade of intense efforts and evidence-based program interventions. Even so, the current infant mortality rate of 7.3 deaths per 1000 live births, which is driven almost entirely by the racial disparity in infant death rates, is still significantly higher than the national average of 5.9. In the past few years, substantial funding has been directed at addressing the social determinants of health which are the major drivers behind the racial disparity. In FY 21, \$1.5 million has been budgeted to this SDOH effort and will remain a priority.

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

The HWB program is housed under the Division of Public Health in the Family Health Systems Section and has completed the first year of the new refreshed model to improve preconception, prenatal, and birth outcomes of Delaware women, particularly those at increased risk. The new model is a value/performance-based approach focused on meeting or exceeding 6 benchmark indicators, with an emphasis on addressing the social determinants of health and incorporates the role of community health workers to further support outcomes. The Division of Medicaid and Medical Assistance (DMMA) was an essential partner in the transformation of the HWHBs 2.0 model and continues to play a role in the program's enhanced model and performance-based redesign. In the next year, we plan to review benchmark data indicators as well as explore data linkages of HWHBs 2.0 patient data with Medicaid claims data to monitor benchmarks and outcomes. Last year, Medicaid hired a MCH Quality Assurance Administrator, and DPH convenes reoccurring monthly meetings with this individual along with the DMMA Medical Director to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women and babies.

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

Over the next year, DPH in collaboration with DHMIC partners plan to further track and analyze benchmark data and the performance based approach to the to the Healthy Women Healthy Babies program, a medical intervention, by simultaneously supporting the 8 community based interventions in high risk zones implemented across the state that address some of the underlying environmental, economic and social structures that impact resources needed for health, such as poverty, lack of stable housing, access to healthy foods, access to early childhood education, medical legal partnership, financial literacy, etc. The plan for the coming year, is to discuss the findings from the Housing Pilot Feasibility Analysis and prepare recommendations that take into account the ROI, costs and sustainability, and explore alternative evidence based models, such as universal base income models (i.e. Abundance birth project in San Francisco, CA). In the coming year, Health Management Associates (HMA) will continue working closely with DPH and DHMIC to serve as a backbone agency as part of the maternal and infant mortality reduction work to build state and local capacity, and test the 8 small scale innovative strategies to shift the impact of social determinants of health tied to root causes related to infant mortality. The primary focus is innovation and to spread evidence-based programs and place-based strategies to improve the social determinants of health and equity in maternal and infant health outcomes. HMA will work with DPH and DHMIC to staff and facilitate the SDOH Workgroup, staff and facilitate a Doula Adhoc Committee, provide coaching and technical assistance to the 8 local community based interventions, schedule quarterly learning collaboratives for partners, provide extensive coaching and technical assistance to existing and new mini-grant awardees, and create shared metrics and tools for quality improvement and overall evaluation.

The Delaware Perinatal Quality Collaborative (DPQC) was established in February 2011 as an action arm of the DHMIC. DPH federally funds a Perinatal Project Nurse Coordinator, which is dedicated to promoting the success of the Cooperative. In response to the opioid epidemic, a large part of the last few 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 criterion. In addition, Dr. Khaleel S. Hussaini, Delaware's CDC MCH 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. In September of 2017, Delaware successfully leveraged a CDC Perinatal Cooperative 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 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. A full-time master's Prepared Nurse position will continue to support the program by going 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.

This year, the DPQC was formally established in Delaware Code and signed by the Governor during a virtual press conference in July 2020. Data collection and analysis is crucial to the DPQC's efforts to improve the care and outcomes of DE's women and their babies. The foundation of the collaborative is to share current data to use for benchmarking and QA/QI, identify best standards of care/protocols, realignment of service providers and service systems, continuing education of professionals and increasing public awareness of the importance of perinatal care. Establishing the Collaborative in Code will allow them the ability to:

1. Enter binding memoranda of understanding among member institutions to hold each other accountable for sharing quality improvement data and for following the protocols for securely handling the shared data.
2. Enter into agreements with data storage and or transmission companies to provide their services to the Collaborative to enable it to do its work.
3. Apply for funding to support the work of the quality collaborative.
4. The confidence that the quality improvement data that members share will not be released to the public. The quality improvement focus of the Collaborative requires that member-birthing institutions be able to share their quality data freely without concern that unauthorized persons may have access to information. The legislation would enable the collaborative to close some of its meetings to the public. Placing the DPQC in statute will allow for sharing of more confidential data and cases that could potentially be a violation of state data laws but are important for continuous quality improvement and learning among providers/ birthing institutions. (i.e. patient data protection including HIPPA). For example, even a medical chart review of 10 patients should not be shared publicly, but this is how the birthing hospitals/institutions learn from each other. The same applies to case reviews.
5. Continue to function in cooperation with the DHMIC.

Preconception peer educators (PPE) 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. PPE is a state-wide initiative originally created by the Office of Minority Health but brought to fruition in Delaware by the DHMIC. PPE consists of college students becoming trained peer educators via statewide training. Once trained, these students are expected to raise awareness and educate their campus and community about Delaware's problematic infant mortality rate and its effect on families in the area. This involves discussing issues with young women and men to ultimately understand that their personal decisions have a major effect on their future family. The main messages that PPE aims to present are:

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

Currently, the PPE's most prominent chapter exists at the University of Delaware. PPE at the U of D's educational outreach has included presentations in high school classrooms, informative kiosks on campus, educational presentations to Greek life organizations, and even occasional abroad experiences in Jamaican villages. Over the years, this chapter has evolved in many ways, but currently its students as well as the DHMIC are less focused on community and abroad outreach and more focused on the internal organization of each chapter as well as their presence on campus. There is a current need over the next year to create standardized operations and procedures within this chapter to keep the organization afloat when faced with turnover of leadership and participants. PPE at the U of D plans to operationalize each of their on-campus outreach initiatives to measure its effectiveness in educating the community. The plan is to quantify the direct impact that the education and awareness will have on the community by adapting data-recording methods that have been successful in similar outreach organizations such as

Planned Parenthood of Newark Delaware and Healthy Hens at the U of D. Simultaneously, PPE at the U of D will establish a “blueprint” of their developed procedures for those who may be interested in instituting a chapter of PPE at other Delaware universities and colleges (i.e. Wesley College, Delaware State University, etc.). This “blueprint” will include descriptive information regarding PPE at U of D’s typical events hosted on campus, the roles and duties of each executive board member, and the methods used to train effective PPEs. In the coming year, efforts will focus on sustaining the UD PPE Chapter, as they identify a new faculty advisor as well as engaging in conversations with the Delaware State University to start a new chapter.

Overall, this current PPE initiative aims to expand preconception health messaging throughout the state to improve the health and well-being of Delaware men, women, and families. By intervening at the high school and college level, PPE brings the topic of family planning to the forefront; through peer-to-peer interactions, the target population of young adults can engage in legitimate and educational conversation about a subject matter that can initially feel intimidating. An annual training will be held in the 2021 for PPEs on several maternal and child health content-based workshops with a second training focused on core competencies and skills training for new recruits based on the peer educator curriculum from NASPA.org.

Preconception CollIN. DE was selected as a state CollIN team for the National Preconception Health and Health Care Initiative’s application for the Collaborative Improvement and Innovation Network on Infant Mortality (IM CollIN) 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. The University of North Carolina requested a no cost extension for an additional year. One of our main initiatives for the upcoming year is the development of patient education materials that incorporate what we have learned as a CollIN over the past couple of years. Delaware will help identify clinicians, largely representing our Healthy Women Healthy Babies program providers and other interested MCH partners to help create some initial materials this fall, as well as those who are willing to review materials and test them with patients. National technical assistance webinars and newsletters on several preconception topics are also available to our state team partners.

Over the next year, we will continue incorporating preconception health education into the clinic-based setting, mainly through our family planning sites as well as our Healthy Women Healthy Babies provider sites. This is an excellent opportunity that will align and enhance Delaware’s efforts to transform the HWHBs 2.0 program. Delaware will sustain the Preconception CollIN work through HWHBS 2.0, and bring lessons learned to scale working with 7 health care providers in Delaware. Milestones include working with providers on implementing small tests of change in asking the Pregnancy Intention Screening Question at the practice site level and gathering data to report on this benchmark indicator, implementing preconception health education in practice based setting, development of education materials and social marketing messaging via DEThrives Facebook, Twitter, and blogs for patients, practice workflow, and prioritizing preconception screening of patients.

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

DPH is very pleased to share that the FY21 State General Funds in the amount of \$1.5M were approved to support the sustainability and ongoing programmatic costs of Delaware Contraceptive Access Now (DE CAN). DPH in-kind support will continue through DPH and DMMA, a contractual MCH Epidemiologist (.15 FTE) as well as the State Pharmacy as a mechanism to track, store and distribute LARC devices to participating Title X network providers to support the ongoing sustainability, infrastructure and ongoing operational costs. In addition, DPH gained two (2) new state funded full-time FTEs to sustain limited program operations. At a minimum, the next phase of DE CAN ensures that health care providers (through the Title X network) who serve low-income uninsured women, are equipped to provide the most effective long acting reversible contraceptive methods. Furthermore, DPH plans to sustain limited training and technical assistance as designed by Upstream, in consultation with the Delaware DPH, to support the 39 community health centers^[1] through attrition and staff turnover who serve the majority of low-income women. The training plan for the upcoming year includes monthly WebEx hosted Contraceptive Counseling training sessions starting on September 23, 2020, offering a morning and afternoon session for staff convenience. In-person clinical insertion and removal training will be offered on a quarterly basis, starting on October 21, 2020 and will also host a morning and afternoon session for providers. The Family Planning team is offering tailored trainings based on specific provider's needs, making sure that training and technical assistance is seamlessly integrated into their organizational processes and culture.

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

^[1] In CY2018, Title X had a total number of 39 provider sites, including SBHCs that provide reproductive health services.

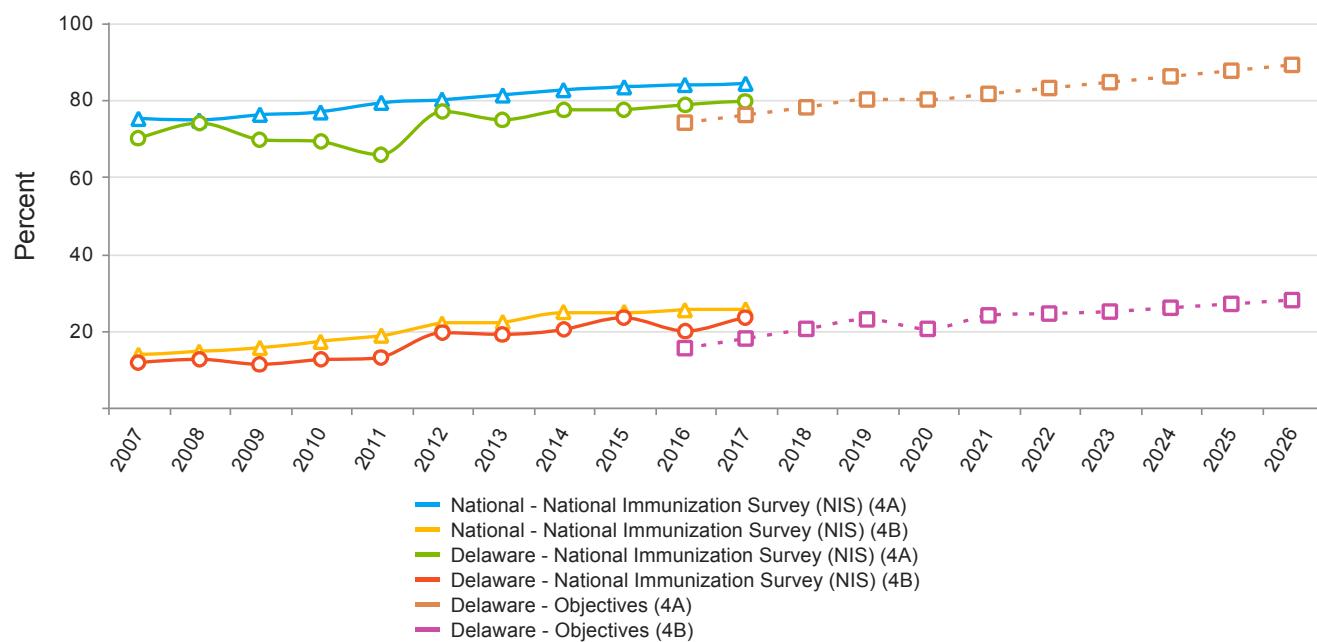
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	113.0	NPM 4

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data						
Data Source: National Immunization Survey (NIS)						
	2016	2017	2018	2019	2020	
Annual Objective	74	76	78	80	80	
Annual Indicator	74.6	77.2	77.4	78.5	79.7	
Numerator	7,709	7,684	7,840	8,010	8,564	
Denominator	10,340	9,953	10,127	10,209	10,741	
Data Source	NIS	NIS	NIS	NIS	NIS	
Data Source Year	2013	2014	2015	2016	2017	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.5	83.0	84.5	86.0	87.5	89.0

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

Federally Available Data						
Data Source: National Immunization Survey (NIS)						
	2016	2017	2018	2019	2020	
Annual Objective	15.5	18	20.5	23	20.5	
Annual Indicator	18.9	20.5	23.6	19.8	23.6	
Numerator	1,847	1,966	2,319	2,019	2,478	
Denominator	9,794	9,570	9,811	10,187	10,493	
Data Source	NIS	NIS	NIS	NIS	NIS	
Data Source Year	2013	2014	2015	2016	2017	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.5	25.0	26.0	27.0	28.0

Evidence-Based or –Informed Strategy Measures**ESM 4.1 - Increase the number of birthing facilities that receive baby friendly designation**

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		4	5	5	4
Annual Indicator	4	4	4	4	4
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	6.0	6.0	6.0	6.0

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

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15	61	65	58
Annual Indicator	17.2	60.3	54.2	54.9	47.9
Numerator					
Denominator					
Data Source	MIECHV program data				
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	62.0	64.0	66.0	68.0	68.0

State Performance Measures**SPM 2 - Reduce the disparity in infant mortality rates**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		4.6
Numerator		
Denominator		
Data Source		HWHB Program Data and Vital Statistics Data
Data Source Year		2019
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Delaware) - Perinatal/Infant Health - Entry 1	
Priority Need	Improve breastfeeding rates.
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By July 2025, increase breastfeeding initiation rates in Delaware from 77% to 84%.	
Strategies	
Continue to strengthen hospital efforts in supporting mothers/babies through comprehensive breastfeeding policies.	
Partner with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to ensure that home visitors have the expertise and supplies to support breastfeeding among their clients.	
Coordinate and standardize breastfeeding messages for all DE DPH programs that work with prenatal and postpartum women.	
Support efforts to increase the number of racial and ethnic minority IBCLCs.	
Provide training and coaching to MIECHV home visiting staff to promote breastfeeding best practices.	
Support hospitals to maintain or receive baby friendly designation.	
ESMs	
ESM 4.1 - Increase the number of birthing facilities that receive baby friendly designation	
ESM 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting	
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Perinatal/Infant Health - Annual Report

According to the 2018 Breastfeeding Report Card, 77.4 % of babies born in Delaware were “ever breastfed or fed breast milk”; lower than the national estimate of 83.2%. Within this measure, there are disparities by both race/ethnicity and household income level. As is the case nationally, rates of breastfeeding 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%.

As per the PRAMS 2019 data the percent overall prevalence of ever breastfed among those who delivered was 87.3% and currently breastfeeding/at the time of survey was 59.0%. As per the PRAMS data, the 2019 prevalence of ever breastfed among non-Hispanic black was 80.5% as compared to 84.0% among non-Hispanic white, and 89.8% among Hispanics. Similarly, the 2019 prevalence of currently breastfeeding (or at the time of survey) among non-Hispanic blacks was 41.4% as compared with 59.9% among non-Hispanic whites, and 57.0% among Hispanics.

The percentage of women who ever breastfed increased by eight-percentage points from 79.2% (95%CI: 76.4-81.9) in 2012 to 87.3% (95%CI: 84.9-89.7) in 2019. Similarly, the percentage of women who indicated currently breastfeeding increased by 11 percentage points from 48.8% (95%CI: 45.2-52.5) in 2012 to 59.0% (95%CI: 55.3-62.8).

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

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

According to the Ripples Group findings in the Final Quarter Report of 2020, WIC WOW Data System:

- Breastfeeding Initiation rates in the WIC population increased to 57% versus 53% in 2019
- Duration at 3 months increased in all clinics, with an average of 42% versus 33% in 2019
- Duration at 6 months averaged 32% in all counties versus 25% in 2019
- Exclusivity rates decreased to an average rate of 23.5% versus 28% in 2019

The Delaware WIC Program continues to partner with Christiana Health Care Systems, The Latin American Community Center, Nemours Pediatrics, Westside Family Health, The Breastfeeding Coalition of Delaware, The Perdue Chicken Plants of Milford and Georgetown and The Delaware Healthy Mother and Infant Consortium to strengthen our breastfeeding services in the heart of the community.

According to Ripples findings in the final quarter report of October 2020 a participant contacted by a peer counselor is 81% more likely to be breastfeeding at 3 months and 88% more likely to be breastfeeding at 6 months. Exclusivity rates among WIC mothers remains 5% higher when mothers are contacted by a peer counselor.

WIC offices closed March 2020 and remain closed to date due to Covid-19 precautions. Participants are contacted by phone for scheduling appointments certifications and recertifications. WIC benefits are loaded remotely and the WIC no show rate as a result of the WIC waiver for Physical Presence remains at an all-time low of 11%.

The virtual breastfeeding classes remain successful. The classes are offered the first and third Wednesday of each month at 11am and 5pm.

One clear need in our state is to enhance the supports that are available to women in the early days and months after birth, when breastfeeding is being initiated and becoming a routine. Over the past several years DPH has worked on expanding state breastfeeding capacity - promoting the transformation of Delaware hospitals into Baby Friendly hospitals and improving access to professional and peer support for breastfeeding in the community. Four out the six birth facilities in the state have received baby friendly designation including our largest birthing hospital. The other two birthing facilities are interested, with one of them starting the process this past year. In the most recent CDC Maternity Practices in Infant Nutrition & Care, Delaware scored an 83 which slighting higher than the national average of 79. The BCD will continue to provide support to birthing facilities to maintain certification or as they work to achieve the certification.

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. The BCD created scholarships to a more racially and ethnically diverse candidate pool to help us broaden our reach within peer and professional support. Scholarships were awarded to two individuals of color in 2020 to attend coursework towards becoming an Internationally Board-Certified Lactation Consultant.

DPH, the BCD, and the DHMIC formed a breastfeeding work group 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 have been added to the website to drive web traffic to the resources.

The ninth annual Black Breastfeeding Week will take place Wednesday, August 25 through Tuesday, August 31. This year's theme is, "The Big Pause: Collective Rest for Collective Power." which focuses on helping Black women give their minds and body the rest they need after 16 months of a pandemic, and to use the "pause" to reenergize, reprioritize, and regain the control and power they must promote healthier lives for their children — starting with breastfeeding.

Statewide virtual events are planned for Black Breastfeeding Week on behalf of DHMIC with partners from WIC and the Breastfeeding Coalition. Virtual events include the following four events:

- Wednesday, August 25 at 6:00 p.m. **The Connect: Black Maternal Health Virtual Pop-Up**
Wednesday, August 25, 6 to 8 p.m.
Join us for featured guests, virtual happy hours and workshops dealing with topics like advocating as a Black man, Breastfeeding programs as safe havens and successful legislative initiatives.
- Friday, August 27 at 6:00 p.m. Chocolate Milk: The Big Latch for Black Families - Black Mothers in Power hosts a movie showing of "Chocolate Milk: The Big Latch for Black Families" at Penn Cinema Riverfront 14 + IMAX in Wilmington, Delaware. Following the movie, a panel of lactation specialists and doulas will provide education and information to all registrants.
- Sunday, August 29 at 11:30 a.m. Nemours Cares Community Baby Shower - Nemours Cares Community Baby Shower will be providing expectant mothers the opportunity to receive education and support on August 29. These expectant mothers are provided resources from multiple community experts as well as essential items to assist with becoming a new mom. To continue support beyond the baby shower, some mothers will also be provided a postpartum doula for additional support with topics such as breastfeeding, postpartum depression, etc. Please RSVP by August 18 to 302-218-8941.

- Monday, August 30 at 6:30 p.m. Lift Every Voice - A listening session, Revive. Restore. Reclaim! where participants will be able to share their experiences, thoughts, and ideas.
- Tuesday, August 31 at XX p.m. It Takes a Village Part II - Learn from state leaders how you can help support breastfeeding, why black breastfeeding week is important, and how breastfeeding relates to black maternal health.

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 in the past. However, DPH has decided to no longer offer evidence-based home visiting internally and all home visiting have been contracted out. We continue to offer this opportunity to nurse home visitors in our MIECHV program as well as nurse home visitors funded by sources such as state general funds. Home visitors were also provided with supplies to support their breastfeeding clients, such as nipple shields and this will support will continue.

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

Perinatal/Infant Health - Application Year

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

The BCD developed and finalized their Strategic Plan in 2019 and includes several goals under the specific domains below that they continue to implement.

Breastfeeding Friendly Environments:

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

Education:

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

Policy and Advocacy:

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

Internal Organization:

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

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

- Create a more diverse board for 2021-2022. Ensure membership is not just diverse but that there are opportunities to contribute and take leadership.
- Zero tolerance for racism for members and those who attend coalition events.
- Create learning opportunities on subjects such as implicit bias, equity and inclusion for the community. These will be taught by black women who live and work in our communities.

An IBCLC from Nemours, a member of the BCD is hosting “Trauma Behind the Milk” webinar in September 2020. She will be presenting on historical and present impacts on trauma in the health care among black families and how it affects breastfeeding disparities today. This is a free webinar and is open to anyone.

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. The following materials have been developed:

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

Members of the BCD have been meeting with one large employer in Delaware to assist them in creating a workplace support program. The partnered with the site to create gift bags to advertise the health center to pregnant moms and families that includes resources for pregnancy and lactation. This employer now has lactation rooms stocked with pumps and supplies though a MOU with WIC. They are also offering breastfeeding friendly items in baskets to moms and dads who work there.

We will continue to utilize social marketing techniques to influence women's decisions around infant feeding. Promoting messages and materials through our DE Thrives website is one strategy. The Delaware Division of Public Health (DPH) and the Delaware Healthy Mother & Infant Consortium (DHMIC) are dedicated to awarding mini grants to support local organizations whose results-driven work strives to reduce infant and mother mortality as well as morbidity among minority populations in Delaware.

The Breastfeeding Coalition of Delaware was one of the awarded community-based organizations. Their goal is to improve breastfeeding rates for women of color to the HWHB high-risk zones of Wilmington, Claymont, and Seaford by providing access to community resources, education and peer support. The project, Delaware Breastfeeding Village is offering accessible support, engaging groups, text check-ins, access to variable levels of lactation support, and incentives for participation. In addition, the Breastfeeding Coalition of Delaware hired three diverse breastfeeding peer counselors (BPC) and one lactation consultant to provide breastfeeding support to women. WIC and Medicaid eligible mothers can participate in a 6-month program where they receive support from a breastfeeding peer counselor and a lactation consultant if needed. Mothers receive incentives to participate in groups and have monthly motivational text from peer counselors. Mothers who complete the program will be invited to a baby shower to celebrate completion. The goal is to decrease isolation among mothers, to increase breastfeeding duration and to decrease barriers to breastfeeding support.

Global Big Latch On events will be held in multiple virtual locations throughout the state of Delaware on August 6th. Locations included several of our birthing facilities as wells as the Breastfeeding Village.

After conducting our required MIECHV benchmark evaluation, we selected CQI projects. Our CQI work will be focused on our breastfeeding rates and safe sleep practices of our families. When developing our updated CQI plan for FY 20, we decided to add tobacco cessation referrals and success rates of families attempting to quit. Our FY 21 MIECHV CQI plan update was developed and approved. Our performance data collected indicated that reported breastfeeding initiation rates were low. The percentage of infants aged 6 to 12 months who were enrolled in home visiting for at least 6 months and were documented to be breastfed for any amount at 6 months of age was 47.9 percent.

Breastfeeding initiation has been an ongoing state priority for the DHMIC as well as for Title V so it makes sense for MIECHV to align with our priorities.

All MIECHV funded programs are aware that breastfeeding and safe sleep practices need to be improved upon and the current methods by which they are carrying out CQI (e.g., trainings, messaging) have assisted to an extent. We have and will continue to give considerable latitude to programs on how they plan to carry out CQI on these constructs and we will continue to provide TA as needed.

In 2018-2019, Delaware moved in a new direction with annual home visitor wrap-around training. The new training plan was organized around the home visitor competencies as described in the *National Family Support Competency Framework for Family Support Professionals*. One of the many competencies is "Child Health, Safety, and Nutrition and there are three training modules around breastfeeding included, 1. Breastfeeding 1: Helping Mothers Choose Breastfeeding, 2. Breastfeeding 2: Helping Mothers Initiate Breastfeeding and 3. Breastfeeding 3: Helping Mothers Continue Breastfeeding.

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

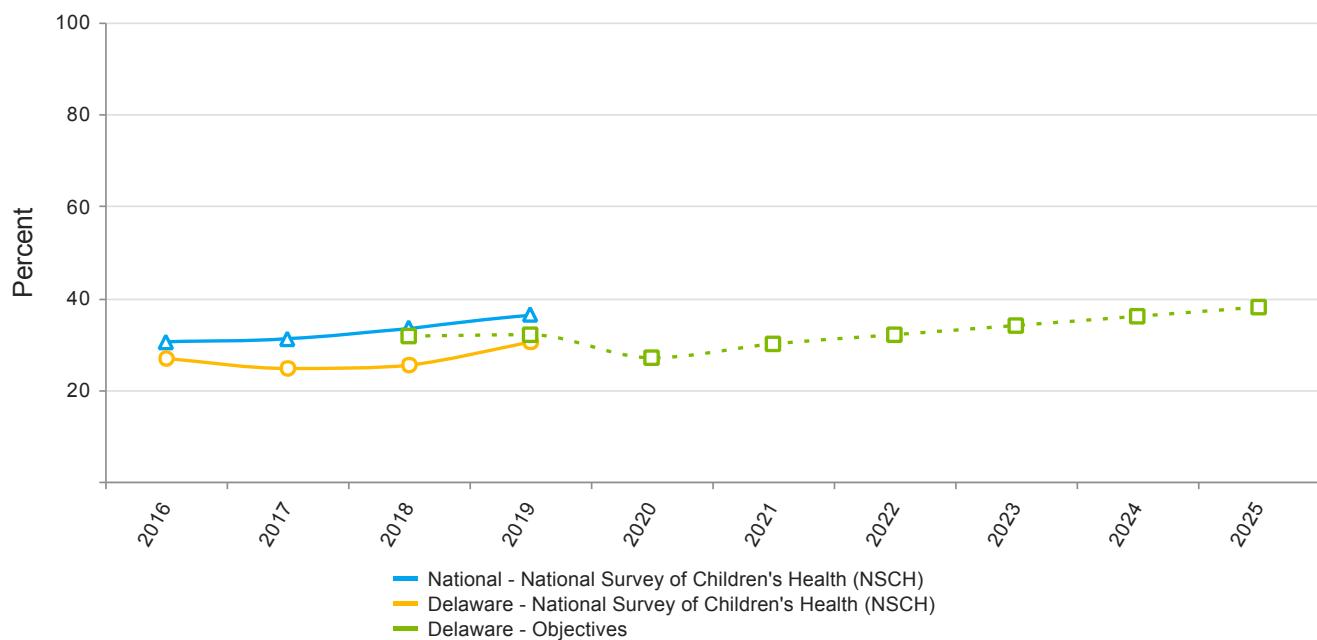
Child Health

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 or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	13.3 %	NPM 13.2
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-2018_2019	15.7 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.5 %	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-2018_2019	16.0 %	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-2018	16.3 %	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-2017	15.1 %	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 Indicators and Annual Objectives



Federally Available Data

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

	2016	2017	2018	2019	2020
Annual Objective				31.7	32
Annual Indicator			26.9	24.8	25.5
Numerator			5,997	5,633	5,939
Denominator			22,305	22,753	23,289
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

ⓘ 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

	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	91.4	83.3
Numerator	433	398
Denominator	474	478
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

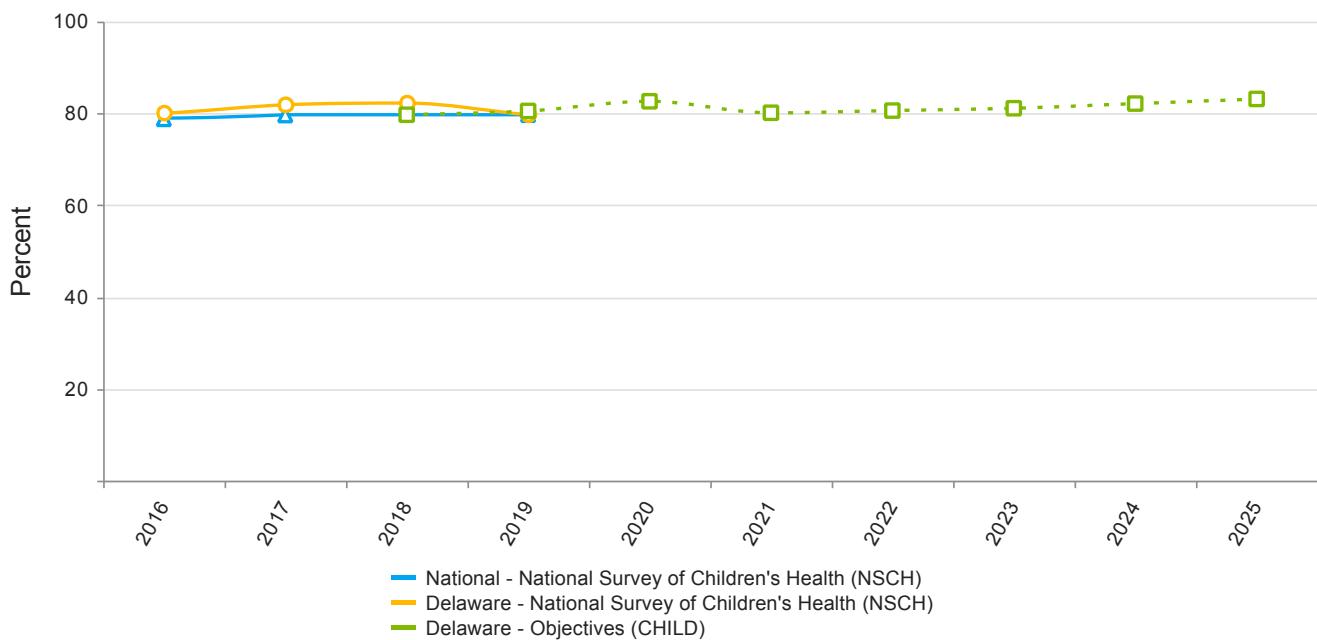
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	94.0	96.0	98.0	100.0	100.0

ESM 6.2 - # of new pediatric practices to adopt PEDs

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		36	39	42	45
Annual Indicator	34	37	40	43	43
Numerator					
Denominator					
Data Source	DE AAP	DE APP	DE APP	DE APP	DE APP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	47.0	49.0	50.0	50.0	50.0	50.0

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



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			79.6	80.4	82.5
Annual Indicator		79.9	81.6	82.0	79.7
Numerator		152,949	155,485	154,827	149,645
Denominator		191,522	190,614	188,877	187,697
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	

i 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	80.5	81.0	82.0	83.0	84.0

Evidence-Based or –Informed Strategy Measures**ESM 13.2.1 - Percent of children enrolled in Medicaid, ages 1 through 17, who had a preventive dental visit in the past year**

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	80.6	78.8
Numerator		
Denominator		
Data Source	NCHS	NCHS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.0	82.0	83.0	84.0	85.0	85.0

State Action Plan Table

State Action Plan Table (Delaware) - Child Health - Entry 1	
Priority Need	Children receive developmentally appropriate services in a well coordinated early childhood system.
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By July 2025, increase the percent of children, ages 9-71 months, receiving a developmental screening using a validated parent-completed screening tool.	
Strategies	
Train medical and childcare providers on developmental screening. Utilize Home Visiting/MIECHV programs to provide the Ages and Stages Developmental Screening tool to clients. Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention. Promote parent and caregiver awareness of developmental screening Recruit new pediatric practices to adopt PEDS Continue to host Books, Balls and Blocks events for families to educate families on developmental milestones, age appropriate activities and provide an opportunity for children to receive developmental screening.	
ESMs	Status
ESM 6.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.	Active
ESM 6.2 - # of new pediatric practices to adopt PEDs	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

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

Priority Need

Improve the rate of Oral Health preventive care in children.

NPM

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

Objectives

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

Strategies

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

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

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

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

ESMs

Status

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

NOMs

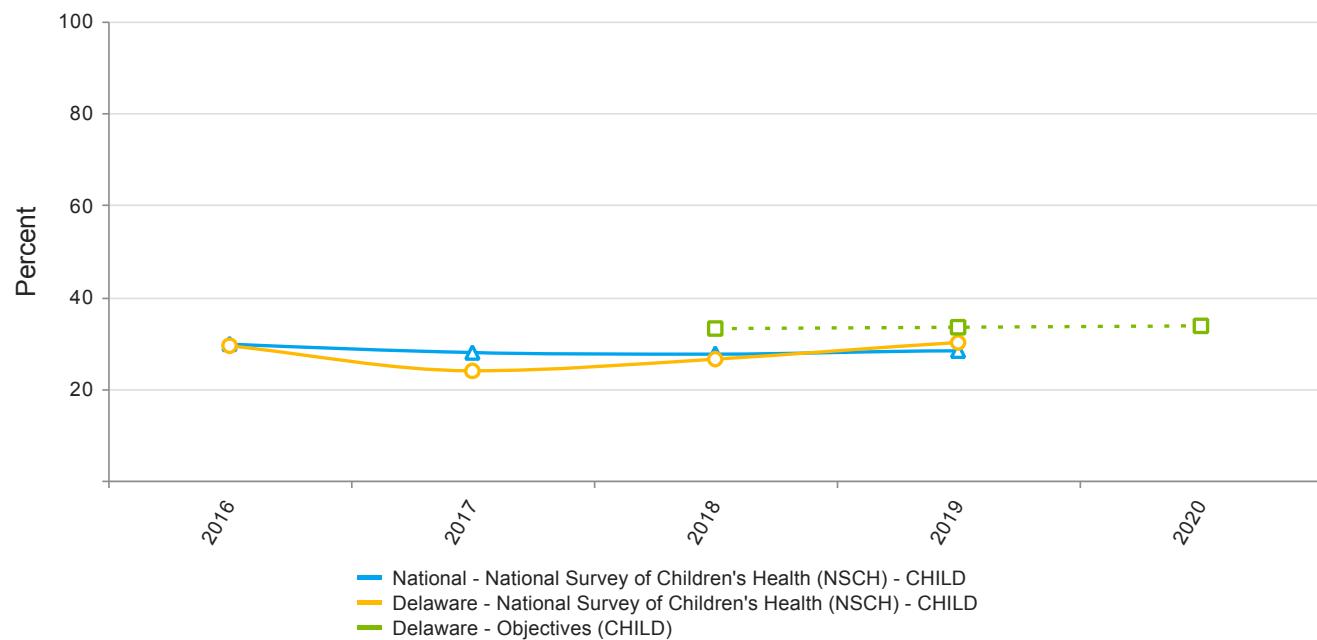
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

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

2016-2020: National Performance Measures

**2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives**



Federally Available Data

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

	2016	2017	2018	2019	2020
Annual Objective			33.1	33.4	33.7
Annual Indicator		29.5	23.8	26.5	30.1
Numerator		17,762	14,550	18,813	22,295
Denominator		60,210	61,193	70,930	74,026
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

ⓘ 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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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	2018	2019	2020
Annual Objective		20	20	20	20
Annual Indicator	0	20	20	20	20
Numerator					
Denominator					
Data Source	google analytics data/Worldways	google analytics data/Worldways	google analytics data/Worldways	Social Marketing Program Data	Social Marketing Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	No	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		1,000	1,000	1,000	1,000
Annual Indicator	877	1,000	1,000	1,000	1,000
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		12	12	12	12
Annual Indicator	12	12	12	8	6
Numerator					
Denominator					
Data Source	SHIP and Healthy Neighborhoods committee minutes				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Child Health - Annual Report

Our 2020 Needs Assessment showed that Delaware is among the lowest of its surrounding states when comparing children, ages 9-35 months, who received a developmental screening in the past year, where only 25.5% of these children received the screening. Delaware is also below the national average of 33.5% of children having a completed developmental screening. Developmental Screening was selected as the Most Important National Performance Measure in the Child Health Domain according to our stakeholders. In addition, it was ranked as the second highest priority, when ranking all priorities overall.

Efforts during the last application year were focused on increasing the number of children who had received a developmental screen, especially coming out of the wake of the lockdown due to the COVID-19 pandemic. The lockdown prevented many children in the early learning and education settings, as well as the healthcare from receiving the routine screens. Delaware's Early Childhood Comprehensive Systems (ECCS) program through collaboration with its partners such as the Office of Early Learning (OEL) in the Department of Education, the Birth to Three Program and other stakeholders focused on improving developmental screening processes within the constraints of the "virtual" environment to remind providers and encourage parents to ensure that screenings are not missed.

The development of the Ages and Stages (ASQ) Online platform led by the OEL, the year prior, set the stage for Early Childcare and Education (ECE) providers to direct parents to their school district website to administer developmental screening. Additionally, funding from the Birth to Three (B23) program to support the hiring of two Child Development Specialist to follow-up on the screens through the OEL platform made it possible to follow up with the screening results and the subsequent appropriate referrals to early intervention.

Outreach efforts, through our partnership with the Delaware Chapter of the American Academy of Pediatrics, to assist pediatric practices with developmental surveillance and screening and referral processes also shifted to focus on the creation of a practice report card to be distributed to practices, launching a care coordination pilot project utilizing Child Health & Development Interactive System (CHADIS) and early literacy pilot projects that provides books and developmental milestones education. Practice outreach and assistance was focused on creating practice report cards with screening and referral data as well as quality improvement and performance efforts.

Due to COVID-19, in-person provider education and practice TA visits were not possible during the fiscal year. Efforts instead focused on continued collaboration with community pediatric partners such as Beacon Pediatrics, Bright Futures, Bear Family Practice, Rainbow Pediatrics and through the DEAAP and the Medical Society of Delaware. This collaboration led to the Help Me Grow Advisory Committee members and Early Child Comprehensive Systems (ECCS) impact team members to develop an online education course for physicians titled, "*Delaware Developmental Screening Initiative*". This online education course currently includes five separate education modules which expands upon the PEDS Online Training from July 2018 titled "*Incorporating Developmental & Autism-Specific Screening into Your Practice*".

The five education modules include an overview of developmental screening best practices, the State of Delaware's developmental screening initiative, PEDS Online tools, early intervention, referral process and community resources, as well as care coordination.

We continued our collaborative efforts with other community partners and stakeholders, through the ECCS Improvement and the Help Me Grow Advisory committees to identify barriers and gaps in developmental screening implementation, referral and intervention processes and explore opportunities to mitigate the identified barriers and gaps. In the fall of 2019, we began the exploration of a care coordination system that would resolve the identified breakdown or gap in our referral system. This led to a series of presentations of three different referral systems

identified across the country (namely, IRIS, CHADIS and UNITE US). The CHADIS system was deemed the system that would resolve the gaps identified across the state. This led to the decision to set up a quality improvement pilot project utilizing the care coordination model by the end of 2019. The CHADIS platform was developed by physicians for physicians and collects patient-generated data that can be used to support clinical and shared decisions, track data and create quality improvement reports.

Efforts to launch the CHADIS pilot were however delayed due to the COVID-19 pandemic and the need for additional fact finding to ensure such a pilot would align with other efforts happening in the state, such as the goals/priorities of the Preschool Development Grant (PDG). In September 2020, we received permission to launch a CHADIS pilot in 3-4 pediatric practices throughout the state using ECCS funds. On October 21, 2020 a CHADIS demonstration and discussion meeting was held to provide more information to three pediatric practices selected to participate in the pilot. Between October 2020 and May 2021 multiple meetings were held to discuss the pilot to determine CHADIS functionality, questionnaires, electronic health record (EHR) integration and cost, participating practice needs and responsibilities as well as state of Delaware specific metrics and outcomes for the pilot project.

Four community pediatric practices were ultimately identified and have been confirmed to participate in the pilot. They represent all three counties, with enrolled patients who have either Medicaid or private insurance coming from diverse cultural backgrounds. The idea is to launch the pilot within the first year and possibly scale up and spread based on the outcomes.

In spite of the delays encountered to set up the pilot, Delaware now has a contract with Total Child Health to run the one-year pilot project to determine the effectiveness of the CHADIS platform to address gaps in the developmental screening and care coordination process.

Efforts by the ECCS Place-based Community partners in collaboration with the Office of Early Learning and other EC partners to improve developmental screening and surveillance, starting from the push in the first year of the ECCS grant to sway the changed from using the DIAL screener to the Ages and Stages Questionnaire within early child care and education settings culminated in the developmental screening Bill released at the end of the grant in May 2021. The universal developmental screening bill is designed to increase the opportunity for Delaware children to undergo developmental screening with a validated screening instrument at an early age in order to identify children who may be eligible for early intervention or special education services. It requires any applicant for a license or renewal of a license to operate a child care facility to commit that each enrolled child between birth to five years will undergo developmental and social emotional screening.

Aggregate data report tracked by the ECCS evaluator through a Memorandum Of Understanding (MOU) between the Office of Early Learning and the ECCS program shows a total of 13,420 (non-Nemours) PEDS Online screens completed on children 0-59 months between July 1, 2020 and June 30, 2021. This corresponds to an estimated 8,316 unique children or 61.97% of the total screens completed that were unduplicated. (This contrasts with 2019 screens of 15,345). This compares to 13,106 (non-Nemours) PEDS Online screens completed on children 0-59 months between July 1, 2019 and June 30, 2020 and an estimated 8,318 unique children or 63.46% of total screens completed were unique. This equates to a 2.40% increase in total screens completed while the number of unique (i.e., unduplicated) children stayed relatively the same. This suggests that PEDS practices were slightly less efficient and there was slightly more duplication during the contract timeframe of July 1, 2020-June 30, 2021 as compared to July 1, 2019-June 30, 2020.

We continue with outreach efforts to educate parents on the importance of developmental screening through the Books Balls and Blocks (BBB) events. For this fiscal year, a series of face-to-face BBB events planned for Sussex County (a partnership with the Division of Libraries) in spring of 2020 were foiled by Covid-19 Pandemic. To show

our resilience the ECCS teams and the family engagement partners pivoted to virtual sessions. This was no easy task as it meant looking for a facilitator who could engage 1-3 year old's (virtually), an individual who could develop a curriculum based on the issues/milestones of focus, etc. Our partnership with Let's Play Inc, made this possible. The first virtual BBB occurred in the summer of 2020 and have held more than 10 virtual events. We have learned through this challenge that we can innovate once we put our minds to it. With more than 10 virtual sessions held, we are confident to embed this in the infrastructure and have been bold to plan for other cultural populations such as the Hispanic population while introducing participating parents to topics such as early literacy and early intervention services. The BBB outreach efforts revealed the need to provide assistance for parents as they respond to the ASQ screens, they are encouraged to complete at the BBB events. This led to the partnership with the Office of Early Learning and Sussex County Health Coalition to organize a series of ASQ trainings for volunteers across the state. Through this training, over 70 volunteers with varying backgrounds have participated in the ASQ training. This training enables them to assist parents with challenges as they attempt to complete the screener at the BBB event.

The expansion of the Ages and Stages screener through early childhood led to a demand for more assistance in the follow up of results and linking parents with the early intervention services. This challenge was mitigated through a partnership between the Help Me Grow/2-1-1(centralized access point) and the Birth to Three program. Two additional staff were hired to support the ASQ follow-up done by the Help Me Grow /2-1- staff. Funding came from the Birth to Three program. This partnership and the subsequent improvements implemented, has led to significant increase in the number of families that have been referred to early intervention (Child Development Watch). From March through May of 2021, 17% of the families for whom a referral was recommended made the referral. However, the numbers were increased to 23% from June to July of the same year. Continuous improvement is key, and we're confident that as new processes are introduced that the referral rate will further improve.

Delaware will continue to implement activities that will improve and increase developmental screenings across the state, especially to anticipate the obvious increase with the passing of the universal developmental screening bill in the state. We will continue with the following:

- Training and education targeting early child care and health providers to increase the number of children who are screened.
- Collaborating with early intervention services to streamline referrals, especially for children with high-risk results.
- Launch and implement the CHADIS pilot project to determine its efficacy, scale-up and spread.
- Continue outreach efforts to educate families about developmental screening and milestones through the BBB events.
- Collaborate with EC community to craft consistent messages on developmental screening.

Dental Visit (child/adolescent)

According to the 2018/2019 National Survey of Children's Health (NSCH), 20.3% of Delaware children, ages 0 through 17, have not had a preventive dental visit in the past year. The Preventive Dental Visit (child/adolescent) was another priority that is important to Delaware stakeholders. Our stakeholders recognize that dental health equals overall health and the Title V team has identified that MCH is able to align our collaborations and resources to make an impact on this population.

MCH continues see value in supporting the activities of the Bureau of Oral Health and Dental Services (BOHDS) to improve the oral health and literacy of the children in Delaware. The Delaware Smile Check Program (DSCP) anticipated screening 14,000 school children during the 2020/2021 year. Unfortunately, the impact of the COVID-19

restricted most screening and preventive activities for oral health for most of the year. Dental had many barriers with the program being viewed as a non-essential services and apprehension of the community. During this time MCH supported BOHDS as they worked on web-based solutions to resolve barriers to oral health care and dental education for children ages 0 -18 years.

MCH provided funds for the Bureau of Oral Health and Dental Service (BOHDS) to add online enrollment, consent forms, screening forms and flyers for the DSCP to DEThrives for portable dental operations. The portable program includes dental screenings and prevention programs onsite that include fluoride application, oral health education and case management. Dental sealants and dental cleanings were not available this year. Although this project was not completed during the 2020/2021 year it will allow schools, organizations and parent/guardians to complete consent forms and other required documents online and eliminate complications for distributing paper documents to these locations and sending them home to students to return. This link is a staging link we are currently working to complete. [Smile Check | Delaware Thrives \(dethrives.com\)](#) Our goal is to have the link and website live for the beginning of the 2021/2022 school year to help children and families.

In addition, we made a great deal of progress with completing a web-based sign up for a newly developed virtual dental screening option for children and adults who are unable to access onsite dental screenings or dental care throughout the year.

The virtual dental screening is separated into different age categories for infants 0 - 1, ages 1 - 5, ages 6 - 12, ages 12 - 18, adults and pregnant women. Once completed the public will be able to sign up to receive the services provide by the DSCP. An organization will be able to complete a consent and submit it directly to the program to sign their location up for an onsite event. Individuals who want virtual services will be able to complete the documents and it will be submitted to a dental hygienist who will review the information submitted to highlight areas of concern and contact the parent/guardian or individual to discuss the screening questions and their concerns. The questions allow the dental hygienist to determine the caries risk for the child, oral health needs of the child, barriers to care, and provide education and case management to improve oral health of the child and family. In addition, the questions are designed to help the dental team identify any children and youth with special health care needs.

[Smile Check Intro | Delaware Thrives \(dethrives.com\)](#)

[Smile Check Intro – Spanish | Delaware Thrives \(dethrives.com\)](#)

From March 2020 to February 2021 when program access was restricted, toothbrushes, toothpaste, dental floss, and oral health education was delivered to 6,320 children ages to 0 - 8 years of age to childcare facilities, day camps, urgent care, baby showers, lactation counselors and pediatricians that included a business card with a new dental help line number that began November 24, 2020. The dental helpline is staffed by the dental team to help address oral health concerns and connect the public to a dental provider that is accepting patients. They can also address their specific needs as well as assist with securing dental or medical insurance, and other resources. The information was shared with CYSHCN, Family Shade, school districts, school nurses, urgent care, home visitors, pediatricians, Delaware Medical Society, and other partners. From November 2020 - June 2021, 1,742 calls were received from the public looking for a dentist or having a dental problem. Calls are triaged and separated into adults and children, pain, swelling or people with disabilities get transferred to a dental hygienist to obtain additional information to assure they are connected to a dentist.

During the 2020/2021 year, DSCP opened the program to encourage early intervention for children ages 0 - 4. The dental flyer was an effective tool to help the employees at the location be more at ease with the program and provided options for outdoor screenings to allow the BOHDS team to move forward with the program. DSCP visited 23 childcare facilities to provide dental education to staff children and oral health resources in additions to dental screening.

During the year, a total of 1,304 children received dental screenings, fluoride varnish application, customized oral health education and case management to assist with eliminating barriers to care and assisting them with connecting to other services needed. Through this program 62 were identified as having an urgent dental need (pain and swelling), 309 had suspected caries, 86 children had no dental insurance, and 379 had no dental home. Through case management completed by dental hygienists, 60 children with urgent needs received dental treatment within 30 days after the dental screening, 86 children who had suspected dental caries were treated in 30 days and 155 received dental treatment within six months, 33 children secured dental insurance, and 315 were connected to a dental home.

Another way MCH has found to provide support to the Bureau of Oral Health and Dental Service was through collaborative efforts to inform home visitors and other community partners about the oral health education program for pregnant women and their infants

Many of these women are part of a Home Visiting program. Through this program, women are inspired and empowered to take control of their prenatal health and birth outcomes through oral care and learn how to give their babies bright futures that start with simple oral hygiene practices and nutrition. From 07/20 - 06/21, 25 women received dental screenings, case management, oral health education, practiced oral health techniques for their infants using a baby simulation doll.

Due to COVID restrictions, the live presentations were discontinued. Virtual training sessions were developed and implemented. Several barriers existed with connecting virtually via Zoom, Teams, Web ex to the participants. Staff on both sides had a learning curve had to be overcome to develop a plan how to implement the technology, share, utilize and coordinate activities. March trainings resumed and two presentations were given where 56 women attended. Due to the challenges of virtual learning, the education is being split up into oral health for pregnant women and one for infants after delivery.

MCH has also supported developing a virtual screening for pregnant women. This will be shared to encourage pregnant women to receive a virtual or onsite dental screening that includes case management and oral health guidance and resources.

[Smile Check — Pregnant Women | Delaware Thrives \(dethrives.com\)](https://dethrives.com)

MCH assists with marketing oral health activities, events, and education through DEThrives Facebook, twitter and sharing with other partners. During this time period BOHDS implemented several new programs to connect with the families with children to improve oral health, nutrition, safety, physical fitness, vaccination, and preventive visits for dental and medical.

Reach out and Read is an example of one program. The Delaware Chapter, American Academy of Pediatrics (DEAAP) is a professional association of pediatricians committed to promoting optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults in Delaware. In support of its mission, the DEAAP recently established an Early Literacy Committee (ELC) tasked with the goal of engaging and supporting Delaware primary care pediatricians to promote early literacy from birth to five years. The DEAAP ELC's efforts are guided by its vision that "*beginning at birth, every Delaware child is read to, every day.*"

DEAAP ELC has partnered with the Bureau of Oral Health and Dental Service (BOHDS) to promote early literacy and a dental home for children by age 1. To help accomplish this goal, partners are working to collaborate on the distribution of the '*Brush, Brush, Brush*' book to pediatric practices that are implementing the evidence-based Reach Out and Read (ROR) literacy program. The book, to be distributed during the 12-month, well-child visit

promotes healthy habits using rhyme to engage and inspire little ones to brush their teeth. Included on the back of the book will be a sticker with the Bureau of Oral Health Dental Services Help Line that supports families to help them find a dentist.

Practices expressing an interest in distributing the 'Brush, Brush, Brush' book as part of the Reach Out and Read program will be contacted by a dental hygienist who will coordinate book delivery, engage in oral health conversations around available resources and supplies (toothbrushes, dental floss, toothpaste, etc.,) and training for caries risk assessment and fluoride varnish application, as requested by the practice.

DEAAP Early Literacy Committee is pleased to be working in collaboration with the Bureau of Oral Health and Dental Service on this initiative to combine two important messages – early literacy and a dental home by age 1.

Through this program, BOHDS dental hygiene team has delivered over 300 'Brush, Brush, Brush' books to pediatricians, built relationships with the staff and has scheduled trainings with three pediatric medical offices to assist the doctors, physician assistant and nurses with implementing fluoride varnish application, caries risk assessment, referrals and discuss the systemic relationship between oral and medical health.

In addition to this program, oral health education has been provided in person for 77 pediatricians to assist them with identifying oral health problems, assist with fluoride application, caries risk assessments, what to do for a dental emergency, HPV, and dental referrals. The course included information about the lack of access to care, hesitancy of the community to visit a dentist and how to partner with oral health.

The Storytime program is another collaboration with the Delaware Libraries to improve oral health literacy and early literacy of children. A children's book about dental is read by a dental hygienist from BOHDS. A demonstration is given on proper brushing and flossing using a puppet. After Storytime, the dental hygienist answers oral health questions, assists families with connecting to resources and can provide dental screenings, fluoride application, and case management. A new oral health web page was developed that is shared with the public.

<https://guides.lib.de.us/oralhealth>

 Delaware Thrives
July 2 at 8:55 AM · 

Join the Bureau of Oral Health and Dental Services and Delaware Division of Libraries for story time on July 6 at 10 a.m. at the Selbyville Public Library! Once story time has ended Delaware Smile Check will offer free dental screenings and fluoride application for children and adults by a Registered Dental Hygienist from the Bureau of Oral Health and Dental Services. Each person screened will receive a toothbrush, toothpaste, dental floss, and a book. Learn more & register here: <https://bit.ly/3hm3w5m>



The Bureau of Oral Health and Dental Services coordinates with MCH to release information through DEThrives at a

minimum monthly on Facebook and twitter. This includes preventive education and oral health events available to the public to support children and their families to maintain good oral health and improve oral health literacy. In addition, MCH has assisted with releasing an updated dental resource guide to over 950 community partners and stakeholders. This resource guide assists families with finding a dental provider since the landscape of the dental community has been rapidly changing. The guide includes information about dental benefits, transportation, how to find a provider, how to enroll with dental coverage and oral health tips. Over 10,000 dental resource guides were distributed, and information posted on websites for different organizations.



MCH also distributed Impression's newsletter through the Sussex County Health Coalition (SCHC) network of over 500 community partners including home visiting programs. The newsletter is developed to address specific oral health concerns in the community and to garner interest in oral health among partners. Below are two of the Impressions newsletters distributed to over 600 community partners and home visiting.

[Impressions Summer 2020_Final \(delaware.gov\)](#)

[Impressions Summer 2021_Final \(delaware.gov\)](#)

MCH has also helped build a lasting connection and relationship with CYSHCN and BOHDS. Information has been shared to assist families with finding a dental provider and approval is waiting for Helpful Tips For Scheduling a dental visit and maintaining good oral health at home. DSCP has targeted schools that have many children with disabilities and collaborated with dental specialist that can meet the needs of the families for treatment.

The last MCH was provided, our Medicaid claims data illustrated a dramatic uptick in the services being provided in the FY18 annual reporting year. Additionally, the data also shows an increase in the number of physicians who billed for fluoride varnish application to 16. This reflects an increase from 12 in 2018 to 16 in 2019. Several individual pediatricians are still 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. Unfortunately, MCH was advised that contract negotiations are still ongoing, so we are not able to access the updated data at this time.

Child Health - Application Year

For the FY2022 application year, Delaware's developmental screening goals will focus on continuous improvement to streamline the developmental screening processes and build in efficiencies that enhance community awareness; improve referrals to early intervention and anticipates the potential uptake in screens following the passing of the developmental screening bill by the Delaware's legislature. Through the ECCS program, we will leverage the strong rapport cultivated with the healthcare provider community and early care/education providers/programs, through the implementation of the Parent's Evaluation of Developmental Status (PEDS) and Ages and Stages Questionnaire (ASQ), respectively. The ECCS program will continue to collect the ASQ and PEDS screen counts through these stakeholders and note areas of strength (e.g., an increase in developmental screening rates) as well as suggested areas for improvement (e.g., based on analyses of these two data sets, enhanced focus should be placed on improving gross and fine motor skills of infants and toddlers). Partnerships with the Delaware Readiness Teams and Public Allies remain robust, longstanding relationships. These two groups have helped carry out early childhood-related events, such as Books, Balls, and Blocks (BBB) as well as other family resource fairs.

Efforts continue, this application year, to enhance the tracking of Intake and referrals for children at higher risk for developmental delays. Increased developmental screening and linkages to services through building partnerships with child-serving providers will increase their awareness of screening and referral services in the state. We will continue to keep the pulse on families referred for early intervention to prevent such families from falling between the cracks. The ECCS program collaborated with early intervention programs to ensure children less than 3 years identified at risk for developmental delays are referred to appropriate services before age 3 to promote early detection and intervention. The partnership between the Birth to Three program and Help Me Grow /2-1-1 staff for follow-up with Ages and Stages screens remain even more established with the hiring of 2 more staff to assist with the uptake of screens. This effort is funded by the Birth to Three program.

The ECCS program in partnership with the American Academy of Pediatrics, will improve previous efforts to streamline and track referrals with the recent collaboration with Total Child Health to introduce the CHADIS pilot project. CHADIS is a web-based platform which enables health providers to access over 400 screeners and also track activities in real time. This approach will enable physicians to screen families during well-child visits and track any referrals to early intervention or other community resources, through a feedback loop. All these efforts will strengthen follow-up services to ensure children identified at risk for delays are referred to and receive early intervention services.

We will also continue to provide technical assistance and training to pediatricians and family practices that are using the PEDS instrument, as well as potential recruits. The training will be in the form of a webinar series, an online education course titled "Developmental & Autism-Specific Screening." The training provides an overview of developmental screening best practices, Delaware's developmental screening initiative, PEDS Online instrument, early intervention, referral and community resources, among others. The webinar will be posted on the AAP website including DEThrives as well as other partner sites.

Partnerships with the Office of Early Learning will continue to improve the delivery of developmental screening services within Delaware's school districts. In 2019-2020, the ECCS teams partnered with the Office of Early Learning, which is housed within the Delaware Department of Education, to get 17 out of the 19 schools districts to post a link to the Ages and Stages developmental screening tool on the school district websites - opening up access for early care and education centers in each school district and their enrolled parents to utilize the platform and the subsequent referral and early intervention processes. This led to a spike in the number of children birth to 5 years receiving developmental screens. In May of 2021, Delaware legislature passed the developmental screening bill requiring all child care centers to administer developmental screens. The ECCS and Help Me Grow programs will

work collectively with the early learning community to anticipate and address any opportunities and challenges that would surface as a result of this expansion.

The ECCS program will continue with outreach efforts to promote developmental screenings and milestones thereby increasing awareness and promoting parental involvement. Outreach efforts such as Books, Balls, and Blocks (BBB) will continue in collaboration with multiple community stakeholders such as United Way of Delaware, Division of Libraries, Help Me Grow/2-1-1, Wilmington Head Start, Project LAUNCH and the Readiness teams. During the 2019-2020 grant period, the ECCS Impact team and its partners held five BBB events within a variety of settings. These settings included Head Start and other childcare centers, community centers and libraries. These events brought in approximately 120 families with about 60 children (birth through 5) receiving ASQ screens. Evaluations turned in after the event indicated that the families found the BBB event very beneficial in increasing their knowledge regarding the expectations for their children's growth based on their ages. The success of the BBB events is due to its alignment to the goal of systems development and improvement through reaching out to a cross-sector of stakeholders who can garner and leverage their resources to benefit the whole. Plans to organize more BBB events in the southern part of the state at the beginning of 2020 were thwarted due to the Covid-19 pandemic. Despite such challenges, the ECCS teams were successful in organizing BBB online using zoom. For this application, we will continue to organize BBB online. Since its inception, we have held about 12 BBB online events.

We will continue to strengthen collaboration with the WIC Program. Through the University of DE Center for Disabilities and Learn the Signs Act Early Ambassador, the ECCS collaborated on a project involving the Special Supplemental Nutrition Program for Women, Infant and Children (WIC). The project introduced a CDC developmental screening checklist at all WIC locations in DE (with RWJF funding). WIC programs added the checklist to their intake system. Clients visiting WIC were asked questions based on the checklist. Families falling below the identified threshold were encouraged to call Help Me Grow/2-1-1 for an actual developmental screening to be administered. The data indicated that, of the approximately 4,000 checklists completed, 758 referrals were made to Help Me Grow, while only six of the referred families called the call center. Though this project has ended, ECCS program will find ways to engage its WIC partners as it serves as a great avenue to reach families enrolled in the program, who are often at-risk. Delaware will continue to implement these activities to achieve its stated goal of increasing screening through the implementation of the following strategies:

- Promoting early detection by encouraging physician practices to increase developmental screens and link families to community resources and services;
- Training and education targeting early childcare and education providers to increase the number of children who have developmental screens;
- Collaborating with early intervention programs to improve referrals following high risk developmental screens to ensure families are connected to treatment services;
- Launch the CHADIS pilot with 4 pediatric practices to improve the coordination of care and systems improvement;
- Building parent/family leadership and capacity to advocate for themselves and their communities; and
- Continue organizing community events such as Books, Balls and Blocks events and determine its sustainability beyond the ECCS grant.

Dental Visit (Child/Adolescent)

Delaware is tracking along with the national average of children, ages 1 through 17, who had a preventive dental visit in the past year. According to the 2018/2019 National Survey of Children's Health, 79.7% of Delaware children had

one or more dental visit, which resembles the national average of 79.6% of children. Unfortunately, this equals to 20.3% of Delaware's children have not had a preventive dental visit in the past year.

MCH feels it is critical to collaborate with the Bureau of Oral Health and Dental Services (BOHDS) while they develop new approaches and integrated new technology into schools and other programs to continue to provide education, dental screenings, and case management to the most vulnerable populations during the COVID-19 pandemic.

Title V MCH feels it is crucial to support BOHDS with completing a statewide oral health survey of children in kindergarten and 3rd grade across the state. The oral health survey was last completed in 2013 and will measure the burden of oral disease including prevalence of dental caries, untreated dental decay, urgent dental needs, dental sealants, and access to care. The survey is part of the oral health surveillance system used by BOHDS to measure, monitor and report on the burden of oral disease in Delaware. The survey was delayed in 2020 due to the complexities of the COVID-19 pandemic. The BOHDS Dental Director has been working with the school nurses and superintendents to garner support for moving forward in 2022 with the survey. Data collected from the survey will be used by BOHDS to develop preventive oral health and nutrition programs targeted for kindergarten and third grade children at the start of the 2022 school year.

BOHDS has been collaborating with the Delaware Department of Education (DOE) to make oral health part of overall health. MCH supports BOHDS in its efforts to include oral health as part of total health through the schools and see it as a critical piece of medical and dental integration. The DOE is working on developing a standard student enrollment form to be used by all schools across the state. BOHDS continues to work with DOE to include valuable dental information on school enrollment forms that have been overlooked in the past. Parents and guardians will be asked if they have dental insurance, date of last visit to a dentist, and the name of their dental home.

BOHDS will continue working on completing oral health educational videos, resources, and online enrollment for oral health programs and education. MCH will be supporting BOHDS with sharing the information that will be posted on each school's websites for teachers, nurses, athletic directors, parents/guardians and children to improve oral health literacy about preventive dental care, fluoride, nutrition, dental sealants, dental decay, oral health, systemic health, dental emergencies, mouth protection, vaccinations, oral cancer (HPV), mental health, oral health, and access to care (find a dentist and enrolling in dental insurance). MCH feels it is extremely important to assist BOHDS with this information campaign. MCH will be utilizing DEThrives to support BOHDS with these educational videos, resources, and online enrollment education.

As explained in the Child Health Annual Report, MCH and the BOHDS dental team collaborated this past year to find a solution to continue the Delaware Smile Check Program (DSCHP), through the COVID-19 pandemic. MCH and the BOHDS dental team have worked to add online enrollment, consent, and screening forms in addition to flyers and a satisfaction survey to our DEThrives website for portable dental operations. The portable program includes dental screenings and prevention programs onsite that include fluoride application, oral health education, and case management.

Although this project was not completed during the Annual Reporting time, MCH will continue to work with the BOHDS dental team and our DEThrives vendor, AB&C, to facilitate the creation of these 12 fillable Virtual forms in English and Spanish in addition to the eight On-Site fillable forms in English and Spanish on our DEThrives website. These forms target the populations: Birth to age 1, Age 1 to 5, Age 6 to 12, Age 13-18, Age 19 or older as well as Pregnant mothers. We are currently in the phase where we are reviewing each form for accuracy and hope to have it live shortly. Once complete, it will allow schools, organizations and parent/guardians to complete consent forms and

other required documents online and eliminate complications for distributing paper documents to these locations and sending them home to students to return.

School personnel and parents will be able to complete through the school's website enrollment in the Delaware Smile Check Program (DSCP). The DSCP is a portable and virtual preventive program that provides dental screenings, fluoride varnish application, customized oral health education and case management to remove barriers to obtaining oral health care for students and their families. BOHDS is targeting the release of a video demonstration of the DSCP requested by the school district. The video will be shared to show students and parents what to expect prior to receiving services.

The DEThrives website houses information that provides resources that benefits any type of person and any type of family situation. The DEThrives site is undergoing a website revamp and it is being reworked to organize and present content in a way where it would be more user-friendly for consumers to easily navigate throughout the site. The goal is to inform and educate the consumer with evidence-based content that is helpful and relatable based on the life stage a consumer would classify themselves in. The website will be set up in a way where the consumer could classify themselves in a category that resonates the best with them in describing their current life situation or life stage they are in. Once the consumer identifies themselves based on the provided options the site offers, relatable content such as the programs or services that DEThrives offers will populate into small groups of info all placed on one webpage. This presentation will help allow the consumer to see a layout of the type of info that may best suit their current life stage with helpful and credible resources. Content for providers and partners will be presented in a short and concise way so they may easily and efficiently refer to the site.

Part of the overhaul of the DEThrives website, will be to incorporate the Bureau of Oral Health and Dental Services information on our site. Our goal will be to add the existing Healthy Smiles dental program to the revamped DEThrives site. The Healthy Smiles landing page will consist of details regarding the BOHDS Delaware Smile Check Program. The Delaware Smile Check Program offers in-person school and organization visits along with virtual options where on-site and virtual forms are available in both English and Espanol. These services are for children as young as 1 year old, adults, and pregnant women and will be provided dental assistance, which includes patient education, regardless of if the consumer has insurance or not.

BOHDS will begin working with the DOE and collaborative partners to develop an effective plan to incorporate oral health into wellness centers in the Colonial School District. This school district is a priority since they have a significant percentage of students with disabilities and unmet dental needs.

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

MCH will also continue to support Delaware's goal to expand their dental early intervention programs for pregnant women and infants. Through this program pregnant women are empowered and inspired to self-advocate for the oral health of their children as well as themselves through receiving preventive dental treatment during pregnancy, assuring their children receive routine preventive dental care and have a dental home by age one. This program has proven to be successful for both the women, infants, and other children in the family.

Delaware's dental team will continue develop collaborations and conversations with the National Federation for the Blind, Autism Delaware, Family Shade, CYSHCN, DOE, Child Development Watch, and families that have a child with a disability. Through these collaborations, BOHDS has purchased assistive devices aimed at helping children and parents/guardians with brushing and flossing to maintain good oral health and overall health. Feedback from these discussions has encouraged the development of educational materials and presentations to begin next year that include for nutrition and medications, brushing, flossing and fluoride supplementation, positions for assisting with home dental care, and devices to assist with maintaining good oral health. MCH will support BOHDS as they collaborate with schools, organizations and families to provide training and education for teachers, staff and families in assistive devices available such as raised dots, putty, wrist straps, electric toothbrushes, flossers, tennis balls, etc., that assist with daily oral health routines and improve oral health literacy.

BOHDS has begun reimplementing training for physicians, physician assistances and nurse for fluoride varnish application, caries risk assessment and referrals for age one visits. During the past year there has been a dramatic decline in the number of pediatricians that continued with oral health activities. MCH supports the continuation of this training and its expansion to nurses for children under age 5.

This is a critical step in addressing the total health of a child and bridging the silos between medical and dental. MCH sees the value in supporting this collaboration between the early literacy program through the Delaware Medical Society and BOHDS to distribute Brush, Brush, Brush books, oral health supplies, and resources to pediatricians. Through this relationship the dental hygienist is building a relationship with the medical teams and serves as point of contact for dental questions, children with urgent dental needs and training for fluoride application, caries risk assessment, dental emergencies, age-appropriate oral health supplies and more. In addition, the dental hygienist has gained knowledge about medical information that they continue to reinforce with their patients (Medical homes, vaccinations, etc.) and assist families with connecting to other social services that are needed. A dental help line was created to assist families with finding a dental provider and business cards distributed to the medical providers. A child who needs a dentist is given the card to contact a dental provider that meets their needs. This was developed to remove the burden of assisting with finding a dentist through the pediatrician's office. Currently the program targets age one and discussions have started to include more books and ages in the upcoming year.

Both BOHDS and MCH expect challenges due to COVID with pursuing oral health activities for the upcoming year. BOHDS has been preparing to provide virtual solutions and implement outreach for families to garner support for school surveys, DSCP and preventive treatments. MCH will support their efforts by continuing to market for their program, fairs, Storytime, and newsletters through DEThrives, Facebook and Twitter and over 200 Community Partners.

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

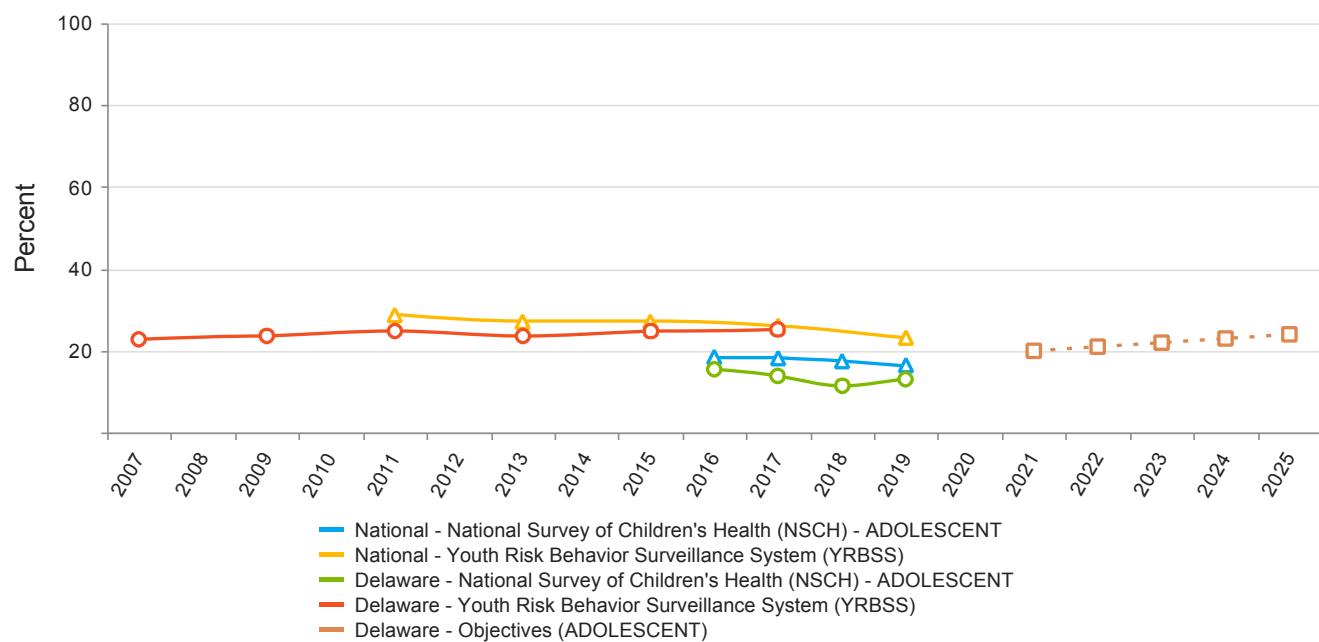
Adolescent Health

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-2019	32.2	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	11.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	8.8	NPM 9 NPM 10
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-2018_2019	15.7 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	54.6 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.5 %	NPM 8.2 NPM 10
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-2018_2019	16.0 %	NPM 8.2 NPM 10
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-2018	16.3 %	NPM 8.2 NPM 10
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-2017	15.1 %	NPM 8.2 NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	68.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	75.4 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.7 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	89.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	14.9	NPM 10

National Performance Measures

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



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2019	2020
Annual Objective		
Annual Indicator	25.1	25.1
Numerator	9,329	9,329
Denominator	37,230	37,230
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2019	2020
Annual Objective		
Annual Indicator	11.6	13.0
Numerator	7,828	8,196
Denominator	67,249	62,967
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	21.0	22.0	23.0	24.0	25.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		Yes
Numerator		
Denominator		
Data Source		MCH Program Data
Data Source Year		2020
Provisional or Final ?		Final

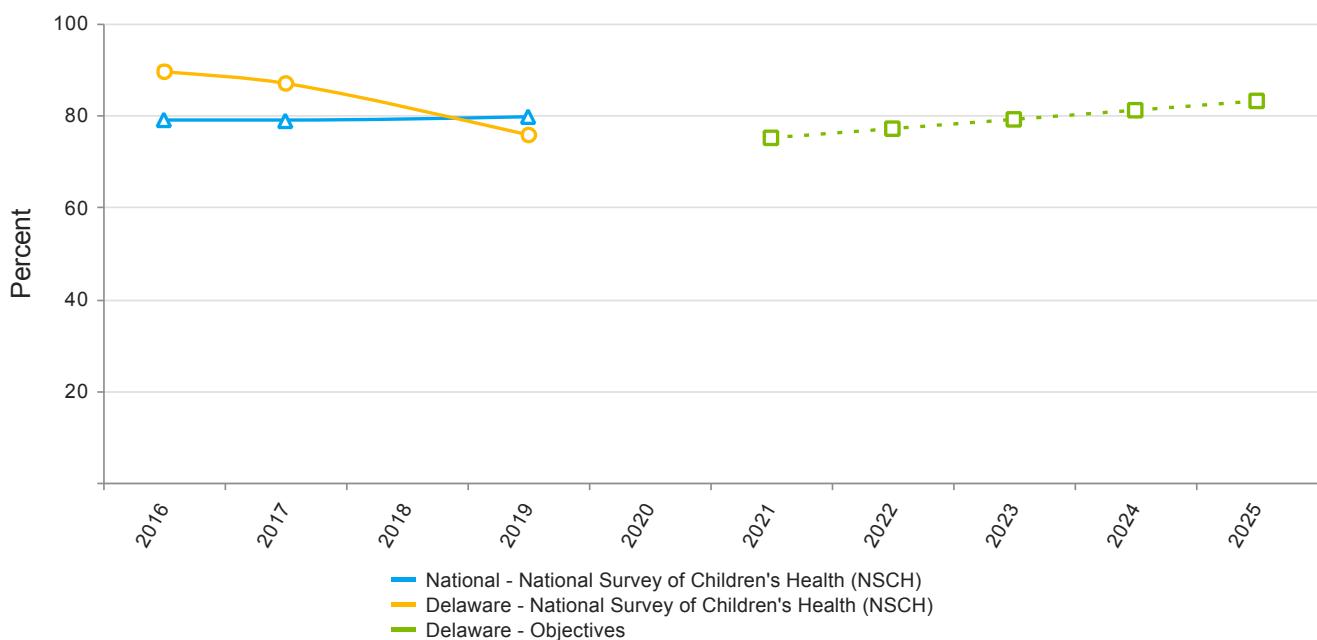
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		No
Numerator		
Denominator		
Data Source		MCH Program Data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	No	Yes	Yes	Yes	Yes	Yes

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



Federally Available Data

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

	2019	2020
Annual Objective		
Annual Indicator	86.9	75.7
Numerator	62,537	47,654
Denominator	71,966	62,974
Data Source	NSCH	NSCH
Data Source Year	2016_2017	2019

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	83.0	85.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		No Yes
Numerator		
Denominator		
Data Source	SBHC Program Data	SBHC Program Data
Data Source Year	SFY 2020	SFY 2021
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 10.2 - Number of adolescent receiving services at a school-based health center who have a risk health assessments completed

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		90.4
Numerator		235
Denominator		260
Data Source	SBHC Program Data	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	30.0	35.0	40.0	45.0	50.0

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		2
Numerator		
Denominator		
Data Source	SBHC Program Data (1 Medical Vendor)	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

State Action Plan Table

State Action Plan Table (Delaware) - Adolescent Health - Entry 1		
Priority Need		
Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.		
NPM		
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		
Objectives		
Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2025.		
Strategies		
Partner with adolescent serving organizations or agencies, including but not limited to family planning, substance abuse and/or community colleges to promote adolescent well visits.		
Complete strategic plan for SBHCs		
Improve data collection at SBHCs		
Communicate with and share resources with school nurses statewide to promote adolescent well visits.		
Provide school-based access to confidential mental health screening, referral and treatment that reduces stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.		
Ensure adolescents are enrolled in a health insurance program.		
Use media strategies (e.g., facebook and instagram posts, websites) in conjunction with other strategies to promote comprehensive adolescent well visits and healthy lifestyles.		
Partner with SBHC and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits.		
ESMs		
Status		
ESM 10.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.		Active
ESM 10.2 - Number of adolescent receiving services at a school-based health center who have a risk health assessments completed		Active
ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees		Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Empower adolescents to adopt healthy behaviors.

NPM

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

Objectives

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

Strategies

Promote physical activity counseling during well-child visits including SBHC visits.

In collaboration with PANO, increase social marketing media and public communication (posters, flyers, etc.) promoting healthy lifestyle and available resources such as bike and walking trails.

Participate in Delaware "cluster collaborative meetings" to encourage coordination among DOE, DPH and DSAMH to address adolescent health and wellness

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

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

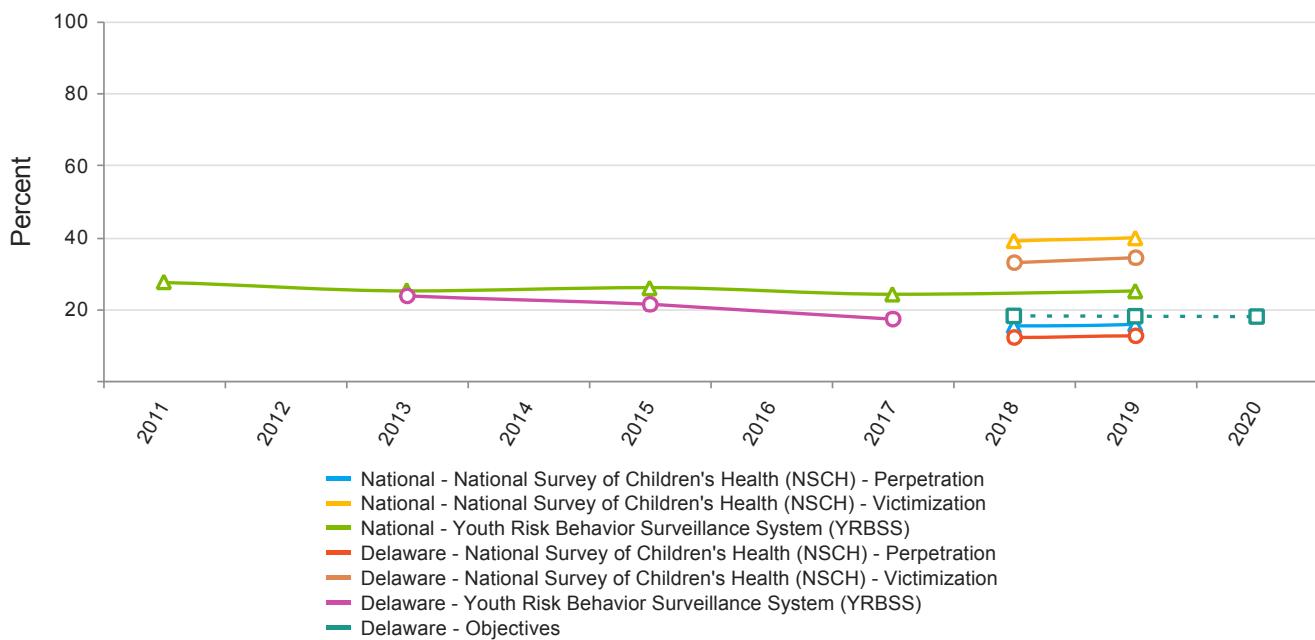
NOMs

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)

2016-2020: National Performance Measures

**2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives**



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2016	2017	2018	2019	2020
Annual Objective	18.5	18.3	18.1	18	17.9
Annual Indicator	21.2	21.2	17.4	17.4	17.4
Numerator	8,235	8,235	6,885	6,885	6,885
Denominator	38,923	38,923	39,480	39,480	39,480
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2017

Federally Available Data

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

	2017	2018	2019	2020
Annual Objective			18	17.9
Annual Indicator			12.2	12.5
Numerator			7,770	7,866
Denominator			63,570	63,129
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

i Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data

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

	2017	2018	2019	2020
Annual Objective			18	17.9
Annual Indicator			32.9	34.1
Numerator			20,925	21,515
Denominator			63,570	63,129
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

i Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

2016-2020: Evidence-Based or -Informed Strategy Measures

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH and Worldways	MCH and Worldways	MCH	MCH	MCH
Data Source Year	2016	2017	2018	2019	2030
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 9.2 - # of people who attend Safe Kids conference

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	75	0	75
Annual Indicator	0	0	75	0	0
Numerator					
Denominator					
Data Source	Safe Kids Conference Planning Committee	Safe Kids Conference Planning			
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

2016-2020: ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2	2	2	2
Annual Indicator	5	1	2	0	0
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		3	4	4	4
Annual Indicator	3	3	3	1	2
Numerator					
Denominator					
Data Source	SBHC and MCH meeting minutes				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		150	150	150	150
Annual Indicator	166	159	165	131	125
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: State Performance Measures**2016-2020: 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	2018	2019	2020
Annual Objective		22	22	21	20
Annual Indicator	22	27.6	27.6	27.6	27.6
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final	Final

Adolescent Health - Annual Report

Adolescent Health Annual Report

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

Adolescent Well-Visit

The National Survey for Children's Health (NSCH) shows that the percentage of Delaware adolescents who have had a preventive medical visit in the past year declined from 2017 to 2018 but is on the rise again in 2019. In 2017, the percentage was 84.2%, while in 2018 the percentage declined to 70.2%. The 2019, Delaware's percentage of adolescents who have had a preventive medical visit in the past year increased to 75.7%. During our 2020 Needs Assessment, our stakeholders identified the adolescent well visit as the number two priority for this population domain and was ranked 7th, overall.

During 2016-2018, like the U.S., Delaware saw a decline in the prevalence of ACEs. There was a three-percentage point decline in "two or more ACEs" in Delaware among children. For instance, in 2016 the prevalence of "two or more ACEs" was 22.6% and in 2018 the prevalence was 19.6%. However, in 2019 there was a two-percentage point increase in two or more ACE's in Delaware, from 19.6% to 21.9% in 2019, while the U.S. had a one-percentage point increase from 17.8% in 2018 to 18.7% in 2019.

In partnership with Planned Parenthood of Delaware, training is offered for staff at School Based Health Centers (SBHCs) each year. Planned Parenthood attendees range from School of the Deaf, Detention and Treatment Centers from within the Department of Services for Children Youth and Their Families (DSCYF), Delaware Adolescent Program Inc. (DAPI), SBHCs, middle schools, high schools as well as community agencies, partners and parents. In addition, mental health and medical providers participate in trainings provided by Planned Parenthood of Delaware throughout the year. The following list represents trainings provided thus far this year. The COVID-19 pandemic has impacted Planned Parenthoods trainings in which all have been virtual. The following courses have taken place thus far:

- Online MPC/BPBR Training - Oct. 1, 2020
- MPC/BPBR Curricula Training - Oct. 14 - 16, 2020
- Let's Talk - CC Camp FRESH-10/29/20 (Parent workshop)
- Teaching about Consent & Healthy Relationships - 12/10/20
- Inclusive Anatomy & Physiology Training - 2/23/21
- Trauma-Informed Sex Education - 4/13/21
- Caring Through Crisis: Trauma Informed Care for Adolescents - 5/26/21
- Supporting an LGBTQ+ Child CAMP Rehoboth - 4/28/21
- Supporting an LGBTQ+ Child CAMP Rehoboth - 4/28/21

COVID-19 impacted School Based Health Centers across the state of Delaware this school year. Given many schools only offering remote learning and/or hybrid there was less access to SBHC's at the beginning of the year. Many SBHC's implemented telehealth in which students were able to access care via this method. Upon availability of the vaccine to adolescents 12 and older, SBHC's have coordinated efforts for the COVID-19 vaccine with medical vendors in the latter months of the school year.

During the 2019/2020 school year, the School Based Health Centers in Delaware schools administered 703 depression screenings, 2,776 STD screenings, 8,304 Emotional (Mental Health) evaluations, 703 depression screenings, and 6,295 risk assessments. In addition to this, SBHC's in Delaware completed 1,558 physical exams (well child), 3,437 sports physicals, 435 administrative physicals (ex. ROTC, pre-employment), 2,686 immunizations, and 3,502 nutritional counseling sessions.

The SBHC Operational meeting this year was held in conjunction with Title X Family planning on October 28, 2020 and May 26, 2021. It comprised of mental health and medical providers from SBHC's, providers and administrative representatives from DPH Clinics, Federally Qualified Health Care Centers, Community Health Care Centers, Planned Parenthood as well as DPH/FHS staff. Training and topics focused on mental health and service delivery this year. Topics of discussion comprised of the following:

- Coping with COVID-19 as a HealthCare Professional - 10/28/2020
- Service Delivery During COVID-19 - 10/28/2020
- Caring Through Crisis: Trauma Informed Care for Adolescents - 5/26/21

In addition to the above training, the Adolescent and Reproductive Health Unit completed a virtual Unconscious Bias Training in four sessions (June 3 - June 24) with Pamela Fuller from the Franklin Covey institute.

This year Division of Public Health, Family Health Systems, Adolescent Health also completed an intense, virtual, strategic planning process in which 13 goals were established to produce a synchronized organization of SBHC's across the state of Delaware. The plan is currently in its implementation stage with continued coordinated efforts with stakeholders such as the department of education, medical vendors, Delaware School-based health Alliance, etc. <https://dethrives.com/sbhc>

DEThrives has developed several organic (non-paid) social tactics to assist Delawareans in understanding the School Based Health Center (SBHC) Strategic Plan. The audience is targeted to stakeholders such as partners, medical providers, parents, schools, community providers, students, other MCH networks (DHMIC, Help Me Grow), other state agencies (such as DSS, Medicaid and managed care organizations, Kids Dept, public libraries, etc.), and with key MCH legislators to increase the awareness of SBHC recommendations.

DPH has signed multi-year MOUs with various school districts in an effort to support and build resilient children and improve the social and emotional wellness of children and adolescents. (<https://www.lifeskillstraining.com/botvin-lifeskills-training-middle-school-program/>). During the 2019/2020 school year, 12 middle schools representing 5 school districts completed the Botvin LifeSkills program. This represents 1,257 students who completed pre/post surveys.

Unfortunately, COVID-19 restrictions have impacted this program. There were no new schools and/or districts in the 2020/21 school year that delivered the program, and no new MOUs were signed. COVID also impacted the implementation in that all curriculum needed to be online and Botvin did not provide an online resource (i.e. – only paper workbooks) for students. Additionally, pre-post assessments are not available online for teachers to access. Unfortunately, this was a major barrier for teachers. The Brandywine School District and the Capital School District did request additional workbooks for children so their students could pick up from school. However, we have not been given the numbers by either district as to how many students were instructed on the curriculum. It will likely not be evaluated this year on account of the pre and post assessment barrier.

We look forward to our continued working relationships to further the implementation of the Botvin LifeSkills training with the school districts that did not implement the program this past year. In addition, we will continue to provide support to our colleagues in DPH as well as Department of Education (DOE). We will also provide assistance if needed, in the analysis of the pre- and post-surveys completed in the schools that implement the training in the future.

The Take Care Delaware Implementation Team, comprised of law enforcement, educators and mental health providers, spent 2018-2019 working together to create guidelines for implementation. On Friday, July 26, 2019, Governor John Carney signed Delaware House Bill 74 (Take Care Delaware program), enabling a partnership between law enforcement and schools to adopt a trauma-informed approach to children who have been identified at the scene of a traumatic event. With that, we had what we needed to address the needs of children traumatized by violence in their homes, schools and communities.

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

In Delaware, the program's intention was to be implemented through one pilot school district in August 2019. Data was scheduled to be available in the fall of 2019, once multiple districts participate in the program. The goal was to begin the program in the five New Castle County School Districts in September. These five districts and the nine police departments in the New Castle County began completing trauma training. Unfortunately, because of the COVID-19 pandemic, school districts were overwhelmed and requested that we put the program on hold for the 2020/2021 school year. Districts are currently being trained or retrained again and we will begin the program in New Castle County at the start of the new school year in September 2021.

Once this is complete, Take Care Delaware will begin the process again of scheduling meetings with New Castle County Vo-Tech and Charter Schools, as well. COVID -19 has unfortunately slowed this progress as well. We look forward to establishing a partnership with DSP to support this effort in an attempt to address the social determinant of health impact on children who are exposed to violence in the home.

Although, we selected Adolescent Well Visit as well as Physical Activity in this domain, we will continue to monitor the mental health status of this population. We know that COVID-19 had an impact on the emotional well-being of our MCH population, so it is important that we maintain our efforts in this area until we understand magnitude of this issue.

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

This past year we began a partnership with the Cooperative Extension, University of Delaware, Health & Wellness

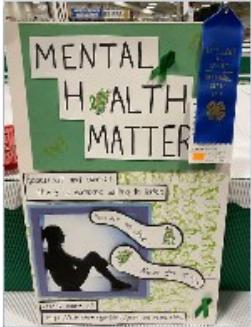
Ambassadors. U of D Health Ambassadors are a team of Teen Leaders and Adult Mentors who advocate for a holistic healthy lifestyle across the state. Health and Wellness Ambassadors are role models and official representatives and promoters who help plan and implement the Delaware 4-H Healthy Living Program aimed at improving the health of themselves, their peers, and their community.

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

Poor mental health in adolescence is more than feeling blue. It can impact many areas of a teen's life. Youth with poor mental health may struggle with school, grades, decision making, and their health. Unfortunately, because of the Covid-19 pandemic, we were unable to partner with our School Based Health Centers and Delaware school districts during the 2020/2021 school year. Our hope was to work with the School Based Health Centers and the school districts to promote teens who need emotional and mental health treatment. Our goal is to begin the partnership once again with the Department of Education and the school districts to promote a health messaging campaign to address mental health treatment.

Instead, we worked with the University of Delaware 4-H Department to sponsor a poster contest that promoted teens to seek emotional and mental health treatment, when needed. Unfortunately, there is oftentimes a stigma associated with mental illness, emotional disturbances and seeking treatment. The purpose was for youth and adolescents to know they can request assistance when dealing with mental illness – and not feel ashamed about it. Mental illness can affect a person's thinking, feeling, mood, or behaviors. Young adults should feel comfortable when asking for help when dealing with mental or emotional concerns and should never feel embarrassed. The University of Delaware promoted and advertised our emotional and mental health treatment poster contest via various avenues. In addition, it was also promoted through the U of D Health Ambassador monthly meetings.

All youth and adolescents ages 11 to 19, were encouraged to submit an original design that helped reduce the stigma associated with seeking treatment for mental illness. Posters were evaluated based on the following rules: provide a clear and understandable message in a concise format; easy to read; letters and words should be clear and legible; language used should be appropriate for age group; and the artwork must be the artist's original creation. The winning poster was determined by a panel of three judges, each of whom is a Program Health Treatment Coordinator within DPH's Maternal and Child Health Bureau (Home Visiting Program Administrator, CYSHCN Program Director and the Title V Coordinator/SSDI Project Director). The posters were each judged by clarity and visual appearance, the overall message, content and balance as well as the overall impact to make a contribution to the field. Our winning exhibit was a 13 year old girl from Seaford, Delaware.



One cash prize will be awarded by DPH to the first-place winner. We plan to share the winning exhibit, along with all entries, on our DEThrives website. We also have plans to advertise the exhibits on our other social media platforms as well. DPH would also like to pursue working with the winner's middle school to advertise the poster directly with the school. We feel this could also reach more adolescents who are struggling with seeking help for emotional or mental health concerns. MCH plans to work with our Adolescent Health Program Manager to expand the poster contest in the future by working with schools and School Based Health Centers. The prizes envisioned for this project will be all health related, such as a Fitbit or gym membership.

Physical Activity (ages 12-17)

The prevalence of obesity among Delaware adults doubled from 13 percent in 1992 to about 28 percent in 2007. Fortunately, the prevalence has been relatively level since 2007, staying close to 29 percent from 2007 through 2015. To address this major public health challenge, DPH promotes policies and systems changes, and implements programs and strategies in the following areas: Physical Activity, Health Eating and Obesity Prevention.

According to the 2018/2019 National Survey of Children's Health (NSCH), Delaware is among the lowest of its surrounding states when comparing the percentage of adolescents, ages 12-17, who are physically active at least 60 minutes per day. Additionally, 17.9% of Delaware's adolescents are physically active zero days per week. Although Delaware is the lowest of its surrounding states when it comes to adolescents being physically active every day, resting at 13.0%, this percentage has increased from 11.6% to 13.0% from the 2017/2018 to the 2018/2019 results. During our 2020 Needs Assessment, our stakeholders selected increasing physical activity among this population as the number one priority for this population domain and was ranked 5th overall.

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

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

Since April 2020, PANO has provided support to the Delaware Cancer Consortium, Cancer Risk Reduction Committee, Healthy Lifestyles Subcommittee (HLSC). In January 2020 the HLSC presented health and wellness

policy recommendations to the Office of the Governor. These 14 recommendations included policy recommendations for children and youth, and some policies identified impact the health and wellness of adolescents:

- Expand DELACARE regulations (Regulations for Early Care and Education and School-Age Centers) to family childcare homes and strengthen physical activity requirements across settings.
- Prohibit sugar sweetened beverages (SSBs) in Early Childhood Care and Education Centers.
- Preserve robust school nutrition standards, as defined in the 2010 U.S. Department of Agriculture (USDA) nutrition guidelines for school lunches and maintain flexible, healthy standards relative to consumption of sodium, whole grain, and milk.
- Strengthen the implementation of annual health related fitness assessment, reporting and compliance standards set forth in Delaware Department of Education Regulation 503 Instructional Program Requirements Section 5.0: Physical Education.
- Develop and implement out-of-school nutrition policies (before-school, after-school, sports).
- Propose and implement time requirement standards for elementary, middle and high school physical education and physical activity.

In August 2020, PANO released a Request for Proposals (RFP) for Advancing Healthy Lifestyles: Chronic Disease, Health Equity & COVID-19 (AHL). One objective of the AHL initiative is to support the next phase of implementation and planning for these policy recommendations.

AHL has four components: A) Project Facilitation; B) Coordinated School Health and Wellness; C) Community Capacity Building; and D) Workplace and Employee Wellness. Each component provides opportunities to implement evidence-based practices and programs that reach broad populations across the lifespan, however with a cross cutting approach that overlaps and interrelates with one another. Each component is designed to engage and support specific objectives of the initiative which will help develop a HLSC Action Plan and a AHL Strategic Plan for PANO (Component A), while connecting to partners in schools (Component B), the community (Component C), and the workplace (Component D).

In Component B of AHL, PANO facilitated a review of best practices for a mini-grant program in Delaware school settings. PANO convened school health stakeholders to discuss the possibilities of implementing a mini-grant program in the 2020-2021 school year. PANO facilitated these discussions to assess the then-current environment for facilitating school health and wellness policies, systems, and environmental (PSE) activities, in the context of the limitations and restrictions in place for the COVID-19 pandemic. Due to those challenges, it was determined not to pursue implementing a mini-grant program in Delaware schools for the 2020-2021 school year. However, plans were developed for ways to engage Delaware schools in PSE strategies to address health promotion and disease prevention initiatives in schools in the 2021-2022 school year.

In Component C of AHL, PANO worked with the contracted vendors to facilitate technical assistance (TA) to three community partners on the planning and implementation of their community-based interventions, all of which impact children and families. PANO worked with the American Lung Association (ALA), University of Delaware (UD), and Delaware State University (DSU) to provide TA on PANO-related interventions which include: an asthma self-management program to be offered to children in schools and/or in youth-serving organizations (YSOs); improving access to healthy, locally produced food in targeted communities; and, a three-pronged intervention for children with autism and their families that teaches water competency to prevent drowning, teaches parents skills to increase the healthfulness of family meals, and increases physical activity for this population.

DPH also partners with state agencies and community organizations to sustain community capacity building. These

efforts enable community-based organizations to achieve long-term and sustainable outcomes around health and wellness initiatives that support young Delawareans and the communities that care for them. PANO promotes PSE strategies and interventions through community-based initiatives such as the Lt. Governor's Challenge and the Community Mini-Grant program. The Lt. Governor's Challenge recognizes an Individual, Workplace, Community, Town/City/Neighborhood, or School for advancing the goals of a healthier Delaware in one of four focus areas: Emotional Well-Being; Healthy Living; Chronic Disease Management and Prevention; and Mother and Child Health. The Community Mini-Grant program awards grants to communities and organizations that exhibit a strong commitment to tobacco prevention and control programs and are enhancing or expanding access to physical activity and healthy eating opportunities for children, families, and communities.

MCH collaborated with PANO this past year during their Healthy Lifestyles World Café. MCH joined in their interest for exploring actions for Healthy Lifestyles. Along with other partners and stakeholders, MCH was willing to participate in important discussions during the World Café. The group engaged in a stimulating and productive series of discussions on the Policy Recommendations that emerged from the Healthy Lifestyles Subcommittee (HLSC) of the Delaware Cancer Consortium's Cancer Risk Reduction Committee (CRRC).

During the World Café, participants joined a modified version of a round-robin discussion. Rather than attendees moving from group to group, the moderators came to us. Each moderator brought a set of Policy Recommendations to consider, and the group commented on. During each discussion input on the priorities from each perspective was provided, as well as what each participant believed would lead to effective change. In addition, participants provided various resources and agencies needed to take action for impact.

The 2020 Lt. Governor's Challenge had over 40 nominations, with 7 final winners. The Lt. Governor's Challenge Virtual Reception was held on October 13, 2020 and recognized all 7 finalists, including 3 winners associated with Delaware youth. The Academia Antonia Alonso Charter School created a Compassionate Schools team consisting of faculty and staff to utilize best practices and initiatives to build a safe environment that nurtures inclusion, respect, and acceptance of diversity. POLYTECH School District developed an initiative that provided nicotine addiction education, resources, and cessation options rather than disciplinary consequences in classrooms where the most vaping incidents were occurring, to decrease the number of vaping students. Mr. Khayree Bey, Health teacher at McCullough Middle School, Colonial School District, implemented a program that teaches students yoga, mindfulness, conflict resolution, calming strategies, and self-awareness. These strategies were also provided to teachers, parents, and community members. PANO continues to partner with the Office of the Lt. Governor to support the 2021 Lt. Governor's Challenge. Dr. Karyl Rattay, director of the Delaware Division of Public Health was invited to participate in the first Lt. Governor Challenge Podcast in early April 2021. The Podcast topic was "COVID-19 & Healthy Lifestyles" and alignment with the overall Lt. Governor Challenge, HLSC recommendations, COVID-19 and the importance of healthy living. The 2021 Lt. Governor's Challenge officially launched mid-March 2021 with a special focus on COVID-19. Nominations opened April 1, 2021 and closed June 11, 2021. Although nominations are closed, PANO continues to encourage those who are using PSE strategies to make Delaware healthier to visit www.ltgovnorschallenge.org to learn more about the Lt. Governor's Challenge.

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

DPH also collaborates with the Tobacco Prevention and Control Program (TPCP) and the American Lung Association to facilitate a Community Mini-Grant program. The Community Mini-Grants award funding to schools, community-based, and youth serving organizations that conduct tobacco prevention programs, physical activity,

nutrition promotion and obesity prevention programs, or implement PSE changes related to tobacco and PANO. Grants are awarded to schools or organizations that exhibit a strong commitment to tobacco prevention and control programs in Delaware and enhancing or expanding access to physical activity and healthy eating opportunities for children, families and communities. Community Mini-Grant activities for the Fiscal Year 2021 (FY 21) were conducted October 2020 to May 2021. Likely due to the uncertainties and challenges of COVID-19, PANO observed that Delaware schools did not apply to participate in the FY 21 Community Mini-Grants program, for the first time in the history of the grant program. However, 29 Community Mini-Grants were awarded, with the majority of the grantees serving youth and families specifically. During FY 21, 43% of events and campaigns worked to prevent the initiation and use of tobacco, and 51% worked to reduce obesity through increased knowledge, skills, and behaviors of healthy eating and physical activity. In FY 21, grantees conducted 49 community groups (573 sessions), reaching over 5,000 individuals. These community groups included youth health promotion, health education, and tobacco prevention groups, with the most common type of community group reported as youth health promotion. Community groups reached a wide range of ages, with 39% reaching middle and high school students. Due to various restrictions and challenges of COVID-19 during this FY 21 grant year, organizations primarily conducted activities in a virtual setting.

DPH collaborates with the Delaware Department of Education (DOE) on coordinated school health and wellness initiatives. To support DOE physical education regulations on annual physical fitness assessment, reporting and compliance standards, we support the utilization and implementation of FitnessGram®, the physical fitness education and assessment tool, developed by the Cooper Institute. PANO continues to collaborate with the Cooper Institute to be able to provide physical education and physical activity resources to Delawareans in addition to providing technical assistance for FitnessGram® implementation, professional development, and training opportunities for Delaware educators, and provides online resources. PANO developed an online Tool Kit for FitnessGram® and physical education resources, available at www.deschoolpe.org, www.deschoolpe.com, and on the HealthyDelaware.org website (<https://fitnessgram.healthydewarre.org> and <https://www.healthydewarre.org/fitnessgram>). In partnership with the Cooper Institute, DPH hosted a FitnessGram® workshop session at the 2020 SHAPE Delaware Conference, held on October 9th: https://fitnessgramsoftwarehelp.files.wordpress.com/2020/09/de_onlineresources.mp4.

SHAPE is the professional Society of Health and Physical Educators. The Delaware SHAPE annual convention is designed to provide SHAPE members and health education professionals the opportunity to share instructional ideas with each other and learn from local and national subject matter experts. We are pleased to participate in the annual learning opportunity to support Delaware educators. PANO also hosted 2 professional development opportunities for Delaware educators, with OPEN, a public service entity of US Games and BSN SPORTS, a Cooper Institute Partner. These trainings: *FitnessGram in a COVID World* and *COVID 19: The Response and Future Resources*, were offered in May 2021. These web-based learning opportunities offered Delaware educators support in administering and assessing FitnessGram® in both hybrid and remote settings, with practical examples and resources, and a live Q&A.

PANO also continues to explore additional opportunities to support increased physical activity and healthy living. In Spring 2021, PANO provided DOE with the Coordinated Approach To Child Health (CATCH) Social-Emotional Learning (SEL) training system, which connects SEL to the physical education curriculum. This SEL CATCH curriculum is designed for students 4 years old to 14 years old, so all Delaware schools serving that population received this CATCH curriculum, including 62 middle schools.

DPH is also working with DOE to facilitate improved responses from schools for school health data surveys, including the School Health Profile (SHP), the Youth Tobacco Survey (YTS) and the Youth Risk Behavior Survey

(YRBS). The YRBS is a biennial (odd years) and anonymous student survey for students in grades 6-12 that provide data on student physical, emotional, and psychological health. Its statistics, charts, and other data report not only on student trends in physical activity, but also on texting and driving, drinking, vaping and drug use, bullying, social media use, and other behaviors. PANO continues to work with DOE to encourage participation in this survey in particular, as 2019 received a very low participation rate for the YRBS.

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

Adolescent Health - Application Year

Adolescent Health Application Year

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

Adolescent Well-Visit

According to the 2019 National Survey of Children's Health (NSCH), 24.3% of Delaware adolescents have had no preventive medical visit in the past year. This trend is decreasing as the 2018 NSCH shows 29.8% of Delaware adolescents had no preventive medical visit in the past year.

Delaware's School Based Health Centers (SBHCs) provide prevention-oriented, multi-disciplinary health care to adolescents in their public-school setting, and contribute to better outcomes related to selected priorities, NPM 1 Well Woman Care, NPM 8.2 Physical Activity and NPM 10 Adolescent Well Visit. There continues to be a growing interest for expansion to elementary, middle, and additional high schools, especially given the COVID-19 pandemic. School Based Health Centers are going through a paradigm shift, and there continues to be a large number of stakeholder interest and commitment to provide evidence based SBHC services based on national and in state innovations in practices and policies, to enhance the growing number of SBHCs in Delaware within the local healthcare, education, and community landscape.

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

The Delaware Division of Public Health (DPH), in collaboration with several key stakeholders, convened this past year to develop a Delaware School-Based Health Center (SBHC) Strategic Plan. The planning process was utilized to develop a model for expansion of SBHCs that was both financially sustainable and anchored in best practices. There were 13 goals established to include a comprehensive list of action items to ensure that SBHCs are responsive to the individual needs of Delaware's children — who, for a variety of reasons, may not otherwise have access to the health care system for critical health and wellness services.

The 13 goals of the plan include items, such as creating new SBHC sites where the need is greatest, establishing a new hub-and-spoke model for SBHC setup, fostering partnerships to increase the base menu of services, facilitating referrals to providers, adopting culturally linguistic appropriate services, increasing the capacity for telehealth, developing data collection infrastructure and analysis, establishing payer relationships and funding channels, and more. The plan will be governed by an independent body from public and private sectors, with a completion target date of 2025. The plan was developed to ensure that SBHCs are responsive to the individual needs of Delaware's

children — who, for a variety of reasons, may not otherwise have access to the health care system for critical health and wellness services. Next steps of the Strategic Planning process include publishing the Strategic Plan and Implementation and Evaluation Plan. We will also begin governance and implementation of the Plan as well as setting up a longer-term governance and accountability model to oversee implementation of the Plan and continued success of School Based Health Centers.

For the past 30 years, Delaware School Based Health Centers, located in 32 public high schools, have contributed to the health of the state's high school adolescents and have been an essential strategy to support individuals overall physical and mental health. Eventually, these young women and men will be our health consumers, so it is essential to support health and wellness during this critical period and coming of age. SBHCs provide at-risk assessment, diagnosis and treatment of minor illness and injury, mental health counseling, nutrition and health counseling and diagnosis and treatment of STIs, HIV testing and counseling and reproductive health services (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 most recent years there have been seven SBHC established in elementary schools with epilogue language from FY2020 expanding SBHC's in elementary schools at two per year in high needs elementary schools throughout the state. There are currently two additional elementary schools going through the process of certification.

In addition, Delaware's SBHCs provide important access to mental health services and help eliminate barriers to accessing mental health care among adolescents (i.e. women). Over the last couple of years, school district school boards voted and approved to add Nexplanon as a birth control method offered at 14 of the school-based health center sites. This is a major accomplishment being that each school district's elected school board members vote on and approve what services can be offered at each SBHC site. Offering the most effective birth control methods as an option, gives more young women informed choices so that they can decide when and if to get pregnant and ultimately reduce unplanned pregnancies.

Information about the SBHCs Strategic Plan will be posted on DEThrives social media channels. A handful of social media tactics have been developed which includes: a few Steering Committee Members answered questions and their recorded answers will be showcased as videos on the DEThrives social channels, the list of SBHC sites have been updated on the DHSS site and is also linked on the "dethrives.com/sbhc" webpage, press release and op-ed documents were created for public relation purposes, a strategy infographic was created for centers to post in their buildings, and a parent handout was created to help parents understand the services that are being offered. The goal is to launch these organic social tactics within the next month or so.

Our CDC assignee has been training and building capacity with our Management Analyst in the Bureau of Adolescent & Reproductive Health section to develop performance metrics, data quality audits, and reporting for School-Based Health Centers data submitted by medical sponsors. Our CDC assignee has also been reviewing YRBS and Delaware School Survey Data to inform surveillance strategies for socio-emotional health of adolescents. Our SBHC evaluation paper is now under publication. These data support the use of School Based Wellness Centers as a strategy to increase preventative well-visits, increase physical activity as well as support emotional well-being.

There is a Sexually Transmitted Infection (STI) campaign that is in the developmental process right now with Delaware Contraceptive Access Now (DE CAN) led by DPH's Family Health Systems', Reproductive Health Program Director and in collaboration with the STI Program Director. The goal of this campaign is to reveal the rising STI rates in Delaware, particularly the Chlamydia rates. The age range for this campaign is meant to target young adults aged 15-29 years old.

Unfortunately, because of the Covid-19 pandemic, we were unable to partner with our School Based Health Centers and Delaware school districts during the 2020/2021 school year. Our hope was to work with the School Based Health Centers and the school districts to promote teens who need emotional and mental health treatment. Our goal is to begin the partnership once again with the Department of Education and the school districts to promote a health messaging campaign to address well visits and mental health treatment.

We will continue our partnership with the Cooperative Extension, University of Delaware (UD), Health & Wellness Ambassadors for the upcoming grant cycle. Health Ambassadors are a team of Teen Leaders and Adult Mentors who advocate for a holistic healthy lifestyle across the state. Health and Wellness Ambassadors are role models and official representatives and promotoris who help plan and implement the Delaware 4-H Healthy Living Program aimed at improving the health of themselves, their peers, and their community. 4-H Healthy Living Program topics include nutrition, fitness, mindfulness, substance prevention and life skills. Their goals are to promote healthy lifestyle choices, create media about healthy living, participate in community outreach and education, asset building, education, and promotion, and to create and facilitate community change.

Our goal is to again work with the UD 4-H Department to sponsor another poster contest that promotes teens to seek emotional and mental health treatment, when needed. Unfortunately, there is oftentimes a stigma associated with mental illness, emotional disturbances and seeking treatment. The purpose will be for youth and adolescents to know they can request assistance when dealing with mental illness – and not feel ashamed about it. Mental illness can affect a person's thinking, feeling, mood, or behaviors. Young adults should feel comfortable when asking for help when dealing with mental or emotional concerns and should never feel embarrassed.

MCH plans to work with our Adolescent Health Program Manager to expand the poster contest in the future by working with schools and School Based Health Centers. The prizes envisioned for this project will be all health related, such as a Fitbit or gym membership.

Physical Activity (ages 12-17)

13.0% of Delaware adolescents, ages 12-17, are not physically active at least 60 minutes each day, when comparing to the national average of 16.5%. Delaware's adolescents who are physically active at least 60 minutes each day, 4-6 days per week, rests at 24.0%, while the national average is 27.3%. Although, NPM 8.2 is a newer priority, MCH has a long history of partnering with the Physical Activity, Nutrition and Obesity prevention (PANO) program In the Health Promotion Disease Prevention Section of DPH. MCH will continue to leverage this partnership to increase physical activity among adolescents.

The Physical Activity, Nutrition, & Obesity Prevention (PANO) activities for the August 2021 through July 2022 Application Year will be prioritized and streamlined, focusing efforts on key healthy lifestyle and chronic disease intervention areas impacting youth and the communities they live in.

Through the PANO Program's Advancing Healthy Lifestyles (AHL): Chronic Disease, Health Equity & COVID-19 initiative, PANO will continue to support youth health through AHL Component B: Coordinated School Health and Wellness activities. Incorporating input from educational stakeholders and partners, PANO has developed a workplan that outlines a school health and wellness strategy for FY 2022 (July 1, 2021 - June 30, 2022). PANO will identify and engage Healthy School Action Team (HSAT) members to involve them in AHL youth health and wellness efforts. HSAT membership will include school wellness champions, youth serving organizations (YSOs), like those that have before-and after-school programs (e.g. YMCA, Boys & Girls Clubs); organizations that address nutrition and healthy eating (e.g. Food Bank of Delaware); and community organizations that support healthy activities for

youth (e.g. First State Community Action Agency). Throughout the 2021-2022 school year, PANO will conduct regular (bi-monthly) meetings with HSATs at the county level. PANO will also be able to provide technical assistance (TA) and consultation to HSAT champions to develop projects for their schools or youth programs and determine outcomes. PANO will facilitate the first annual statewide HSAT meeting which will include, schools, YSOs, community partners, and state leadership. The purpose of the event will be to highlight the work of the AHL Component area to promote and educate participants on the importance of this initiative. The content of the meeting will include state and national data that supports the efforts, as well as subject matter expert panel discussions. PANO will also conduct a systematic review of evidence-based strategies and best practices that schools in Delaware and nationally, are doing to address childhood obesity, nutrition, and physical activity for students and school employees. Based on this review PANO will develop a white paper on coordinated school health and wellness to educate and inform state, school, and community partners on school health and wellness. PANO plans to compile this content into a resource (booklet or on-line tool) that will offer a menu of evidence-based school health policies, systems, and environmental (PSE) strategies; interventions that highlight the PSE changes; and resources required to implement strategies related to partners, costs, and materials.

In Component C of AHL: Community Capacity Building, PANO plans to continue working with contracted vendors to facilitate technical assistance (TA) to three community partners on the implementation of community-based interventions, all of which impact children and families. In 2021, PANO began working with the American Lung Association (ALA), University of Delaware (UD), and Delaware State University (DSU) to provide TA on PANO-related interventions which include: an asthma self-management program to be offered to children in schools and/or in youth-serving organizations (YSOs); improving access to healthy, locally produced food in targeted communities; and, a three-pronged intervention for children with autism and their families that teaches water competency to prevent drowning, teaches parents skills to increase the healthfulness of family meals, and increases physical activity for this population. In the fall 2021, PANO will work with these community partners to implement their project activities. The plan is to also engage at least one new community partner agency to provide TA for a PANO-related youth-serving project plan.

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

PANO will partner with other state agencies and community organizations to sustain Community Capacity Building. PANO will engage community partners who are primarily serving disparate or targeted communities, to develop strategies that address PANO related activities. These efforts will enable community-based organizations to achieve long-term and sustainable outcomes around health and wellness initiatives that support young Delawareans and the communities that care for them. PANO will promote policy, systems, and environmental (PSE) change strategies and interventions through community-based initiatives such as the Lt. Governor's Challenge and Community Mini-Grants. The Lt. Governor's Challenge recognizes an Individual, Workplace, Community, Town/City/Neighborhood, or School for advancing the goals of a healthier Delaware in one of four focus areas: Emotional Well-Being; Healthy Living; Chronic Disease Management and Prevention; and Mother and Child Health. The Community Mini-Grant program awards grants to communities and organizations that exhibit a strong commitment to tobacco prevention and control programs and are enhancing or expanding access to physical activity and healthy eating opportunities for children, families and communities.

The 2021 Lt. Governor's Challenge has received about 50 nominations, an increase from the 2020 Challenge, though several are duplicate nominations this year. The Lt. Governor's Challenge Review Committee will review nominee applications through August 2021 and announce the 2021 winners the 1st week of September. PANO will

host a virtual awards ceremony with the Lt. Governor on September 10, 2021. PANO continues to encourage those who are using PSE strategies to make Delaware healthier to visit www.ltgovernorschallenge.org to learn more about the Lt. Governor's Challenge.

Additionally, in September 2021, PANO will collaborate with the Tobacco Prevention and Control Program (TPCP) and the American Lung Association (ALA) to facilitate a Community Mini-Grant program. The Community Mini-Grants award funding to schools, community-based, and youth serving organizations that conduct tobacco prevention programs, physical activity, nutrition promotion and obesity prevention (PANO) programs, or implement PSE changes related to tobacco and PANO. Community Mini-Grant applications will be received in September 2021 and activities will be conducted October 2021 to May 2022. ALA will produce a report in July 2022 that will provide a summary of activities conducted over the course of the grant program.

PANO will continue to collaborate with the Delaware Department of Education (DOE) on Coordinated School Health and Wellness initiatives. Currently, DOE has state regulations on Physical Education which includes a requirement for annual physical fitness assessment, reporting and compliance standards. PANO will continue supporting the utilization and implementation of FitnessGram®, the physical fitness education and assessment tool developed by the Cooper Institute. PANO will also continue to provide technical assistance for FitnessGram® implementation, professional development, and training opportunities for Delaware educators, and keep the PANO-developed online resources and Tool Kit up to date and reflective of best practices from the Cooper Institute. As in FY 21, PANO will host at least one professional development training for Delaware educators to better inform and support FitnessGram®, implementation with OPEN, a public service entity of US Games and BSN SPORTS, a Cooper Institute Partner. PANO will also host a workshop or training session at the 2021 Delaware SHAPE Conference which is scheduled for October 8, 2021. SHAPE is the professional Society of Health and Physical Educators. The Delaware SHAPE annual convention is designed to provide SHAPE members and health education professionals the opportunity to share instructional ideas with each other and learn from local and national subject matter experts. PANO is pleased to participate in this annual learning opportunity to support Delaware educators.

For the 2021 - 2022 school year, PANO will collaborate with DOE to explore efforts to ensure students with special needs are included in the physical fitness assessment resources, and that adaptive resources are available for Delaware students. This may require additional tools that can supplement FitnessGram®, or it could mean a new process or system will be supported. PANO will work with DOE to make sure all Delaware students have access to physical education resources as needed.

PANO will continue to partner with DOE to facilitate improved responses from schools for school health data surveys, including the School Health Profile (SHP), the Youth Tobacco Survey (YTS) and the Youth Risk Behavior Survey (YRBS). The YRBS is a biennial (odd years) and anonymous student survey for students in grades 6-12 that provide data on student physical, emotional, and psychological health. Its statistics, charts, and other data report not only on student trends in physical activity, but also on texting and driving, drinking, vaping and drug use, bullying, social media use, and other behaviors. PANO continues to work with DOE to encourage participation in the YRBS in particular, as 2019 received a very low participation rate for the YRBS. The YRBS will be conducted in September 2021, so special efforts will be made in August 2021 to promote and educate DOE on the YRBS to increase participation this year.

DPH will continue to facilitate collaborative work efforts and interventions that address increased physical activity, mental health awareness, improved nutrition, healthier lifestyles, and information and resources for Delaware children and adolescents. MCH will continue to utilize DEThrives to engage and inform our adolescent population with up to date information pertaining to various needs and topics via social media posts, Facebook Instagram and

Twitter. Subjects pertaining to Adolescents, such as My Life My Plan Teen, Addiction, Mindfulness, Covid-19, School Based Health Centers, Anxiety and Depression, Mental Illness, Exercise, and more have been posted. In working with our partners, MCH will continue to use social media to promote adolescent health comprehensively. Social media messages will be developed around the importance of preventative well visits, healthy lifestyles and emotional wellbeing. We are currently working on revamping our DeThrives website and we will ensure these messages are present on the website as well. Our website will also include resources and links to available community programs.

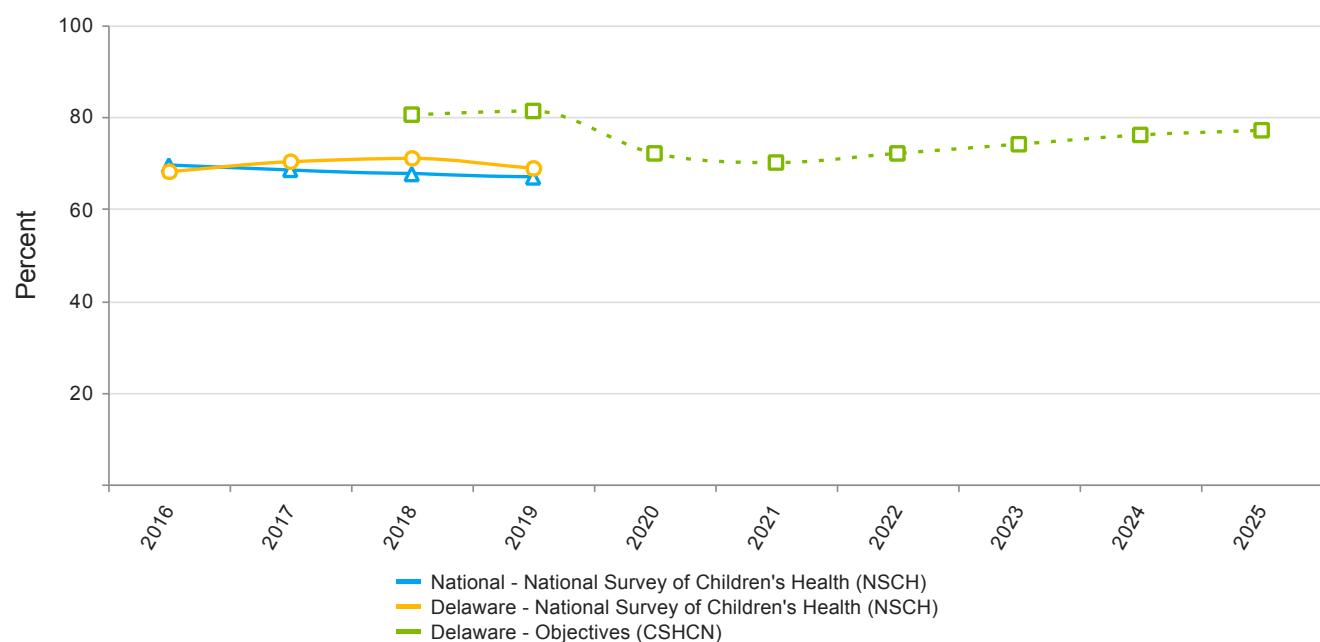
Children with Special Health Care Needs

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-2018_2019	15.7 %	NPM 11 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	54.6 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.5 %	NPM 11 NPM 15
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	NIS-2016	70.6 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	68.1 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	75.4 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.7 %	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-2019	89.0 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.5 %	NPM 11 NPM 15

National Performance Measures

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



NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			80.4	81.2	72
Annual Indicator		67.9	70.2	70.9	68.6
Numerator		137,974	142,861	144,257	138,831
Denominator		203,264	203,480	203,436	202,281
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

ⓘ 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	74.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures**ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid**

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			0	0
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Active		
State Provided Data			
	2018	2019	2020
Annual Objective			4
Annual Indicator		4	4
Numerator			
Denominator			
Data Source		MCH Program Data	MCH Program Data
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		90
Numerator		564
Denominator		627
Data Source		MIECHV Program data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	92.0	94.0	96.0	98.0	98.0

State Action Plan Table

State Action Plan Table (Delaware) - Children with Special Health Care Needs - Entry 1	
Priority Need	Increase the percent of children with and without special health care needs who are adequately insured.
NPM	
NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured	
Objectives	
By 2025, increase the percent of families reporting that their CYSHCN's insurance is adequate.	
By 2025, increase the number of health plans whose member services staff are linked to relevant family organizations and programs to meet the needs of CYSHCNs.	
Strategies	
Design, establish and implement the Cross-Agency Coordination Committee that will support the execution of the Title V/Title XIX Memorandum of Understanding.	
Support workforce development training for Title V staff and family organizations to ensure knowledge of insurance coverage options in the State of Delaware.	
Continue to be involved in the Complex Medical Needs Advisory Council lead by Medicaid to address needed services that Medicaid may or may not cover.	
Health Insurance Enrollment Outreach and Support for un-/under-insured families.	
Investigate providing care coordination to guide patients through supports with our family led organization.	
Develop and release a RFP that includes a set of benchmarks and indicators, specifically for Family SHADE that align with the Title V MCH Block Grant performance measures and the National Standards for CYSHCN and design a scorecard to track and measure progress.	
ESMs	
Status	
ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid	Active
ESM 15.2 - # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.	Active
ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants	Active

NOMs

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

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

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

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

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

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

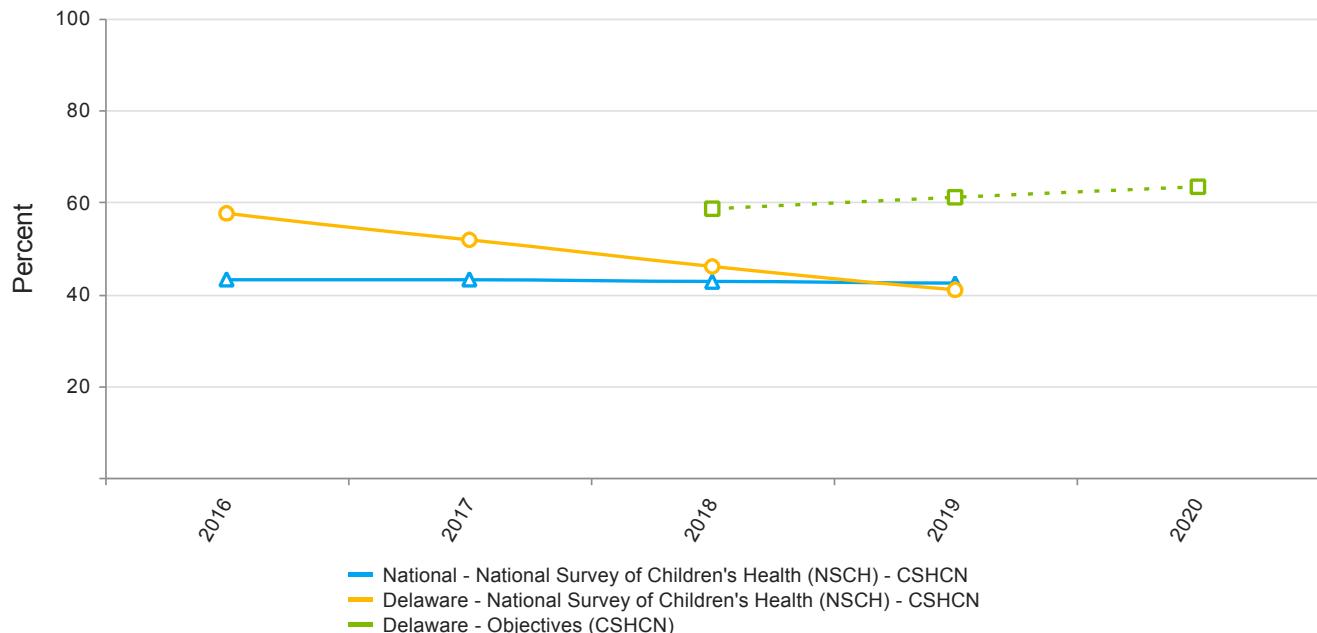
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

2016-2020: National Performance Measures

2016-2020: NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home Indicators and Annual Objectives



2016-2020: NPM 11 - Children with Special Health Care Needs

Federally Available Data

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

	2016	2017	2018	2019	2020
Annual Objective			58.5	61	63.3
Annual Indicator		57.4	51.7	46.0	40.8
Numerator		26,743	24,288	20,853	17,702
Denominator		46,594	46,973	45,379	43,419
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

① 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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	Family SHADE data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		No	0	0	0
Annual Indicator	No	No	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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	2018	2019	2020
Annual Objective		2	2	2	2
Annual Indicator	2	2	2	0	2
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			0	0
Annual Indicator			No	No
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Children with Special Health Care Needs - Annual Report

During calendar year 2020-2021, Delaware continued to serve Children and Youth with Special Health Care Needs (CYSHCN) through a collaboration of our parent lead organization-Hands and Voices/Guide by Your Side (H&V/GBYS) and our Statewide Programs for the Deaf, Hard of Hearing, and Deaf Blind and Delaware School for the Deaf as well as Family SHADE (Support and Healthcare Alliance Delaware). Our community partners serve our Deaf/Hard of Hearing (D/HH) population as well as all our children with special health care needs ages 0 through 17. H&V/GBYS has provided statewide services that consist of Learning Communities and Deaf/Hard of Hearing Mentorships for families of children and youth who are D/HH. Family SHADE promotes both of the efforts as well as promoting access to high quality health care, including having adequate health insurance that reduces barriers to primary and specialty care continues to be of most importance to women, children, and families to live their fullest lives. Family SHADE has a website as well as regularly monthly scheduled Networking Breakfast meetings which are held virtually now due to the COVID-19 pandemic. Family SHADE also distributes a Family Knows Best Survey (FKBS) on a quarterly basis to maintain awareness of the gaps in services throughout the state. The website and the FKBS make it feasible for families and professionals to access and share information on CYSHCN topics.

Although, not identified as a priority in the 2020 Needs Assessment process, we will continue to work on providing education and resources for providers, families, and family organizations around the need for and benefits of the medical home model for CYSHCN and their families. With increased knowledge of the subject, we hope to provide a consistent message that will ensure clear guidance to the family to aid in decision making and self-advocacy. Our parent lead organization-Hands and Voices Guide By Your Side (H&VGBYS) will promote the importance of medical home as well. These efforts have been supported through our Universal Newborn Hearing Screening and Intervention Program funded by the Health and Resources Services Administration. Family SHADE will continue to offer information at networking breakfasts as well as training sessions on topics that are requested by organizations serving CYSHCN and families of CYSHCN.

Through the Family Knows Best Survey (FKBS) and collaborative initiatives with organizations serving the CYSHCN population, Family SHADE has steadily begun to address the National Performance Measure 15, Adequate Insurance, which has been selected by our stakeholders as the most unmet need of families in Delaware communities.

Medical Home

Delaware has continued to work 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 HRSA. Under this program, we implemented Learning Communities which were led by parent lead organization Hands and Voices who has worked with families of infants who are Deaf or Hard of Hearing (D/HH). In calendar year 2020, Delaware's parent lead organization, Hands and Voices, successfully served these families and provided guidance on navigating the EHDI system of care in the state of Delaware.

Hands and Voices also provided information through dissemination of information and presentations to audiologists, otolaryngologists, neonatal nurses, neonatologists, physicians, early intervention providers, and teachers of children with hearing loss on the importance of securing a medical home and education on meeting the recommended 1-3-6 Timeline for an infant to receive their birth hearing screening by one month of age and if needed, enrolling the infant into Early Intervention Services with Delaware's Child Development Watch (CDW) program. Hands and Voices were selected and contracted to reconvene the Learning Communities. The Learning Community topics included: Medical Home and the Care Notebook and Joint Committee on Infant Hearing (JCIH) Recommendations: What 1-3-6 means to you. Due to COVID-19, the workshops were offered virtually to all 3 counties (New Castle, Kent, and

Sussex). The virtual Learning Communities were held during the day and in the evening to afford working families an opportunity to participate. Since the pandemic our Parents and professional's participation have increased. Hands and Voices continues to utilize a pre and post-test to participants to measure knowledge gained on the EHDI Program. Hands and Voices is also a partner organization of Family SHADE who assists with advertising the Learning Communities.

During the COVID-19 pandemic, many parents were hesitant to take their newborns to the hospital laboratories, for needed repeat screens. The Delaware Newborn Screening Program recognized four practices throughout the state who volunteered to collect repeat newborn screens on Delaware infants. They recognized the importance of the screening and quickly opened their practices to be collection sites for not just their own patients, but for any Delaware infant needing a screen. We applauded them for their efforts as we knew that implementing this change required a great deal of effort on their part. Each practice quickly reached out to the Newborn Screening Program to obtain supplies and shipping instructions, staff were trained in collection and rearranged scheduling protocols to take in any infant needing a repeat screen.

Family SHADE and Danio Diary were one of seven winning entrants in the first phase of the Health Resources and Services Administration's (HRSA) Care Coordination for Children with Special Health Care Needs Challenge, unfortunately, they did not make it to Phase Three. However, with their monetary winnings, they created a competitive Mini-Grant process. Through their competitive Mini-Grant process, three organizations were awarded \$1,000.00 which helped them enhance their current programs serving CYSHCN. The winners of the mini-grants were:

1. Art Therapy Express Program, Inc., they used their winnings and met with the Meadowood Program administration to provide creative arts therapy programming virtually. They were not able to do the arts therapy program within the schools like they initially envisioned, because there were several internal priorities within the school districts in calendar year 2020 due to the COVID-19 pandemic. In addition, they received a Delaware Relief Grant which also enhanced their Virtual Teaching through Visual Sensory Teaching with music and creative movement and dance. They also provided lesson plans to teachers and parents through Google Drive on Virtual Art Therapy Expression. They were able to Conduct Virtual Art Therapy Express sessions that ran from September 2020 - June of 2021.
2. The Down Syndrome Association utilized their grant money to help fund existing programming which included Down to Box - fitness programming. Due to COVID-19 this was done virtually since March 15, 2020 serving individuals ages 5-12 years of age. Also, Yoga and Cardio classes were implemented virtually as well for ages 13 and older as a transition to adulthood geared programming.
3. Nemours Alfred I. duPont Hospital for Children provided information and a safe space for young adults with special health care needs and their families to discuss and learn about sexuality and relationships. Through the creation of educational information (in the form of a trifold) that was accessible, age appropriate and targeted to the needs of the individual and caregivers. Also, they purchased carefully selected books to facilitate conversations within the family at home.

Due to COVID-19, Family SHADE had to rethink innovative activities to reach and serve CYSHCN due to their partner organizations adhering to the required self-isolation mandates. Therefore, the mini-grants allowed them to continue to serve CYSHCN as well as build capacity with their partners serving CYSHCN.

Family SHADE utilized the feedback from the board members and partners throughout the state to provide technical assistance and workshops for organizations serving CYSHCN, so that they are better equipped to serve CYSHCN in Delaware. One highlighted experience last year was the opportunity to offer their partners with a grant writing workshop. This workshop better positioned their organizations to compete for grant funding opportunities by providing grant writing workshops to their board members who managed large and small grassroot organizations. The workshops were such a success that additional workshops were scheduled virtually from August 2020 to

October 2020.

Throughout the year, Family SHADE provided virtual workshops that were selected by our partnering organizations and families of CYSHCN. Trainings such as:

- Delaware Assistive Technology Initiative (DATI). They help families find and try tools that support learning, communication, personal care, employment, and leisure. DATI raises awareness of assistive technology.
- Family SHADE also a Workshop on Delaware Readiness: Parent and Family Voices: Delaware Education and COVID-19. This served as a platform for Q&A for families that had questions specific to the pandemic.
- A workshop was held on How Community Health Workers Can Support Individuals with Complex Needs amid COVID-19 through the utilization of Better Care Playbook.
- Through Facebook and other social platforms, COVID-19 Related Stories for Schools – Autism Little Learners were implemented for the families.
- Through their partnership with Parent Information Center (PIC) of Delaware, virtual events were shared on Family SHADE's website. Topics on Early Childhood: Ideas for Home Learning, Coronavirus and Delaware Education Updates. These events were offered in both English and Spanish language.
- Family SHADE promoted DE Hands and Voices Learning Community, Topic: Stephanie Olson presented on fostering effective collaboration between parents and professionals across philosophies and communication methods. This training empowered families of Deaf/Hard of Hearing children to become advocates for their children and develop a partnership with their medical homes. This is one of several trainings that were promoted by Family SHADE.
- Easterseals provides workshops on respite services at the Family SHADE Networking virtual Breakfast meetings.
- Family SHADE created a series of Social Justice trainings in February of 2021. They were coordinated at the request of their partnering organizations and families. The Social Justice trainings came about due to the climate of the environment and the racial tensions in the United States.
- Diversity, Equity & Inclusion workshops were provided to partnering organizations and families that wanted to talk and express what they were feeling. Family SHADE coordinated a series of three workshops in the months of March and April of 2021.
- Childcare was an issue due to the COVID-19 pandemic. Family SHADE partnered with Childcare providers in the state and provided a Childcare workshop series in the month of June of 2021. The topics were specific to CYSHCN.

These topics were all coordinated with the input of organizations that serve the CYSHCN population and families that needed to participate in trainings on these topics so that they could enhance their quality of life for their CYSHCN overall wellbeing.

Family SHADE also worked with the Bureau of Oral Health and Dental Services (BOHDS) to expand their reach to the CYSHCN population by putting the BOHDS information on their Family SHADE website. This afforded families easy access to Dentist that were able to serve their CYSHCN. Having the BOHDS information on the Family SHADE website makes it more convenient for families to access the doctors that will best serve their CYSHCN and eliminate them calling each doctor to ask if they can serve their child.

Adequate Insurance

Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 30,231. According to the 2018-2019 National Survey of Children's Health (NSCH), 69.6% of Delaware children are adequately insured in comparison to the national average of 62.1%. This includes CYSHCN between the ages of 0 through 17.

Delaware chose Adequate Insurance Coverage as a key priority area based on the 2020 Needs Assessment final rankings. This issue was consistently ranked among the greatest concerns for our stakeholders throughout the Needs Assessment process. During the 2020 Stakeholder Survey adequate insurance coverage ranked 1st among the three issues directly linked to CYSCHN domain and 2nd when all 15 priorities were considered. Key Informant Interviews also expressed a strong desire to address this issue within the state.

Family SHADE utilizes the Family Knows Best Surveys (FKBS) for families of CYSCHN on a quarterly basis to get a pulse on what were the needs of the families caring for their CYSCHN between the ages of 0-21. The FKBS captures demographic information and information that is specific to the type of disability as well as insight on where there are gaps in services. In the most recent survey administered in March of 2021, the survey covered topics related to Knowledge and Awareness of COVID-19 Vaccine Information. They also included questions specific to adequate insurance. Below are some of the questions that were captured in the March of 2021 FKBS:

- Do you consider your child's health insurance coverage to be adequate to meet your child's needs?
- Have you tried to access information and resources related to the COVID-19 vaccine?
- Were you able to access needed information and resources about the COVID-19 vaccine?
- What are your sources of information regarding COVID-19 Vaccine?
- What were the barriers to accessing the needed information and resources relating to the COVID-19 Vaccine?
- Is your child eligible to receive the COVID-19 vaccine?
- What are your reasons for not wanting to have your child vaccinated?
- Is there any other information you would like to share in regards to resources and information available to you regarding the COVID-19 vaccine?

In an effort to align the FKBS with the states National Performance Measure 15 Adequate Insurance, Family SHADE has asked in each quarterly FKBS that has been administered on a quarterly basis the question which states: "Do you consider your child's health insurance coverage to be adequate to meet your child's needs?" This question is presented as an open-ended question in the FKBS where the person completing the survey can elaborate on their response. This feedback allows us to assess where the needs are in meeting the unmet need of adequate insurance in the state of Delaware.

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 met 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 beginning of every meeting a parent provided a presentation on her family's 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 a result of the Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity, several workgroups were put in place to continue progress. The COVID-19 pandemic impacted the approach of how Children with Medical Complexities would attain services due to the COVID-19 pandemic limiting accessibility to services. The pandemic impacted how families of children with medical complexity, in many cases would receive

daily nursing supports due to fears related to contracting the coronavirus and strict quarantine necessities due to the pandemic. On March 13, 2020, the President issued a proclamation that the COVID-19 outbreak in the United States constituted a national emergency. State Medicaid programs across the country, including Delaware, promptly made changes to their program to ensure the continuity and availability of medical care for their members. Delaware quickly made the following policy changes in response to the pandemic:

1. Waived all premiums
2. Kept Medicaid eligibility in place (i.e., paused Medicaid eligibility redeterminations)
3. Provided coverage for COVID-19 testing
4. Provided coverage of COVID-19 diagnosis, testing, and treatment during the public health emergency to non-residents
5. Extended all Prior Authorizations for 6 months
6. Waived all pharmacy copays
7. Relaxed early refill limits and limits on certain Durable Medical Equipment (DME) items
8. Changed status of hydroxychloroquine to require a PA unless the member was previously established on this medication for lupus, rheumatoid arthritis, and other autoimmune condition 6
9. Instituted telehealth using Zoom and telephonic audio only where appropriate
10. Suspended all provider revalidations
11. Allowed temporary enrollment in Delaware Medicaid for providers who are appropriately enrolled in other states' Medicaid programs

Children with medical complexity and their families faced unique challenges during the pandemic in calendar year 2020. In the April, July, and November CMCAC meetings, families provided their perspective on the toll of COVID-19. Parents communicated their feelings of exhaustion, fears of contracting the virus, concerns about services, DME, medication shortages, and concerns about the economic impact of the pandemic, among others. Parents also shared the difficulties they experienced day-to-day with coordinating service coverage and navigating public health guidance to prevent spread of the virus. The CMCAC meetings has provided an opportunity for members to hear the perspective of families and to provide updates on measures taken to address member and family needs during the pandemic. The pandemic also impacted the work of the CMCAC. State offices were closed for the majority of the year. With state staff and other CMCAC members working remotely, the group continued its meetings virtually. The CMCAC held its April, July, and November meetings remotely. The Skilled Home Health Nursing Work (SHHN) Workgroup also held its meetings remotely. Despite these challenges, the CMCAC and the SHHN Workgroup continued their work in the spirit of addressing the needs of children with medical complexity and their families.

As in years past, Title V supported a very important activity, 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 questions or discuss an issue. On the call are representatives from various agencies and organizations, such as Medicaid, private practitioners, Disability Law Program, and HMO representatives, to listen and help problem solve. These calls give families a non-adversarial venue discussion to share their concerns. These calls are offered in both English and Spanish. As a result, many families get a better understanding of how the system works and the providers and policymakers hear how a family is impacted by the rules and regulations.

Children with Special Health Care Needs - Application Year

Delaware estimates a population size of Children and Youth with Special Health Care Needs (CYSHCN) of 30,231. According to the 2018-2019 National Survey of Children's Health (NSCH), 69.6% of Delaware children are adequately insured in comparison to the national average of 62.1%. This includes CYSHCN between the ages of 0 through 17.

Delaware's Title V/Title XIX Memorandum of Understanding (MOU) will continue to establish the Cross-Agency Coordination Committee with our Medicaid partners. We reconvened our meetings with Medicaid to meet the needs of our MCH population with the data collected from the Title V Needs Assessment last year. Medicaid and the Division of Public Health (DPH) sees this as a fantastic opportunity to align quality improvement efforts with Title V MCH priorities to improve health outcomes for women, babies and CYSHCN. We have established this committee and we will continue to meet virtually and pending the results of COVID-19 pandemic will determine if we will begin to meet in person. The committee will work together to be creative in establishing training, messaging, case management, and procedures in promoting accessibility to adequate insurance coverage.

In Year two, Delaware will utilize Family Support Healthcare Alliance Delaware (SHADE) programmatic approach to extend family and professional partnerships at all levels of decision making to best serve our Children and Youth with Special Health Care Needs (CYSHCN).

Delaware's Title V utilized the Needs Assessment results to revitalize the approach in executing the Family Support Healthcare Alliance Delaware (SHADE) Program contracted with the University of Delaware. In preparation to the contract ending, with the University of Delaware, a competitive Request for Proposal (RFP) was created and administered in our state. The RFP was developed in alignment with the three National Performance Measures (NPM) that are specific to Children and Youth with Special Health Care Needs (CYSHCN) birth to age 21 population, who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

The three NPMs specific to CYSHCN are:

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

Delaware Division of Public Health will contract with a qualified organization to operate and manage the Family SHADE mini-grant project. The established Family SHADE Advisory Board will serve as the interconnecting hub of an alliance of organizations that serve families of CYSHCN. Through this governing ordinance that has been established within the Family SHADE Advisory Board, the execution of services to CYSHCN are not duplicative in services. This board and the leadership of Family SHADE contracted recipient will serve as the fiduciary agent and convener for the mini-grant project. The recipient will work to build state and local capacity, and test small scale innovative strategies to improve the overall systems of care. The primary focus is innovation and strategies to improve the Title V National Performance Measures and/or support the implementation of the standards for systems of care for CYSHCN through measurable outcomes.

Until the current contract comes to an end, Family SHADE will continue to utilize their board members and partners

throughout the state to provide technical assistance and trainings to better serve families of CYSHCN. Trainings that will better position their organizations to compete for grant funding opportunities by providing grant writing workshops to their board members who manage large and small grassroot organizations.

In 2021, Family SHADE coordinated an Emergency Preparedness Workshop. This workshop was a collaborative effort with the Delaware Department of Health and Social Services, Division of Public Health, Office of Preparedness and Sussex County Emergency Operations, the Developmental Disabilities Council, as well as the University of Delaware Center for Disabilities Studies. The workshop was designed to provide an overview of basic important steps which individuals and families, need to take to be better prepare for a variety of potential emergencies. Participants were encouraged to take the time to plan and prepare in advance. With this training, Individuals and families can help minimize the negative impact of unexpected emergencies or disasters, and improve one's personal level of resiliency, as well as the resiliency of our community.

Items that were included in the Emergency Preparedness Workshop:

- Methods for developing emergency plans that are sensitive to the unique needs of families, including those with children with special healthcare needs
- Steps to develop an effective family communication plan
- A description of the Delaware communication systems in place to support preparedness
- A review of methods to develop individual emergency kits and go-bags.

Family SHADE held a workshop on Nemours Transition Plan Program which provides services to children, especially those with chronic (ongoing) or complex medical conditions. Their transition care team can help make the switch to adults a lot easier for adult services. This training also assisted families and adolescents understand the services the Transition Team provides, such as with self-management skills like appointments, and understanding how to navigate their insurance. Making sure that they had adequate insurance to meet their health needs was a topic that was part of the discussion. Transition is a very important step in preventing interruptions in care as well as delays in necessary medications and tests.

We will continue to support the Family Voices Managed Care Calls in both Spanish and English as they continue to be a wanted resource. Family SHADE will continue to assist with advertising these calls to ensure families have access to Medicaid staff to discuss any issues they may have or address questions they may have about what services are covered.

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

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

- We will continue to keep the CMCAC in place.

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

While Preventative Dental Care Visits for Children and Adolescents/CYSHCN is not one of MCHs identified goals for the upcoming application year, our CYSHCN Director and Family SHADE will continue to work in collaboration with the Bureau of Oral Health and Dental Services (BOHDS) for the coming 2021/2022 year. The goal of the project is to promote and provide essential public health services to improve and promote preventative care and oral health for Children and Youth with Special Health Care Needs. Improving access to Dental Care for Delawareans with Disabilities will help the dental workforce provide more effective and culturally competent care to patients with disabilities. Through outreach, information dissemination, and education made available to pediatricians and dental practitioners, this collaborative will educate practitioners on best practices on serving the CYSHCN population. Delaware's BOHDS is currently in the process of creating, "Dental Tips for Scheduling a Dental Visit for People with Disabilities." They are also creating a Disabilities Fillable Form which a parent can use to capture all the information needed prior to scheduling a dental appointment with a dentist that will see their CYSHCN. Through this collaborative initiative we will explore the implementation of a Toolkit of resources for practitioners which will include a patient assessment tool, medical and physical evaluation tool, and other tools that will assist the practitioner in best serving CYSHCN.

Family SHADE will continue to work with the Title V Children and Youth with Special Health Care Needs Director to educate families of CYSHCN on the available medical insurance coverage that is available in Delaware through innovative approaches such as Zoom meetings, emails, mail distribution and through the distribution contact list of partnering agencies that serve CYSHCN.

The Work Plan for 2020 Family SHADE/Title V will continue to be implemented and enhanced once a new vendor is selected to execute the Family SHADE project. The Work Plan consists of the following:

- Families of children and youth with special health care needs (CYSHCN) will have access to the community-based services that they need.
 - 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.
 - Improve access of CYSHCN and their families to information, resources, and services.
 - Support an improvement in the infrastructure, capacity, and effectiveness of services of Family SHADE member organizations.
- Improve the health and access to health care of CYSHCN in Delaware.
 - Family SHADE will implement their recently completed Strategic Plan which will align with the Delaware Division of Public Health, Maternal and Child Health Bureau's identified Domains and National Performance Measures.
 - Increase the knowledge of families of CYSHCN about medical insurance, medical homes, and access to healthcare in Delaware.
 - Increase access of CYSHCN to healthcare by providing families with information about insurance options for CYSHCN in Delaware.
 - Assist Delaware MCH in addressing cross-cutting priorities which also meet the needs of CYSHCN

and their families.

- Delaware CYSHCN and their families will be better prepared for the transition to adulthood.
 - Connect Youth with Special Health Care Needs and their families to information about transition to adult life including health care services and systems.
- Enhance the role of the Family SHADE program to include educating governmental entities and others regarding recognized gaps in services and family support to CYSHCN 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.
 - On the Family SHADE website, a Roadmap is now featured on every landing page of the website and includes information about medical home/insurance.

Additionally, while we have not chosen to continue the Medical Home National Performance Measure for CYSHCN for the upcoming application year, we will continue to pursue avenues of improvement for this population and will leverage work under the adolescent domain to address preventative well-visits for adolescent with special health care needs. We will also be developing messaging on what a medical home is and the importance of a medical home. Work will also continue to promote the developed care coordination notebook for families to help promote medical home and care coordination for CYSHCN. Specifically, through contracts with Hands & Voices Chapters a care coordination handbook was modified for families with children who are deaf or hard of hearing. 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.

Throughout the year we will continue to use the Family SHADE Families Know Best (FKB) 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 three, 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.

Cross-Cutting/Systems Building**State Performance Measures**

SPM 3 - Strengthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68
Numerator		17
Denominator		25
Data Source		FHS Data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	75.0	75.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Delaware) - Cross-Cutting/Systems Building - Entry 1

SPM

SPM 3 - Strengthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Objectives

Build MCH capacity and support the development of a trained, qualified workforce by providing professional development opportunities.

All MCH staff will have at least one professional development goal annually included in their performance plan.

Strategies

Develop a system to capture increases in MCH staff completing training such as the MCH navigator self-assessment.

Incorporate MCH competencies more intentionally into MCH position descriptions and performance plans.

Incorporate health equity, disparities, and cultural appropriateness/competence concepts into all workforce development activities.

Deliver annual training and education to ensure that providers can promote diversity, inclusion, and integrate supports in the provision of services for the Special Health Care Needs population into adulthood.

Cross-Cutting/Systems Building - Annual Report

Even though workforce development was not a formal priority, we have been focused on improvement and ensuring staff have the resources they need to feel confident in the job they are doing. However, we feel accountability is needed to ensure a more intentional approach as well as the ability devote resources and capacity to our community partners.

Training and development of our workforce is one part of a comprehensive strategy to improve the competence of, and services delivered by the Delaware Division of Public Health (DPH). Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the assessment of the employee's individual needs and addressing those gaps through targeted training and development opportunities.

It's important to note that not all learning occurs in a classroom or on an electronic device. Learning can be as simple as a supervisor observing an employee performing a task and offering suggestions on how to improve that performance (i.e. on-the-job training). It can occur during staff, one-on-one, and, performance feedback meetings, or by reading an article in a professional periodical and putting the concepts to work on the job. Supervisors can also facilitate learning by adding a Professional Development section to employees' Performance Plans. Working together on this will help employees focus on his/her training goals and establish a more productive working relationship. To keep track of this, employees can use the [DPH Personal/Professional Development Plan](#), as a tool to help them and their supervisors, develop goals and document uniquely tailored training needs and experiential learning exercises to expand their knowledge, skills and abilities to provide the best service possible to the citizens of Delaware.

In October 2018, 30 MCH staff members from across the Division of Public Health participated in a two-day training on *FranklinCoveys 7 Habits of Highly Effective People*. Our workforce gained hands on experience, applying timeless principles that yielded greater productivity, improved communication, strengthened relationships, increased influence, and laser-like focus on critical priorities.

All staff that participated in the training, have a 3 year All Access Pass to the entire *FranklinCovey* Library. The All Access Pass was designed to help organizations achieve strategic initiatives, develop leaders, and build skills and capabilities across the organization in a completely nimble and flexible way that helps them overcome those challenges - all at the very best value. With access to *FranklinCovey* courses, assessments, videos, tools, and digital assets, we can utilize the content in a wide variety of ways and across multiple delivery modalities to best meet the needs of our organization. MCH has begun to refamiliarize ourselves with the All Access Pass to the *FranklinCovey* Library as we start returning to the office. We feel that prompting our leaders with the trainings and videos that are available to us, will awaken the spirit of developing leaders and further build their skills. Because the courses are offered in formats that are convenient to participants and on a schedule that is most convenient to them, we feel the continued education will reenergize our leaders. Our Title V Deputy Director has spoken with the *FranklinCovey* expert assigned to Delaware to discuss the needs of our MCH staff and programming that might be beneficial.

We were in the process of coordinating our annual MCH Retreat, which was to be held in May 2020. Our retreat theme was "Vision for a Healthy Community" and some of our meeting outcomes were to focus on DPH Strategy Priorities: Healthy Lifestyles, Health Reform, Performance Management, Substance Abuse Prevention, and Health Equity. Unfortunately, this event had to be canceled due to the pandemic. We were able to conduct some of the activities that were planned for this retreat earlier this year. We moved office locations in May 2021, so we decided to do an "open house" where staff could pop in at different times to participate in activities including training. We provided access to some *FranklinCovey* modules related to change management which was very relevant to our current work environment due to moving office location as well as the pandemic.

We were able to reschedule our teambuilding event was Painting with a Twist this past May. Our aim was to inspire action that sparks creativity, uplift spirits and improve teamwork, the way our section operates and the way our staff interacts and communicates. We had most of our staff members participate, from administrative to leadership roles, all contribute to two murals that now hang in our conference room. Each mural has a tree, one tree represents spring/summer and the other represents fall/winter.

The strengths of the MCH leadership and core team lie in our depth of professional experience, educational background, and passion for the work. Therefore, we feel that it is in our best interest to pursue a collaboration with the Office of Performance Management to identify the training needs of MCH staff. Together OPM and MCH could develop a training plan that would strengthen Title V staff's capacity for data-driven and evidence-based decision making. Especially due to the pandemic, virtual and/or hybrid trainings would be afforded to each participant.

As part of the Governor's Trauma-Informed Care initiative, DHSS required every employee to complete the online course titled: DHSS Trauma Informed Awareness Training. This training is also part of the New employee/supervisor curricula for future new hires. DHSS Trauma Informed Awareness Training examines the pervasive effects trauma has on individuals, families and organizations. Trauma results from many experiences such as an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects. Many DPH programs are considered trauma informed, some sections have no idea about the impacts of trauma on our clients, patients and co-workers, therefore, the Governor's initiative is that we all become trauma aware.

Cross-Cutting/Systems Building - Application Year

Having a well-prepared work force is critical to meet the maternal and child health needs of the people of Delaware. Having a committed, empowered workforce, with a wide-range of expertise, is necessary to create a resilience-oriented, trauma-informed system of care. As part of our Five-Year Needs Assessment, MCH conducted a Workforce Capacity Analysis where the objective was to identify Delaware's Title V program capacity, including the organizational structure, agency capacity and MCH workforce capacity.

Delaware partnered with John Snow Inc. (JSI) to facilitate and analyze our Workforce Capacity Analysis. An online survey was the source of the information. A sampling frame consisting of leaders, from state government (primarily from the Delaware Division of Public Health) and other key organizations (non-profits, hospital, university, consulting firm) was created. The analysis addressed the following questions:

- Among the Delaware MCH leadership, what is the focus of their current work and what are their related training needs?
- To what extent does Delaware MCH leadership serve as supervisors and how do they currently develop staff?
- For MCH leadership, what do they believe are the essential/critical skills needed in their workforce? Do they think their workforce needs more training/development in these areas?
- In what ways is staff training currently operationalized? Do these ways seem sufficient to address the articulated workforce development areas?

Delaware's MCH leaders have multiple complex responsibilities, and yet they are also open to learning new skills, especially in the areas of leadership and knowledge of the practice. They recognize a need to learn how: to balance the needs of diverse stakeholders, to find evidence, to learn quality improvement methods, and to understand health disparities and Culturally and Linguistically Appropriate Services in Health (CLAS) education and outreach.

Leaders are also concerned with staff development and succession planning. They prioritized workforce skills around program evaluation and data literacy. They also prioritized systems thinking and change management, as well as cultural competence. The expectation is for multidisciplinary teams to have all these skills. In a team approach, it could be that staff with technical skills regarding evaluation and analysis are able to understand the context in which their results will be used, effectively collaborating with systems thinkers and leaders on the team. Similarly, systems thinkers and leaders will be able to use information and data to enact change and will be able to collaborate with the analytic thinkers on the team.

Particularly for leaders themselves, but also for the workforce, on the job training is desired. Yet mechanisms for this approach may not be as strong as for formal training. Figuring out ways to carve out time for both the trainer and trainee will be important; or perhaps new modes of training that hybridize formal and, on the job, methods could be developed. Finally, more work needs to be done to communicate and fully incorporate resilience oriented/trauma-informed care into leaders' and their staff's work.

Other internal DPH workforce development opportunities include our Office of Performance Management, which has created a comprehensive workforce development plan outlining DPH training goals and objectives, as well as resources, roles and responsibilities related to the plan's implementation. With regard to specialized cultural and linguistic competency training, DPH offers in-house training opportunities. In addition, DPH offers training opportunities through a collaborative agreement with Johns Hopkins Bloomberg School of Public Health/Mid-Atlantic Public Health Training Center.

DPH staff are also afforded the opportunity to advance their skills through the DE TRAIN Learning Network. DE TRAIN is an affiliate of the TRAIN national learning network that provides quality-training opportunities for professionals who protect and improve Delaware's public health. This is a free service funded by Delaware Public

Health's Emergency Medical Services and Preparedness Section (EMSPS) in partnership with the Public Health Foundation Training.

The most recent Performance Plans for all staff members in the MCH Bureau, include a professional development goal of completing a minimum of 15 hours of training annually. The Performance Plans specifically state to use either the *FranklinCovey* or MCH Navigator platforms. Performance Plans are reviewed annually, however supervisors meet with staff 1:1 regularly to provide support, coaching and feedback related to performance.

We are currently planning a training series through *FranklinCovey* titled 6 Critical Practices for mid-level managers and above. This program equips first-level leaders with the essential skills and tools to get work done with and through other people. The program is ideal for new first-level leaders who need to transition successfully from individual contributors to leaders of others. However, this program also applies to leaders who have been in their roles for some time and are looking for practical and relevant guidance on how to effectively lead and manage their teams.

FHS leadership will continue to work with staff internally to develop annual training plans and support staff in prioritizing professional development and identifying strengths and weaknesses. On the Job training was the preferred method to formal training however, in the current environment we are not sure this format will be the most practical. The FHS leadership team will be discussing this at future leadership meetings. We will also working with our key partners to determine when and what training and/or professional development they would like to see how us offer this coming year.

III.F. Public Input

Input following submission of Delaware's Fiscal Year 2021 Application / 2019 Annual Report.

In 2020, we solicited input from professional partners, stakeholders and the public by posting our FY21 Title V application on our website, <https://dethrives.com/title-v>, a website that serves as the hub for information on many maternal and child health efforts in Delaware. The proposed Title V, Five-Year Action Plan and selected priorities were also posted online for review on <https://dethrives.com/title-v/2015-needs-assessment-information>. The website is available to everyone, including stakeholders, partners 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. Family SHADE also holds monthly virtual 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. 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.

Input to FY22 Application

The Delaware Title V Maternal and Child Health (MCH) team is committed to collecting input throughout the year and works in partnership with local agencies to assess and identify needs and priorities. Delaware's MCH team attends webinars, is present at community meetings, joins advisory groups, attends conferences, presents at events, and more. This is to guarantee Title V obtains available data and to ensure that Title V is always at the table.

The Title V team recognizes the need for Delaware to seek and obtain a broad spectrum of input and obtained many voices throughout the Title V application year – men, women, families, stakeholders, MCH workforce, partners, health experts, advisory boards, and more.

Delaware partnered with Forward Consultants for our ongoing Title V Mini Needs Assessment process. MCH intensely worked with Forward Consultants to modify our 2020 Needs Assessment Professional Stakeholder Survey. Our finalized objectives for our Mini Needs Assessment were:

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

Part of this survey included additional questions for our Title V Partners of the various ways Title V is able to provide technical assistance. The Division of Public Health (DPH) coordinates and collaborates with many organizations and other state agencies to implement activities that address grant goals and objectives. Title V was concerned about how we can better support our partners. We asked for various ways Title V could provide technical assistance to our partners to be better responsive to their needs. We listed the different ways Title V could provide technical

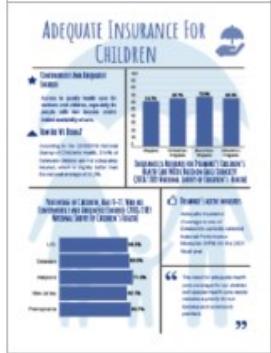
assistance and requested they rank their most pressing needs. We supplied examples such as:

- Provide data
- Assist with data to apply for resources
- Strategic planning
- Disseminate information via social media outlets
- Guide a grant writing process

Our Professional Stakeholder Survey for our Mini Needs Assessment was ultimately distributed to more than 950 partners and stakeholders of MCH service agencies, organizations, coalitions and programs for input on MCH population needs, the impact of the COVID-19 pandemic, and technical assistance needs. The survey also provided stakeholders an opportunity to rank the 15 national priority areas as a result of the pandemic on their organization. Unfortunately, because our partners continue to work through the pandemic, responses were not as robust as we had originally hoped. Even after repeat requests, only a fraction of responses were received.

In the field of technical assistance, we learned that our Title V funded partners ranked “provide data” as either the first or second choice by 60% of Title V partners. Conversely, assistance with strategic planning was considered to be the first or second most important need to be addressed by only 20% of Title V partners. Therefore, during this upcoming year, our SSDI Project Director will work with our CDC Epidemiologist to continue with a previous goal identified prior to the pandemic. We will pursue including data relevant to the MCH population on the State Action Plan Snapshot created for our partners last year (described below). Our intentions will be for our partners and stakeholders to be able to view Delaware’s data in one document. This will also include previous year’s data, so our partners can track the information from year to year. We understand that we may face additional challenges that might rise, such as repetitive display of data, partner agencies not allowing us to use the data publicly, and obtaining the perfect conduit for partners accessing the data. In the future, Title V may pursue an app for our Title V information. We feel that our partners, stakeholders and the general public will be in favor of having Delaware’s data readily available via an application on their cellular device. We believe finding all maternal and child health resources in one place would be beneficial to their work. Our plan will be to begin with obtaining and displaying the data on our colorful State Action Plan Snapshot first, and then we will research pursuit of an app.

Through our 2020 Needs Assessment process, MCH created detailed and specialized Health Infographics for each of the 15 National Performance Measures. The aim was to provide our stakeholders and partners with a snapshot of Delaware’s health status as it related to each measure. Information such as Delaware’s goals and objectives, Delaware’s baseline data, how Delaware compares to our neighboring states as well as nationally, and more. This year, MCH amended these Health Infographics once the 2019 and 2018/2019 NSCH data was released. Below is a picture of one of our Health Infographics. All of our Title V and Needs Assessment information, including our health Infographics, is found in one central location, our DEThrives website (<https://dethrives.com/title-v>). We encourage all of our stakeholders and partners to check back often for updated information and resources.



As part of the Title V Maternal and Child Health (MCH) Block Grant, Delaware has developed another graphic for our partners to use as an additional resource. This colorful snapshot is a glimpse of Delaware's Title V, five-year State Action Plan to address our priority needs. Our Plan is organized by the six reporting domains, which includes five MCH population domains (Women/Maternal Health, Perinatal/Infant Health, Child Health, Children and Youth with Special Health Care Needs (CYSHCN), and Adolescent Health). The sixth domain addresses state-specific Cross-cutting/Systems Building needs.

This State Action Plan offers an at-a-glance snapshot for the public, our partners, and our stakeholders to better understand our five-year plan. This report identifies the priority needs within each of the six domains, the program objectives, key strategies and relevant national and state performance measures for addressing each objective. Provided below is a picture of our colorful State Action Plan that can be utilized by our partners.



The following email was sent by the Title V Coordinator to partners and stakeholders statewide regarding our completed Needs Assessment process, selection of National Performance Measures, public comment period and our five-year State Action Plan.

Maternal & Child Health (MCH) Community Stakeholders:

As you are aware, the Division of Public Health's (DPH) Maternal & Child Health (MCH) Bureau has completed our Title V 2020 Five-Year Needs Assessment process. The Needs Assessment helped us gain an accurate and complete picture of the strengths and weaknesses of our public health system, informed our priorities and helped us to understand the gaps to meet the needs and improve maternal, child, family and community health concerns. We were looking to identify findings, such as Delaware's population health status, the Title V program capacity (organizational structure, agency and MCH workforce capacity), and Delaware's partnerships, collaboration and coordination. This process helped MCH establish our priority needs 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.

Throughout our Needs Assessment process, we reached out to you, our valuable community partners and stakeholders, to help us identify the priorities in the health of mothers, children and families in Delaware. You participated in our Stakeholder Survey, Key Informant Interviews and/or our Workforce Capacity Analysis. Thank you for your participation! The input you shared was invaluable and we appreciate the time you provided to assist us during our Needs Assessment process.

In an effort to for continued involvement, we're happy to report that we've recently submitted our Title V application to the Health Resources & Services Administration (HRSA). As part of the application process, we'd like to have an open public comment period. We're looking to solicit your feedback on the Title V application. Please reach out with comments, suggestions, questions or updated information.

As part of the Title V MCH Block Grant, Delaware developed a five-year State Action Plan Snapshot to address our priority needs. Our Plan is organized by six reporting domains, which includes five MCH population domains (Women/Maternal Health, Perinatal/Infant Health, Child Health, Children and Youth with Special Health Care Needs (CYSHCN), and Adolescent Health). The sixth domain addresses state-specific Cross-Cutting/Systems Building needs. This State Action Plan offers an at-a-glance snapshot for the public, our partners, and our stakeholders to better understand our five-year plan. This report identifies the priority needs within each of the six domains, the program objectives, key strategies and relevant national and state performance measures for addressing each objective.

This State Action Plan Snapshot, our Title V application, and all other Title V information can be found in one central location, our DEThrives website, <https://dethrives.com/title-v>. We encourage you to download a copy of the Snapshot and share with your partners.

Again, if you have any comments or questions, don't hesitate to reach out. We'd love to hear from you.

As in years past, other stakeholders are contacted by MCH for input and feedback through various meetings, conferences, surveys, and other community activities. Our stakeholder involvement and input has been taken into consideration as our team began to prepare for the FY22 application. Our Domain Leads have made it a practice to keep in mind our Title V strategies as they take on new projects and activities with their partners, ensuring alignment where possible.

Family SHADE, our partner supporting our CYSHCN program, continues to engage parents and families through the Families Know Best surveys. Family SHADE previously reached out to their voluntary parent advisory group to see what their needs and concerns were during the beginning stage of the COVID-19 pandemic and then again as Delaware phased out of the stay at home orders. Information gained through these ongoing surveys is typically shared during membership meetings as well as with other organizations, policy makers and agencies statewide. In addition, all survey information is used to inform the direction of the work for the CYSHCN population.

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 questions or discuss an issue. On the call are representatives from various agencies and organizations, such as Medicaid, private practitioners, Disability Law Program, and HMO representatives, to listen and help problem solve. These calls are offered in both English and Spanish. As a result, the providers and policymakers hear how a family is impacted by the rules and regulations.

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

All our Title V information is found in one central location, our DEThrives website. <https://dethrives.com/title-v> Here MCH has all the detailed Title V information, including our FY21 block grant application, Delaware's Five-Year State Action Plan, infographics on each of our 15 NPMs, a framework of the Needs Assessment process, reports on our Focus Group studies, results of the Stakeholder Survey and more. We encourage families, partners and stakeholders to check back often for updated information and resources and to reach out with any questions.

Following the submission of our FY22 Block Grant application, we plan to post the documents on our website. At that time, we will again solicit feedback and input into our Title V block grant application. Any major adjustments that are suggested will be documented for future consideration as the TVIS system will not be opened again after the submission of our application.

III.G. Technical Assistance

Delaware is laser focused on transforming several initiatives to improve maternal and infant health outcomes and demonstrate impact and progress using a performance-based approach. Examples of such initiatives include:

- Healthy Women, Healthy Babies 2.0 program and transitioning towards a performance-based model incentivizing providers for reaching and exceeding several benchmark indicators, and
- Healthy Women Healthy Babies Zones, state demonstration projects concerned with matters regarding the social determinants of health for infants and women of childbearing age, through comprehensive place based interventions managed and coordinated by a backbone agency, using a collective impact framework.
- NEW—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.

DPH will be looking for technical assistance in the development of a statewide focused set of benchmarks and indicators, specifically for Family SHADE that align with the Title V MCH Block Grant performance measures and the National Standards for Children and Youth with Special Health Care Needs (CYSHCN) and design a scorecard to track and measure progress (i.e. <http://cyshcnstandards.amchp.org/>). Delaware is interested in funding small community based demonstration projects, focused on any of the six quality indicators of a system of CYSHCN services (i.e. family professional partnerships, adequate insurance and financing, medical home, early and continuous screening and referral, easy to use services and supports, and transition to adulthood). In addition, DPH is looking for any evidence based or promising approaches and contacts in other states that have been implemented community based interventions to improve the system of services for CYSHCN that focus on the principles of family centered, community-based, and a coordinated systems of care.

Additional technical assistance is also requested to assist with any workforce development strategies and professional development training that is available to support our Maternal and Child Health team of professionals and partners. To assist with skill building and meeting the MCH core competencies, it would be helpful to know of MCHB training opportunities that are available for state MCH professionals.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - [Executive Summary.pdf](#)

Supporting Document #02 - [MCH Resources and Links to Publications_Supporting Docs.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [2021 Organizational Chart.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Delaware

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		\$ 2,042,781
A. Preventive and Primary Care for Children	\$ 619,520	(30.3%)
B. Children with Special Health Care Needs	\$ 660,500	(32.3%)
C. Title V Administrative Costs	\$ 145,655	(7.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)		\$ 1,425,675
3. STATE MCH FUNDS (Item 18c of SF-424)		\$ 9,957,273
4. LOCAL MCH FUNDS (Item 18d of SF-424)		\$ 0
5. OTHER FUNDS (Item 18e of SF-424)		\$ 0
6. PROGRAM INCOME (Item 18f of SF-424)		\$ 2,053,906
7. TOTAL STATE MATCH (Lines 3 through 6)		\$ 12,011,179
A. Your State's FY 1989 Maintenance of Effort Amount \$ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)		\$ 14,053,960
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)		\$ 9,974,592
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)		\$ 24,028,552

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 139,652
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 7,466,240
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,033,700
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000

	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,993,981	\$ 2,027,826
A. Preventive and Primary Care for Children	\$ 599,064 (30%)	\$ 614,754 (30.3%)
B. Children with Special Health Care Needs	\$ 660,386 (33.1%)	\$ 650,311 (32%)
C. Title V Administrative Costs	\$ 161,830 (8.1%)	\$ 145,655 (7.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,421,280	\$ 1,410,720
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 10,287,704	\$ 10,287,704
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)	\$ 2,973,146	\$ 2,973,146
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 13,260,850	\$ 13,260,850
A. Your State's FY 1989 Maintenance of Effort Amount \$ 5,679,728		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 15,254,831	\$ 15,288,676
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 6,162,044	\$ 6,162,064
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 21,416,875	\$ 21,450,740

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 145,870	\$ 145,870
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 4,005,571	\$ 4,005,571
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,100,000	\$ 1,100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 248,000	\$ 248,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 426,475	\$ 426,475
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 136,128	\$ 136,148

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts: None

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

State: Delaware

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 421,097	\$ 421,097
2. Infants < 1 year	\$ 0	\$ 0
3. Children 1 through 21 Years	\$ 619,520	\$ 614,754
4. CSHCN	\$ 660,500	\$ 650,311
5. All Others	\$ 196,009	\$ 196,009
Federal Total of Individuals Served	\$ 1,897,126	\$ 1,882,171

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 2,452,369	\$ 2,452,369
2. Infants < 1 year	\$ 2,486,969	\$ 2,486,969
3. Children 1 through 21 Years	\$ 501,436	\$ 501,436
4. CSHCN	\$ 501,436	\$ 501,436
5. All Others	\$ 1,867,369	\$ 1,867,369
Non-Federal Total of Individuals Served	\$ 7,809,579	\$ 7,809,579
Federal State MCH Block Grant Partnership Total	\$ 9,706,705	\$ 9,691,750

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:	2020
	Column Name:	Annual Report Expended
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:	2020
	Column Name:	Annual Report Expended
Field Note:		
DE 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	FY 22 Application Budgeted	FY 20 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	\$ 1,429,947	\$ 1,425,562
3. Public Health Services and Systems	\$ 612,834	\$ 602,264
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	\$ 0
Physician/Office Services	\$ 0	\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)	\$ 0	\$ 0
Dental Care (Does Not Include Orthodontic Services)	\$ 0	\$ 0
Durable Medical Equipment and Supplies	\$ 0	\$ 0
Laboratory Services	\$ 0	\$ 0
Direct Services Line 4 Expended Total	\$ 0	\$ 0
Federal Total	\$ 2,042,781	\$ 2,027,826

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 3,363,130	\$ 2,899,104
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 3,363,130	\$ 2,899,104
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 0	\$ 0
2. Enabling Services	\$ 6,245,813	\$ 5,381,948
3. Public Health Services and Systems	\$ 2,402,236	\$ 2,006,652
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		\$ 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
Other		
Duplicate to show in total below		\$ 2,899,104
Direct Services Line 4 Expended Total		\$ 2,899,104
Non-Federal Total	\$ 12,011,179	\$ 10,287,704

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Delaware

Total Births by Occurrence: 10,457

Data Source Year: 2020

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	10,444 (99.9%)	50	27	26 (96.3%)

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)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, β -Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
β -Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

DPH does not cover older children which are under the Dept. of Education.

Children that are 0-3 yrs. of age and diagnosed Deaf/Hard of Hearing (D/HH) are referred to Part C - Early Intervention Services known as Child Development Watch (CDW). On the child's 3rd birthday they are transitioned into the Department of Education Part B program.

The state of Delaware contracts with A.I. DuPont for the metabolic screening of all infants born in the state of Delaware. Infants that are diagnosed with a metabolic disorder are referred to A.I. DuPont Children's Hospital. The team of geneticist work with the infant's pediatrician and the family to provide follow up care through neighboring children's hospital Children's Hospital of Pennsylvania (CHOP). Each case is unique to the diagnosis.

Form Notes for Form 4:

All conditions are tested for in newborn screening program. Critical Congenital heart disease is not blood spot test but noted on card, same for hearing loss. CCHD is tested for and tracked by hospitals, not DPH.

Field Level Notes for Form 4:

1.	Field Name:	Core RUSP Conditions - Total Number Referred For Treatment
	Fiscal Year:	2020
	Column Name:	Core RUSP Conditions

Field Note:

One infant died of other causes prior to treatment (was a CF positive). Family was counselled that CF did not play a role in infant's death and that they are most likely carriers and might want to look into genetic testing.

Data Alerts: None

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

State: Delaware

Annual Report Year 2020

**Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)**

		Primary Source of Coverage					
Types Of Individuals Served		(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women		209	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age		10,457	44.4	0.0	53.3	2.2	0.1
3. Children 1 through 21 Years of Age		22,355	39.1	0.0	34.3	26.6	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age [^]		1,049	39.8	0.0	59.7	0.0	0.5
4. Others		779	0.0	0.0	100.0	0.0	0.0
Total		33,800					

**Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)**

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	10,562	No	12,156	100.0	12,156	209
2. Infants < 1 Year of Age	10,935	No	10,457	100.0	10,457	10,457
3. Children 1 through 21 Years of Age	241,346	Yes	241,346	100.0	241,346	22,355
3a. Children with Special Health Care Needs 0 through 21 years of age [^]	54,172	Yes	54,172	3.0	1,625	1,049
4. Others	721,800	Yes	721,800	100.0	721,800	779

[^]Represents a subset of all infants and children.

Form Notes for Form 5:

Form 5a counts based on known direct/enabling services at time of submission. CSHCN reference value includes all ages. DPH does not cover older children who are under Dept of Education, so count value/percent served is low.

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2020
Field Note: 40 from MIECHV home visiting, 169 from state funded Home Visiting program. HWHB no longer collects this information. Coverage 100% from federal grant funds and state funds. Would be 19% federal, 81% state funds based on percent of counts.		
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2020
Field Note: From Newborn Screening Program, value same as on Form 4. NBS may have some non-resident counts. Coverage is based on 2019 Health Statistics Center information Table C35 Births by Payment. None is self-pay. Private/Other includes Other and Other Government.		
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2020
Field Note: Data source is Title V FPAR 1 to 24 yrs old (3975), PEDS (14,697, July 2020 - June 2021), CDW referrals (2609), DPH EMR (295). MIECHV Home Visiting 607 households (564 female HH, 43 male HH), 10/2019 - 9/2020. Home Visiting assumes at least one child per household. State funded Home Visiting 172 female caregivers = 172 children. Source coverage from 2017 Table 5a. 7546 is minimum number of children as some households will have more than one child.		
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2020
Field Note: Data source is Child Development Watch data and includes CDW-Watch and CDW Part C clients, 1049 eligible. Coverage is from Title V 2017 Table 5a.		
5.	Field Name:	Others
	Fiscal Year:	2020
Field Note: 564 MIECHV female care givers, 43 male caregivers, 607 total adults, plus 172 female caregivers, 779 adults overall total. The number of preconception clients is not available from current DPH databases. Coverage the same as item 1.		

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2020
Field Note: Value from 2019, DE Health Statistics Center, newer value not available. Comes from Table D1 from annual report.		
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2020
Field Note: From above and Form 4, value from newborn screening program (10,457) plus (PPPPPPP).		
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2020
Field Note: Count value is population in DE, estimated by Census.		
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2020
Field Note: Population count value is estimate given by grant application, ages to 21. 5a count (and percent served) from those with CSHCN served by Title V. DPH does not serve older children, they are under Dept of Education.		
5.	Field Name:	Others
	Fiscal Year:	2020
Field Note: Denominator population comes from US Census bureau (a given estimate) of population 22+. 100% served comes from substance abuse education and programming which covers all genders and ages. Other programs that cover large percentage of population are safe sleep, breastfeeding materials, LARC education.		

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

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

State: Delaware

Annual Report Year 2020

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	10,790	5,327	2,840	1,838	48	648	10	0	79
Title V Served	10,790	5,327	2,840	1,838	48	648	10	0	79
Eligible for Title XIX	4,232	1,271	1,570	1,220	19	112	4	0	36
2. Total Infants in State	10,327	4,864	2,877	1,801	50	648	11	0	76
Title V Served	10,327	4,864	2,877	1,801	50	648	11	0	76
Eligible for Title XIX	4,213	1,268	1,571	1,203	20	110	4	0	37

Form Notes for Form 6:

Data is from DE Health Statistics Center, 2020 CY, as of August 2021.

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2020
	Column Name:	Total
Field Note:		
All Form 6 data from DE Health Statistics Center, CY 2020 counts. This cell is resident and non-resident counts		
2.	Field Name:	2. Total Infants in State
	Fiscal Year:	2020
	Column Name:	Total
Field Note:		
This is resident births. From Health Statistics Center, CY 2020 counts.		

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

State: Delaware

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 464-4357	(800) 464-4357 x464435
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"		1,506

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://dhss.delaware.gov/dph/chca/dphmchhome.html	https://dhss.delaware.gov/dph/chca/dphmchhome.html
4. Number of Hits to the State Title V Program Website		2,930
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		115,000

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Delaware

1. Title V Maternal and Child Health (MCH) Director

Name	Leah J. Woodall
Title	Chief, Family Health Systems
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5754
Extension	
Email	leah.woodall@delaware.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Isabel Rivera-Green
Title	CYSHCN Director
Address 1	1351 W. North Street
Address 2	Suite 103
City/State/Zip	Dover / DE / 19904
Telephone	(302) 608-5747
Extension	
Email	isabel.rivera-green@delaware.gov

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 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five- year reporting period)
1.	Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	Revised
2.	Improve breastfeeding rates.	Continued
3.	Children receive developmentally appropriate services in a well coordinated early childhood system.	Revised
4.	Empower adolescents to adopt healthy behaviors.	New
5.	Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.	New
6.	Increase the percent of children with and without special health care needs who are adequately insured.	Continued
7.	Improve the rate of Oral Health preventive care in children.	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	Revised
2.	Improve breastfeeding rates.	Continued
3.	Children receive developmentally appropriate services in a well coordinated early childhood system.	Revised
4.	Empower adolescents to adopt healthy behaviors.	New
5.	Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.	New
6.	Increase the percent of children with and without special health care needs who are adequately insured.	Continued
7.	Improve the rate of Oral Health preventive care in children.	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Delaware

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

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	76.9 %	0.4 %	8,001	10,408
2018	77.8 %	0.4 %	8,044	10,335
2017	78.9 %	0.4 %	8,426	10,676
2016	78.8 %	0.4 %	8,534	10,829
2015	78.6 %	0.4 %	8,666	11,022
2014	78.7 %	0.4 %	8,510	10,814
2013	76.8 %	0.4 %	8,144	10,602
2012	74.7 %	0.4 %	8,026	10,745
2011	75.7 %	0.4 %	8,297	10,954
2010	75.0 %	0.4 %	8,403	11,210
2009	74.7 %	0.4 %	8,089	10,824

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	68.8	8.2	71	10,326
2017	55.2	7.3	58	10,515
2016	63.1	7.7	67	10,621

Legends:

█ Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	NR	NR	NR	NR
2014_2018	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a 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
2019	9.4 %	0.3 %	995	10,552
2018	8.9 %	0.3 %	948	10,614
2017	9.0 %	0.3 %	981	10,853
2016	8.9 %	0.3 %	982	10,984
2015	9.3 %	0.3 %	1,036	11,162
2014	8.3 %	0.3 %	908	10,970
2013	8.3 %	0.3 %	900	10,827
2012	8.3 %	0.3 %	913	11,018
2011	8.4 %	0.3 %	942	11,253
2010	8.9 %	0.3 %	1,016	11,357
2009	8.6 %	0.3 %	994	11,556

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.7 %	0.3 %	1,130	10,560
2018	9.6 %	0.3 %	1,015	10,621
2017	10.2 %	0.3 %	1,108	10,846
2016	10.1 %	0.3 %	1,105	10,982
2015	9.9 %	0.3 %	1,101	11,153
2014	9.3 %	0.3 %	1,019	10,965
2013	9.4 %	0.3 %	1,022	10,818
2012	9.5 %	0.3 %	1,049	11,009
2011	9.3 %	0.3 %	1,051	11,247
2010	10.2 %	0.3 %	1,153	11,355
2009	10.0 %	0.3 %	1,160	11,543

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	29.1 %	0.4 %	3,072	10,560
2018	27.7 %	0.4 %	2,940	10,621
2017	25.5 %	0.4 %	2,765	10,846
2016	24.1 %	0.4 %	2,649	10,982
2015	25.0 %	0.4 %	2,792	11,153
2014	24.4 %	0.4 %	2,676	10,965
2013	22.7 %	0.4 %	2,454	10,818
2012	22.5 %	0.4 %	2,473	11,009
2011	22.7 %	0.4 %	2,550	11,247
2010	24.2 %	0.4 %	2,752	11,355
2009	23.8 %	0.4 %	2,749	11,543

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	1.0 %			
2014/Q2-2015/Q1	1.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	2.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2018	6.9	0.8	74	10,660	
2017	6.4	0.8	70	10,888	
2016	6.4	0.8	70	11,020	
2015	9.2	0.9	103	11,202	
2014	7.4	0.8	81	11,007	
2013	6.8	0.8	74	10,863	
2012	8.2	0.9	91	11,056	
2011	8.8	0.9	99	11,291	
2010	7.5	0.8	85	11,401	
2009	6.6	0.8	77	11,584	

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2018	4.0	0.6	43	10,621	
2017	4.1	0.6	45	10,855	
2016	5.0	0.7	55	10,992	
2015	7.2	0.8	80	11,166	
2014	5.0	0.7	55	10,972	
2013	4.4	0.6	48	10,831	
2012	6.1	0.7	67	11,023	
2011	6.5	0.8	73	11,257	
2010	5.0	0.7	57	11,364	
2009	5.8	0.7	67	11,559	

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.3 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	197.7	43.2	21	10,621
2017	230.3	46.1	25	10,855
2016	354.8	56.9	39	10,992
2015	456.7	64.1	51	11,166
2014	319.0	54.0	35	10,972
2013	295.4	52.3	32	10,831
2012	371.9	58.2	41	11,023
2011	426.4	61.7	48	11,257
2010	281.6	49.9	32	11,364
2009	346.1	54.8	40	11,559

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.5 - Notes:**

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.8 %	0.9 %	662	9,744
2018	6.4 %	0.9 %	624	9,746
2017	6.4 %	0.9 %	640	9,936
2016	6.2 %	0.8 %	637	10,202
2015	8.1 %	0.9 %	839	10,319
2014	6.3 %	0.8 %	639	10,225
2013	7.7 %	0.9 %	766	10,018
2012	6.0 %	0.8 %	612	10,186
2011	6.3 %	0.7 %	657	10,418
2010	7.3 %	0.8 %	755	10,402
2009	9.4 %	0.9 %	1,004	10,696
2008	7.0 %	0.7 %	778	11,166
2007	5.9 %	0.9 %	438	7,454

Legends:

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

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

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	23.3	1.5	242	10,391
2017	24.2	1.5	258	10,647
2016	26.8	1.6	288	10,731

Legends:

█ Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.3 %	1.5 %	25,206	188,875
2017_2018	10.8 %	1.5 %	20,343	188,712
2016_2017	11.0 %	1.4 %	20,905	190,361
2016	11.7 %	1.7 %	22,451	191,338

Legends:

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

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

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 15 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	11.0	2.5	20	181,122
2016_2018	9.4 	2.3 	17 	181,393 
2015_2017	8.8 	2.2 	16 	181,147 
2014_2016	9.4 	2.3 	17 	180,556 
2013_2015	12.2	2.6	22	179,785
2012_2014	11.6	2.5	21	181,255
2011_2013	10.9	2.4	20	183,456
2010_2012	11.2	2.4	21	188,321
2009_2011	13.0	2.6	25	191,829
2008_2010	13.9	2.7	27	194,904
2007_2009	15.4	2.8	30	194,529

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.2 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2017_2019	8.8 	2.2 	16 	181,122 	
2016_2018	9.4 	2.3 	17 	181,393 	
2015_2017	8.3 	2.1 	15 	181,147 	
2014_2016	6.6 	1.9 	12 	180,556 	
2013_2015	6.7 	1.9 	12 	179,785 	
2012_2014	9.9 	2.3 	18 	181,255 	
2011_2013	13.1	2.7	24	183,456	
2010_2012	13.8	2.7	26	188,321	
2009_2011	9.4 	2.2 	18 	191,829 	
2008_2010	5.6 	1.7 	11 	194,904 	
2007_2009	5.1 	1.6 	10 	194,529 	

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.3 - Notes:**

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**Data Source:** National Survey of Children's Health (NSCH)**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	21.5 %	1.6 %	43,524	202,837
2017_2018	22.3 %	1.7 %	45,379	203,587
2016_2017	23.1 %	1.6 %	46,973	203,603
2016	22.9 %	1.8 %	46,594	203,511

Legends:

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

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.7 %	2.5 %	6,845	43,524
2017_2018	18.8 %	3.3 %	8,525	45,379
2016_2017	18.3 %	3.0 %	8,589	46,973
2016	18.5 %	3.1 %	8,616	46,594

Legends:

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

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

NOM 17.2 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	4.0 %	1.0 %	6,721	167,698
2017_2018	3.9 %	1.0 %	6,517	168,465
2016_2017	4.2 %	1.0 %	7,253	172,095
2016	3.1 %	0.9 %	5,355	174,664

Legends:

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

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

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.6 %	1.4 %	19,348	167,449
2017_2018	10.3 %	1.4 %	17,207	166,845
2016_2017	10.7 %	1.2 %	18,204	170,256
2016	12.0 %	1.7 %	20,659	172,211

Legends:

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

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

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	54.6 % 	5.6 % 	13,898 	25,437 
2017_2018	56.7 % 	5.7 % 	14,525 	25,613 
2016_2017	64.3 %	5.2 %	16,333	25,398
2016	69.5 % 	6.0 % 	16,759 	24,128 

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	89.5 %	1.4 %	180,982	202,323
2017_2018	89.8 %	1.4 %	182,705	203,402
2016_2017	90.3 %	1.2 %	183,623	203,356
2016	91.1 %	1.4 %	185,058	203,190

Legends:

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

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

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

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

Legends:

█ Indicator has a denominator <50 and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.1 %	1.1 %	5,159	34,095
2015	15.8 %	0.9 %	5,380	34,119
2013	14.2 %	0.7 %	4,959	34,970
2011	12.2 %	0.8 %	4,169	34,173
2009	13.5 %	0.8 %	4,543	33,562
2007	13.2 %	0.8 %	4,389	33,287
2005	14.0 %	0.7 %	4,519	32,311

Legends:

█ Indicator has an unweighted denominator <100 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	16.0 %	2.2 %	13,031	81,324
2017_2018	15.1 %	2.1 %	12,408	82,438
2016_2017	16.7 %	2.1 %	14,359	86,238
2016	16.8 %	2.6 %	14,304	85,051

Legends:

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

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

NOM 20 - Notes:

None

Data Alerts: None

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

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.3 %	0.9 %	8,745	203,953
2018	3.8 %	0.9 %	7,804	203,319
2017	3.4 %	0.7 %	6,937	204,345
2016	3.7 %	0.7 %	7,474	204,214
2015	2.8 %	0.7 %	5,730	204,356
2014	5.0 %	1.0 %	10,145	204,238
2013	5.1 %	1.0 %	10,294	203,729
2012	3.6 %	0.7 %	7,271	204,974
2011	3.5 %	0.6 %	7,089	204,528
2010	5.6 %	0.9 %	11,456	205,695
2009	5.7 %	0.9 %	11,823	206,826

Legends:

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

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

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	70.6 %	3.9 %	8,000	11,000
2015	70.1 %	3.9 %	8,000	11,000
2014	78.5 %	3.5 %	9,000	11,000
2013	75.3 %	3.7 %	8,000	11,000
2012	76.3 %	3.3 %	9,000	11,000
2011	75.1 %	3.5 %	9,000	12,000

Legends:

█ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	68.1 %	1.6 %	130,544	191,694
2018_2019	66.0 %	1.6 %	126,523	191,672
2017_2018	65.2 %	1.9 %	125,814	192,884
2016_2017	65.4 %	2.3 %	125,447	191,903
2015_2016	69.2 %	2.7 %	132,417	191,243
2014_2015	66.2 %	2.2 %	127,154	192,133
2013_2014	66.7 %	1.9 %	128,042	192,065
2012_2013	67.4 %	3.2 %	129,839	192,518
2011_2012	55.1 %	3.1 %	107,291	194,657
2010_2011	52.1 %	4.3 %	101,548	194,909
2009_2010	46.8 %	2.7 %	84,412	180,367

Legends:

█ Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.4 %	2.9 %	43,615	57,824
2018	73.9 %	3.2 %	42,936	58,093
2017	75.3 %	2.9 %	43,430	57,644
2016	70.7 %	2.8 %	40,877	57,853
2015	65.2 %	2.9 %	37,503	57,505

Legends: Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable**NOM 22.3 - Notes:**

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	89.7 %	2.2 %	51,845	57,824
2018	89.1 %	2.2 %	51,757	58,093
2017	89.6 %	2.2 %	51,660	57,644
2016	87.5 %	2.0 %	50,644	57,853
2015	88.7 %	1.9 %	51,004	57,505
2014	90.5 %	1.9 %	51,554	56,943
2013	84.4 %	2.3 %	48,139	57,056
2012	77.8 %	3.0 %	44,397	57,081
2011	80.7 %	2.3 %	47,258	58,593
2010	65.5 %	3.0 %	37,427	57,165
2009	53.4 %	3.3 %	31,064	58,209

Legends:

█ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

↳ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	89.0 %	2.2 %	51,454	57,824
2018	85.9 %	2.7 %	49,904	58,093
2017	90.5 %	2.0 %	52,145	57,644
2016	87.3 %	2.2 %	50,523	57,853
2015	87.5 %	2.1 %	50,332	57,505
2014	86.7 %	2.4 %	49,345	56,943
2013	81.8 %	2.6 %	46,657	57,056
2012	78.0 %	3.2 %	44,507	57,081
2011	78.2 %	2.5 %	45,835	58,593
2010	71.2 %	3.0 %	40,719	57,165
2009	58.4 %	3.3 %	33,991	58,209

Legends:

█ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

█ Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

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

Legends:

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

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.5 %	0.7 %	5,014	201,501
2017_2018	3.1 %	0.8 %	6,267	203,075
2016_2017	3.5 %	0.9 %	7,102	203,324
2016	2.6 % 	0.9 % 	5,326 	203,101 

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 25 - Notes:**

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Delaware

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	2017	2018	2019	2020
Annual Objective					80
Annual Indicator				78.2	75.6
Numerator				127,950	124,769
Denominator				163,676	165,041
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

i Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data						
Data Source: National Immunization Survey (NIS)						
	2016	2017	2018	2019	2020	
Annual Objective	74	76	78	80	80	
Annual Indicator	74.6	77.2	77.4	78.5	79.7	
Numerator	7,709	7,684	7,840	8,010	8,564	
Denominator	10,340	9,953	10,127	10,209	10,741	
Data Source	NIS	NIS	NIS	NIS	NIS	
Data Source Year	2013	2014	2015	2016	2017	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.5	83.0	84.5	86.0	87.5	89.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data						
Data Source: National Immunization Survey (NIS)						
	2016	2017	2018	2019	2020	
Annual Objective	15.5	18	20.5	23	20.5	
Annual Indicator	18.9	20.5	23.6	19.8	23.6	
Numerator	1,847	1,966	2,319	2,019	2,478	
Denominator	9,794	9,570	9,811	10,187	10,493	
Data Source	NIS	NIS	NIS	NIS	NIS	
Data Source Year	2013	2014	2015	2016	2017	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.5	25.0	26.0	27.0	28.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			31.7	32	27
Annual Indicator		26.9	24.8	25.5	30.3
Numerator		5,997	5,633	5,939	6,522
Denominator		22,305	22,753	23,289	21,559
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	2020
Annual Objective		
Annual Indicator	25.1	25.1
Numerator	9,329	9,329
Denominator	37,230	37,230
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2019	2020
Annual Objective		
Annual Indicator	11.6	13.0
Numerator	7,828	8,196
Denominator	67,249	62,967
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	21.0	22.0	23.0	24.0	25.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2019	2020
Annual Objective		
Annual Indicator	86.9	75.7
Numerator	62,537	47,654
Denominator	71,966	62,974
Data Source	NSCH	NSCH
Data Source Year	2016_2017	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	77.0	79.0	81.0	83.0	85.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			79.6	80.4	82.5
Annual Indicator		79.9	81.6	82.0	79.7
Numerator		152,949	155,485	154,827	149,645
Denominator		191,522	190,614	188,877	187,697
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	80.5	81.0	82.0	83.0	84.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			80.4	81.2	72
Annual Indicator		67.9	70.2	70.9	68.6
Numerator		137,974	142,861	144,257	138,831
Denominator		203,264	203,480	203,436	202,281
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	74.0	76.0	77.0	78.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Delaware

2016-2020: 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	2018	2019	2020
Annual Objective			33.1	33.4	33.7
Annual Indicator		29.5	23.8	26.5	30.1
Numerator		17,762	14,550	18,813	22,295
Denominator		60,210	61,193	70,930	74,026
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i 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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective	18.5	18.3	18.1	18	17.9
Annual Indicator	21.2	21.2	17.4	17.4	17.4
Numerator	8,235	8,235	6,885	6,885	6,885
Denominator	38,923	38,923	39,480	39,480	39,480
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2017

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2017	2018	2019	2020	
Annual Objective			18	17.9	
Annual Indicator			12.2	12.5	
Numerator			7,770	7,866	
Denominator			63,570	63,129	
Data Source			NSCHP	NSCHP	
Data Source Year			2018	2018_2019	

① Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data

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

	2017	2018	2019	2020
Annual Objective			18	17.9
Annual Indicator			32.9	34.1
Numerator			20,925	21,515
Denominator			63,570	63,129
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

① Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective			58.5	61	63.3
Annual Indicator		57.4	51.7	46.0	40.8
Numerator		26,743	24,288	20,853	17,702
Denominator		46,594	46,973	45,379	43,419
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i 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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective	39.4	39.8	40.2	40.6	41
Annual Indicator	42.2	44.4	43.5	38.5	41.8
Numerator	4,224	4,562	4,461	3,777	4,101
Denominator	10,020	10,267	10,261	9,807	9,807
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2016	2018	2019

Field Level Notes for Form 10 NPMs:

None

Form 10
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	2018	2019	2020
Annual Objective		57	56	52	30
Annual Indicator	57	45.5	43	27.5	28.7
Numerator					
Denominator					
Data Source	Health Statistics	DE PRAMS	DE PRAMS	DE PRAMS	DE PRAMS
Data Source Year	2015	2016	2017	2016-2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	25.0	24.0	23.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
Field Note:		
The 2017 value is from Delaware PRAMS 2016 data. It is an estimate based on live births, not the overall female population of 15 - 44 yr olds.		
2.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
2018 data is from 2017 Delaware PRAMS data, which is an estimate based on live births, not the overall female population of 15 -44 yrs old.		
3.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
2016-2018 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined.		
4.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
2019 PRAMS data using Question: Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Response choices 1)wanted to be pregnant later and 4) I didn't want to be pregnant then or at any time in the future were combined. Not sure is an option that was included with our "I didn't want to be pregnant....", however CDC does not want states to include that option in their numbers now. Even with this change, Delaware numbers have still been decreasing since 2012.		

SPM 2 - Reduce the disparity in infant mortality rates

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		4.6
Numerator		
Denominator		
Data Source		HWHB Program Data and Vital Statistics Data
Data Source Year		2019
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data

Field Note:

This is only represents 4 months of data.

Disparity ratio = HWHB Black preterm/State White preterm = 9.48/9.49 = 1 i.e., same.

Difference in HWHB Black preterm and State Black preterm = 9.48 - 14.07 = -4.59 lower!

SPM 3 - Strengthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68
Numerator		17
Denominator		25
Data Source		FHS Data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	75.0	75.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percent of Black, non-Hispanic mothers who initiate breastfeeding.

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		67	68	69	70
Annual Indicator	67	66	69.4	79.2	80.5
Numerator					
Denominator					
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Immunization Survey	PRAMS	PRAMS
Data Source Year	2011/2012	2016	2015	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Data from National Immunization Survey 2015. Value is 69.4% +/- 3.5%.		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
As per the PRAMS data, the 2018 prevalence of ever breastfed among non-Hispanic black was 79.2% as compared to 87.2% among non-Hispanic white, and 93.4% among Hispanics. Similarly, the 2018 prevalence of currently breastfeeding (or at the time of survey) among non-Hispanic blacks was 38.1% as compared with 61.1% among non-Hispanic whites, and 58.7% among Hispanics.		

2016-2020: 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	2018	2019	2020
Annual Objective		22	22	21	20
Annual Indicator	22	27.6	27.6	27.6	27.6
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Data Source Year	2015	2017	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1. **Field Name:** 2018

Column Name: State Provided Data

Field Note:

Data source: 2017 DE YRBS.

2. **Field Name:** 2020

Column Name: State Provided Data

Field Note:

Delaware did not have enough usable data to do any analysis in 2019.

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

State: Delaware

ESM 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15,000	15,500	15,700	17,000
Annual Indicator	14,998	15,891	16,386	16,672	8,488
Numerator					
Denominator					
Data Source	FPAR Title X/Family Planning Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	17,250.0	17,500.0	17,750.0	18,000.0	18,250.0	18,250.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note: New service sites; SBHC addition of reproductive health (La Red and Milford)		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note: Actual number served was 16,672 but field would not allow us to go over 16,500.		
3.	Field Name:	2020
	Column Name:	State Provided Data
Field Note: 50% drop due to COVID.		

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		88
Numerator		
Denominator		
Data Source		HWHB Program Data
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	92.0	94.0	96.0	98.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		62
Numerator		
Denominator		
Data Source		Medicaid Claims Data
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	65.0	67.0	69.0	70.0	72.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Increase the number of birthing facilities that receive baby friendly designation

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		4	5	5	4
Annual Indicator	4	4	4	4	4
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15	61	65	58
Annual Indicator	17.2	60.3	54.2	54.9	47.9
Numerator					
Denominator					
Data Source	MIECHV program data				
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	62.0	64.0	66.0	68.0	68.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Reported breastfeeding behaviors were missing for two (2) infants who met the criteria for the denominator. This continues to be a construct on which both LIAs are working to improve. Through their CQI efforts, the LIAs are providing education and resources to mothers both prenatally and postpartum in an effort to improve both breastfeeding initiation and duration.

ESM 6.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	91.4	83.3
Numerator	433	398
Denominator	474	478
Data Source	MIECHV program data	MIECHV program data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	94.0	96.0	98.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - # of new pediatric practices to adopt PEDs

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		36	39	42	45
Annual Indicator	34	37	40	43	43
Numerator					
Denominator					
Data Source	DE AAP	DE APP	DE APP	DE APP	DE APP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	47.0	49.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		Yes
Numerator		
Denominator		
Data Source	MCH Program Data	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		No
Numerator		
Denominator		
Data Source		MCH Program Data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	No	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	SBHC Program Data	SBHC Program Data
Data Source Year	SFY 2020	SFY 2021
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Number of adolescent receiving services at a school-based health center who have a risk health assessments completed

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		90.4
Numerator		235
Denominator		260
Data Source		SBHC Program Data
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	30.0	35.0	40.0	45.0	50.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
Field Note: 260 unique patients were seen and 235 risk assessments were completed in school year 2021 (8/2020-5/2021). This does not represent all of the SBHC in Delaware. However, it was our largest medical sponsor that submitted the data that represents 18 wellness centers. Delaware has 32 wellness centers in total.		

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		2
Numerator		
Denominator		
Data Source		SBHC Program Data (1 Medical Vendor)
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	4.0	6.0	8.0	10.0	12.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
Field Note: Numbers are not unduplicated and only one medical sponsor submitted program data. However, it was our largest medical sponsor that submitted the data that represents XX wellness centers. There were 486 mental visits among 940 unique students.		

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

Measure Status:	Active	
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	80.6	78.8
Numerator		
Denominator		
Data Source	NCHS	NCHS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.0	82.0	83.0	84.0	85.0	85.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			0	0
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
Field Note: An entire committee has not been established however, the Title V Director and Deputy Director meeting monthly with the DMMA Medical Director, MCH Quality Administrator and policy staff members. This arrangement currently meets our needs and helps us move priorities forward such as providing education around the extended postpartum coverage and Medicaid financing for home visiting.		

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

Measure Status:	Active		
State Provided Data			
	2018	2019	2020
Annual Objective			4
Annual Indicator		4	4
Numerator			
Denominator			
Data Source		MCH Program Data	MCH Program Data
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		90
Numerator		564
Denominator		627
Data Source		MIECHV Program data
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	92.0	94.0	96.0	98.0	98.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	99% (533/537) of children had health insurance per the FY20 MIECHV program data.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: 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	2018	2019	2020
Annual Objective			100	110	121
Annual Indicator	0	111	104	58	64
Numerator					
Denominator					
Data Source	google analytics data/Worldways	google analytics data/Worldways	google analytics data	google analytics data	Social Marketing Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note: # of social media msgs for Healthy Women/preconception (unique ads; engagement info and posts)		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note: switched social media vendors # of social media msgs for Healthy Women/preconception (unique ads; engagement info and posts)		

2016-2020: 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	2018	2019	2020
Annual Objective		8,300	8,500	8,700	8,900
Annual Indicator	8,146	8,819	7,100	0	0
Numerator					
Denominator					
Data Source	Healthy Women Health Babies Program data	Healthy Women Health Babies Program data	HWHB	HWHB	HWHB
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
This is provisional for 2018 based on estimates. Program is changing in 2019/2020. One location closed for a period of time (HJMC).		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
The HWHB program was transformed to a performance contract with relevant benchmarks. Bundles of services include Bundle A are no longer counted this way.		
3.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
The HWHB program was transformed to a performance contract with relevant benchmarks. Bundles of services include Bundle A are no longer counted this way.		

2016-2020: ESM 4.2 - Increase the number of downloads and/or web hits to already vetted materials

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		100	130	150	170
Annual Indicator	98	0	23	16	12
Numerator					
Denominator					
Data Source	google analytics data/Worldways	google analytics data/Worldways	google analytics data/Worldways	Social Marketing Program Data	Social Marketing Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
This number is not inclusive of the materials that were distributed regarding the dangers substance use during pregnancy and while breastfeeding which was our biggest push this year. If we include these material, we distributed over 2,000.		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
Switched social media vendors so promotion was stalled.		
3.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
We have been focusing on promoting breastfeeding through social media not handouts or downloads.		

2016-2020: ESM 4.3 - # of home visitors who are certified by the International Board of Lactation Consultants

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		5	7	9	11
Annual Indicator	4	5	5	5	3
Numerator					
Denominator					
Data Source	MIECHV program data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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 though 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.		
3.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Due to staff turn over, this number decreased this past year. We also pushed training around providing services for NAS infants and supporting families caring for NAS infants.		
4.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
Due to staff turnover, the number of Lactation Consultants decreased.		

2016-2020: ESM 6.2 - # of referrals to HMG/2-1-1 from pediatric practices

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45	65	85	105
Annual Indicator	32	10	4	6	28
Numerator					
Denominator					
Data Source	HMG 2-1-1				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: Doctor/Medical Provider referrals	

2016-2020: 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	2018	2019	2020
Annual Objective		15	20	100	100
Annual Indicator	15	100	100	100	100
Numerator					
Denominator					
Data Source	CDW program data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 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.		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
This indicator should be 262 but TVIS will not allow me to change the Annual Indicator.		
3.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
This indicator should be 209 but TVIS will not allow me to change the Annual Indicator.		

2016-2020: ESM 6.4 - # of screens following expansion to include HMG 2-1-1 call center

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	75	25	35
Annual Indicator	20	18	5	7	3
Numerator					
Denominator					
Data Source	HMG 2-1-1	HMG 2-1-1	HMG 2-1-1	HMG 2-1-1	HMG 2-1-1
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 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.		
2.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Our FY19 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.		
3.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
Our FY19 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 developmental screening over the phone. We worked with the call center staff to change this practice at the hotline but due increase in calls due to COVID-19 made it impossible.		
4.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
Our FY 20 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 developmental screening over the phone. We worked with the call center staff to change this practice at the hotline but due increase in calls due to COVID-19 made it impossible. We all partnered with our Part C program and they have additional staff to the HMG call center to focus on developmental screening specifically and completed 121 screenings.		

2016-2020: ESM 6.5 - # of new partnerships/collaborations

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2	2	2	2
Annual Indicator	10	10	7	2	1
Numerator					
Denominator					
Data Source	ECCS Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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.

2016-2020: ESM 6.6 - # of YouTube views of educational video on developmental screening

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		100	150	650	700
Annual Indicator	41	163	653	125	64
Numerator					
Denominator					
Data Source	google analytics data/Worldways	google analytics data/Worldways	google analytics data/Worldways	Social Marketing Program Data	Social Marketing Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
88 Youtube video watch 565 video watches via Facebook posts		
2.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
New social media vendor and we did not market the videos via Facebook this past year where we saw the most activity vs. going to You Tube directly to watch.		
3.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
We did not market the videos via Facebook this past year where we saw the most activity vs. going to You Tube directly to watch. We spent much of our time filming families for videos to be included in the QT 30 App which activities align with developmental milestones.		

2016-2020: 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	2018	2019	2020
Annual Objective		20	20	20	20
Annual Indicator	0	20	20	20	20
Numerator					
Denominator					
Data Source	google analytics data/Worldways	google analytics data/Worldways	google analytics data/Worldways	Social Marketing Program Data	Social Marketing Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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		

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	No	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		1,000	1,000	1,000	1,000
Annual Indicator	877	1,000	1,000	1,000	1,000
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
We distributed 4,613 HEPA booklets this past year but once unable to increase annual indicator.		
2.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
We distributed close to 5,000 HEPA booklets this past year but unable to increase annual indicator.		

2016-2020: 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	2018	2019	2020
Annual Objective		12	12	12	12
Annual Indicator	12	12	12	8	6
Numerator					
Denominator					
Data Source	SHIP and Healthy Neighborhoods committee minutes				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH and Worldways	MCH and Worldways	MCH	MCH	MCH
Data Source Year	2016	2017	2018	2019	2030
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
Field Note: This was originally done some time ago. However, we are now focused on the broader scope for mental health needs as it relates to the adolescent population and are working on understanding our capacity on the state for mental health services.		

2016-2020: ESM 9.2 - # of people who attend Safe Kids conference

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	75	0	75
Annual Indicator	0	0	75	0	0
Numerator					
Denominator					
Data Source	Safe Kids Conference Planning Committee	Safe Kids Conference Planning			
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Actual number of attendees was 96 but TVIS will only allow a number between 0-75.		
2.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
MCH did not receive any requests for support or to serve on the planning committee last year as we have in years past.		

2016-2020: ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2	2	2	2
Annual Indicator	5	1	2	0	0
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective		3	4	4	4
Annual Indicator	3	3	3	1	2
Numerator					
Denominator					
Data Source	SBHC and MCH meeting minutes				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective		150	150	150	150
Annual Indicator	166	159	165	131	125
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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.		
2.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Data includes all partners including community members and families.		
3.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
Data includes all partners including community members and families.		
4.	Field Name:	2020
	Column Name:	State Provided Data
Field Note:		
Data includes all partners including community members and families. Presentations and/or training focused on emotional well-being this past year.		

2016-2020: 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	2018	2019	2020
Annual Objective		Yes	0	0	0
Annual Indicator	Yes	Yes	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	Family SHADE data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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.		

2016-2020: 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	2018	2019	2020
Annual Objective		No	0	0	0
Annual Indicator	No	No	Yes	Yes	Yes
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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	2018	2019	2020
Annual Objective		2	2	2	2
Annual Indicator	2	2	2	0	2
Numerator					
Denominator					
Data Source	MCH Program Data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			0	0
Annual Indicator			No	No
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1. Field Name:	2020
Column Name:	State Provided Data

Field Note:

SB 136 passed this last year which transfers responsibility for the Infants and Toddlers Early Intervention Program from the Department of Health and Social Services (DHSS) to the Department of Education (DOE) on July 1, 2023. We will continue to work with the program to promote a consistent message around available services and how to access them.

2016-2020: 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	2018	2019	2020
Annual Objective		5,000	10,000	5,000	5,000
Annual Indicator	3,989	5,530	1,101	989	1,184
Numerator					
Denominator					
Data Source	DPH Google Analytics				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.

Measure Status:	Active			
State Provided Data				
	2017	2018	2019	2020
Annual Objective			25	50
Annual Indicator			0	4
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1. Field Name:	2019
Column Name:	State Provided Data
Field Note: Switched social marketing vendors	

2016-2020: ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			2	3
Annual Indicator			2	0
Numerator				
Denominator				
Data Source			MCH Program Data	MCH Program Data
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.2.2 - # of presentations completed for partners & community members

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15	15	10	10
Annual Indicator	6	7	6	8	15
Numerator					
Denominator					
Data Source	BOHDS program data				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 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.		
2.	Field Name:	2018
	Column Name:	State Provided Data
Field Note:		
Our oral health program staff moved from one central office to multiple offices across the state. One of the reasons for this was for administrative oral health staff to have better connection with the dentists and dental hygienists working in the dental clinics. A new program manager also started this year which another reason presentations and outreach was a little lower than expected this year.		
3.	Field Name:	2019
	Column Name:	State Provided Data
Field Note:		
The program manager was out on leave this past year and then COVID-19 hit which is the reason presentations and outreach was a little lower than expected this year.		

2016-2020: ESM 13.2.3 - # of pediatric practices who are providing fluoride treatments

Measure Status:			Active		
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		25	30	32	34
Annual Indicator	21	17	12	12	12
Numerator					
Denominator					
Data Source	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
Data Source Year	2016	2017	2018	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 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.		
2.	Field Name:	2018
	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.		

Form 10
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:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Number of mothers reporting that their pregnancy was wanted later or unwanted
	Denominator:	Number of women who responded to PRAMS
Data Sources and Data Issues:	PRAMS	
Significance:	Unplanned pregnancies are expensive and cost women, families, government, and society. Extensive data show that unplanned pregnancies have been linked to increased health problems in women and their infants, lower educational attainment, higher poverty rates, and increased health care and societal costs. And, unplanned pregnancies significantly increase Medicaid expenses. By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.	

SPM 2 - Reduce the disparity in infant mortality rates

Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active									
Goal:	By 2025, reduce and maintain the disparity ratio among enrolled and non-enrolled women by five percentage points.									
Definition:	<table border="1"><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of black/Hispanic women in HWHB/HV or mini grantee who experienced an infant death.</td></tr><tr><td>Denominator:</td><td>Denominator: Number of black/Hispanic women non-enrolled in HWHB/HV or mini grantee (i.e., Medicaid) who experienced an infant death.</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of black/Hispanic women in HWHB/HV or mini grantee who experienced an infant death.	Denominator:	Denominator: Number of black/Hispanic women non-enrolled in HWHB/HV or mini grantee (i.e., Medicaid) who experienced an infant death.
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of black/Hispanic women in HWHB/HV or mini grantee who experienced an infant death.									
Denominator:	Denominator: Number of black/Hispanic women non-enrolled in HWHB/HV or mini grantee (i.e., Medicaid) who experienced an infant death.									
Data Sources and Data Issues:	MCH Program Data , Medicaid and Vital Statistics									
Significance:	While Delaware has made significant improvements in our infant mortality rates, the disparity has remained. We have recently switched gears and transformed our HWHB program as well implement community mini grants to address black infant mortality in our state.									

SPM 3 - Strengthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active	
Goal:	To increase the number of well qualified MCH leaders in the field.	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	The number of MCH staff that have completed at least one professional development opportunity
	Denominator:	The number of MCH staff
Data Sources and Data Issues:	MCH data	
Significance:	There are many reasons why having a highly qualified workforce is important to ensure that employees are consistently growing or sharpening their saw. Workforce development ensures staff are properly prepared to deliver and produce high quality work. Workforce development helps prepare the MCH workforce in succession planning and decreased staff turnover.	

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: 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:	<table border="1" style="width: 100%;"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of Black, non Hispanc women who report breastfeeding initiation</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births in Delaware</td> </tr> </table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of Black, non Hispanc women who report breastfeeding initiation	Denominator:	Number of live births in Delaware
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of Black, non Hispanc women who report breastfeeding initiation									
Denominator:	Number of live births in Delaware									
Data Sources and Data Issues:	Health Statistics									
Significance:	<p>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)</p>									

2016-2020: 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:	Unit Type:	Percentage
	Unit Number:	100
	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
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 10
State Outcome Measure (SOM) Detail Sheets

State: Delaware

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Delaware

ESM 1.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics

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

Measure Status:	Active	
Goal:	Increase the number of women of reproductive age receiving family planning services.	
Definition:	Unit Type:	Count
	Unit Number:	20,000
	Numerator:	Total # of women of reproduction age that received family planning services
	Denominator:	
Data Sources and Data Issues:	FPAR Title X/Family Planning Data	
Significance:	Family planning visits not only help women to avoid unintended pregnancies, but also help a women prepare for healthy pregnancies by addressing important preventive care issues among women of reproductive age.	

**ESM 1.2 - % of women served by the HWHBs program that were screened for pregnancy intention
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

Measure Status:	Active	
Goal:	Increase # of women served by the HWHBs program that were screened for pregnancy intention	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	# of women that were screening for pregnancy intention
	Denominator:	# of women served
Data Sources and Data Issues:	HWHB Program Data	
Significance:	Asking the pregnancy intention question gives women an opportunity to discuss their future and offers providers to further discuss contraception option that are best for her based on her answer.	

ESM 1.3 - % of Medicaid women who use a most to moderately effective family planning birth control method
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active	
Goal:	To reduce unintended pregnancies	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Medicaid women who use a most to moderately effective family planning birth control method
	Denominator:	Medicaid women who use other types of family planning birth control
Data Sources and Data Issues:	Medicaid Claims Data	
Significance:	By reducing unintended pregnancy, we can reduce costs for pregnancy related services, particularly high risk pregnancies and low birth weight babies, improve overall outcomes for Delaware women and children, decrease the number of kids growing up in poverty, and even potentially reduce the number of substance exposed infants.	

ESM 4.1 - 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:	Unit Type:	Count
	Unit Number:	6
	Numerator:	Number of birthing facilities that received baby friendly designation
	Denominator:	
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 4.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active	
Goal:	Increase the percentage of infants enrolled in home visiting receiving breast milk	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Number of infants enrolled in home visiting receiving breast milk at 6 months of age
	Denominator:	Number of infants enrolled in home visiting at 6 months of age
Data Sources and Data Issues:	MCH/MIECHV program data	
Significance:	Our home visiting programs enroll the most vulnerable families that are of lower socio-economic status. Mothers in this population have lower rates of initiating breastfeeding as well as difficulty continuing to breastfeed through 6 months of age.	

ESM 6.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program.

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

Measure Status:	Active	
Goal:	Increase the percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool (NFP and MIECHV Programs)	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	# of children receiving a developmental screening
	Denominator:	# of children enrolled in MIECHV program
Data Sources and Data Issues:	MIECHV program data	
Significance:	Developmental screening using a validated screening tool at regular intervals is an important part of making sure a child is healthy. When a developmental delay is not recognized early, children must wait to get the help they need. The earlier a child with a delay is identified, the sooner they can start receiving support for the delay and may even enter school more ready to learn.	

ESM 6.2 - # of new pediatric practices to adopt PEDs

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

Measure Status:	Active	
Goal:	Increase the number of pediatric practices who sign up to use the PEDS tool and receive training and TA.	
Definition:	Unit Type:	Count
	Unit Number:	50
	Numerator:	The number of practices that sign up and receive subsequent training and TA.
	Denominator:	
Data Sources and Data Issues:	DE APP	
Significance:	In order to increase developmental screening, additional providers need to screen using a validated tool within the new recommended AAP guidelines. It is important for Delaware to continue to recruit new practices to receive training and offer ongoing TA to utilize the PEDs tool enhancing early detection and intervention.	

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

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

Measure Status:	Active	
Goal:	To identify which recommendation(s) MCH can assist or lead implementation efforts.	
Definition:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Did MCH identify which recommendation we can assist and/or lead?
	Denominator:	
Data Sources and Data Issues:	PANO program data	
Significance:	Habits developed during adolescence play a key role in adult health and help prevent diseases. It is important for adolescents feel empowered to have a lifestyle and have access to the resources and support needed to achieve a healthy lifestyle.	

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

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

Measure Status:	Active	
Goal:	Increase adolescent physical activity	
Definition:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	How many schools receive training
	Denominator:	
Data Sources and Data Issues:	DPH and DOE Program Data	
Significance:	Regular physical activity can help children and adolescents improve cardiorespiratory fitness, control weight, reduce symptoms of anxiety and depression, and reduce the risk of developing health conditions	

**ESM 10.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Measure Status:	Active	
Goal:	Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.	
Definition:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Strategic Plan complete
	Denominator:	
Data Sources and Data Issues:	MCH Program Data	
Significance:	School Based Health Centers play a key role in providing comprehensive services for adolescents especially are most vulnerable. Services offered include physicals, health assessments, mental health, physical activity consults, nutrition consults as well as reproductive health.	

ESM 10.2 - Number of adolescent receiving services at a school-based health center who have a risk health assessments completed

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

Measure Status:	Active	
Goal:	To increase the number of adolescents identified in need of services (i.e. mental health; nutrition; reproduction health)	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	# of children receiving an assessment
	Denominator:	# of children enrolled and receiving services at a SBHC
Data Sources and Data Issues:	SBHC program data	
Significance:	Standardized assessment are important to ensure adolescents receive the services specific to their need.	

ESM 10.3 - Increase the # of unique mental health visits provided to SBHC enrollees**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Measure Status:	Active	
Goal:	Increase the number of mental heath visits for adolscents enrolled in SHBCs and Medicaid	
Definition:	Unit Type:	Count
	Unit Number:	15
	Numerator:	Number of students (i.e., 13-18 year olds) enrolled in SBHCs with Medicaid as their payor who had a mental health visit.
	Denominator:	
Data Sources and Data Issues:	SBHC program data and Medicaid claims data	
Significance:	Adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; taking regular exercise; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school and in the wider community are also important.	

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

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

Measure Status:	Active									
Goal:	Increase the percent of children enrolled in Medicaid, ages 1 through 17, who had a preventive dental visit in the past year									
Definition:	<table border="1"><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of children enrolled in Medicaid who received a preventative dental visit in the last year</td></tr><tr><td>Denominator:</td><td>Number of children who received a preventative dental visit in the last year</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of children enrolled in Medicaid who received a preventative dental visit in the last year	Denominator:	Number of children who received a preventative dental visit in the last year
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of children enrolled in Medicaid who received a preventative dental visit in the last year									
Denominator:	Number of children who received a preventative dental visit in the last year									
Data Sources and Data Issues:	National Survey for Children's Health									
Significance:	Preventive dental visits ensure children have a bright and healthy smile. It also spares children the aches of tooth decay. We know the sooner families start regularizing their child's dental visits, the better their oral health will be throughout their lives.									

**ESM 15.1 - Establishment of Cross-Agency Coordination Committee between DPH and Medicaid
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured**

Measure Status:	Active	
Goal:	Work with Medicaid partners to develop the structure, process, and policy that will support the creation of the Cross-Agency Coordination Committee (CACC).	
Definition:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Structure and schedule for CACC
	Denominator:	
Data Sources and Data Issues:	CACC meeting minutes.	
Significance:	As described in our recently signed MOU, the CACC will work to establish a multi-disciplinary coordination committee who will be responsible for working together on training, messaging, case management, and procedures. The overarching goals of this committee is to ensure that the mothers and families in Delaware who are eligible for services are given a clear understanding of where and how they can obtain those services. This group will address any redundant services and activities between agencies as well as filling any gaps in services that exist.	

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

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

Measure Status:	Active									
Goal:	For Title V/MCH to participate and stay engaged in the CMCAC meetings and share information with Family Shade and other CYSHCN partners.									
Definition:	<table border="1"><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>4</td></tr><tr><td>Numerator:</td><td>Number of meetings attended by Title V/MCH</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	4	Numerator:	Number of meetings attended by Title V/MCH	Denominator:	
Unit Type:	Count									
Unit Number:	4									
Numerator:	Number of meetings attended by Title V/MCH									
Denominator:										
Data Sources and Data Issues:	MCH program data									
Significance:	During development of Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity (the Plan), it became evident early in the planning process that there would not be enough time to perform an in-depth analysis of the full continuum of care for children with medical complexity. The data needed to perform a quantitative analysis is very detailed and complex. Therefore, the first recommendation made as a result of the Plan development, was for DMMA to continue working with stakeholders to address the needs of this vulnerable population. As a result, the Children with Medical Complexity Advisory Committee (CMCAC) was developed. This group meets quarterly to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ultimately ensure that every child with medical complexity has the opportunity to receive the adequate and appropriate health care services they need and deserve.									

ESM 15.3 - % of primary caregivers and children with health insurance among Home Visiting participants
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active	
Goal:	To increase the number of primary caregivers and children with health insurance	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	# of primary caregivers and children (families) with health insurance
	Denominator:	# of families enrolled
Data Sources and Data Issues:	MIECHV program data	
Significance:	Health insurance covers essential health benefits critical to maintaining general health, preventive care, treating illness and accidents	

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: 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:	Unit Type:	Count
	Unit Number:	150
	Numerator:	Total number of social media messages
	Denominator:	
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.	

2016-2020: 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:	<table border="1"><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>10,000</td></tr><tr><td>Numerator:</td><td>Number of women who receive Bundle A services/preconception services</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of women who receive Bundle A services/preconception services	Denominator:	
Unit Type:	Count									
Unit Number:	10,000									
Numerator:	Number of women who receive Bundle A services/preconception services									
Denominator:										
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.									

2016-2020: 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:	Unit Type:	Count
	Unit Number:	200
	Numerator:	Total number of breastfeeding material downloads
	Denominator:	
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.	

2016-2020: 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:	Unit Type:	Count
	Unit Number:	12
	Numerator:	Number of MIECHV home visitors who become certified
	Denominator:	
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.	

2016-2020: 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:	Unit Type:	Count
	Unit Number:	150
	Numerator:	The number of referrals to HMG/2-1-1 from pediatric practices
	Denominator:	
Data Sources and Data Issues:	HMG/211 data on Practice Referrals	
Significance:	<p>To reach the goal of ensuring all eligible children receive developmental screens, we recognized the barriers faced if primary care was the sole delivery mechanism. Consideration for a non-traditional approach led to the expansion of screening by phone through the Help Me Grow/2-1-1 (HMG/2-1-1) call center. After receiving standard 2-1-1 service, parent callers of children birth to 8 years will be invited by the HMG/2-1-1 call staff to complete a questionnaire regarding their child's development. The tool of preference is the Parents' Evaluation of Developmental Status - (PEDS online). Indicator that families are actually receiving the appropriate services they need.</p>	

2016-2020: 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:	<table border="1"><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Percentage of high risk screens referred to early intervention/Part C.</td></tr><tr><td>Denominator:</td><td>N/A</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Percentage of high risk screens referred to early intervention/Part C.	Denominator:	N/A
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Percentage of high risk screens referred to early intervention/Part C.									
Denominator:	N/A									
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.									

2016-2020: 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:	Unit Type:	Count
	Unit Number:	200
	Numerator:	Number of screens after PEDS/HMG intergration
	Denominator:	
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.	

2016-2020: 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:	Unit Type:	Count
	Unit Number:	10
	Numerator:	Number of new partnerships made
	Denominator:	
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.	

2016-2020: 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:	Unit Type:	Count
	Unit Number:	5,000
	Numerator:	Total number of views to the YouTube videos
	Denominator:	
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 developmental screening as well as indicate parent engagement on the topic of developmental screening	

2016-2020: ESM 8.1.1 - # of MCH social marketing materials (brochures, blogs, website content, tweets, etc) that include healthy lifestyle messages for children

2016-2020: 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:	Unit Type:	Count
	Unit Number:	20
	Numerator:	Number of MCH materials that include incorporation healthy lifestyle messages for children
	Denominator:	
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.	

2016-2020: ESM 8.1.2 - Create a marketing message to address healthy lifestyles and active living for children ages 6-11

2016-2020: 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:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Marketing message developed
	Denominator:	
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.	

2016-2020: ESM 8.1.3 - # of Healthy Lifestyles brochures for children ages 6-11 distributed

2016-2020: 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:	Unit Type:	Count
	Unit Number:	1,000
	Numerator:	# of brochures disseminated
	Denominator:	
Data Sources and Data Issues:	MCH Program Data	
Significance:	The brochures reach to birth to age 8...prevention targeting young children	

2016-2020: 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

2016-2020: 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:	Unit Type:	Count
	Unit Number:	12
	Numerator:	Number of meetings attended by MCH and/or Bureau of Health Promotion
	Denominator:	
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.	

2016-2020: ESM 9.1 - Complete environmental scan of all the activities and messages being promoted around bullying prevention to ensure alignment

2016-2020: 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:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Environmental scan of DOE and MCH messages
	Denominator:	
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.	

2016-2020: ESM 9.2 - # of people who attend Safe Kids conference

2016-2020: 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:	Unit Type:	Count
	Unit Number:	75
	Numerator:	Number of people in attendance
	Denominator:	
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.	

2016-2020: ESM 9.3 - # of trainings and learning sessions presented to staff focused on bullying

2016-2020: 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:	Unit Type:	Count
	Unit Number:	5
	Numerator:	# of trainings/learning sessions offered
	Denominator:	
Data Sources and Data Issues:	MCH program data	
Significance:	Bullying is a new 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.	

2016-2020: ESM 9.4 - # of meetings, conferences, webinars MCH staff attend in partnership with School Based Health Centers that address bullying

2016-2020: 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:	<table border="1"><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>6</td></tr><tr><td>Numerator:</td><td>Number of meetings attended by both MCH and SBHC staff</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	6	Numerator:	Number of meetings attended by both MCH and SBHC staff	Denominator:	
Unit Type:	Count									
Unit Number:	6									
Numerator:	Number of meetings attended by both MCH and SBHC staff									
Denominator:										
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.									

2016-2020: ESM 9.5 - # of partners who attend various information sessions and conferences presented by DPH around bullying and/or emotional well-being.

2016-2020: 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:	Unit Type:	Count
	Unit Number:	200
	Numerator:	# of partners who attend DPH/MCH hosted sessions
	Denominator:	
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.	

2016-2020: ESM 11.1 - Include questions around the availability of medical homes within an annual survey conducted by Family SHADE

2016-2020: 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:	<table border="1"><tr><td>Unit Type:</td><td>Text</td></tr><tr><td>Unit Number:</td><td>Yes/No</td></tr><tr><td>Numerator:</td><td>Survey disseminated and contains questions regarding medical home</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Text	Unit Number:	Yes/No	Numerator:	Survey disseminated and contains questions regarding medical home	Denominator:	
Unit Type:	Text									
Unit Number:	Yes/No									
Numerator:	Survey disseminated and contains questions regarding medical home									
Denominator:										
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.									

2016-2020: ESM 11.2 - Identification of a care coordination toolkit to be recommended for use by both clinicians and families

2016-2020: 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:	Unit Type:	Text
	Unit Number:	Yes/No
	Numerator:	Identification of a toolkit
	Denominator:	
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.	

2016-2020: ESM 11.5 - Convene education sessions/workshops/seminars explaining medical home and care coordination concepts to public health professional who interface with CYSHCN.

2016-2020: 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:	Unit Type:	Count
	Unit Number:	2
	Numerator:	Number of educational sessions
	Denominator:	
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 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.	

2016-2020: ESM 11.6 - Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.

2016-2020: 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:	Develop a marketing campaign that highlights our early intervention birth to three program and how to access services.								
Definition:	<table border="1"><tr><td>Unit Type:</td><td>Text</td></tr><tr><td>Unit Number:</td><td>Yes/No</td></tr><tr><td>Numerator:</td><td>0</td></tr><tr><td>Denominator:</td><td></td></tr></table>	Unit Type:	Text	Unit Number:	Yes/No	Numerator:	0	Denominator:	
Unit Type:	Text								
Unit Number:	Yes/No								
Numerator:	0								
Denominator:									
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 meet our social marketing vendor to start the process to develop a campaign that will highlight early intervention services and how to access them but also the importance of a medical home.								

2016-2020: 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.

2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active	
Goal:	Promote BOHDS new website which includes community member materials as well as the Oral Health Tool Kit.	
Definition:	Unit Type:	Count
	Unit Number:	60,000
	Numerator:	# of hits on BOHDS website
	Denominator:	
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.	

2016-2020: ESM 13.1.2 - Promote the importance of good oral health during pregnancy through social marketing.
2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active									
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:	<table border="1"><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>200</td></tr><tr><td>Numerator:</td><td>Social Marketing campaign presented on dethrives.com</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	200	Numerator:	Social Marketing campaign presented on dethrives.com	Denominator:	
Unit Type:	Count									
Unit Number:	200									
Numerator:	Social Marketing campaign presented on dethrives.com									
Denominator:										
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.									

2016-2020: ESM 13.1.3 - Increase awareness of expanded Medicaid coverage for adult dental health care.

2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active									
Goal:	Work with DPH staff, contractors, and community partners to ensure pregnant mothers who have AmeriHealth Caritas Delaware MCO coverage know of the oral health benefits available to them during their pregnancy.									
Definition:	<table border="1"><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>5</td></tr><tr><td>Numerator:</td><td># of community presentations completed</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	5	Numerator:	# of community presentations completed	Denominator:	
Unit Type:	Count									
Unit Number:	5									
Numerator:	# of community presentations completed									
Denominator:										
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.									

2016-2020: 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	
Goal:	Provide presentation regarding the importance of Oral Health, available resources and new initiatives to MCH partners and community members.	
Definition:	Unit Type:	Count
	Unit Number:	15
	Numerator:	# of presentations completed
	Denominator:	
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.	

2016-2020: 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:	Unit Type:	Count
	Unit Number:	40
	Numerator:	Number of pediatric practices who are providing fluoride treatments
	Denominator:	
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.	

Form 11

Other State Data

State: Delaware

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

Form 12
MCH Data Access and Linkages

State: Delaware

Annual Report Year 2020

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	Quarterly	18		
2) Vital Records Death	Yes	No	Quarterly	18	Yes	
3) Medicaid	Yes	Yes	Daily	0	Yes	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	No	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	No	
7) Hospital Discharge	Yes	No	Annually	24	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	0	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None