Delaware State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	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	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.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics ESM 1.2: % of women served by the HWHBs program that were screened for pregnancy intention ESM 1.3: % of Medicaid women who use a most to moderately effective family planning birth control method	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

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	Support the development and implementation of the housing pilot for pregnant women in collaboration with the DHMIC's Social Determinants of Health workgroup. Ensure the data reports produced by Title V describe releveant disparities and discuss potential root causes, implications, and recommendations for moving towards equity and improved health outcomes for women and babies.				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
Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	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	By July 2025, decrease the number of live births that were the result of an unintended pregnancy.	SPM 1: Percent of Delaware women with a recent live birth who indicated that their pregnancy was unintended.		
Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	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.	Decrease the Black/White Infant Mortality Ratio from 3.8 in 2020 to 2.0 in 2025	SPM 2: Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Perinatal/Infant Health					
Improve breastfeeding rates.	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.	By July 2025, increase breastfeeding initiation rates in Delaware from 77% to 84%.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	***Inactive -*** *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	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
Child Health					
Children receive developmentally appropriate services in a well coordinated early childhood system.	Train medical and childcare providers on developmental screening. Utilize Home Visiting/MIECHV programs to provide the Ages and Stages Developmental Screening tool to clients. Improve coordination of referral and services between early care and education, home visitors, medical homes, and early intervention. Promote parent and caregiver awareness of developmental screening Recruit new pediatric practices to adopt PEDS Continue to host Books, Balls and Blocks events for families to educate families on developmental milestones, age appropriate activities and provide an opportunit for children to receive developmental screening.	By July 2025, increase the percent of children, ages 9-71 months, receiving a developmental screening using a validated parent-completed screening tool.	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	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. ***Inactive -*** *ESM 6.2: # of new pediatric practices to adopt PEDs*	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

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	Pilot CHADIS with 4 pediatric practices.			ESM 6.3: % of children at pediatric practices who adopt PEDS and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.	
Improve the rate of Oral Health preventive care in children.	Promote practice of early childhood medical providers providing oral health screenings, fluoride varnish application, anticipatory guidance, and dental referrals by age one. Collaborate with Medicaid to increase the number of children and youth who have had a preventive dental visit in the past year. Increase oral health referrals among children and youth through School Based Health Centers. Work with Family SHADE and BODS to promote avaialble dental service for CYSHN Continue to foster discussions with school districts to develop a dental program within SBHCs to promote dental health as an integral part of the overall health of students. Incorporate oral health education into school curriculum. Collaborate with DE AAP to promote early literacy through purchasing the book "Brush, Brush, Brush" that are distributed by a dental hygienist to pediatric provider offices for children ages 1-5.	By 2025, the percent of children 1-17 who had a preventive dental visit in the past year will increase to 87%	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year. ESM 13.2.2: Increase the referrals received for dental services via the DEThrives website.	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Adolescent Health					
Increase the number of adolescents receiving a	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.	Develop a cross-system partnership and protocols to increase the proportion of adolescents receiving annual	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in	***Inactive -*** *ESM 10.1: Finalize the School Based Health Center Strategic Plan, which*	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
preventative well-visit annually to support their social, emotional and physical well-being.	Improve data collection at SBHCs Communicate with and share resources with school nurses statewide to promote adolescent well visits. Provide school-based access to confidential mental health screening, referral and treatment that reduces stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment. Ensure adolescents are enrolled in a health insurance program. Use media strategies (e.g., facebook and instagram posts, websites) in conjunction with other strategies to promote comprehensive adolescent well visits and healthy lifestyles. Partner with SBHC and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits. Continue to work with our partners and health providers to implement the 13 strategic goals with the SBHCs which are a result of the SBHC strategic plan. Collaborate with DOE and the DE State Education Assocation (DSEA) to promote mental wellness.	preventive services by 2025.	the past year.	*is anchored in best-practices.* ESM 10.2: % of adolescents receiving services at a school-based health center who have a risk health assessment completed ***Inactive -*** *ESM 10.3: Increase the # of unique mental health visits provided to SBHC enrollees* ESM 10.4: % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues. ESM 10.5: % of children and adolescents receiving services for Project THRIVE	NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
					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
Empower adolescents to adopt healthy behaviors.	Promote physical activity counseling during well-child visits including SBHC visits. In collaboration with PANO, increase social marketing media and public communication (posters, flyers, etc.) promoting healthy lifestyle and available resources such as bike and walking trails. Participate in Delaware "cluster collaborative meetings" to encourage coordination among DOE, DPH and DSAMH to address adolescent health and wellness Align with Whole School, Whole Community, Whole Child model and develop a strategy that includes coordination and collaboration with child and adolescent health priorities. Partner with SBHCs to provide COVID 19 strategies, mitigation practices, testing, vaccinations and resource allocation to middle and high school students as well as their family members.	Increase the percent of adolescents students who are physically active at least 60 minutes a day to 49%.	NPM 8.2: Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day	***Inactive -*** *ESM 8.2.1: Determine which policy recommendations that address health promotion and disease prevention initiatives in schools and community-based settings that MCH can assist or lead implementation efforts.* ***Inactive -*** *ESM 8.2.2: DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online*	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)

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				resources and Tool Kit. ESM 8.2.3: Increase the percent of locations implementing the Triple Play model within DE schools.	
Children with Special Health Care Needs					
Increase the percent of children with and without special health care needs who are adequately insured.	Support workforce development training for Title V staff and family organizations to ensure knowledge of insurance coverage options in the State of Delaware. Continue to be involved in the Complex Medical Needs Advisory Council lead by Medicaid to address needed services that medicaid may or may not cover. Health Insurance Enrollment Outreach and Support for un-/under-insured families. Investigate providing care coordination to guide patients through supports with our family led organization. Continue to implement the Family SHADE mini grantee program that aligns with the Title V MCH Block Grant performance measures and the National Standards for CYSHCN. Continue to support the collaboration of a cross agency coordination committee between DPH and Medicaid. Establish a LOA with our family delegate to attend the AMCHP annual conference and develop their knowledge and understanding on how to enhance Delaware's efforts on addressing a targeted NPMs. Support and assist the Parent Information Center in providing training and technical assistance to the Family SHADE mini grantees on best practices	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.	NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured	***Inactive -*** *ESM 15.1: Establishment of Cross-Agency Coordination Committee between DPH and Medicaid* ***Inactive -*** *ESM 15.2: # of Children with Medical Complexities Advisory Committee (CMCAC) meetings and/or sub-committee meetings attended to improve support of these children included Medicaid coverage.* ESM 15.3: % of primary caregivers and children with health insurance among Home Visiting participants ESM 15.4: Increase	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,

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	for program development, management, evaluation and quality improvement as the selected contract vendor.			the percent of families enrolled as a member of the Family Leadership Network. ESM 15.5: Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.	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
Cross-Cutting/Systems Building					
	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.	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.	SPM 3: Strenghthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities		