Delaware State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.	Increase the percent of women participating in a MCH program (HWHB, Home Visiting) who have a postpartum visit within 12 weeks after giving birth.	HWHBs Community Health Workers will serve as a liaison between patients and health care providers to improve access to postpartum care. Ensure that they are recruited, trained, and deployed to support postpartum care access and coordination. HWHB programs will improve their data collection and reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are meticulously documented. Train CHWs and track core competencies in perinatal health, postpartum care, and community engagement. Evidence-based home visiting programs will support and assist women who have recently given birth in completing a postpartum visit within 12 weeks. Build community awareness and the availability of doula services and that this services are now covered by Medicaid including 3 visits during the postpartum period.	ESM PPV.1 - 80% of women enrolled in the HWHBs program will have a documented postpartum visit checkup in the record. (Improve data collection and HWHBs program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are ESM PPV.2 - Mothers enrolled in home visiting will receive a postpartum visit within 12 weeks of giving birth.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Women have access to safe and supportive patient centered care, where their concerns are listened to, and they are included as	Develop dissemination plan for Her Story 2.0 series to ensure broad and targeted reach, including community providers (e.g., DPQC, Ob/Gyn, Primary Care providers (MDs and Nurses), doulas, influencers) by December 2026.	Develop Her Story 2.0 by engaging community partners, providers and women in uplifting information, patient navigation resources and expertise that can enhance maternal health initiatives and messaging. A series of videos will recognize the complex interaction of social context issues (i.e. implicit bias within the health system, reduced access to perinatal and postpartum care, food insecurity, lack of housing, SUD, etc.) in the lives of pregnant and postpartum women of minority status, and specifically Black women, which contribute to an increase in poor health outcomes.	ESM DSR.1 - Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, co-designed and co-	NPM - Perinatal Care Discrimination	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Preterm-Related Mortality

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partners in health decision making.			delivered with women and communities most impacted by negative maternal healthcare outcomes. (i		Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Pregnant and parenting women have stable housing and are connected to essential resources and services that can improve their outcomes.	By 2030, decrease the number of pregnant women facing housing instability.	Partner with Community Legal Aid to prioritize services for pregnant women. Continue to partner with the DHMIC SODH Committee to implement the core set recommendations that have been developed to address housing instability for pregnant and parenting women. CHWs will screen the women they are serving for SODH related needs including housing and connecting them to appropriate resources.	ESM HI-Pregnancy.1 - Decrease the number of pregnant women facing housing instability.	NPM - Housing Instability - Pregnancy	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Postpartum Depression Postpartum Anxiety
Child Health					
Children receive developmentally appropriate services in a well-coordinated early childhood system.	By July 2030, increase the percentage of children, ages 9 through 71 months, receiving a developmental screening using a validated parent-completed screening tool. By July 2030, increase the percentage of pediatric clinics and childcare programs that are using evidence-based screening tools. By July 2030, reduce the disparity in developmental screening outcomes between children, ages 36 through 47 months residing in	Continue to train medical and childcare providers on developmental screening. Utilize Home Visiting/MIECHV programs to assist families in completing the Ages and Stages Developmental Screening tool to clients but also providing education/resources on milestones and referrals to early intervention when needed. 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. Continue to host Books, Balls and Blocks events to educate families on developmental milestones, age-appropriate activities, and provide an opportunity for children to receive developmental screening.	ESM DS.1 - Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool enrolled in a MIECHV program. ESM DS.2 - Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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	higher risk geographic regions as compared to children ages 36 through 47 months residing in lower risk geographic regions.	Continue to build out the CHADIS platform with pediatric practices. Provide System Coordination of developmental screenings with partners and providers. This includes HMG, childcare, home visiting programs, and primary care providers to assess for gaps, assure access and reduce duplication.	or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen. ESM DS.3 - Decrease the disparity in developmental screening outcomes for children residing in different regions (higher versus lower) within the state.		
All children, with and without special health care needs, have access to a medical home model of care.	Increase the number of children who report having a medical home.	Partner with HMG and home visiting programs to identify families who have children without a medical home and provide resources and referrals. Develop educational materials on what a medical home is and disseminate. Offer ongoing professional development opportunities for providers to support family-centered care with a medical home.	ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Adolescent Health					
Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health	Expand the number of qualified providers through strategic partnership with the DSCYF DCPAP Pediatric Mental Health Grant. Increase the percentage of high school students enrolled in	Enhance the capacity of behavioral and mental health providers both working in and referred by Delaware SBHCs through partnership with DSCYF Delaware Child Psychiatry Access Program – Pediatric Mental Health Grant. Improve the outreach of Delaware SBHCs in enrolling and screening high school students for behavioral and mental health services.	ESM MHT.1 - Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP. ESM MHT.2 -	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care

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services among those who are shown to be at higher risk for anxiety or depression, per screening	Delaware SBHCs. Increase the percentage of students enrolled in Delaware SBHCs who are screened for behavioral and mental health services.		Percentage of high school students enrolled in Delaware SBHCs. ESM MHT.3 - Percentage of high school students enrolled in Delaware SBHCs who are screened for behavioral and mental health services (PHQ and GAD-7 are usually components of a risk assessment).		Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
All children, with and without special health care needs, have access to a medical home model of care.	By 2030, increase the percent of parents of CYSHCN who feel that are a part of a medical home model of care.	Utilize universal practices to promote all children and CYSHCN have access to care that meets the medical home model of care criteria, which includes comprehensive care, patient-centered, coordinated care, accessible services, quality and safety. Develop a survey which will be utilized by mini-grantees who are awarded by Family SHADE, which captures the families that are served and have access to care which meets the medical home model of care criteria. Family SHADE will collaborate with Family to Family to educate health care providers and build partnerships by providing educational sessions on medical home model of care. Develop and disseminate a variety of culturally relevant educational messages and resources on the medical home model of care. Assist families with Medicaid enrollment.	ESM MH.1 - Increase the percentage of children enrolled in home visiting services who receive the recommended number of well-child visits according to the American Academy of Pediatrics (AAP) Bright Futures schedule.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
All CYSHCN receive the necessary organized	By 2030, increase the percent of adolescents with special health care needs who received services necessary to make transitions to	Mini-grantees will survey adolescents, ages 12 through 17, with special health care needs to assess their knowledge and awareness on the importance of an organized transition process and if they feel they have the necessary support to develop a plan.	ESM TAHC.1 - Increase the number of adolescents with a transition plan into an	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

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services to make the transition to adult health care.	adult health care.	Partner with the Family Leadership Network (FLN) will customize a transition plan tool kit to assist families on things to consider, questions to ask their doctors as their child with a special health care need transitions to adult health care. Mini-grantees will educate adolescents and families they serve with special health care needs, ages 12 through 17, on how to prepare for transition to adult health care plan. Work with current partners (Parent Information Center, Family Voices) and mini-grantees to provide education and skill-building opportunities for youth and families on navigating insurance; making appointments; self-management. Explore adolescents and their family's needs to help with transition to adult healthcare, insurance, employment, education and housing.	adult health care system of care for CYSHCN ages 12-17.		
Cross-Cutting/Systems Building					
	Build MCH capacity and support the development of a trained and qualified workforce by providing professional development opportunities.	Develop an Accountability Matrix, which provides specific workgroup, contact, and data information about each NPM to ensure no overlap and to track progress. Create ongoing learning resources and videos to internal employees as well as partners to address topics such as: onboarding, burnout, Title V resources, technical assistance opportunities, and more. Periodically survey and deliver to our internal and external partners the needed training opportunities that are requested to develop our workforce and address actual competency needs.	SPM ESM 1.1 - To increase the percentage of MCH staff that have completed at least one professional development opportunity.	SPM 1: Strengthen Delaware's Tittle V Workforce and community stakeholder capacity and skill building via training and professional development opportunities.	