Delaware State Action Plan Table 2025 Application/2023 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 access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	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.	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	ESM WWV.1 - # of women who receive preconception counseling and services during annual reproductive health and preventive visit at family planning clinics ESM WWV.2 - % of women served by the HWHBs program that were screened for pregnancy intention ESM WWV.3 - % of Medicaid women who use a most to moderately effective family planning birth control method	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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		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.			NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Women have access to and receive coordinated, comprehensive services before, during and beyond pregnancy.	By July 2025, decrease the number of live births that were the result of an unintended 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		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.	Decrease the Black/White Infant Mortality Ratio from 3.8 in 2020 to 2.0 in 2025	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.		SPM 2: Reduce the percent of infant deaths of black women enrolled in HWHB programs as compared to black women not enrolled in HWHB.	
	Increase the percent of women in the Healthy Women Healthy Babies program who attended a post partum check up within 12 weeks of giving birth.	Incorporate a fourth trimester benchmark in the Healthy Women Healthy Babies program, that incentivizes providers to implement strategies to better meet the needs of women in the postpartum period, with an assessment, either in person or by phone with follow up as needed.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Improve breastfeeding	By July 2025, increase breastfeeding initiation rates in	Continue to strengthen hospital efforts in supporting mothers/babies through comprehensive breastfeeding policies.	***Inactive -*** *ESM BF.1 - Increase the number*	NPM - A) Percent of infants who are ever	NOM - Infant mortality rate per 1,000 live births (Infant Mortality,

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rates.	Delaware from 77% to 84%.	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.	*of birthing facilities that receive baby friendly designation* ESM BF.2 - Percent of infants receiving breast milk at 6 months of age enrolled in home visiting	breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Child Health					
Children receive developmentally appropriate services in a well coordinated early childhood system.	By July 2025, increase the percent of children, ages 9-71 months, receiving a developmental screening using a validated parent-completed screening tool.	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. Pilot CHADIS with 4 pediatric practices.	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. ***Inactive -*** *ESM DS.2 - # of new pediatric practices to adopt PEDs* ESM DS.3 - % of children at pediatric practices who adopt PEDS and/or use CHADIS with	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			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.	By 2025, the percent of children 1-17 who had a preventive dental visit in the past year will increase to 87%	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.	ESM PDV-Child.1 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year. ESM PDV-Child.2 - Increase the referrals received for dental services via the DEThrives website.	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
	Increase the percent of families reporting that their child has a medical home.	Work with our partners to provide education and awareness around the importance of being connected to a primary care provider.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Increase the	Develop a cross-system	Partner with adolescent serving organizations or agencies, including but	***Inactive -*** *ESM*	NPM - Percent of	NOM - Adolescent mortality rate

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number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being.	partnership and protocols to increase the proportion of adolescents receiving annual preventive services by 2025.	not limited to family planning, substance abuse and/or community colleges to promote adolescent well visits. 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.	*AWV.1 - Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices.* ESM AWV.2 - % of adolescents receiving services at a school-based health center who have a risk health assessment completed ***Inactive -*** *ESM AWV.3 - Increase the # of unique mental health visits provided to SBHC enrollees* ESM AWV.4 - % of mental health visits within a SBHC that include screening and assessment for developmental, emotional, and behavioral issues. ESM AWV.5 - % of children and adolescents receiving services for Project THRIVE	adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese

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					(BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Empower adolescents to adopt healthy behaviors.	Increase the percent of adolescents students who are physically active at least 60 minutes a day to 49%.	Promote physical activity counseling during well-child visits including SBHC visits. In collaboration with PANO, increase social marketing media and public	***Inactive -*** *ESM PA-Adolescent.1 - Determine which policy*	NPM - Percent of adolescents, ages 12 through 17 who are physically active at least 60	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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		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.	*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 PA-Adolescent.2 - DPH will provide technical assistance for FitnessGram implementation, professional development and training opportunities for Delaware educators, and provide online resources and Tool Kit.* ESM PA-Adolescent.3 - Increase the percent of locations implementing the Triple Play model within DE schools.	minutes per day (Physical Activity - Adolescent, Formerly NPM 8.2) - PA-Adolescent	NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Children with Special Health Care Needs					
Increase the percent of children with and without special health	By 2025, increase the percent of families reporting that their CYSHCN's insurance is adequate.	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	***Inactive -*** *ESM AI.1 - Establishment of Cross-Agency Coordination Committee between*	NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance,	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN

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care needs who are adequately insured.	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.	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 for program development, management, evaluation and quality improvement as the selected contract vendor.	*DPH and Medicaid* ***Inactive -*** *ESM AI.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 AI.3 - % of primary caregivers and children with health insurance among Home Visiting participants ESM AI.4 - Increase the percent of families enrolled as a member of the Family Leadership Network. ESM AI.5 - Increase the percent of CYSHCN 0-17 that are served by the Family SHADE mini-grantees.	Formerly NPM 15) - AI	Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the

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					Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
	By July 2030, increase the percent of families reporting that their CYSHCN is connected to a medical home.	MCH, in partnership with the Parent Information Center, will promote medical home education and awareness among CYSHCN and their families.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
	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.	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.		SPM 3: Strenghthen Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities	