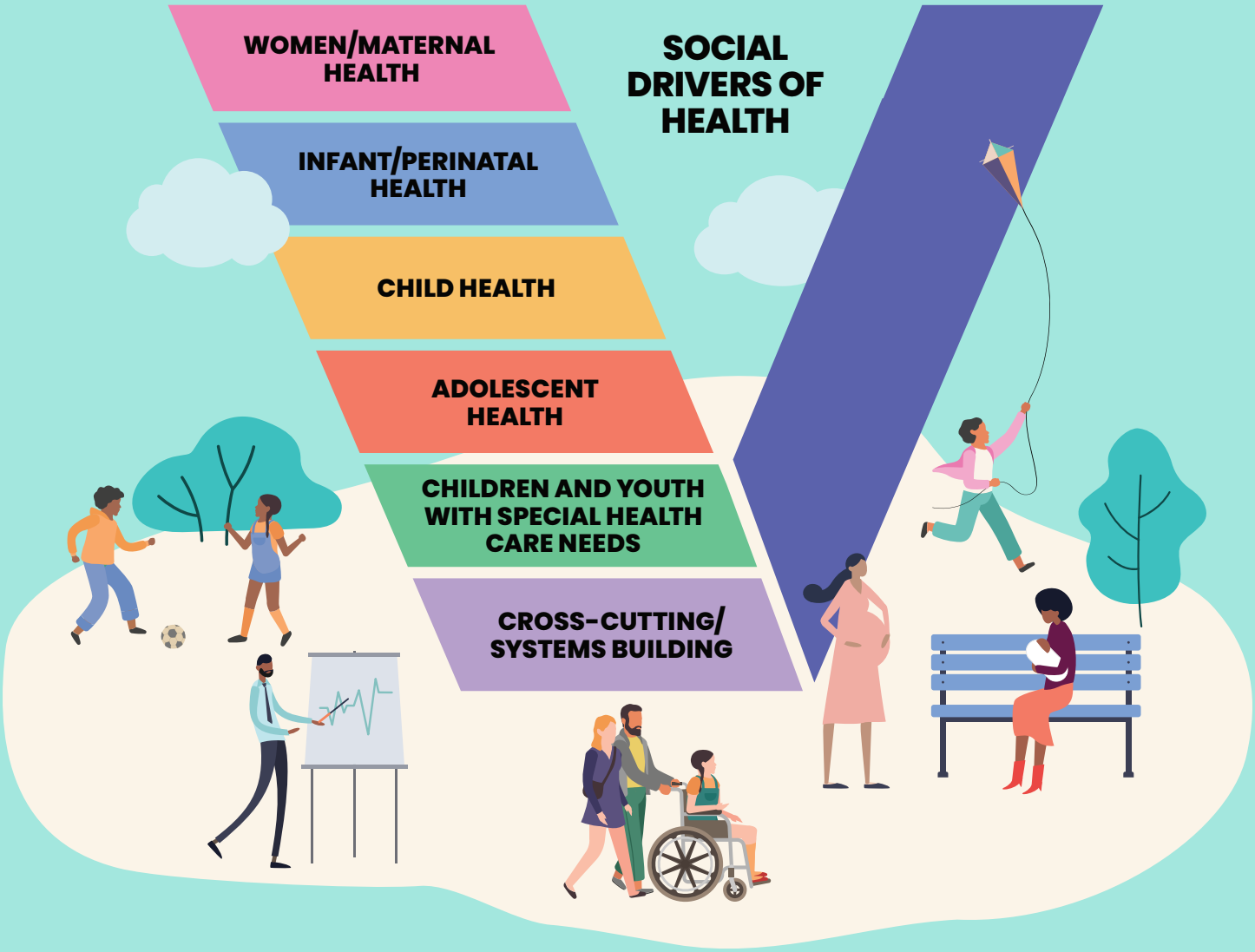
DELAWARE'S TITLE V MATERNAL & CHILD HEALTH STATE ACTION PLAN

2026–2030



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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Maternal and Child Health Bureau

WOMEN/MATERNAL HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components.

PRIORITY NEED 1

Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.

OBJECTIVE 1.1

Increase the percent of women participating in an MCH program (HWHB, Home Visiting) who have a postpartum visit within 12 weeks after giving birth.

STRATEGY 1.1.1 HWHB 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.

STRATEGY 1.1.2 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.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
PPV.1: *80% of women enrolled in the HWHB program will have a documented postpartum checkup in the record. (Improve data collection and HWHB program reporting so that infant DOB, postpartum visit date, and number of gestation weeks at enrollment are meticulously documented.)*

STRATEGY 1.1.3 Train CHWs and track core competencies in perinatal health, postpartum care, and community engagement.

STRATEGY 1.1.4 Evidence-based Home Visiting Programs will support and assist women who have recently given birth in completing a postpartum visit within 12 weeks.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
PPV.2: *Mothers enrolled in Home Visiting will receive a postpartum visit within 12 weeks of giving birth.*

STRATEGY 1.1.5 Build community awareness and the availability of doula services — and ensure that these services are now covered by Medicaid, including three visits during the postpartum period.

WOMEN/MATERNAL HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Perinatal Care Discrimination: Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting health care during pregnancy or delivery, or postpartum.

PRIORITY NEED 2

Women have access to safe and supportive patient-centered care, where their concerns are heard, and they are included as partners in health decision-making.

OBJECTIVE 2.1

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 doctors and nurses, doulas, influencers) by December 2026.

STRATEGY 2.1.1 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 (e.g., 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.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):

DSR.1: *Number of partnerships established with community-based organizations and providers to deliver patient education through Her Story 2.0, codesigned and codelivered with women and communities most impacted by negative maternal health care outcomes. (e.g., vignettes and videos of individuals with lived experience).*

INFANT/PERINATAL HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Housing Instability — Perinatal/Infant: Percent of children, ages 0 through 11, who experienced housing instability in the past year.

PRIORITY NEED 3

Pregnant and parenting women have stable housing and are connected with essential resources and services that can improve their outcomes.

OBJECTIVE 3.1

By 2030, decrease the number of pregnant women facing housing instability.

STRATEGY 3.1.1 Partner with Community Legal Aid to prioritize services for pregnant women.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
HI-PREGNANCY.1: *Decrease the number of pregnant women facing housing instability.*

STRATEGY 3.1.2 Continue to partner with the DHMIC SDOH Committee to implement the core set of recommendations that have been developed to address housing instability for pregnant and parenting women.

STRATEGY 3.1.3 CHWs will screen the women they are serving for SDOH-related needs, including housing and connecting them with appropriate resources.

CHILD HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Developmental Screening: Percent of children, ages 9 months through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

PRIORITY NEED 4

Children receive developmentally appropriate services in a well-coordinated early childhood system.

OBJECTIVE 4.1

By July 2030, increase the percentage of children, ages 9 months through 71 months, receiving a developmental screening using a validated parent-completed screening tool.

STRATEGY 4.1.1 Utilize Home Visiting/MIECHV programs to assist families in completing the Ages and Stages Developmental Screening tool, but also provide education/ resources on milestones and referrals to early intervention when needed.

STRATEGY 4.1.2 Promote parent and caregiver awareness of developmental screening.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
DS.1: *Percentage of children, ages 9 months through 71 months, receiving a developmental screening using a parent-completed screening tool enrolled in an MIECHV program.*

OBJECTIVE 4.2

By July 2030, increase the percentage of pediatric clinics and childcare programs that are using evidence-based screening tools.

STRATEGY 4.2.1 Continue to train medical and childcare providers on developmental screening.

STRATEGY 4.2.2 Improve coordination of referrals and services between early care and education, Home Visitors, medical homes, and early intervention.

STRATEGY 4.2.3 Continue to build out the CHADIS platform with pediatric practices.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
DS.2: *Increase the percentage of children at pediatric practices who adopt an evidence-based screening tool (ASQ or PEDS) and/or use CHADIS with documentation of a referral to early intervention due to having a higher risk developmental screen.*

CHILD HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Developmental Screening: Percent of children, ages 9 months through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

PRIORITY NEED 4

Children receive developmentally appropriate services in a well-coordinated early childhood system.

OBJECTIVE 4.3

By July 2030, reduce the disparity in developmental screening outcomes between children, ages 36 months through 47 months, residing in higher-risk geographic regions as compared with children of the same age residing in lower-risk geographic regions.

STRATEGY 4.3.1 Continue to host Books Balls & Blocks events to educate families on developmental milestones and age-appropriate activities, as well as provide an opportunity for children to receive developmental screening.

STRATEGY 4.3.2 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, ensure access, and reduce duplication.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
DS.3: *Decrease the disparity in developmental screening outcomes for children residing in different regions (higher risk versus lower risk) within the state.*

CHILD HEALTH

NATIONAL PERFORMANCE MEASURE (NPM):

Medical Home — Overall: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

PRIORITY NEED 5

All children, with and without special health care needs, have access to a medical home model of care.

OBJECTIVE 5.1

Increase the number of children who report having a medical home.

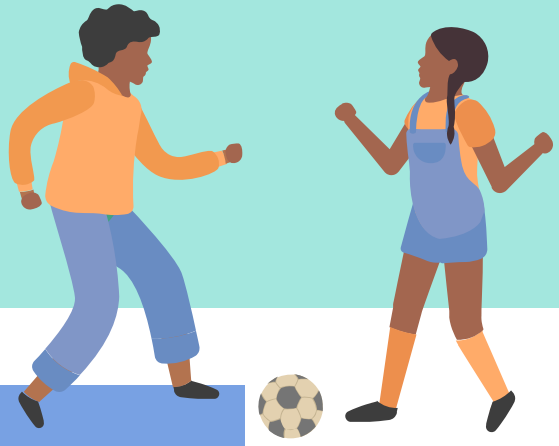
STRATEGY 5.1.1 Partner with HMG and Home Visiting Programs to identify families who have children without a medical home and provide resources and referrals.

STRATEGY 5.1.2 Develop educational materials on what a medical home is and disseminate the materials.

STRATEGY 5.1.3 Offer ongoing professional development opportunities for providers to support family-centered care with a medical home.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
MH.1: *Increase the percentage of children enrolled in Home Visiting Programs who receive the recommended number of well-child visits, according to the American Academy of Pediatrics (AAP) Bright Futures schedule.*

ADOLESCENT HEALTH



NATIONAL PERFORMANCE MEASURE (NPM):

Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling.

PRIORITY NEED 6

Increase the percentage of high school SBHC-enrolled adolescents receiving behavioral and mental health services among those who are shown to be at higher risk for anxiety or depression, per screening.

OBJECTIVE 6.1

Expand the number of qualified providers through a strategic partnership with the DSCYF's DCPAP Pediatric Mental Health Grant.

STRATEGY 6.1.1 Enhance the capacity of behavioral and mental health providers both working in and referred by Delaware SBHCs through a partnership with DSCYF's DCPAP Pediatric Mental Health Grant.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
MHT.1: *Percentage of behavioral and mental health providers within high school SBHCs who are linked with DCPAP.*

OBJECTIVE 6.2

Increase the percentage of high school students enrolled in Delaware SBHCs.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
MHT.2: *Percentage of high school students enrolled in Delaware SBHCs.*

OBJECTIVE 6.3

Increase the percentage of students enrolled in Delaware SBHCs who are screened for behavioral and mental health services.

STRATEGY 6.3.1 Improve the outreach of Delaware SBHCs in enrolling and screening high school students for behavioral and mental health services.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (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).*

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

NATIONAL PERFORMANCE MEASURE (NPM):

Medical Home — Overall: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

PRIORITY NEED 7

All children, with and without special health care needs, have access to a medical home model of care.

OBJECTIVE 7.1

By 2030, increase the percent of parents of CYSHCN who feel that they are part of a medical home model of care.

STRATEGY 7.1.1 Utilize universal practices to ensure that 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.

STRATEGY 7.1.2 Develop a survey that will be utilized by mini-grantees who are awarded by Family SHADE, which captures the families that are served and have access to care that meets the medical home model of care criteria.

STRATEGY 7.1.3 Family SHADE will collaborate with Family to Family to educate health care providers and build partnerships by providing educational sessions on the medical home model of care.

STRATEGY 7.1.4 Develop and disseminate a variety of culturally relevant educational messages and resources on the medical home model of care.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
MH.1: *Increase the percentage of children enrolled in Home Visiting Programs who receive the recommended number of well-child visits, according to the American Academy of Pediatrics (AAP) Bright Futures schedule.*

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

NATIONAL PERFORMANCE MEASURE (NPM):

Transition to Adult Health Care: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.

PRIORITY NEED 8

All CYSHCN receive the necessary organized services to make the transition to adult health care.

OBJECTIVE 8.1

By 2030, increase the percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

STRATEGY 8.1.1 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.

STRATEGY 8.1.2 Partner with the Family Leadership Network (FLN) to customize a transition plan toolkit to assist families on things to consider and questions to ask their health care providers as their child with special health care needs transitions to adult health care.

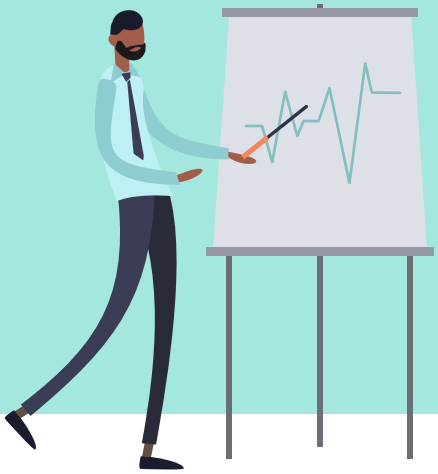
STRATEGY 8.1.3 Mini-grantees will educate adolescents with special health care needs, ages 12 through 17, and their families on how to prepare for transition to an adult health care plan.

STRATEGY 8.1.4 Work with current partners (Parent Information Center and Family Voices) and mini-grantees to provide education and skill-building opportunities for youth and families on navigating insurance, making appointments, and self-management.

STRATEGY 8.1.5 Explore the needs of adolescents and their families to help with transition to adult health care, insurance, employment, education, and housing.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
TAHC.1: *Increase the number of adolescents with a transition plan into an adult health care system of care for CYSHCN ages 12 to 17.*

CROSS-CUTTING/SYSTEMS BUILDING



STATE PERFORMANCE MEASURE (SPM):

Strengthen Delaware's Title V workforce and community stakeholder capacity and skill building via training and professional development opportunities.

PRIORITY NEED 9

Multiple workforce skills and identified needs are critical for addressing public health challenges now and into the future.

OBJECTIVE 9.1

Build MCH capacity and support the development of a trained and qualified workforce by providing professional development opportunities.

STRATEGY 9.1.1 Develop an accountability matrix that provides specific workgroup, contact, and data information about each NPM to ensure no overlap and to track progress.

STRATEGY 9.1.2 Create ongoing learning resources and videos for internal employees as well as partners to address topics such as onboarding, burnout, Title V resources, technical assistance opportunities, and more.

STRATEGY 9.1.3 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.

EVIDENCE-BASED OR INFORMED STRATEGY MEASURE (ESM):
SPM1.1: *To increase the percentage of MCH staff that have completed at least one professional development opportunity.*