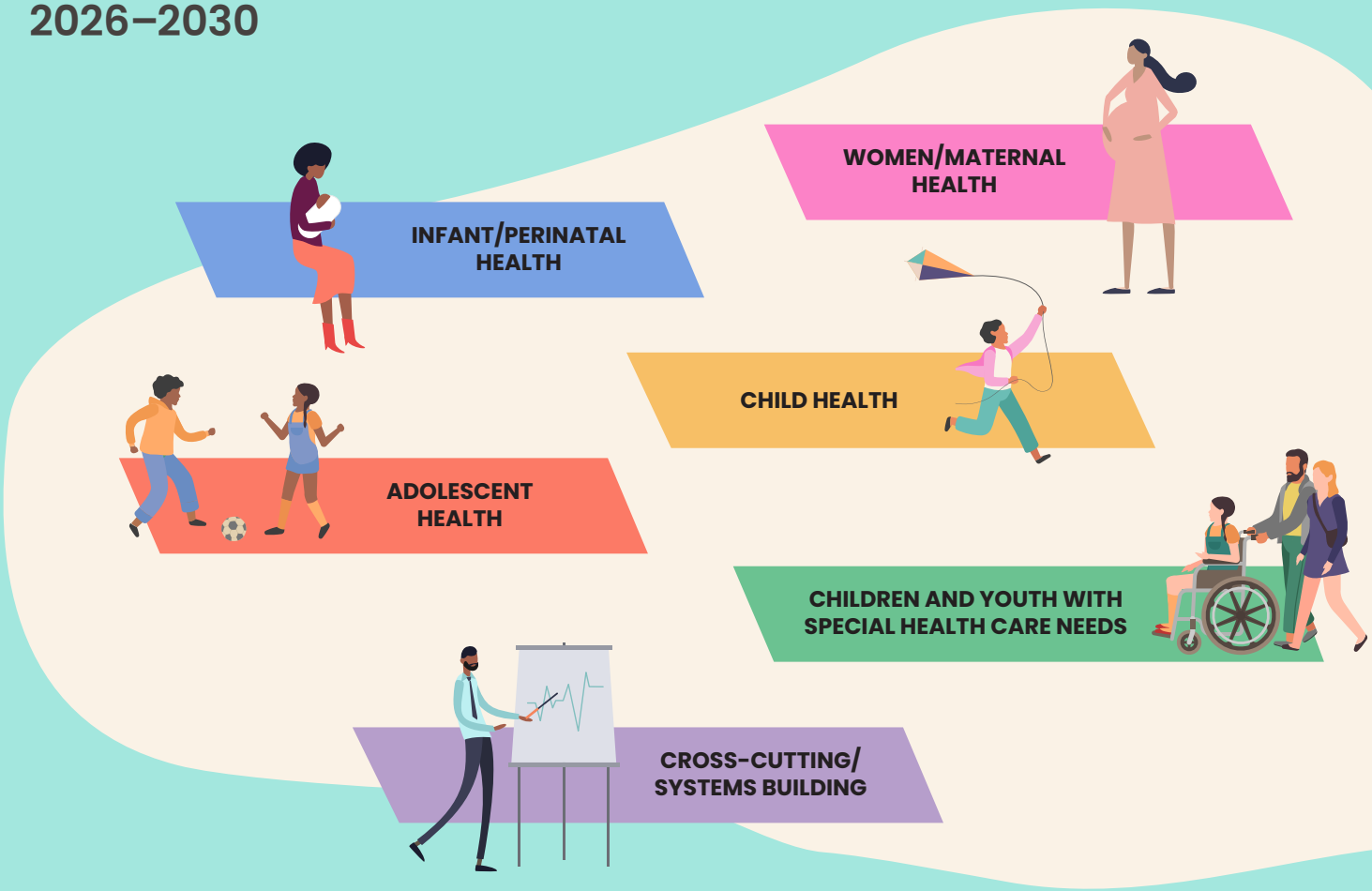
DELAWARE'S TITLE V MATERNAL & CHILD HEALTH

ADVANCING IDEAS THAT INSPIRE CHANGE

Five-Year State Action Plan Snapshot 2026–2030



Providing women, children, and families with the services and support they need to thrive.

Title V supports mothers, children, and families during each stage of life, from infancy through adulthood, and we fund work that promotes family-centered, proven methods that improve a person's health. Title V supports doctors, nurses, behavioral health clinicians, public health professionals, Community Health Workers, Home Visitors, and others working together to care for Delawareans. Our investments and partnerships contribute to building healthy people and communities.

Our work is funded by Title V of the Social Security Act. The Title V Block Grant serves as the financial foundation for much of our Maternal and Child Health Program. 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.

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

DEThrives.com

V DE THRIVES

This report offers an at-a-glance snapshot of the next five-year plan. For more information about our Maternal and Child Health Program, visit DEThrives.com.

WOMEN/ MATERNAL HEALTH	Women have timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs.
	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.
INFANT/PERINATAL HEALTH	Pregnant and parenting women have stable housing and are connected with essential resources and services that can improve their outcomes.
CHILD HEALTH	Children receive developmentally appropriate services in a well-coordinated early childhood system.
	All children, with and without special health care needs, have access to a medical home model of care.
ADOLESCENT HEALTH	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.
CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS	All children, with and without special health care needs, have access to a medical home model of care.
	All CYSHCN receive the necessary organized services to make the transition to adult health care.
CROSS-CUTTING/ SYSTEMS BUILDING	Multiple workforce skills and identified needs are critical for addressing public health challenges now and into the future.

WOMEN/MATERNAL HEALTH

PRIORITY 1:

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

STRATEGY 1.1 HWHBs Community Health Workers (CHWs) 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 1.2 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.

STRATEGY 1.3 Train CHWs and track core competencies in perinatal health, postpartum care, and community engagement.

STRATEGY 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.

STRATEGY 1.5 Build community awareness and increase the availability of doula services — and ensure that these services are now covered by Medicaid, including three visits during the postpartum period.

National Performance Measures

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 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.

STRATEGY 2.1 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.

National Performance Measures

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

INFANT/PERINATAL HEALTH

PRIORITY 3:

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

STRATEGY 3.1 Partner with Community Legal Aid to prioritize services for pregnant women.

STRATEGY 3.2 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 3.3 CHWs will screen the women they are serving for SDOH-related needs, including housing and connecting them with appropriate resources.

National Performance Measures

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

CHILD HEALTH

PRIORITY 4:

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

STRATEGY 4.1 Continue to train medical and childcare providers on developmental screening.

STRATEGY 4.2 Utilize Home Visiting/MIECHV programs to assist families in completing the Ages and Stages Developmental Screening tool. Also provide education/resources on milestones and referrals to early intervention when needed.

STRATEGY 4.3 Improve coordination of referrals and services between early care and education, Home Visitors, medical homes, and early intervention.

STRATEGY 4.4 Promote parent and caregiver awareness of developmental screening.

STRATEGY 4.5 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 a developmental screening.

STRATEGY 4.6 Continue to build out the CHADIS platform with pediatric practices.

STRATEGY 4.7 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.

National Performance Measures

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 5:

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

STRATEGY 5.1 Partner with HMG and Home Visiting Programs to identify families who have children without a medical home and provide resources and referrals.

STRATEGY 5.2 Develop educational materials on what a medical home is and disseminate these materials.

STRATEGY 5.3 Offer ongoing professional development opportunities for providers to support family-centered care with a medical home.

National Performance Measures

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

ADOLESCENT HEALTH

PRIORITY 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.

STRATEGY 6.1 Enhance the capacity of behavioral and mental health providers both working in and referred by Delaware SBHCs through a partnership with the DSCYF's Delaware Child Psychiatry Access Program Pediatric Mental Health Grant.

STRATEGY 6.2 Improve the outreach of Delaware SBHCs in enrolling and screening high school students for behavioral and mental health services.

National Performance Measures

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

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

PRIORITY 7:

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

STRATEGY 7.1 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, patient-centered, coordinated care; accessible services; quality; and safety.

STRATEGY 7.2 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 7.3 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 7.4 Develop and disseminate a variety of culturally relevant educational messages and resources on the medical home model of care.

National Performance Measures

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

PRIORITY 8:

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

STRATEGY 8.1 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 8.2 Partner with the Family Leadership Network (FLN) to customize a transition plan toolkit to assist families with 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 8.3 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 8.4 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 8.5 Explore the needs of adolescents and their families to help with transition to adult health care, insurance, employment, education, and housing.

National Performance Measures

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.

CROSS-CUTTING/SYSTEMS BUILDING

PRIORITY 9:

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

STRATEGY 9.1 Develop an accountability matrix that provides specific workgroup, contact, and data information about each NPM to ensure no overlap and to track progress.

STRATEGY 9.2 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 9.3 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.

National Performance Measures

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