Community Health Needs Assessment

2025

Delaware Report

NEMOURS CHILDREN'S HEALTH

Well Beyond Medicine

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About Nemours Children's Health

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, which includes two freestanding children's hospitals and a network of more than 75 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also addressing children's needs well beyond medicine. In producing the highly acclaimed, award-winning pediatric medicine podcast Well Beyond Medicine, Nemours Children's underscores that commitment by featuring the people, programs, and partnerships addressing Whole Child Health. Nemours Children's also powers

trusted by millions worldwide for more than 30 years to help keep families healthy.

Our mission is to provide leadership, institutions, and services to restore and improve the health of children through care and programs not readily available, with one high standard of quality and distinction regardless of the recipient's financial status. We are committed to providing patient- and family-centered health care; educating the next generation of healthcare providers through a variety of education affiliations; offering extensive online and in-person continuing medical education; providing health and wellness information for kids, teens, parents and educators via KidsHealth.org; and offering families 24/7 access to virtual consults with our health care providers via mobile and computer devices.

We have been recognized as a model of, and an advocate for, transforming the pediatric health care system from a focus on sickness to a focus on wellness, often in collaboration with community and health care partners. Our leaders and associates serve on numerous boards of organizations addressing health and children's issues, and a wide range of community organizations also receive sponsorship support as part of our commitment to support those who support children. We are also focused on bringing our standard of care — and better health — to local communities. Everything we do — our medical care, research, education, and prevention and advocacy efforts — is focused on kids. We maintain facilities in Delaware, Maryland, Pennsylvania, New Jersey, and Florida — providing services to over 500,000 patients annually. Our expansive footprint provides an opportunity and a responsibility to help share the future of medicine by reimagining pediatric care through innovation, health equity, workforce development, and integrated models that extend well beyond the walls of hospitals. Key initiatives include: 1) Advancing health equity through the Ginsburg Institute, 2) Delivering integrated, patient-centered clinical innovations, 3) Building the pediatric workforce of the future, 4) Expanding access to specialized care, and 5) Elevating public understanding through the "Well Beyond Medicine" podcast.

In 2025, Nemours Children's launched a more unified yet locally responsive approach to its Community Health Needs Assessment (CHNA) by initiating a joint contract with Strategy Health, LLC, to support both its Florida and Delaware Valley hospitals. This collaboration marked a significant shift toward shared learning and systemwide alignment, with CHNA teams from each region codeveloping a process that harnessed their collective expertise while honoring the distinct needs of the communities they serve. While the initiative fostered a more coordinated infrastructure and consistent methodology across the enterprise, the decision to maintain separate CHNA reports for each region underscored our commitment to place-based insight and responsiveness. This ensured that findings, priorities, and strategies remained deeply rooted in the lived experiences and voices of local families and stakeholders. The result is a process that is both cohesive and community-driven — amplifying shared strengths while preserving the nuances that make each region unique.

Nemours Children's Hospital, Delaware

In the Delaware Valley, we provide comprehensive pediatric care at our nationally ranked hospital, Nemours Children's Hospital, Delaware (NCHDE). As Delaware's only Level 1 Pediatric Trauma Center, we have reduced child deaths from injuries and contributed to statewide injury prevention initiatives. With over 30 care locations in Delaware, Maryland, Pennsylvania, and New Jersey, including the children's hospital in Wilmington, outpatient and primary care sites as well as specialty care centers, Nemours Children's served over 224,000 unique patients in the last year alone. The scope of our services is further expanded through collaborations with Federally Qualified Health Centers (FQHCs) in the state, as well as 19 other hospitals across the region.

Over the past 20 years, Nemours Children's has made significant investments in prevention, access, and value-driven care. A decade ago, we advanced these efforts by establishing the Value-Based Services Organization (VBSO), uniting our resources to deliver more coordinated care through a strong network of patient-centered medical homes and enhanced population health management. We've since deepened this commitment through a Medicaid Global Budget arrangement with the Delaware Medicaid and Medicare Administration (DMMA), which received final CMS approval on May 29, 2025. This prospective hospital global budget ensures predictable funding for all hospital services provided to Delaware Medicaid-enrolled children — regardless of where they receive primary care through Nemours Children's. It represents a significant advancement in our shift to being paid for value and quality, focusing on reducing avoidable emergency visits and improving health outcomes. The model supports proactive, equitable care and long-term investment in Whole Child Health — underscoring our mission to redefine children's health well beyond medicine.

Nemours Children's Hospital, Florida

Located in Orlando's Lake Nona Medical City, Nemours Children's Hospital, Florida (NCHFL) is a nationally ranked hospital offering families access to 27 primary, specialty, and urgent care locations in the central Florida target service area. In the last year alone, Nemours Children's served over 221,500 unique patients and continues to provide signature services including a Cardiac Center, award-winning Center for Cancer and Blood Disorders, and Center for Fetal Care.

Nemours Children's is going well beyond medicine by investing in the infrastructure and people needed to deliver lasting, generational impact. Recognizing that high-quality pediatric care depends on a strong, well-trained, and diverse workforce, we are proactively addressing national pediatric provider shortages through strategic partnerships and forward-looking investments. In 2024, Nemours Children's announced a $5 million investment in collaboration with the University of Central Florida (UCF) to bolster pediatric workforce development. This includes funding a new pediatric nursing training unit, designed to stimulate real-world clinical experiences, and supporting an interdisciplinary research impact fund that will fuel innovations in child health. The partnership also aims to expand clinical rotations for medical students and nursing trainees, with a focus on child and adolescent health. By strengthening the training pipeline and promoting research that addresses pressing pediatric issues, we are ensuring the next generation of caregivers is equipped to not only treat illness, but to improve lifelong outcomes for children and families.

Executive Summary

Once every three years, we conduct a CHNA in compliance with requirements in the Affordable Care Act. The CHNA allows us to obtain a comprehensive data set on the health status, behaviors, and needs of children in our community, which for this assessment includes the three counties in the state of Delaware (New Castle, Kent, and Sussex). This data set allows us to develop a focused plan to address community health needs. We began this process with our very first CHNA in 2013, marking 2025 as our fifth CHNA cycle. This report details the CHNA conducted in 2025, which identifies the needs we will be addressing from 2026-2028.

Purpose of the Needs Assessment

In addition to fulfilling the requirement by the IRS Section H/Form 990 mandate, the CHNA process facilitates an informed and responsive strategic advancement process that fosters collaboration, community engagement, and data-driven insights to empower healthcare providers, patients, and the broader community to be active participants in the achievement of Whole Child Health, well beyond medicine.

For the 2025 cycle, we focused on the following overarching goals:

- Update information and progress from the previous CHNA cycle (2022).
- Deploy an informed, community-engaged approach to data collection that includes expert input, widespread community perspectives, and local and national benchmarks.
- Identify gaps in access, disparities in outcomes, and social determinants that influence health to facilitate alignment between clinical practice and community priorities.
- Develop a roadmap to proactively address issues that affect health outcomes before they manifest in the clinical setting.
- Ensure that improvements in quality and safety are grounded in the voices of families and communities, advancing more equitable, effective, and responsive pediatric care.
- Support a continuous improvement process that leverages the value of the CHNA as both a community engagement effort and a strategic asset.
- Innovate the process to support local responsiveness within a national model — reflecting system alignment that includes a singular and strong purpose and message, with local tailoring that elevates and honors the regional differences and diversity of the families we serve in each region.

As we remain anchored to our commitment to this process, we recognize that each cycle brings new insights and opportunities. In 2025, we built on key aspects of previous iterations while adapting to emerging needs and evidence-based approaches.

Summary of Previous Community Health Needs Assessment

In 2022, our associates approached primary data collection differently than in years past. Instead of only asking the community “what” is wrong, we took the opportunity to draw from multidisciplinary expert panel discussions, in conjunction with information collected from over 30,000 Social Determinants of Health (SDOH) screenings in primary care locations across the region, to develop a more robust community-facing survey that leverages existing knowledge of the issues that persist with solution-driven questions related to their upstream causes and potential intervention strategies. By expanding the scope of questions at the survey development stage, we ensured the community voice was not only present in the prioritization phase but also included in the implementation process and plan.

Engagement with other internal and external networks involved in this work bolstered our own efforts in crafting a CHNA in 2022 that was truly responsive to the health landscape of our region. Our CHNA team remains in regular contact with the CHNA team at our Florida hospital as well as other health systems across

the state to facilitate alignment, awareness of data-driven approaches, and partnership opportunities where appropriate. As part of our journey to create the healthiest generations of children, Nemours Children's is a member of the Healthcare Anchor Network (HAN). The HAN is a national collaboration of health systems that aims to improve community health and well-being by leveraging their assets to address social determinants of health. Momentum behind efforts like these directly align with the CHNA work and are key to ensuring a meaningful investment in community is built into everything we do.
During the 2022 CHNA prioritization process, we asked survey participants to identify:

- The two most important characteristics of a healthy community
- The top three needs when thinking about the health of children, teens, and adolescents in their household and their community

Participant feedback was aggregated to compile the prioritization list for Delaware. This was the second CHNA iteration where Health Care Access, Behaviors, and Outcomes were ranked separately from SDOH in the survey. This intentional focus on a more comprehensive model — with SDOH being recognized as the root causes of unhealthy behaviors, poor health care access, and poor health outcomes — enables our continuous dedication to treating symptoms and diseases, while also creating opportunities to shift focus to further upstream strategies.

During the 2022 evaluation and planning period, we considered data we received from our Social Determinants of Health Screening tool in multiple ways. As previously mentioned, it was used on the front-end to inform the community survey instrument development. Another way this information was incorporated was during the prioritization process. When the data was pulled in 2022, we had already collected screening results from more than 54,000 patients. According to those results, 13.1% of those screened indicated a need in one or more areas, and of those, 34.3% indicated that they would like support and resources. Additionally, the SDOH data from the prior 12 months showed food insecurity in the top three identified needs. Based on this information, coupled with food insecurity falling within the top ten community-identified SDOH needs in our 2022 CHNA, Nemours Children's, together with Delaware Valley Leadership (DVL) and the Board of Managers (BOM), decided to incorporate food insecurity into the implementation plan for 2023-2025.

The final top two areas chosen were:

1. Violence prevention
2. Food insecurity

Methods and Timeline

In January 2025, NCHDE began a Community Health Needs Assessment for the state of Delaware and sought input from people who represent the broad interests of the community using several methods:

- Information gathering and analysis from secondary data sources occurred in January and February of 2025 to begin building a robust profile of community demographics, social and economic factors, health access, birth characteristics, chronic disease, and health behaviors.
- Interviews with key informants representing multiple sectors of the state's workforce — including private, nonprofit, government, academia, health care, and more — occurred from March 5–12, 2025, to collect systems-level perspectives on specific barriers and opportunities of achieving health and wellness.
- A mixed-methods population health survey of the community was fielded from February 14 through May 9, 2025, to solicit community-driven health needs.
- Community Health Summits were conducted in two locations — Georgetown and New Castle, Delaware — on April 14 and 15, 2025, respectively. The audience consisted of healthcare professionals, concerned parents and citizens, educators, community workers, advocates, employers, and other stakeholders and focused on the prioritization and strategic planning components of the CHNA process.

- Nemours Children's also solicited data from our patient-facing Social Determinants of Health screening tool deployed in all primary care locations across the state of Delaware to obtain information on top SDOH domains among positive screens during the same time period of assessment (January 1–May 31, 2025).

Key Findings and Recommendations

The 2025 Community Health Needs Assessment (CHNA) for Delaware identifies a set of interconnected pediatric health and social priorities that reflect both urgent needs and long-term equity challenges across the state. Top findings include limited access to pediatric mental health services and trauma-informed support, persistent food and housing insecurity, rising youth behavioral health concerns, and barriers to preventive care and economic stability — especially among low-income families, youth of color, and rural communities. Many of these issues are rooted in systemic inequities and disproportionately impact children in underserved zip codes and historically marginalized populations.

Opportunities to move the needle on these complex and overlapping issues exist in prioritizing investments and partnerships that:

- Expand access to mental health and trauma services, especially in schools and underserved areas.
- Address social drivers of health like food insecurity, housing conditions, and caregiver economic stability.
- Strengthen community-based prevention, early intervention, and care coordination
- Scale successful internal programs — such as behavioral health integration, EVOLV trauma intervention, and Food as Medicine pilots — to reach more children, earlier.
- Leverage our role as a statewide pediatric leader to drive policy, workforce development, and systems change in collaboration with partners.

These findings provide a clear path to guide strategic prioritization, align resources with Nemours Children's broader strategic framework, and accelerate measurable improvements in child health outcomes across Delaware.

After careful consideration, Nemours Children's will prioritize the following areas of need in the 2026–2028 Delaware CHNA Implementation Plan:

1) **Affordable Health Care**
2) **Access to Primary Care Services**
3) **Asthma and Other Respiratory Conditions**

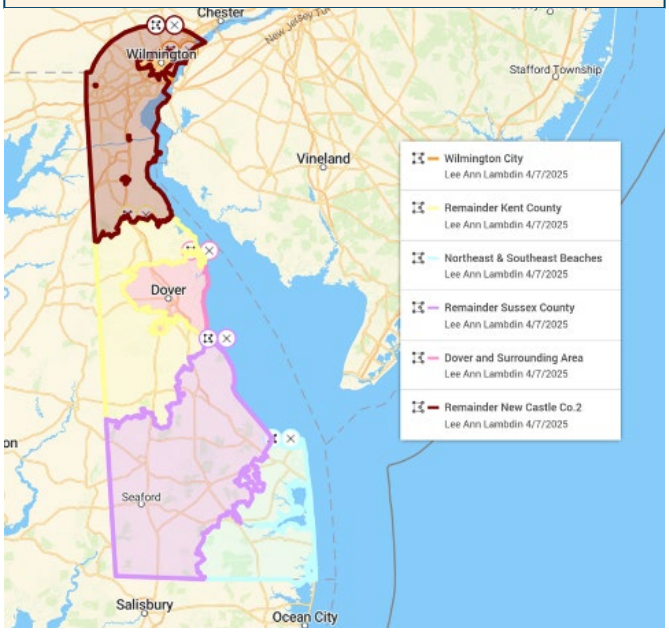
Introduction

A Community Health Needs Assessment (CHNA) facilitates an informed and responsive strategic advancement process that fosters collaboration, community engagement, and data-driven insights to empower health care providers, patients, and the broader community to be active participants in the achievement of whole child health, *Well Beyond Medicine*. This report details the 2025 Nemours Children's Hospital, Delaware CHNA.. Findings will be incorporated into a 3-year strategic plan, which will be formally adopted by the hospital for the 2026-2028 implementation period.

Definition of the Community

The community for the purposes of this needs assessment is defined as the residents of **the three-county state of Delaware** (Pop. 956,712, based on 2023 estimates). Delaware includes all communities within New Castle, Kent and Sussex counties. While Delaware is a relatively small and unified state geographically, health outcomes and social drivers of health vary considerably across and within these counties and it is critical to analyze health needs at a more granular level than county boundaries alone can provide. To support this, specific ZIP Code regions have been highlighted where applicable due to their unique demographic profiles and the impact those variables can have on health outcomes.
In addition, we divided each county into two distinct survey regions. These regions are delineated using ZIP code clusters to reflect residential areas that share similar population characteristics:

Figure 1. CHNA Service Area, with Community Survey Zip Code Regions Outlined, 2025



- **New Castle County:**
  - Wilmington City – 19801, 19802, 19806
  - Remainder of/Remaining New Castle County – 19701, 19702, 19703, 19706, 19707, 19709, 19711, 19713, 19716, 19717, 19720, 19734, 19735, 19736, 19803, 19804, 19807, 19808, 19809, 19810
- **Kent County:**
  - Dover and Surrounding Areas – 19901, 19902, 19904, 19905, 19906
  - Remainder of/Remaining Kent County – 19934, 19938, 19943, 19946, 19950, 19952, 19953, 19954, 19960, 19962, 19963, 19964, 19977, 19979
- **Sussex County:**
  - Northeast (NE) and Southeast (SE) Beaches – 19930, 19939, 19944, 19945, 19951, 19958, 19966, 19967, 19970, 19971, 19975
  - Remainder of/Remaining Sussex County – 19931, 19933, 19940, 19941, 19947, 19950, 19956, 19960, 19963, 19968, 19973

Report Insights

To support accurate interpretation of data presented in this report, common visual cues are used throughout the report's charts, graphs, and tables. These cues are designed to highlight key trends, benchmarks, and/or significant differences across the data.

All data figures are labeled with the type of data shown (e.g., percents, counts, rates), the year(s) collected, and the population or region represented. When applicable, indicators are compared to state or national benchmarks to highlight disparities or progress. Various visual elements have been applied to patterns in findings that may warrant further analysis or action. This key helps ensure consistent understanding of these visuals across all sections of the report.

Visual Cue	Description	Where it Appears
	A green shaded circle indicates the value is >/= 2 units of measurement* better than the comparison group.	Table
	A red shaded circle indicates the value is >/= 2 units of measurement worse than the comparison group.	Table
	A yellow shaded circle indicates the value differs by < 2 units of measurement from the comparison group (similar).	Table
	A purple data line indicates a Healthy People 2030 target value.	Graph
X	A dark blue X indicates the value does meet the corresponding Healthy People 2030 target (worse than).	Table
	A green check mark indicates the value meets or exceeds the corresponding Healthy People 2030 target goal.	Table
	A gray data line benchmarks the top reported value based on the most recent available data.	Graph

**Differences of ~2 percent points/units (rate) or more were used to indicate likely statistical significance (p<.05) based on large sample size conventions.*

Process and Methods

Approach

To build a comprehensive portrait of child, family, and community health needs, Nemours Children's Health partnered with Strategy Health, a Nashville-based consultancy, to facilitate our 2025 Community Health Needs Assessment (CHNA) together with, both, our Florida and Delaware Valley hospitals. Now in our fifth cycle, this collaboration marked a significant shift toward shared learning and system-wide alignment, with CHNA teams from each region co-developing a process that harnessed their collective expertise while honoring the distinct needs of the communities they serve. The result is a process that is both cohesive and community-driven—amplifying shared strengths while preserving the nuances that make each region unique.

Our approach integrated both quantitative and qualitative methods, leveraging lessons learned from prior assessments while advancing how we engage communities, structure data collection, and frame priorities. Each component of the process was designed to uncover gaps, lift community strengths, and ensure that health equity, prevention, and upstream solutions remain central to our organizational strategy.

Community Engagement

Community voice was central to this assessment. We conducted interviews with key informants representing multiple sectors of the workforce in each area, utilizing the Essential Public Health Services (EPHS) framework to guide conversations. These informants represented a range of sectors—healthcare, education, social services, advocacy, government, and business—and were invited to share perspectives on priority health needs, barriers to care, and opportunities for responsive strategies at the systems level.

In addition to these one-on-one interviews, we also convened two regional community summits—one in Georgetown and one in New Castle, Delaware. These events brought together a diverse cross-section of the community, including healthcare professionals, educators, concerned parents, youth advocates, employers, and community-based organizations. Participants were invited to respond to data trends, identify top needs in their communities, and propose real-world solutions. The summits created space for honest dialogue, community connection, and alignment around the health challenges most urgent to Delaware families.

Survey and Data Collection

We surveyed 975 households across Delaware to gather insights into health status, health needs, and barriers to well-being. The sample was drawn to represent geographic, racial, and socioeconomic diversity, with an error rate of +/- 3.1%. To ensure findings reflected regional variation, Delaware was divided into six areas for reporting purposes, with results grouped accordingly. Secondary data sources—such as County Health Rankings and National Survey of Children's Health—were also used to round out our understanding of trends and disparities.

Survey questions covered a broad range of topics, from chronic conditions and mental health to access to care, community safety, and child development. The survey instrument was designed with input from internal leaders and external partners and was informed by real-time data emerging from SDOH screening within our clinical settings.

Guiding Framework: Social Determinants of Health (SDOH)

Since 2019, Nemours Children's Health has grounded its CHNA work in the Social Determinants of Health (SDOH) framework, reflecting a sustained commitment to understanding and addressing the structural and environmental conditions that shape child and family well-being. Over time, we have not only embraced SDOH as a guiding lens but have also deepened and operationalized its application across assessment, care delivery, and strategic planning.

Recognizing the importance of addressing upstream drivers of health outcomes, we have continued to refine our approach by distinguishing SDOH-related needs from clinical outcomes, health behaviors, and other community priorities. This separation enables a more nuanced understanding of the root causes of disparities and the ways in which environmental and social conditions impact overall health.
We have also integrated SDOH more intentionally into our care delivery model, including the implementation of a screening tool across various clinical settings to identify and address social needs at the point of care. Since implementation in 2019, we've completed over 182,254 screens in the Delaware CHNA service area, over 26,249 screens in Florida's CHNA service area, and nearly 333,500 enterprise-wide (based on annual distinct patient screens). The data gathered through these screenings, along with insights from local and national sources, inform every stage of our CHNA process—from the development of survey instruments to leadership prioritization and strategy alignment. Through this ongoing evolution, Nemours has embedded SDOH into both philosophy and practice, leveraging it as a framework for equity, a tool for discovery, and a foundation for action.

A Foundation for Action

In 2022, the assessment process evolved from simply soliciting community input in the identification of top health needs, to incorporating their voices into the development of actionable solutions as well. Nemours continues to explore ways to elevate the value of the community experience and perspective(s). With a clearer picture of how social and environmental conditions interact with health outcomes, Nemours is better positioned to invest in upstream strategies that improve well-being and close equity gaps. By aligning across regions, integrating clinical and community insights, and amplifying the voices of those most impacted, the 2025 CHNA process provides a strong foundation for the next phase of population health and community engagement work.

Primary Data Collection

Primary data collection utilized online surveys with small numbers of landlines and cell phones added in — a community survey (n=968 English, n=7 Spanish) (Appendix C, D and E), and ten key stakeholder interviews (Appendix B and F). We used Wilkins Research Services in Chattanooga TN to perform random dial landline and cell phone surveys as well as online surveys from throughout the state based on population estimates. We employed a stratified sampling strategy that divided each county into two distinct survey regions based on unique demographic, socioeconomic, and health profiles. These regions were delineated using ZIP codes or ZIP code clusters to reflect residential areas that share similar population characteristics. This sub-county regionalization allows for more nuanced analysis and ensures that underrepresented and disproportionately impacted communities are not masked by aggregate county-level data. Our approach was informed by both public data sources and local contextual knowledge to ensure that the defined regions capture the lived realities of Delaware residents. In total, we surveyed 975 households in the state of Delaware for their input on health status and health needs in their communities. This sample size yielded an error rate of +/- 3.1%.

Additionally, we deployed a robust multilevel marketing strategy to expand our reach that involved email, social media, flyers with QR codes, patient and family advisory group outreach, and promotion across community partner networks. This engagement reached an estimated 250,000+ patients and families, and many more in the broader community footprint.

The survey data and some census data were cross tabulated by geography using the six regional designations defined in Figure 2 below. Wherever data allows findings in this report are disaggregated by these regions to elevate geographic differences and inform place-based interventions.

Figure 2. CHNA Service Area Surveys by ZIP Code Region Totals, 2025

County	Community Survey Region	ZIP Code Definition	Sample (% of total)
New Castle	Wilmington City	19801, 19802, 19805, 19806	227 (23.4%)
	Remainder of/ Remaining New Castle County	19701, 19702, 19703, 19706, 19707, 19709, 19711, 19713, 19716, 19717, 19720, 19734, 19735, 19736, 19803, 19804, 19807, 19808, 19809, 19810	270 (27.6%)
Kent	Dover and Surrounding Area	19901, 19902, 19904, 19905, 19906	116 (11.9%)
	Remainder of/ Remaining Kent County	19934, 19938, 19943, 19946, 19950, 19952, 19953, 19954, 19960, 19962, 19963, 19964, 19977, 19979	121 (12.4%)
Sussex	Northeast (NE)/Southeast (SE) Beaches	19930, 19939, 19944, 19945, 19951, 19958, 19966, 19967, 19970, 19971, 19975	123 (12.6%)
	Remainder of/ Remaining Sussex County	19931, 19933, 19940, 19941, 19947, 19950, 19956, 19960, 19963, 19968, 19973	118 (12.1%)
		Total	**975 (100%)**

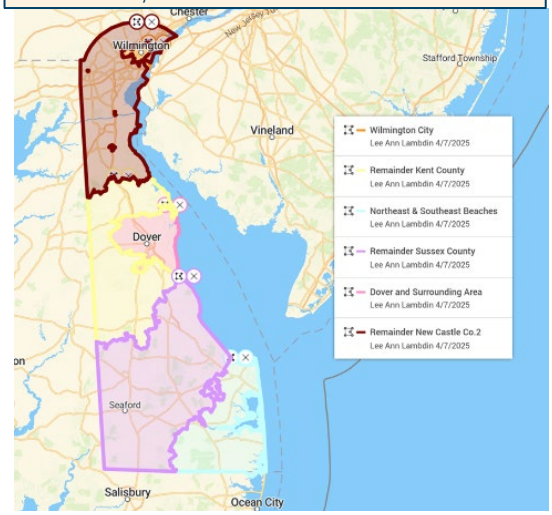
The community survey sample was designed to approximate Delaware's county population distribution – with over half of survey participants residing in New Castle County (495, 51%), followed by Sussex County (240, 25%), then Kent County (237, 24%).

Survey respondents were asked questions about the following topics:

1. Demographics
2. Socio-economic status
3. Access to and utilization of services
4. Health status and health literacy
5. Other social drivers of health

We also engaged in primary research, collecting qualitative data from the community during key informant interviews and community summit breakout sessions.

Figure 3. CHNA Survey ZIP Code Areas Outlined, 2025



Engagement Process

The process centered on gathering and analyzing data, as well as receiving input from people who represented the broad interests of the community, to provide direction for the community and the health system to create a plan to improve the health of the communities.
We interviewed eleven community experts and stakeholders for their input using key aspects of the Essential Public Health Services (EPHS) framework. Participants from these areas are not only engaged in the work from previous CHNA cycles, they also are uniquely connected to other community initiatives and, as such, are acutely aware of the breadth of needs of the patients, clients, students, and their communities, as well as where key gaps exist.
Additionally, we conducted two community health summits to share the primary and secondary data gathered to build a common database of understanding. Then the participants prioritized the most significant health needs based on the data presented. There were 37 attendees in attendance at the summits.

Secondary Data Collection

In addition to primary data collection efforts, existing data drawn from the most up-to-date national, state and local sources were reviewed. Sources of data included the American Community Survey and the National Survey of Children's Health, among others. Types of data included self-report of health behaviors from large, population-based surveys such as the Youth Risk Behavior Surveillance System, as well as vital statistics. It should be noted that in these existing reports and data sets, data on race and ethnicity were gathered through self-report.

Secondary data were collected from a variety of sources to present community demographics, social and economic factors, health access, birth characteristics, chronic disease, and health behaviors. Analysis was conducted using data from:

- The County Health Rankings (CHR) Program provides data measuring vital health factors in nearly every county in America. University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. www.countyhealthrankings.org Any graphs using CHR used the year the data was released as the x-axis label. The actual year and source of the data will be in the source note below the graph.
- The annual American Community Survey (ACS), conducted by the U.S. Census Bureau, provides vital information about our nation and its people.
- CDC 500 Cities Project is a collaboration between the CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes and clinical preventive services use for the largest 500 cities in the United States.
- The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives — including physical and mental health, access to quality health care and the child's family, neighborhood, school and social context.
- The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence; sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity. YRBSS also measures the prevalence of obesity and asthma and other health-related behaviors plus sexual identity and sex of sexual contacts.
- KIDS COUNT®, a project of the Annie E. Casey Foundation that produces a comprehensive report — the KIDS COUNT® Data Book — that assesses child well-being in the United States.
- Calls to 2-1-1: Delaware (2021). Delaware 2-1-1 provides one central resource for access to health and human service organizations offering support to make a difference.
- Demographics from Esri, a global market leader in geographic information systems and demographic data and the U.S. Census Bureau.

For some secondary data sources used throughout this report, data is only available at the city or county level. In those instances, individual cities (such as Wilmington City or Dover) may be highlighted separately to provide insight into various health disparities.

Summary of Key Findings

The following section provides a brief overview of key findings that emerged from this assessment.

Community Survey

Figure 4. Nemours Community Survey Top Health Needs* Delaware, 2025

Rank (HS/B/O, Overall)	Health Status, Behaviors and Outcomes	Totals	Rank (SDOH, Overall)	Social Determinants of Health (SDOH)	Totals
1, 3	Mental/behavioral health	21%	1, 1	Affordable health care	41%
2, 5	Asthma	18%	2, 1	Affordable health insurance	30%
3, 6	Stress and/or anxiety	17%	3, 4	Access to mental & behavioral health services/providers	19%
3, 6	Attention-Deficit/Hyperactivity Disorder	17%	4, 6	Access to primary care services/providers	17%
4, 7	Food and/or medication allergies	16%	5, 8	Access to dental services	14%
5, 8	Airborne and/or skin allergies	14%	6, 11	Affordable fresh/natural foods	9%
6, 9	Developmental delays/disabilities	12%	6, 11	Crisis intervention & support	9%
7, 10	Respiratory conditions other than asthma	11%	8, 12	Safe, affordable housing	8%
8, 11	Screen time	9%	8, 12	Positive youth development programs & activities	8%
9, 13	Overweight/obesity	7%	10, 13	Affordable quality education	7%
10, 15	Substance/drug abuse	5%	10, 13	Food insecurity/food deserts	7%
10, 15	Unhealthy diet	5%	10, 13	Availability of care – office hrs., accepting insurance/payment methods	7%
10, 15	Inactive lifestyle	5%	11, 14	Bullying	6%
10, 15	Hearing and or vision impairments	5%	12, 14	More urgent care, walk-in clinics, after hours care	6%
			13, 14	Access to specialty care/providers	6%

**Community members were asked to rank health status, behaviors and outcomes separately from SDOH. The goal in having two different categories of need is to focus on a more comprehensive model — designing interventions that treat symptoms and conditions while investing in upstream strategies that address root causes.*

Key Informant Interviews

Figure 5. Top Health, Safety and Wellbeing Challenges, Key Informant Interviews, Delaware, 2025*
Poverty, low income
Access to behavioral health services
Safe, affordable housing
Transportation
Health literacy
Education, increase reading levels; early childhood education
Access to providers, not enough capacity
More cultural competence in healthcare
Maternal/child health
Vaccine education
Staffing/workforce (general)
How to access services; navigation difficulties
Social drivers of health investment
Access to insurance
Collaboration and sharing
Funding cuts potential for HIV, Medicaid
Lack of equal treatment for people of color
Community education on reproductive health care and gender affirming care
Climate change impact on asthma/ allergies
Community safety, violence, drugs.

**This list was generated from key informant responses to the following question: " "In your opinion, what are the top three challenges affecting the overall health, safety, and wellbeing in your service area?" See Appendix F for a complete list of key informant interview questions.*

Secondary Data Highlights – County, State, National Comparisons

Differences of ~ 2 percent points/units (rate) or more were used to indicate likely statistical significance (p<.05) based on large sample size conventions.[1]

Figure 6. Secondary Data Highlights by County, Delaware, U.S.

Percent of children (<18) in poverty* (2023 &2019-2023)[2]

	New Castle	Kent	Sussex	DE	U.S.
Value	16.2	14.6	17.1	15.4	16.0
vs. DE avg.	🟠	🟠	🟠	-	🟠
vs. U.S. avg.	🟠	🟠	🟠	🟠	-
HP2030 Target (<8%)	X	X	X	X	X

**Children in poverty include those people under the age of 18 who live in households with income below the federal poverty threshold.*

Percent of households who are ALICE* (2022)[3]

	New Castle	Kent	Sussex	DE	U.S.
Value	30.0	29.0	27.0	29.0	29.0
vs. DE avg.	🟠	🟠	🟢	-	🟠
vs. U.S. avg.	🟠	🟠	🟢	🟠	-

**ALICE stands for Asset Limited, Income Constrained, Employed and refers to households that earn above the Federal Poverty Level (FPL) but still struggle to afford basic necessities like housing, childcare, food, transportation, and healthcare.*

Percent of population (14+) who do not speak English, (2019-2023)[4]

	New Castle	Kent	Sussex	DE	U.S.
Value	2.8	2.0	2.5	2.6	4.2
vs. DE avg.	🟠	🟠	🟠	-	🟠
vs. U.S. avg.	🟠	🟢	🟠	🟠	-

Percent of total population who are food insecure*, (2022)[5]

	New Castle	Kent	Sussex	DE	U.S.
Value	12.0	13.7	13.3	11.8	14.0
vs. DE avg.	🟠	🔴	🟠	-	🔴
vs. U.S. avg.	🟢	🟠	🟠	🟢	-
HP2030 Target (≤6%)	X	X	X	X	X

**Food insecure is defined as a lack of access, at times, to enough food for an active, healthy life or with uncertain availability of nutritionally adequate foods.*

Percent of disconnected youth* ages 16-19 (2019-2023)[6]

	New Castle	Kent	Sussex	DE	U.S.
Value	4.4	5.9	8.8	5.5	7.0
vs. DE avg.	🟠	🟠	🔴	-	🟠

1 Centers for Disease Control and Prevention, BRFSS Data Quality Report Handbook (2004), V.3.2.0. https://www.cdc.gov/brfss/annual_data/pdf/2004DQRHandbook.pdf. Accessed August 12, 2025.

2 County Health Rankings, (CHR), 2025; Census Bureau, Small Area Income and Poverty Estimates, 2023 & 2019-2023

3 United Way 2022

4 American Community Survey (ACS) 2019-2023

5 CHR, 2025; Feeding America, Map the Meal Gap, 2022

6 CHR, 2025; ACS, 2019-2023

vs. U.S. avg.	🟢	🟡	🟡	🟡	-
HP2030 Target (11.2%)**	✓	✓	✓	✓	✓

**Disconnected youth is defined as young people ages 16-19 who are not enrolled in school or are not currently employed. **HP2030 defines this indicator as youth ages 16 to 24 who are not enrolled in school or are not currently employed.*

Percent of households with at least 1 of 4 housing problems*, (2017-2021)[7]

	New Castle	Kent	Sussex	DE	U.S.
Value	14.4	15.0	13.7	14.3	17.0
vs. DE avg.	🟡	🟡	🟡	-	🔴
vs. U.S. avg.	🟢	🟢	🟢	🟢	-

**Housing problems in this measure include overcrowding, high housing costs, lack of kitchen facilities, and/or lack of plumbing facilities.*

Percent of households spending 30% or more of monthly income on housing (2023)[8]

	New Castle	Kent	Sussex	DE	U.S.
Value	26.1	25.0	20.0	23.8	26.7
vs. DE avg.	🔴	🟡	🟢	-	🔴
vs. U.S. avg.	🟡	🟡	🟢	🟢	-

Percent of uninsured children (2022)[9]

	New Castle	Kent	Sussex	DE	U.S.
Value	13.4	14.3	16.8	14.3	16.0
vs. DE avg.	🟡	🟡	🔴	-	🟡
vs. U.S. avg.	🟢	🟡	🟡	🟡	-

Percent of children who received recommended vaccinations (2021)[10]

	New Castle	Kent	Sussex	DE	U.S.
Value	-	-	-	95.4	86.2
vs. DE avg.	-	-	-	-	🔴
vs. U.S. avg.	-	-	-	🟢	-

Percent of children (9-35 months*) whose parent/caregiver completed a developmental screening tool in the past year (2022-2023)[11]

	New Castle	Kent	Sussex	DE	U.S.
Value	-	-	-	32.8	35.6
vs. DE avg.	-	-	-	-	🟢
vs. U.S. avg.	-	-	-	🔴	-
HP2030 Target (35.8%)	-	-	-	**X**	**X**

**Based on guidelines from the American Academy of Pediatrics recommending developmental screenings at 9, 18, and 24 or 30 months during well-child visits.*

Teen birth rate* (2017-2023)[12]

	New Castle	Kent	Sussex	DE	U.S.

7 CHR, 2025; U.S. Dept of Housing and Urban Development, 2017-2021

8 ACS, 2023

9 CHR, 2025; US Census Bureau's Small Area Health Insurance Estimates, 2022

10 CDC, ChildVaxView, 2021

11 National Survey of Children's Health, 2022-2023

12 CHR, 2025; Feeding America, Map the Meal Gap, 2022

Value	11.9	14.7	26.6	15.1	16.0
vs. DE avg.	🟢	🟡	🔴	-	🟡
vs. U.S. avg.	🟢	🟡	🔴	🟡	-
HP2030 Target (31.4)	✓	✓	✓	✓	✓

**Number of births per 1,000 female population ages 15-19.*

Percent of adolescents (grades 9-12) who currently* vape (2023)[13]**

	New Castle	Kent	Sussex	DE	U.S.
Value	16.5	17.0	18.5	18.3	16.8
vs. DE avg.	🟡	🟡	🟡	-	🟡
vs. U.S. avg.	🟡	🟡	🟡	🟡	-

Current vape use is defined as those who report vaping at least 1 day out of the last 30 days.A vape or an electronic vapor product is defined as any device that delivers nicotine, flavorings, and other substances in vapor form, often including e-cigarettes.*

Percent of adolescents (grades 9-12) who currently* drink alcohol (2023)[14]

	New Castle	Kent	Sussex	DE	U.S.
Value	17.0	18.0	19.5	19.9	22.1
vs. DE avg.	🟢	🟡	🟡	-	🔴
vs. U.S. avg.	🟢	🟢	🟢	🟢	-

**Current alcohol use is defined as consuming at least 1 alcoholic drink during the last 30 days.*

Percent of children (<6) whose family read to them less than 4 days per week (2022-2023)[15]

	New Castle	Kent	Sussex	DE	U.S.
Value				47%	43%
vs. DE avg.					🟢
vs. U.S. avg.				🔴	
HP2030 Target (36.8%)*	-	-	-	**X**	**X**

**HP230 defines this indicator as children 5 years and under whose parents or caregivers reported that someone in their family read to the child 4 or more days in the past week. The inverse HP2030 indicator is used here for comparison purposes.*

Percent of adolescents ages 12-17 with a preventative medical visit in the past year (2022-2023)[16]

	New Castle	Kent	Sussex	DE	U.S.
Value	-	-	-	72.6	71.4
vs. DE avg.	-	-	-	-	🟡
vs. U.S. avg.	-	-	-	🟡	-
HP2030 Target(82.6%)	-	-	-	**X**	**X**

Infant death (mortality) rate* (2016-2022)[17]

	New Castle	Kent	Sussex	DE	U.S.
Value	6.9	6.2	5.0	6.4	6.0
vs. DE avg.	🟡	🟡	🟡	-	🟡

13 YRBS, 2023

14 YRBS, 2023

[15] National Survey of Children's Health, 2022-2023

[16] National Survey of Children's Health, 2022-2023

17 CHR, 2025; National Center for Health Statistics, National Vital Statistics System, 2016-2022

vs. U.S. avg.	🟠	🟠	🟠	🟠	-
HP2030 Target(5.0)	X	X	✓	X	X

**Number of infant deaths (under 1 year of age). per 1,000 live births.*

Child and teen death (mortality) rate* (2023)[18]

	New Castle	Kent	Sussex	DE	U.S.
Value	20.3	32.5	30.0	25.0	29.3
vs. DE avg.	🟠	🔴	🟢	-	🟢
vs. U.S. avg.	🔴	🔴	🟡	🔴	-
HP2030 Target (18.4)	X	X	✓	X	X

**Number of deaths per 100,000 children and teens aged 1-19years.*

Percent of children (4 mo. – 17 yrs.) who get sufficient sleep*, 2022-2023[19]

	New Castle	Kent	Sussex	DE	U.S.
Value	-	-	-	61.0	64.8
vs. DE avg.	-	-	-	-	🟢
vs. U.S. avg.	-	-	-	🔴	-
HP2030 Target (70.6%)**				X	X

** Children are considered to get insufficient sleep if parents report they get less sleep than the recommended hours for their age.*
***HP2030 defines this indicator as children ages 4 months to 14 years who are considered to get insufficient sleep if parents report they get less than the recommended hours for their age.*

Percent of children ages 0-17 who currently have asthma (2022-2023)[20]

	New Castle	Kent	Sussex	DE	U.S.
Value	-	-	-	7.8	6.6
vs. DE avg.				-	🟠
vs. U.S. avg.				🟠	-

Number of people per mental health provider* (2024)[21]

	New Castle	Kent	Sussex	DE	U.S.
Value	251.0	434.0	446.0	309.0	320.0
vs. DE avg.	🟢	🔴	🔴	-	🟢
vs. U.S. avg.	🟢	🔴	🔴	🟢	-

**Mental health providers are defined as professionals who offer services to improve an individual's mental health and wellbeing or treat mental health conditions, including psychiatrists, psychologists, social workers, therapists, , and advanced practice nurses specializing in mental health care.*

Average number of adult-reported (18+) poor mental health days* (2022)[22]

	New Castle	Kent	Sussex	DE	U.S.
Value	4.9	5.4	4.9	4.8	5.1

Average number of adult-reported (18+) poor mental health days* (2022)[23]

	New Castle	Kent	Sussex	DE	U.S.

[18] *Delaware Department of Health and Social Services. Delaware Vital Statistics Report 2017-2021. Available at: https://dhss.delaware.gov/wp-content/uploads/sites/10/dph/pdf/mort21.pdf. Accessed August 2025.*

[19] *U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2022-2023*

[20] *U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2022-2023*

21 CHR, National Provider Identification Registry, 2024

22 CHR, BRFSS, 2022

23 CHR, BRFSS, 2022

Value	4.9	5.4	4.9	4.8	5.1
vs. DE avg.	●	●	●	-	●
vs. U.S. avg.	●	●	●	●	-

**Poor mental health can include stress, depression, and emotional problems, but not necessarily a clinical diagnosis. Poor mental health days are defined as any number of days in the past 30 days when mental health was not good (poor) overall.(age-adjusted).*

Percent of adults (18+) who report frequent mental distress* (2022)[24]

	New Castle	Kent	Sussex	DE	U.S.
Value	15.9	17.3	16.9	16.5	16.0
vs. DE avg.	●	●	●	-	●
vs. U.S. avg.	●	●	●	●	-

**Frequent mental distress is defined as 14 or more poor mental health days in past 30 days (age-adjusted).*

Nemours Children's Patient Data: Social Determinants of Health Screening

Figure 7. Number of Positive SDOH Screens in Nemours Patients ages 0-18, by Screening Domain and County of Residence, Delaware, January 1 – May 31, 2025

	New Castle	Kent	Sussex	Total DE
Positive - FOOD	434	102	150	**689**
Positive - HOUSING	611	118	202	**932**
Positive – TRANSPORTATION	201	63	71	**336**
Positive – FINANCIAL	893	211	216	**1,327**

24 CHR, BRFSS, 2022

Prioritization

Themes Across the Data

All primary and secondary data were compiled and presented at two community summits in the spring of 2025. Following the presentation, a comprehensive list of twenty-one needs was shared with participants that summarized themes across the data (below).

Access to mental health services/providers	Access to primary care services /providers (locations, hours, flexible payments, etc.)	Affordable/quality education (includes early education)	Affordable/ accessible quality food (fresh, natural, nutritional)
Affordable healthcare	Affordable insurance	Allergies (food, medication, airborne, skin)	Asthma or other respiratory conditions
Attention deficit/hyperactivity disorder (ADHD)	Crisis and trauma intervention and support	Developmental delays/disabilities	Employment/ workforce challenges and economic opportunity
Health and in-home services for seniors	Mental/behavioral health	Positive youth development program and opportunities	Safe, affordable housing
Sedentary lifestyle/screen time	Sexual and reproductive health	Stress and/or anxiety	Substance use disorder – drugs
Transportation			

Participating community members were asked to use this list to rank the top three health needs in their community. This essential component of the CHNA process facilitates a community-driven, region-specific list of top health needs that is utilized during strategic planning discussions.

Top Community Health Needs

The highest-ranking results from both summits were placed in the following list of Top Community Health Priorities. These priorities will be the foundation of our internal strategic development process and implementation plan.

Figure 8. Top Community Health Priorities, Delaware, 2025

Rank	Community Health Priority	Vote (%)
1	Affordable healthcare	35.1%
2	Mental/behavioral health	29.7%
2	Safe, affordable housing	29.7%
3	Access to mental health services/providers	27.0%
4	Affordable, accessible, quality food	21.6%
5	Access to primary care services/providers	16.2%
5	Positive youth development programs and opportunities	16.2%
6	Affordable insurance	13.5%
7	Substance use disorder	13.5%
7	Employment/workforce challenges and economic opportunity	8.1%
8	Asthma and other respiratory conditions	5.4%
8	Crisis and trauma intervention and support	5.4%

Once voting results were tallied, summit participants engaged in group breakout sessions to identify strategies to address priorities. This information has been incorporated in the following section ("recommendations").

Recommendations

This assessment report develops a social, economic and health portrait of our priority communities. The data highlighted, and the community confirmed, the health issues and concerns that Delaware children and families are most affected by, which include: access to affordable and insurance; mental and behavioral health conditions; safe, affordable housing; access to mental health care, including trauma and crisis intervention and support; affordable, accessible quality food; positive youth development programs and opportunities; asthma and other respiratory conditions; and employment/workforce challenges and economic opportunity.

Community Health Priorities – Impact and Opportunity

In addition to grounding the recommendations section in community-identified priorities, we have also incorporated community-driven solutions collected during the engagement process. While some of the information has been embedded within other proposed approaches (Opportunities), other, more direct, input has been italicized to distinguish those unique and valuable insights.

1) Affordable Healthcare/Insurance

Impact:

- U.S. health expenditures per person have skyrocketed from $353 in 1970 to $14,570 in 2023, [25] far outpacing income growth.
- Delaware families—especially those with low incomes, public insurance, or medically complex children—report skipping care or rationing medication due to cost. [26] In Kent and Sussex counties, affordability concerns are exacerbated by fewer peds access points. [27]
- Delayed or forgone care results in avoidable hospitalizations, unmet chronic needs + greater long-term costs.

Opportunities:

- Embed financial navigators in care locations to support enrollment in Medicaid, CHIP, and other plans.
- Utilize community health workers to provide culturally responsive navigation.
- Expand system-wide infrastructure—such as EMR-embedded screenings for financial strain— to link families to cost-relief programs.
- *Partner with the Dept. of Health and other healthcare orgs. to implement free children's clinics.*
- *Advocate at the state and federal level to expand (not cut) Medicaid.*

2) Mental/Behavioral Health Challenges

Impact:

FOCUS 1: Substance Use Disorder (SUD)

- Delaware ranks among the top states for opioid overdose mortality. [28]
- Children living in homes affected by substance use disorders (SUD) face higher risks of trauma, neglect, mental illness, and developmental delays. These children are also more likely to become involved in the child welfare system and experience lifelong health and educational challenges.

FOCUS 2: Crisis and Trauma Intervention & Support

Opportunities:

FOCUS 1: SUD

- Embed trauma-informed care and SUD screenings into care settings.
- Partner with adult-focused SUD treatment providers to develop family-centered models.
- Support kinship caregivers and resilience-building for children of parents in recovery.

FOCUS 2: Crisis and Trauma

- Embed trauma-informed care and crisis response protocols across clinical and educational settings.

[25] *Peterson-KFF Health System Tracker (2024). "Health Expenditures Over Time." https://www.healthsystemtracker.org*

[26] *Delaware Kids Count (2023). "Indicators of Health & Well-Being." https://datacenter.kidscount.org*

[27] *Delaware Health Tracker (2023). "Primary Care Access by County."*

[28] *Delaware.gov, My Healthy Community, Delaware Environmental Public Health Tracking Network, CDC*

- Delaware youth report high exposure to trauma—including violence, abuse, and parental substance use. [29] Nearly half of children in Wilmington have experienced at least one Adverse Childhood Experience (ACE). [30]
- Youth exposed to trauma are at greater risk of developing PTSD, anxiety, suicidality, and academic disengagement. Trauma-specific interventions are scarce, particularly outside of crisis stabilization units. School staff, pediatricians, and caregivers lack proper tools to respond effectively.

- Build mobile crisis teams and expand access to trauma-specific therapy.
- Train frontline professionals (healthcare, education, public safety) in trauma recognition and response.
- *Collaborate with schools, public health and MH providers to offer education on prevention and management of mental health.*
- *Invest in post-partum support services.*

3) Safe, Affordable Housing

Impact:

- In Delaware, more than 30% of renters are severely cost-burdened, paying over half their income on housing.[31] In areas like Wilmington and southern Sussex, families face high eviction rates, substandard conditions (mold, lead), and overcrowding—all linked to asthma, developmental delays, and school absenteeism.[32]
- Housing instability also increases ER visits and family stress, undermining child development and recovery from illness.
- Homes with features such as first-floor bathrooms, widened doorways, or modified entries are scarce and more expensive. This is compounded by policy gaps in the federal Fair Housing Act, leaving many single-family and older homes outside of newer accessibility standards. In Delaware, the poverty gap for children with disabilities is higher than the national average, meaning these families are simultaneously coping with economic strain and housing environments that fail to meet their children's basic needs for accessibility and safety.

Opportunities:

- Expand housing-related screening.
- Strengthen medical-legal partnerships for families facing unsafe housing conditions.
- Collaborate on state and local housing policy advocacy and anchor institutional investments in housing infrastructure and *standardized home assessments.*
- Support community-led solutions to neighborhood safety and stability.
- Partner with state public housing authorities to track and expand accessible housing stock.
- *Develop a clearing house of home modification resources for parents and those with accessibility challenges.*
- *Connect parents/caregivers with support prior to discharge of a pediatric patient with medical complexities or other physical disabilities/limitations.*

4) Access to Mental Health Services and Providers

Impact:

- Delaware ranks 47th nationally in youth mental health access. [33] An estimated 15% of Delaware youth with behavioral health needs did not receive treatment in the past year,[34] and others routinely wait weeks to months for psychiatric, psychological, or counseling appointments.

Opportunities:

- Scale cross-sector behavioral health integration and delivery (schools, childcare, tele-behavioral health)
- Invest in workforce development and pipelines to recruit and retain diverse

29 National Survey of Children's Health (2024)

30 CDC Youth Risk Behavior Survey (2023)

31 Delaware State Housing Authority (2023). Delaware Housing Needs Assessment 2023–2028

32 National Low Income Housing Coalition (2023). "Delaware Housing Profile."

33 Mental Health America (2024). Youth Mental Health Ranking. https://mhanational.org/issues/2024/mental-health-america-youth-data

34 SAMHSA (2023). Behavioral Health Barometer: Delaware, Volume 7. https://www.samhsa.gov/data

Sussex and Kent counties face critical provider shortages, and bilingual services are rare.

- Rural youth and youth of color face significant disparities in access, compounded by provider shortages and cultural barriers. Mental health challenges—left unaddressed—are linked to suicide risk, school absenteeism, youth justice involvement, and lifelong chronic disease. [35] Lack of access prolongs suffering, increases ER visits, and worsens long-term educational and health outcomes.

pediatric mental/behavioral health professionals

- Partner with trusted community organizations to deliver peer-led programming and culturally relevant mental health education and trauma-informed care.
- Partner with state agencies to improve pediatric reimbursement rates and incentives for rural practice.
- *Invest in mental health navigators to bridge the gap between patients/ families and the complex behavioral health system.*

5) Access to Quality Affordable Food

Impact:

- Food insecurity rose in Delaware between 2021 and 2022, especially in Black, Latino, and rural communities. [36]
- Over 1 in 5 Delaware children may experience food insecurity, contributing to increased risk for obesity, diabetes, and anemia. [37]
- Children without reliable nutrition are also more likely to miss school, perform poorly academically, and experience behavioral challenges.

Opportunities:

- Embed food insecurity screening and WIC/SNAP enrollment into clinical visits.
- Partner with local food banks and pantries to develop pediatric-focused referral loops.
- Expand food-as-medicine interventions and produce prescription programs for at-risk children.
- *Build support for local school systems to provide families with a variety of produce.*
- *Work with local universities, agriculture and nutrition departments and other orgs. to offer seasonal, hands-on nutrition education.*

6) Access to Primary Care Services and Providers

Impact:

- Over 55% of Delaware children lack a medical home, undermining continuity of care and early intervention.[38] Families in Kent and Sussex counties report delayed or missed care due to provider shortages, lack of transportation, or cost barriers.
- Delayed access to vaccinations, well visits, and developmental screenings increases risk for preventable illness, missed diagnoses, and developmental delays. [39]

Opportunities:

- Expand telehealth, mobile units, and school-based care.
- Invest in rural recruitment, training, and retention pipelines.
- Partner with community clinics and FQHCs to close care gaps.
- *Partner with state agencies and other orgs. to resource innovative transit options like Uber Health for patients requiring transportation support.*
- *Increase outreach to nurse practitioners and P.A. programs.*

7) Positive Youth Development Programs and Opportunities

35 CDC, Children's Mental Health, 2025

36 Feeding America (2023). "Map the Meal Gap: Delaware." https://map.feedingamerica.org

37 Feeding America (2022). "Map the Meal Gap: Delaware." https://map.feedingamerica.org

38 HRSA Data Warehouse. "Medically Underserved Areas – Delaware."

39 Lebrun-Harris LA, Sappenfield OR, Warren MD. Missed and Delayed Preventive Health Care Visits Among US Children Due to the COVID-19 Pandemic. Public Health Rep. 2022 Mar-Apr;137(2):336-343. doi: 10.1177/00333549211061322. Epub 2021 Dec 30. PMID: 34969335; PMCID: PMC8900224.

Impact:

- Youth in under-resourced neighborhoods lack safe, supportive environments after school—particularly in rural Sussex and urban Wilmington.
- Stakeholders emphasized the need for mentorship, social-emotional learning, and leadership opportunities. Without them, young people are at higher risk for violence exposure, dropout, isolation, and negative long-term health outcomes. [40]

Opportunities:

- Collaborate with community youth organizations and schools to co-create afterschool and summer programs.
- Elevate youth voice in civic health initiatives and youth-led advisory boards.
- Expand family strengthening programs.
- Expand safe zones through parks, libraries, & rec. center partnerships.

8) Employment/Workforce Challenges and Economic Opportunity

Impact:

- In some Delaware census tracts, over 35% of children live in poverty. [41]
- Youth in poverty are more likely to experience food insecurity, housing instability, and poor academic outcomes.
- Parental unemployment and unstable jobs reduce access to health benefits and increase toxic stress within the household.

Opportunities:

- Support family economic mobility via workforce development partnerships.
- Align early care and education access with job training.
- Use anchor strategies to increase local hiring and support community investment.

9) Asthma and other Respiratory Conditions

Impact:

- Delaware ranks in the bottom 10 nationally for pediatric asthma outcomes, with 7.8% of children diagnosed. [42]Asthma-related ER visits and hospitalizations are highest among Black children in Wilmington and low-income families statewide.
- Environmental triggers—mold, pests, smoke—go unaddressed without coordinated home-based care.

Opportunities:

- Expand asthma home visits and environmental remediation partnerships.
- Coordinate school and clinical asthma action plans.
- Embed social drivers of health into respiratory care protocols.

40 Delaware Afterschool Network (2024). "Youth Development Policy Brief."

41 Census Bureau, 2019-2023

42 U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2022-2023

Nemours-Identified Priorities for Implementation

Senior leaders at Nemours Children's examined this information in conjunction with primary and secondary data that informed top community health priorities to identify the top three focus areas to be incorporated into the 2026-2028 Implementation Plan. Our leadership considered the magnitude and severity of issues, the impact of these issues on the most vulnerable populations, resources available, areas in which we should be partnering with other key stakeholders, feasibility of addressing these issues over the next three years, and potential alignment with broader organizational strategies and efforts. The following table was used as a discussion prompt during the prioritization exercise:

Magnitude	How big is the problem? How many people does the problem affect/potentially affect?
Seriousness of the Consequences	What would happen if the issue were not made a priority?
Equity	Does this affect one group more than others?
Feasibility	Is the problem preventable? How much change can be made? Is there capacity to address it?
Alignment (added in 2025)	Are there opportunities for alignment with other strategic initiatives? Could an integrated approach to this issue improve health outcomes and operational efficiency?

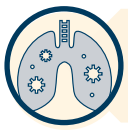
The fourth criteria – alignment – was added in 2025 to underscore the evolution of the CHNA into a dynamic and integrated piece of the health system's mission. By aligning the CHNA with broader organizational strategies, we can improve operational efficiencies and streamline efforts; and, by integrating community health priorities with strategic goals, we are better positioned to address the needs of the communities we serve, contributing to better health outcomes. This is just another way to ensure that CHNA priorities remain relevant and effective overtime.

This is the second evaluation and planning period that our Delaware CHNA incorporated data from the Social Determinants of Health Screening tool. This is in alignment with the 2020-2022 DE CHNA Implementation plan, which includes a specific goal around the use of SDOH screening tool data to inform strategy and recommendations in future iterations. From January 1, 2025-May 31,2025, Nemours collected approximately 29,985 completed screens from patients enterprise-wide, with 16,503 of those from patients in the state of Delaware. Delaware patients/families screened positive most often for financial-related challenges (n= 1,327), followed by housing (n=932) and food (n=689). And approximately 22% (n=1,335) of the total number of positive responses across the enterprise were reflective of unique patient screens with more than one area of need indicated. These data reinforce community priorities and strengthen the scope of our response.

The final three priority areas chosen were:

Affordable Healthcare

Access to Primary Care Services



Asthma and other Respiratory Conditions

While Nemours chose these three priorities in 2025, the full set of findings and recommendations will continue to inform our own strategic conversations. We also encourage partners and organizations across the state to draw on this information as they build their own strategic roadmaps.

Nemours is engaged in the implementation planning process, and the 2026-2028 plan will be approved and formally adopted on or before May 15, 2026. A copy of the implementation plan will be published on Nemours.org by June 30 of the same year.

Limitations

As with all research efforts, there are several general limitations of CHNA research methods that should be acknowledged:

- It should be noted that for secondary data analyses in several instances current neighborhood level data were not available. Data access and analysis remain a challenge in Delaware, especially below the county level, which poses a challenge for strategic planning and tailored interventions.
- While the surveys conducted for this CHNA provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size.
- Data based on self-reports should be interpreted with caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.
- Respondents may be prone to recall bias — that is, they may attempt to answer accurately but remember incorrectly, especially when serving as a proxy for their child/ren.
- Finally, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

Data Findings

Obtaining information from multiple sources, known as triangulation, helps provide context for information and allows researchers to identify results that are consistent across more than one data source. The following section includes both primary and secondary, quantitative and qualitative data to provide a comprehensive snapshot of the population in the three-county CHNA region of Delaware.

The State of Health

This section presents key indicators that reflect the current state of health in the community, including life expectancy, self-reported health status, mortality rates, and birth outcomes. Together, these measures provide a snapshot of population well-being and longevity – how healthy people feel, how long they live, and how life begins.

Life Expectancy

Life expectancy in both the United States and Delaware experienced a sharp decline in 2020 due to the COVID-19 pandemic, which caused unprecedented mortality, especially among older adults and vulnerable populations. In the U.S., life expectancy dropped from 78.8 years in 2019 to 77.0 years in 2020, the largest single-year decline since World War II. Delaware followed a similar pattern, falling from 77.8 years in 2019 to 76.7 years in 2020.[43] [44] These decreases were driven not only by COVID-19 itself, but also by increases in deaths related to substance use, chronic conditions exacerbated by pandemic disruptions, and delayed access to care. As the immediate mortality burden of the pandemic began to subside and vaccination, treatment, and public health measures improved, life expectancy began to rebound. Between 2021 and 2023, the U.S. saw measurable gains in life expectancy, moving closer to—but still slightly below—their pre-pandemic baselines.[45] [46]

Life expectancy in the U.S. increased 2.0 years from 2021 (76.4 years) to 2023 (78.4 years)[47]. Life expectancy in Delaware increased 1.8 years during that same time period from 76.3 in 2021[48] to 78.1 years in 2023[49], approaching the national average but remaining marginally lower.

Figure 9. Average Number of Years of Life Expectancy at Birth*, Delaware, 2023

	Delaware	U.S.
Life Expectancy (years)	**78.1** ⬆ *+2.36*	**78.4** ⬆ *+2.62%*

Source: NCHS, Mortality in the United States, 2023 (Data Brief No. 521); Delaware Life Expectancy (wisevoter.com, 2023)

**Life expectancy at birth is defined as how long, on average, a newborn can expect to live, if current death rates do not change (CDC).*

Understanding these trends in life expectancy is critical for contextualizing progress in public health. While the upward shift reflects a hopeful trajectory, it also underscores the importance of addressing persistent health inequities, chronic disease, and behavioral health risks that the pandemic amplified.

43 Arias E, Xu JQ. United States Life Tables, 2019. National Vital Statistics Reports; vol 70 no 19. Hyattsville, MD: National Center for Health Statistics; 2022. Available from: https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-19.pdf

44 USAFacts. Health in Delaware: Life Expectancy Over Time. Updated 2024. Available from: https://usafacts.org/topics/health/state/delaware/

45 Arias E, Tejada-Vera B, Ahmad F, Kochanek KD. Mortality in the United States, 2023. NCHS Data Brief No. 521. Hyattsville, MD: National Center for Health Statistics; 2024. Available from: https://www.cdc.gov/nchs/products/databriefs/db521.htm

46 National Center for Health Statistics. U.S. State Life Tables, 2022. National Vital Statistics Reports; 2024. Available from: https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-07.pdf

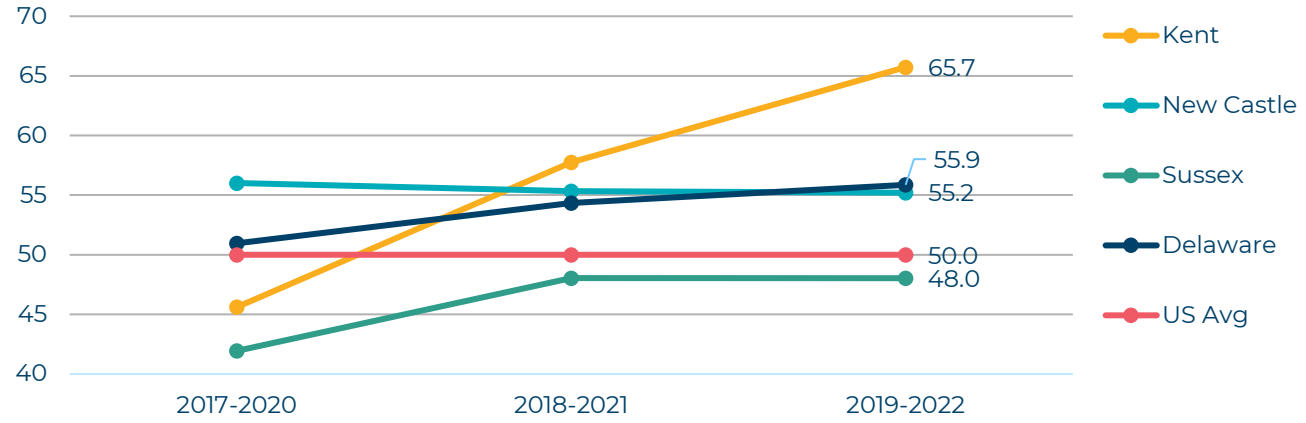
47 Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2023. NCHS Data Brief, no 521. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/170564.

[48] Centers for Disease Control and Prevention (CDC), "Delaware", Stats of the States, accessed August 26, 2025, https://www.cdc.gov/nchs/state-stats/states/de.html.

[49] WiseVoter. "Life Expectancy by State 2023." Accessed August 26, 2025. https://wisevoter.com/state-rankings/life-expectancy-by-state/.

The youth mortality rate in children and adolescents under age 18 in Delaware is generally similar to national trends, though disparities exist by region, race, and socioeconomic status. As part of a broader view of vital statistics, youth mortality highlights the underlying social, economic, and environmental factors that affect well-being.[50] [51]

Figure 10. Youth Mortality Rate per 100,000 Population Under Age 18, by County, Delaware, 2017–2022



Source: National Center for Health Statistics, National Vital Statistics System, 2017-2022

Kent County had the highest youth mortality rate (65.7), and Sussex County has the lowest (48.0) when comparing all three counties in Delaware. In recent years, the youth mortality rate has increased in Kent and Sussex counties and decreased in New Castle County.

Unintentional injuries are the leading cause of death in Delaware among those 1 to 24 years of age (19.7 per 100,000), followed by assaults (9.9). These rates are higher than the national average in each category (17.2 and 6.8, respectively). The third leading cause of death in Delawareans ages 1-24 is intentional self-harm.

Figure 11. Mortality Rate per 100,000 Population Ages 1-24 by Cause, Delaware, 2019–2022

Cause of Death	DE	U.S.
Accidents (unintentional injuries) *	19.7	17.2
Assault (homicide)	9.9	6.8
Intentional self-harm	5.3	6.7
Malignant neoplasms	2.4	2.5
Diseases of heart	1.8	1.2
Congenital malformations, deformations & chromosomal abnormalities	Unreliable	1.2

Source: CDC Wonder, crude mortality rates, 2019-2022

* Unintentional or accidental injuries *resulting in death can* include *motor vehicle crashes*, falls, drownings, poisoning, *suffocation, firearm injuries and others.*

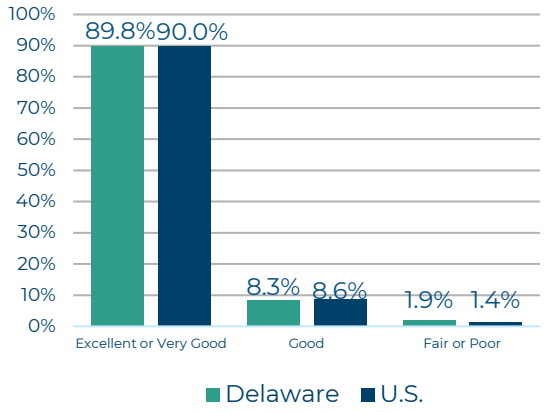
[50] *Centers for Disease Control and Prevention (CDC). Child and Adolescent Mortality, 2023. https://www.cdc.gov/nchs/fastats/infant-health.htm.*

[51] *Delaware Health and Social Services, Division of Public Health. Delaware Vital Statistics Annual Report, 2022. https://dhss.delaware.gov/dph/hp/annrepvs.html*

Health Status

Self- or proxy-reported health is a valid measure of a variety of physical and emotional dimensions of child and adolescent well-being.[52] In Delaware, 89.8% of children and adolescents are reported to be in excellent or very good health, which is slightly lower than the national average (90.0)[53].

Figure 12. Percent of Children Ages 0–17 by Reported Health Status*, Delaware, 2022-2023

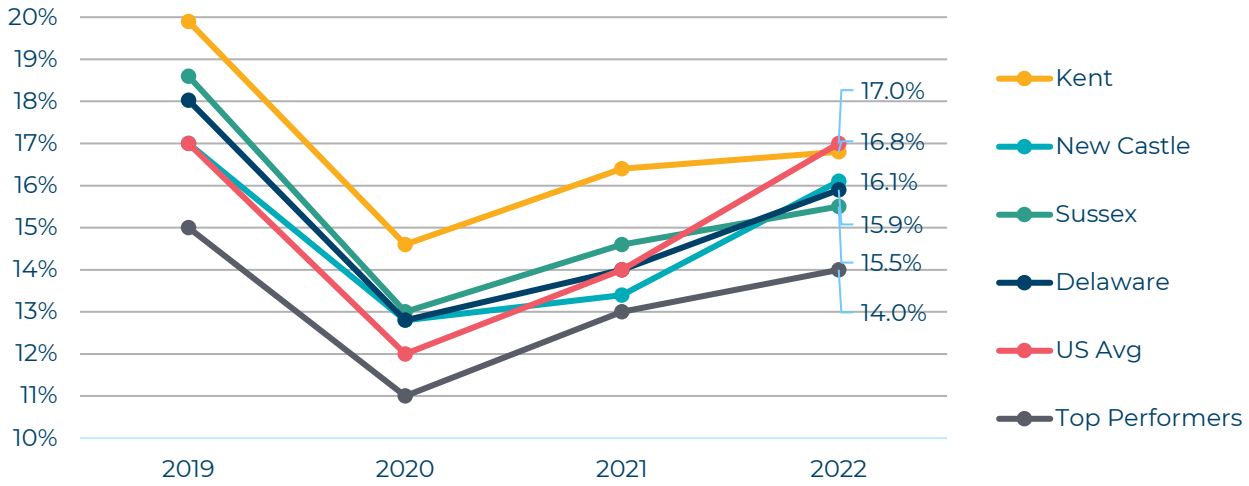


Between 2019 and 2020, the percentage of adults aged 18 and older reporting fair or poor health declined unexpectedly, according to the Behavioral Risk Factor Surveillance System (BRFSS). While this might seem counterintuitive given the onset of the COVID-19 pandemic, researchers suggest that shifts in health behaviors (such as increased hygiene, reduced exposure to other illnesses, or postponed medical visits) and changes in health perception during a public health crisis may have influenced how people rated their own health.[54] However, by 2021 and 2022, the percent of adults reporting fair or poor health rose again, returning to levels similar to those in 2019—suggesting a reversion to baseline as the pandemic evolved and health care access resumed.[55]

Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau, 2022-2023

**Based on parent(proxy)-reported general health status.*

Figure 13. Percent of Adults 18+ Who Reported They Were in Fair or Poor Health by County, Delaware, 2019-2022



Source: CHR, 2025; Behavioral Risk Factor Surveillance System (BRFSS), 2019-2022

> *All three counties have lower percents of people in fair or poor health than the U.S. (17.0%). However, Kent was very close (16.8%). Sussex County had the lowest percent in fair or poor health (15.5%).*

[52] Fosse NE, Haas SA. Validity and stability of self-reported health among adolescents in a longitudinal, nationally representative survey. Pediatrics. 2009 Mar;123(3):e496-501. doi: 10.1542/peds.2008-1552.

[53] *Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services* Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [05/03/25] from [www.childhealthdata.org].

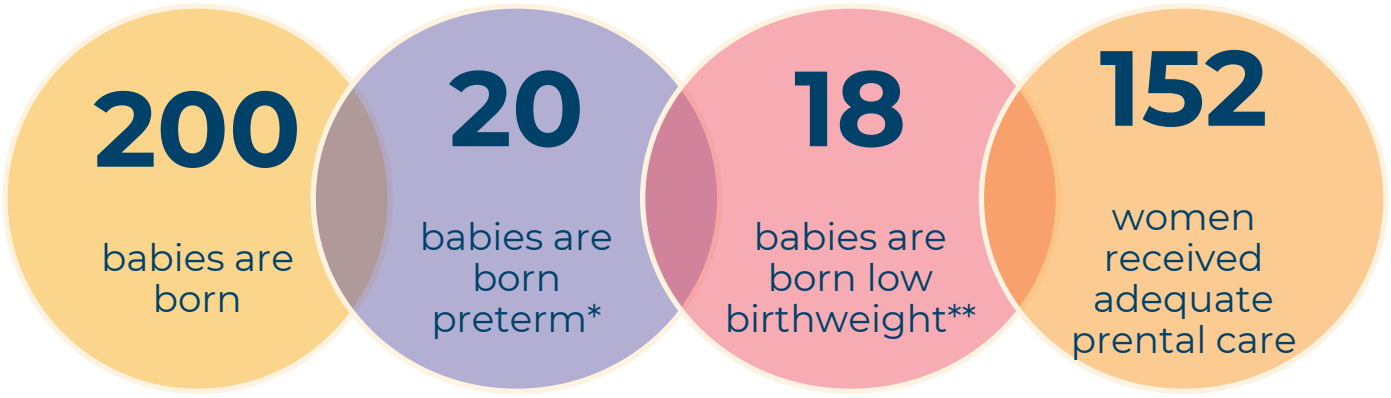
54 CDC Disability & Health Data System. Fair or Poor Self Rated Health, BRFSS 2019–2022. https://www.cdc.gov/dhds

55 County Health Rankings & Roadmaps. Poor or Fair Health Among Adults, BRFSS. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings/poor-or-fair-health

Birth Outcomes

Birth outcomes include low birth weight, premature birth and infant mortality. They are an important measure of the health of the baby, the amount and quality of prenatal care, and the health of the mother. Poor birth outcomes have adverse consequences for children and families, and society. The annual societal cost of preterm birth in the United States is over $26.2 billion. [56]

In an average week in Delaware[57]:



**Preterm is less than 37 weeks of pregnancy.*
***Low birthweight refers to infants weighing less than 2,500 grams at birth.*

Children born too early or too small have a greater risk of death and disability than full-term and heavier infants.[58] Preterm and low-birth-weight infants have significantly more hospitalizations than full-term and normal-birth-weight infants, particularly for respiratory illness and infection.[59] While preterm and low-birth-weight infants account for a small percent of all infant hospitalizations, they constitute almost half of all infant hospitalization costs.[60]

Prenatal care is critical for identifying medical risks, supporting healthy pregnancy behaviors, and connecting families to supportive services. Timely prenatal care is associated with lower rates of preterm birth, low birthweight, and infant mortality, [61] while receiving little or no prenatal care is a significant risk factor for adverse birth outcomes. In Delaware and nationally, Black mothers are less likely than White mothers to receive adequate prenatal care.[62]

Indicator	Black (Non-Hispanic)	White (Non-Hispanic)	Hispanic (all races)
Early Prenatal Care*	**66.3%**	82.4%	68.9%
Late or No Prenatal Care**	**10.4%**	4.7%	9.7%
Preterm Births	**13.4%**	9.9%	9.4%
Low Birth Weight	**13.7%**	7.1%	NS

[56] Institute of Medicine (U.S.) Committee on Understanding Premature Birth and Assuring Healthy Outcomes (2007).
[57] March of Dimes PeriStats: State Summary for Delaware, 2023. https://www.marchofdimes.org/peristats/state-summaries/delaware?lev=1&obj=3&reg=99&slev=4&sreg=10&stop=55&top=3. Accessed August 25, 2025.
[58] Martin et al. (2017); Matthews, et. al., (2015); Institute of Medicine (U.S.) Committee on Understanding Premature Birth and Assuring Healthy Outcomes (2007).
[59] Yüksel and Greenough (1994); Cunningham, McMillan, and Gross (1991); Lamarche-Vadel et al. (2004); Doyle, Ford, and Davis (2003).
60 Mariel Sparr, Alexandra Joraanstad, Grace Atukpawu-Tipton, Nicole Miller, Julie Leis, and Jill Filene (2017). Promoting Prenatal Health and Positive Birth Outcomes: A Snapshot of State Efforts. OPRE Report 2017-65. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. HHS
[61] CDC. Prenatal Care: Why It's Important. cdc.gov
[62] March of Dimes. PeriStats: Delaware Maternal and Infant Health. marchofdimes.org

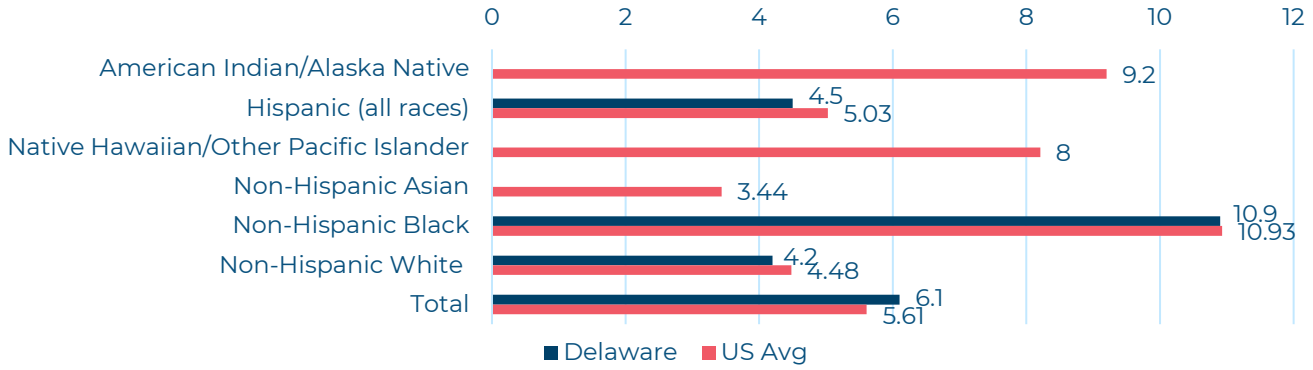
Source(s): Delaware Health and Social Services, Division of Public Health, Delaware Vital Statistics (via March of Dimes PeriStats, 2023) [prenatal care, preterm birth, low birth weight by race]; Centers for Disease Control and Prevention, National Vital Statistics Systems, Birth Data, 2023 [preterm birth by race].

**Early Prenatal Care Initiation is defined as pregnant individuals who received their first prenatal care visit during the first trimester (weeks 1-12 of gestation). **Late or no prenatal care is defined as pregnant individuals who either began prenatal care after the first trimester or did not receive any prenatal care during pregnancy. ***Data by race are not included if data is not sufficient (NS), or sample sizes are unreliable for an entire racial/ethnic category. These groups are represented in national datasets but are suppressed at the state level to maintain statistical reliability.*

Black mothers in Delaware have the lowest rate of early prenatal care initiation (66.3%) and the highest rate of late or no prenatal care (10.4%) compared to other racial/ethnic groups in the state. Nationally, Black mothers also have the lowest rate of early prenatal care initiation (67.9%) and the highest rate of late or no prenatal care (10.0%). Black infants in Delaware have substantially higher rates of both preterm birth (15.2%) and low birthweight (14.2%) than White or Hispanic infants.

Delaware's overall rates (10.4% and 8.3%, respectively) are similar to U.S. averages (10.4% and 8.2%, respectively), but disparities by race are pronounced. These disparities are linked to systemic barriers including limited access to providers, transportation challenges, insurance gaps, and experiences of racism within healthcare systems.[63] These barriers contribute to higher rates of adverse birth outcomes among Black infants, highlighting the need for targeted interventions to improve equity in maternal and infant health. Infant mortality – the number of infant deaths per 1,000 live births before the first birthday – is one of the most widely used measures of a community's health. It reflects not only the health of mothers and infants, but also broader conditions such as access to quality healthcare, socioeconomic stability, and structural inequities.[64] Delaware's infant mortality rate (IMR) is higher than the national average (6.1 vs. 5.61 per 1,000 live births, respetively). These values do not meet the Healthy People 2030 goal of reducing infant mortality to 5 infant deaths per 1,000 live births.

Figure 14. Infant Mortality Rate per 1,000 Live Births* by Race, Delaware**, USA, 2023



Source: NCHS, "Infant mortality in the United States, 2023." National Vital Statistics Reports 74(4). Delaware-specific data is aggregated from 2021-2023 averages.

**Deaths occurring in infants under 1 year of age per 1,000 live births. The data are reported by place of residence, not place of death.*
***Estimates that aren't present have been suppressed because NCHS reporting standards are not met (i.e., inadequate sample size).*

*Across the country, infant mortality rates vary significantly by race. In Delaware, the 2021-2023 average IMR was 10.93 for Black infants – nearly **2.6 times** the rate for White infants (4.2) and more than double the rate for Hispanic infants (4.5). We see similar disparities among the 2023 national averages, with additional data available for other racial/ethnic groups revealing American Indian/Alaska Native infants at an IMR of 9.2 which is closely behind Non-Hispanic Black infants at 10.9 per 1,000 live births.*

[63] *Petersen EE, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMWR Morb Mortal Wkly Rep. 2019;68:762-765.*

[64] *MacDorman MF, et al. Trends in infant mortality in the United States, 2005-2014. NCHS Data Brief, No. 279. Hyattsville, MD: National Center for Health Statistics.*

Because infant mortality is closely tied to factors like prenatal care, maternal health, and safe living environments, it serves as a sentinel indicator of how well a community supports its youngest and most vulnerable residents. Tracking IMR by race provides important insight into health disparities and how to target interventions where they are needed most.[65]

The leading cause of death in infants in the state of Delaware can be attributed to disorders related to short gestation and low birth weight (113.8 per 100,000). This rate is significantly higher than the U.S. rate overall (84.1). The secondary cause of infant death was congenital anomalies, also referred to as birth defects which can be environmental or genetic based on the diagnosis.

Figure 15. Infant Mortality Rate per 100,000 Population by Cause, Delaware, 2019–2022

Cause of Death	DE	U.S.
Disorders related to short gestation & low birth weight	113.8	84.1
Congenital malformations*, deformations & chromosomal abnormalities	87.7	110.2
Newborn affected by maternal complications of pregnancy**	73.5	31.8
Sudden infant death syndrome	49.8	38.1
Accidents (unintentional injuries)	Unreliable	34.7

Sources: CDC Wonder, crude mortality rates, 2019-2022

**A malformation refers to the abnormal development of embryonic tissue, such as a congenital heart defect[66]. **Maternal complications of pregnancy can have adverse effects on the newborn, including but not limited to gestational diabetes, high blood pressure, Group B Streptococcus, and Fetal Alcohol Syndrome.*

In addition to foundational indicators that reflect the overall state of health of the population, this report includes evidence-based indicators that describe economic, environmental, and social or cultural conditions that contribute to health and well-being of the community. These indicators are paramount to capturing a comprehensive community health profile of Delaware that reflects the purpose and goals of the CHNA process.

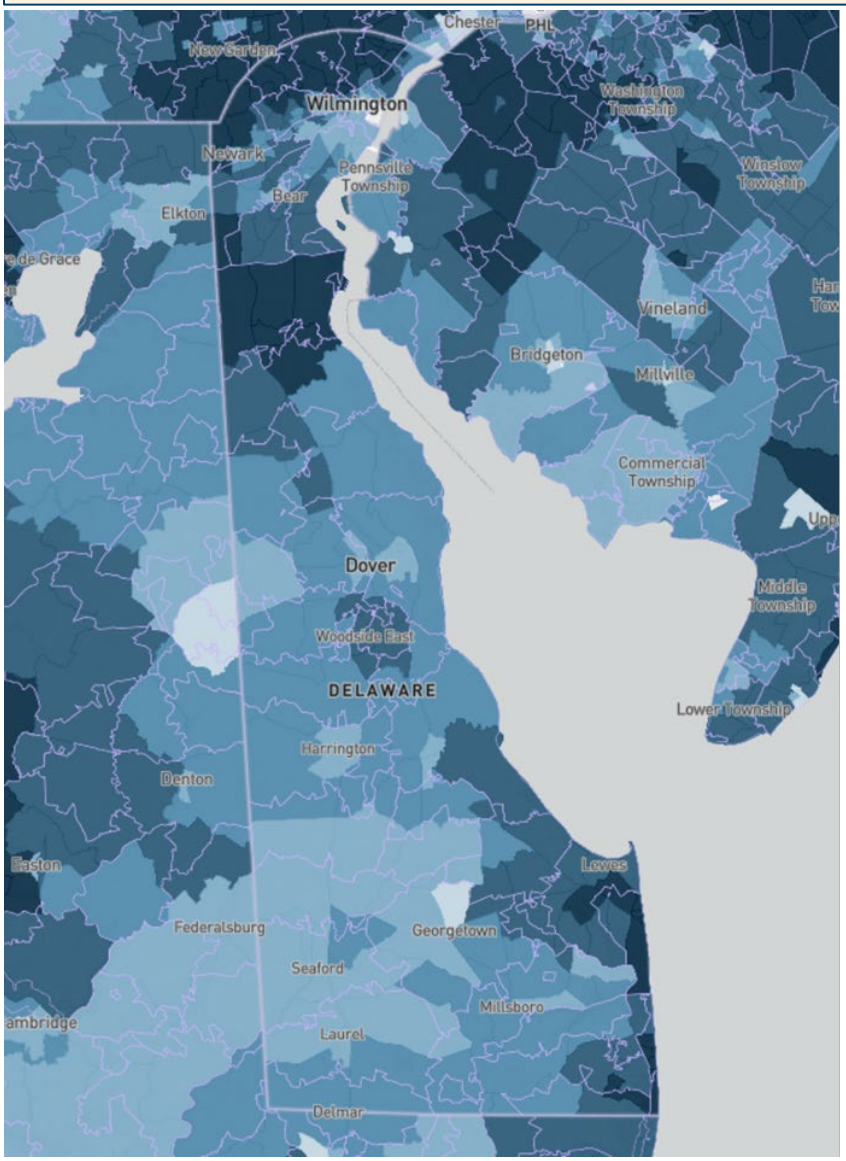
[65] *CDC. Infant Mortality in the United States, 2023: Data from the Period Linked Birth/Infant Death File. NVSR 74(7).*

[66] *Wojcik M, Agrawal PB. Congenital Anomalies. In: Jain L, Suresh GK. eds. Clinical Guidelines in Neonatology. McGraw-Hill Education; 2019. Accessed May 06, 2025. https://accesspediatrics.mhmedical.com/content.aspx?bookid=2671&sectionid=218700686*

Community Social and Economic Context

Efforts to improve the health of our communities have traditionally focused on expanding access to quality medical care. This is an important piece of the puzzle, but medical care alone cannot address what makes us sick. Increasing health care costs and worsening life expectancy are the result of a "frayed social safety net, economic challenges, insecure housing, racism and discrimination, disparities in education and nutrition, as well as risks within the physical environment. These factors impact our health long before and after the health care system.[67]

Figure 16. Child Opportunity Levels by Census Tract, Delaware, 2021



Source: Diversity Data Kids – diversitydatakids.org/child-opportunity-index, 2021

The Child Opportunity Index (COI) measures and maps the quality of resources and conditions that matter for children's healthy development in the neighborhoods where they live. The COI is a composite index of children's neighborhood opportunity that contains data for every census tract in the U.S. It is comprised of 44 indicators in three domains – education, health and environment, and social and economics, and 14 subdomains. It measures how equal the opportunity to grow and learn is throughout the state.

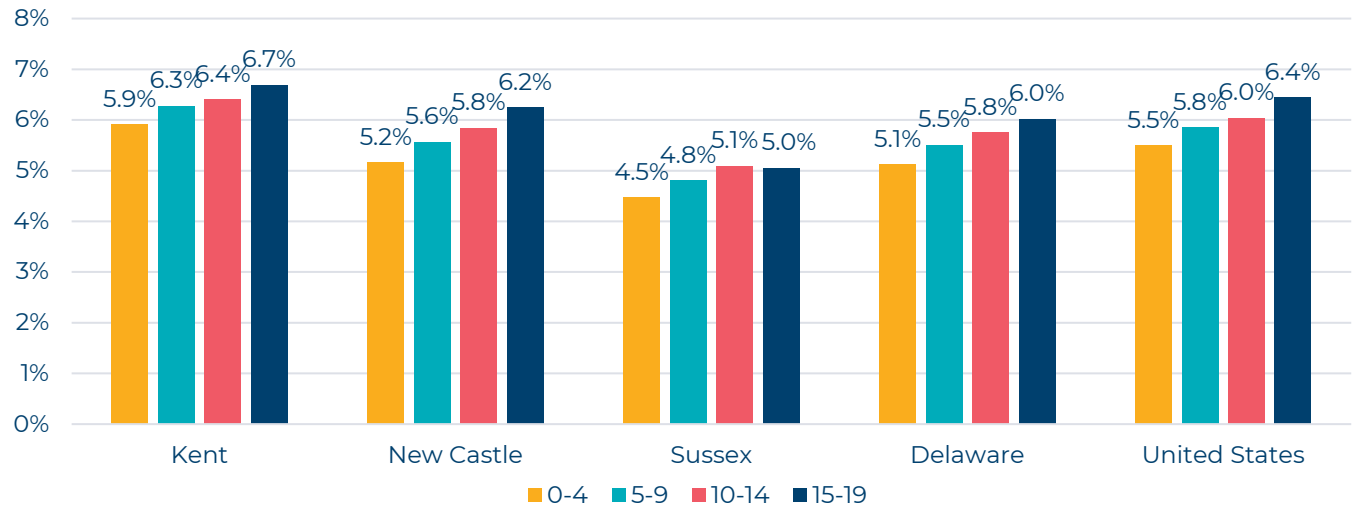
Higher opportunity neighborhoods are concentrated around suburban and more affluent regions, whereas urban centers, including parts of Wilmington and Dover, as well as rural communities in southwest Sussex County, exhibit lower levels. This geographic pattern underscores disparities in access to resources related to education, health, environment, and social and economic conditions across the state, emphasizing the need for targeted strategies to improve equitable child development opportunities.

67 "Health Affairs: Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health," de Beaumont, accessed August 25, 2022, https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health/?gclid=EAIaIQobChMIx7rj567i-QIVU8yzCh2P8AWWEAAYASAAEgJQIvD_BwE

Demographic Characteristics

There are 231,251 children and teens ages 0-19 living in Delaware. This accounts for 22.4% of the total population. The largest proportion of these youth are between the ages of 10 and 19 (52.6%), followed by children ages 9 and under (47.4%). See Appendix E for this and other demographic data below the county level.

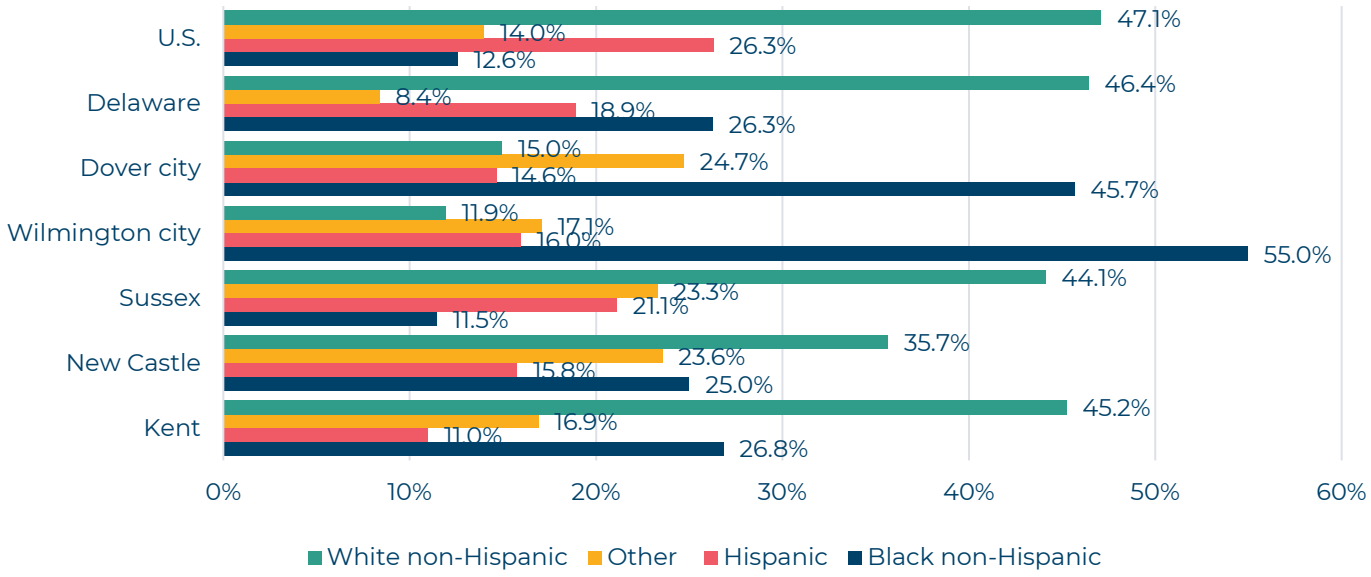
Figure 17. Percent of Total Population Under Age 20 by County, Delaware, 2024



Source: Esri, 2024

> *Approximately a quarter (25.3%) of Kent county's population is under 20 years of age, followed by New Castle County (22.8%). Sussex had the lowest percent of population under 20 at 19.4%.*[8]

Figure 18. Percent Race and Ethnicity* of Children Under Age 18 by City and County, Delaware, 2018–2023

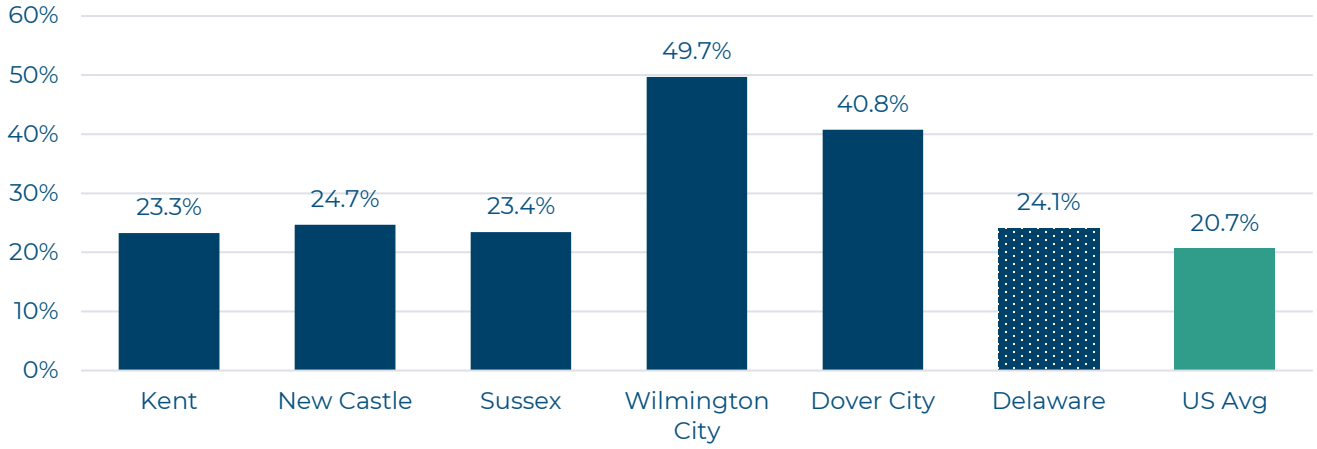


Source: U.S. Census Bureau. American Community Survey, 2018-2023
**Persons of Hispanic origin may be of any race*

Forty four percent of Sussex County is white, and one fifth are Hispanic (21.1%) – accounting for the highest percent of Hispanics amongst the three counties. New Castle County has the smallest proportion of white residents (35.7%) in Delaware, but the largest "other" population at 23.6% which is almost double the national average (14%). Kent County has the highest white population (45.2%), and the highest black (26.8%), but the Hispanic population in Kent County is the lowest in the state (11.0%) and more than two times lower than the national average (26.3%).

Family structure is an important factor in understanding child and family well-being. Family led by one parent may experience added financial and time constraints, which can influence children's access to resources that support healthy development.[68] In Delaware, nearly one-fourth (24.1%) of households are run by a single parent, a rate that is higher than the national average (20.7%).

Figure 19. Percent of Single-Parent Households of Total Households with One or More People under 18 Years of Age by City and County, Delaware, 2019-2023



Source: U.S. Census Bureau. American Community Survey,, 2019-2023

New Castle County had the highest percent of single-parent households (24.7%) followed by Sussex (23.4%) and Kent County (23.3%). However, Dover and Wilmington had much higher (40.8% and 49.7%, respectively) percentages of single-parent households.

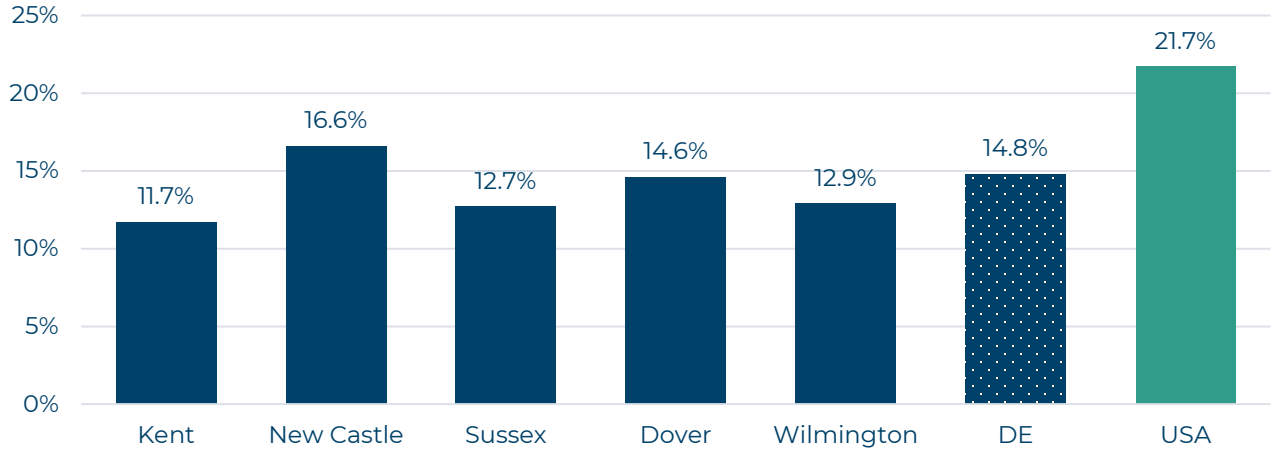
Language spoken in the home is a key factor in children's health and development. Families who speak a language other than English may face additional challenges accessing health care, educational resources, and community supports, particularly when translation or culturally appropriate services are limited.[69,70] These challenges can also impact literacy, school readiness, and overall family well-being. Approximately 15% of Delawareans report a language other than English being spoken in their home, compared to 21.7% nationwide.

[68] *Amato PR. The impact of family formation change on the cognitive, social, and emotional well-being of the next generation. Future of Children. 2005;15(2):75-96.*

[69] *Flores G. Language barriers to health care in the United States. New England Journal of Medicine. 2006;355(3):229-231.*

[70] *Zong J, Batalova J. The Limited English Proficient Population in the United States. Migration Policy Institute. 2015. http://www.migrationpolicy.org*

Figure 20. Percent of Population Aged 5 and Older with Language Other Than English Spoken at Home by City and County, Delaware, 2019–2023



Source: U.S. Census Bureau. American Community Survey, 2019-2023.

New Castle County has the highest percent of the population who lives in a home in which a language other than English is spoken (16.6%), followed by Sussex (12.7%) and Kent (11.7%) Counties. Below the county level, Dover, a city within Kent County, is nearly 3 percent points higher than Kent County overall, which is worth exploring further when targeting programs and outreach by geographic area.

Young people who are immigrants or are a part of immigrant families may also face challenges related to economic hardship, limited access to health insurance, or fear of engaging with public systems.[71,72] These factors can compound stress within households and influence health outcomes, even when children themselves are U.S. citizens. Approximately 25,000 (19%) youth and young adults (ages 14 to 24) living in Delaware are immigrants or live in immigrant families, compared to 23% (10,777,000) nationally. In addition, children in immigrant families are far more likely to live in linguistically isolated households – where no one over the age of 14 speaks English "very well" – compared with children in U.S. born families. This creates more significant barriers to accessing healthcare, understanding public health messaging, and navigating community resources. Children in immigrant families are 13 times more likely to be linguistically isolated, and 16 times more likely to experience linguistic isolation nationwide.

Figure 21. Percent of Children (<18) Living in Linguistically Isolated* Households by Family Nativity, 2021

	Delaware	United States
Children in immigrant families	13% (n=6,000)	16% (n=2,976,000)
Children in U.S. born families	1% (n=2,000)	1% (n=400,000)

Source: PRB analysis of data from the U.S. Census Bureau, Census Supplementary Survey & American Community Survey, 2021.

**A linguistically isolated household is defined as a household in which no person 14 years old and over speaks only English, and no person 14 years old and over who speaks a language other than English speaks English "very well. All members of a linguistically isolated household are tabulated as linguistically isolated, including members under 14 years old who may speak only English.*

[71] *Perreira KM, Yoshikawa H, Oberland J. A new threat to immigrants' health – the public-charge rule. New England Journal of Medicine. 2018;379(10):901-903.*

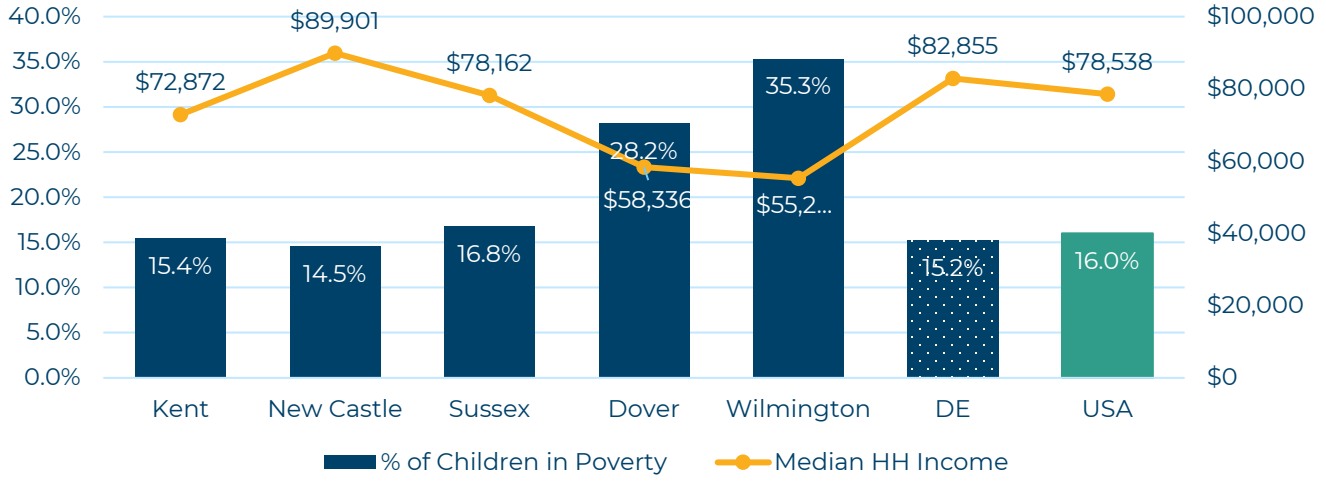
[72] *Capps R, Fix M, Van Hook J. Immigrant Families and Child Health. The Future of Children. 2019;29(1):65-92.*

Income and Poverty

Economic hardships can harm health and family relationships, as well as make it more difficult to afford things that impact health such as safe housing, nutritional meals and medical costs. Children living in low socioeconomic conditions are more likely to be exposed to adverse childhood experiences (ACES) that can cause adverse health outcomes across the lifespan.

Nearly 1 in 6.5 (15.2%) children in Delaware live below the poverty level. The median household income in the state was $82,855 per year, an increase of over $13,000 from 2016-2020 five-year estimates.

Figure 22. Percent of Children Under 18 Living Below Poverty Level* and Median Household Income by City and County, Delaware, 2018–2023

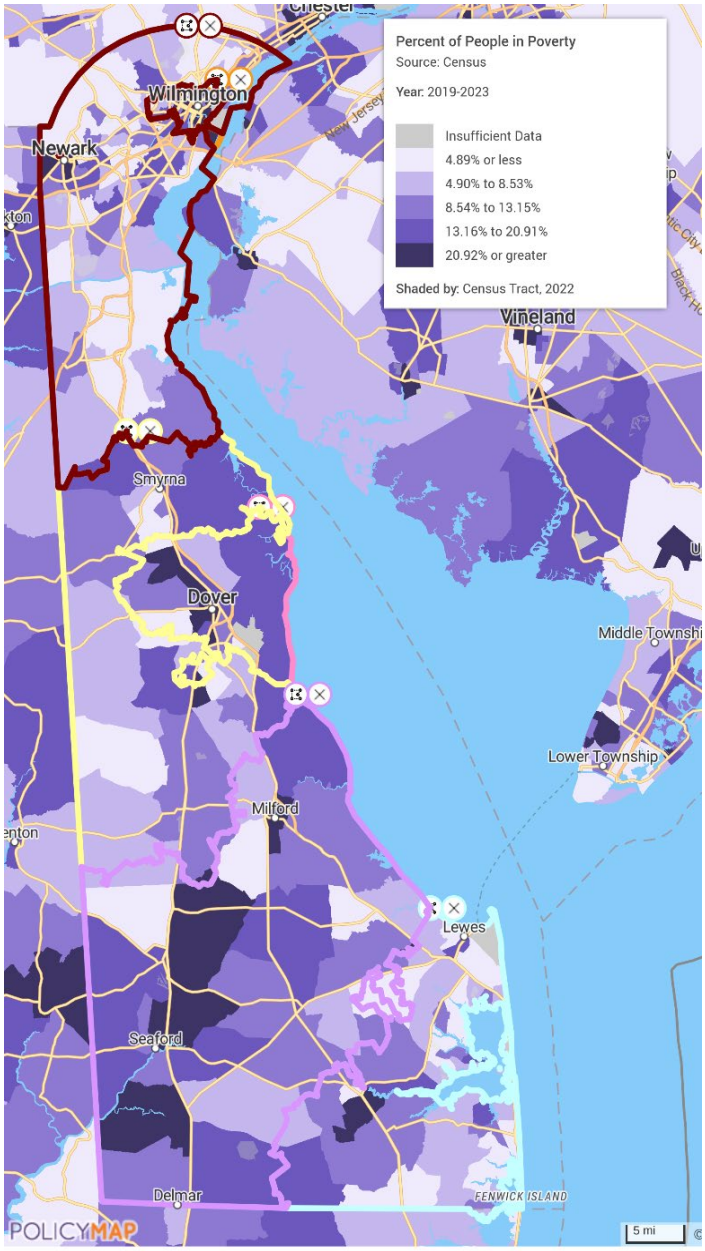


Source: U.S. Census Bureau. American Community Survey.,2018- 2023.

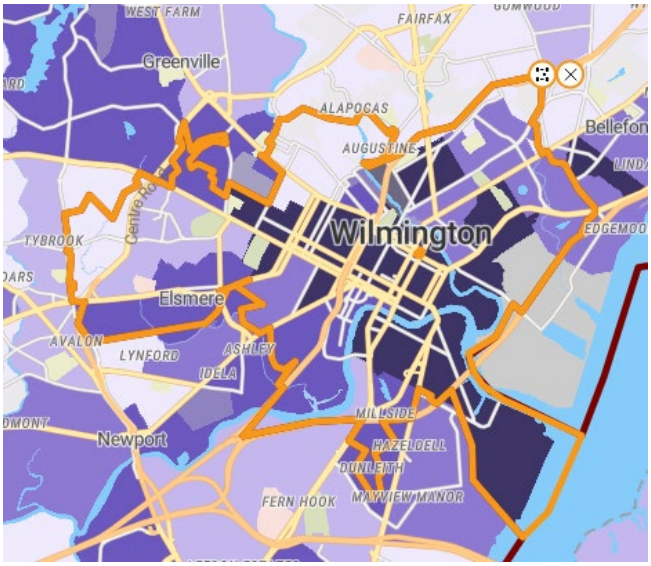
**The Census Bureau poverty definition - Following the Office of Management and Budget's (OMB) Statistical Policy Directive 14, the Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. The official poverty thresholds do not vary geographically, but they are updated for inflation using Consumer Price Index (CPI-U). The official poverty definition uses money income before taxes and does not include capital gains or noncash benefits (such as public housing, Medicaid, and food stamps).*

Kent and New Castle counties have lower proportions of children under the age of 18 living below poverty level (15.4% and 14.5%, respectively), when compared to Sussex County overall (16.8%). Below the county level, however, cities within Kent and New Castle are nearly two times the county rate – with 28.2% of children in Dover and 35.3% of children in Wilmington living below the poverty line. A similar trend is observed when layering median household income. Median incomes in Wilmington and Dover are $15-30,000 lower than the counties they are located in.

Figure 23. Percent of People in Poverty, by Census Tract, Delaware, 2019–2023



The map on the left has been adjusted to a larger scale to highlight Wilmington City (below).



Source: Census Bureau, 2019-2023

This map illustrates the distribution of poverty across Delaware by census tract, with darker shading representing higher poverty levels. Census tracts where 20% or more residents live in poverty are shown in the darkest shade, while lighter areas indicate tracts with lower rates of poverty (under 5%).

Poverty is not evenly distributed across the state. Concentrations of higher poverty are most evident in and around the city of Wilmington, where several census tracts report poverty rates exceeding 30%. Smaller but notable clusters of elevated poverty are also seen in portions of Kent and Sussex counties. By contrast, many suburban and coastal areas show relatively low levels of poverty.

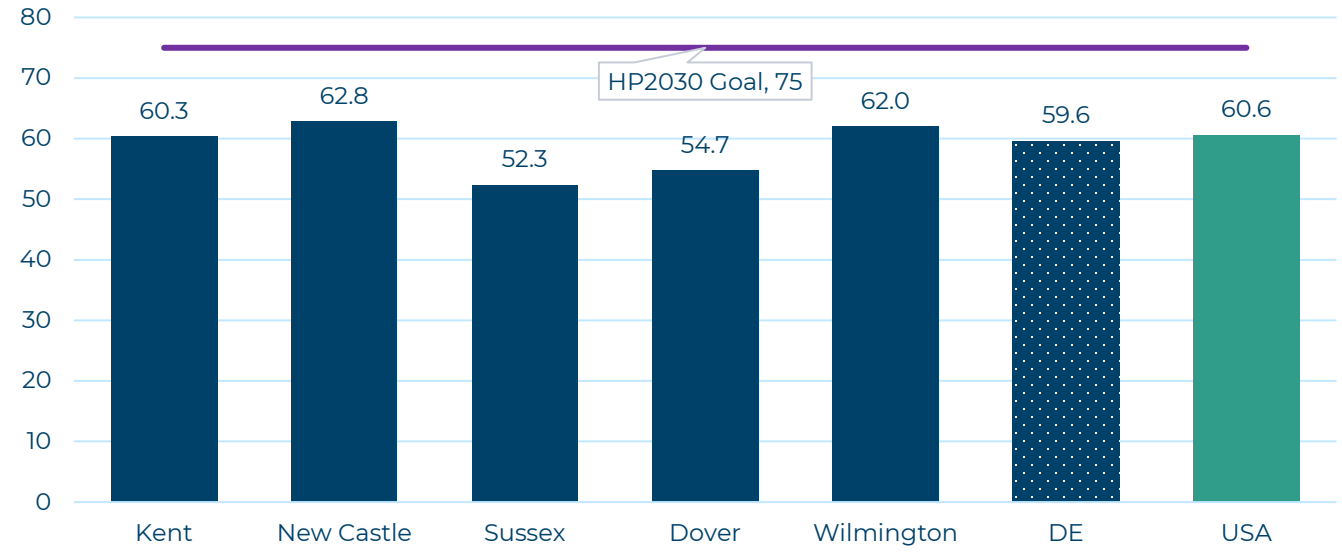
These patterns highlight the geographic disparities in economic well-being across the state. Areas with high poverty often overlap with communities that face additional barriers to health, including limited access to safe housing, nutritious food, and health care services. Addressing poverty and its associated risks is central to advancing health equity and improving overall community health outcomes.

Community members echoed the need for a broader understanding of poverty. One stakeholder stated, "There is a continuum of poverty, those who live in substandard housing... all the way to those experiencing homelessness and the health risks they face."

Employment

Employment is a key determinant of health that shapes long-term outcomes for children. Caregiver employment supports access to health insurance, stable housing, nutritious food, and other essentials that promote healthy development. Research shows that unemployment and underemployment are linked with increased risks for poor child health, behavioral concerns, and barriers to academic success.[73] [74]. Delaware does not meet the Healthy People 2030 goal to increase employment in working-age people to 75.0%.

Figure 24. Percent of Population 16 Years and Older in the Labor Force, by City and County, Delaware, 2018–2023



Source: U.S. Census Bureau. American Community Survey, 2018-2023

> *New Castle County has the highest percent of the population 16 years and older in the labor force (62.8%), followed by Kent (60.3%) and Sussex (52.3%) counties.*

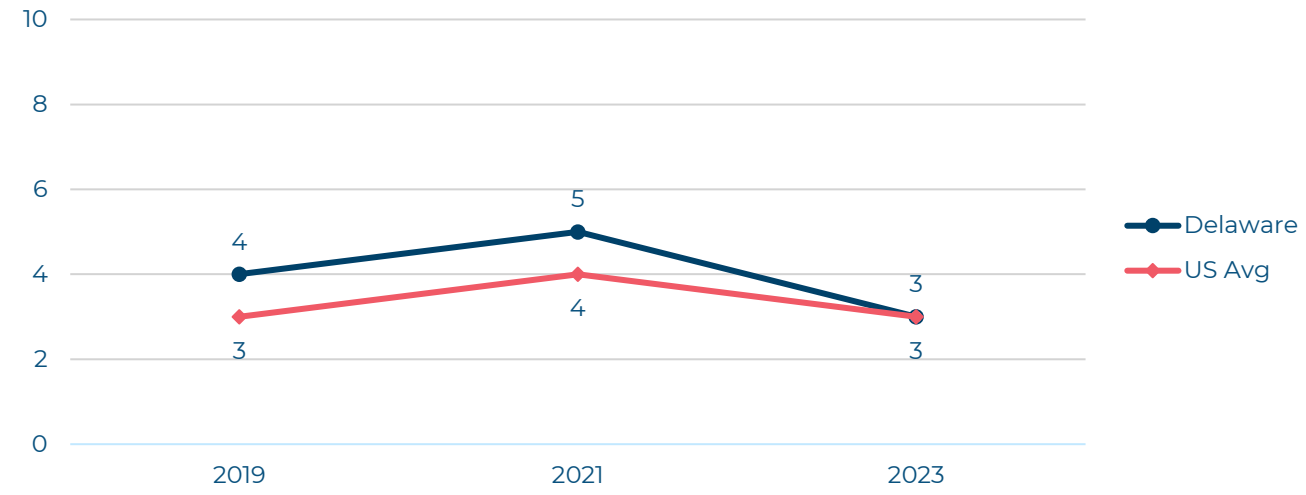
Children living in families lacking secure parental employment are especially vulnerable. Without at least one parent employed full-time, children are more likely to fall into poverty.[75] In Delaware, approximately 3% of parents are unemployed, which is consistent with the national average. This represents a 2% decrease from 2021 to 2023.

[73] *Robert Wood Johnson Foundation. Why Does Employment, or the Lack of It, Affect Health? Issue Brief. Princeton, NJ: Robert Wood Johnson Foundation, 2013.*

[74] *Anne Case and Christina Paxson, "Economic Status and Health in Childhood: The Origins of the Gradient," American Economic Review 100, no. 5 (2010): 1909-1929. https://doi.org/10.1257/aer.100.5.1909*

[75] *KIDS COUNT Data Book: http://datacenter.kidscount.org/publications. Accessed August 22, 2025.*

Figure 25. Percent of Unemployed Parents*, Delaware, 2023



Source: PRB analysis data from the U.S. Census Bureau, Current Population Survey, Basic Monthly Data Files, 2019-2023

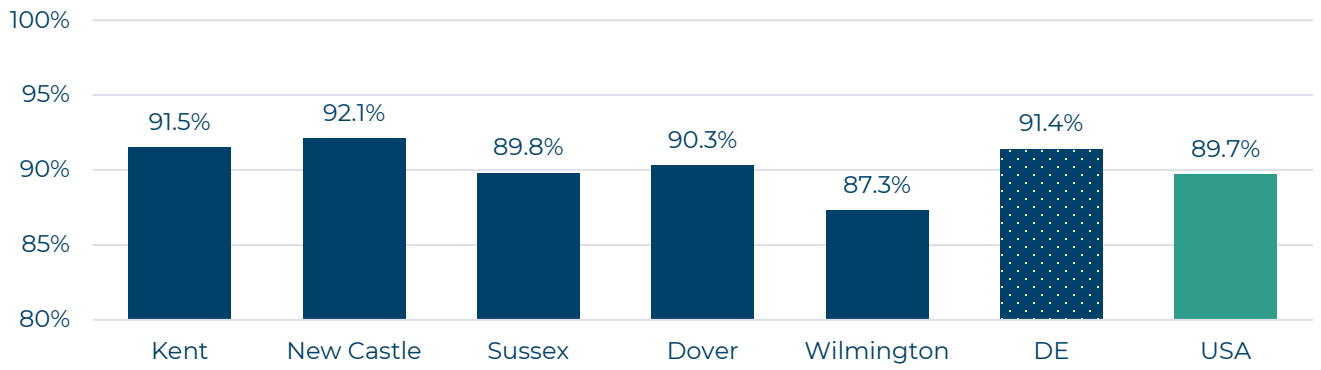
**The unemployment rate of parents is the total number of parents unemployed divided by the total number of parents in the labor force. Parents who are not working AND are not looking for work are not considered to be in the labor force, and so are not included in the unemployment rate.*

Education

Health benefits of education include better jobs, higher earnings, and thus, increased resources for good health. There are also social and psychological benefits to education such as reduced stress, improved social and psychological skills, and larger social networks. An individual's knowledge and skill level can impact their ability to learn healthy behaviors, understand their own health needs, follow instructions, advocate for themselves/ families, and communicate effectively with providers.[76]

Parent education levels are among the best predictors of student success.[77] Over ninety-one percent of Delaware residents age 25 and older have at least a high school degree, compared to 89.7% nationwide.

Figure 26. Percent of Population Aged 25 and Older with a High School Degree or Higher by City and County, Delaware, 2023

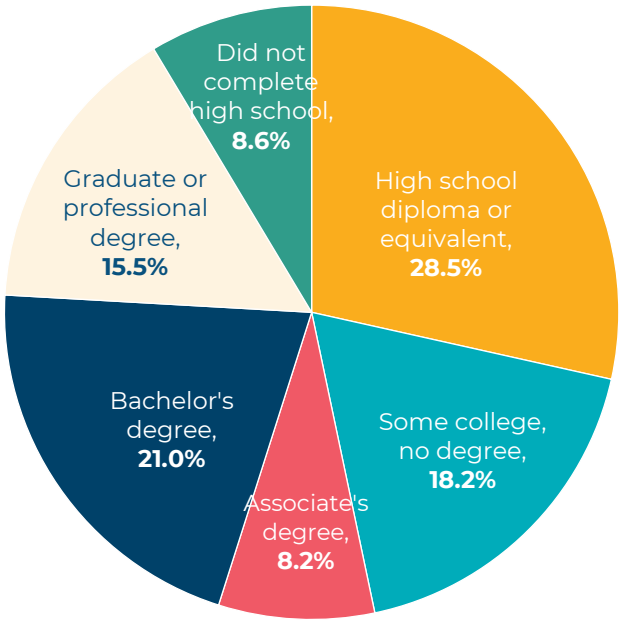


Source: U.S. Census Bureau. American Community Survey, 2023..

76 "Why Education Matters to Health: Exploring the Causes," Virginia Commonwealth University: Center on Society and Health, accessed September 9, 2022, https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.

77 "Geographic Disparity: States with the best (and worst) schools," Delaware Online, 2018, accessed September 9, 2022, https://www.delawareonline.com/story/money/economy/2018/02/08/geographic-disparity-states-best-and-worst-schools/1079181001/

Figure 27. Percent of Population Aged 25 and Older by Educational Attainment, Delaware, 2023



Educational attainment influences health well beyond high school completion. Higher education levels are linked to lower rates of chronic disease, better health behaviors, increased economic stability, and improved health literacy. Communities with higher educational attainment often see better health outomces across generations, as education shapes access to resources, opportunities, and social support that promote well-being.[78,79,80]

While 63% of the Delaware adult population has earned at least some postsecondary education*, only 45% of Delaware's adult population has received a college degree (2 or 4 years), or graduate degree**.

**Postsecondary educational attainment includes some college, a two-year, four-year, or professional degree.*
***This data does not include populations that have attained a nondegree postsecondary education such as a credential, or an apprenticeship.*

Source: U.S. Census Bureau, Educational attainment Population over 25, American Community Survey, 2023.

Reading together or encouraging children to read independently several times a week is strongly linked to early literacy and long-term educational success. Shared reading builds language skills, vocabulary, and comprehension, while independent reading fosters critical thinking, confidence, and sustained attention as a learner. Children who are regularly read to before kindergarten are more likely to demonstrate school readiness, enter formal education with stronger pre-literacy skills, and sustain higher levels of academic achievement across subjects. Approximately 32% of survey respondents report reading their child and/or their older child reading independently every day, while 11% report no reading time at all.

Early enrollment in high-quality early education programs further enhances these benefits – children who attend preschool or pre-kindergarten at age 3 or 4 demonstrate stronger language development, math and literacy skills, and are more likely to sustain higher academic achievement throughout school.[81,82,83] Three in four (76%) survey respondents report their child's first enrollment in an education program was at or before the age of four. Still, 11% report their child is not enrolled at all – with 6% of those responses indicating that their child was/is homeschooled.

[78] *Zimmerman, E.B., & Woolf, S.H. (2014). Understanding the Relationship Between Education and Health. Institute of Medicine. Retrieved from http://nam.edu/wp-content/uploads/2015/06/BPH-UnderstandingTheRelationship1.pdf*

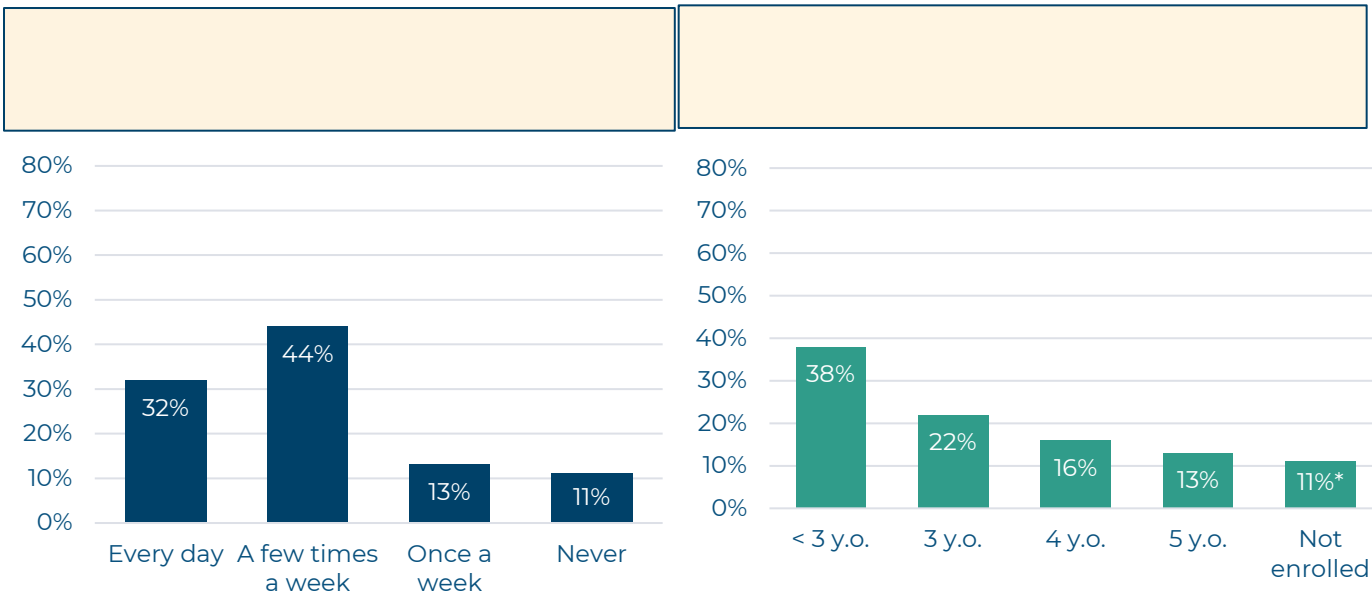
[79] *Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. Public Health Reports, 129(Suppl 2), 19-31. Retrieved from https://pubmed.ncbi.nlm.nih.gov/24385661/.*

[80] *Cutler, D. M. & Lleras-Muney, A. (2006). Education and health: Evaluating theories and evidence. National Bureau of Economic Research Working Paper No. 12352. Retrieved from https://www.nber.org/papers/w12352*

[81] *National institute for Literacy. Developing Early Literacy: Report of the National Early Literacy Panel. Washington, DC: National Institute for Literacy; 2008.*

[82] *Magnuson KA, Waldfogel J. Early Childhood Care and Education: Effects on Ethnic and Racial Gaps in School Readiness. Future Child. 2005; 15(1):169-196*

[83] *Annie E. Casey Foundation. Early Warning! Why Reading by the End of Third Grade Matters. Baltimore, MD: Annie E. Casey Foundation; 2010.*



Source: Nemours Community Survey, 2025

**Of the 11% (n=108) of responses that indicated their child was not enrolled in school: 84% was because the child is not old enough for school and 6% are homeschooled.*
***We asked two questions about children's education in the community survey. One regarding how often the respondent reads books or stories with this child or how often the child has read on their own in the past 7 days. We also asked at what age the child began their earliest formal education program.*

1. D.C.
2. Vermont
3. Oklahoma
4. Florida
5. Wisconsin
6. Iowa
7. Georgia
8. West Virginia
9. New York
10. Texas

41 Delaware

National Rankings for Pre-K Access and Enrollment, Top States and DE

Early Care and Education (ECE) encompasses the learning time that occurs between birth and the age of eight. These years are critical for a child's long-term intellectual and social-emotional development. Despite the importance of these early years, only 16% of Delaware children birth to five have access to publicly funded early care and education and roughly 50 percent of children in Delaware ages three to five (13,902 kids) are not enrolled in school, including nursery school, preschool, or kindergarten.

Delaware is ranked **41st in the county for pre-K access and enrollment**. Only 845 children, five percent of four-year-olds and two percent of three-year-olds, were enrolled in state sponsored pre-K in 2018-2019. [84]

Compared to K-12 students, Delaware invests a fraction of what it does in children under five:

With only one out of seven children having access to publicly funded care, the cost burden on families for early childhood education (ECE) places it out of reach for many. In fact, the state of Delaware funded

[84] *National Institute for Early Education Research. (2019). The State of Pre-school 2018: Delaware state profile.*

30% fewer children in 2023 than in 2018, widening pre-existing gaps in access.[85]

Without publicly funded care, the average annual cost for center-based care for a 4-year-old is between $11-12,000 per year – an amount comparable to annual in-state college tuition, or several months of housing payments – making ECE accessible primarily to higher-income households. Such financial barriers limit participation for children from lower-income families, delaying school readiness and exacerbating disparities in educational, developmental, and long-term health outcomes.[86]

Figure 30. Average Weekly Cost* of Early Childhood Education Programs* by Child Age, Delaware, 2024

	New Castle	Kent	Sussex	Delaware	% change from 2020 (DE overall)
< 3 years of age**	$255	$218	$204	$238	↑ 40.25%
3 years of age	$233	$203	$188	$218	↑ 40.65%
4 years of age	$231	$202	$185	$216	↑ 40.26%

Source: Children and Families First via KidsCount Delaware, 2024

**Average weekly cost in dollars to families for full time child care by child's age, all types of care combined (licensed only): licensed child care centers, licensed large family child care home, licensed family child care homes.*
*** Under 3 years of age was calculated by taking the average costs of 3 age groups: 0-12 months, 12-24 months, and 2 years old.*

In 2024, Delaware's average eighth-grade reading score was 249, below the national average of 257 (≥262 considered proficient). The average eighth-grade mathematics score was 263, compared to the national average of 272 (≥282 considered proficient).[87] The decrease in proficiency from 4th to 8th grade mirrors national trends and reflects multiple underlying factors, including social determinants such as neighborhood resources, and educational inequities.[88] The gaps in Delaware are especially concerning, indicating that students may not have equitable access to high-quality instruction and supports, and emphasizing the importance of early interventions even further, particularly in literacy and numeracy.[89]

Figure 31. NAEP* Proficiency Scores, Delaware, 2024

	Delaware	U.S.
4th Grade: NAEP reading (ELA) score / Percent of students below proficiency	210 74%	214 70%
4th Grade: NAEP math score/ Percent of students below proficiency	233 65%	237 60%
8th Grade: NAEP reading (ELA) score / Percent of students below proficiency	249 77%	257 71%
8th Grade: NAEP math score/ Percent of students below proficiency	263 81%	272 73%

Sources: Education Data org. Public Education Spending Statistics, 2024. https://educationdata.org/public-education-spending-statistics; U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Available online at http://nces.ed.gov/nationsreportcard/. 2024

**NAEP stands for the National Assessment of Educational Progress. Proficiency is determined by thresholds established for each subject and grade and represents a solid academic performance and competency over challenging subject matter, not just minimal skills. Score below proficiency indicate students are basic or below basic, meaning that partial mastery of the skills expected at that grade level.*

Community members highlighted education as a concern in every corner of the state. One stakeholder noted, "Education and literacy levels of adults and children are not where we need to them to be to fully navigate the world and make informed choices."

[85] . Rodel Foundation of Delaware. (2024, April). Public Education at a Glance 2024 (Report No. PO-8988). Rodel Foundation of Delaware. https://rodelde.org/wp-content/uploads/2024/04/PO-8988_Rodel-At-a-Glance-2024_Final.pdf

[86] National Institute for Early Education Research (NIEER). The State of Preschool 2023 Yearbook. Rutgers University, 2024.

[87] National Center for Education Statistics. NAEP 2024 Delaware State Snapshot, Grades 4 and 8. https://nces.ed.gov/nationsreportcard/subject/publications/stt2024

[88] Reardon, S.F. (2011). The widening academic achievement gap between the rich and the poor: New evidence and possible explanations. Whither Opportunity? Rising Inequality, Schools, and Children's Life Chances, 91-116.

[89] National Center for Education Statistics. NAEP 2024 Reading & Mathematics Assessments, U.S. Results for Grade 4 and 8. https://nces.ed.gov/nationsreportcard

Average Per-Pupil Expenditures

Delaware's overall spending on schools, when examined at a per-pupil level, is on par with other states.

Delaware lags in providing additional support for multilingual learners and students from low-income backgrounds.

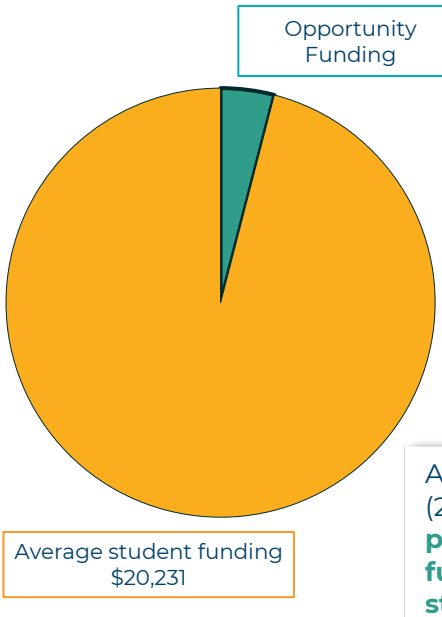
Delaware is ranked **14th** (15th including D.C.) **nationally** in **spending per student.**

In **2023**, Delaware schools spent an average of

$20,231 per student

according to the Delaware Department of Education's calculations

**Average revenues per pupil were calculated by dividing revenue by student enrollment based on the September 30th unit count. Vocational technical school districts and charter schools are funded differently than traditional school districts. Delaware does not fund per student, so the average spending per student in 2022 is an estimate. This includes federal, state, and local funding.*



Delaware utilizes **Opportunity Funding** to provide for high-need students, which as of **2023** allocates:

approximately **$800** to **$900** per learner student or student from a low-income background. If a student fits in both categories they receive **both allocations**

American Institutes of Research (2023) suggests systems should **provide 100-200% more funding** based on **individual student needs.**

Opportunity Funding equates to **only an additional 3-4%** of the **estimated average spending** per student.

*Source: Morse, Richard. (2023). Delaware Public Schools Litigation. Community Legal Aid Society. Delaware Department of Education. (2023). Delaware Report Card: Average Spending per Student. *Adapted from Rodel, "Delaware Public Education at a Glance", (2024).*

According to the Rodel Foundation, Delaware is one of only seven states that funds schools based on faculty needs, rather than student needs. Delaware's neighboring states and more than 80% of the country use a student-based system that provides additional annual funds for multi-learner students and students from low-income backgrounds. The American Institutes for Research (AIR) released "The Assessment of Delaware Public School Funding" in December 2023 that mapped out a potential student-centered funding formula that could be utilized in Delaware. In response to the AIR report, the Public Education Funding Commission was established by Senate Concurrent Resolution 201 in June 2024. The Commission, comprised of 31 members including legislators, Department of Education, administrators, educators, charter representatives, community members, and other experts, is expected to deliver preliminary recommendations for a new "hybrid" finding system this Fall (2025).[90]

Addressing educational disparities as a component of public health is critical, as academic achievement strongly correlates with long-term health outcomes, economic opportunity, and overall well-being.[91] Student-centered investments are effective in transforming outcomes in the classroom and beyond. While educational outcomes impact the broader conditions in which we live, those same conditions deeply influence education as well. Stable housing is one of the most critical measures when demonstrating this reciprocal relationship. Children experiencing homelessness face significant barriers to learning, including

[90] *Rodel Foundation of Delaware. (2024, April). Public Education at a Glance 2024 (Report No. PO-8988). Rodel Foundation of Delaware. https://rodelde.org/wp-content/uploads/2024/04/PO-8988_Rodel-At-a-Glance-2024_Final.pdf*

[91] *Duncan, G.J., & Magnuson, K. (2011). The long reach of early childhood poverty. Pathways, Summer 2011, 22-27.*

higher rates of absenteeism, difficulty concentrating, and lower academic performance compared to peers in stable homes. Nationally, students experiencing homelessness are more than twice as likely to be chronically absent and less than one-third achieve academic proficiency in reading and math compared to their peers.[92]

In Delaware, **more than 4,420 students were identified as experiencing homelessness during the 2022-2023 school year**, representing more than 3% of the K-12 student population.[93] These realities highlight the inextricable link between housing and education, and underscore how social determinants shape opportunity from an early age.

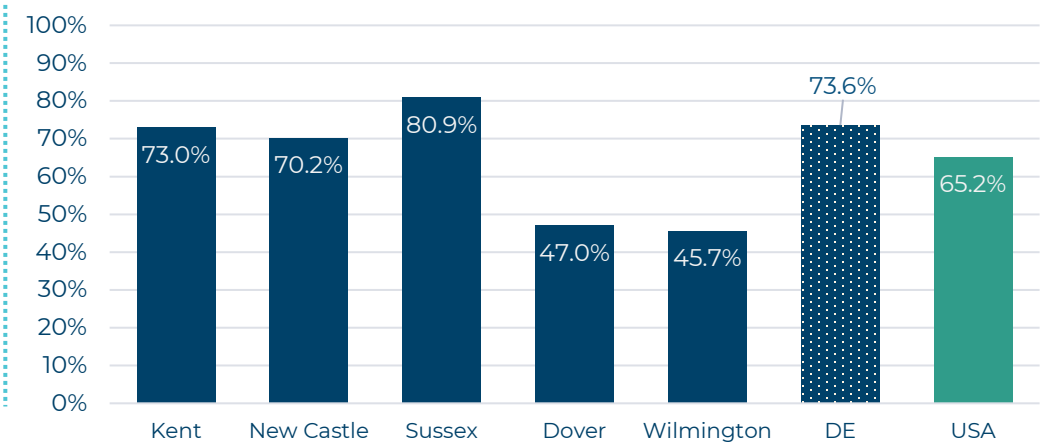
Housing and Living Conditions

Beyond educational implications, housing is a fundamental building block for health and well-being. Safe, stable, and affordable housing provides not only shelter but also a foundation for physical and mental health, security, and the ability to thrive. Conversely, housing instability, substandard housing conditions, and homelessness are associated with higher risks of chronic disease, injury, poor mental health, and negative outcomes across the lifespan.[94]

The majority of Delawareans are homeowners (73.6%), which is higher than the national rate (65.2%). Over half (51.6%) of Delaware residents who rent their homes are spending 30% or more of their household income on their rent payments.

Figure 32. Percent of Homeownership by City and County, Delaware, 2019-2023

Three in ten (30%) survey respondents rent, while just over half (51%) own a home.



Source: Census Bureau, American Community Survey, 2019-2023

> *At the county level, New Castle County had the lowest percent (70.2%) of homeownership in Delaware, while Sussex County had the highest (80.9%). Available data below the county level reveals less than half of residents in Wilmington City (45.7%) and Dover (47.0%) own a home.*

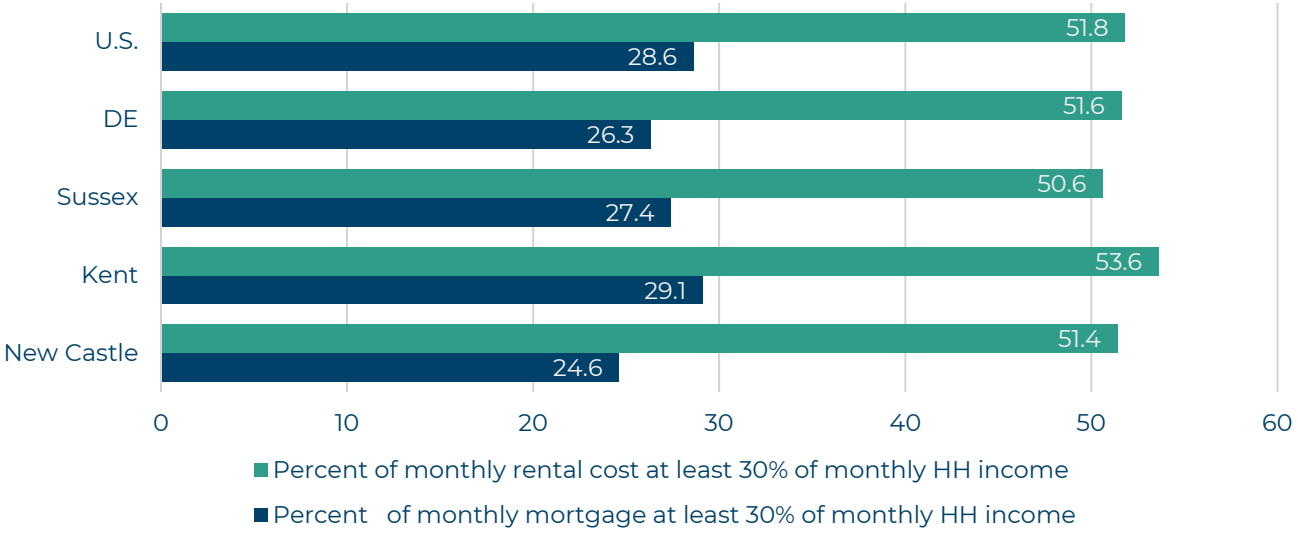
[92] *National Center for Homeless Education. Federal Data Summary: School Years 2018-19 to 2020-21. University of North Carolina at Greensboro; 2022.*

[93] *Delaware Department of Education: https://education.delaware.gov/wp-content/uploads/2025/06/mv_sy2022-2023.pdf. Accessed September 2025*

[94] *Office of Disease Prevention and Health Promotion. Healthy People 2030: Housing and Homes. U.S. Department of Health and Human Services.*

Family income is only one factor of financial security; the cost of basic expenses also matters. Housing is typically one of the largest expenses that families face. Low-income families are unlikely to be able to meet all their basic needs if housing consumes nearly one-third or more of their income.[95]

Figure 33. Percent of Monthly Mortgage and Rental Cost 30% and Over of Monthly Household Income by County, Delaware, 2023



Source: U.S. Census Bureau. American Community Survey, 2023.

Kent County accounts for the highest percent of residents who report spending at least 30% of their monthly household income on their mortgage (29.1%) and their rental costs (53.6%), respectively. Rental costs account for more than 30% of monthly household income for most residents in all 5 comparison areas (>50). Contrastingly, only about a quarter of residents (24-29%) in these same areas report spending 30% or more of the monthly household income on mortgage payments.

Community members echoed the need for safe, affordable, quality housing, particularly for children. One stating, there is "widespread agreement we're [Delaware] in crisis mode and the lack of safe, affordable housing and people experiencing homelessness are both crises that need to be addressed." Another stakeholder noted, however, "there is a lack of consensus on solutions."

[95] *The Anne E. Casey Foundation. Kids Count Data Center: https://datacenter.aecf.org/data/tables/7244-children-living-in-households-with-a-high-housing-cost-burden?loc=9&loct=2#detailed/2/9/true/2545/any/14287,14288. Accessed August 31, 2025.*

When households spend a sizeable share of income on housing, children are more likely to experience unstable living situations, overcrowding, or unmet needs like healthcare, nutrition, and school supplies. These conditions disrupt healthy development and educational success, making housing affordability not just an economic issue, but a child health and equity issue. In Delaware, nearly 1 in 4 children live in households with a high housing cost burden.

Figure 34. Percent of Children (< 18) Living in Households with a High Housing Cost Burden*, Delaware, 2023

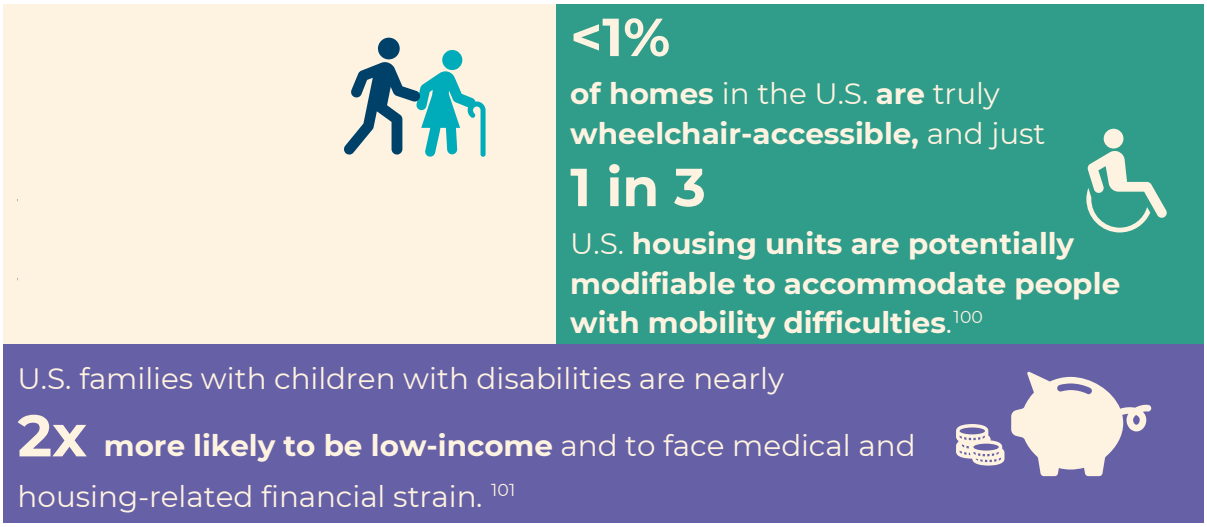
Source: PRB Analysis of data from the U.S. Census Bureau, American Community Survey, 2023.

Economic trends, like increases in housing costs, affect people with and without disabilities differently. Nationally, families of children with disabilities are disproportionately burdened by housing costs, with many spending more than 50% of their income on rent or mortgages.[96] These disparities are not only about income – they translate directly to barriers to securing stable and accessible housing. Families raising children with disabilities often face higher out-of-pocket healthcare costs and caregiving responsibilities that limit work opportunities, leaving fewer resources to afford housing.[97] At the same time, accessible housing is in short supply: homes with features such as first-floor bathrooms, widened doorways, or modified entries are scarce and more expensive. This is compounded by policy gaps in the federal Fair Housing Act with design requirements that only apply to newer multi-family buildings (first occupied after March 13, 1991), leaving many single-family and older homes outside of those standards.[98]

[96] *Cooper, E., & Himmelstein, G. (2020). The Housing Crisis for People with Disabilities. Urban Institute.*

[97] *National Low Income Housing Coalition. (2023). The Gap: A Shortage of Affordable Homes.*

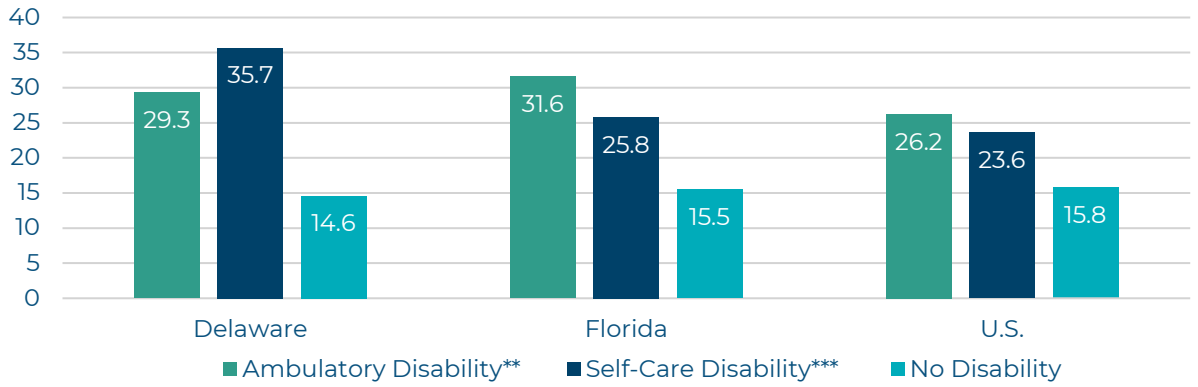
[98] *U.S. Department of Housing and Urban Development and U.S. Department of Justice, Joint Statement of the Department of Housing and Urban Development and the Department of Justice: Accessibility (Design and Construction) Requirements for Covered Multifamily Dwellings Under the Fair Housing Act (Washington, DC: HUD/DOJ, April 30,2013), https://www.hud.gov/sites/documents/JOINTSTATEMENT.PDF.*



**This indicator includes households that have 1 or more people who have difficulty entering the home or accessing or using a kitchen, bathroom, or bedroom due to a disability.*

For caregivers of children with medical complexities or special health care needs, the result is a frequent trade-off between affordability, accessibility, and proximity to services. Across the U.S., and in our Delaware and Florida regions, children with ambulatory or self-care disabilities are far more likely to live in poverty than children without disabilities. In Delaware, more than one in three children with self-care disabilities (35.7%) live below the poverty line, compared to just 14.6% of their peers without disabilities.[102]

Figure 35. Percent of Population (<18) Living in Poverty* by Disability Status, Delaware, Florida, U.S., 2023



Source: U.S. Census Bureau, American Community Survey, 2023

**Poverty (ACS): The Office of Management and Budget in Statistical Policy, Directive 14 makes income thresholds, called poverty lines, based on the prices of a standard set of goods and services that families need. Different income thresholds are created based on family size and age of people (like the number of people under age 18 or the number of people over age 65 and older). In the ACS, details about income, family size, and age are used to figure out if someone's family income is below the poverty line.*
***Ambulatory disability (ACS): An ambulatory disability is when a person responds "yes" when asked in the American Community Survey if they have "serious difficulty walking or climbing stairs". This question is only asked of people ages five years or older.*
****Self-care disability (ACS): In the American Community Survey, people who said "yes" when asked, if they "have difficulty dressing or bathing". This question is only asked of people ages five years or older.*

[99] *U.S. Department of Housing and Urban Development (HUD), Accessibility in Housing: Findings from the 2019 American Housing Survey, March 17, 2022, https://www.huduser.gov/portal/sites/default/files/pdf/accessibility-in-housing-report.pdf.*

[100] *Harvard Joint Center for Housing Studies, How Well Does the Housing Stock Meet Accessibility Needs? (Cambridge, MA: Harvard University, 2016), https://www.jchs.hardvard.edu/research-areas/working-papers/how-well-does-housing-stock-meet-accessibility-needs.*

[101] *U.S. Census Bureau, "United States Childhood Disability Rate Up in 2019 from 2008," Census.gov, March 2021, https://www.census.gov/library/stories/2021/03/united-states-childhood-disability-rate-up-in-2019-from-2008.html.*

[102] *Thomas, N., Bach, S., & Houtenville, A (2025). Annual Disability Statistics Compendium: 2023 (Custom Table). Durham, NH: University of New Hampshire, Institute on Disability. Source: U.S. Census Bureau, American Community Survey 1-year estimates. https://data.census.gov. Based on a sample and subject to sampling variability.*

Families with limited income are faced with restricted ability to move to or retrofit an accessible home, as well as the reality of living in inaccessible housing (e.g., a child with mobility challenges navigating stairs to reach the only bathroom) further jeopardizing their health, safety, and daily functioning. In Delaware, where the poverty gap for children with disabilities is higher than the national average, this means many families are simultaneously coping with economic strain and housing environments that fail to meet their children's basic needs for accessibility and safety.

Parents and caregivers raised housing accessibility concerns during the community summits. One parent spoke from personal experience, noting that it's not just about getting to the appointments, it's also about the challenges within the home environment once the patient is discharged: "children with [physical] limitations are discharged to a home with the laundry room or bathroom upstairs and they can't get to it." A healthcare worker added, "disability is another disparaged community, and resources are either nonexistent, or people don't know who or what to ask for to get connected."

When poverty intersects with disability, children face compounded disadvantages that can hinder development, increase social isolation, and perpetuate intergenerational inequity. These data highlight housing accessibility (not just crowding, lead, mold, or affordability) as a health equity issue and demonstrate the need for targeted interventions – such as retrofit funding, prioritizing accessible units in voucher programs, and partnership with state public housing authorities to track and expand accessible stock – to mitigate the disproportionate burden on families raising children with disabilities.

Substandard housing is associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries and mental health.[103] We asked community members specific survey questions about their living conditions, with 8-11% indicating issues from major systems in need of repair to risk factors in the home environment such as mold or mildew and pests.

Figure 36. Percent of Survey Respondents Who Report Living in Adverse Conditions by Issue Type, Delaware, 2025

	**8%** of survey respondents live in a place that currently needs a **roof repair**.
	**9%** of survey respondents live in a place that currently has **plumbing and/or water leaks** that need repair.
	**9%** of survey respondents live in a place that currently has an **inadequate heating and/or cooling system**.
	**10%** of survey respondents live in a place that has **mold or mildew**.
	**11%** of survey respondents live in a place that has rodents **or pests**.

103 *Chakraborty, Ougni, Kacie L. Dragan, Ingrid Gould Ellen, et. al., Health Affairs, Vol. 43, no. 2. "Housing-Sensitive Health Conditions Can Predict Poor-Quality Housing, February 2024*

Source: Nemours Community Survey, 2025

Elevated Lead Levels

Lead exposure is particularly harmful to children under 6 years old due to the high vulnerability of their developing brains and nervous systems. Even low levels of lead can impair cognitive development, reduce IQ, cause attention and behavioral problems, and negatively affect academic achievement.[104],[105] Young children are also more likely to ingest lead through hand-to-mouth behavior, making early prevention and screening critical. Long-term consequences can include learning disabilities, delayed growth, and increased risk of behavioral and health problems later in life.

Poor housing conditions, such as aging homes with lead-based paint or deteriorating plumbing, disproportionately expose children in low-income or older housing to lead, contributing to health inequities and higher rates of elevated blood lead levels in these populations.[106] Nationally, lead exposure tends to be highest among Black children and those living in areas of high poverty.[107]

Delaware law requires ALL Delaware health care providers ensure their patients who are children receive a blood lead test (either capillary or venous test) at 12 months of age and again at 24 months.

In 2023, approximately 6.2% of initial (first) Blood Lead Level (BLL) screens completed in children under 72 months of age came back positive for Elevated Blood Lead Levels (EBLL) at or above the threshold of 3.5 µg/dl.[108]

Figure 37. Number of Individual Children (< 72 months) Who Received an Initial Blood Lead Level (BLL)* Test and Total Results with Elevated Blood Levels (EBLL)**, Delaware, CY 2023

Location	Total Number of Initial Screens	Number of Initial Screens with EBLLs	Percent of Initial Screens with EBLLs
1st Screen or Test	13,600	780	6.19%

Source: Delaware Health and Social Services, Division of Public Health, Childhood Lead Poisoning Prevention Program, Calendar Year (CY), 2023.

**A patient's blood lead level (BLL) is measured in micrograms of lead per deciliter of blood (mg/dL).*
***The national standard for an elevated blood lead level test result is now >= 3.5 µg/dl.[109]*

One stakeholder remarked, "Lead is a pretty big struggle and is mostly found in low-income housing,in housing of people of color, and in rural schools." Another noted, "We're addressing some of the lead poisoning issues from lead paint and lead in the water in [Delaware]. The state is trying to remediate lead pipes. School water may be contaminated."

In 2023, the American Civil Liberties Union (ACLU) of Delaware reported that lead was detected in every school drinking water sample tested statewide, with many fixtures exceeding health-based guidelines, yet the Delaware Department of Education (DOE) was only filtering the highest-level fixtures rather than addressing all consumption points.[110] In response, Delaware allocated $3.8 million through the "Filter

104 CDC. Blood Lead Reference Value and Blood Lead Testing. Centers for Disease Control and Prevention, 2023. https://www.cdc.gov/lead.
105 Lanphear BP, Hornung R, Khoury J, et al. Low-level environmental lead exposure and children's intellectual function: An international pooled analysis. Environ Health Perspect.. 2005; 113(7):894-899.

106 WHO. Childhood Lead Poisoning. World Health Organization. 2020. https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health.

107 CDC, Childhood Lead Poisoning Prevention, "People at Increased Risk for Childhood Lead Poisoning," April 10, 2024

108 Delaware Department of Health and Social Services, Division of Public Health, Childhood Blood Lead Surveillance in Delaware 2024 Annual Report, March 2025

109 Lead Poisoning Prevention, Centers for Disease Control and Prevention: CDC Updates Blood Lead Reference Value (2021). https://www.cdc.gov/lead-prevention/php/news-features/updates-blood-lead-reference-value.html. Accessed: August 31, 2025.

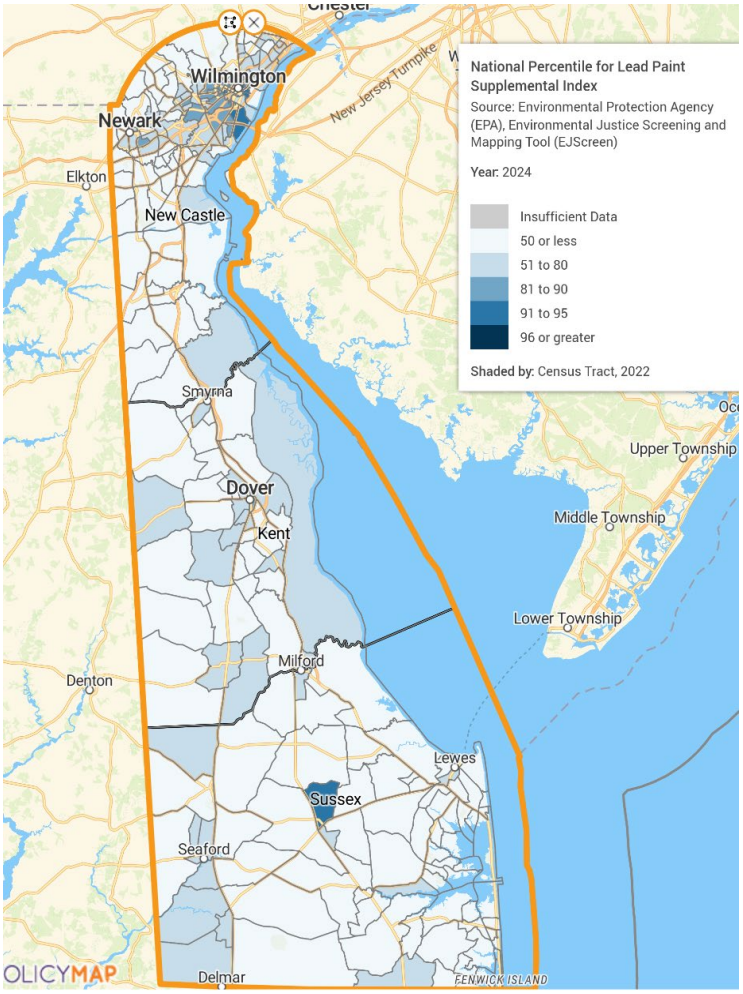
110 American Civil Liberties Union of Delaware. Health and Education Advocates Urge Department of Education to "Filter First" to Address Lead Contamination in School Water. October 19, 2023. http://www.aclu-de.org/en/press-releases/health-and-education-advocates-urge-dept-education-filter-first-address-lead

First Initiative" to install filtration systems in schools, retested fixtures with elevated lead levels, and committed to a statewide "Filter First" approach.[111,112] Additionally, federal funding totaling $24.9 million was directed toward lead pipe replacement and inventory projects, including priority support for disadvantaged communities.[113] Advocates continue to urge the DOE to adopt stricter lead thresholds and ensure comprehensive remediation to fully protect children from lead exposure.

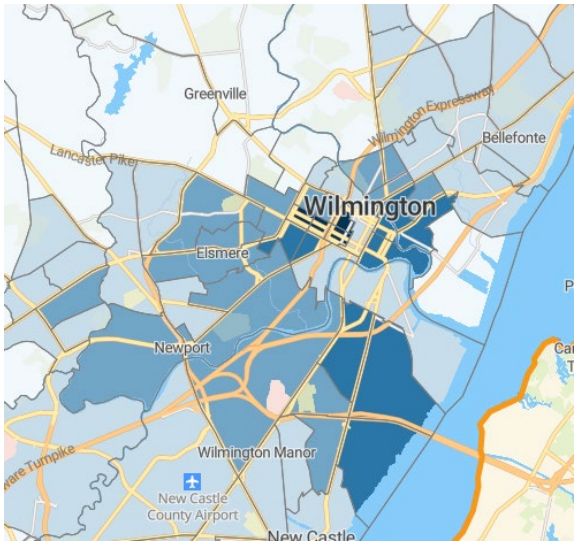
Environmental Justice

Environmental justice (EJ) ensures that communities historically overburdened by environmental hazards have equitable protection and access to healthy environments. Tools like the Environmental Protection Agency's (EPA) Environmental Justice Screening and Mapping Tool (EJSCREEN) help identify populations disproportionately exposed to pollution, hazardous sites, or other environmental risks, which are key social determinants of health influencing outcomes such as asthma, lead exposure, and cardiovascular disease.[114]

Figure 38. Percent of Nationwide Census Tracts with Less Lead Paint Exposure, Supplemental Index by Census Tract, Delaware, 2024.



The map on the left has been adjusted to a larger scale to highlight Wilmington (below).



Source: EPA Environmental Screening and Mapping tool

The EPA's EJScreen provides a nationally consistent dataset and approach to present three kinds of information: environmental burden indicators, socioeconomic indicators, and EJ/ supplemental Indexes.[115] EJScreen combines demographic and environmental indicators to highlight places that may have environmental quality issues, higher environmental burdens and vulnerable populations.

[111] *Cris Barrish. Delaware Finally Has a Plan to Remove Lead from School Drinking Water. WHYY, June 7, 2023. http://whyy.org/articles/delaware-plan-lead-removal-school-drinking-water/*

[112] *Christina School District. Facilities Services/ Lead Water Testing Results Updates. Accessed August 2025. https://www.christinak12.org/page/5444.*

[113] *U.S. Environmental Protection Agency. EPA Awards Delaware Department of Education $209,000 to Test for Lead in Drinking Water at Schools. April 1, 2020. https://www.epa.gov/newsreleases/epa-awards-delaware-department-education-209000-test-lead-drink-water-schools*

[114] U.S. Environmental Protection Agency. Environmental Justice. 2023. https://www.epa.gov/environmentaljustice

[115] *U.S. Environmental Protection Agency. Environmental Justice Screening and Mapping Tool (EJSCREEN). 2023. https://www.epa.gov/ejscreen.*

When examining the Lead Paint EJ Index (national percentiles) on the tract-level, a lead paint EJ Index percentile of 80 means that 80% of tracts across the nation have less potential exposure to lead paint than the tract of interest, and that 20% of tracts in the nation have greater potential exposure to lead paint. The U.S. percentiles use the U.S. population as the basis of comparison.

> *A census tract in west center city Wilmington was the only census tract in Delaware that scored a 96 or greater on the EJ Index – meaning 96% of census tracts nationwide have less potential exposure to lead paint. Another census tract in Sussex County that includes Georgetown scored in the 91-95% range, indicating only 5-9% of census tracts in the nation have a greater potential of lead paint exposure.*

Incorporating EJ data into strategic planning efforts facilitates targeted interventions and resources in communities facing systemic environmental and health inequities.[116]

Noise Pollution

Noise pollution is more than a nuisance – it is a measurable health risk. Defined as chronic unwanted or disturbing sound in the environments where people live, work, or travel. It's measured in decibels (dB) using day–evening–night (L_den) and night (L_night) averages; health risk typically increases with each +10 dB step.[1] The World Health Organization (WHO) advises keeping average daytime levels ≤55 dB and nighttime ≤40 dB to protect sleep, learning, and cardiovascular health.[117][118] Disparities arise where exposures cluster: transportation noise (highways, rail, aircraft) disproportionately affects low-income and minority neighborhoods; neighborhood noise (sirens, horns, amplified music, shouting) adds sustained 70–100+ dB peaks in dense urban areas; industrial noise (construction, plants, ports, logistics yards) can layer on chronic exposure near facilities and freight corridors.[119] [120]

Across studies, noise harms health via sleep disruption, stress-hormone activation, oxidative stress, and vascular dysfunction.[1] A meta-analysis found aircraft noise ↑ depression risk ~12% per +10 dB(A);[121] longitudinal work links noise annoyance to later depression/anxiety;[122] and a national cohort showed ~4% higher suicide risk per +10 dB road-traffic noise—even after adjusting for air pollution and greenness.[123] Because depression and psychological distress elevate cardiovascular disease (CVD) risk, these
mental-health pathways help explain consistent associations between noise and heart attack, stroke, hypertension, and premature mortality.[124]

[116] *Marmot M, Allen J. Social Determinants of Health Equity. Am JPublic Health. 2014; 104(S4): S517-S519*
[117] *World Health Organization, Environmental Noise Guidelines for the European Region (Copenhagen: WHO Regional Office for Europe, 2018), https://www.euro.who.int/en/health-topics/environment-and-health/noise/publications/2018/environmental-noise-guidelines-for-the-european-region-2018.*
[118] *Thomas Münzel et al., "Transportation Noise Pollution and Cardiovascular Disease: A Review," Circulation Research 134, no. 8 (2024): 591–610, https://doi.org/10.1161/CIRCRESAHA.123.323584.*
[119] *CDC, "What Noises Cause Hearing Loss?," last modified 2020, https://www.cdc.gov/nceh/hearing_loss/what_noises_cause_hearing_loss.html*
[120] *European Environment Agency, "Exposure of Europe's Population to Environmental Noise," December 13, 2024, https://www.eea.europa.eu/en/analysis/indicators/exposure-of-europe-population-to-noise.*
[121] *Johannes Hegewald et al., "Traffic Noise and Mental Health: A Systematic Review and Meta-Analysis," International Journal of Environmental Research and Public Health 17, no. 17 (2020): 6175, https://doi.org/10.3390/ijerph17176175.*
[122] *Manfred E. Beutel et al., "Noise Annoyance Is Associated with Depression and Anxiety in the General Population—The Gutenberg Health Study," European Journal of Public Health 30, no. 3 (2020): 507–512, https://doi.org/10.1093/eurpub/ckz243.*
[123] *Beat Wicki et al., "Suicide and Transportation Noise: A Prospective Cohort Study," Environmental Health Perspectives 131, no. 10 (2023): 107001, https://doi.org/10.1289/EHP11675.*
[124] *Andrew Steptoe and Mika Kivimäki, "Stress and Cardiovascular Disease," Nature Reviews Cardiology 9, no. 6 (2012): 360–370, https://doi.org/10.1038/nrcardio.2012.45.*

What is Noise Pollution?	How is it measured?	What is the source?	What is the impact?	What are the Levers?
Unwanted or disturbing sound that interferes with normal activities such as sleeping or conversation or disrupts one's quality of life. *	**Decibels (dB)** Risk increases with each incremental increase of +/= 10dB.	**Transit** Roads, highways, railways, aircraft **Industrial** construction, plants, ports, logistics yards **Neighborhood** Sirens, horns, shouting, music	**Overall Population** Sleep loss, stress, depression, anxiety, suicide risk, CVD, hypertension, heart attack, and stroke. **Children** Lack of sleep and/or focus, delays in cognitive development	**Quieter Infrastructure** Quiet roads, speed control **Noise Barriers** Buffers, sound walls **Operational Controls** Flight-path changes, restrict construction hrs. **Community Planning** Noise mapping, local ordinances, zoning

**Noise pollution refers broadly to sound that is unwanted or harmful–especially when it interferes with normal life, such as disturbing sleep, conversational comfort, or general well-being. This definition aligns with both EPA's legal framing[125] and APHA's public health perspective.[126]*

Noise control levers include quiet road surfaces, speed management, flight-path optimization, operational limits, building insulation, and highway noise barriers. Delaware follows FHWA 23 CFR 772 via DelDOT's Noise Policy—requiring noise studies and considering abatement (e.g., noise walls)[127] when criteria are met; DelDOT also runs a public process on barrier design.[128][129] The U.S. DOT National Transportation Noise Map shows higher modeled exposure along I-95/I-295 through Wilmington, SR-1 near Dover, and rail/airport corridors—hotspots where transportation noise coincides with denser, often disadvantaged neighborhoods.[130] (Local ordinances, such as Wilmington's, set enforceable limits for stationary/impulse sources and amplified sound, complementing state/federal standards.)[131]

Natural Environment

The natural environment—including air, water, and —directly shapes pediatric health.

Ozone develops in the atmosphere from gases that come out of tailpipes, smokestacks and many other sources. When these gases come in contact with sunlight, they react and form ozone smog. This can inflame and damage cells that line your lungs and reduce the immune system's ability to fight off certain bacterial infections, among others.[132] According to the American Lung Association's State of the Air 2025, Kent and New Castle counties received "C" grades for ozone pollution while Sussex received a "B." All three counties received "D" grades for short-term particulate matter ($PM_{2.5}$).

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[125] U.S. Environmental Protection Agency, "Clean Air Act Title IV – Noise Pollution," in Clean Air Act Overview: https://www.epa.gov/clean-air-act-overview/clean-air-act-title-iv-noise-pollution. Accessed September 2025.

[126] American Public Health Association, "Noise is defined in this policy statement as 'unwanted and/or harmful sound,'" Noise as a Public Health Hazard (2021). https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2022/01/07/noise-as-a-public-health-hazard. Accessed September 2025.

[127] DelDOT, "Highway Noise Abatement" (public process and barrier design overview), https://deldot.gov/Programs/highway_noise/index.shtml.

[128] Delaware Department of Transportation, DelDOT Noise Policy (Feb 11, 2021), https://deldot.gov/Programs/highway_noise/pdfs/Noise-Policy-Final.pdf.

[129] Formerly Appendix L—DelDOT Transportation Noise Policy (FHWA 23 CFR 772 implementation), https://deldot.gov/Business/subdivisions/pdfs/AppendixL.pdf.

[130] U.S. DOT, National Transportation Noise Map, https://maps.dot.gov/BTS/NationalTransportationNoiseMap/ (see modeled high-exposure corridors in Delaware: I-95/I-295 Wilmington, SR-1 near Dover, rail/airport).

[131] Wilmington, DE Code of Ordinances—Noise (allowable levels, stationary/impulse sources), June 12, 2016, https://www.nonoise.org/lawlib/cities/ordinances/Wilmington%2C%20Delaware.pdf.

132 "Ozone," American Lung Association, accessed August 24, 2022, https://www.lung.org/clean-air/outdoors/what-makes-air-unhealthy/ozone

Figure 39. Grade of Air Quality* by County, Delaware 2021-2023

County	Ozone Grade	Particle Pollution
Kent County	C	D
New Castle County	C	D
Sussex County	B	D

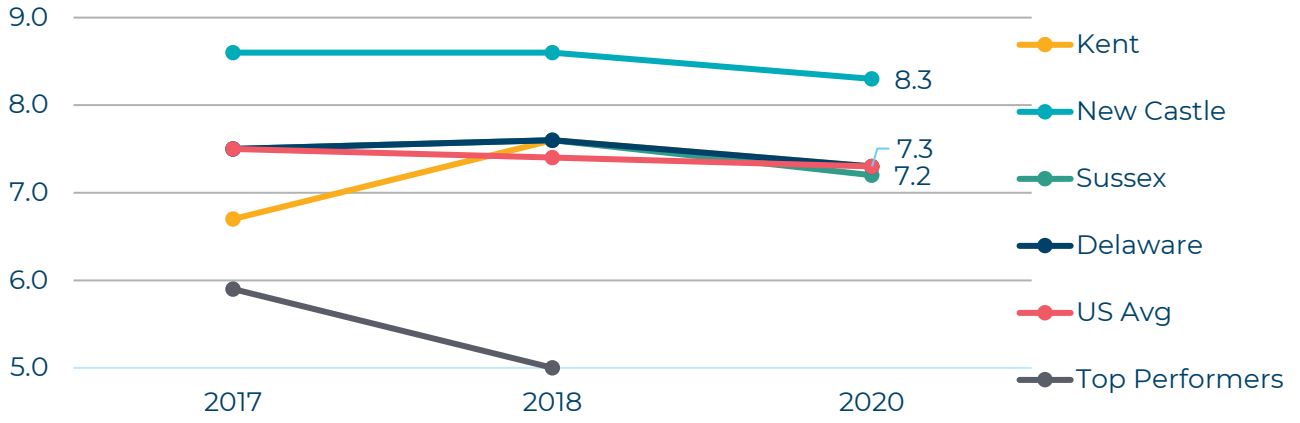
Source: U.S. Environmental Protection Agency: Air Quality System (AQS), 2021-2023

**The American Lung Association contracted with Dr. Allen S. Lefohn, A.S.L. for the three- year period for 2021-2023 for each monitoring site.*

Delaware consistently receives failing or near-failing grades for $PM_{2.5}$, highlighting elevated risk for respiratory conditions compared to national benchmarks. [133] The relationship between elevated air pollution (especially fine particulate matter and ozone) and compromised health has been well documented.[134]

Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. Long-term exposure to fine particulate matter increases premature death risk among people age 65 and older, even when exposure is at levels below the National Ambient Air Quality Standards.[135] The state of Delaware overall had a slightly lower fine particulate matter than the nationwide average (7.2 and 7.3, respectively).

Figure 40. Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5), by County, Delaware, 2017-2020



Source: CDC's National Environmental Public Health Tracking Network, 2017-2020

New Castle County had the highest density of fine particulate matter of the three counties (8.3).

[133] *American Lung Association. State of the Air 2025. Chicago: American Lung Association, 2025. https://www.lung.org/research/sota.*

134 Pope CA, Dockery DW, Schwartz J. Review of epidemiological evidence of health-effects of particulate air-pollution. Inhalation Toxicology. 1995;7(1):1-18.

135 Harvard T.H. Chan School of Public Health. More evidence of causal link between air pollution and early death. Boston. 2020. Accessed February 2, 2023. https://www.hsph.harvard.edu/news/press-releases/more-evidence-of-causal-link-between-air-pollution-and-early-death/

Minority populations and those living in poverty are more likely to be exposed because of historic practices like redlining, which segregated neighborhoods and limited housing choices for these groups. Formerly redlined neighborhoods are more likely to include environmental health hazards such as coal-fired power plants.[136] In 2010, approximately 164,000 premature U.S. deaths were related to fine particulate matter (PM 2.5) exposure and immigrants experienced 2.11 more deaths per 100,000 population than the U.S.-born.[137]

In April 2024, the U.S. Environmental Protection Agency finalized the first enforceable national drinking water standards for PFAS, chemicals linked to developmental delays, immune suppression, and cancer.[138] In June 2025, Veolia opened a PFAS treatment facility at the Stanton Water Treatment Plant in New Castle County, designed to serve over 100,000 residents.[139] Although Delaware has taken steps to address PFAS, children in areas with older water infrastructure remain vulnerable. Healthy People 2030 calls for all residents to be served by systems meeting safe drinking water standards, a benchmark Delaware has not fully achieved.

Figure 41. Occurrence of Drinking Water Violations by County, Delaware, 2021-2023

	Kent	New Castle	Sussex
2021	Yes	No	Yes
2022	No	No	Yes
2023	Yes	No	Yes

Source: CHR, 2025; Safe Drinking Water Information System, EPA, 2021-2023

> *Sussex County had water violations 2021 through 2023. Kent had violations in 2021 and 2023. New Castle did not have water violations during this time period.*

136 Braveman PA, Arkin E, Proctor D, Kauh T, Holm N. Systemic and structural racism: Definitions, examples, health damages, and approaches to dismantling. Health Affairs. 2022;41(2):171-178.

137 Fong KC, Bell ML. Do fine particulate air pollution (PM2.5) exposure and its attributable premature mortality differ for immigrants compared to those born in the United States?. Environmental Research. 2021;196:110387.

138 U.S. Environmental Protection Agency. "National Primary Drinking Water Regulations for Per- and Polyfluoroalkyl Substances (PFAS)." Federal Register, April 10, 2024. https://www.epa.gov/pfas.

139 Veolia North America. "Veolia Opens First-in-the-Nation PFAS Treatment Facility in Delaware." Press release, June 25, 2025. https://www.veolianorthamerica.com.

Disaster Preparedness

Delaware's coastal location increases vulnerability to flooding and sea level rise. Flood events disrupt schooling, damage homes, and elevate stress among children. Research shows that youth exposed to climate-related disasters are at higher risk for anxiety, depression, and post-traumatic stress.[140]

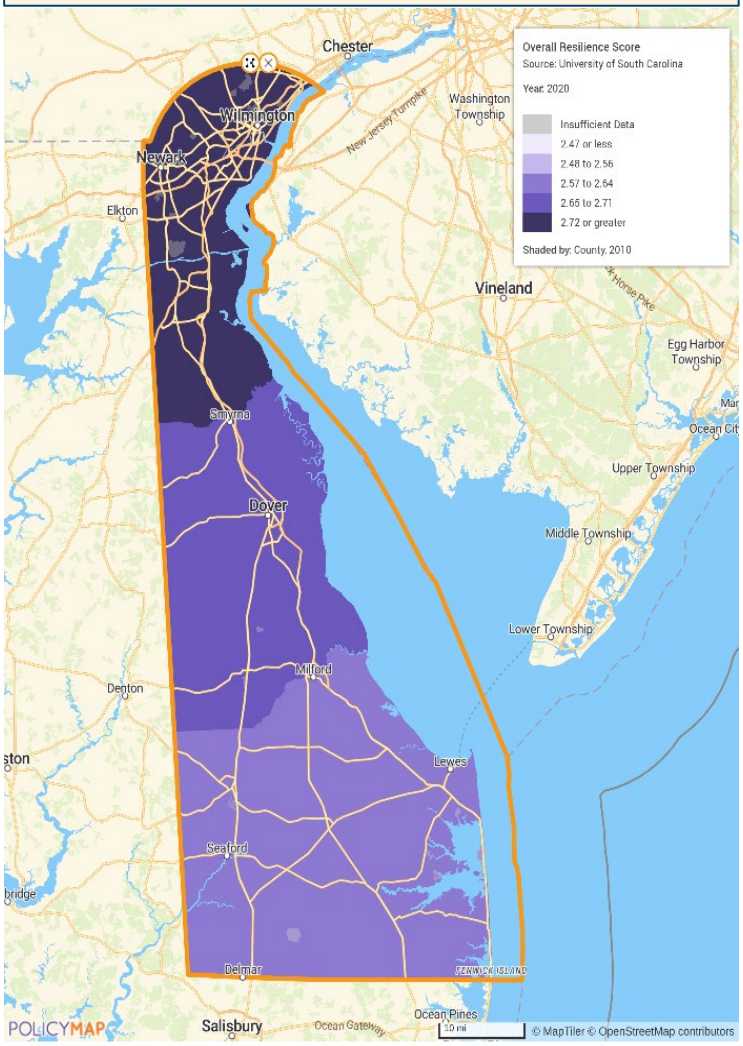
Green space provides protective health benefits, yet access is uneven. Suburban and coastal communities often have well-maintained parks, while Wilmington and rural areas have limited safe outdoor options. Unequal access to green space contributes to physical inactivity, higher obesity risk, and gaps in mental well-being.[141]

The Community Resilience Score reflects a community's capacity to prepare for, respond to, and recover from natural and human-caused disasters, based on indicators related to social, economic, housing, and healthcare infrastructure. Higher scores indicate greater resilience and a stronger foundation for community health and recovery.

In 2020, New Castle County had the highest resilience in Delaware (>2.72), followed by Kent then Sussex County. This mirrors broader patterns in infrastructure and opportunity. Compared to surrounding states, Delaware's resilience is moderate overall, with New Castle aligning more closely with neighboring urban counties in states like Pennsylvania and Maryland, and southern Delaware resembling more vulnerable rural regions.

Understanding community resilience is essential because areas with lower resilience are more likely to experience prolonged health impacts from disasters, including disruption of medical care, displacement, and increased mental health burden. Improving resilience is a proactive strategy to protect community well-being, reduce health inequities, and enhance recovery capacity.

Figure 42. Community Resilience Score*, Delaware,



Source: PolicyMap, University of South Carolina HVRI, BRIC, 2020

**University of South Carolina, Hazards and Vulnerability Research Institute, Baseline Resilience Indicators for Communities is a score of overall resilience to natural hazards as of 2020. The Baseline Resilience Indicators for Communities (BRIC) index considers six categories of community disaster resilience: social, economic, community capital, institutional, infrastructural, and environmental. Resilience refers to the ability to prepare and plan for, absorb, recover from, and more successfully adapt to adverse events. Such events may include floods or hurricanes in the context of BRIC. The overall resilience score is calculated by summing the category scores. Overall resilience scores can range from 0 to 6, where higher scores correspond to higher overall resilience*

[140] *Burke, Susie E., et al. "Children and Youth in the Climate Crisis: Understanding Risks and Promoting Resilience." Annual Review of Public Health 43 (2022): 143–160.*

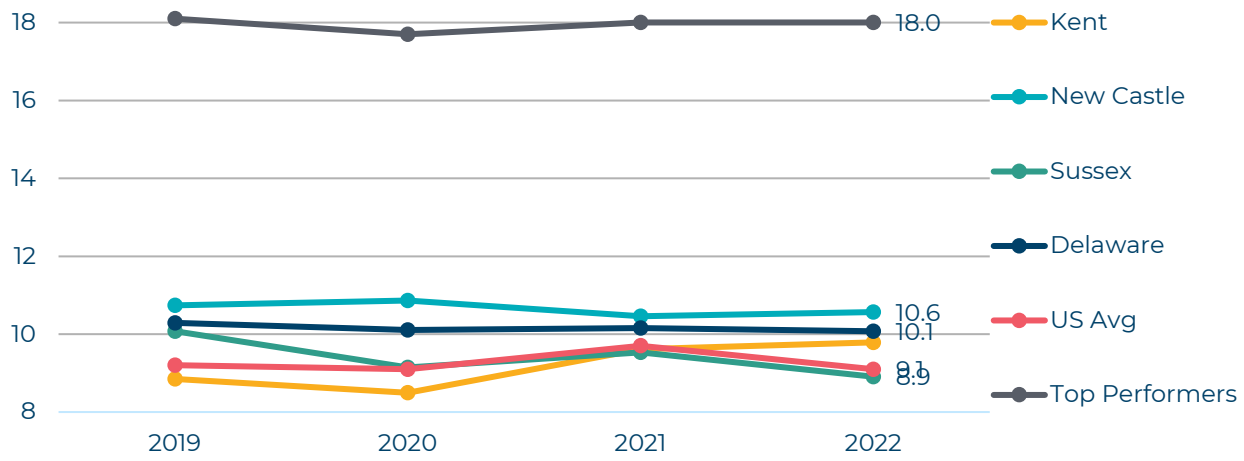
[141] *Jennings, Viniece, and Cassandra Gaither. "Approaching Environmental Health Disparities and Green Spaces: An Ecosystem Services Perspective." International Journal of Environmental Research and Public Health 12, no. 2 (2015): 1952–1968.*

Social Capital

Social capital characterizes the relations and interactions between individuals and groups. It has been suggested that social capital affects health through several mechanisms: norms and attitudes that influence health behaviors, psychosocial networks that increase access to health care and psychosocial mechanisms that enhance self-esteem.[142]

Health is relative to feeling connected to others in the community, to participating in community activities where they can feel emotional support.

Figure 43. Number* of Membership Associations** Per 10,000 Population, by County, Delaware, 2019-2022



Source: Census Bureau, County Business Patterns, 2019-2022

The numerator is the total number of membership associations in a county. The denominator is the total resident population of a county. The membership organizations (NAICS code) in this measure include civic organizations (813410), bowling centers (713950), golf clubs (713910), fitness centers (713940), sports organizations (711211), religious organizations (813110), political organizations (813940), labor organizations (813930), business organizations (813910), and professional organizations (813920).*

> *New Castle County had the highest rate of membership associations (10.6), followed by Kent and then Sussex Counties. New Castle and Kent counties have a higher rate than the U.S. overall.*

Voting influences the health of our communities and healthier communities are more likely to vote.[143] Studies show that communities with higher voter turnout tend to also have better self-reported general health,[144], [145] fewer chronic health conditions,[146] and less depression.[147] Moreover, the census is critical for public health. The census provides a basis for the socioeconomic indicators used to monitor disparities - including formal categories for counting and sorting by race, ethnicity, household income, and poverty.

142 Martin Lindström, Psychosocial work conditions, social participation and social capital: A causal pathway investigated in a longitudinal study, Social Science & Medicine, Volume 62, Issue 2, 2006, Pages 280-291

143 Healthy Democracy, Healthy People. Health & Democracy Index. 2021. https://democracyindex.hdhp.us/

144 Blakely TA, Kennedy BP, Kawachi I. Socioeconomic inequality in voting participation and self-rated health. American Journal of Public Health. 2001;91(1):99-104.

145 Kim D, Kawachi I. A multilevel analysis of key forms of community- and individual-level social capital as predictors of self-rated health in the United States. Journal of Urban Health. 2006;83(5):813-826.

146 Gollust SE, Rahn WM. The bodies politic: chronic health conditions and voter turnout in the 2008 election. Journal of Health Politics, Policy and Law. 2015;40(6):1115-1155.

147 Ojeda C. Depression and political participation. Social Science Quarterly. 2015;96(5):1226-1243.

Figure 44. Percent of Population Who Participate in Civic Engagement Activities, By County, Delaware, 2020

Voting participation* (2020)[148]

	New Castle	Kent	Sussex	DE	U.S.
Value	70.1	69.7	72.2	69.7	67.9
vs. DE avg.	●	●	●	-	●
vs. U.S. avg.	●	●	●	●	-

**Percent of Population aged 18 or older who voted in the 2020 U.S. Presidential election*

Census participation* (2020)[149]

	New Castle	Kent	Sussex	DE	U.S.
Value	68.7	68.1	56.3	-	65.2
vs. U.S. avg.	●	●	●	-	-

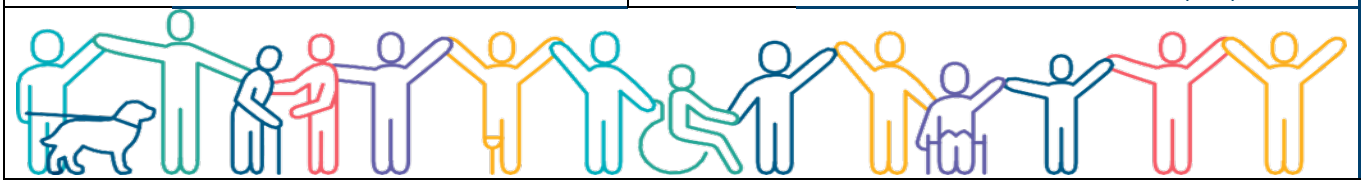
**Percent of Households that responded to the 2020 census by internet, paper questionnaire or telephone*

> *New Castle had the second highest voter turnout as well as the highest census participation. Sussex had the highest voter turnout and the lowest census participation. Census participation was lower than voting participation in each county.*

Evidence shows that participating in our communities strengthens our social connections and sense of belonging, which, in turn, benefits our physical and mental health[150].

Figure 45. Survey Respondents and Perceived Community Belonging, Delaware, 2025

11%	of survey respondents "somewhat or strongly disagree" they belong in their community/ neighborhood.	**2x**	as many respondents in Wilmington City and Dover/Surrounding Area (15%) do not feel like they belong in their community compared to the remainder of their respective counties (8%)
12%	of respondents "somewhat or strongly disagree" that people in their community are willing to help each other.	**1 in 5**	respondents in Dover/Surrounding Area and Wilmington City (18%) disagree that people in their community are willing to help each other, a proportion over 3x higher than the NW/SW Beaches (6%) area.



Source: Nemours Community Survey, 2025

148 CHR, 2025; MIT Election Data and Science Lab, Citizen Voting Age and Ethnicity

149 CHR, 2025; US Census Bureau

150 University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. www.countyhealthrankings.org.

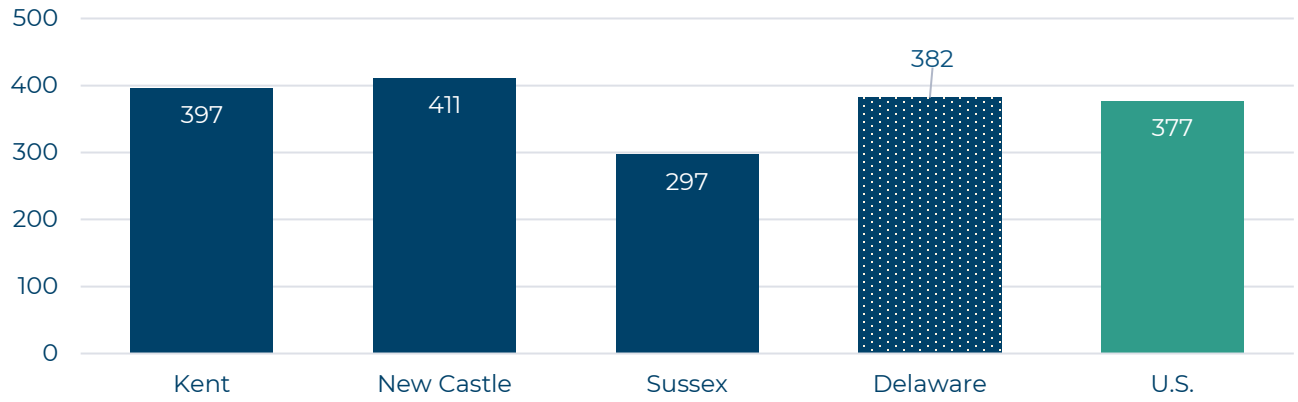
Community Safety

Community members cannot thrive or enjoy good health unless they are safe. Exposure to violence in a community can be experienced at various levels, including victimization, directly witnessing acts of violence, or hearing about events from other community members. It can also include property crimes that result in damage to the built environment.

Crime rates in the U.S. have declined from their post-COVID peaks – particularly homicide and other violent offenses – but overall levels remain elevated compared to pre-pandemic norms. A report by the Council on Criminal Justice shows that although homicide fell in 2023 compared to 2022, "most violent offenses remained higher in 2023 compared to 2019, the year prior to the outbreak of COVID and the widespread social unrest of 2020"[151]

The violent crime rate in the state of Delaware – which includes murder and non-negligent manslaughter, rape, robbery, and aggravated assault – is 382 offenses per 100,000 population.

Figure 46. Rate of Violent Crime* per 100,000 Population by County, Delaware, 2022



Source: County Health Rankings. FBI Uniform Crime Reporting Data, 2022.

**Violent crime includes four offenses: murder and non-negligent manslaughter, rape, robbery and aggravated assault.*

> *New Castle County had the highest crime rate (411 per 100,000), followed by Kent County (397 per 100,000) and Sussex County (297 per 100,000).*

Of the community survey respondents that indicated they feel somewhat or very unsafe when their child plays outside during the day, walks to or from school or a park, or is outside after dark:

36%
attributed their lack of perceived safety to a
fear of crime

23%
To the
presence of strangers
or unfamiliar people in the area

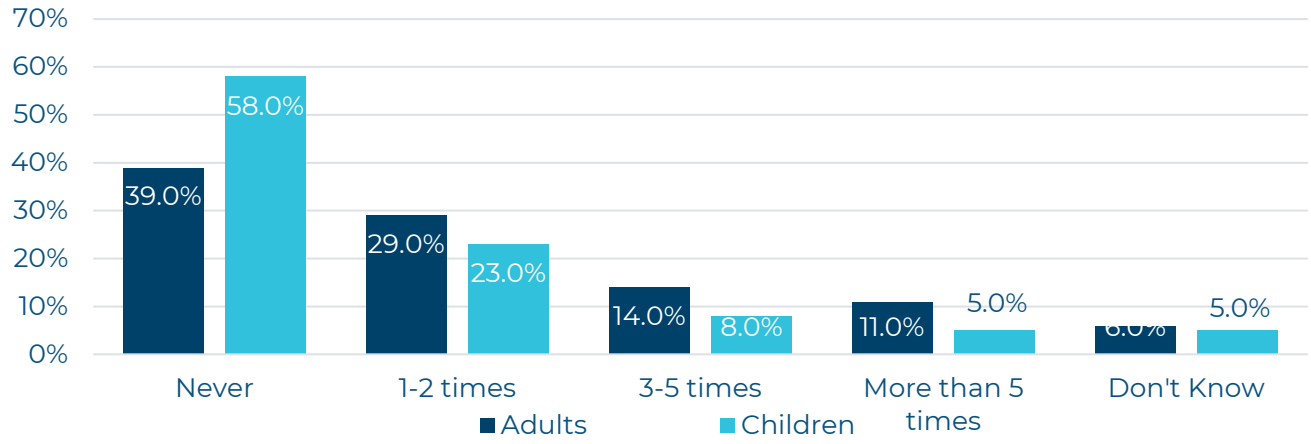
Other top categories were related to community infrastructure:

Traffic safety (16%)
Inadequate sidewalks, crosswalks, streetlights (11%)
Lack of safe spaces to play (6%)

[151] *Council on Criminal Justice. (2025, July 24). Violent crime continues to drop across U.S. cities, report shows. Stateline. https://stateline.org/2025/07/24/violent-crime-continues-to-drop-across-us-cities-report-shows/. Accessed August 18, 2025.*

Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes regardless of whether they are victims, direct witnesses, or hear about the crime.[152],[153]Fifteen percent of adult survey respondents report having witnessed violence in their home or community on three or more occasions in the last 12 months but report the child/children in their household having witnessed violence at that frequency less than half the time (8%).

Figure 47. Percent of Survey Respondents Who Reported Having Witnessed Violence* in Their Home or Community in the Last 12 Months, by Frequency, Delaware, 2025



Source: Nemours Community Survey 2025

**Witness violence is defined as having seen or heard violence in your home or community. Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.* [154]

Approximately one quarter (24%) of survey respondents in Dover and the Surrounding Area report witnessing violence on 3 or more occasions in the last 12 months compared to the other highly populated ZIP code area of Wilmington City (15%) and the NE/SE Beaches (5%). Rural communities in western (Remainder of) Sussex County have the second-highest rate among all ZIP code areas at just under 20%.

Trust in neighbors is a powerful reflection of how safe families feel in their daily environments. Communities with higher levels of social trust are more likely to have stronger networks of support, greater cooperation, and lower rates of violence.[155] When trust is low, families often experience increased stress, social isolation, and weaker resilience to health challenges, making it valuable marker for both community safety and well-being.[156]

Nearly

1 in 4

(23%) survey participants in Wilmington City do not trust their neighbors.*

Just

7 percent

of survey participants in the remainder of the county (NCC) feel the same.

**Somewhat disagree or strongly disagree that people in your neighborhood can be trusted.*

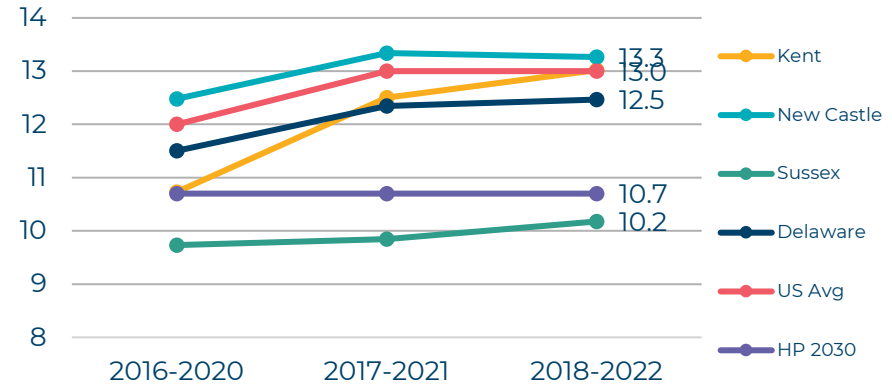
152 Jones-Webb, R., & Wall, M. (2008). Neighborhood racial/ethnic concentration, social disadvantage, and homicide risk: An ecological analysis of 10 U.S. cities. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 85(5), 662–676. doi: 10.1007/s11524-008-9302-yThis link is external to odphp.health.gov.
153 Fowler, P. J., Tompsett, C. J., Braciszewski, J. M., Jacques-Tiura, A. J., & Baltes, B. B. (2009). Community violence: A meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. Development and Psychopathology, 21(1), 227–259. doi: 10.1017/S0954579409000145
154 J Epidemiol Community Health. 2007 Aug; 61 (8):676-680. Doi:10.1136/jech.2005.043711
155 Sampson, et al., "Neighborhoods and Violent Crime: A multilevel Study of Collective Efficacy," Science 277, no. 5328 (1997): 918-924.
156 Ichiro, et al., "Social Cohesion, Social Capital, and Health," in Social Epidemiology, 2nd ed. (New York: Oxford University Press, 2014), 290-319.

These values don't differ as significantly in Kent County between Dover and the Surrounding Area (12%), and the remainder of the county (15%). However, there's a similar discrepancy to NCC in Sussex County, with just 7% in the NE/SE Beaches regions reporting low trust, vs. 13% in the remainder of the county.

Community safety not only shapes how families trust their neighbors or cope with violence but it also impacts other factors like student success in school. Districts with high crime rates show significantly higher absenteeism among students, underscoring the impact of community safety on educational and health outcomes.[157]

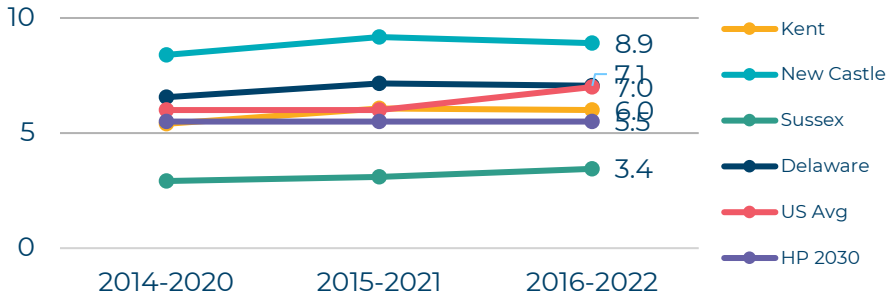
Firearm-related injuries are a major cause of death in the United States, including deaths from homicides, suicides, and unintentional injuries.

Figure 48. Firearm-Related Deaths Per 100,000 Population, by County, Delaware, 2016-2022



Source: National Center for Health Statistics, National Vital Statistics System, 2016-2022.

Figure 49. Age-Adjusted Death Rate Due to Homicide per 100,000 Population by County, Delaware, 2014–2022



Source: National Center for Health Statistics, National Vital Statistics System, 2014-2022.

While firearm related deaths and the age-adjusted homicide rate in Sussex County (10.2 and 3.4, respectively) not only meet but exceed the Healthy People 2030 targets for both indicators, over **3 in 5** survey participants in Sussex County (62%) report having witnessed violence in their home or community on more than one occasion over the last 12 months.

This variance emphasizes that mortality data alone does not capture the full impact of violence on daily life. Exposure – even without fatalities – carries deep consequences for mental health, child development, and community well-being, underscoring the importance of weighing lived experience alongside traditional health metrics.

Firearm injuries impose long-term costs on communities, not only in lost lives but also in the form of lasting disability, trauma, and healthcare expenditures. National data show that firearm-related injuries generate an estimated $2.8 billion annually in direct hospital costs, disproportionately affecting younger populations and communities already experiencing health inequities.[158] Recent analyses show that nonfatal firearm injury rates, while declining nationally from over 100 per 100,000 population in 2015 to about 54 per 100,000 in 2020, remain significantly higher than the Healthy People 2030 target of 10.1 per 100,000 population[159] – with national advocacy groups noting that roughly twice as many Americans are wounded by firearms as are killed each year.[160]

[157] *Opara et al., "School Absenteeism and Neighborhood Deprivation and Crime: A multilevel Analysis of Urban Youth," Journal of Community Psychology 50, no. 6 (2022): 2271-2287. it*

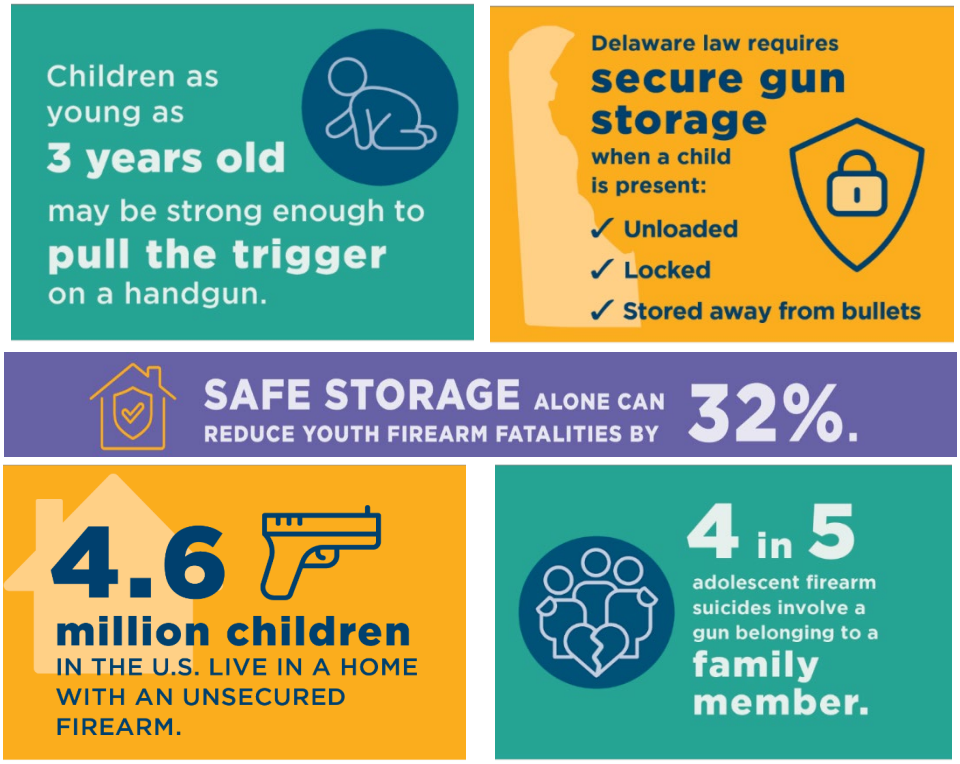
[158] *Song, et al., "Impact of Firearm Injuries on Health Care Costs and Utilization in the United States," Health Affairs 39, no. 11 (2020): 1941-1949, https://doi.org/10.1377/hlthaff.2020.01520.*

[159] *Chen, et al., "Trends in Firearm Injuries in the United States, 2009-2020, "Injury Prevention 31, no. 3 (2025): 253-259, https://injuryprevention.bmj.com/conetent/31/3/253.*

[160] *Everytown Research & Policy, "Nonfatal Firearm Injury Rate by State," updated 2025, https://everytownresearch.org/graph/nonfatal-firearm-injury-rate-by-state/.*

Both firearm injuries and deaths represent a major public health burden across the general population, with their impact especially stark among children. Firearms have now surpassed motor vehicle crashes as a leading cause of death for youth in the United States, underscoring the urgency of examining child-specific firearm mortality as an essential piece of the broader safety challenges communities face.[161]

Research shows that children as young as three years old may be strong enough to pull the trigger on a handgun, underscoring the urgency of secure firearm storage practices.[162] Secure storage – defined as keeping firearms unloaded, locked, and stored separately from ammunition – has been shown to reduce youth firearm fatalities by up to 32%.[163] Despite this evidence, an estimated 4.6 million children live in homes with at least one unlocked, loaded firearm.[164] Moreover, four in five adolescent suicides involving firearms use a gun belonging to a family member, making anticipatory guidance and resources especially critical in preventing impulsive tragedies.[165]



*Source: Nemours Children's Health and **Coalition for a Safer Delaware**, Secure Storage Campaign (2024- current)*
Access is available here: https://coalitionforasaferdelaware.org/secure-storage/

In addition to trusted community leaders, pediatricians play a unique role in prevention, as they are often the most consistent point of contact for families with children. Clinical encounters provide trusted opportunities to educate parents on the risks of unsecured firearms and to counsel them on practical secure storage methods.

The American Academy of Pediatrics (AAP) recommend that pediatricians incorporate firearm safety counseling as a routine part of well-child visits. This approach mirrors other health and safety conversations (e.g., car seats, safe sleep) and is an effective, evidence-based strategy to reduce preventable injuries and deaths.

[161] *Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, "Underlying Cause of Death, 1999-2022, CDC WONDER Online Database," released 2023, https://wonder.cdc.gov/.*
[162] *E. Grossman et al., "Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries," JAMA Pediatrics 172, no. 5 (2018): 463-470.*
[163] *D.C. Webster et al., "Evidence Concerning the Regulation of Firearms Design, Sale, and Carrying on Firearm Violence," Annual Review of Public Health 42 (2021): 359-379*
[164] *M.S. Azrael, D. Cohen, and D. Miller, "Firearm Storage in Gun-Owning Households with Children: Results of a 2015 National Survey," Journal of Urban Health 95, no.3 (2018): 295-304*
[165] *C. Fowler et al., "Childhood Firearm Injuries in the United States," Pediatrics 140, no. 1 (2017):e20163486*

Access to Care

Access to affordable, timely, and high-quality healthcare is a cornerstone of community health. Limited access contributes to unmet medical needs, delayed treatment, and higher rates of preventable conditions, disproportionately affecting children, rural residents, and families with low incomes.[166] Nationally, more than one in ten individuals report lacking a usual source of healthcare, with barriers such as cost, workforce shortages, and geographic distance continuing to widen disparities in outcomes.[167]

Economic Barriers

Figure 50. Percent of Survey Respondents Who Indicated They Had Difficulty Accessing Care, Delaware, 2025

1 in **5**

survey respondents indicated one or more instances in the last year that they **did not seek health care** for their sick or injured child(ren), and

42%

of those respondents identified **cost** as the primary reason.

These results do not meet the Healthy People 2030 target to reduce the proportion of people who can't get medical care when they need it to **5.9%.**

Among survey respondents who reported their child(ren) **went without needed mental or behavioral health care** in the last year (15%),

44%

identified **cost** as the driving factor.

38%

of survey respondents who revealed gaps in their ability to effectively manage their child(ren)'s health (14% overall) identified affordable healthcare/treatment options as the missing link.

Source: Nemours Community Survey, 2025

In addition to **cost** (generally), the following barriers to care were mentioned most often by survey respondents:

- **Insurance barriers**
- **Lack of transportation**
- **Availability of appointment**

[166] *Agency for Healthcare Research and Quality (AHRQ), 2022 National Healthcare Quality and Disparities Report (Rockville, MD: U.S. Department of Health and Human Services, 2022), https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[167] *Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, "National Health Interview Survey: Percentage of Persons of All Ages Who Delayed or Did Not Receive Medical Care Due to Cost, 2022," Health, United States Spotlight (Hyattsville, MD: U.S. Department of Health and Human Services, 2023),*

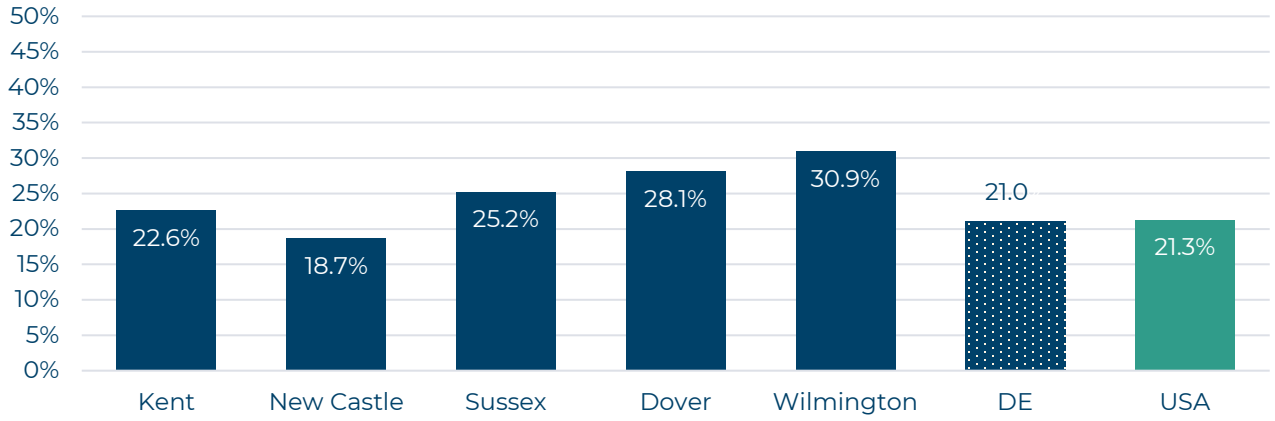
Insurance Status

Insurance coverage is a critical indicator of access to care, shaping whether individuals can obtain timely, affordable, and comprehensive health services. Without coverage, people are more likely to delay or forgo necessary medical care due to cost, which can lead to worse health outcomes and higher long-term expenditures.[168]

Public insurance programs – such as Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and VA Health Care – play an especially important role in filling coverage gaps for children, low-income families, older adults, and individuals with disabilities.[169] For many Delawareans, public coverage represents the only pathway to primary and preventative care, behavioral health services, and life-saving treatment.[170]

Just over one in five Delawareans (21.0%) have public health insurance only. This is compared to 21.3% nationwide.

Figure 51. Percent of Persons with Public Health Insurance Only* by City and County, Delaware, 2019–2023



Source: U.S. Census Bureau. American Community Survey, 2019–2023.

**This indicator shows the percent of persons who have public health insurance only. Public health coverage includes the federal programs Medicare, Medicaid, and VA Health Care (provided through the Department of Veterans Affairs); the Children's Health Insurance Program (CHIP); and individual state health plans.*

> *Sussex has the highest proportion of people using public health insurance as their only source of health coverage (25.2%), followed by Kent (22.6%) and New Castle (18.7%) Counties. However, in Wilmington City, nearly one in every three residents (30.9%) used public health insurance only. Dover wasn't too far behind (28.1%) for residents using public health insurance.*

[168] *Centers for Disease Control and Prevention (CDC), National Health Interview Survey: Percentage of Persons All Ages Who Delayed or Did Not Receive Medical Care Due to Cost, 2022 (Hyattsville, MD: U.S. Department of Health and Human Services, 2023).*

[169] *Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP, March 2023 (Washington, DC: MACPAC, 2023).*

[170] *Agency for Healthcare Research and Quality (AHRQ), 2022 National Healthcare Quality and Disparities Report (Rockville, MD: U.S. Department of Health and Human Services, 2022).*

Figure 52. Percent of Survey Respondents Who Indicated Their Child Had Insurance and Were on Medicaid, Delaware, 2025

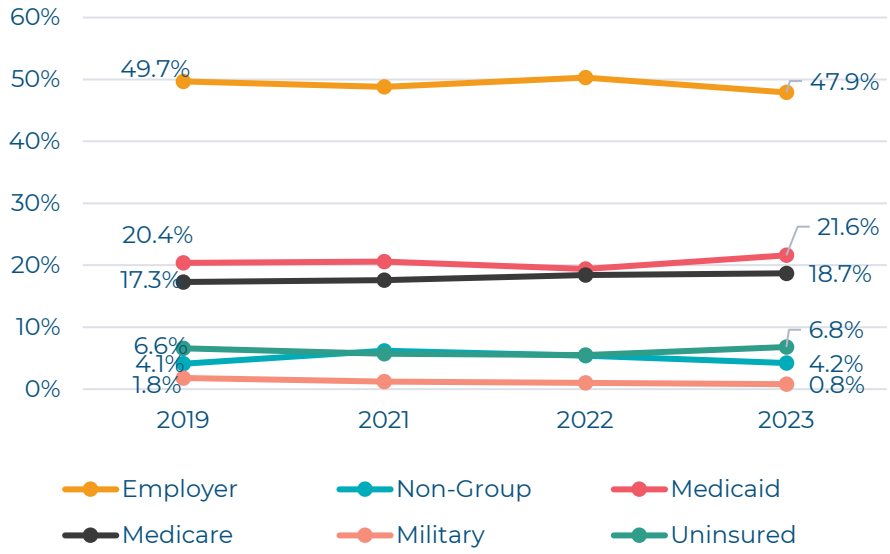
96 percent
of survey respondents report their child is covered under a (any) health plan.

51 percent
of survey respondents reported their child was on Medicaid.

Source: Nemours Community Survey 2025

Nearly half of Delawareans have insurance coverage through their employer (48%), which has remained relatively unchanged since 2019. Close to a quarter of the population (22%) has Medicaid coverage, followed by Medicare at 19%. A small portion of the state (4%) has non-group insurance (i.e., through the marketplace) or are insured through the military (1%). Approximately 7% of people living in Delaware remain uninsured.

Figure 53. Percent of Health Insurance Coverage by Payer, Delaware, 2019–2023



Source: KFF; American Community Survey, 2019-2023

Community members echoed these results, noting that in Delaware, insurance is often tied to employment, which can make coverage feel unstable or limiting. Others emphasized that even with insurance, high out-of-pocket costs – especially for services like mental health and specialty care – can often place treatment out of reach. These insights highlight that while insurance status does offer some insight into access, it does not capture the full picture of how people experience barriers to care.

Over the past 15 years, while the proportion of children insured has expanded, there has been a steady growth in the number of children enrolled in high-deductible health plans (HDHPs). A data analysis by HealthCore found that the use **of high-deductible plans increased from 0.5 percent of the study population with commercial insurance in 2006 to 26 percent in 2021**.[171] This increase was also reported in another 2021 study which used data from the National Health Interview Survey to examine pediatric enrollment in HDHPs and associations with health service use.[172] The data revealed substantial growth in high-deductible plans (those with a minimum deductible of $2,700 per family per year) in the last decade – with the proportion of children with private insurance who were enrolled in these plans increasing from

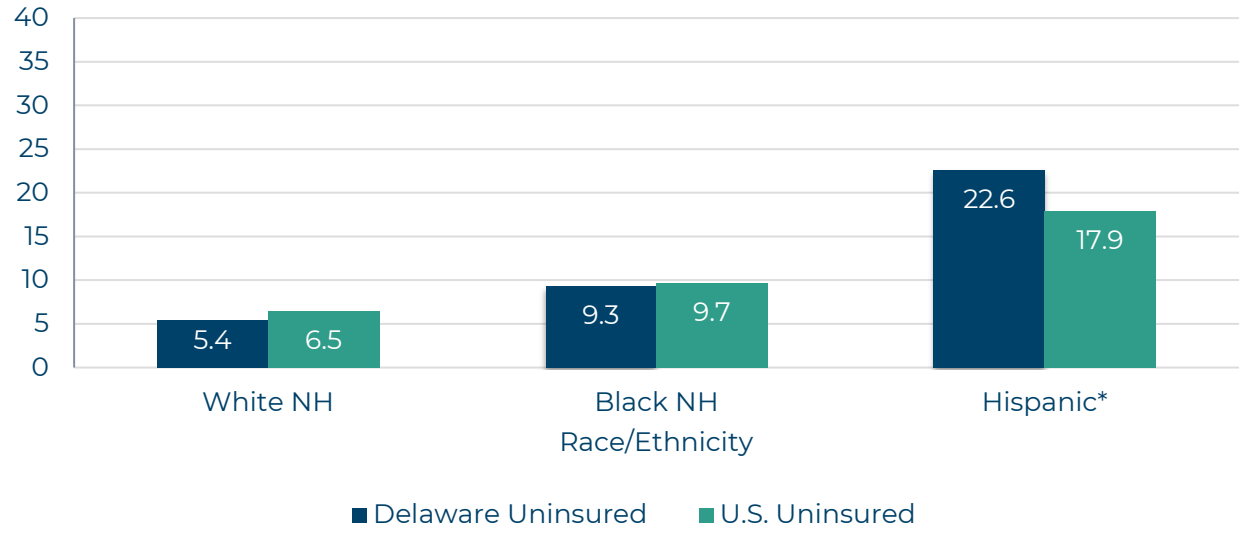
[171] *National Academies of Sciences, Engineering, and Medicine. 2023. The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents. Washington, DC: The National Academies Press. https://doi.org/10.17226/27207.*

[172] *Larson K, Gottschlich EA, Cull WL, Olson LM. High-deductible health plans for U.S. children: Trends, health service use, and financial barriers to care. Academic Pediatrics. 2021;21(8):1345–1354.*

18 percent in 2007 to 49 percent in 2018.^ They also found that **compared with children with conventional private insurance, those with HDHPs were more likely to forgo needed medical care and reported problems paying medical bills**.

Studies have found that uninsured children are five times more likely than insured peers to have an unmet medical need and three times more likely to lack a usual source of care.[173] Gaps in coverage can also increase school absenteeism, worsen behavioral and mental health outcomes, and deepen family financial strain due to out-of-pocket costs.[174] Hispanic/Latino residents in Delaware are more than four times as likely to be uninsured (22.6%) compared with White residents (5.4%) and are uninsured at a rate twice as high as Black residents (9.3%). A similar pattern is observed at the national level, leaving many children without regular preventative care.

Figure 54. Percent Uninsured* Ages 0-64 by Race/Ethnicity, Delaware, 2023



Source: American Community Survey, 2023 (KFF).

**Uninsured includes those without health insurance and those who have coverage under the Indian Health Service only.*
***Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic (NH).*

Research from the Kaiser Family Foundation reveals that 13.5% of Hispanic children in non-Medicaid expansion states are uninsured, highlighting how policy decisions compound inequities.[175] Structural barriers – such as immigration related fears, language barriers, and limited provider availability in Latino-majority neighborhoods – lead to a cycle of exclusion from essential care. This cycle is reinforced by under-enrollment in programs like Medicaid and CHIP, even when children qualify, often due to distrust or fear of the system.[176]

> *"People with low income have a mistrust of institutions and are not getting the healthcare they're warranted or deserve." -Stakeholder*

Without addressing these structural and cultural barriers, efforts to achieve equitable health access will fall short. By understanding who is covered, who is not and why – health systems and policymakers can design targeted outreach, enrollment supports, and culturally responsive services that truly reach underserved children and families.

[173] *K. Kenny et al., "Uninsured Children: Who Are They and Where Do They Live?" Urban Institute, August 2012.*

[174] *American Academy of Pediatrics, "Providing Care for Children in Immigrant Families," Pediatrics 144, no. 3 (2019): e20192077*

[175] *K. Orgera and A. Damico, "Health Coverage by Race and Ethnicity, 2010-2023," Kaiser Family Foundation (Feb. 13, 2025)*

[176] *J. Flores and H. Tomany-Korman, "The Language Spoken at Home and Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children," Pediatrics 121, no.6 (2008): e1703-e1714*

Transportation Challenges

Transportation barriers are consistently linked to missed visits, delayed care, and gaps in preventive services and chronic disease management. In pediatrics, nonattendance rates of 20–35% are reported in outpatient clinics; travel time and mobility barriers are associated with no-shows, which means lost opportunities for immunizations, developmental screening, and specialty follow-up. National child health surveys also record transportation/child-care problems among reasons children do not receive needed services.[177, 178,179, 180, 181, 182]

In Delaware, the transportation burden is not evenly shared. The *Dart Reimagined: Final Report* (2023)[183] shows that **children and families most likely to experience poor health outcomes are also those most reliant on public transit.**

- Two-thirds of riders earn less than $30,000 annually
- In New Castle County three-quarters of riders are people of color, with more than half identifying as Black or African American.
- Many riders are caregivers balancing multiple responsibilities
- One in ten speak a language other than English.

Families without reliable vehicles face the greatest challenges

- Approximately **90% of Delawareans** are reliant on a **car as their primary mode of transportation.**
- Commuters with **long travel times** are **4X** more likely to **lack a car**.
- Households in **New Castle and Kent counties** are nearly **2X** more likely to be carless than households in **Sussex County**.

Disparities in public transit magnify challenges

- Only about **1 in 3 Delawareans** live **within a quarter mile of a bus stop.**
- Nearly **40%** of Delaware residents and **25%** of jobs are in areas of **potential transit undersupply.**
- **Rural areas of Sussex County** have longer commutes to services with limited to no public transit.
- **Pockets of high poverty in Kent County** are reliant on infrequent public transit routes.
- **Limited walkability scores in Suburban New Castle County** create isolated populations with low car ownership rates (particularly youth and seniors).

Source: Delaware Department of Transportation, DART Reimagined: Final Report, 2023.

Community summit participants recommended the use of mobile health units to address transportation gaps in care by meeting the community where they are – one stating, "health systems can collaborate with each other to share costs of mobile health vans."

Community feedback collected by DART reinforces that access must be close to home: 73% of riders prefer shorter walking distances even if trips take longer, a reality especially relevant for parents traveling with children. DART Reimagined provided recommendations for public transit service improvements and

[177] *M. H. Hauschild et al., "Transportation Barriers in Pediatric Orthopaedic Clinic Visits," Journal of Pediatric Orthopaedics (2024), abstract via PubMed.*
[178] *D. J. Wallace et al., "Transportation Characteristics Associated with Non-Arrivals to Pediatric Appointments," BMC Health Services Research 17 (2017).*
[179] *S. T. Syed, B. S. Gerber, and L. K. Sharp, "Transportation Barriers to Health Care Access," Journal of Community Health 38, no. 5 (2013): 976–93.*
[180] *Data Resource Center for Child & Adolescent Health, "NSCH 2020: Problems with Getting Transportation or Child Care Contributed to Child Not Receiving Needed Services," accessed September 6, 2025.*
[181] *Roy Grant et al., "Better Transportation to Health Care Will Improve Child Health and Lower Costs," Advances in Pediatrics 63, no. 1 (2016): 389–401.*
[182] *Roy Grant et al., "Transportation Barriers to Child Health Care Access Remain After Health Reform," JAMA Pediatrics 168, no. 4 (2014): 385–86.*
[183] *Delaware Department of Transportation. Dart Reimagined: Final Report. Dover, DE: Delaware Transit Corporation, 2023. https://www.dartreimagined.com/images/project_resources/state_of_the_system_ADA_PDFUA_WEB.pdf*

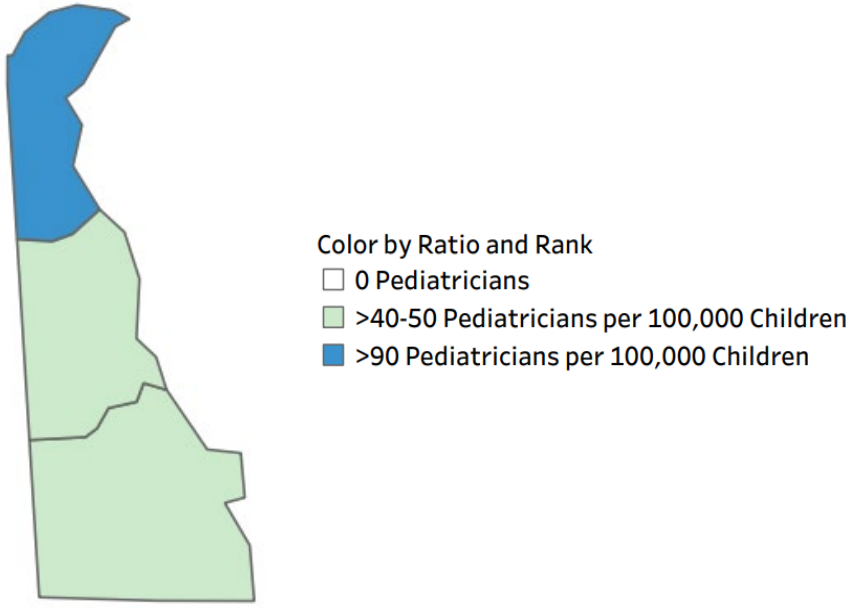
enhancements to reach an estimated 35% more people.[184] For health systems, these findings point to opportunities to align services with transit expansion, advocate for equitable coverage, and strengthen school-based, mobile, and NEMT programs in the highest-need tracts.

Provider Supply and Availability

Provider availability is a fundamental driver of access to care because the number and distribution of clinicians in a community directly shape whether patients can secure timely appointments.[185] In pediatrics, limited availability can translate to long waits for well-child visits, delayed vaccinations, or missed opportunities to detect developmental or behavioral concerns during critical stages of growth.[186] Even when providers are present, if families cannot schedule an appointment when needed, access is functionally restricted – showing how provider supply and appointment availability are key measures of access to care.[187]

Delaware is the 8th highest state for availability of General Pediatricians with 84.50 (179 providers total across the state) general pediatricians (age 70 and under) currently certified by the American Board of pediatrics (ABP) per 100,000 children (0-17). **The rate in Delaware is higher than the U.S average of 65.9 per 100,000 children.[188]**

Figure 55. Distribution of Those Certified in General Pediatrics (alone) by Pediatricians* per 100,000 Children (0-17) by County, Delaware, 2024



Location	Pediatrician Count	Rate per 100,000 children	Children per Pediatrician
New Castle County	135	110.4	906
Kent County	21	48.8	2,047
Sussex County	23	49.3	2,030
Delaware (total)	**179**	**84.50**	**1,184**

Source: American Board of Pediatrics (ABP), Certification Management System, 2024

[184] *https://www.dartreimagined.com/images/project_resources/state_of_the_system_ADA_PDFUA_WEB.pdf*

[185] *U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Access to Primary Care: Healthy People 2030 Literature Summary. https://odphp.health.gov/healthypeople/priorityareas/social-determinants-health/literature-summaries/access-primary-care.*

[186] *National Academies of Sciences, Engineering, and Medicine. Achieving Rural Health Equity and Well-Being: Proceedings of a Workshop. Washington, DC: The National Academies Press, 2018.*

[187] *Anne S. O'Malley, Johanna Samuelson, and Robert S. Haber. "Continuity of Care and the Use of Health Care Services in Older Adults with Complex Care Needs." Health Services Research 46, no. 5 (2011): 1616-1638. https://doi.org/10.1111/j.1475-6773.2011.01262.x.*

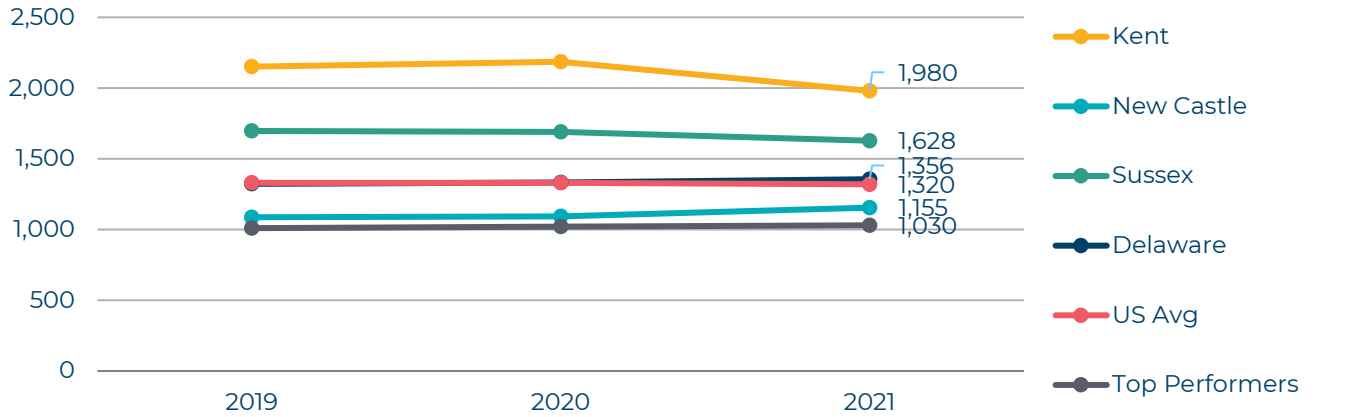
[188] *ABP Certification Management System (8/21/2024), American Board of Medical Specialties (June 2024), and the U.S. Census Bureau Population Estimates (2023). https://www.abp.org/dashboards/general-pediatricians-us-state-and-county-maps. Accessed September, 2025.*

*Sample includes US-based diplomates currently certified, age 70 and under.

Kent County has the lowest rate of general pediatricians at 48.8 per 100,000 children or approximately 2,047 children to one provider. New Castle County has nearly 1.15 more pediatricians per child than Kent and Sussex counties (110.4 per 100,000 children).

Primary care is the entry point to prevention, early detection, and chronic disease management. In Delaware and the surrounding region, persistent gaps in primary care access remain a significant driver of health inequity.[189] In 2021, Delaware had a statewide average of 1,356 residents per primary care physicians, compared with the U.S. average of 1,320. However, county-level variation reveals important disparities.

Figure 56. Population* per Primary Care Physician** by County, Delaware, 2019-2021



Source: County Health Rankings. 2025; Area Health Resource File Area Health Resources Files (AHRF) 2022-2023. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, Rockville, MD; /American Medical Association, Physician Masterfile, 2021

**Lower ratios reflect relatively better access to primary care physicians.*
***Primary care providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine and pediatrics.*

Kent County had the highest population-to provider ratio (1,980 residents per primary care physician), while New Castle County had the lowest (1,155 per provider). Both Kent and Sussex (1,628) counties are worse than DE overall and national benchmarks.

Wait times for appointments add another layer of access barriers. For established patients, the average wait time for a primary care appointment is about 8.7 days statewide but stretches to nearly 26 days for new patients.[190]

Figure 57. New Patient Primary Care Wait Times by County, Delaware, 2021

New Castle County:	Kent County:	Sussex County:
7 DAYS	**58 DAYS**	**27 DAYS**

Source: Delaware Department of Health and Social Services, Primary Care and Specialist Physician Survey 2021 (Dover, DE: DHSS, 2021)

Kent County experiences the most significant delays, with new patients waiting an average of 58 days, compared with just 7 days in New Castle County. Long waits for new patients are particularly concerning children, where preventative services, vaccinations, and early developmental screenings depend on timely access.[191]

[189] *Delaware Health and Social Services, Delaware State Health Assessment 2023: Findings Report (Dover, DE: Division of Public Health, 2023), https://dhss.delaware.gov/dph/.*

[190] *Delaware Department of Health and Social Services. Primary Care and Specialist Physician Survey 2021. Dover, DE: DHSS, 2021. https://dhss.delaware.gov/wp-content/uploads/sites/4/dhcc/pdf/pcpdelawarestudy2021.pdf*

[191] *National Center for Biotechnology Information. "Delaware's Primary Care Workforce: Trends and Implications." Public Health Reports (2021). https://pmc.ncbi.nlm.nih.gov/articles/PMC7882751*

These differences across geographies demonstrate challenges families – especially those seeking care for the first time – can face beyond provider supply that impact access to care during critical periods of growth and development for children

> *"There is a long wait for providers, a lack of providers across the board, not just in the underserved areas."*

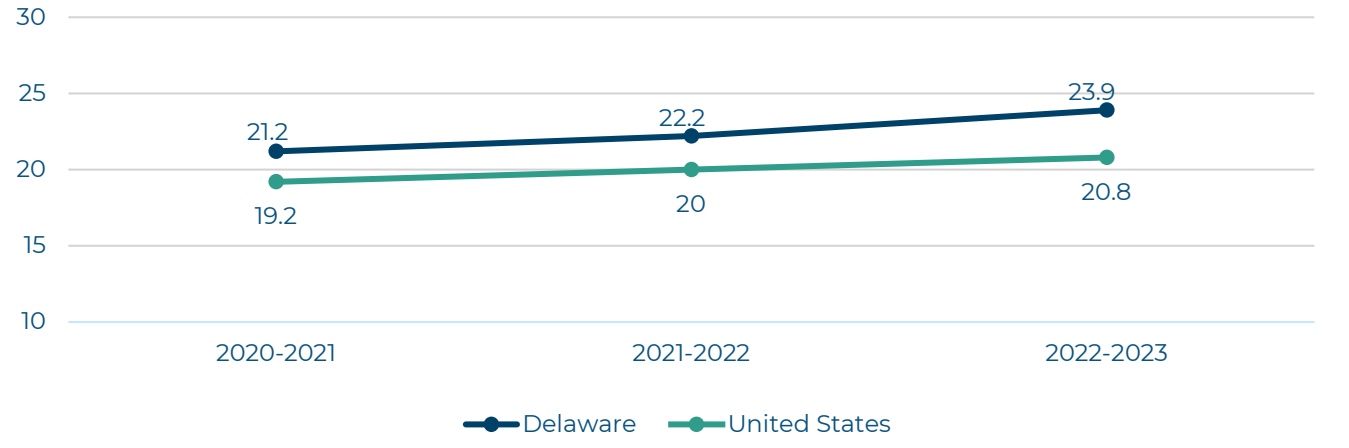
Primary care is the first point of contact for many children, providing preventative care, early detection, and ongoing management. For a lot of conditions, however, primary care alone is not enough, and children may require referral to pediatric subspecialists for diagnosis treatment, or ongoing management of complex or chronic needs. The bridge between primary and specialty care is important: how well these systems connect often determines whether families receive timely, coordinated services or face delays or fragmentation. In fact, evidence shows that when primary care providers and subspecialists work together, children experience **fewer preventable hospitalizations, less emergency department use, and better continuity of care**.[192]

Children with special health care needs have, or are at high risk for, chronic physical, developmental or behavioral conditions and require more health services than most children. These children are a diverse group with varying degrees of health care needs. Families who have children with special health care needs may also:

- Require complex and long-term health services.
- Spend more on health care.
- Experience disparities in accessing care.[193]

Approximately 14.1 million children— or 21% of children in the United States — have special health care needs. In Delaware, this rate is even higher at nearly 1 in 4 (24%).

Figure 58. Percent of Children ages 0-17 with Special Health Care Needs*, Delaware, 2020-2023



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2020-2023

**Special health care needs can include "physical, intellectual, and developmental disabilities, as well as long-standing medical conditions such as asthma, diabetes, a blood disorder, or muscular dystrophy".[194]*

[192] *Homer, Charles J., et al. "The Medical Home: A Review of the Evidence." Pediatrics 113, no.5 (2004): 1478-1485. https://doi.org/10.1542/peds.113.5.S1.1478.*

[193] *America's Health Rankings analysis of U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, United Health Foundation, AmericasHealthRankings.org, accessed 2025.*

[194] *https://www.cdc.gov/childrenindisasters/children-with-special-healthcare-needs.html#:~:text=Children%20and%20youth%20with%20special%20healthcare%20needs%20(CYSHCN)%2C%20also,than%20their%20typically%20developing%20peers*

Children and families rely on specialists for a wide spectrum of services – from vision care and orthopedics, to endocrinology, cardiology, and beyond.[195] Subspecialty consultation and referral demand can be driven by patients, families, or primary care clinicians who perceive a need for consult with a subspecialist. When specialty services are limited or difficult to reach, preventable problems can escalate into costly, complex conditions that undermine health, school readiness, and family stability.[196] When specialists are out of reach – especially for underserved communities – the pressure shifts back onto primary care, or worse – it goes unmet.

The National Picture

1 in 5 children

~10-20% of U.S. children see a subspecialist each year.*

Growing Complexity

Multi-subspecialty care rose from 4.7% → 5.9% over a decade reflecting a 25% relative growth in complex care needs (CCNs).**

Inequitable Distribution

Most pediatric subspecialists are concentrated in metropolitan areas because the likelihood of any one rural community adequately supporting a subspecialty practice is very low.

Coverage on Paper

Children enrolled in Medicaid/CHIP are 2x more likely to see multiple subspecialists than commercially insured peers→ Subspecialists limit their participation due to lower reimbursement rates.

Source: National Academies of Sciences, Engineering, and Medicine. 2023. The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents. Washington, DC: The National Academies Press. https://doi.org/10.17226/27207.

** The percentage range of annual outpatient use of pediatric subspecialists was developed from data across three major U.S. data sources – including commercial insurance (Elevance Health), Medicaid/CHIP (T-MSIS), and pediatric academic medical centers (PEDSnet). Temporal trends vary significantly by subspecialty type and payer. **Children's CCNs refer to multidimensional health and social care needs in the presence of a recognized medical condition or where there is no unifying diagnosis. They are present across a range of settings, impacted by family and healthcare structures.[197]*

The Delaware Context

~1 in 4 children

24% of children in the state of Delaware have special health care needs. *

Family Burden

Travel time, wait times, and missed school/work compound stress for families managing complex needs.

Geographic Gaps

Kent and Sussex counties face fewer subspecialists and longer travel distances to centralized pediatric care centers.

Equity Challenge

Over half of Delaware's children rely on Medicaid. Access is disproportionately difficult for DE's low income/high Medicaid populations, children with complex needs, and rural families.

Source(s): Delaware Department of Health and Social Services. Specialist Physicians in Delaware 2018. Bureau of Health Planning and Resources Management. Dover, DE: DHSS, 2022; DHSS. Primary Care and SPECIALIST Physician Survey 2021. Dover, DE 2022; Georgetown University Health Policy Institute, Center for Children and Families. "'Medicaid in Delaware." Updated 2023. https://ccf.georgetown.edu.

***Special health care needs can include "physical, intellectual, and developmental disabilities, as well as long-standing medical conditions such as asthma, diabetes, a blood disorder, or muscular dystrophy".[198]*

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[195] *National Academies of Sciences, Engineering, and Medicine. Essential Health Benefits: Balancing Coverage and Cost. Washington, DC: The National Academies Press, 2012.*

[196] *U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD HHS, 2000.*

[197] *Brenner M, Kidston C, Hilliard C, Coyne I, Eustace-Cook J, Doyle C, Begley T, Barrett MJ. Children's complex care needs: a systematic concept analysis of multidisciplinary language. Eur J Pediatr. 2018 Nov;177(11):1641-1652. doi: 10.1007/s00431-018-3216-9. Epub 2018 Aug 8. PMID: 30091109.*

[198] *https://www.cdc.gov/childrenindisasters/children-with-special-healthcare-needs.html#:~:text=Children%20and%20youth%20with%20special%20healthcare%20needs%20(CYSHCN)%2C%20also,than%20their%20typically%20developing%20peers*

. During the 2017-2018 school year, 21.4% of children with special health care needs missed seven or more days of school due to illness or injury, compared with 6.4% of children without special health care needs.[199] Access to specialty care services is a crucial dimension of health because many conditions and preventive needs cannot be addressed by primary care alone.

> *"Delaware is lucky. There is a legislative mandate that each school has a nurse. Every student has access to a healthcare provider. Receiving free public education provides care for students with health conditions." -Community member*

In Delaware schools, student health is supported through a combination of school nurses and school-based health centers (SBHCs), each playing a distinct but complementary role. School nurses are the daily front line, administering medications, responding to emergencies, and conducting screenings that connect students to broader systems of care. Their consistent presence makes them a trusted link between families, educators, and health providers. SBHCs, by contract, operate as on-site clinics staffed by nurse practitioners, physicians, and behavioral health specialists. They provide comprehensive services that go beyond the scope of school nursing, including physical exams, immunizations, mental health counseling, and acute care for illness and injury. Together, these two resources ensure that immediate needs are met while also addressing deeper barriers to access.

Research shows the SBHCs not only improve access to preventive and acute care, but also play a vital role in managing chronic conditions and coordinating referrals to subspecialists.[200] For children with asthma, diabetes, behavioral health needs, or developmental concerns, SBHCs provide ongoing management during the school day (e.g., medication administration), reducing missed school time and helping families navigate the continuum of care.[201] From national studies, SBHCs have a documented positive impact on students' physical and behavioral health. A 2016 systematic review of 46 studies on SBHCs impact on academic and health outcome across SBHCs in K-12 schools catalogues this impact[202]:

- A median reduction of 51.6% in non-asthma-related hospitalizations. A median reduction of 40.0% in teen pregnancy among females.
- A median reduction of 5.7% in self-reported mental health problems.
- A median reduction of 15.7% in any reported substance use (including tobacco and alcohol).

Delaware's investment in SCHCs is notable – with over 60 SBHC's in elementary schools, middle schools, and high schools in New Castle, Kent, and Sussex counties.[203] Specifically, every public high school in the state has a wellness center, funded by the Division of Public Health and operated through several health system partners.

Nemours Children's Health operates 17 SBHCs across elementary and middle schools throughout the state in partnership with local school districts – Colonial (8 elementary, 1 middle), Christina (2 early education centers, 2 academies – grades 1-8th grade), and Seaford (4 elementary).[204] These locations

[199] *America's Health Rankings analysis of U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, United Health Foundation, AmericasHealthRankings.org, accessed 2025.*
[200] *Keeton, Victoria, Smaira Soleimanpour, and Claire D. Brindis. "School-Based Health Centers in an Era of Health Care Reform: Building on History." Current Problems in Pediatric and Adolescent Health Care 42, no. 6 (2012): 132-156. https://doi.org/10.1016/j.cppeds.2012.03.002.*
[201] *Alison, M.A. et al., "School-Based Health Centers and Pediatric Practice." Pediatrics 129, no. 2 (2012): 387-393. https://doi.org/10.1542/peds.2011-3443.*
[202] *Knopf, Johanna A., Sarah M. Finnie, Robert S. Peng, et al. "School-Based Heatlh Centers to Advance Health Equity: A Community Guide Systematic Review." American Journal of Preventative Medicine 51, no. 1 (2016): 114-126. https://doi.org/10.1016/j.amepre.2016.01.009.*
[203] *Delaware Division of Public Health. (2025, March 2). School-based Health Center Locations [webpage]. Delaware Health and Social Services. https://dhss.delaware.gov/dph/chca/dphsbhcceninfo01/. Accessed September 10, 2025.*
[204] *Nemours Children's Health. Visionary Reforms: School-Based Care (2024). https://nemours.org/well-beyond-medicine/visionary-reforms.html.*

served 2,369 enrolled students accounting for 3,656 behavioral health and 2,200 physical health visits during the 2024-2025 academic year.

Nemours SBHC's
(2024-2025)

Colonial School District
8 elementary schools
1 middle school

Christina School District
2 early education centers
2 academies (1st-8th grade)

Seaford School District
4 elementary schools

Enrollment
(2024-2025)

There are **2,369** enrolled students at our SBHCs,

or ~30% of the participating school population.

Encounters
(2024-2025)

3,656
Behavioral health visits

2,200
Physical health visits

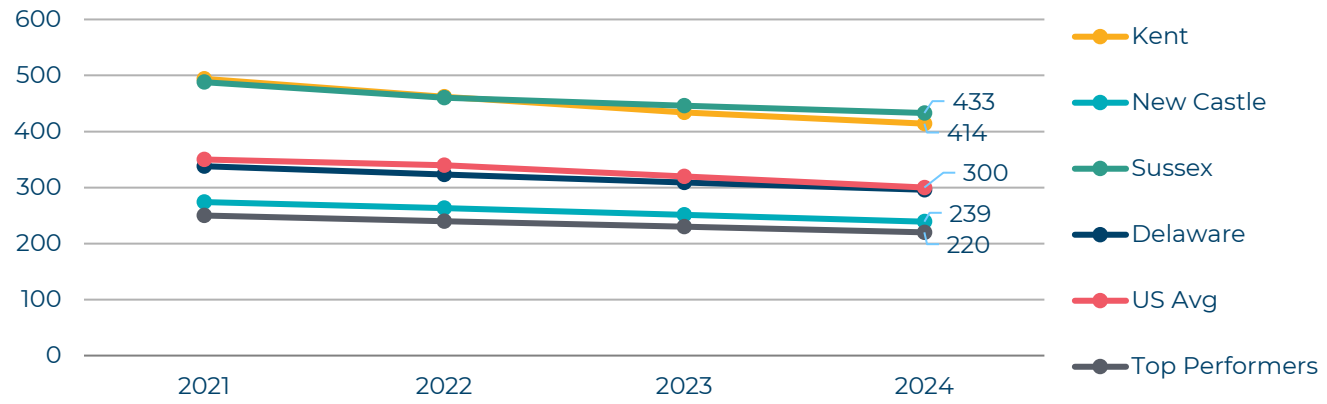
Nemours Staffing
(2024-2025)

6 Nurse Practitioners
8 Medical Assistants
3 Care Coordinators
8 Behavioral Health Therapists
1 Pediatric Psychologist
2 Behavioral Health Educators

Nemours Children's Health School-Based Health Centers demonstrate how integrated, accessible care in schools saves lives and strengthens student well-being. Through coordinated medical and behavioral health services, SBHCs helped a student with a history of seizures receive a life-saving diagnosis after navigating complex specialty care and supported another student in overcoming behavioral and medical challenges that improved school performance and health outcomes. These stories are just two examples that highlight the critical role SBHCs play in bridging gaps between education and healthcare – especially for students facing transportation, financial, or systemic barriers.

Within Delaware's network of school health supports, Nemours SBHCs complement the vital presence of school nurses, forming a strong safety net supporting equity, attendance, and learning for children statewide. Behavioral health services offered through SBHCs are credited with reducing violent student behaviors and absenteeism and improving school achievement, attention, and social skills. The availability of these services in the school setting is invaluable in Delaware where concerns around access to mental and behavioral health services, particularly for children and adolescents, are always at the forefront of health needs conversations. Demand for services continues to rise, but the availability and distribution of providers remains uneven, limiting access for many families. In 2024, mental health provider ratios at the state level (296:1) were slightly lower than the national average (300:1).

Figure 59. Population Count per Mental Health Provider by County, Delaware, 2024



Source: National Provider Identification (NPI) registry, 2024

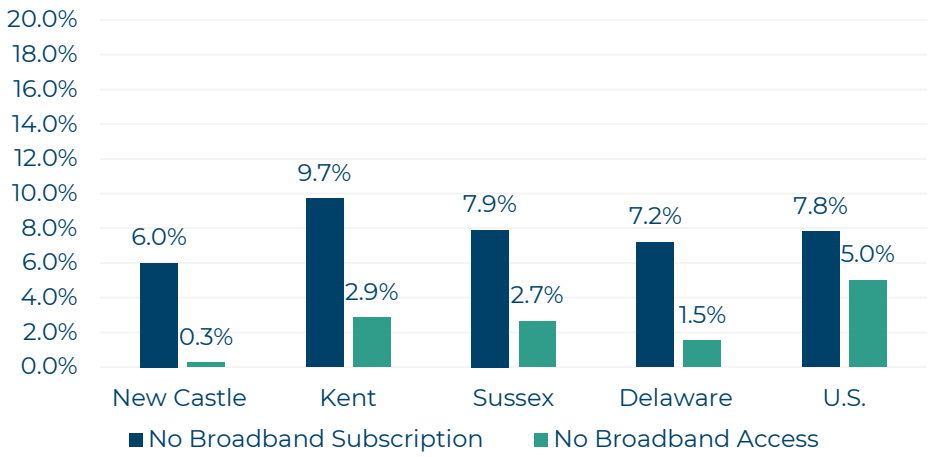
Sussex County had the highest population per mental health provider (433), followed by Kent (414) and New Castle County (239).

Delaware's challenges reflect broader national patterns. More than 60% of federally designated mental health professional shortage areas are in rural communities,[205] which could explain the disparities observed in Kent and Sussex counties when compared to New Castle County. To respond, Delaware has implemented innovative solutions like integrated behavioral health in satellite outpatient locations and school-based health centers, as well as the Delaware Child Psychiatry Access Program (DCPAP), which connected pediatric primary care provers with same-day telepsychiatry consultation and referral support.[206] **Integrated approaches like these help mitigate provider shortages, but significant gaps in meeting the scale of pediatric behavioral health needs remain.**

Expanding psychiatry and behavioral health through telehealth has been a lifeline in Delaware, especially through programs like DCPAP. However, access to virtual care is only as strong as a family's ability to connect. Broadband coverage is uneven across the state, and this digital divide introduces a new layer of inequity in behavioral health access.

Delaware compares favorably to the nation in infrastructure, with only 1.5%[207] of households lacking broadband availability, compared to 5% nationally.[208] Approximately 7.2 percent of Delaware households (29,509 homes) do not subscribe to broadband despite having service available[209] – demonstrating that availability does not guarantee use. [210]

Figure 60. Percent Broadband Access and Subscription Gaps by County, Delaware, 2023



Community members revealed disparities below the county level. One stating, "availability of broadband has been increasing steadily over the last few years. Wilmington needs more focus to reach the levels of the other areas in Delaware."

*Source(s): FCC, Fixed Broadband Deployment Data, 2023; U.S. Census Bureau, ACS 1-year estimates, 2023*Broadband access in this analysis is defined using the Federal Communications Commission's updated benchmark of 100 Mbps download / 20 Mbps upload (100/20 Mbps) service, adopted in March 2024 as the new national standard for fixed broadband. Data are reported as the percentage of housing units without broadband service available at this threshold. This higher standard reflects current expectations for work, learning, and healthcare in a digital environment. Source: Federal Communications Commission, Fixed Broadband Deployment Data, County Summary (December 2024).*

[205] *Health Resources and Services Administration (HRSA), Designated Health Professional Shortage Areas (HPSA) Statistics, HPSA Quarterly Summary. U.S. Department of Health and Human Services, 2023.*

[206] *Delaware Division of Public Health. Delaware Child Psychiatry Access Program (DCPAP): Program Overview. Delaware Health and Social Services, 2022. https://dhss.delaware.gov/dhss/dph/behavioral/dcpap.html.*

[207] *U.S Census Bureau. American Community Survey, 1-Year Estimates, 2023: Table S2802, Types of Internet Subscriptions by Household. Department of Commerce, 2024. https://data.census.gov/*

[208] *Federal Communications Commission, "Broadband Data Collection Shows Access to High-Speed Internet Services." FCC News & Events Blong, May 20, 2025.*

[209] *U.S. Census Bureau, U.S. Department of Commerce. "Types of Computers and Internet Subscriptions." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2801, https://data.census.gov/table/ACSST1Y2023.S2801?q=s2801&g=040XX00US10$0500000. Accessed on 10 Sep 2025.*

[210] *Federal Communications Commission. Fixed Broadband Deployment Data: County Summary, December, 2023. https://broadbandmap.fcc.gov/data-download/nationwide/dec2023/summary/fixed_broadband_summary_county.csv.*

Subscription and infrastructure gaps are highest in Kent County (9.7%, and 2.9%, respectively), followed by Sussex County with 2.7% without access, and 7.9% without a subscription. While only 0.3% of New Castle are without the infrastructure to access broadband, 6.0% do not have a subscription.

The adoption gap is larger in magnitude than the access gap, underscoring that **affordability and digital inclusion – not just infrastructure – are central to ensuring equitable access to telehealth and behavioral health services.**

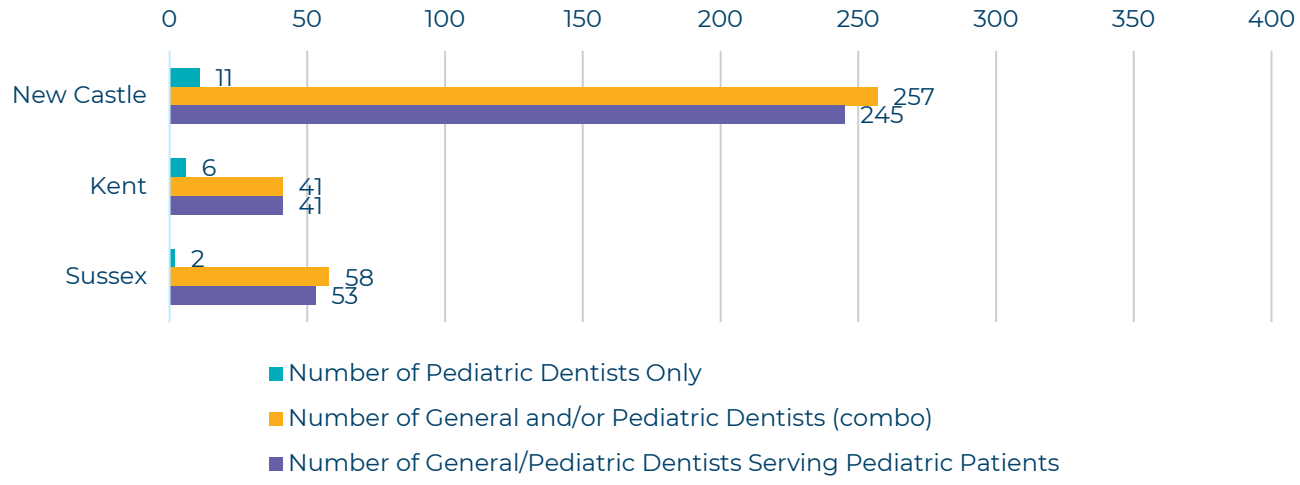
Just as provider distribution and adoption barriers shape access to care in other areas, the same dynamics affect children's access to oral health services. Dental care is an essential part of overall health – early prevention and treatment influence everything from nutrition to school readiness. **Delaware's dental workforce falls severely below the national average – by nearly one-third**. In the U.S. there were approximately 60.8 practicing dentists per 100,000 population (2021)[211], while Delaware had just 42.5 general dentists and dental therapists (2024) ranking the state among the bottom nationally.[212]

The Dental Association and the American Academy of Pediatric Dentistry recommend *a child's first dental checkup occurs no later than her or his first birthday.*

~93% of dentists in Delaware evaluate and/or treat children under the age of 3. (up from 47% in 2006)[213]

According to the Delaware Dentist Survey (2022)[214], there are a total of 19 dentists specializing in pediatrics practicing across the state. However, an overwhelming majority of general dentists in Delaware serve pediatric patients as well. A study released in May 2023 by the Delaware Public Health Bureau of Health Planning and Resources Management found that 339 (or 95.5%) of generalists in Delaware serve pediatric patients.

Figure 61. Number of General and/or Pediatric Dentists by County, Delaware, 2022



Source: DHSS, DPH, Delaware Dentist Survey, 2022

[211] *Centers for Disease Control and Prevention (CDC), Health, United States, 2021: Table Dentists per 100,000 Population, United States, National Center for Health Statistics, 2022. https://www.cdc.gov/nchs/hus/topics/dentists/htm.*

[212] *America's Health Rankings, Dental Providers: Delaware 2024, United Health Foundation. https://www.americashealthrankings.org/explore/measures/dental_provider/DE.*

[213] *Delaware Department of Health and Social Services, Division of Public Health, Delaware Dentist Survey 2022, May 2023*

[214] *Delaware Department of Health and Social Services, Division of Public Health, Delaware Dentist Survey 2022, May 2023*

There are eleven pediatric dentists in New Castle County, and approximately 245 general dentists who serve pediatric patients. Kent county has half the amount of pediatric focused dentists (6) as NCC, and only about 41 generalists who serve pediatric patients. Sussex county has the lowest number of pediatric dentists at 2, but more generalists serving children (58) than Kent.

The variability in the workforce produces a mixed system with direct implications for families. With only 19 pediatric dental specialists in the state, most patients depend on general dentists who are willing to see children. **While over 95% of generalists report serving pediatric patients, the level of training, equipment, and comfort with very young children can vary significantly**. Families with infants, children and special health care needs, or those requiring sedation dentistry may struggle to find appropriate providers nearby.

In addition to challenges related to general appointment availability across all patients, families relying on public coverage still face narrower provider networks and longer waits for appointments. For children in low-income households – already at higher risk for dental disease – these limitations translate into a higher likelihood of untreated decay, missed preventative visits, and downstream health issues.

~1 in 3
Delaware dentists **offer flexible hours** by remaining open at night and on Saturday.

**General/pediatric dentists are more likely to offer such hours than specialists.*

Medicaid is accepted by approximately
64%
of the general/pediatric dentists and
24%
of specialists.

Health literacy is the bridge between available services and meaningful use of care**.** On paper, families may have the resources they need to access appropriate, timely care, but without the skills to understand and act on health information, access remains incomplete. Health literacy – the ability to find, process, and apply health information to make appropriate decisions – determines whether preventative care is sought, treatment plans are followed, and chronic conditions are managed effectively.
Limited health literacy can create barriers as significant as provider shortages, cost barriers, or transportation gaps. The modern focus on health literacy began with the Institute of Medicine's landmark 2004 report, *Health Literacy: A prescription to End Confusion,* which reframed it as not simply an individual challenge but a systemic one.[215] The report revealed that **nearly half of U.S. adults** at the time lacked the skills needs to understand and act on health information, a gap that undermined prevention, treatment adherence, and health equity. Cited in the report is the 2003 National Assessment of Adult Literacy (NAAL), which remains the only large-scale, nationally representative assessment of adult health literacy. NAAL defines four levels of health literacy proficiency that are still used today as a measure and critical determinant of health outcomes and equity.[216]

[215] *Institute of Medicine (US) Committee on Health Literacy. Health Literacy: A Prescription to End Confusion. Nielsen-Bohlman L, Panzer AM, Kindig DA, editors. Washington (DC): National Academies Press (US); 2004. PMID: 25009856.*

[216] *U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics. National Assessment of Adult Literacy (NAAL), 2003. https://nces.ed.gov/naal/.*

Proficient	Intermediate	Basic	Below Basic
skills for complex and challenging tasks.	skills for moderately challenging tasks.	skills for simple, everyday health tasks.	no more than simple, concrete literacy skills.
Examples: calculate an employee's share of health insurance costs using a table; interpret differences between two insurance plans.	Examples: use a BMI chart to determine a healthy weight range; find the age range for childhood vaccinations in brief text.	Examples: read a short pamphlet and give two reasons to get screened; identify how often a test should be done.	Examples: circle the date of a medical appointment; identify what you can drink before a test from a short instruction sheet.

Today, issues of health equity remain pervasive, with an estimated 9 in 10 U.S. adults experiencing some level of difficulty using everyday health information that is routinely available at health care facilities, retail outlets, and in our communities. These limitations contribute to higher hospitalization rates, reduced use of preventative services, and poorer outcomes in chronic disease management.

Nearly
9 in 10
U.S. adults have difficulty using the everyday health information that is routinely available in our health care \facilities, retail outlets, media, and communities.[217]

12%
of U.S. adults are at a proficient health literacy level and

14%
are below basic proficiency.[218]

Delaware-specific findings mirror these challenges. Results from Nemours' 2025 community survey indicate that nearly **1 in 4 respondents (22%) reported "sometimes", "often", or "always" having difficulty understanding information or instructions** from their healthcare provider, and **over one-quarter (27%) expressed less than full confidence in using health information to make decisions about their health.**

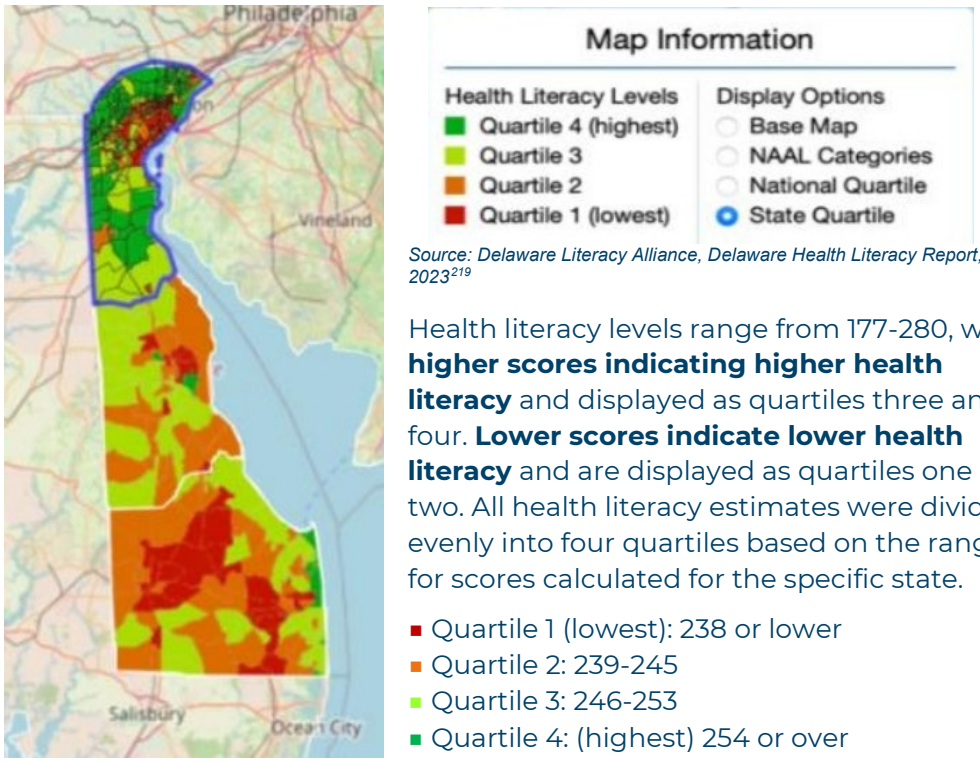
"We need to be actively working on increasing health literacy in the state."
-Stakeholder

These self-reported challenges aligned with modeled estimates from University of North Carolina at Chapel Hill's Health Literacy Data Map, which illustrates that large portions of Delaware fall into the lowest two quartiles of health literacy, particularly in southern and rural regions. Figure 62 depicts a map of Delaware's health literacy levels provided by the University of North Carolina Chapel Hill. The map utilizes the 2010 U.S. Census Bureau data and American Community Survey summary files to calculate health literacy estimates by state.

[217] *U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy. Washington, DC:*

[218] *Claude Lopez, Bumyang Kim, and Katherine Sacks, Health Literacy in the United States: Enhancing Assessments and Reducing Disparities. Milken Institute, 2022. https://milkeninstitute.org/sites/default/files/2022-05/health_literacy_united_states_final_final_report.pdf.*

Figure 62. Health Literacy Levels, Delaware, 2023



Source: Delaware Literacy Alliance, Delaware Health Literacy Report, 2023[219]

Health literacy levels range from 177-280, with **higher scores indicating higher health literacy** and displayed as quartiles three and four. **Lower scores indicate lower health literacy** and are displayed as quartiles one and two. All health literacy estimates were divided evenly into four quartiles based on the range for scores calculated for the specific state.

- Quartile 1 (lowest): 238 or lower
- Quartile 2: 239-245
- Quartile 3: 246-253
- Quartile 4: (highest) 254 or over

Taken together, these findings underscore that more work is needed to address the deficits in health literacy in pockets across the state, but more specifically in the City of Wilmington, Dover, and the southernmost part of Delaware.

[219] *Delaware Literacy Alliance. Delaware Health Literacy Report, 2023. https://delawareliteracyalliance.org/wp-content/uploads/2024/06/HLC-Final-Report.pdf.*

Preventative Screening and Immunizations

Preventive screening and immunizations are among the most effective strategies in medicine to reduce illness, disability, and premature death. Screenings identify health conditions or developmental concerns early—before symptoms arise—allowing for timely intervention when treatment is most effective. For children, this includes vision and hearing tests, developmental and behavioral assessments, and monitoring growth milestones. Immunizations prepare the immune system to fight off infectious diseases that once carried high risks of severe illness or death, such as measles, polio, or meningitis. In pediatrics, these services are especially critical because children's bodies and brains are rapidly developing, and early detection or prevention ensures they remain on track for healthy growth. For example, routine developmental screening can identify autism or speech delays early, when interventions are most effective.[220] Likewise, vaccines given to children born in the past 30 years are estimated to prevent more than 21 million hospitalizations and 732,000 premature deaths in the United States.[221]

The pediatric "periodicity schedule" (well-child visits) is the backbone of this system; it is where vision, hearing, developmental screening, fluoride varnish/oral risk checks, caregiver guidance, and immunizations happen in a single, coordinated touchpoint.[222] Preventive benefits compound over time: screening or vaccinating on-time reduces missed opportunities later, lowers downstream costs, and improves school readiness and long-term health.[223]

Delaware's utilization of well-child and other preventive services is strong in the early years and more variable later in childhood.

Figure 63. Percent of Children Who Received Preventative Care by Age and Type, Delaware, 2021-2022, 2023

	Received Preventative Medical and Dental Care*		Received Vision Screening**		Received Hearing Screening***		HP2030 Target
	DE	U.S.	DE	U.S.	DE	U.S.	
0-5 years old	54.4%	59.9	36.5%	36.8			Vision (3-5 yo): **63.7%**
6-11 years old	74.9%	71.3%	73.4%	67.2%			Preventative care visit (0-17): **82.6%**
12-17 years old	66.4%	64.8%	68.1%	59.4%			
Newborn (~1 m. old)					95.4%	95.6%	Hearing (1 mo): **97%**
⇨ **Follow-up (≤3 m. old)**					6.1%	39.9%	
⇨ **Early Intervention (≤6 m. old)**					18.2%	40.9%	

Source(s):(1) National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau, 2021-2022.(2) National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau, 2021-2022;(3) Centers for Disease Control and Prevention. (2025, March 25). Annual summary: Early Hearing Detection and Intervention (EHDI) Program. National Center on Birth Defects and Developmental Disabilities, 2023.

[220] *Centers for Disease Control and Prevention (CDC). "Developmental Monitoring and Screening." Updated April 2023. https://www.cdc.gov/ncbddd/actearly/screening.html*

[221] *Centers for Disease Control and Prevention (CDC). "Benefits from Immunization During the Vaccines for Children Program Era — United States, 1994–2013." MMWR 62, no. 16 (2013): 352–355. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6216a4.htm*

[222] *American Academy of Pediatrics, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th ed. (Elk Grove Village, IL: AAP, 2017; periodicity schedule updated annually).*

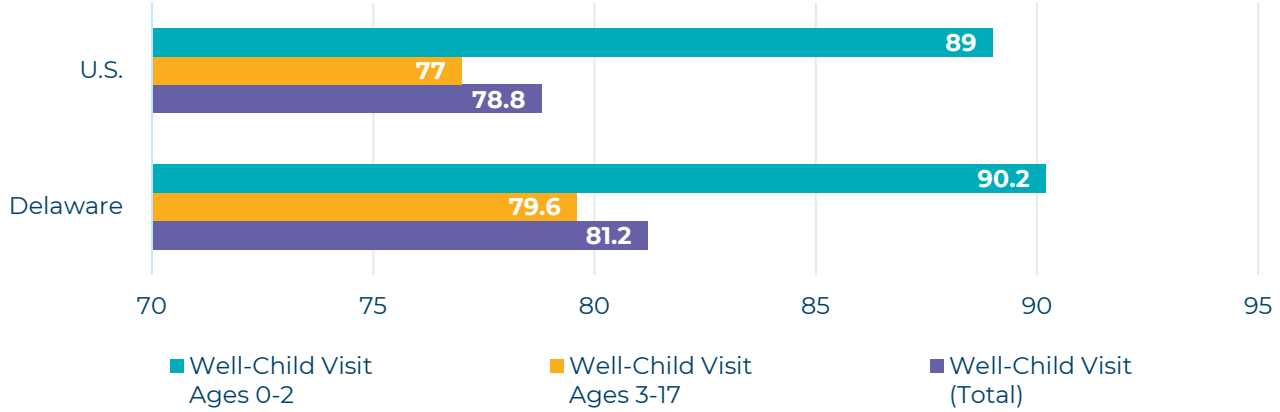
[223] *Centers for Disease Control and Prevention (CDC), "Childhood Preventive Care and Lifelong Health," in Healthy People 2030 Framework (Washington, DC: U.S. Dept. of Health and Human Services, 2020).*

**Child (0-17) received both preventative medical and dental care in past 12 months. **Child received a vision screening from a provider other than eye doctor ever (children age 0-5 years)/ in the past 2 years (for children age 6-17 years). ***1-3-6 Benchmarks: all infants should have their hearing screened by 1 month of age, all infants who do not pass their hearing screening (or are directly referred to an audiologist) should receive a confirmed diagnosis by 3 months of age, all infants diagnosed as deaf or hard of hearing (DHH) should be enrolled in early intervention (EI) by 6 months of age.*

Delaware's infants receive their first newborn hearing screening at a rate above 95%, aligning with national performance and meeting or approaching HP2030 targets for universal screening and rapid follow-up.[224] Vision screening in early childhood is comparable to U.S. averages, while well-child and preventive dental care show drop-offs in school-age years, signaling missed opportunities for anticipatory guidance, behavioral health surveillance, fluoride application, and catch-up vaccines.[225],[226] These patterns echo a national reality: **once children age out of frequent infant visits, transportation, work schedules, competing demands, and coverage nuances begin to shape access and adherence**.[227]

In 2022–2023, Delaware's 0–2 well-child visit rate sits around 90%, slightly above the U.S., while rates for school-aged youth (3–17) are modestly lower than for toddlers (79.6%) but on par or marginally better than U.S. peers (77%).

Figure 64. Percent of Children Ages 0-17 Who Received One or More Preventative Visits in the Past 12 Months by Age Group, Delaware, 2022-2023



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2022-2023 (Retrieved from America's Health Rankings)

Because well-child care is the delivery vehicle for immunizations and screenings, maintaining high attendance through adolescence is a primary access lever for prevention.

Developmental screening during well-child care identifies children at risk for delay and triggers referral to Early Intervention (EI) or other supports—interventions that are time-sensitive for language, social-emotional, and learning outcomes.[228] Delaware's parent-reported screening completion (≈33%) trails the U.S. (≈36%) and misses the HP2030 goal (~35.8%).[229]

[224] *CDC, "Early Hearing Detection and Intervention (EHDI) – 1-3-6 Benchmarks," updated 2024.*

[225] *American Academy of Pediatrics, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th ed. (Elk Grove Village, IL: AAP, 2017; periodicity schedule updated annually).*

[226] *U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), National Survey of Children's Health (NSCH) 2022–2023: Preventive Visits and Developmental Screening Indicators (Rockville, MD: HRSA, 2024).*

[227] *Agency for Healthcare Research and Quality (AHRQ), "Barriers and Facilitators to Well-Child Care," EvidenceNOW Issue Brief, 2022.*

[228] *CDC, "Developmental Monitoring and Screening," updated April 2023.*

229 "Strengthening the Developmental Screening Process," National Institute of Children's Health Quality, accessed September 2, 2025, https://www.nichq.org/insight/strengthening-developmental-screening-process

Figure 65. Percent of Parents Completing a Developmental Screening*, Delaware, 2022–2023

	Parent completed developmental screening	Parent **did not** complete developmental screening	Meets Healthy People 2030 Target (35.8%)
Delaware	32.8%	67.2%	No
Nationwide	35.6%	64.4%	No
HRSA Region III**	34.5%	65.5%	No

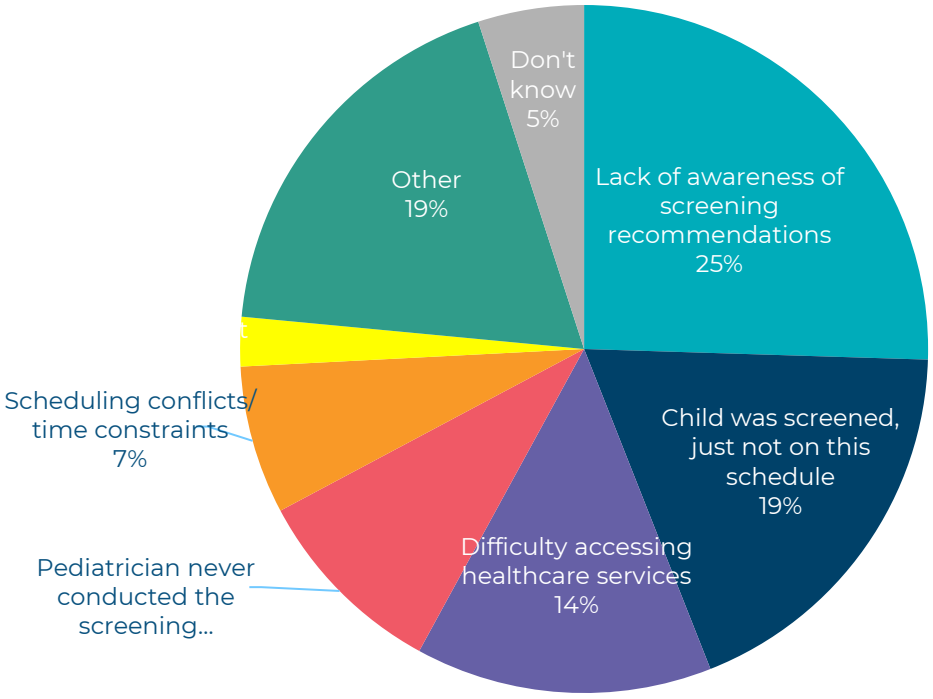
Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health (NSCH), 2022-2023

**This indicator is defined as parent reported completion of a developmental screening tool at any time in the past 12 months.*
****HRSA Region 3 is a geographical destination that encompasses the District of Columbia (D.C.), Delaware, Maryland, Pennsylvania, Virginia and West Virgina. It is used to benchmark local data to regional averages.*

Gaps here do not necessarily imply parental indifference; they can point to system friction—inconsistent provider workflows, limited appointment time, uncertainty about who administers screens, and referral bottlenecks.[230] Delaware survey data underscore that reality: the most-cited reason for missed screening is lack of awareness of screening recommendations (25%), followed by children being screened but not at the recommended time (19%), difficulty accessing care (14%), and provider-level misses (9%).

Approximately 13% of survey respondents overall were asked this follow-up question because they indicated their child did not receive a developmental screening at or around 9, 18 and 30 months of age.

Figure 66. Percent of Survey Respondents Who Provided the Primary Reason Their Child Did NOT Receive Developmental Screening at or Around the Recommended Ages* by Response Type, Delaware, 2025

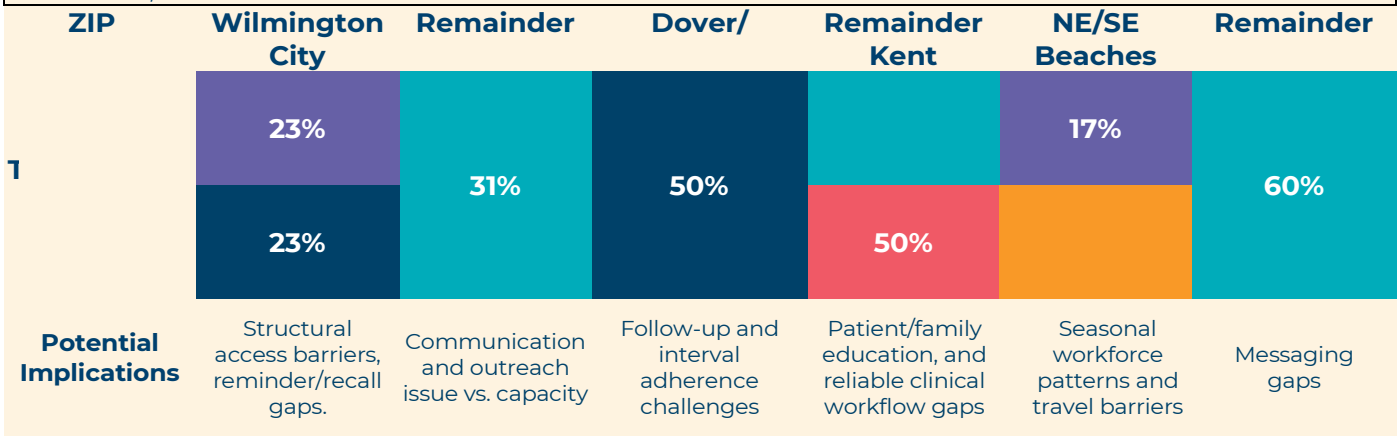


**Recommended ages for developmental screenings are at or around 9, 18, and 30 months old.*

[230] *Camden et al., "Workflow and Referral Challenges to Universal Developmental Screening," Academic Pediatrics 21, no. 5 (2021): 820–828.*

While statewide averages highlight broad barriers to developmental screening, the regional breakdown reveals important geographic variation.

Figure 67. Primary Reason Most Often Cited by Survey Respondents in Each ZIP Code Region, Delaware, 2025*



Source: Nemours Community Survey, 2025

**Colors in the table correspond with response categories in the pie chart above. **If a region's top response was "other" that next largest proportion was reported.*

These variations suggest region-specific solutions:

- Expand access (mobile/after-hours) where services are hard to reach;
- Strengthen recall systems and standardized workflows where timing and provider follow-through lag; and
- Deploy plain-language, culturally tailored communication through childcare, WIC, and schools where awareness is lowest.[231]

The same access, timing, and awareness factors also shape on-time vaccination for infants and toddlers. **Vaccines** are one of the most powerful and cost-effective public health interventions ever developed. By priming the immune system before exposure, they prevent not only individual illness but also the spread of disease across families, schools, and communities. Routine childhood vaccines in the United States are estimated to prevent more than 400 million illnesses and $1.7 trillion in societal costs for each birth cohort vaccinated.[232] The stakes are particularly high for infants and toddlers, who are more vulnerable to complications from measles, pertussis, influenza, and other vaccine-preventable diseases. For this reason, both the CDC and the American Academy of Pediatrics recommend an intensive vaccination schedule in the first two years of life, when protection against these threats is most urgent.[233]

In Delaware, as in the nation, monitoring coverage in this age group provides an early indicator of how well the system is protecting its youngest residents.[234] Delaware monitors the same indicators through both state immunization information systems (DelVAX) and periodic surveys, producing an early barometer of whether children are getting protected on time.[235]

Coverage among young children in the state has generally remained high—often above 85–90% depending on vaccine type—but has shown slight downward trends since 2019. Even a 2–3 percentage point decline translates into hundreds of children unprotected, leaving space for outbreaks of measles,

[231] *Centers for Disease Control and Prevention, "Developmental Monitoring and Screening," updated April 2023, U.S. Department of Health and Human Services.*

[232] *Whitney, Cynthia G., Fangjun Zhou, James Singleton, and Anne Schuchat. "Benefits from Immunization during the Vaccines for Children Program Era — United States, 1994–2013." MMWR 63, no. 16 (2014): 352–355.*

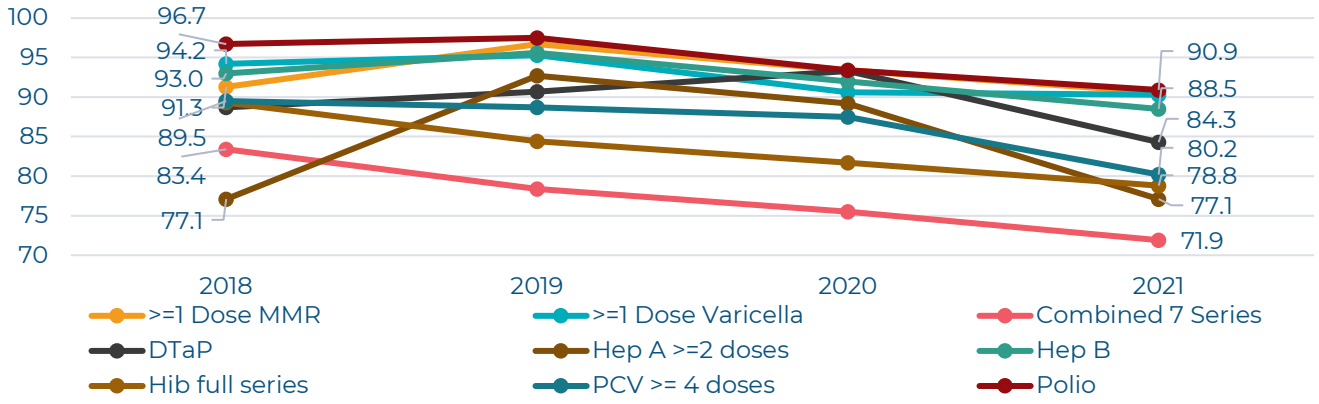
[233] *American Academy of Pediatrics. Red Book: 2024 Report of the Committee on Infectious Diseases. Elk Grove Village, IL: AAP, 2024.*

[234] *Centers for Disease Control and Prevention (CDC). "Childhood Vaccination Coverage, 19–35 Months." National Immunization Survey–Child 2023. Atlanta: U.S. Department of Health and Human Services, 2024.*

[235] *Delaware Division of Public Health (DPH). Childhood Immunization Coverage Reports, 2018–2021. Dover, DE: DPH, 2022.*

pertussis, and varicella. Tracking coverage in this age group is essential because it reflects both care access (do families get to visits on time?) and provider workflow (are all indicated vaccines delivered without missed opportunities?).[236]

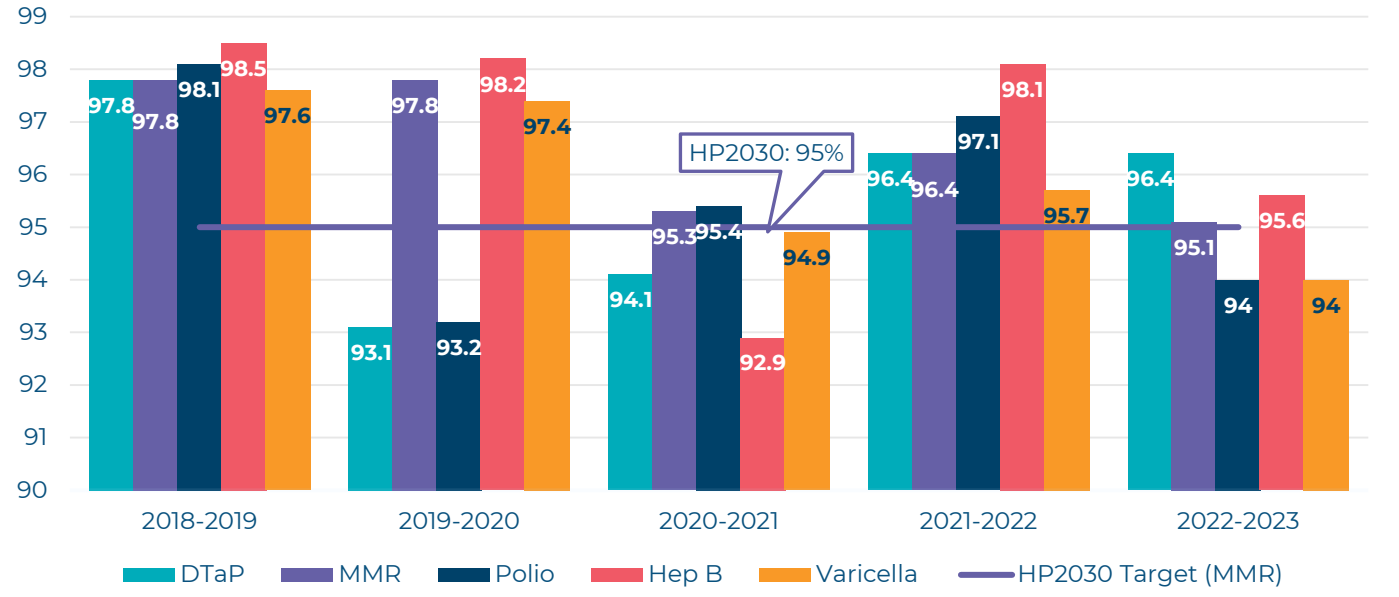
Figure 68. Percent of Children Vaccinated Age 0-35 months, Delaware, 2018–2021



Source: CDC. Vaccinations and Immunizations, ChildVaxView,

As children enter kindergarten, Delaware conducts annual audits of immunization records, providing a standardized, comparable dataset to monitor coverage at the point of school enrollment.[237] This measure is critical: kindergarten requirements are often the last backstop ensuring children complete missed doses before joining group learning environments. Delaware's kindergarten coverage has been consistently strong, with most vaccines (DTaP, MMR, polio, varicella) hovering around or above 95%,
the HP2030 target.

Figure 69. Percent of Immunization Coverage in Kindergarten Students by Type and Academic Year, Delaware, 2018-2023



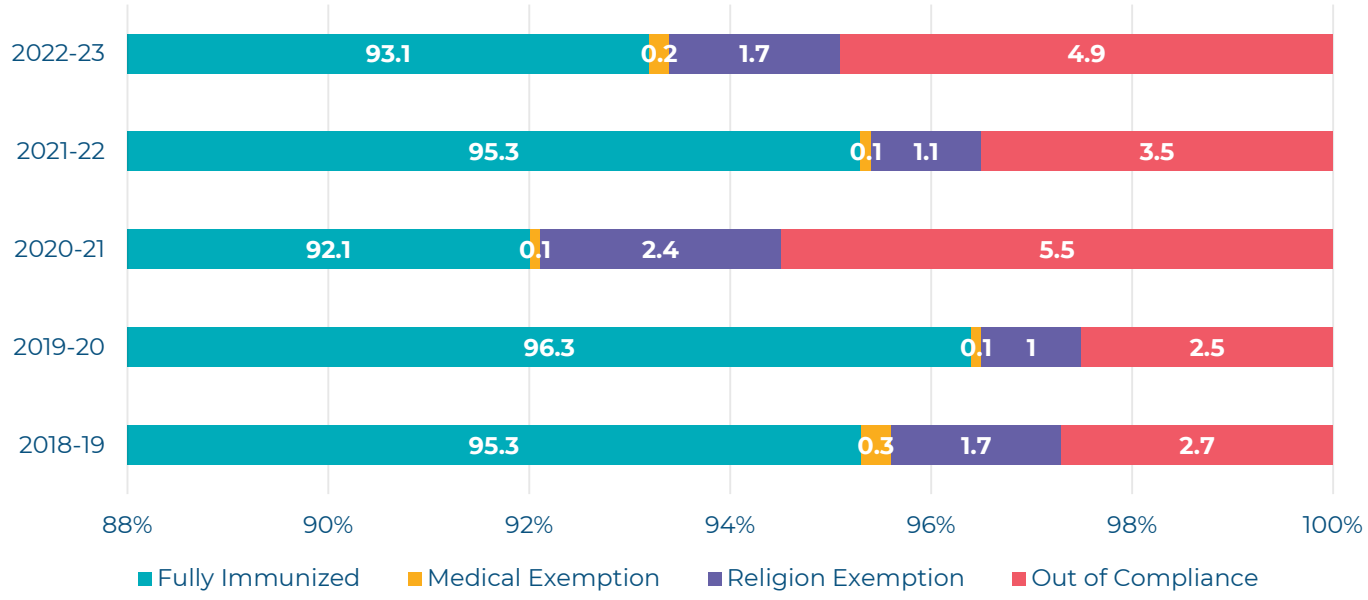
Source: Delaware Division of Public Health (DPH). Kindergarten Immunization Coverage Rates, 2018-2023

[236] *Whitney, Cynthia G., Fangjun Zhou, James Singleton, and Anne Schuchat. "Benefits from Immunization during the Vaccines for Children Program Era — United States, 1994–2013." MMWR 63, no. 16 (2014): 352–55.*

[237] *Delaware DPH. Kindergarten Immunization Coverage, Exemptions, and Compliance Status, 2018–2023. Dover, DE: DPH, 2024.*

However, data reveal that the share of students fully immunized slipped in 2022–2023, while "out of compliance" rose to nearly 5%. Though medical and religious exemptions remain low (~1-2%) with slight increases year over year, **the rise in noncompliance signals both record-keeping gaps and hesitancy behaviors that can cluster geographically and undermine herd immunity**.[238]

Figure 70. Percent Immunized in Kindergarten Students by Immunization Status and Academic Year, Delaware, 2018-2023



Source: Delaware Division of Public Health (DPH), Kindergarten Immunization Coverage Rates, Exemptions, and Compliance Status: 2018-2023

These concerns are consistent with national trends. In 2024–2025, the CDC reported that kindergarten coverage decreased in more than half of states and that exemptions increased in 36 states and DC, with 17 states exceeding the critical threshold of 5%.[239] During this time period, the U.S. experienced a measles resurgence: 1,491 cases in the first nine months of 2025, 86% outbreak-associated, with 12% hospitalized and three confirmed deaths. Nearly all cases (92%) occurred in children who were unvaccinated or of unknown status. [240]

[238] *Omer, Saad B., Daniel A. Salmon, Walter A. Orenstein, M. Patricia deHart, and Neal Halsey. "Vaccine Refusal, Mandatory Immunization, and the Risks of Vaccine-Preventable Diseases." New England Journal of Medicine 360, no. 19 (2009): 1981–88.*

[239] *CDC. "Vaccination Coverage and Exemptions among Kindergartners — United States, 2024–25 School Year." MMWR 73, no. 30 (July 2025): 685–89.*

[240] *CDC. "Measles Cases and Outbreaks — United States, January–September 2025." Surveillance Summary. Atlanta: CDC, 2025.*

The National Picture in 2024/2025

Vaccination coverage among kindergartners in the U.S. decreased for all reported vaccines from the year before, ranging from 92.1% for diphtheria, tetanus, and acellular pertussis vaccine (DTaP) to 92.5% for measles, mumps, and rubella vaccine (MMR) and polio vaccine.

Coverage with MMR, DTaP, poliovirus vaccine (polio), and varicella vaccine (VAR) **decreased in more than half of states**, compared with coverage the year before.

Exemptions increased in 36 states and DC.

17 states reporting **exemptions exceeding 5%**

U.S. Measles Cases in 2025

(January September only):

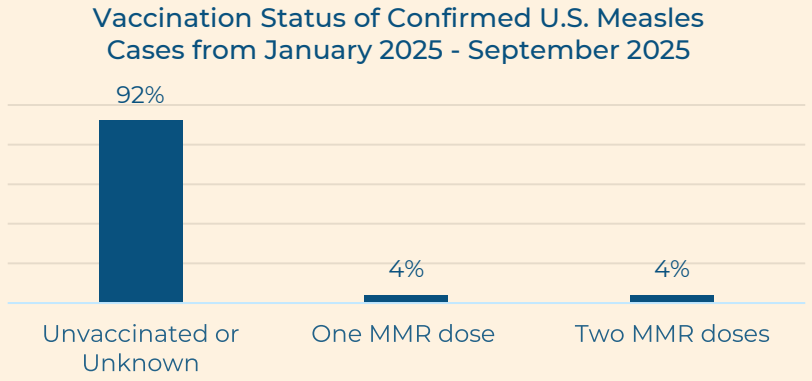
- **1,491 total cases****

(compared to 285 in 2024 and 59 in 2023)

- **12% hospitalized**
- **3 confirmed deaths**

There have been **38 Measles outbreaks* reported in 2025** (so far), and 86% of confirmed cases (1,284 of 1,491) are outbreak associated.

For comparison, **16 outbreaks were reported during 2024** and 69% of cases (198 of 285) were outbreak associated.



Source: (1) Centers for Disease Control and Prevention. (2025, July 31). Vaccination coverage and exemptions among kindergartners: 2024–2025 school year. SchoolVaxView. U.S. Department of Health & Human Services. Retrieved from https://www.cdc.gov; (2) Centers for Disease Control and Prevention. (2025,September 17). Measles cases and outbreaks in the United States – 2025 update. U.S. Department of Health & Human Services. https://www.cdc.gov/measles/cases-outbreaks.html

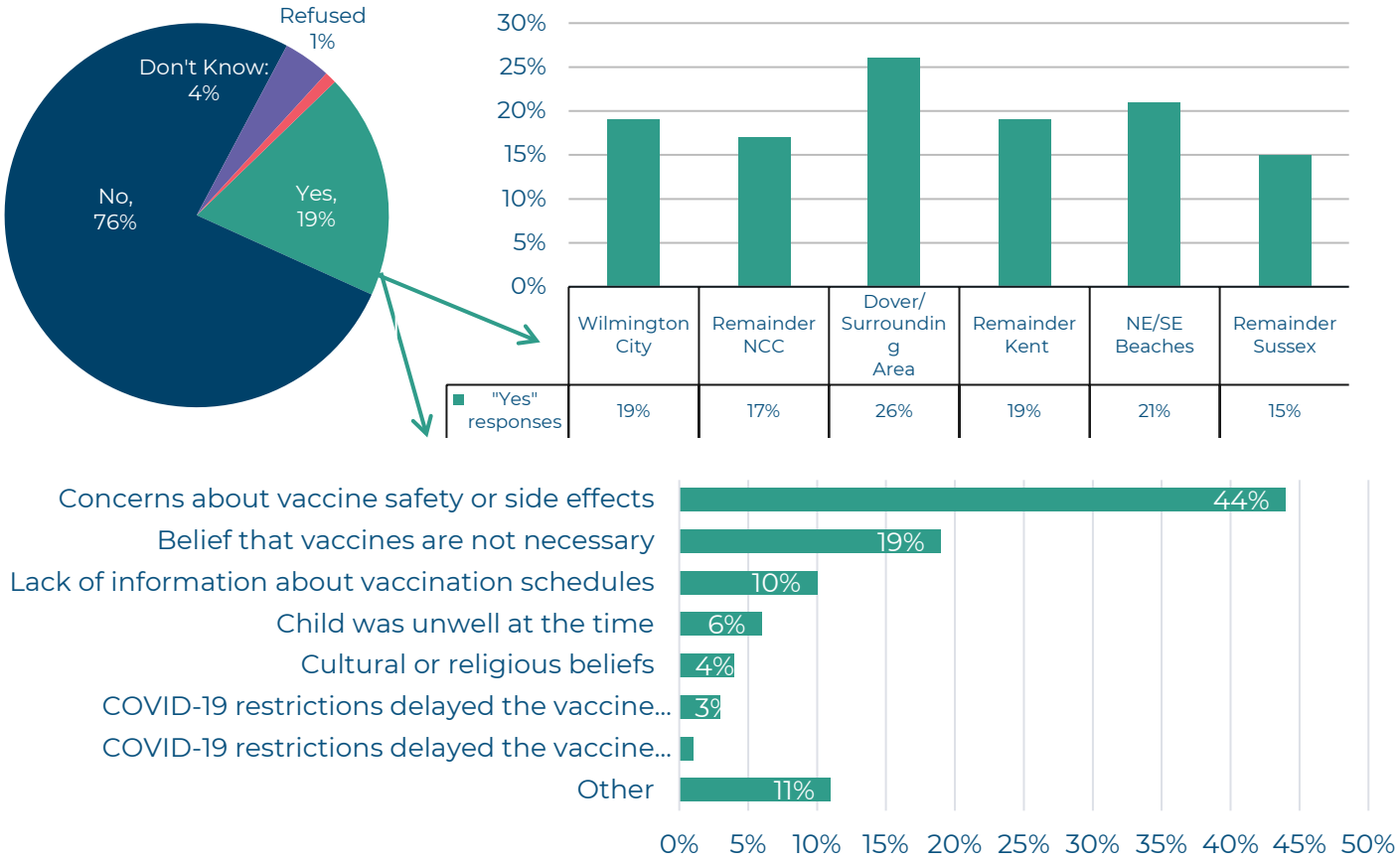
CDC reports the cumulative number of measles outbreaks (defined as 3 or more related cases) that have occurred this year in the U.S.; states have the most up-to-date information about cases and outbreaks in their jurisdictions.CDC is aware of probable measles cases being reported by jurisdictions. However, the data on this page only includes confirmed cases jurisdictions have notified to CDC.*

For Delaware, these figures underscore why maintaining high coverage and tight exemption processes is essential—small drops at the population level can reopen outbreak risk even in states with generally high compliance.

> *"We [Delaware] make it really easy to **not** vaccinate," one community member explained. Another stated, "all a child needs for an exemption in Delaware is one notarized letter.... states like Utah require parent ed before exemption requests are approved."*

Nemours' community survey adds further nuance. Nearly 1 in 5 parents (19%) reported delaying or skipping at least one recommended vaccine for their child. Among those respondents, the most common reason for skipping or delaying at least one recommended vaccine for their child was attributed to safety or side effect concerns (44%), followed by the belief vaccines are not necessary (19%), lack of information about schedules (10%), and cultural or religious beliefs (4%). Another 6% indicated their child was unwell at the time, which could explain delays based on provider recommendations.

Figure 71. Percent Survey Respondents Who Ever Delayed of Skipped a Recommended Vaccination for their Child by ZIP Code Region and Reason, Delaware 2025



Source: Nemours Community Survey, 2025

Regional patterns highlight that hesitancy is not uniform: higher delay/skip rates were reported in Dover and the Surrounding Area (26%), and the NE/SE Beach Regions (21%), while Wilmington City reported lower delay/skip rates (19%), but cited access barriers at a higher frequency than other regions. **These findings reinforce that hesitancy is both an attitudinal issue (safety concerns, necessity beliefs) and an access issue (time constraints, provider communication), requiring multipronged solutions.**

Unlike most childhood vaccines, HPV is recommended in adolescence (ages 9–12 optimal, catch-up through 26) and is therefore a sensitive marker of preventive care continuity into the teen years. The HPV vaccine protects against six cancers, including cervical and oropharyngeal cancers, and is safe and effective in preventing >90% of HPV-related cancers when given on time.[241]

[241] *President's Cancer Panel. HPV Vaccination for Cancer Prevention: Progress, Opportunities, and a Renewed Call to Action. Bethesda, MD: National Cancer Institute, 2024.*

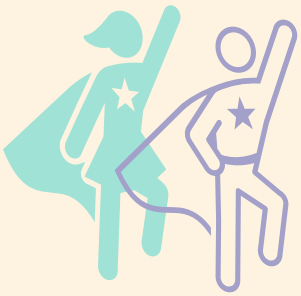
HPV Vaccine Facts

for boys and girls

Every year, **37,000** people in the U.S. develop HPV-related cancer.

HPV causes more **mouth and throat cancers** than smoking

79 million Americans are infected with HPV. Some infections can go away on their own, but others may lead to cancer.



The HPV vaccine protects against **6 kinds of cancer.**

HPV vaccine is very safe and can prevent over **90%** of all HPV cancers.

9-12 years is the optimal age for the vaccine because it is more effective during the preteen years than when given later.

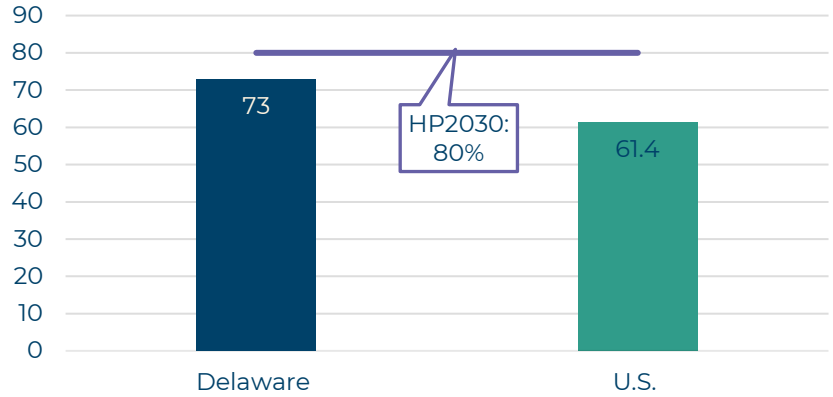
Source: Adapted from www.cdc.gov/hpv/parents/about-hpv.html *and* www.thevaccinepage.org

Adolescents remain the focus of HPV immunization in the United States. HPV infections happen quickly and reduce the efficacy of the HPV vaccine, so it is essential to immunize youth before they become sexually active. **Populations of teens with higher HPV immunization coverage include**[242]**:**

- American Indian/Alaska Native, Asian and non-Hispanic Black teens compared with non-Hispanic white and multiracial teens.
- Teens with health insurance compared with uninsured teens.
- Teens living in metropolitan areas compared with those living in nonmetropolitan areas

Delaware's series-complete coverage stands at 73%, outperforming the U.S. average (61.4%) but still falling short of the HP2030 target (80%). Community survey findings reveal wide regional variation: lowest adherence in the Remainder of Kent and Sussex counties (25–27%), highest in the Remainder of New Castle County (68%) and Dover and the Surrounding Area (67%).

Figure 72. Percent of Adolescents (13-17 years) Who Received All Recommended Doses of the Human Papillomavirus (HPV) Vaccine, Delaware 2023



Nearly **1 in 4** (23%) survey respondents reported their teen **has not had at least 2 doses of the HPV vaccine**. Lowest adherence is observed in the Remainder of Kent (27%) and Sussex (25%) counties, and highest vaccine rate is reported in the Remainder of New Castle County (68%) and the Dover Area (67%).

Source: CDC, National Immunization Survey – Teen (NIS – Teen), 2023 (Retrieved from America's Health Rankings)

Disparities reflect both access barriers and hesitancy drivers—families uncertain about safety, unaware of cancer-prevention benefits, or lacking strong provider recommendations. **Research confirms that a clear, strong provider recommendation is the single most important factor in HPV uptake**,[243] underscoring the need to strengthen communication in primary care, embed reminder/recall in DelVAX, and expand school-based vaccination efforts.

[242] *America's Health Rankings analysis of U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, National Immunization Survey-Teen, United Health Foundation, AmericasHealthRankings.org, accessed 2025.*

[243] *Gilkey, Melissa B., et al. "Provider Communication and HPV Vaccine Uptake: A Meta-Analysis." Vaccine 34, no. 5 (2016): 604–12.*

Delaware state law requires immunization documentation for school entry and delineates medical (provider-certified) and religious (notarized affidavit) exemptions; the Division of Public (DPH) conducts annual coverage assessments and publishes results to target improvement. The DelVAX immunization information system and cross-system collaborations (schools, primary care, pharmacies) are critical to identify under-immunized pockets, run recall lists, and close gaps before outbreaks occur.[244] Aligning DPH, health systems, and community partners around evidence-based strategies from The Community Guide (reminder/recall, standing orders, school/childcare requirements, provider A&F) yields reliable gains, particularly when paired with trust-building communication where hesitancy is highest.[245] Additional evidence-based best practices include:

- Client reminder/recall and provider reminders increase on-time vaccination and developmental screening completion—effective across age, setting, and socioeconomic groups.[246],[247]
- Standing orders and vaccination at every opportunity (sick visits, sports physicals) reduce missed opportunities, including for HPV.[248],[249]
- School/childcare requirements with limited non-medical exemptions preserve high coverage and reduce outbreaks.[250]
- Integrated screening in childcare/WIC/Head Start and electronic screening tools raise developmental screening rates, particularly where well-child attendance is inconsistent.[251]
- Reduced practical barriers—transportation, evening/weekend hours, mobile teams—raise completion among families facing time and access constraints.[252],[253]

The habits established in childhood form the foundation for lifelong health behaviors. Children who grow up receiving consistent preventive care are more likely to engage in adult screenings such as mammograms, Pap smears, colonoscopies, and blood pressure checks, which are designed to catch cancer and chronic conditions early when treatment is most effective. This continuity reduces the risk of missing lifesaving services later in life, helping to prevent complications from heart disease, diabetes, and cancer—the leading causes of morbidity and mortality in the U.S. In this way, pediatric preventive services do more than protect children in the present; they shape long-term health trajectories that lessen the burden of chronic disease across the lifespan.

Screening finds pre-cancers or early cancers—when treatment is most effective—and some tests (like colonoscopy) prevent cancer entirely by removing polyps. Current recommendations reflect where risk and test performance balance best: colorectal cancer screening for ages 45–75[254], biennial mammography from 40–74[255], cervical screening from 21–65 (via Pap and/or HPV testing)[256], and low-dose CT (LDCT) for lung cancer among adults 55–80 with a ≥20 pack-year smoking history who currently smoke or quit within the last 15 years.[257] Healthy People 2030 (HP2030) sets targets to move systems toward equitable, routine uptake of these services. For the indicators used in the table below, the HP2030 targets are 72.8% (colorectal), 80.3% (breast), 79.2% (cervical), and 7.5% (lung screening; target set on the earlier 2013 criteria).

[244] *Delaware Health and Social Services. DelVAX Immunization Information System. Available from: https://dhss.delaware.gov/dph/dpc/immunize-providers*
[245] *Centers for Disease Control and Prevention. Strategies to Increase Immunization Opportunities in Primary Care. Childhood Immunization Toolkit. Available from: https://wcaap.org/wp-content/uploads/2025/06/Childhood-Immunization-Toolkit_Final_4.11.2025.pdf*
[246] *Community Preventive Services Task Force, "Increasing Appropriate Vaccination: Client Reminder and Recall Systems," The Community Guide, updated 2023.*
[247] *Szilagyi et al., "Effect of Patient Reminder/Recall Interventions on Immunization Rates: Updated Review," American Journal of Preventive Medicine 49, no. 6 (2015): 917–931.*
[248] *Community Preventive Services Task Force, "Provider Assessment and Feedback; Standing Orders; IIS-Based Interventions; School/Childcare Requirements," The Community Guide, updated 2022–2024.*
[249] *Gilkey et al., "Provider Communication and HPV Vaccine Uptake: A Meta-Analysis," Vaccine 34, no. 5 (2016): 604–612.*
[250] *Community Preventive Services Task Force, "Increasing Appropriate Vaccination: Client Reminder and Recall Systems," The Community Guide, updated 2023.*
[251] *National Institute for Children's Health Quality (NICHQ), "Improving the Developmental Screening Process," 2022.*
[252] *Agency for Healthcare Research and Quality (AHRQ), "Barriers and Facilitators to Well-Child Care," EvidenceNOW Issue Brief, 2022.*
[253] *Starfield et al., "Continuity and Access in the Medical Home and Preventive Service Use," Pediatrics 127, no. 2 (2011): 521–528.*
[254] *U.S. Preventive Services Task Force (US PSTF). "Recommendation: Colorectal Cancer: Screening," 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.*
[255] *U.S. PSTF "Recommendation: Breast Cancer: Screening," 2024. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.*
[256] *U.S. PSTF. "Recommendation: Cervical Cancer: Screening," 2018. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening.*
[257] *U.S. PSTF. "Recommendation: Lung Cancer: Screening," March 9, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening.*

Figure 73. Percent of Recommended Population (Adults) Up to Date* on Preventative Screenings by Screening Type, Delaware, 2020, 2022**

Screening Type	Recommended Population**	Delaware (% of recommended population up to date[a])	U.S. (% of recommended population up to date)	Healthy People 2030 Target (population, %)
Colorectal Cancer Screening	Adults age 45+	**70.1%** (2022)[258]	**61.4%** (2022)[259]	45-75 years old: **72.8%**
Delaware's 2022 prevalence of adults aged 45–75 who are up to date on colorectal screening (70.1%) is higher than the U.S. benchmark used here (61.4%) and within striking distance of the HP2030 target (72.8%).[260],[261] The 2021 USPSTF age expansion to begin at 45 lowered national "up-to-date" percentages in the short term by adding newly eligible 45–49-year-olds—an age group with historically low prior screening—which is why the U.S. estimate appears lower than many pre-2021 figures.[262],[263] This context underscores a near-term need for outreach tailored to				
Breast Cancer Screening (Mammography)	Women age 50+	**79.7** (2022)[264]	**76.3** (2022)	50-74 years old: **80.3%**
Delaware's 2022 mammography (women 50+) reaches 79.7%, outperforming the U.S. 76.3% and nearly meeting the HP2030 target (80.3% for women 50–74).[265] The 2024 USPSTF shift to start at 40 biannually amplifies the importance of reminder-recall and navigation supports for women in their 40s—groups that show larger gains when systems reduce scheduling and cost frictions.[266],[267]				
Cervical Cancer (Pap/HPV)	Women age 21+	**77.0%** (2020)[268]	**77.7%** (2020)	21-65 years old: **79.2%**
In 2020, Delaware (77.0%) approximated the U.S. (77.7%) but remained below HP2030 (79.2%).[269] Cervical screening is highly sensitive to coverage and continuity: extending primary-care access, co-testing options, and reminder systems is associated with higher adherence and fewer "screening deserts," especially for postpartum and low-income patients.[270]				
Lung Cancer (Low-dose CT)	Adults 55-80 (smoking history)	**22.7%** (2022)[271]	**18.1%** (2022)[272]	55-80 years old**:** **7.5%**
Lung cancer (LDCT): Delaware's LDCT screening among those at high risk (22.7% in 2022, ACR registry) is well above the HP2030 target of 7.5% (which used the earlier 2013 eligibility), and above national registry-based estimates, though reported national rates vary by method and time window.[273] This is promising but still leaves most eligible adults unscreened. Primary-care prompts tied to smoking history, streamlined coverage (particularly in Medicaid), and removal of prior authorization are documented facilitators of higher LDCT uptake.				

*[a]Up to date with screening includes those screened by any of the screening tests recommended by US Preventive Services Task Force within the suggested screening interval.**To enable valid Delaware–U.S. comparisons, all indicators use the most recent year shared by*

[258] National Cancer Institute and CDC. State Cancer Profiles: Colorectal Cancer Screening, Up to Date, Ages 45–75, Delaware, 2022. https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=delaware#t=Riskfactors&v=colorectal
[259] Centers for Disease Control and Prevention (CDC). "Baseline Estimates of Colorectal Cancer Screening Among Adults Aged 45 to 75 Years—United States, 2022." Preventing Chronic Disease 22 (2025). https://www.cdc.gov/pcd/issues/2025/25_0175.htm.
[260] King, S. C., et al. "Baseline Estimates of Colorectal Cancer Screening Among Adults Aged 45 to 75 Years—United States, 2022 BRFSS." Preventing Chronic Disease 22 (2025). https://www.cdc.gov/pcd/issues/2025/25_0175.htm.
261[261] National Cancer Institute and CDC. State Cancer Profiles, "Colorectal Cancer Screening, Up to Date, Ages 45–75, 2022—Delaware." https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=delaware#t=Riskfactors&v=colorectal.
[262] U.S. Preventive Services Task Force. "Recommendation: Colorectal Cancer: Screening." May 18, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.
[263] King, S. C., et al. "Baseline Estimates of Colorectal Cancer Screening Among Adults Aged 45 to 75 Years—United States, 2022 BRFSS." Preventing Chronic Disease 22 (2025). https://www.cdc.gov/pcd/issues/2025/25_0175.htm.
[264] National Cancer Institute and CDC. State Cancer Profiles: Mammogram in Past 2 Years, Ages 40+, Delaware and United States, 2022. https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=delaware#t=Riskfactors&v=mammogram.
[265] National Cancer Institute and CDC. State Cancer Profiles, "Mammogram in Past 2 Years, Ages 40+, 2022—Delaware and U.S." https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=delaware#t=Riskfactors&v=mammogram.
[266] Community Preventive Services Task Force. "Breast Cancer Screening: Client Reminders." https://www.thecommunityguide.org/findings/cancer-screening-client-reminders-breast-cancer.html.
[267] Tian, L., et al. "Impact of Patient Navigation on Breast Cancer Screening." Cancer Medicine 11, no. 16 (2022).
[268] National Cancer Institute and CDC. State Cancer Profiles: Pap Test in Past 3 Years, Ages 21–65, Delaware and United States, 2020. https://statecancerprofiles.cancer.gov/risk/index.php?risk=v17&type=risk.
[269] National Cancer Institute and CDC. State Cancer Profiles, "Pap Test in Past 3 Years, Ages 21–65, 2020—Delaware and U.S." https://statecancerprofiles.cancer.gov/risk/index.php?risk=v17&type=risk.
[270] Baron, R. C., et al. "Client-Directed Interventions to Increase Community Demand for Breast, Cervical, and Colorectal Cancer Screening." American Journal of Preventive Medicine 35, no. 1 (2008).
[271] American Lung Association. "State of Lung Cancer: Delaware." American Lung Association Research, 2023. https://www.lung.org/research/state-of-lung-cancer/states/delaware.
[272] American Lung Association. State of Lung Cancer 2023. Chicago: American Lung Association, 2023. https://www.lung.org/getmedia/186786b6-18c3-46a9-a7e7-810f3ce4deda/SOLC-2023-Print-Report.pdf.
[273] American Lung Association. State of Lung Cancer 2023 (methodology and registry source: ACR Lung Cancer Screening Registry, 2022). https://www.lung.org/getmedia/186786b6-18c3-46a9-a7e7-810f3ce4deda/SOLC-2023-Print-Report.pdf.

both Delaware and U.S. sources with the same measure definition. CRC and mammography values are from 2022 BRFSS; cervical screening is from 2020 BRFSS (latest aligned year available for both jurisdictions with the defined measure); lung cancer screening uses 2022 ACR Lung Cancer Screening Registry estimates reported by the American Lung Association. U.S. comparators use national BRFSS pooled estimates (not the U.S. median) where available; when national sources report multiple statistics for the same indicator and year, we use the definition that matches Delaware's measure. Differences from other dashboards reflect alternate denominators (e.g., U.S. median vs. national estimate), eligibility updates (USPSTF 2013 vs. 2021 lung screening criteria), and data systems (survey vs.registry).[274]
***Screening recommendations vary by age, race, and medical history: (1) Colorectal Tests: Men and women age 45 and older should have regular colorectal cancer screening tests, as recommended by their doctor or health care professional. These tests may include colonoscopy, sigmoidoscopy, or home-test kits (called FIT, for Fecal Immunochemical Test), (2) Breast Exams: All women should have their breasts examined by a doctor or other health professional once a year/ Mammograms: Women age 40 and older should have regular mammograms, as recommended by their doctor or health professional. (3) Pap Tests: All women age 21 and older, especially if they are active sexually, should have regular Pap tests and pelvic exams, and (4) Lung Test: Men and women who are 55-80 years of age may be eligible for a lung cancer screening if they: currently smoke or have quit smoking during the past 15 years; and smoke or smoked a pack a day for 30 or more years, or two packs a day for 15 or more years. Talk with your doctor about individual screening recommendations. If you have a family history of cancer or are experiencing certain symptoms, you may qualify for screening at an earlier age.[275]*

Adult vaccines protect families by preventing severe disease, hospitalization, and long-term disability—the very complications that destabilize caregiving, employment, and finances. Recommendations vary by age and risk because immune responses, baseline disease risk, and vaccine effectiveness shift across the life course. National surveillance through the National Health Interview Survey (NHIS) and Delaware's Behavioral Risk Factor Survey (BRFS) together provide insight into how coverage has shifted over time.

Influenza vaccination remains the most widely used adult vaccine but shows persistent gaps.

⇨ Coverage among all U.S. adults aged ≥19 hovered around 45–50% from 2017 to 2022, while high-risk adults (chronic condition or older age) reached higher coverage levels of about 60–65%. *In Delaware, 48.2% of adults reported a flu shot in the past year (2022), aligning closely with the national average but falling short of Healthy People goals.[276]*

This means **more than half of Delaware adults remain unprotected** each influenza season, a concern given the virus's annual toll of hospitalizations and deaths, especially among seniors and those with chronic conditions.[277]

Pneumococcal vaccination demonstrates a widening gap between older and younger at-risk populations.

⇨ Coverage among U.S. adults ≥65 increased steadily, from about 35% in 2017 to 44% in 2022.[278] *Delaware outperforms this benchmark: 74.6% of adults ≥65 reported ever receiving a pneumonia vaccine in 2022.[279]*

Coverage among younger adults with risk factors (ages 19–64 with chronic disease) remains low nationally (~24%) and in Delaware, reflecting insurance and access barriers.

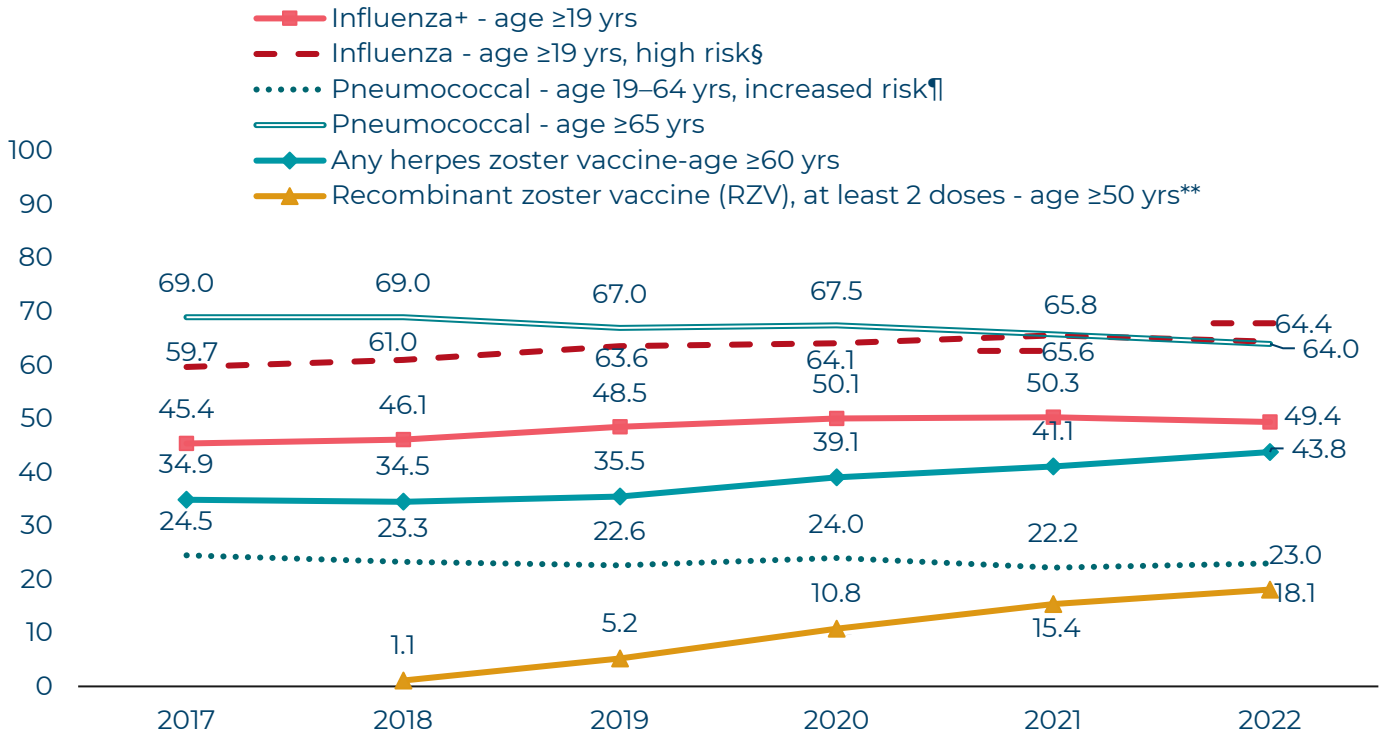
Herpes zoster vaccination uptake accelerated following the introduction of recombinant zoster vaccine (RZV, Shingrix) in 2017.

⇨ Coverage among U.S. adults ≥60 climbed from ~35% in 2017 to ~49% in 2022, while RZV two-dose completion among adults ≥50 increased from 1% to 18%.[280] *Delaware mirrors this growth with: 30.5% of adults overall and 42.5% of those ≥65 reported ever having received a shingles vaccine in 2020.[281]*

This suggests **improving adoption** but also highlights **gaps in completing the recommended two-dose regimen.**

[274] *American Lung Association. "Delaware—State Data (Screening, High Risk)." https://www.lung.org/research/state-of-lung-cancer/states/delaware*
[275] *Delaware Division of Public Health. (2025). Screening for Life: Cancer screening services for eligible Delaware residents. Delaware Health and Social Services. Retrieved from https://www.dhss.delaware.gov*
[276] *Delaware Department of Health and Social Services, Division of Public Health (DPH). Behavioral Risk Factor Survey (BRFS) 2022 Data Report: Adult Immunizations. Dover, DE: DPH, 2023.*
[277] *Centers for Disease Control and Prevention (CDC). AdultVaxView: Vaccination Coverage among Adults in the United States, NHIS 2017–2022. Atlanta: U.S. Department of Health and Human Services, 2023. https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/index.html*
[278] *CDC. "Shingles Vaccination Coverage among Adults in the United States." AdultVaxView, 2017–2022. https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/shingles.html.*
[279] *Delaware Department of Health and Social Services, Division of Public Health (DPH). Behavioral Risk Factor Survey (BRFS) 2022 Data Report: Adult Immunizations. Dover, DE: DPH, 2023.*
[280] *Centers for Disease Control and Prevention (CDC). AdultVaxView: Vaccination Coverage among Adults in the United States, NHIS 2017–2022. Atlanta: U.S. Department of Health and Human Services, 2023. https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/index.html.*
[281] *Delaware Department of Health and Social Services, Division of Public Health (DPH). Behavioral Risk Factor Survey (BRFS) 2022 Data Report: Adult Immunizations. Dover, DE: DPH, 2023.*

Figure 74. Estimated Proportion of Adults aged ≥19 Years who Received Selected Vaccines, * by Age Group and Risk Status, United States, 2017-2022



Source: Centers for Disease Control and Prevention (CDC), National Health Interview Survey (NHIS), AdultVaxView, 2017-2022

**Trends in adult vaccination were assessed from 2017 through 2022, including influenza, pneumococcal, and herpes zoster vaccinations. For herpes zoster vaccine, in 2017, ACIP preferentially recommended recombinant zoster vaccine (RZV) for use in immunocompetent adults aged ≥50 years over zoster vaccine live (ZVL) due to higher and longer-lasting efficacy and recommended RZV vaccination of persons who previously received ZVL. +Estimates are season specific. Year 2022 corresponds to the 2021-22 influenza season. § Adults were categorized as being at increased risk for influenza-related complications if they had ever been told by a doctor or other health professional that they had diabetes, emphysema, chronic obstructive pulmonary disease, chronic bronchitis, coronary heart disease, angina, or heart attack; had a diagnosis of cancer during the previous 12 months (excluding nonmelanoma skin cancer); had ever been told by a doctor or other health professional that they had lymphoma, leukemia, or blood cancer; had ever been told by a doctor or other health professional that they had weak or failing kidneys; had an asthma episode or attack during the preceding 12 months; or were current smokers. ¶Adults were categorized as being at increased risk for pneumococcal disease if they had ever been told by a doctor or other health professional that they had diabetes, emphysema, chronic obstructive pulmonary disease, chronic bronchitis, coronary heart disease, angina, or heart attack; had a diagnosis of cancer during the previous 12 months (excluding nonmelanoma skin cancer); had ever been told by a doctor or other health professional that they had lymphoma, leukemia, or blood cancer; had ever been told by a doctor or other health professional that they had weak or failing kidneys, cirrhosis or any other chronic liver condition; had an asthma episode or attack during the preceding 12 months; or were current smokers. **Two doses of recombinant zoster vaccine (RZV) have been recommended for all adults ≥50 years since 2018.*

Findings demonstrate that Delaware tracks closely with national averages for influenza vaccination, surpasses the U.S. in pneumococcal coverage for older adults, and shows promising though incomplete progress on shingles vaccination. Gaps remain in extending protection to younger high-risk groups, maintaining consistent influenza uptake, and ensuring adherence to multi-dose regimens. Addressing these will require strategies proven effective in both pediatric and adult populations:

- Reminder-recall systems, standing orders in clinics and pharmacies, reducing out-of-pocket costs, and embedding provider prompts within electronic health records.[282]

Pediatric prevention lays the groundwork for lifelong risk reduction. When children receive on-time screenings and complete vaccine series, families build habits of preventive care and remain tethered to systems that can detect hypertension, diabetes, breast/cervical/colorectal and lung cancers earlier—

[282] *Community Preventive Services Task Force. "Increasing Appropriate Vaccination: Client Reminder and Recall Systems; Standing Orders; Provider Assessment and Feedback." The Community Guide, updated 2023. https://www.thecommunityguide.org.*

where outcomes and costs are better.[283,284] In short, strong pediatric prevention today is a first defense against the chronic conditions covered in the next section; the same access levers (coverage, convenience, reminder systems, trusted messengers) will drive Delaware's progress on chronic disease tomorrow.

Physical Health and Lifestyle

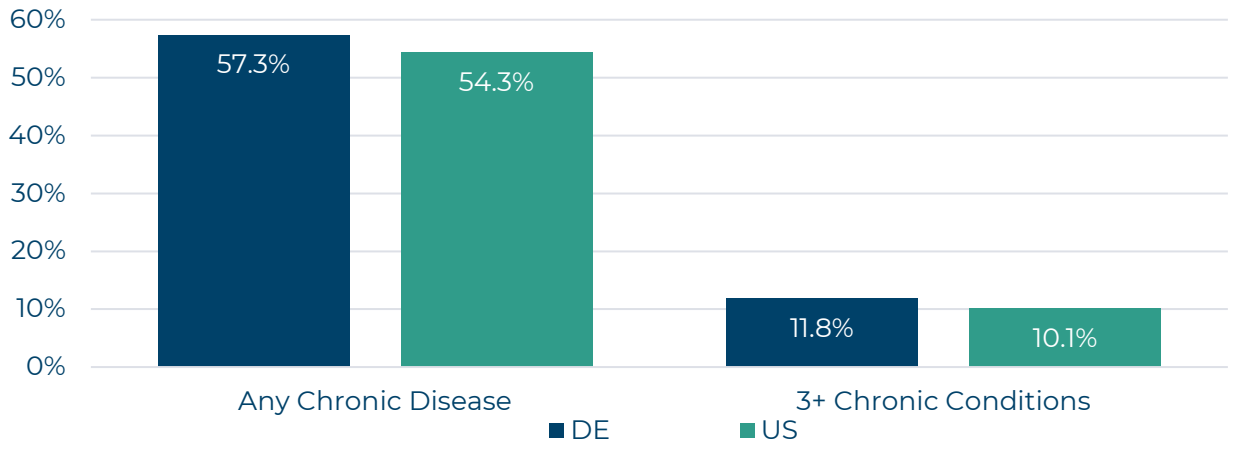
Physical health and lifestyle factors—such as diet, physical activity, sleep, and avoidance of harmful behaviors—are key determinants of overall health. National research shows that these behaviors directly affect growth, development, and the risk of chronic disease across the lifespan. For children, healthy habits established early influence physical and cognitive development, school performance, and long-term well-being, while unhealthy patterns contribute to preventable illness and disparities in health outcomes.

Chronic Health Conditions

Chronic diseases are a leading driver of poor health and health care costs in the United States, and many are directly linked to lifestyle behaviors such as diet, physical activity, and tobacco use. According to CDC, six in ten U.S. adults live with at least one chronic disease, and four in ten live with two or more, conditions that often begin with risk factors established in childhood[285]. For children, chronic conditions such as asthma, obesity, and diabetes not only affect immediate health and development but also increase the likelihood of persistent health challenges into adulthood. Addressing chronic disease early in life is therefore critical to improving population health and reducing long-term disparities.

Delaware had a higher percent of adults with at least one chronic disease (57%) as well as three or more chronic conditions (11.8%) than the U.S.

Figure 75. Percent of Adults With 1 or 3+Chronic Conditions*, Ages 18-64, Delaware, 2023



Source: BRFSS, 2023

**Chronic conditions included are hypertension, diabetes, cancer, arthritis, asthma, COPD, depression, and kidney disease.*

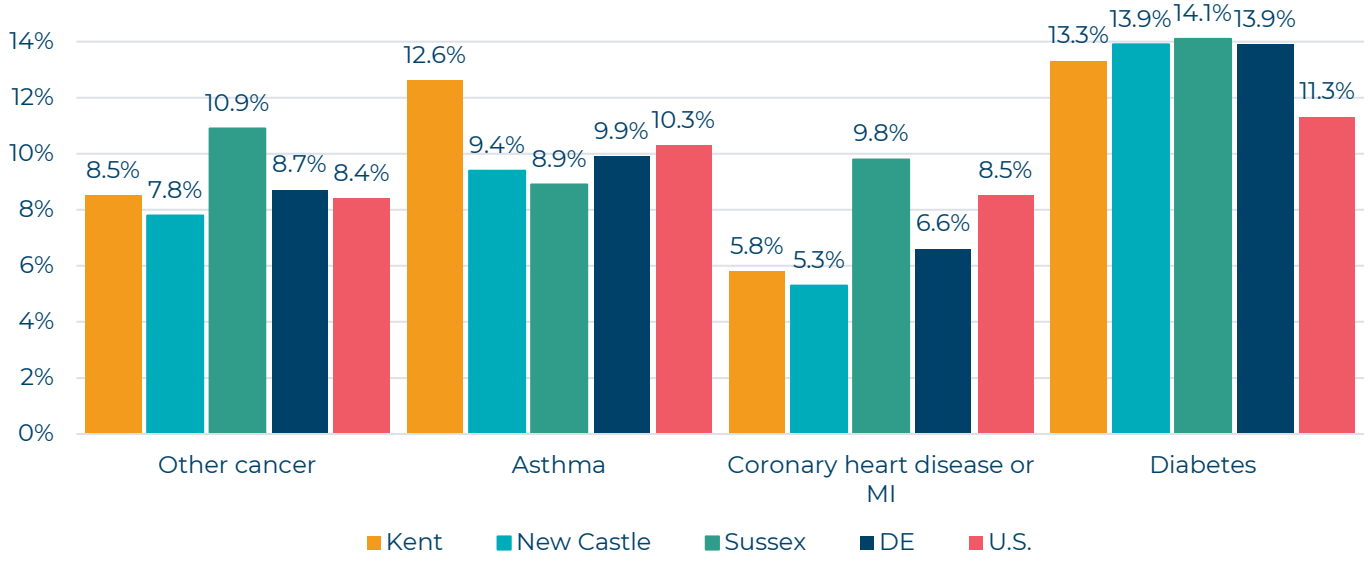
[283] *Centers for Disease Control and Prevention (CDC), "Childhood Preventive Care and Lifelong Health," in Healthy People 2030 Framework (Washington, DC: U.S. Dept. of Health and Human Services, 2020).*

[284] *U.S. Preventive Services Task Force (USPSTF), recommendations for CRC (ages 45–75), breast cancer (50–74), cervical cancer (21–65), and lung cancer LDCT (ages 50–80 with 20 pack-years, current or quit <15 years), 2021–2024.*

[285] *Centers for Disease Control and Prevention: About Chronic Diseases. U.S. Department of Health and Human Services, 2023.*

Delaware adults have a higher prevalence of diabetes (13.9%) and cancer (excluding cancers of the skin) (8.7%%) than the U.S. (11.3% and 8.4%, respectively).

Figure 76. Percent of Adults Age 18 and Older Who Report Ever Having Been Told by a Health Professional They Have Cancer*Asthma, Coronary Heart Disease or Myocardial Infarction, or Diabetes by County, Delaware, 2023



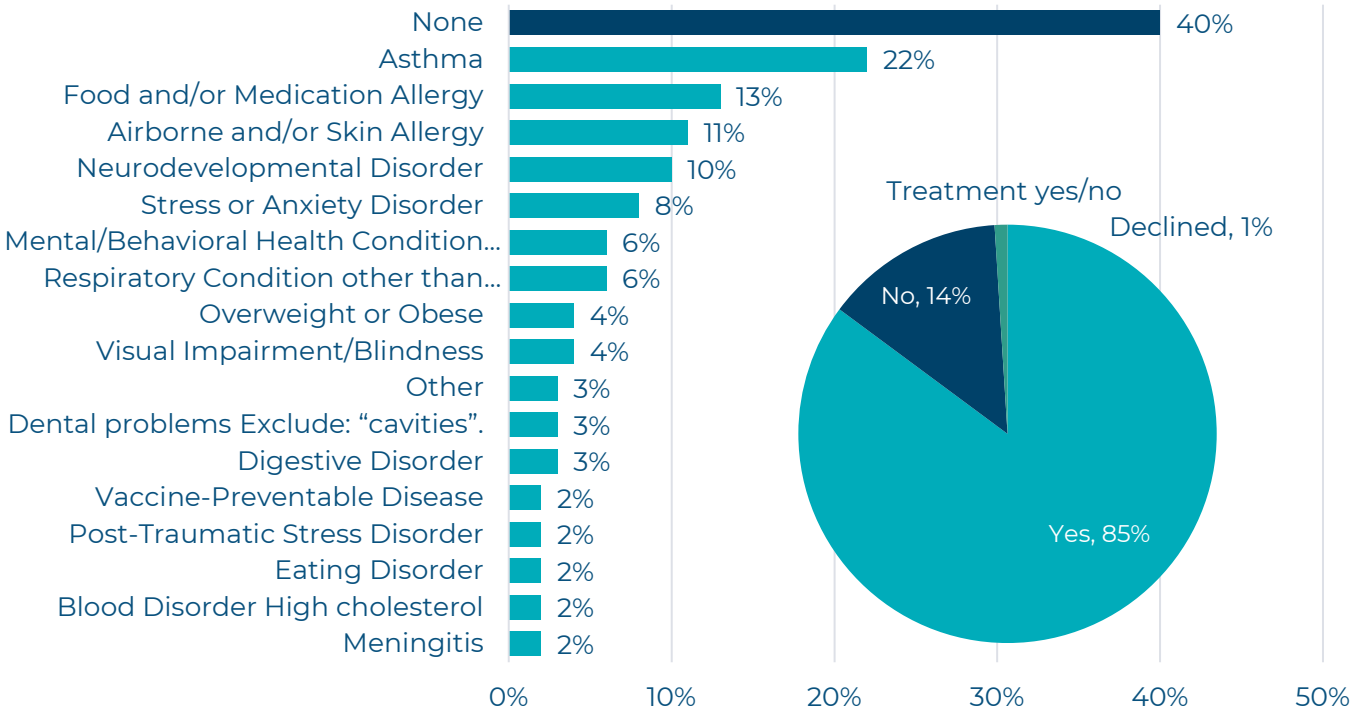
Source: BRFSS, 2023

**Cancer data includes all cancers except skin cancer.*

While adult health indicators underscore the burden of chronic conditions such as cancer, heart disease, asthma, and diabetes across Delaware counties, the outlook for children demonstrates challenges and opportunities. According to the Nemours' 2025 Community Survey, 40% of respondents report their child does not have a chronic health condition. However, of the 59% (1% refusal) that do, the most common conditions reported include asthma, food or medication allergies, airborne or skin allergies, and neuro-developmental disorders. Over 8 in 10 (86%) of children with a health condition reportedly receive/ received treatment for it. However, the 14% of children not receiving treatment for their condition highlight critical gaps in access, awareness, and resources

> *Sussex County had the highest proportion of adults with cancer other than skin cancer (10.9%), adults with coronary heart disease or myocardial infarction (9.8%), and diabetes (14.1%) when compared to the other counties Kent County had the highest percentage of adults with asthma (12.6%), followed by New Castle (9.4%), then Sussex Counties (8.9%). New Castle County had the lowest proportion of adults with cancer other than skin (7.8%), and coronary heart disease (5.3%).*

Figure 77. Percent of Children with a Health Condition (by type) and Treatment Behaviors, Delaware, 2025



Source: Nemours Community Survey, 2025

**Responses with 2% or more were included.*

Survey respondents in Delaware indicated a diagnosis of asthma (22%) more frequently than other conditions. Food and/or medication (13%) and airborne/skin allergies (11%) were each mentioned about half the time, followed by neurodevelopmental disorders at the 4th highest diagnostic category (10%). Vaccine-preventable disease, PTSD, eating disorders, high cholesterol, and meningitis were mentioned the least at 2% each.

Respiratory Conditions

Asthma is a chronic respiratory disease that causes inflammation and narrowing of the airways, leading to recurrent episodes of coughing, wheezing, chest tightness, and shortness of breath. Both genetic and environmental factors contribute to its prevalence and when environmental triggers interact with genetic susceptibility it further increases risk and severity.

Asthma is one of the most **common chronic conditions in childhood affecting nearly**

5 million

children in the U.S.[286]

Children with one parent with asthma are

3x

more likely* to develop the disease[287]

Children with both parents with asthma are

6x

more likely* to develop the disease[288]

Asthma is also triggered by factors in the environment, like:

poor housing conditions - dust mites – mold - secondhand smoke- outdoor air pollution

**Compared to children with no parental history.*

[286] *Asthma and Allergy Foundation of America (AAFA). "Asthma Facts." 2023. https://aafa.org/asthma/asthma-facts/.*

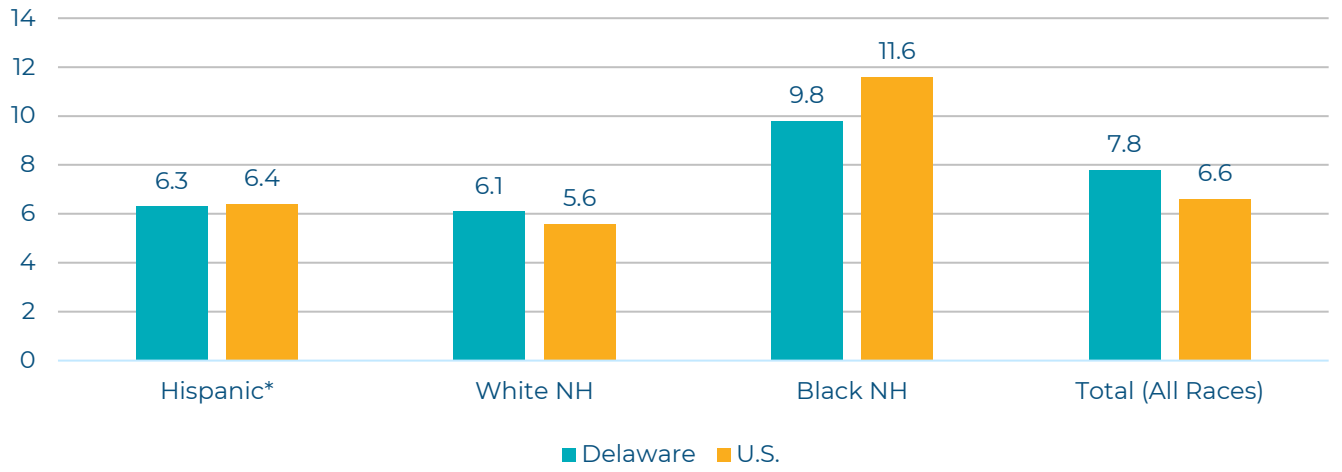
[287] *Björkstén, Bengt, et al. "Risk Factors for Childhood Asthma in a Birth Cohort Study: Family History and Environmental Exposures." The Journal of Allergy and Clinical Immunology 102, no. 6 (1998): 111–16. https://pubmed.ncbi.nlm.nih.gov/9655726/*

[288] *Yang, Huixia, et al. "Parental Asthma and the Risk of Childhood Asthma: A Family-Based Cohort Study." Frontiers in Pediatrics 9 (2021): 720273. https://doi.org/10.3389/fped.2021.720273.*

National survey data show that about **39% of children with asthma experienced at least one asthma attack in the past year**, making it a leading cause of emergency department visits, hospitalizations, and missed school days.[289]

In Delaware, childhood asthma prevalence (7.8%) is **higher than the national average** (6.6%), with notable disparities by race, ethnicity, and socioeconomic status.

Figure 78. Percent of Children (0-17) who Currently Have Asthma by Race/Ethnicity, Delaware, 2022-2023



Source: NSCH, 2022-2023

**Hispanic includes all races. NH = non-Hispanic.*

Non-Hispanic Black children experience asthma at rates 1.5x higher or more those of their White and Hispanic peers. **These inequities reflect the combined influence of environmental exposures, structural conditions such as housing and neighborhood quality, and limited access to preventive care**.

For children, the consequences of asthma extend beyond immediate breathing difficulties. Poorly controlled asthma is strongly associated with:

Chronic school absenteeism

Reduced participation in physical activity

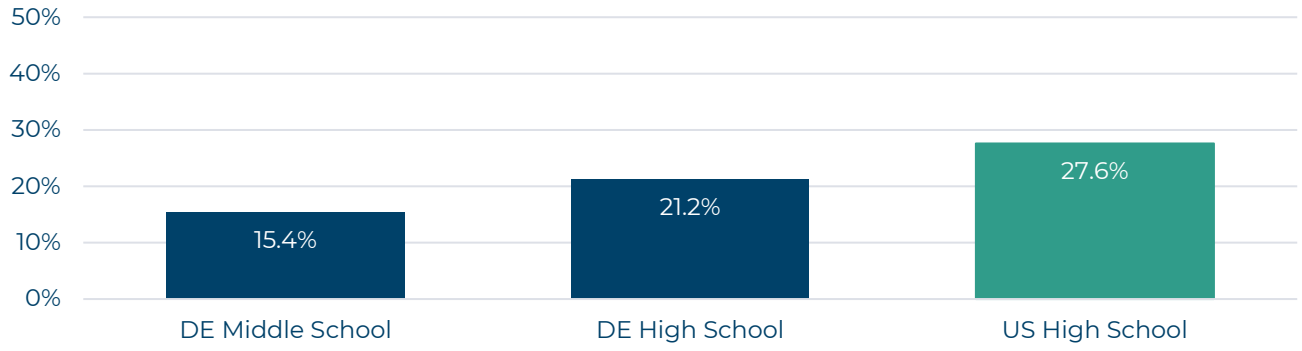
Lower quality of life

... and can lead to impaired lung development and increased vulnerability to other chronic conditions.

Asthma prevalence among adolescents is a critical measure because symptoms often intensify during periods of rapid growth, increased physical activity, and exposure to environmental triggers common in middle and high school settings. In Delaware, 15.4 percent of middle school students and 21.2 percent of high school students report having been diagnosed with asthma. High school students in Delaware have a lower prevalence of self-reported asthma compared with the U.S. overall (27.6%).

[289] *Centers for Disease Control and Prevention. "Most Recent National Asthma Data." 2023. https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm.*

Figure 79. Percent of Middle and High School Students Who Have Been Diagnosed with Asthma, Delaware, 2023



Source: CDC. Youth Risk Behavior Surveillance System, 2023

Self-reported data provide valuable insight into lived experiences but can underrepresent the true burden due to underdiagnosis, lack of medical follow-up, or disparities in healthcare access. Medication management is a particular challenge for adolescents, as proper use of inhalers and adherence to daily controller medications often decline with age, leading to preventable exacerbations and school absenteeism.[290] Understanding asthma prevalence in these age groups is essential for tailoring school-based health interventions, improving medication adherence, and reducing the long-term impact of uncontrolled asthma on academic achievement and overall quality of life.

Addressing asthma through both **medical management and environmental improvements** is essential to reducing preventable illness and advancing health equity for children in Delaware and across the United States.

The immune system is designed to protect the body, but in children with **allergies**, it can react to normal everyday exposures – like foods, medications or factors in the environment – like they are a threat. These heightened responses can lead to skin conditions like eczema, respiratory problems triggered by pollen or mold, or even life-threatening reactions to certain foods or medications. Allergies in children are shaped by a mix of inherited and environmental influences.

A child with one allergic parent is approximately **30-50%** more likely to develop allergies themselves.

The risk of developing allergies increases to **60-80%** in children with both parents affected.[291]

Early-life microbial exposures, urban air quality, dietary patterns, and household conditions such as mold, cockroach allergens, or dust mites further shape the risk of developing allergic disease.[292]

According to a 2023 data brief from the National Center of Health Statistics[293]:

* **27.2% of U.S. children had one or more selected allergic conditions**.
  - **~1 in 5 children had a seasonal allergy** (18.9%)
  - **1 in 10 had eczema** (10.8%), and
  - **1 in 20 had a food allergy** (5.8%)

[290] *Centers for Disease Control and Prevention. Most Recent National Asthma Data, 2023. https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm.*

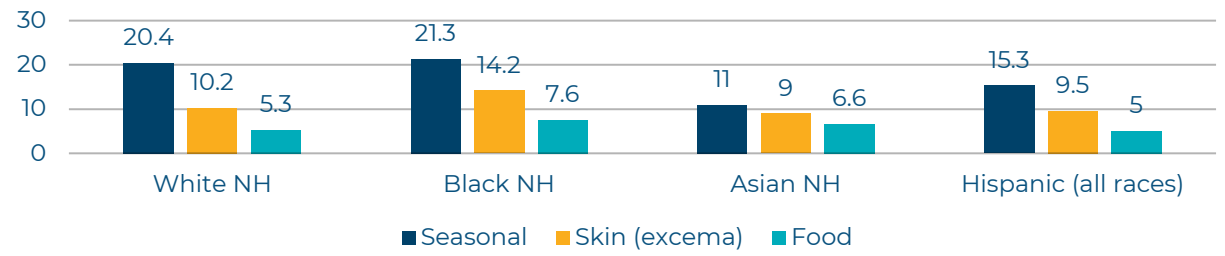
[291] *Centers for Disease Control and Prevention. Allergies and Hay Fever: Risk Factors. Last reviewed May 9, 2023. https://www.cdc.gov/nchs/fastats/allergies.htm.*

[292] *National Institutes of Health. Environmental Influences on Child Health Outcomes (ECHO) Program. Updated 2022. https://echochildren.org.*

[293] *Zablotsky B, Black LI, Akinbami LJ. Diagnosed allergic conditions in children aged 0–17 years: United States, 2021. NCHS Data Brief, no 459. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi.org/10.15620/cdc:123250*

Racial and ethnic disparities in allergic conditions are well-documented. **Non-Hispanic Black children experience seasonal, skin, and food allergies at higher rates** than children from any other racial or ethnic group.

Figure 80. Percent of Children Aged 0-17 years with a Diagnosed Allergy by Type and Race/Ethnicity, United States, 2021



Source: National Center for Health Statistics, National Health Interview Survey, 2021.

National survey data show food allergy prevalence at 7.6 percent among Black children compared to 6.6 percent among Asian children, 5.3 percent among White children, and 5% percent among Hispanic children. Black and White Non-Hispanic children experience seasonal allergies at proportions nearly 2x the rate of Asian children, and 1.5x the rate of Hispanic children. These differences are not explained by genetics alone.

Structural inequities—such as greater exposure to **environmental pollutants, higher rates of poor housing quality, and reduced access to dermatology and allergy specialists**—contribute to worsening allergic conditions among Black children.[294] Disparities in access to allergen-safe foods and inequities in diagnosis and treatment increase risk of severe reactions and poorer outcomes.

Allergic conditions in childhood illustrate how a common chronic health issue reflects broader inequities in living conditions and healthcare access. Reducing disparities requires both clinical care and upstream interventions to address the environments in which children live, learn, and grow.

Neurodevelopmental disorders (NDs) are conditions that affect brain growth and development, leading to difficulties with learning, behavior, and social interaction. Some of the most common diagnoses in childhood include **attention-deficit/hyperactivity disorder (ADHD)**, **autism spectrum disorder (ASD)**, **cerebral palsy, intellectual disability, and learning disorders**. These conditions often emerge early in life and can persist into adulthood, influencing educational achievement, employment opportunities, and long-term health outcomes. The causes of neurodevelopmental disorders are complex and multifactorial: genetics, prenatal and perinatal health, environmental exposures, and early childhood experiences all play a role.[295]

[294] *Jonathan I. Silverberg. "Disparities in Atopic Dermatitis and Allergic Disease." Journal of Allergy and Clinical Immunology 143, no. 6 (2019): 2149–2155. https://doi.org/10.1016/j.jaci.2019.03.017.*

[295] *National Institutes of Health. Child Development and Developmental Disorders. Updated 2023. https://www.nichd.nih.gov/health/topics/child-development.*

Attention-Deficit/ Hyperactivity Disorder is the most prevalent ND, affecting

9.8%

of U.S. children ages 3-17 years old.[296]

Learning Disorders and Intellectual Disabilities* are reported in approximately

8.7%

of U.S. children ages 3-17 years old. [297]

Autism Spectrum Disorder (ASD) affects an estimated

2.8%

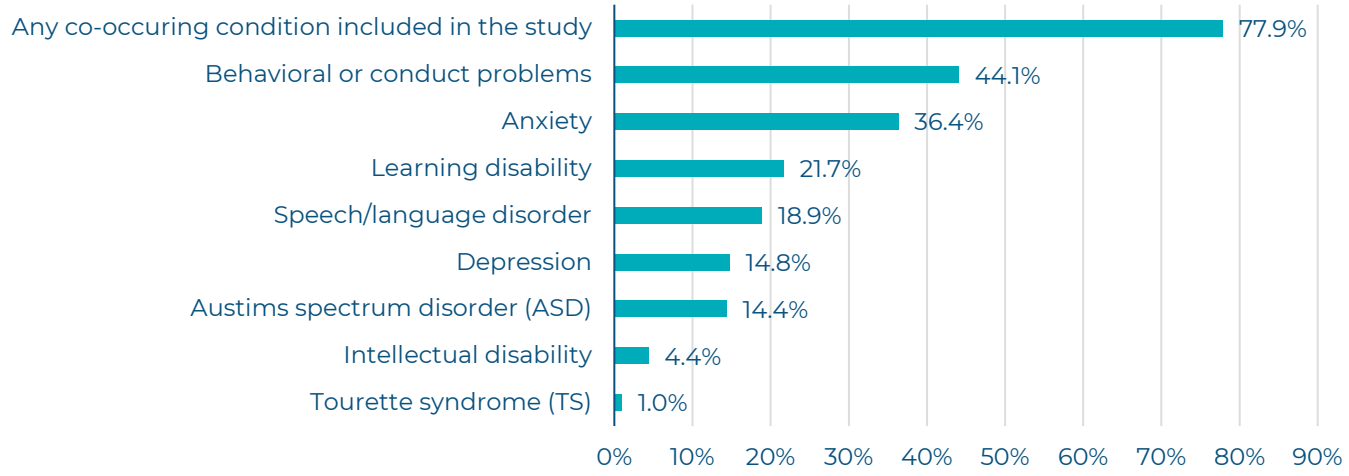
of U.S. children ages 3-17 years old. [298]

**For reporting purposes, learning disorders and intellectual disabilities were combined into a single statistic. While both involve challenges in academic or adaptive functioning, they are distinct conditions with different diagnostic criteria, causes, and long-term prognoses. Intellectual disabilities (1%) reflect global limitations in cognitive and adaptive skills, whereas learning disorders (7.7%) involve specific deficits (e.g. reading, math, writing) in the context of average intelligence. This consolidation reflects the way data are aggregated in some surveys but does not diminish the importance of addressing each condition with tailored interventions.*

These conditions often overlap with children experiencing more than one diagnosis, further complicating care and educational needs. According to a national 2022 parent survey, nearly **78% of children with ADHD** had at least **one other co-occurring condition**[299]:

- Almost half of the children with ADHD had a behavior or conduct problem.
- About 4 in 10 of the children with ADHD had anxiety.
- Other conditions affecting children with ADHD include depression, autism spectrum disorder, and Tourette syndrome.

Figure 81. Percent of Children with ADHD and a Co-occurring Condition by Condition Type, United States, 2022



Source: National Survey of Children's Health (NSCH), 2022

The clustering of disorders not only complicates diagnosis and treatment, but also intensifies the impact on school performance, peer relationships, and family stress. Children with ADHD and co-occurring conditions are more likely to require individualized education plans (IEPs), behavioral health interventions, and medication management, often spanning multiple specialist – **emphasizing the importance of integrated systems of care that bridge pediatrics, behavioral health, and education settings.** Without effective coordination, families may struggle to manage fragmented services, and children risk poorer

[296] *Centers for Disease Control and Prevention. Data and Statistics on ADHD. Last reviewed October 6, 2023. https://www.cdc.gov/adhd/data/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/data.html*

[297] *Centers for Disease Control and Prevention. Facts About Developmental Disabilities. Last reviewed April 6, 2023. https://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html.*

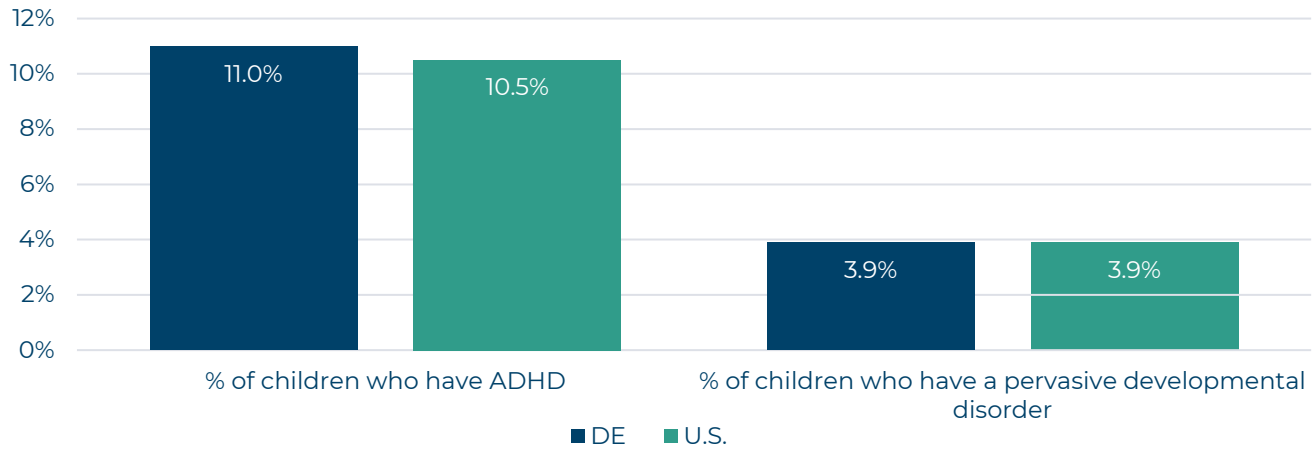
[298] *Centers for Disease Control and Prevention. Data and Statistics on ADHD. Last reviewed October 6, 2023. https://www.cdc.gov/adhd/data/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/data.html*

[299] *Danielson ML, Claussen AH, Bitsko RH, et al. ADHD Prevalence Among U.S. Children and Adolescents in 2022: Diagnosis, Severity, Co-Occurring Disorders, and Treatment. J Clin Child Adolesc Psychol. Published online May 22, 2024.*

outcomes across health, education, and social domains.

Delaware trends are consistent with the national picture. According to the National Survey of Children's Health, 11 percent of Delaware children ages 3–17 have ADHD, which is slightly lower than the national average (10.5%). The rate of children ages 3–17 with a reported pervasive developmental disorder is 3.9% in Delaware and nationwide. While lower in prevalence than ADHD, PDDs represent some of the most impactful childhood conditions due to their effects on communication, learning, and adaptive functioning. Children with PDDs often require coordinated care, specialized educational support, and early intervention services. Delays in recognition or access to treatment can significantly affect developmental trajectories.

Figure 82. Percent of Children Ages 3–17 Who have ADHD or a Pervasive Developmental Disorder*, Delaware, 2022-2023



Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health (NSCH), 2022-2023

*Pervasive developmental disorders (PDDs) are a group of conditions that involve delays or impairments in communication, social interaction, and behavior. Historically, the term encompassed several diagnoses—autism, Asperger's disorder, childhood disintegrative disorder, Rett syndrome, and pervasive developmental disorder-not otherwise specified (PDD-NOS). In 2013, these conditions were reclassified under the broader umbrella of autism spectrum disorder (ASD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Despite the terminology change, survey datasets such as the National Survey of Children's Health continue to report PDD as a category, largely reflecting autism spectrum diagnoses.

The burden of neurodevelopmental disorders underscores the importance of early screening, access to diagnostic services, and strong systems of educational and therapeutic support. **Addressing disparities in recognition and care is critical** to ensuring that all children, regardless of race, income, or geography, can reach their full developmental potential.

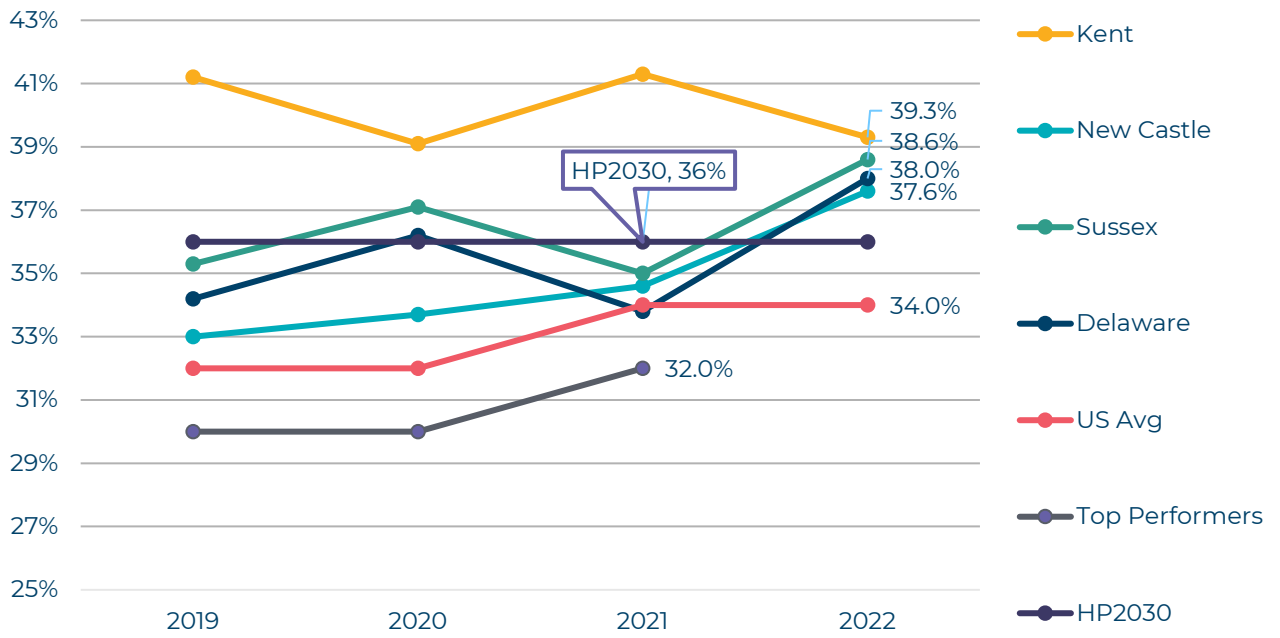
Overweight and Obesity

According to the National Institutes of Health, obesity is associated with increased morbidity and mortality. There is strong evidence that weight loss in overweight and obese individuals reduces diabetes, heart disease and high blood pressure.[300]

Nearly 4 in 10 (38%) adults (18+) in Delaware are obese, compared to 34% nationwide. Delaware does not meet the Healthy People 2030 goal to reduce the proportion of adults with obesity to 36.0%.

[300] *"Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults," National Institutes of Health, accessed August 2, 2022, https://www.nhlbi.nih.gov/files/docs/guidelines/obesity_guidelines_archive.pdf.*

Figure 83. Percent of Population (Age 18+) Who are Obese* by County, Delaware, 2019-2022



Source: CHR 2025; CDC. Behavioral Risk Factor Surveillance System (BRFSS), 2019-2022.

In adults 18 years of age and older, obese is defined as a BMI of 30.0 or higher. **BMI or Body Mass Index is calculated from self-reported height and weight using the following formular: (weight in pounds /[height in inches x height in inches]) x 703.*

Kent County had the highest proportion of adults who were obese (39.3%), followed by Sussex and New Castle counties (38.6% and 37.6%, respectively).

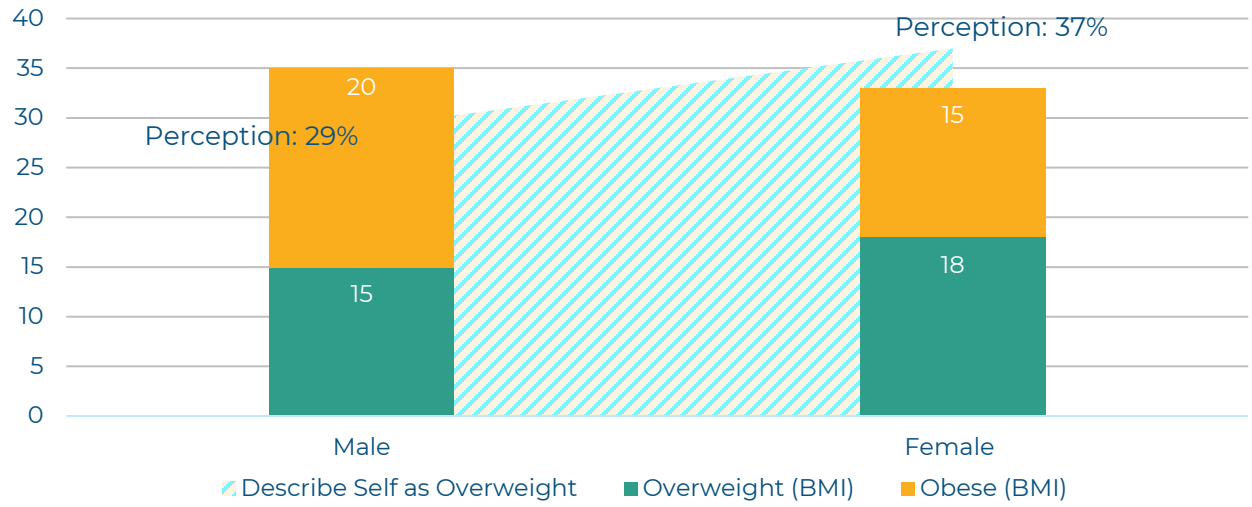
Adolescents' perceptions of their weight often differ from their actual weight status, and this mismatch has important implications for health.

Teens who **perceive themselves as overweight** – regardless of their true weight – are at a greater risk for low self-esteem, unhealthy dieting, and disordered eating behaviors. Conversely, youth who **underestimate their weight** may be less likely to adopt healthy habits or seek support for weight management.

Understanding how teens view their own bodies alongside objective measures of weight is critical for identifying risks to both physical and mental health.

In Delaware, more than one in three (37%) of teenage girls perceive themselves as overweight, compared to 29% of teenage boys, **underscoring a gender difference in self-perception**. However, BMI data show a slightly different picture: 33% of girls and 35% of boys are classified as overweight or obese. This mismatch highlights that **girls are more likely to perceive themselves as overweight than their BMI indicates**, while boys – despite a higher measured prevalence of overweight and obesity – are less likely to see themselves that way. The Healthy People 2030 goal for adolescent obesity prevalence is 15.5%, demonstrating that Delaware youth rates do not meet the national benchmark as whole – but when stratified by gender, females narrowly meet the goal at 15%, while males do not at 20% obese (BMI).

Figure 84. Percent of Teens Who Are Overweight or Obese* and Perceived Weight**, by Gender, Delaware, 2023



Source: Youth Risk Behavior Survey. Center for Drug and Health Studies. University of Delaware, 2023.

**Overweight is defined as BMI in the 85th to <95th percentile for age and sex, and Obese is defined as BMI >95th percentile for age/sex. These two categories are distinct and do not include an overlap in population.*
***This indicator is defined as teens who describe themselves as slightly/very overweight compared to teens who are overweight or obese (overweight and obese are calculated body mass index from self-reported height and weight).*

Addressing these issues requires strategies that promote **positive body image, support healthy behaviors, and account for gender differences in both perceptions and health risk**.

Healthy Living

Healthy living encompasses the daily practices that influence long-term health—such as nutrition, physical activity, hygiene, sleep, and avoidance of tobacco—but these practices are not shaped by individual choice alone. Social and economic circumstances, such as food insecurity, housing conditions, neighborhood safety, and access to recreational space or dental care, strongly determine whether people can maintain healthy routines.[301] For example, families facing food insecurity may struggle to access nutritious foods despite knowledge of their importance, while adolescents in high-stress or unsafe environments may find it difficult to prioritize sleep or physical activity.[302]

Nationally, three modifiable lifestyle factors—poor diet, physical inactivity, and tobacco use—are estimated to account for nearly one-third of all deaths in the United States.[303] Yet these behaviors are deeply influenced by structural inequities that disproportionately affect children and adolescents in under-resourced communities. Patterns of healthy living established—or disrupted—during childhood and adolescence often persist into adulthood, underscoring the importance of creating environments that enable, rather than hinder, healthy choices.[304]

[301] *Braveman, Paula, and Laura Gottlieb. "The Social Determinants of Health: It's Time to Consider the Causes of the Causes." Public Health Reports 129, no. 1_suppl (2014): 19–31. doi:10.1177/00333549141291S206.*

[302] *Gundersen, Craig, and James P. Ziliak. "Food Insecurity and Health Outcomes." Health Affairs 34, no. 11 (2015): 1830–1839. doi:10.1377/hlthaff.2015.0645.*

[303] *Mokdad, Ali H., James S. Marks, Donna F. Stroup, and Julie L. Gerberding. "Actual Causes of Death in the United States, 2000." JAMA 291, no. 10 (2004): 1238-1245. doi: 10.1001/jama.291.10.1238.*

[304] *Sawyer, Susan M., et al. "Adolescence: A Foundation for Future Health." The Lancet 379, no. 9826 (2012): 1630–1640. doi:10.1016/S0140-6736(12)60072-5.*

Nutrition

The foods children and adolescents consume set the trajectory for health and well-being across their lives. Nutrition shapes growth and brain development in early years, fuels learning and behavior in school, and lays the foundation for chronic disease risk in adulthood.[305] Diets rich in fruits, vegetables, and whole grains are linked to lower rates of obesity, diabetes, and cardiovascular disease, while regular intake of sugar-sweetened beverages and highly processed foods increases the likelihood of preventable illness.[306] Globally, poor diet is now one of the leading drivers of death and disability, responsible for an estimated 14% of all deaths each year.[307]

Nutrition at the very start of life lays a foundation for lifelong health and development. The foods and feeding practices infants and young children experience shape growth, immune resilience, and risk for chronic disease later in life.[308] Breastfeeding is widely recognized as the gold standard for infant feeding. Breast milk provides antibodies, hormones, and nutrients that help protect infants from infections and chronic conditions, while also supporting maternal health.[309] Infants who are breastfed have lower risks of respiratory illness, ear infections, sudden infant death syndrome (SIDS), and later obesity, among other outcomes.[310]

While breastfeeding offers unique health benefits, it is also critical to emphasize that "fed is best." Every family's feeding journey is different, and barriers such as medical complications, return-to-work timelines, structural inequities, and mental health needs can make exclusive breastfeeding unattainable. Formula and other supplemental feeding options provide safe and reliable nutrition that supports healthy growth, ensuring that all infants—regardless of feeding method—can thrive when given adequate nutrition.[311] Recognizing this nuance is essential in pediatric and community health contexts, where **equitable support means meeting families where they are**.

In Delaware, most families initiate breastfeeding, but continuation is more challenging. As shown in Figure 82, 80.2% of infants born in 2022 were (ever) breastfed, compared to 85.7% nationally. However, only 24% of Delaware infants were still breastfed at 12 months, far below the U.S. average of 40.8%.[312] This indicates that while many families start out breastfeeding, far fewer can sustain it through the first year of life, which can decrease benefits associated with longer duration. [313]

[305] *U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS). Dietary Guidelines for Americans, 2020–2025. 9th ed. December 2020. https://www.dietaryguidelines.gov.*

[306] *World Health Organization (WHO). "Healthy Diet." 2023. https://www.who.int/news-room/fact-sheets/detail/healthy-diet.*

[307] *Afshin, Ashkan, et al. "Health Effects of Dietary Risks in 195 Countries, 1990–2017: A Systematic Analysis." The Lancet 393, no. 10184 (2019): 1958–1972. doi:10.1016/S0140-6736(19)30041-8.*

[308] *U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS). Dietary Guidelines for Americans, 2020–2025. 9th ed. December 2020. https://www.dietaryguidelines.gov*

[309] *CDC. "National Immunization Survey–Child (NIS-Child): 2023 and 2024 Data Among Children Born in 2022." Centers for Disease Control and Prevention. Accessed September 2025. https://www.cdc.gov/breastfeeding/data/nis_data/index.htm*

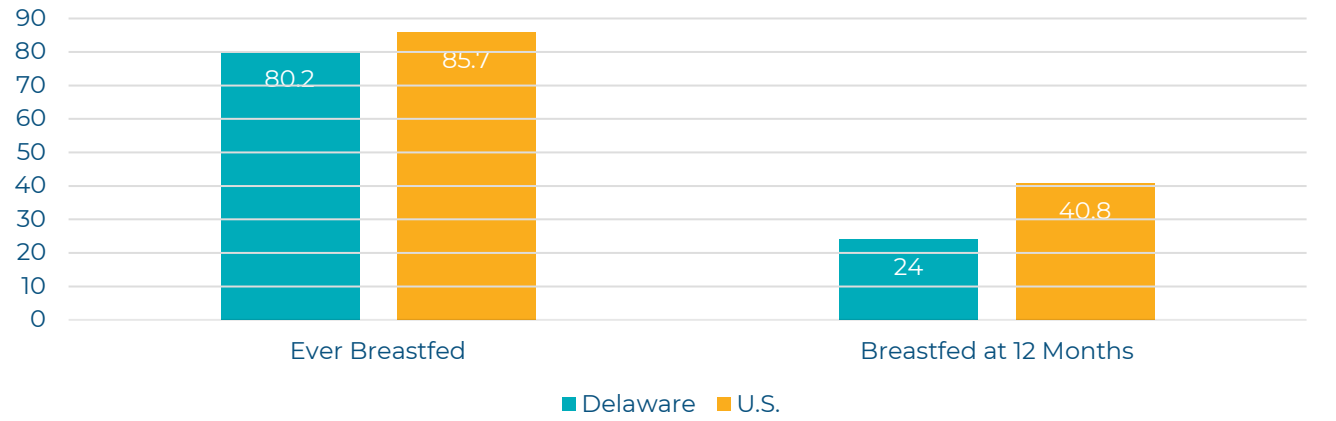
[310] *Kramer, Michael S., and Ruth A. Kakuma. "Optimal Duration of Exclusive Breastfeeding." Cochrane Database of Systematic Reviews 2012, no. 8 (2012): CD003517. https://doi.org/10.1002/14651858.CD003517.pub2*

[311] *Brown, Amy, and Natalie Shenker. "Infant Feeding and Health Inequalities." Journal of Health Visiting 6, no. 9 (2018): 446–52. https://doi.org/10.12968/johv.2018.6.9.446*

[312] *CDC. "National Immunization Survey–Child (NIS-Child): 2023 and 2024 Data Among Children Born in 2022." Centers for Disease Control and Prevention. Accessed September 2025. https://www.cdc.gov/breastfeeding/data/nis_data/index.htm*

[313] *Centers for Disease Control and Prevention. Early Childhood Nutrition Report 2025. Atlanta, Georgia. 2025*

Figure 85. Percent of Infants that Are Breastfed by Incidence and Duration, Delaware, 2022



Source: CDC National Immunization Survey – Child (NIS-Child) 2023 and 2024, among children born in 2022.

Supports for infant feeding—such as maternity care practices, early care and education (ECE) policies, and paid family leave—play a vital role in helping families achieve their goals. CDC's Maternity Practices in Infant Nutrition and Care (mPINC) survey highlights that Delaware scored 93 out of 100 in 2024, reflecting strong maternity care practices, but Florida (85) and nationally (82) demonstrate greater room for improvement. State ECE licensing standards also matter: while Delaware fully meets standards for encouraging breastfeeding in center-based care, not all states, including Florida, achieve this level of support. Similarly, access to paid family and medical leave gives parents time to establish feeding routines and bond with infants, but Delaware—like many states—still has gaps in ensuring comprehensive coverage.[314]

Location	Total mPINC Score, 2024 (out of 100)[a, 315]	Weeks of Paid Family/ Medical Leave for Care of New Child, 2025[b,316, 317]	*Encourage and Support Breastfeeding*: State Center-Based ECE Licensing Standard, 2023[c,318]
Delaware	93	12 weeks*	Fully met
Florida	85	7 weeks**	Partially met
Nationwide	82	-	-

[a]Possible mPINC scores are 0 to 100, with higher scores indicating better maternity care practices and policies. [b]*Among states with enacted legislation, the number of weeks presented are those that can be claimed by eligible employees for the care of a new child by birth, adoption, or foster care. Weeks may also be used for other family and medical leave events as specified by the state (e.g., a serious health condition of a qualified family member); in some states, additional weeks of benefits may be available for other needs. Employees must meet eligibility requirements to claim benefits; requirements vary across state programs. Voluntary paid family and medical leave programs in New Hampshire and Vermont are not included.* [c]States can include high-impact obesity prevention standards in their ECE licensing and administrative regulations. Family child care homes are not included. This indicator reports whether states fully met, partially met, did not address, or contradicted, the standard Encourage and Support Breastfeeding: Encourage and support breastfeeding and feeding of breast milk by making arrangements for mothers to feed their children on-site.

**State has enacted legislation to create a paid family and medical leave insurance program, but the program is not currently paying benefits. Paid leave benefits for eligible employees in Delaware, Maine, Maryland, and Minnesota will be available in 2026. **Florida law does not require private employers to provide paid family leave. However, September 2023 the Florida Governor expanded maternal/family leave for eligible state employees: 7 weeks paid maternity leave and 2 weeks paid parental leave.*

[314] *CDC. Maternity Practices in Infant Nutrition and Care (mPINC) Survey, 2024. Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/breastfeeding/data/mpinc/index.htm*

[315] *Maternity Practices in Infant Nutrition and Care (mPINC) Survey, 2024. https://www.cdc.gov/breastfeeding-data/mpinc/index.html*

[316] *Congressional Research Service Report: Paid Family and Medical Leave in the United States as of March 26, 2025. (Donovan, SA). Paid Family and Medical Leave in the United States (CRS Report No. R44835). https://www.congress.gov/crs_external_products/R/PDF/R44835/R44835.30.pdf*

[317] *Executive Office of Governor Ron DeSantis. (2023, September 18).* Governor Ron DeSantis expands maternity and family leave for state employees. *https://www.flgov.com*

[318] *University of Colorado College of Nursing. 2023 Supplement: Achieving a State of Healthy Weight. State Profile Pages: Child Care Centers. University of Colorado Anschutz Medical Campus; 2024 https://nursing.cuanschutz.edu/research/healthy-weight*

These patterns across data demonstrate how infant nutrition is deeply connected to systems of care. While biological advantages of breastfeeding are well established, ensuring that all children receive safe and adequate nutrition requires community-wide commitment:

- Supportive hospital policies
- Equitable workplace protections
- Culturally responsive education
- Recognition that nourishing infants—by breast, bottle, or both

Once children transition to solid foods, their eating habits begin to set the trajectory for health throughout adolescence and into adulthood. The 2020–2025 Dietary Guidelines for Americans provide age-specific targets: toddlers need about 1 cup total of each per day, elementary-aged children 1–1½ cups fruit and 2 cups vegetables, and teens up to 2 cups fruit and 3–4 cups vegetables daily. Meeting these targets helps prevent chronic disease, supports healthy growth, and contributes to cognitive and academic outcomes.

Children and adolescents are encouraged to eat about **5 servings of fruits and vegetables daily**, which translates to roughly 2 cups of fruit and 2½–3 cups of vegetables depending on age and sex.[319],[320]

The 2020–2025 **Dietary Guidelines for Americans** provide age-specific targets (**daily**) [321]:

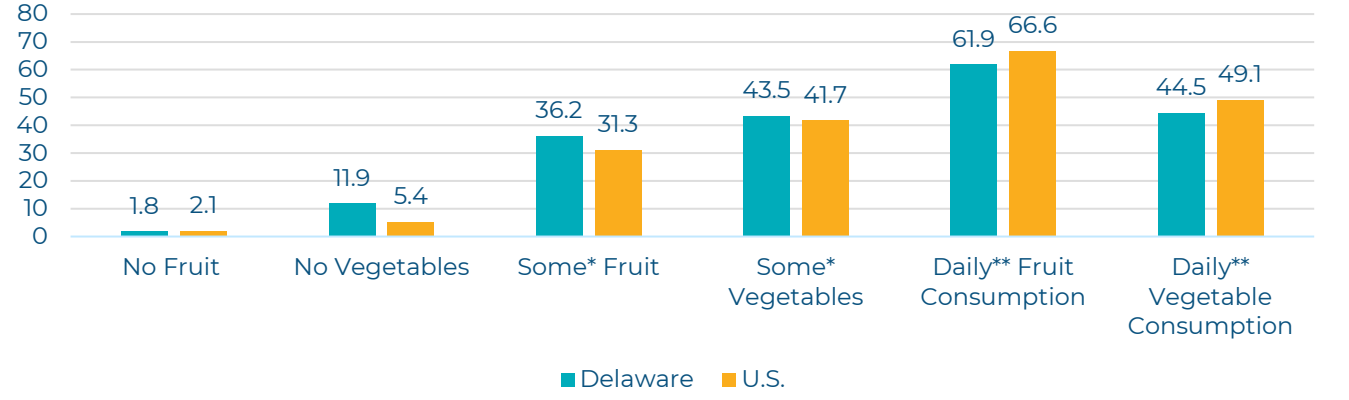
Toddlers
~1 cup of fruit
~1 cup of veggies

Elementary age
1-1½ cups fruit
2 cups veggies

Teens
up to **2 cups** fruit
3–4 cups veggies

In practice, however, most children and adolescents fall far short of these recommendations. Nationally, fewer than one in ten adolescents consume the recommended five daily servings of fruits and vegetables[322] In Delaware, 61.9% of children ages 1–5 consumed fruit daily, fewer than half (44.5%) consumed vegetables daily, rates similar to U.S. averages (66.6% fruit; 49.1% vegetables).[323]

Figure 86. Percent of Children Ages 1-5 Who Consumed a Fruit or Vegetable in the Past Week by Frequency and Race/Ethnicity, Delaware, 2022-2023



[319] *CDC. "Fruit and Vegetable Intake Among Children and Adolescents." 2022.*

[320] *USDA & HHS. Dietary Guidelines for Americans, 2020–2025. 9th ed.*

[321] *USDA. "MyPlate Fruit and Vegetable Group Recommendations."*

[322] *CDC. Adolescent Fruit and Vegetable Consumption. National Center for Chronic Disease Prevention and Health Promotion, 2023. https://www.cdc.gov/healthyyouth/data/yrbs/national-and-state-surveys.htm*

[323] *National Survey of Children's Health (NSCH), 2022–2023. Health Resources and Services Administration (HRSA) & Child and Adolescent Health Bureau. https://www.childhealthdata.org*

	Hispanic (%)	White, NH (%)	Black, NH (%)	Asian, NH (%)	Other, NH (%)
No fruits	DE: 0	DE: 1.9	**DE: 3.9**	DE: 1.9	DE: 0
	U.S.: 2.3	U.S.: 1.8	**U.S.: 2.9**	U.S.: 1.0	U.S.: 1.3
No vegetables	**DE: 20.5**	DE: 7.3	DE: 15.5	DE: 6.2	DE: 4.8
	U.S.: 6.5	U.S.: 4.6	**U.S. 6.8**	U.S. 4.0	U.S.: 4.8
Some fruit	DE: 43.5	DE: 24.7	**DE: 53.5**	DE: 29.5	DE: 25.7
	U.S.: 33.9	U.S.: 26.7	**U.S.: 46.6**	U.S.: 33.5	U.S.: 28.3
Some vegetables	DE: 40.5	DE: 38.4	**DE: 54.8**	DE: 36.9	DE: 43.3
	U.S.: 48.8	U.S.: 42.5	**U.S.: 53.6**	U.S.: 42.6	U.S.: 43.2
Daily fruit consumption	DE: 51.9	DE: 73.4	**DE: 42.6**	DE: 68.6	**DE: 74.3**
	U.S.: 63.7	**U.S.: 71.5**	**U.S.: 50.5**	U.S.: 64.4	U.S.: 70.3
Daily vegetable consumption	DE: 39.1	DE: 54.3	**DE: 29.7**	**DE: 57.0**	DE: 51.8
	U.S.: 44.7	**U.S.: 52.9**	**U.S.: 39.6**	**U.S.: 52.9**	U.S.: 52.1

Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau., 2022-2023

**"Some" fruit/vegetables is defined as reported intake of 1-6 times in the last week. The NSCH categories "1-3 times" and "4-6 times" were condensed into one with includes all intake less than 7 (1-6 times) when daily intake could not be reasonably assumed. **"Daily" fruit/vegetable consumption is defined as reported daily intake of fruits/vegetables at least once daily. The NSCH categories "1 time per day", "2 times per day", and "3 or more times per day" were condensed into one overall daily intake category.*

Nutritional disparities are significant across racial and ethnic groups:

In Delaware, ***only 29.7% of Black non-Hispanic children in ate vegetables daily, compared to over half (54.3%) of White non-Hispanic peers***.[324]

The proportion of children consuming no fruit or vegetables at all in the past week—though small overall—was significantly higher among Black and Hispanic children than other groups, underscoring inequities in food access and dietary quality.[325]

Sugary drink consumption compounds these concerns. Nationally, six in ten adolescents report drinking at least one sugar-sweetened beverage daily.[326]

In Delaware, ***children under age 5 who are Black non-Hispanic were nearly twice as likely as White peers to consume three or more sugary drinks per day.***

These products contribute substantially to added sugar intake and displacement of healthier beverages like water and milk.

Patterns of broader diet quality also reveal challenges. While fruit and vegetable intake is a critical marker of diet quality, a comprehensive look at children's eating patterns requires examining the full range of food groups. Data from the Nemours Community Survey (2025) highlight, both, strengths and areas of concern across major dietary categories.

- Approximately 41% of children ate fresh fruit daily, and 34% ate fresh vegetables daily, with another third eating these foods 5–6 days per week.
- Half of children reported eating protein-rich foods every day, and 31% consumed whole grains daily.

These findings suggest a substantial proportion of children are receiving the building blocks needed for growth and development, including fiber, vitamins, minerals, and protein.

- More than one in four children ate sugary snacks or desserts every day, and another 48% consumed them at least 3–6 days per week.

[324] *National Survey of Children's Health (NSCH), 2022–2023. Health Resources and Services Administration (HRSA) & Child and Adolescent Health Bureau. https://www.childhealthdata.org*

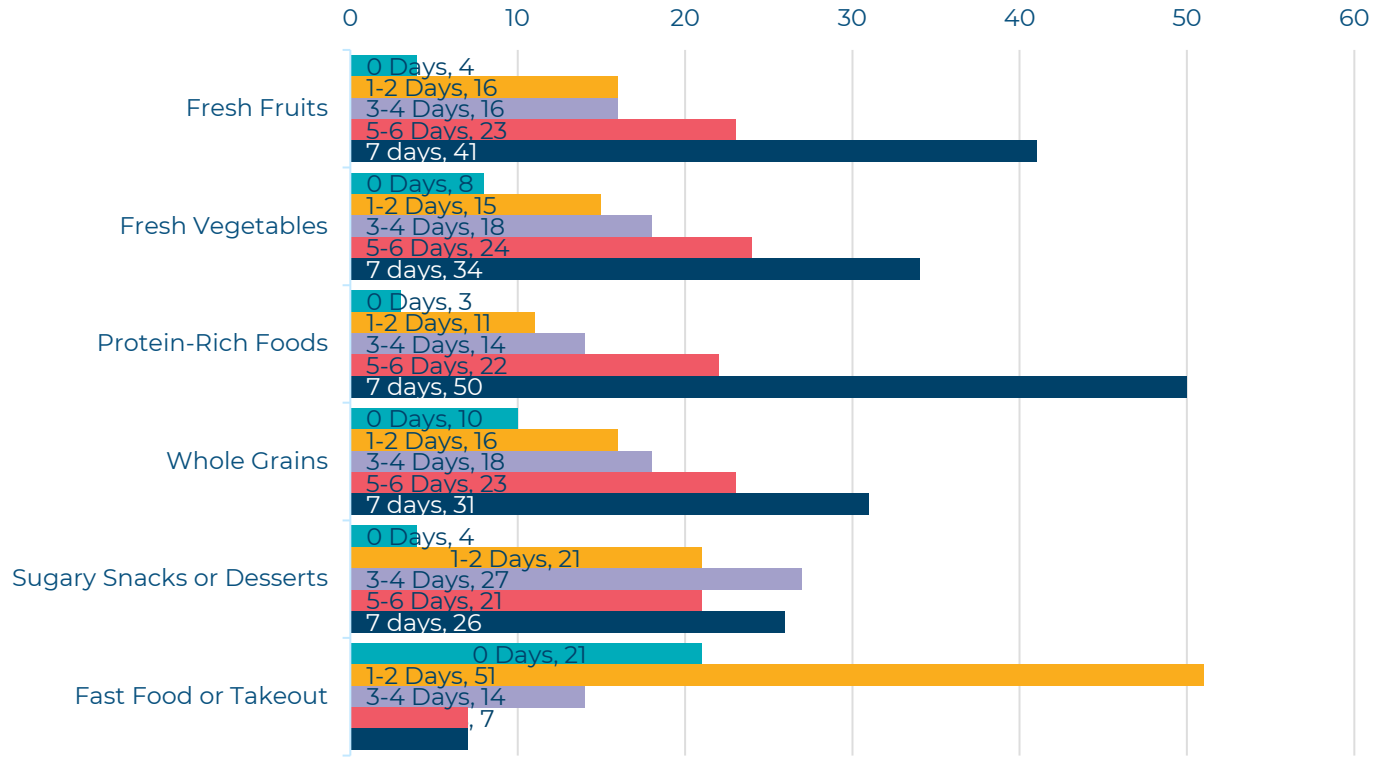
[325] *National Survey of Children's Health (NSCH), 2022–2023. Health Resources and Services Administration (HRSA) & Child and Adolescent Health Bureau. https://www.childhealthdata.org*

[326] *CDC. Adolescent Fruit and Vegetable Consumption. National Center for Chronic Disease Prevention and Health Promotion, 2023. https://www.cdc.gov/healthyyouth/data/yrbs/national-and-state-surveys.htm*

- While only 7% reported eating fast food daily, more than half (51%) ate fast food one to two days per week.

These data reflect national evidence that diets high in added sugars, sodium, and saturated fats contribute disproportionately to childhood obesity, type 2 diabetes, and cardiovascular risk later in life.[327]

Figure 87. Percent of Proxy-Reported Weekly Food Consumption in Children (<18) by Food Group and Number of Days, Delaware, 2025



Source: Nemours Community Survey, 2025

Self- or proxy-reported survey data can introduce recall bias or social desirability bias meaning respondents overestimate "healthy" foods or underreport "unhealthy" foods. Even so, proxy surveys provide valuable insights when combined with national surveillance systems like NHANES or YRBS, because they ground the numbers in local context and highlight both alignment with national trends and unique state and community-level challenges. When examining the Nemours community survey data below the county level, geographic variability offers key insights into the specific challenges behind the outcomes:

- Survey respondents in the **Remainder of Kent County** reported their child had **0 fresh fruits and 0 vegetables at more than twice the rate of any other region** (11% and 16%, respectively).
- 1 in 4 children in **Wilmington City**, and 1 in 3 children in the **Remainder of Kent and Sussex** counties **ate sugary snacks or desserts every day in the week** prior to the survey.
- Most respondents reported **eating takeout or fast food** 1-2 days a week. However, the Remainder of Kent County cited "0" days most often, while the majority of residents in Dover and the Surrounding Area reported eating fast food and takeout on **all 7 days of the prior week**– highlighting community-level conditions that county or state averages can mask.

Diet quality consistently worsens as children get older. While more than 90% of young children ages 2–5 eat fruit daily, this declines to just 64% in teens. These declines are mirrored in vegetable intake and in the

[327] *Feeding America. Map the Meal Gap. 2023. https://map.feedingamerica.org/*

tendency for older youth to consume more processed and energy-dense foods. Skipping breakfast becomes common in adolescence, with three in four middle and high school students not eating breakfast daily—an important concern given links between breakfast and both academic outcomes and metabolic health. Fast food and "empty calories" also dominate youth diets. Nationally, nearly 40% of calories for children ages 2–19 come from added sugars and solid fats, with fast food contributing 8.5% of calories per day for younger children and 14.6% for teens.

Dietary Characteristics of Children, Teens, and Adolescents in the United States

Diet quality tends to decline with age.[328,329]

Who eats fruit daily?

>90% of young kids (2-5)
80.6% of adolescents (6-11)
~64% of teens (12-19) [333]

Skipping breakfast is common.

3 in 4 middle and high school students do not eat breakfast daily. [335]

Males tend to have lower diet quality than females.

Boys eat fewer fruits and vegetables and more sugar than girls on average.[337]

Sugary beverages and sports drinks start early.

~15% of teens and adolescents (ages 6-17) drink **soda** and **~11%** drink **sports drinks** daily. [330]

vs.

Water intake is inadequate.

44.2% of high school students drank **less than 3 glasses** of plain water daily.[331]

Fast food and empty calories dominate.

~40% of daily calories (ages 2-19) are from **added sugars and solid fats.**[332]

Ages 2-11:
8.5% of calories/day come from **fast food.**

Ages 12-19:
14.6% of calories/day come from **fast food.** [334]

Fruit and vegetable intake is low. About **half** of teens eat fruit or vegetables less than once/day.[336]

Nutrition impacts academic performance.

Students who ate breakfast every morning, and included fruit and vegetables in their daily diet were more likely to get A's. [338]

Black high school students report lower fruit, vegetable, and water intake than peers from other racial/ethnic groups.[339]

School-based interventions show promise.

School programs that improve cafeteria offerings alongside nutrition education saw increases in fruit and vegetable intake among students. [340]

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[328] *da Costa, L. C., Silva, L. B., & Fisberg, R. M. (2024). Longitudinal changes in diet quality from childhood to adolescence. Appetite, 196, 107633. https://doi.org/10.1016/j.appet.2024.107633*
[329] *Uzhova, I., Buck, C., & Hebestreit, A. (2023). Assessment of diet quality in children and adolescents: A review of methodological aspects. Nutrients, 15(13), 2921. https://doi.org/10.3390/nu15132921*
[330] *CDC. "Youth Risk Behavior Survey—United States, 2019." MMWR Surveillance Summary 69(1): 1–83. https://www.cdc.gov/mmwr/volumes/69/su/su6901a8.htm*
Centers for Disease Control and Prevention. (2023). Youth Risk Behavior Survey data summary & trends report: 2011–2021. U.S. Department of Health and Human Services. https://www.cdc.gov/mmwr/volumes/72/su/pdfs/su7201a9-h.pdf
332 CDC. "Facts about Child Nutrition." Centers for Disease Control and Prevention, 2022. https://www.cdc.gov/school-nutrition/facts/index.html
[333] *CDC. "Youth Risk Behavior Survey—United States, 2019." MMWR Surveillance Summary 69(1): 1–83. https://www.cdc.gov/mmwr/volumes/69/su/su6901a8.htm*
[334] *Fryar, Cheryl D., et al. "Fast Food Consumption Among Children and Adolescents in the United States, 2015–2018." NCHS Data Brief No. 375. https://www.cdc.gov/nchs/products/databriefs/db375.htm*
[335] *CDC. "Youth Risk Behavior Survey—United States, 2019." MMWR Surveillance Summary 69(1): 1–83. https://www.cdc.gov/mmwr/volumes/69/su/su6901a8.htm*
[336] *Centers for Disease Control and Prevention. (2023). Youth Risk Behavior Survey data summary & trends report: 2011-2021. U.S. Department of Health and Human Services. https://www.cdc.gov/mmwr/volumes/72/su/su7201a9.htm*
[337] *Scaglioni, Silvia, et al. "Factors Influencing Children's Eating Behaviours." Nutrients 10, no. 6 (2018): 706. https://doi.org/10.3390/nu10060706*
[338] *CDC. "Healthy Students Are Better Learners: Diet and Academic Performance." 2019. https://www.cdc.gov/healthy-schools/health-academics/diet-grades.html*
[339] *CDC. "Youth Risk Behavior Survey – United States, 2019." MMWR Surveillance Summary 69, no. 1 (2020): 1–83. https://www.cdc.gov/mmwr/volumes/69/su/su6901a8.htm*
[340] *Micha, Renata, et al. "School Food Policy and Childhood Obesity: A Systematic Review." American Journal of Clinical Nutrition 103, no. 2 (2016): 505–522. https://doi.org/10.3945/ajcn.115.112904*

Sports drinks are often overlooked as a type of sugary beverage that threatens child nutrition.

Sports drinks are widely marketed as performance-enhancing or hydrating options for youth, but many contribute to **large amounts of added sugar**, **unnecessary calories**, and **acids that damage teeth**, while offering **little nutritional benefit** outside of high-intensity athletic activity.[341] Research shows that overconsumption of sugar-sweetened beverages—including sports drinks—drives risk for obesity, type 2 diabetes, and cardiovascular disease across the lifespan.[342] Yet **policies to limit or discourage sports drink consumption lag behind those targeting soda,** signaling an area for stronger pediatric and community intervention.

The consequences of poor diet quality extend beyond physical health. Students who eat breakfast consistently and incorporate fruits and vegetables into their daily meals are significantly more likely to earn mostly A's in school, highlighting the role of nutrition in shaping academic success as well the unique opportunity educational institutions have to influence long-term trajectories.

Improvements in cafeteria offerings to increase nutritional value of meals.[343]	Establishing school garden or "living labs" so students can engage directly in the process.[344]	Incorporating nutrition education into the core curriculum to promote food literacy, etc.[345]	Enact policies that limit availability of sugary drinks and expand free meals in schools.[346]

Programs that combine improvements to create healthier food environments in the places where children learn and play remain critical levers for improving nutrition in Delaware's youth.

Together, these findings underscore that pediatric nutrition cannot be assessed only by fruit and vegetable consumption. A balanced perspective requires attention to the overall dietary pattern: whether children are eating enough whole grains, protein-rich foods, and fresh produce, while limiting intake of processed snacks, sugary drinks, and fast food. These behaviors are shaped not just by individual choice but by broader community conditions — such as **access to affordable groceries, availability of healthy options in schools and childcare, and marketing of unhealthy foods to children**. Addressing these upstream factors is central to improving nutrition equity across Delaware and beyond.

In Delaware, food insecurity affected between 9.7% and 11.8% of the population between 2019 and 2022, with important county-level differences. These numbers do not meet the Healthy People 2030 target of eliminating food insecurity (0%). Families with children are disproportionately represented within these statistics, underscoring the link between stable access to healthy food and pediatric well-being.

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[341] *American Academy of Pediatrics Committee on Nutrition and Council on Sports Medicine and Fitness. "Sports Drinks and Energy Drinks for Children and Adolescents: Are They Appropriate?" Pediatrics 127, no. 6 (2011): 1182–1189. https://doi.org/10.1542/peds.2011-0965*

[342] *Malik, Vasanti S., et al. "Sugar-Sweetened Beverages and Risk of Metabolic Syndrome and Type 2 Diabetes." Diabetes Care 33, no. 11 (2010): 2477–2483. https://doi.org/10.2337/dc10-1079*

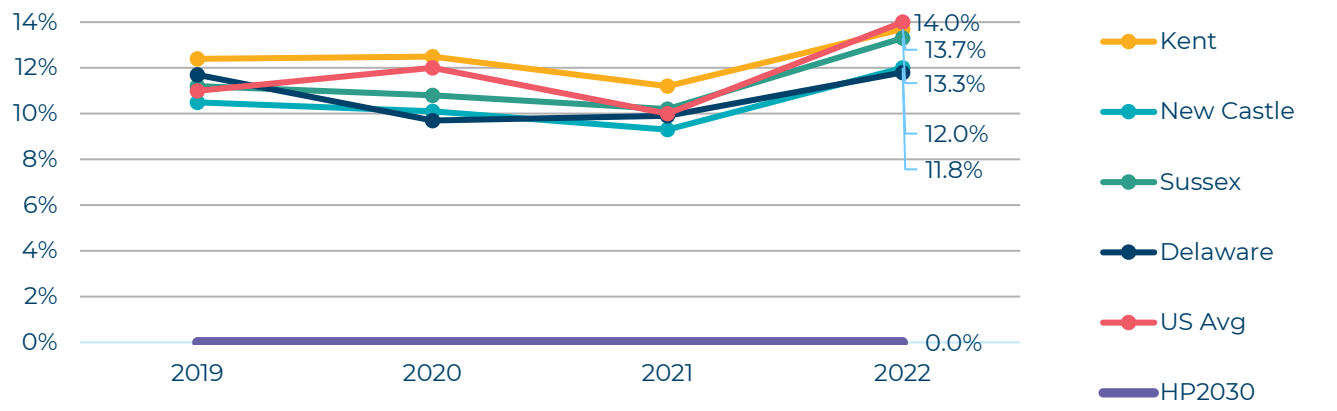
[343] *Juliana F. W. Cohen, Scott Richardson, and Eric B. Rimm, "Impact of the New U.S. Department of Agriculture School Meal Standards on Food Selection, Consumption, and Waste," American Journal of Preventive Medicine 46, no. 4 (2014): 388–394, https://doi.org/10.1016/j.amepre.2013.11.013.*

[344] *Lucy C. Barnard, Carolyn N. Trapl, and Meredith A. Jones, "The Impact of School Garden Programs on Children's Dietary Behaviors: A Systematic Review," Preventive Medicine Reports 31 (2023): 102110, https://doi.org/10.1016/j.pmedr.2023.102110.*

[345] *Karen Lock et al., "School Nutrition Education Programmes: An Evidence-Based Review," Public Health Nutrition 8, no. 6 (2005): 729–739, https://doi.org/10.1079/PHN2005727.*

[346] *Erin R. Hennessy, Rebekka M. Lee, and Christina D. Economos, "Changes in School Food and Beverage Environments after Implementation of National School Lunch Program Standards: Findings from a Nationwide Sample," Journal of the Academy of Nutrition and Dietetics 118, no. 7 (2018): 1151–1159, https://doi.org/10.1016/j.jand.2017.12.010.*

Figure 88. Percent of the Population Who Lack Access to Healthy Foods or Food Insecure* by County, Delaware, 2019-2022



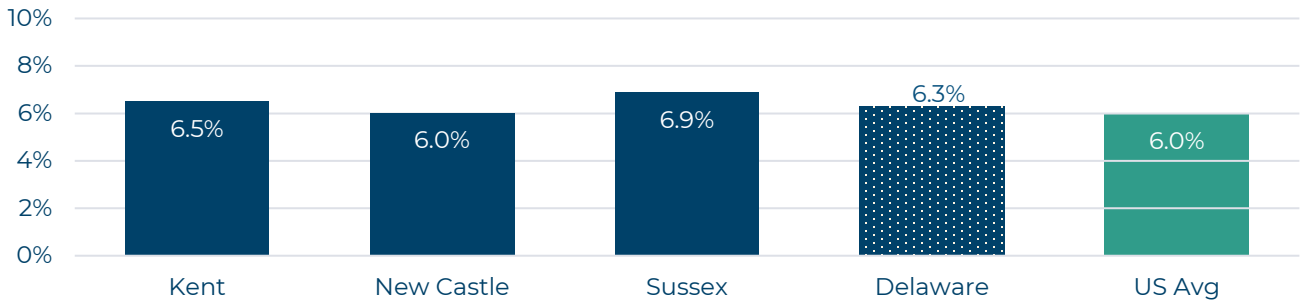
Source: Feeding America, Map the Meal Gap, 2019-2022

**The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways.*

In 2022, Kent County had the highest rate of food insecurity at 13.7%, followed by Sussex (13.3%) and New Castle counties (12.0%).

Food insecurity is rarely the result of a single barrier. Instead, it reflects an intersection of structural factors that constrain families' ability to reliably access healthy foods. Delaware data illustrate how geography, affordability, and income stability shape household food environments. In 2019, about 6.5% of residents in Kent County, 6.9% in Sussex, and 6.0% in New Castle were both low-income and living far from a supermarket or large grocery store—defined as more than one mile in urban areas or ten miles in rural areas. Statewide, 6.3% of Delaware's population faced this dual barrier, a rate higher than the U.S. average (6.0%).

Figure 89. Percent of the Population Who are Low-Income and Do Not Live Close to a Grocery Store* by County, Delaware 2019.



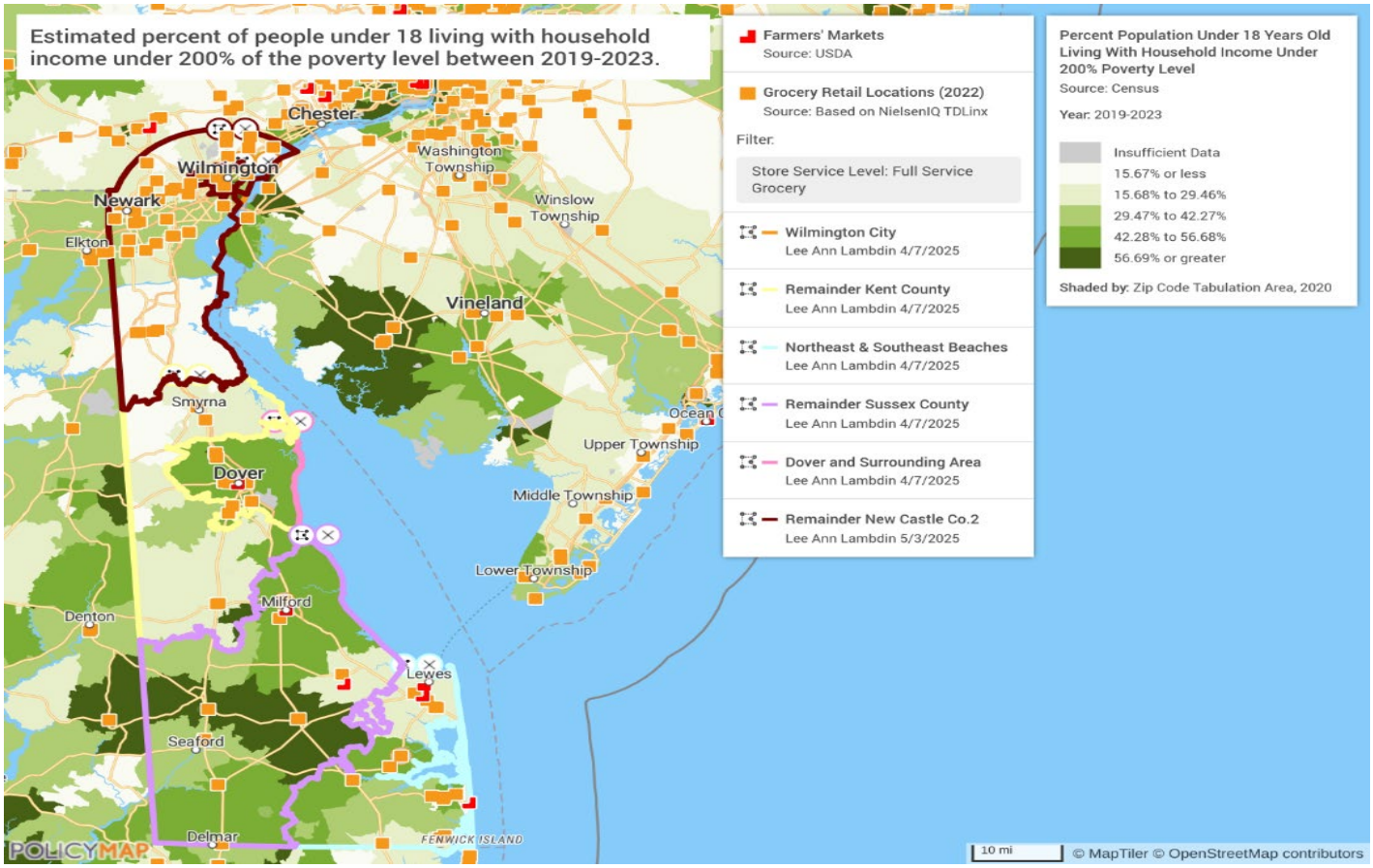
Source: CHR; USDA Food Environment Atlas, 2019

**Percentage of individuals living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area. Low income is 200% of poverty line.*

Income and geography overlap in important ways. Sussex County's higher share reflects how rural geography compounds access issues, while urban areas can also experience "food deserts" when stores are limited or when healthier items are priced out of reach.

Census data from 2019–2023 show that higher concentrations of **children living in households under 200% of the federal poverty level are often the same areas with fewer supermarkets or farmer's markets**.[347]

Figure 90. Percent of People Under 18 Living in Low Income Households and Access to Grocery Stores and Farmers Markets, by Census Tract, Delaware, 2019-2023



Source: Census Bureau, 2019-2023 and Nielsen IQ, 2022

**Points displayed on PolicyMap include the following store types from that database: supermarkets, supercenters, limited assortment stores, natural food stores and grocery warehouses. As part of their Limited Supermarket Access analysis, Reinvestment Fund defines a store service level – Full Service or Non-Full Service. Full-Service grocery stores include Supercenters and Conventional Supermarkets. Non-Full Service grocery stores include Limited Assortment Supermarkets, Natural/Gourmet Food Stores and Grocery Warehouses.*

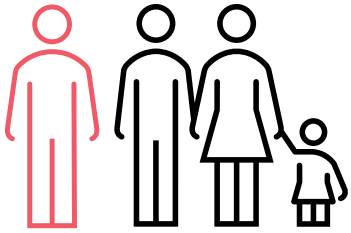
These overlapping patterns suggest that economic vulnerability and geographic isolation compound food access challenges, particularly for children. Areas with higher poverty rates often lack the infrastructure, transportation, and retail density needed to support consistent access to healthy, affordable food. This reinforces the need for **place-based interventions**—such as:

- Mobile markets
- Produce prescription programs
- School-based nutrition supports
- Transportation solutions for grocery access

Food insecurity directly shapes diet quality. Families experiencing these barriers often turn to cheaper, energy-dense foods that are widely available but poor in nutritional value. Over time, this deepens the same diet-related risks—obesity, diabetes, and other chronic conditions—that already appear in childhood nutrition data.

[347] *U.S. Census Bureau. American Community Survey, 2019–2023. https://data.census.gov/*

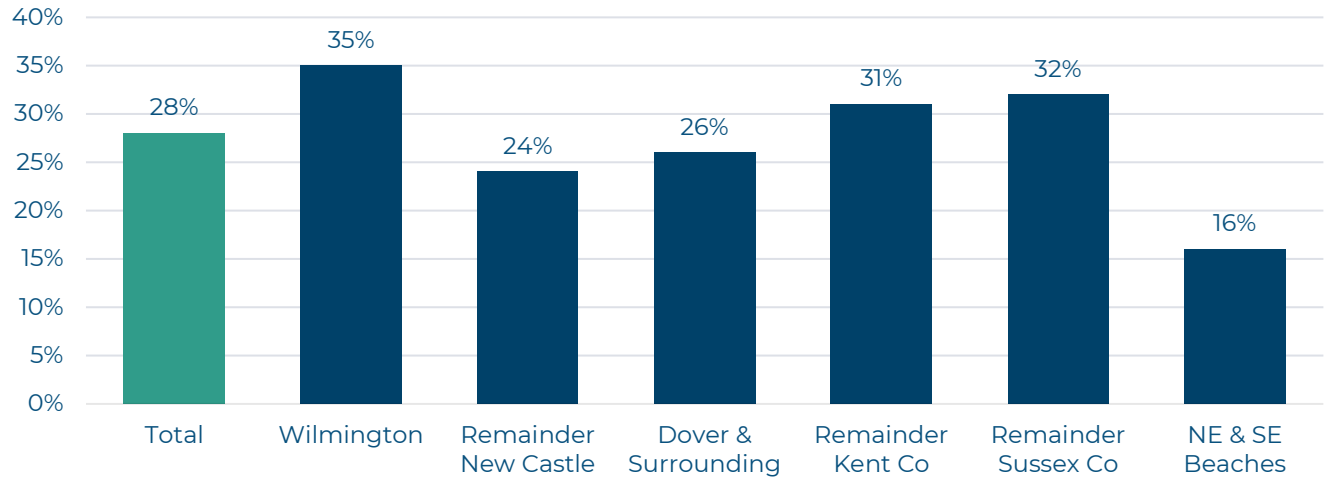
Cost is the most cited barrier to food access in Delaware. In the 2025 Nemours Community Survey, 28% of respondents statewide reported their family was unable to access enough food due to cost in the past year.



Approximately
1 in 3.5
(28%) survey respondents cited **cost** as a barrier to food access over the past 12 months.

These rates were even higher in Wilmington City (35%), and the Remainder of Sussex (32%) and Kent (31%) counties outside their more densely populated cities and towns. This suggests that **economic pressure, rather than availability alone, remains a key driver of food insecurity across both urban and rural contexts**.

Figure 91. Percent of the Survey Respondents Who Indicated Cost of Food Was the Reason They Could Not Access Enough Food, by ZIP Code Region, 2025



Source: Nemours Community Survey, 2025

Families also identified additional challenges:

Transportation

15% of respondents reported difficulty getting to a grocery store or food source with the highest rates in Wilmington City (25%) and Dover/Surrounding Areas (23%).

Limited Food Options

9% of respondents cited lack of stores that sell fresh or healthy food, a concern particularly noted in Dover/Surrounding Area (16%), and Wilmington City (11%).

Time Constraints

10% of respondents reported limited time to shop or prepare meals as a primary barrier, with higher rates in Dover/ Surrounding Area (16%), followed by Wilmington City (11%).

Food insecurity in Delaware is not simply about the absence of food but about the affordability and accessibility of healthy foods that prevent and manage chronic disease. Addressing cost barriers is essential not just for meeting basic needs, but for advancing health equity and preventing diet-related illnesses.

Community members echoed the need for a statewide food-as-medicine strategy in Delaware.

Evidence shows that nutrition interventions work. Medically tailored meals, produce prescription programs, and "food farmacy" models have been associated with improvements in dietary behaviors, reductions in chronic disease risk, and lower healthcare costs.[348] Local health systems in the region have advanced this work, embedding nutrition supports within pediatric prevention strategies and piloting food-as-medicine programs that link families directly to healthy food and wraparound services.[349] Building on this foundation, Delaware established a Food Is Medicine Committee in 2025 to coordinate efforts across healthcare, community organizations, and agriculture to scale these models statewide.[350]

At the same time, nutrition policy has become a critical lever. Delaware has joined national momentum around expanding access to school meals, recognizing the profound impact of nutrition on children's ability to learn and thrive. Universal free school lunch has long been championed by healthcare systems, educators, and public health advocates, and **while Delaware students currently have access to free breakfast, gaps remain in ensuring that every child receives nutritious lunch at no cost**.[351] Expanding these programs represents a tangible, evidence-based step to reduce child hunger and promote equity across income and racial groups.


Food-as-medicine


Agriculture to scale


School-based strategy


Food access systems

Strengthening the nutrition safety net through programs like SNAP and WIC, while expanding community access points such as pantries, mobile markets and culturally tailored food options[352], ensures that health food is both affordable and within reach of all families. These efforts not only reduce financial, geographic and transportation barriers, but also help normalize availability of healthy, culturally appropriate foods within communities that have long been underserved. Foundational safety net programs like WIC provide critical nutritional benefits during pregnancy, infancy, and early childhood[353] that are consistently linked to healthier birth outcomes, reduced infant mortality, and improved child growth trajectories, with long-term returns in education and economic stability.[354] However, because WIC is federally funded, it is subject to annual appropriations. Proposed cuts and benefit restrictions would leave more families facing the cost barriers already driving food insecurity. For Delaware families, that means the **46.8% of eligible young children enrolled in WIC** could potentially lose access.

Aligning agriculture, retail, and food access systems with health goals—and tailoring interventions to ZIP code-level disparities will be key. By pairing evidence-based healthcare interventions with bold policies, Delaware can shift from treating hunger as a symptom to treating nutrition as a foundation of health and prevention while protecting the most vulnerable from slipping through the gaps.

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[348] *Berkowitz SA, Terranova J, Hill C, et al. "Meal Delivery Programs Reduce the Need for Costly Health Care." Health Affairs, 2018.*
[349] *Healthcare x Food. "The Effectiveness of Delaware's Feeding Families Program." 2024. https://www.healthcarexfood.org/en/knowledge-hub/publication-hub/food-is-medicine-the-effectiveness-of-delawares-feeding-families*
[350] Delaware Governor's Office. "Governor Carney Establishes Food Is Medicine Committee." Delaware.gov, May 2025. https://news.delaware.gov/2025/05/06/governor-meyer-establishes-food-is-medicine-committee
[351] *Food Research & Action Center. "School Meals are Essential for Student Health and Learning." 2024. https://frac.org/research/resource-library/school-meals*
[352] *L.lyerly et al., "Effectiveness of mobile produce markets in increasing fruit and vegetable intake: A systematic review," Frontiers in Nutrition 7 (2020): Article 577584, https://doi.org/10.3389/fnut.2020.577584*
[353] *America's Health Rankings. "2024 Health of Women and Children Report: Delaware." 2024. https://www.americashealthrankings.org/learn/reports/2024-health-of-women-and-children-report/state-summaries-delaware*
[354] *U.S. Department of Agriculture, Food and Nutrition Service. "WIC 2022 Eligibility and Coverage Rates." 2023. https://fns-prod.azureedge.us/sites/default/files/resource-files/wic-eer-2022-report.pdf*

Physical Activity

Physical activity is a powerful determinant of child health, linked with lower risks of obesity, type 2 diabetes, cardiovascular disease, hypertension, and even certain cancers. Active lifestyles in childhood not only reduce immediate health risks but also set the foundation for healthier patterns into adulthood. Children who engage in regular movement demonstrate stronger bone and muscle development, improved mental health, and better academic performance. Conversely, being inactive or sedentary raises the likelihood of excess weight gain and chronic disease later in life. Importantly, the environments where children live—such as neighborhoods with accessible sidewalks, parks, and recreational facilities—play a critical role in enabling consistent opportunities for physical activity.[355]

National guidelines outline clear activity goals for children across developmental stages. These activities not only support healthy physical development but also improve attention, reduce stress, and build resilience.

Ages 3-5

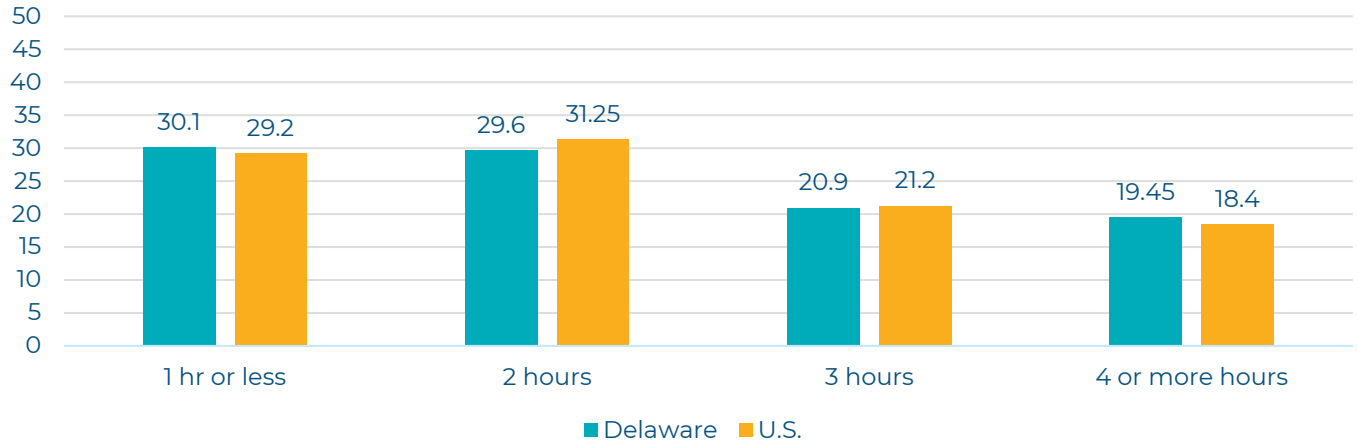
- Should be physically active throughout the day for growth and development – about 15 min. for every waking hour.
- Adults caregivers should encourage children to be active when they play, for example by jumping, throwing or riding a tricycle.

Ages 6-17

- 60 min. or more of moderate-to-vigorous physical activity each day, including:
  - Aerobic activity: walking, running (anything to raise heart rate).
  - Muscle-strengthening: climbing, doing pushups
  - Bone-strengthening: jumping, running

The data show how Delaware children compare to their peers nationwide in meeting these recommendations. In Delaware and nationwide, approximately 30% of children aged 3-5 spent one hour or less per day outdoors, and just under one-fifth spending four or more hours daily.

Figure 92. Percent of Children ages 3-5 and Time Spent Playing Outdoors in an Average Week*, Delaware, 2022-2023



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2022-2023

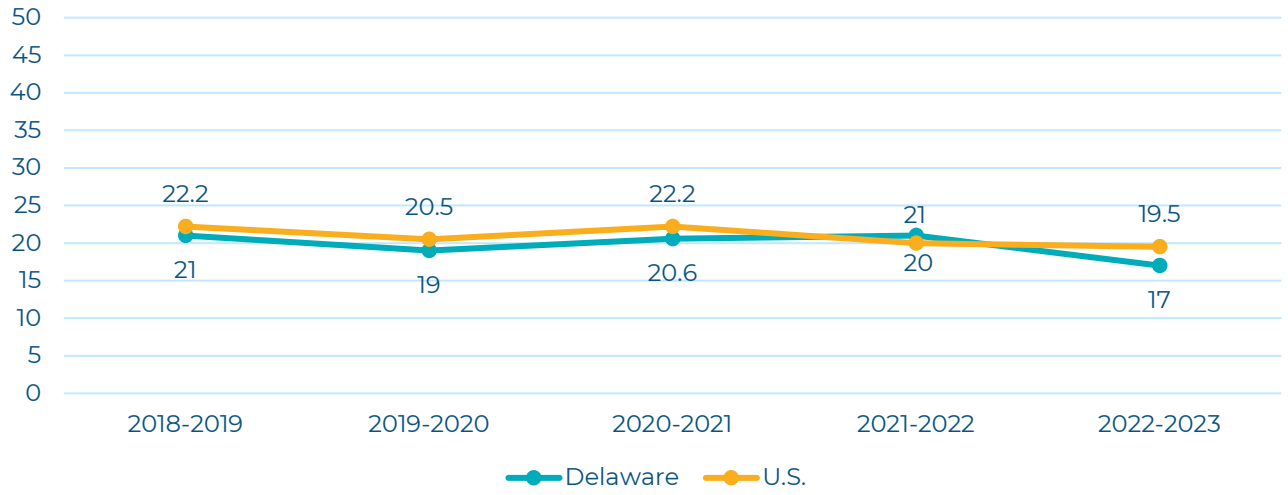
**NSCH weekend and weekday data were combined into one category that represents all days in an average week.*

For youth ages 6–17, the percentage meeting the daily 60-minute physical activity recommendation remains low and relatively flat over the past five years. In Delaware, rates declined from 21% in 2018–2019 to 17% in 2022–2023, compared to U.S. trends where 19.5% of youth achieved the standard.

[355] *University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. Available at: www.countyhealthrankings.org.*

[356] *Centers for Disease Control and Prevention. (2024, January 8). Physical Activity Basics: Child Activity Overview. U.S. Department of Health & Human Services. Retrieved from https://www.cdc.gov/physicalactivity/basics/children/index.htm*

Figure 93. Percent of Children ages 6-17 Who were Physically Active at Least 60 Minutes Every Day in the Past Week, Delaware, 2018-2023



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, 2018-2023

Community survey findings show 36% of children report daily physical activity of 60 minutes or more, while 20% reported five to six days, and 13% reported just three to four days. A small but notable share (7%) were active for only one to two days or not at all, underscoring potential inequities in consistent access to movement opportunities.

Children Ages 6-17 Engaged in Physical Activity for at Least 60 min. in the Last Week

0 Days	1-2 Days	3-4 Days	5-6 Days	7 Days
1%	**6%**	**13%**	**20%**	**36%**

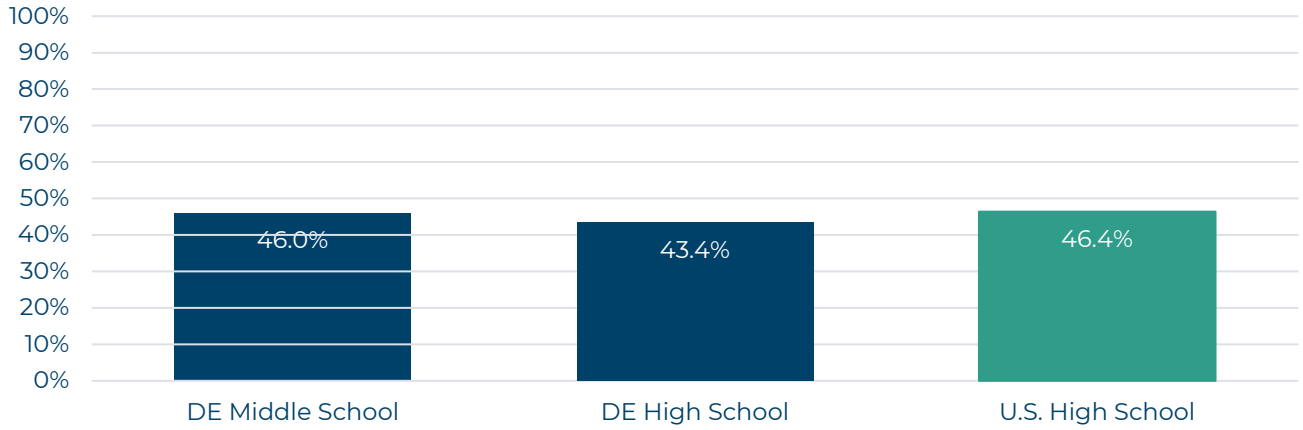
This meets the Healthy People 2030 goal of ~30% of youth (6-13 and high school age) engaged in 60 minutes or more of aerobic physical activity.

Source: Nemours Community Survey, 2025

**36% reported that their child was not able to be physically active and 4% did not know the amount of days their child was physically active in the last week.*

Differences emerge by age group and school level. In Delaware, 46% of middle school students reported at least 60 minutes of activity on five or more days in the past week, compared with 43% of high school students, slightly below the U.S. average of 46%.

Figure 94. Percent of DE Middle and High School Students Who Were Physically Active* At Least 60 Minutes Per Day On 5 or More Days, 2023



Source: CDC, Youth Risk Behavior Survey, 2023 In any kind of physical activity that increased their heart rate and made them breathe hard some of the time, during the 7 days before the survey.*

When examining physical activity, it is important to recognize that outcomes vary not only by age group but also by the type of activity measured. To support healthy growth and long-term fitness:

- Younger children may meet recommendations through active play, whereas
- Adolescents are expected to balance aerobic movement with muscle-strengthening and bone-strengthening activities.

Measures such as daily minutes of movement, frequency of muscle-strengthening exercise, and participation in school or community sports teams each capture different dimensions of activity and highlight the multiple pathways through which young people can stay healthy. Beyond aerobic minutes, teens are expected to include **muscle-strengthening activity on at least 3 days each week** (e.g., push-ups, sit-ups, resistance training) because it builds peak bone mass, improves insulin sensitivity and cardiometabolic health, supports healthy weight, and contributes to mental health and academic focus.[357]

In 2023, **51.1%** of U.S. high school students met the muscle-strengthening guideline—which is down from 55.6% in 2011.[358]

This does not meet the Healthy People 2030 target of 56.1%.

Approximately 1 in 6 U.S. students met both the daily aerobic and 3-day muscle-strengthening standards in 2023, **underscoring why schools, families, and community programs need to protect time and access for resistance-type activities—not just "cardio."**[359]

Longitudinal data suggest a broader national decline in structured activity, such as participation in sports teams, with fewer adolescents playing on at least one team compared to previous decades.[360] This trend contributes to reduced opportunities for regular, organized exercise and highlights the need for community and school supports to keep adolescents engaged.

[357] *U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd ed. Benefits for youth include stronger bones and muscles, better cardiometabolic health, and improved cognition. https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf*

[358] *CDC Youth Online, Delaware — High School YRBS (2021) (state results page; muscle-strengthening indicator available in 2021 cycle). https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=DE*

[359] *Cornett K, et al. Physical Activity Behaviors and Negative Safety and School Experiences — U.S. High School Students, 2023. MMWR Suppl. 2024;73(Suppl-4). Notes 16.5% met both aerobic and muscle-strengthening guidelines. https://www.cdc.gov/mmwr/volumes/73/su/su7304a11.htm*

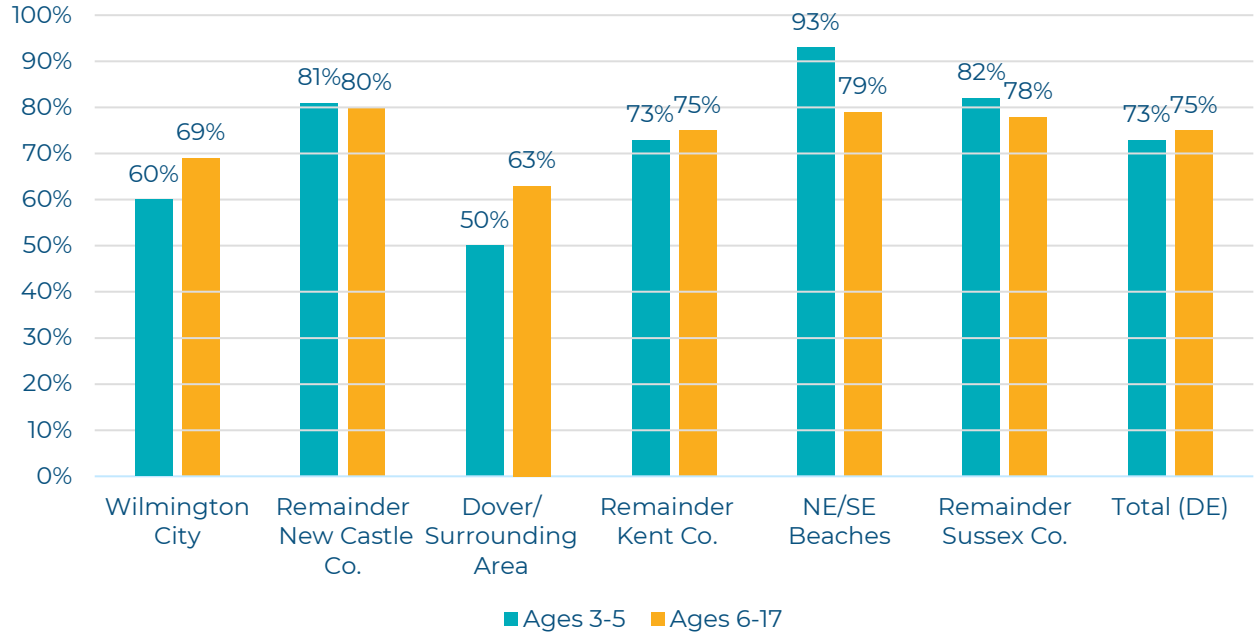
[360] *Centers for Disease Control and Prevention. Youth Risk Behavior Survey, 2023. https://www.cdc.gov/yrbs*

In 2023, **51.9%** of U.S. high school students played on at least one sports team – down from 54% in 2013. Delaware's most recent data from 2021 show a similar trend, with 47.6% of high school students playing on at least one sports team in 20201 – down from 56.6% in 2013. [361]

This does not meet the Healthy People 2030 target of 63.2%.

Data from the Nemours Community Survey reveal variation below the state and county level. Results showed that the share of children who were physically active during the week ranged from 50-63%% in Dover and the Surrounding Area to 79-93% in the NE/SE Beaches, with statewide totals averaging 73–75%. These geographic differences point to local influences—such as availability of recreational spaces, safety, and family resources—that shape children's ability to remain active.

Figure 95. Percent of Children (Ages 3-5 and Ages 6 and older) Who Were Physically Active* 1 or more days of the week by ZIP code Region, Delaware, 2025



Source: Nemours Community Survey, 2025

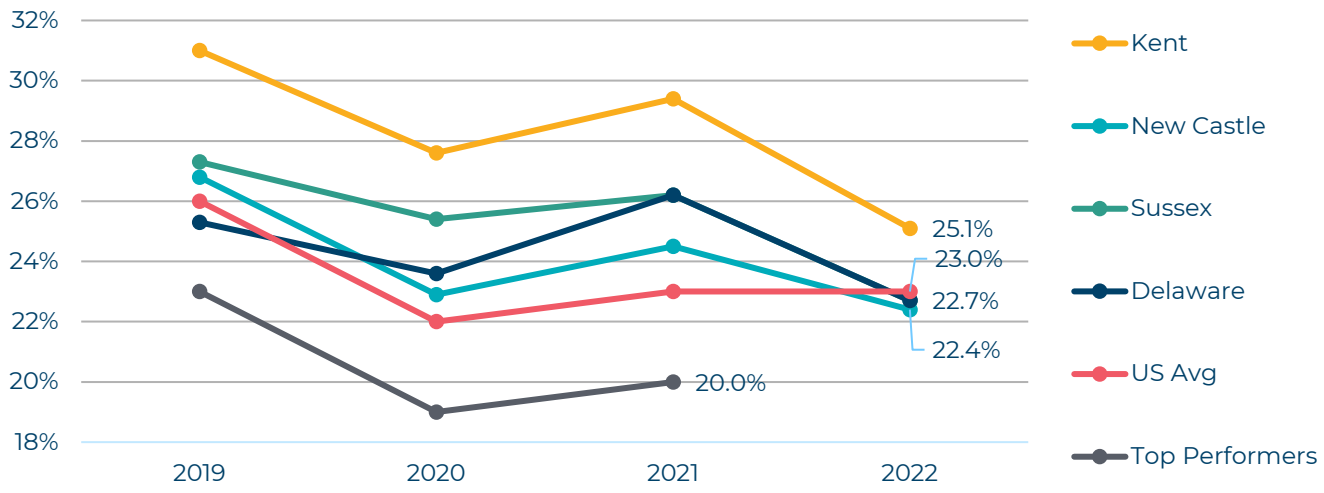
**Physically active for children ages 3-5 is defined as a total of at least 3 hours or about 15 minutes every hour they are awake on a given day. For children ages 6 or older, physically active is defined as a total of at least 60 minutes of moderate to vigorous activity on a given day.*

As children move into adulthood, the habits formed in youth often persist, making early activity patterns a predictor of health outcomes later. Looking at adult trends provides a broader view of how inactivity carries across the life course and reinforces the need for interventions that support active lifestyles from childhood onward.

In 2022, about 22.7% of Delaware adults reported no leisure-time physical activity, a rate slightly lower than the U.S. average (23.0%). Within Delaware, there are notable county-level differences: Kent County had the highest proportion of adults reporting no activity (25.1%), compared with 22.7% in Sussex County, and 22.4% in New Castle County. While the statewide rate has hovered between 22% and 26% over the past five years, this persistence indicates that barriers to consistent physical activity remain entrenched.

[361] *Centers for Disease Control and Prevention. Youth Risk Behavior Survey, 2023. https://www.cdc.gov/yrbs*

Figure 96. Percent of Adults Age 18 and Over Reporting No Leisure-time Physical Activity (age-adjusted) by County, Delaware 2022

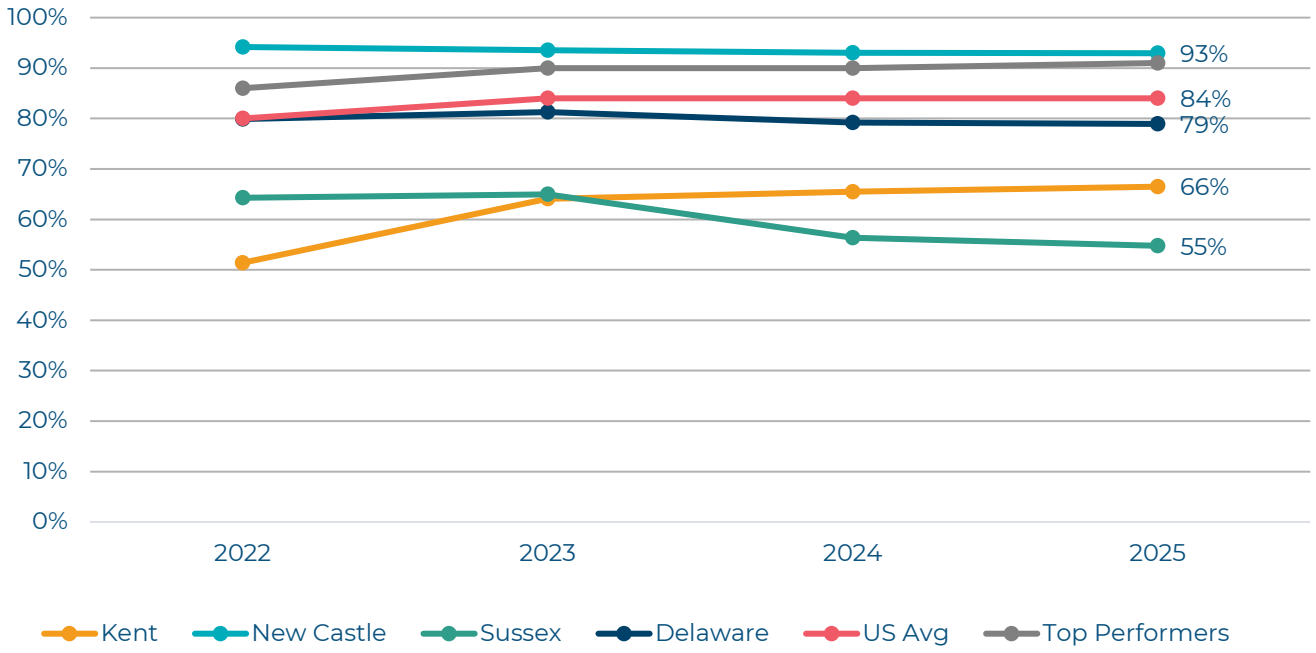


Source: CHR, Behavior Risk Factor Surveillance System (BRFSS), 2022

Adults who do not engage in regular physical activity face higher risks of obesity, cardiovascular disease, diabetes, and premature death. When combined with the earlier data showing low adherence to youth activity guidelines, the continuity is clear: Delaware residents are entering adulthood without a strong foundation of physical fitness, which has cascading effects on health outcomes and healthcare costs. **Addressing these gaps requires strategies that bridge childhood and adulthood—ensuring that opportunities for daily movement are accessible, culturally relevant, and sustained across the life span.** Access to safe and supportive environments shapes whether both youth and adults can realistically meet recommendations. Having parks, sidewalks, and recreational facilities nearby is critical, but proximity alone does not guarantee that families feel safe or able to use these spaces consistently. Delaware's data show that the availability of opportunities varies significantly by geography and that perceptions of safety often determine whether spaces are used.

Across the state, 79% of residents report living reasonably close to places for physical activity. Disparities emerge below the state level with only 55% of residents in Sussex County and 66% of residents in Kent County reportedly living reasonably close to exercise opportunity, compared with 93% in New Castle County.

Figure 97. Percent of Individuals Who Live Reasonably Close to Exercise Opportunities* by County, Delaware, 2024



Sources: County Health Rankings, 2025, ArcGIS Pro, USA Parks data, YMCA, TIGER/Line Shapefiles. The 2025 data release used data from 2024, 2022 & 2020 for this measure. 2020= population, 2022 = ArcGIS TIGER/Line Shapefiles, 2024 = ArcGIS Places

**Access to Exercise Opportunities measures the percent of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Generic 6-digit SIC codes were used to identify these locations. In addition. Individuals are considered to have access to exercise opportunities if they: (1) reside in a census block that is within a half mile of a park, or (2) reside in an urban census block that is within one mile of a recreational facility, or (3) reside in a rural census block that is within three miles of a recreational facility.*

These patterns show that while proximity is necessary, it is not sufficient. Even when families live close to parks or recreational spaces, safety concerns—ranging from crime to traffic to lack of sidewalks—limit whether those opportunities are used. **Accessibility, therefore, is shaped not only by proximity but by whether families feel their children can safely walk, play, and be active in those spaces.**

Youth in the city of Wilmington echoed these concerns, citing that BOTH structured youth programs and opportunities in secure spaces AND free and safe transportation to travel to and from them are key to increase utilization and enhance their ability to thrive outside of the unsafe conditions in their immediate environments. -Redding Consortium Project (2025)

*Special acknowledgments: the Youth Researchers at **Center for Structural Equity**: A. Muhammad, Z. Muhammad, M. Colbert, and J. Saylor; and University of Delaware Graduate Students: J. Yap, and B. Petit*[1]

Hygiene

Hygiene is an essential component of child and adolescent health. Good hygiene practices reduce the spread of infectious diseases, strengthen self-esteem during critical developmental years, and establish behaviors that influence health across the life course. For young people, hygiene extends beyond handwashing; it includes oral health, personal care (including menstrual hygiene), digital hygiene, and sleep hygiene. These domains are interrelated and strongly shaped by environmental, social, and economic conditions. Deficits in any area can have cascading effects on health, education, and psychosocial outcomes.

Oral hygiene refers to daily practices such as toothbrushing, flossing, and dental visits that prevent cavities and gum disease. It is one of the most widely recognized hygiene domains in childhood and adolescence, with clear links to long-term health outcomes.[362] The American Dental Association and CDC emphasize oral hygiene as foundational to child health and disease prevention.

Daily Oral Hygiene

Brushing twice a day for 2 minutes with fluoride toothpaste reduces caries risk.

Professional bodies recommend parent-supervised fluoride toothpaste (smear/rice-grain for under-3; pea-size for ages 3–6) and establishing a dental home by age 1.[363,364,365,366]

Fluoride (population & clinical). Community water fluoridation reduces cavities by ~25% across age groups and saves families and systems money;[367,368]

Clinical fluoride varnish and supplements (if water is not fluoridated) are USPSTF "B" recommendations in primary care for children.[369]

Poor oral health limits a person's ability to eat, learn, and work; left untreated it causes pain, infection, tooth loss, and—rarely—death.[370] Each year in the U.S., oral disease leads to an estimated **34 million school hours lost** for children and adolescents,[371] and **320.8 million work hours lost** among adults,[372] disproportionately impacting low-income families.

Children in Delaware are not immune to these challenges. Recent data show that 12.9% of 1–17-year-olds experienced one or more oral health problems in the past year, and 10.8% had untreated tooth decay or cavities. Nationally, the burden is even higher, with 14.1% of children reporting oral health problems and 12.1% reporting untreated cavities. These findings illustrate that while Delaware performs slightly better than the national average, more than one in ten children still face preventable oral health issues.

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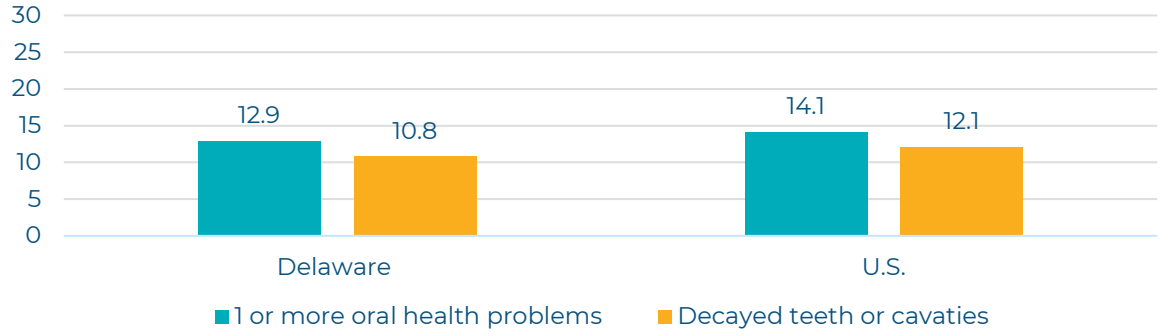
[362] *Centers for Disease Control and Prevention (CDC). "Oral Health: At a Glance." National Center for Chronic Disease Prevention and Health Promotion, 2022. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/oral-health.htm.*
[363] *American Academy of Pediatric Dentistry (AAPD). "Best Practices: Fluoride Therapy." Updated 2023. https://www.aapd.org/research/oral-health-policies–recommendations/fluoride-therapy/*
[364] *AAPD. "Policy on the Use of Fluoride." 2022. https://www.aapd.org/research/oral-health-policies–recommendations/use-of-fluoride/*
[365] *AAPD. "Best Practices: Infant Oral Health Care." 2019. https://www.aapd.org/research/oral-health-policies–recommendations/infant-oral-health-care/*
[366] *American Academy of Pediatrics. "Maintaining and Improving the Oral Health of Young Children." Pediatrics 134, no. 6 (2014): 1224–29. https://doi.org/10.1542/peds.2014-2984.*
[367] *Griffin, Susan O., et al. "Effectiveness of Fluoride in Preventing Dental Caries in Adults." Journal of Dental Research 86, no. 5 (2007): 410–15. https://doi.org/10.1177/154405910708600502.*
[368] *CDC. "Community Water Fluoridation: A Cost-Saving, Effective Public Health Strategy." Division of Oral Health, 2022. https://www.cdc.gov/fluoridation/index.html.*
[369] *U.S. Preventive Services Task Force. "Fluoride Varnish and Oral Fluoride Supplementation for Young Children." JAMA 325, no. 21 (2021): 2171–79. https://doi.org/10.1001/jama.2021.4760.*
[370] *American Dental Association. "Oral Health Topics: Dental Caries (Tooth Decay)." ADA, 2023. https://www.ada.org/resources.research/science-and-research-institute/oral-health-topics/dental-caries.*
[371] *Centers for Disease Control and Prevention (CDC). "Children's Oral Health: Fast Facts." National Center for Chronic Disease Prevention and Health Promotion, 2022. https://www.cdc.gov/oralhealth/fast-facts/childrens-oral-health.html.*
[372] *U.S. Department of Health and Human Services. Oral Health in America: Advances and Challenges. National Institutes of Health, National Institute of Dental and Craniofacial Research, 2021. https://www.nidcr.nih.gov/research/oral-health-in-america.*

Figure 98. Percent of Children (1-17) with Any Oral Health Problems and Decayed Teeth or Cavities in Last 12 months, Delaware 2022-2023



Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau., 2022-2023

Untreated caries cause pain, missed school days, and nutritional issues. These disparities highlight broader inequities: children in low-income households and racial/ethnic minority groups have higher rates of untreated decay.

School-based oral health screenings reinforce these concerns, with 45% of Delaware kindergarteners with reported caries experience, and more than 1 in 5 (22%) with untreated decay. By third grade, the rate of children with untreated decay and preventative sealants do not meet each respective Healthy People 2030 target – with untreated decay nearly double the HP2030 benchmark.

Delaware School Screening Findings:

45% of kindergarteners had caries experience

22% of kindergarteners had untreated decay

19% of 3rd graders had untreated decay. This **does not meet** the Healthy People Target: 10.2%

38% of 3rd graders had dental sealants This **does not meet** the Healthy People Target: 42.5%

77% of Delaware children received a preventative dental service in 2020-2021.

Source: Delaware Division of Public Health, Office of Oral Health. Delaware Oral Health Surveillance Report 2021-2022.

There are encouraging signs: 77% of Delaware children received a preventive dental service between 2020 and 2021, demonstrating that many families are engaged in care when access is available.[373]

Oral health outcomes in childhood have lasting consequences. Caries in primary teeth predict higher risk of decay in permanent teeth and into adolescence,[374,375] linking untreated disease to growth, weight, and long-term educational outcomes.

- **~21%** of U.S. adults age 20-64 have untreated decay;[376]
- **~42%** of U.S. adults ≥30 have periodontitis,[377] and
- **~8.9%** of U.S. adults ≥45 have lost all their teeth (HP2030 Target 5.4%).[378]

In 2023, 65.5% of U.S. adults reported a dental visit in the past year, Delaware adults were similar at 64.6%.[379]

[373] *Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau. National Survey of Children's Health (NSCH) 2020-2021: Preventative Dental Services Data. https://www.childhealthdata.org*
[374] *Broadbent, Jonathan M., W. Murray Thomson, Terrie E. Moffitt, et al. "Dental Caries and Oral-Health Practices in Childhood Are Associated with Caries in Adulthood." Journal of Dental Research 92, no. 4 (2013): 323–29. https://doi.org/10.1177/0022034513481190.*
[375] *Mejàre, Ingegerd, Gösta Stenlund, and Ulf Larsson. "Caries Incidence among Schoolchildren—A 4-Year Longitudinal Study." Community Dentistry and Oral Epidemiology 26, no. 1 (1998): 12–18. https://doi.org/10.1111/j.1600-0528.1998.tb01920.x.*
[376] *Fleming, Elyse, and Robin A. Cohen. "Dental Caries and Tooth Loss in Adults in the United States, 2015–2018." NCHS Data Brief no. 368 (2020). https://www.cdc.gov/nchs/products/databriefs/db368.htm.*
[377] *Eke, Paul I., et al. "Update on Prevalence of Periodontitis in Adults in the United States: NHANES 2009 to 2012." Journal of Periodontology 86, no. 5 (2015): 611–22. https://doi.org/10.1902/jop.2015.140520.*
[378] *Office of Disease Prevention and Health Promotion. "Healthy People 2030 Objective OH-06: Reduce Total Tooth Loss in Adults Aged 45 or Older." U.S. Department of Health and Human Services, 2020. https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions.*
[379] *Centers for Disease Control and Prevention (CDC). "Oral Health Surveillance Report: Trends in Dental Care and Tooth Loss." National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health, 2019. https://ww.cdc.gov/oralhealth/publications/OHSR-2019-index.html*

Delaware's fluoridation coverage is strong, with 85.9% of residents on community water systems receiving fluoridated water in 2018—above the national average of 72.7%,[380,381] But fluoride alone is not enough. Oral health should be embedded in a broader hygiene framework that also addresses handwashing, acne, and menstrual health. School-based programs that combine brushing, sealants, and fluoride varnishes with education on daily hygiene reduce infection, stigma, absenteeism, and long-term disparities.[382,383,384] *Personal hygiene* extends beyond the mouth to encompass daily care of the body, skin, hair, and nails, as well as handwashing and safe grooming practices. In adolescence, puberty introduces additional needs, including body odor management, acne prevention, and menstrual hygiene – or menstrual hygiene management (MHM) – which the World Health Organization defines as using clean materials to absorb menstrual blood, changing them in privacy, and having access to soap and water for washing.[385] Deficits in personal or menstrual hygiene can lead to infections, stigma, and absenteeism from school.[386]

Acne is one of the most common health conditions of adolescence, with studies estimating that up to 87% of teenagers experience acne at some point

Acne is the prevalent skin condition.[387]

It affects nearly **50 million people** annually.

Acne is strongly associated with **poor self-esteem, anxiety, depression, and social withdrawal.**[389]

Acne can cause permanent **scarring, post-inflammatory pigmentation**, and secondary **infection**.[388]

Skin hygiene is **not a cosmetic concern**, but a **health and psychological issue.**

What adolescents can do:

- **mild cleansing** 2x daily
- **Avoid** squeezing or picking pimples
- **Protect** skin from sun
- **Moisturize** appropriately (lightweight/oil free)
- Use over-the-counter **topical treatments** (benzoyl peroxide/ salicylic acid
- Seek **medical care** when needed.

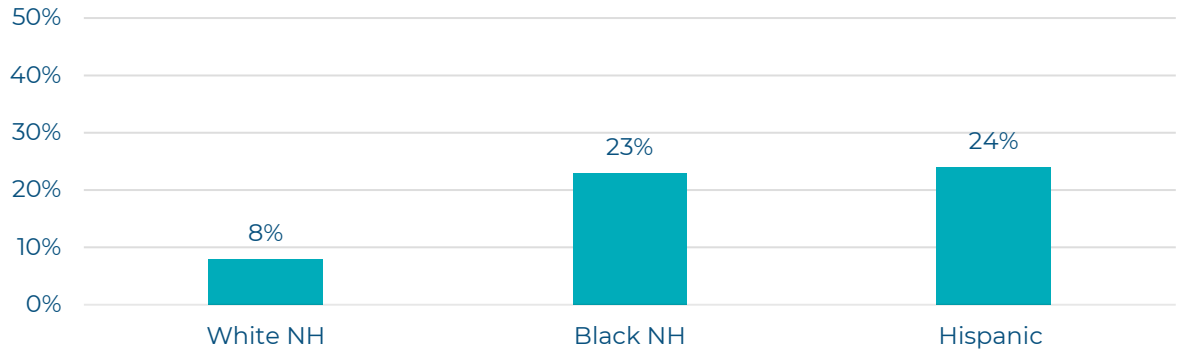
Menstrual hygiene insecurity – or period poverty – is defined as limited or inadequate access to menstrual products or education due to financial constraints or socio-cultural stigma. Period poverty affects nearly one in five U.S. adolescents.[390]

- **1 in 4** U.S. students struggle to afford period products.
- **44%** of teens feel stress/embarrassment due to lack of access.
- **92%** believe periods should be seen as a sign of health.
- **78%** support menstrual health education in core curriculum.[391]

These challenges **disproportionately affect low-income and minority youth**. The 2023 State of the Period Study commissioned by Thinx and PERIOD found that 23% of Black non-Hispanic and 24% of Hispanic (all) respondents experienced product insecurity compared to 8% of White respondents.[392]

[380] *Centers for Disease Control and Prevention (CDC). "2018 Fluoridation Statistics—United States." Division of Oral Health, 2019. https://www.cdc.gov/fluoridation/statistics/2018stats.htm.*
[381] *Centers for Disease Control and Prevention (CDC). "Community Water Fluoridation Coverage, 2018." Division of Oral Health, 2019. https://www.cdc.gov/fluoridation/statistics/2018stats.htm.*
[382] *U.S. Preventive Services Task Force. "Fluoride Varnish and Oral Fluoride Supplementation for Young Children." JAMA 325, no. 21 (2021): 2171–79. https://doi.org/10.1001/jama.2021.4760.*
[383] *UNICEF. Guidance on Menstrual Health and Hygiene. New York: UNICEF, 2019. https://www.unicef.org/documents/guidance-menstrual-health-and-hygiene.*
[384] *Sommer, Marni, et al. "A Comparison of the Menstrual Beliefs and Practices of Ghanaian and American Adolescent Girls." Journal of Adolescent Research 30, no. 1 (2015): 74–95. https://doi.org/10.1177/0743558414559770.*
[385] *World Health Organization (WHO). "Adolescent Health: Menstrual Hygiene Management." 2020. https://www.who.int/health-topics/adolescent-health#tab=tab_1.*
[386] *Sommer, M., et al. "A Comparison of the Menstrual Beliefs and Practices of Ghanaian and American Adolescent Girls." Journal of Adolescent Research 2015.*
[387] *American Academy of Dermatology Association. "Acne: Facts and Statistics." 2023. https://www.aad.org/media/stats-numbers.*
[388] *Borowski, Julia, et al. "Period Poverty and Its Reach Across the U.S." Brookings Institution, 2023. https://www.brookings.edu/articles/period-poverty-and-its-reach-across-the-us/.*
[389] *Magin, Parker, et al. "The Psychological Impact of Acne Vulgaris." British Journal of Dermatology 155, no. 4 (2006): 725–30. https://doi.org/10.1111/j.1365-2133.2006.07418.x.*
[390] *Ibid.*
[391] *Thinx Inc. & PERIOD. (2023). State of the Period 2023. Survey conducted by SKDK, September 5–10, 2023. Retrieved from Thinx.com*
[392] *Thinx & PERIOD. State of the Period Study 2023. Survey conducted by SKDK, September 2023. Accessed September 2025. https://period.org/uploads/SOTP-2023.pdf*

Figure 99. Percent of Youth Ages 13-19 Who Experienced Menstrual Product Insecurity by Race, United States, 2023



Source: Thinx & PERIOD. State of the Period Study, 2023.

Puberty also brings physiological changes in sweat and body odor. New compounds in adolescent sweat metabolized by skin bacteria produce strong odors.[393] While body odor is a normal part of puberty, stigma or teasing about odors can reduce school and social participation, especially if youth lack access to deodorant, a bath/shower, or private facilities.

Together, acne, body odor, and menstrual hygiene highlight how personal hygiene intersects with both physical health and social determinants. Poor hygiene access can fuel infections, stigma, and absenteeism, while adequate hygiene supports adolescent health, self-confidence, and school engagement.

Locally, we can address these challenges using evidence-based best practice:

Supply School-based hygiene kits to reduce resource barriers; including products like

soap, menstrual products, acne-friendly cleanser, deodorant, etc.[394]

Restroom infrastructure for safe hygiene management without stigma;

including privacy, soap, running water, disposal bins, etc.[395]

Integrate hygiene education into school health curricula/ normalize topic;

including puberty changes, menstrual hygiene, and body odor management[396]

Train school nurses/ health staff to identify and address barriers

by connecting students to needed hygiene-related supplies or referrals.[397]

Conduct local hygiene surveys with school nurses or students

to generate more Delaware-specific data on access gaps, absenteeism, product affordability.

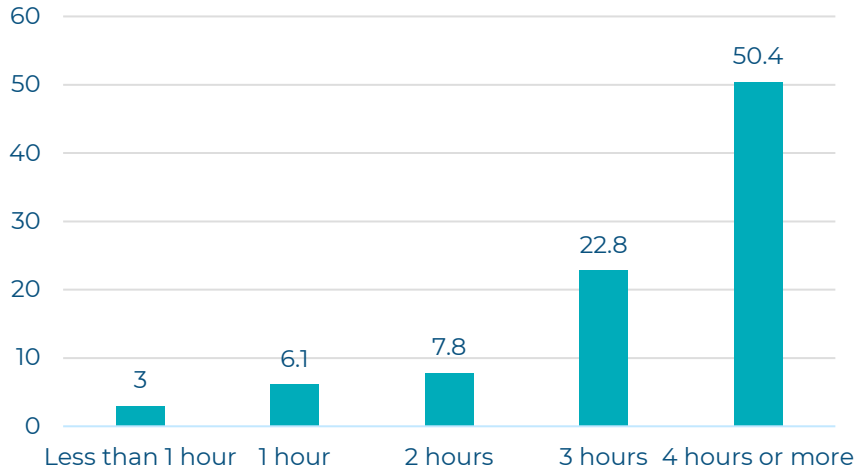
[393] *Sommer, Marni, et al. "A Comparison of the Menstrual Beliefs and Practices of Ghanaian and American Adolescent Girls." Journal of Adolescent Research 30, no. 1 (2015): 74–95. https://doi.org/10.1177/0743558414559770.*

[394] *UNICEF. Guidance on Menstrual Health and Hygiene. New York: UNICEF, 2019. https://www.unicef.org/documents/guidance-menstrual-health-and-hygiene.*
[395] *UNICEF. Guidance on Menstrual Health and Hygiene. New York: UNICEF, 2019. https://www.unicef.org/documents/guidance-menstrual-health-and-hygiene.*
[396] *American Academy of Pediatrics. "Puberty: Normal Growth and Development in Boys and Girls." Pediatrics in Review 41, no. 4 (2020): 189-201. https://doi.org/10.1542/pir.2018-0056*
[397] *National Association of School Nurses. "Hygiene Resource Access and School-Based Supports." NASN Issue Brief, 2022. https://www.nasn.org/nasn-resources/practice-topics/student-hygiene.*

Practices like handwashing, dental care, and menstrual hygiene support physical health and social wellbeing in the offline world. The concept of hygiene, however, increasingly extends into the digital environment. *Digital hygiene*—sometimes framed as digital wellness—describes the set of practices that promote safe, balanced, and healthy use of digital devices and online platforms. It includes managing screen time, limiting device use before bed, maintaining online privacy, and avoiding harmful content.[398] In adolescent health literature, digital hygiene is often linked to sleep, mental health, and academic performance.[399]

Most U.S. teenagers ages 12-17 report high daily screen time. Just 3% spend less than one hour per day, while over half (50.4%) spend four or more hours per day on screens. Moderate use is less common: 6.1% spend one hour, 7.8% two hours, and 22.8% spend three hours daily.

Figure 100. Percent Distribution of Teenagers Ages 12-17, by Hours of Daily Screen Time, United States, 2021-2023



Source: National Center for Health Statistics, National Health Interview Survey – Teen, July 2021–December 2023.

Four or more hours of screen time varies by age, race, and income.

- **Teenagers ages 15-17** (55%) were more likely than those ages 12-14 (45.6%).
- **Black non-Hispanic teens** (60.4%) were more likely than their peers from other racial groups (47.9-52.8%).
- **Teens living in households with income <200% FPL** (51.7%) were more likely than those ≥ 200% FPL (49.6%).

Teens reporting four or more hours of daily screen time were more common among ages 15-17 (55%), Black non-Hispanic youth (60.4%), and those in households below 200% Federal Poverty Level (FPL), compared with younger teens (45.6%), other racial groups (47.9-52.8%), and higher income peers (49.6%). These distinctions in digital hygiene can shape broader health and academic outcomes but also inform targeted interventions.

Patterns in digital hygiene emerge much earlier than the teen years, however. A 2023 systematic review of screen time among scho-14 years) found:

- Average screen time in this age group is approximately 2.77 hours/day
- 46.4% of children exceeded 2 hours/day
- Screen time increased significantly after COVID-19
  - Before January 2020: 41.3% ≥ 2 hours/day → after January 2020: 59.4% ≥ 2 hours/day

These data demonstrate that high levels of screen time begin in early childhood, shaping habits and risks well before the teen years.

Healthy practice focuses less on a single "hour limit" and more on **balancing screen time with sleep, school, physical activity, and offline relationships** via a structured family media plan from the American Academy of Pediatrics (AAP) Center of Excellence (CoE) on social media and Youth Mental Health.[400]

[398] *Montag, C., & Hegelich, S. "Understanding Digital Hygiene: How to Protect Mental Health in the Age of Screens." Frontiers in Psychology 2020.*
[399] *UNICEF. "Digital Literacy and Digital Hygiene." UNICEF Office of Global Insight and Policy, 2021. https://www.unicef.org/globalinsight/reports/digital-literacy-digital-hygiene.*
[400] *American Academy of Pediatrics (AAP) Center of Excellence (CoE) on Social Media and Youth Mental Health. Family Media Plan and Guidance on Healthy Digital Practices. Itasca, IL: AAP, 2022. https://www.healthychildren.org/English/fmp/Pages/MediaPlan.aspx.*

Delaware's Digital Hygiene

75.9% of high school students reported spending an average of three or more hours per day on a screen on most days (excluding schoolwork).

>1 in 3 or 35.2% of high school students emailed or texted while driving during the 30 days before the survey.

~1 in 4 or 23% of high school students spend 3 or more hours playing video or computer games on a standard school day.

Source: CDC, Youth Risk Behavior Survey, 2023

The YRBS indicator for texting or emailing while driving in the past 30 days remains a key risky behavior tracked nationally.[401] **Delaware law has banned handheld device use while driving since 2011**; state safety materials echo NHTSA's risk framing: reading or sending a text takes your eyes off the road for ~5 seconds—about a football field at 55 mph.[402] Delaware's Office of Highway Safety and recent media analyses have flagged elevated teen crash fatality rates, with impairment and distraction as persistent contributors, underscoring the priority of enforcement plus youth-focused prevention.[403,404]

While overall screen time carries risks for health and safety, social media use adds another layer, shaping teens' daily routines and amplifying concerns about wellbeing. Nationally, social media use is nearly universal among teens, with ~95% reporting use and 77% using it several times per day or more and about 29.5% using it more than once an hour.[405]

~95% of teens report **social media use.**

77% of teens report using social media **several times a day or more.**

29.5% of teens report using social media **more than once an hour.**

Pew finds **teens broadly acknowledge the pull of platforms**:

- 36% of teens say they spend too much time on social media
- 54% of teens say giving it up would be hard.[406]

Heavy evening screen and social media use exacerbate the normal adolescent "phase delay" in circadian rhythm, undercutting the recommended 8–10 hours of sleep for ages 13–18 and impairing attention, grades, and safety.[407] The U.S. Surgeon General warns that while evidence is still developing, **high-intensity social media use is associated with poor sleep, body-image concerns, and depressive symptoms, especially among females**.[408]

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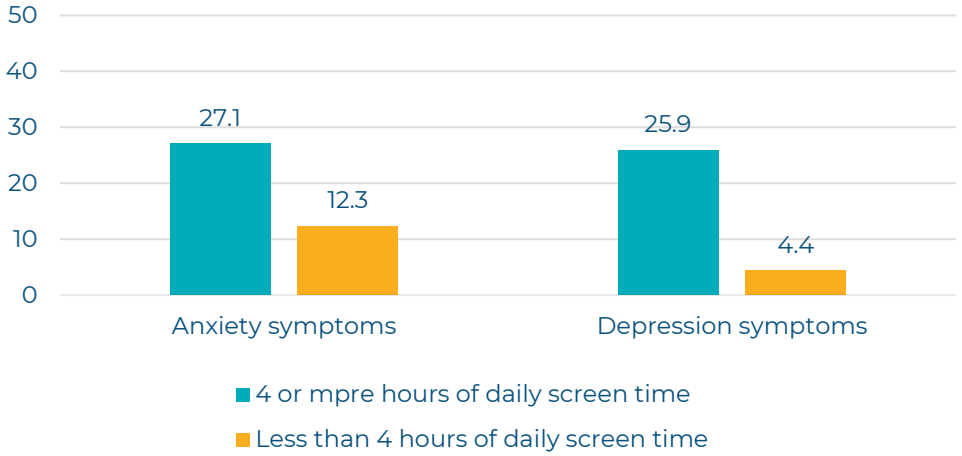
[401] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey (YRBS), 2021 Results: Health-Related Behaviors and Texting While Driving Indicator. Atlanta, GA: Division of Adolescent and School Health, 2022. https://www.cdc.gov/yrbs.*
[402] *National Highway Traffic Safety Administration. Distracted Driving. U.S. Department of Transportation, 2024. https://www.nhtsa.gov/risky-driving/distracted-driving.*
[403] *Delaware Office of Highway Safety. Annual Traffic Statistical Report. Dover, DE: Delaware Department of Safety and Homeland Security, 2022. https://ohs.delaware.gov/reports/.*
[404] *National Highway Traffic Safety Administration (NHTSA). "Distracted Driving 2021." Traffic Safety Facts, Report No. DOT HS 813 507. Washington, DC: U.S. Department of Transportation, 2023. https://crashstats.nhtsa.dot.gov/.*
[405] *Rideout, Victoria, and Michael Robb. Common Sense Census: Media Use by Tweens and Teens, 2021. San Francisco, CA: Common Sense Media, 2022. https://www.commonsensemedia.org/research.*
[406] *Pew Research Center. "Teens, Social Media and Technology 2022." Pew Research Center, 2022. https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/.*
[407] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey (YRBS), 2021 Results: Health-Related Behaviors and Texting While Driving Indicator. Atlanta, GA: Division of Adolescent and School Health, 2022. https://www.cdc.gov/yrbs.*
[408] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey (YRBS), 2021 Results: Health-Related Behaviors and Texting While Driving Indicator. Atlanta, GA: Division of Adolescent and School Health, 2022. https://www.cdc.gov/yrbs.*

These concerns are reflected in data from the National Health Interview Survey, which show that teens with higher daily screen use are significantly more likely to report symptoms of anxiety and depression compared to peers who report less time on screens.

Figure 101. Percent of Teenagers Ages 12-17 Who Had Depressive Symptoms of Anxiety or Depression in the Past 2 Weeks by Daily Screen Time, United States, 2021-2023



Alongside mental/behavioral health and stress and anxiety, Nemours Community Survey respondents placed **screen time in the top 10 most important health needs to prioritize** for the health and wellbeing of youth in Delaware.

Source: National Center for Health Statistics, National Health Interview Survey–Teen, 2021-2023.

Nemours Community Survey participants prioritized screen time (9%) more than concerns around any other lifestyle-related factor – including unhealthy diet (5%), inactive lifestyle (5%), oral health (4%), e-cigarette use (3%), and sleep health (3%). Screen time was mentioned most often in respondents from the Remainder of Kent County outside of Dover (15%), the NE/SE Beaches (14%), and the Remainder of New Castle County outside of Wilmington (10%).

The Surgeon General's Advisory synthesizes converging signals: exposure to harmful content, social comparison, disrupted sleep, and harassment are credible pathways of harm—balanced against some benefits (connection, identity exploration) when use is moderated and supported by adults.[409]

For health systems and schools, best practice emphasizes:

- Family media plans and device-free time (meals, 1 hour before bed),
- sleep protection (no phones overnight in bedrooms; night-shift settings),
- platform literacy (privacy settings, harassment reporting), [410] and
- safety norms (no phone use when driving; passenger empowerment to intervene).[411]

Embedding digital wellness alongside physical activity, nutrition, and personal hygiene keeps the focus on whole-child health and equity.[412]

Sleep habits play a critical role in supporting growth, learning, and mental health. *Sleep hygiene* refers to behaviors (habits) and environmental conditions that support consistent, high-quality sleep, such as going to bed at the same time each night, avoiding screens before sleep, and creating a quiet, dark environment. The American Academy of Sleep Medicine highlights sleep hygiene as

[409] *U.S. Surgeon General. Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory. Washington, DC: U.S. Department of Health and Human Services, 2023. https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/social-media/index.html.*

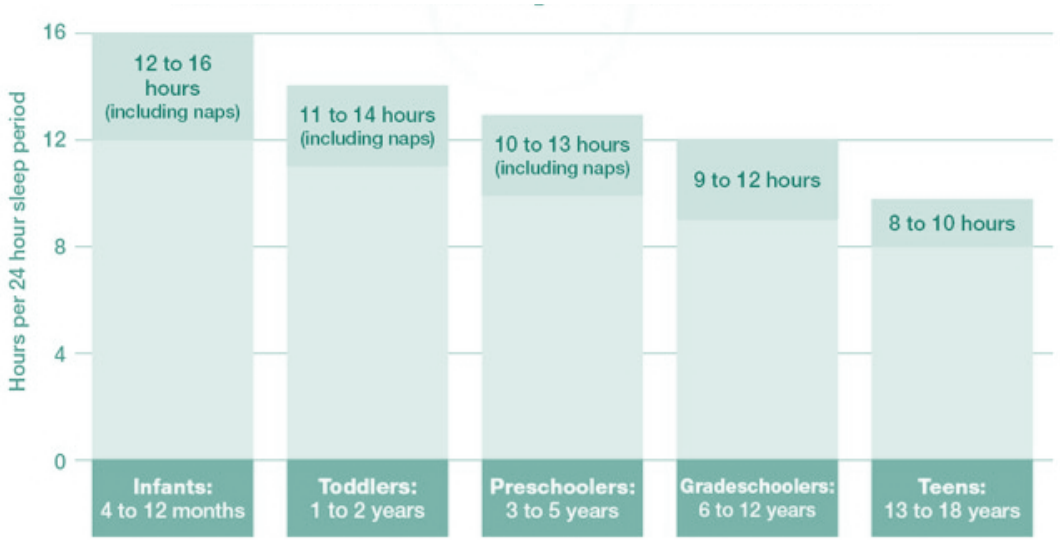
[410] *American Academy of Pediatrics (AAP) Center of Excellence (CoE) on Social Media and Youth Mental Health. Family Media Plan and Guidance on Healthy Digital Practices. Itasca, IL: AAP, 2022. https://www.healthychildren.org/English/fmp/Pages/MediaPlan.aspx.*

[411] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey (YRBS), 2021 Results: Health-Related Behaviors and Texting While Driving Indicator. Atlanta, GA: Division of Adolescent and School Health, 2022. https://yrbs-explorer.services.cdc.gov/#/.*

[412] *U.S. Surgeon General. Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory. Washington, DC: U.S. Department of Health and Human Services, 2023. https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf.*

critical for children and adolescents, given links to obesity, learning, and mental health.[413]

Insufficient sleep is one of the most common health challenges for adolescents. The nightly duration of healthy sleep needed by children varies by age and individual biology. In general, the American Academy of Sleep Medicine recommends that children get the following amounts of sleep on a regular basis to promote optimal health, daytime alertness and school performance.[414]

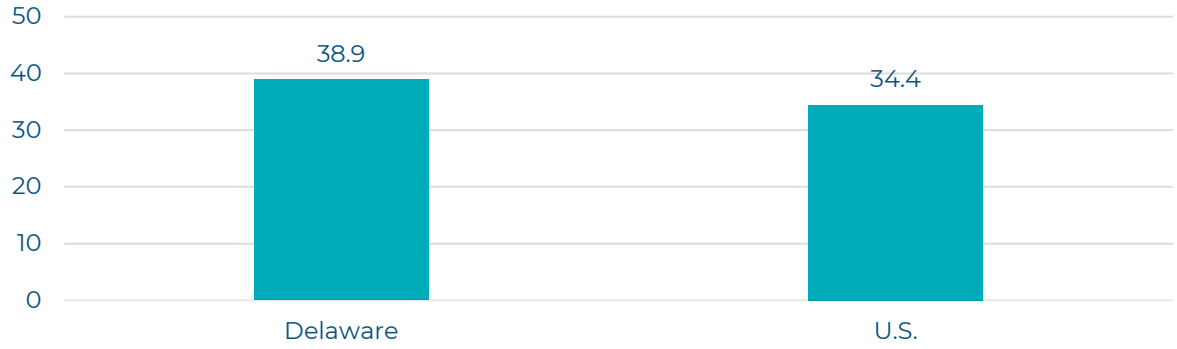


Source: Paruthi S, Brooks LJ, D'Ambrosio C, Hall W, Kotaeal S, Lloyd RM, Malow B, Maski K, Nichols C, Quan SF, Rosen CL, Troester MM, Wirse MS. Recommended Amount of Sleep for Pediatric Populations: A Statement of the American Academy of Sleep Medicine. J Clin Sleep Med. 2016 May 25. pii: jc-00158-16. PubMed PMID:27250809.

**The American Academy of Pediatrics (AAP) has issued a Statement of Endorsement supporting these guidelines from the American Academy of Sleep Medicine (AASM).*

While recommended sleep duration varies by age, many children and adolescents fall short of these targets. As shown in Figure 99, more than one in three youth in Delaware sleep less than the recommended hours per day – a rate higher than the U.S. average.

Figure 102. Percent of Children Ages 4 months-17 years Who Sleep Less Than the Recommended Hours Per Day*, Delaware, 2022-2023



Source: National Survey of Children's Health (NSCH), 2022-2023

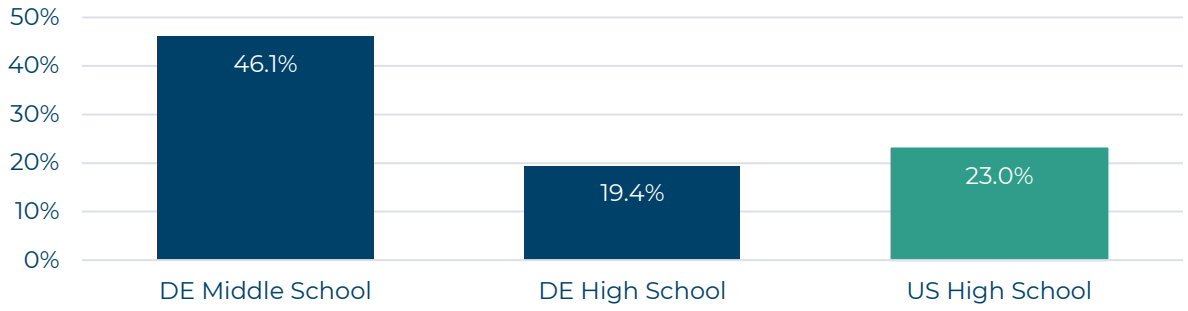
**Sleep hours for children 0-5 include daytime naps and nighttime sleep. Sleep hours for children 6+ includes nighttime sleep only.*

Nationally, less than one in four (23%) U.S. high school students report achieving the recommended hours of sleep at night. In Delaware, only 19.4% of high school students report adequate sleep, while middle school students get 8+ hours of sleep at more than twice the rate (46.1%).

[413] *American Academy of Sleep Medicine. "Sleep Hygiene for Children and Adolescents." 2021. https://aasm.org/resources/factsheets/sleep-hygiene.*

[414] *American Academy of Sleep Medicine (AASM). Sleep Education: Sleep Hygiene for Children and Teens. Darien, IL: AASM, 2021. https://sleepeducation.org/healthy-sleep/healthy-sleep-habits/children-and-teens/.*

Figure 103. Percent of Middle and High School Students Who Slept for 8 or More Hours Per Night, Delaware, 2023



Source: Youth Risk Behavior Survey (YRBS), 2023

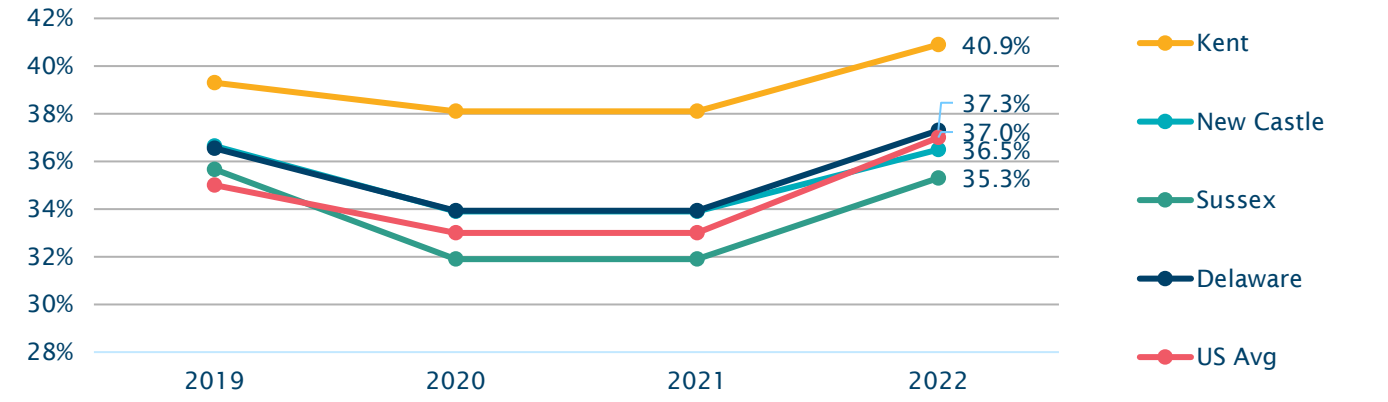
Multiple factors contribute to chronic sleep deprivation, including:

- early school start times,
- increased academic demands,
- extracurricular activities,
- part-time work,
- screen time and social media use late into the night, and
- physiological changes in circadian rhythm that naturally delay sleep onset during puberty.[415]

Ongoing sleep deficiency has been linked to chronic health conditions, including cardiovascular disease and stroke, as well as psychiatric disorders such as depression and anxiety, risky behavior, and even suicide.[416] Sleepiness can lead to motor vehicle crashes and put the lives of others in jeopardy.[417] Sleep duration has also been found to be inversely related to diabetes mellitus.[418]

Sleep challenges are not limited to youth – adult sleep patterns across Delaware show concerning gaps. In 2022, more than one-third of adults reported sleeping fewer than seven hours per night, with notable county differences.

Figure 104. Percent Adults Who Report Fewer than 7 Hours of Sleep on Average, by County, Delaware, 2019-2022



Source: CDC, Behavioral Risk Factor Surveillance System (BRFSS), 2019-2022

[415] American Academy of Sleep Medicine (AASM). Sleep Education: Sleep Hygiene for Children and Teens. Darien, IL: AASM, 2021. https://sleepeducation.org/healthy-sleep/healthy-sleep-habits/children-and-teens/.

416 Seixas AA, Gyamfi L, Newsome V, et al. Moderating effects of sleep duration on diabetes risk among cancer survivors: Analysis of the National Health Interview Survey in the USA. Cancer Management and Research. 2018;10(1):4575-4580.

417 Harris LM, Huang X, Linthicum KP, Bryen CP, Ribeiro JD. Sleep disturbances as risk factors to suicidal thoughts and behaviours: A meta-analysis of longitudinal studies. Scientific Reports. 2020;10(13888).

418 Tefft BC. Acute sleep deprivation and culpable motor vehicle crash involvement. Sleep. 2018;41(10).

Kent County has the highest rate of insufficient sleep (40.9%), followed by New Castle (36.5%) and Sussex (35.3%).

Safety

Sleep hygiene is not just about duration and quality of sleep; it is also about safety. Safe sleep practices in infancy remain a cornerstone of early prevention that carry over as children grow and safety concerns expand to include biking, swimming, driving, and protecting skin from harmful UV exposure. These behaviors may seem routine yet lapses carry life-altering consequences.

	National Evidence	Delaware Context	Countermeasure/Guidance
Safe Sleep (Infants)	**~3,500 infant deaths** annually are sleep-related (SIDS, suffocation, etc.)[419]	**Every month in DE, an infant dies** from unsafe sleep conditions.[420]	Infants should sleep alone, on their back, in an empty crib, in a smoke free area.
Bicycle Safety	In 2023, 1,168 pedal cyclist fatalities; **41 were children** ≤14.[421]	**50 children and teens aged 0-19 are injured** in bicycle accidents each year: **40%** of all bike accident injuries.[422]	Helmet use reduces the risk of head injury by ~85%; safe routines, bike lanes, and traffic education programs.[423]
Swim Safety	**~945 children (0-19) die from drowning** annually; **leading injury death** for ages 1-4.[424]	The age-adjusted unintentional drowning death rate (2018-2021) is 0.83 per 100,000.[425]	Swim lessons, adult supervision, 4-sided pool fencing, and coastguard-approved, evidence-based floatation/protection devices.[426]
Driving Safety	In 2023, **1,019 child fatalities** (≤14); car seats reduce fatal injury by 71% (<1 yr) and 54% (ages 1-4)[427]	In 2023, **11% of the motor vehicle fatalities in DE were minors** ≤21 years old.[428]	Correct car seat/booster use, graduated driver licensing (GDL) laws, and bans on handheld phone use.
Skin Safety	**Skin cancer is the most common U.S. cancer**; ~1 in 3 White HS students report ≥1 sunburn annually.[429]	The skin cancer rate (Melanoma of the skin) in Delaware is **26.7 per 100,000 population**, compared to 22.7 nationwide.[430]	Broad spectrum SPF 30+ sunscreen, sun protective clothing, hats and sunglasses, avoid tanning beds, seek shade during peak sun, and know the ABCDEs of early detection.[431]
Playground Safety	**Each year, 200,000 kids are treated in hospital ERs** for playground related injuries.[432]	Under Delaware's **licensing regulations** for Early Care and Education/ School-Age Centers, there are safety requirements for **outdoor play areas**.[433]	Adult supervision, educate kids on playground safety – especially on monkey bars, swings, slides, and climbing equipment – follow safe equipment and fall surfacing guidelines.[434]

[419] *Centers for Disease Control and Prevention (CDC). "Sudden Unexpected Infant Death and Sudden Infant Death Syndrome (SUID/SIDS)." Updated 2023. https://www.cdc.gov/sids/index.htm.*
[420] *Delaware Division of Public Health. (2025). Safe Sleep – Delaware Thrives. Retrieved from https://www.delawarethrives.com*
[421] *National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts: Bicyclists and Other Cyclists, 2023 Data. Washington, DC: U.S. Department of Transportation, 2024. https://crashstats.nhtsa.dot.gov/Api/Public/Publication/813712.*
[422] *Knepper, E. Martin. Children, Teens & Bicycle Accidents in Delaware. Delaware Car Accident Law Firm, Doroshow, Pasquale, Krawitz & Bhaya. Accessed September 28, 2025. https://knepperlaw.com*
[423] *Delaware Office of Highway Safety. (2025). Bicycle Safety. Delaware Department of Safety and Homeland Security. Retrieved from https://ohs.delaware.gov*
[424] *Children's Safety Network. "Childhood Drowning Facts." 2023. https://www.childrenssafetynetwork.org/infographics/facts-childhood-drowning.*
[425] *Centers for Disease Control and Prevention. (2024, October 29). Drowning Prevention. National Center for Health Statistics. Retrieved from https://www.cdc.gov*
[426] *Delaware Division of Public Health. (2025). Prevention of Drowning and Submersion Injuries. Delaware Coalition for Injury Prevention. Retrieved from https://www.dhss.delaware.gov*
[427] *National Highway Traffic Safety Administration (NHTSA). 2022 Child Passenger Safety Fact Sheet. Washington, DC: U.S. Department of Transportation, 2023. https://www.codot.gov/safety/shift-into-safe-news/2024/july/2022-child-traffic-safety-facts-nhtsa.*
[428] *Delaware State Police. (2024). Delaware Annual Traffic Statistical Report: Crash Data 2023. Retrieved from https://dsp.delaware.gov/reports*
[429] *Kann, Laura, et al. "Youth Risk Behavior Surveillance—United States, 2019." MMWR Surveillance Summaries 69, no. 1 (2020): 1–83. https://www.cdc.gov/yrbs.*
[430] *National Cancer Institute. "State Cancer Profiles: Delaware." State Cancer Profiles, U.S. Department of Health and Human Services, National Institutes of Health, September 27, 2025. https://statecancerprofiles.cancer.gov/.(2017-2021).*
[431] *University of Delaware. "Skin and Sun Safety." Student Wellbeing, Division of Student Life, University of Delaware. Accessed September 27, 2025. https://sites.udel.edu/studentwellbeing/skin-and-sun-safety/.*
[432] *The Nemours Foundation. (2023, April). Playground Safety. Nemours® KidsHealth®. Retrieved from https://kidshealth.org*
[433] *Delaware Administrative Code, Title 9, 101-33.0 Outdoor Area. Amended May 1, 2024. https://www.publichealthlawcenter.org/sites/default/files/Delaware%20101-330%20Outdoor%20Area.pdf. Accessed September 27, 2025*
[434] *Ragali, A. (2024, April 17). Exploring Playground Safety: Facts, Figures, and Strategies. HAI Group. Retrieved from https://www.haigroup.com*

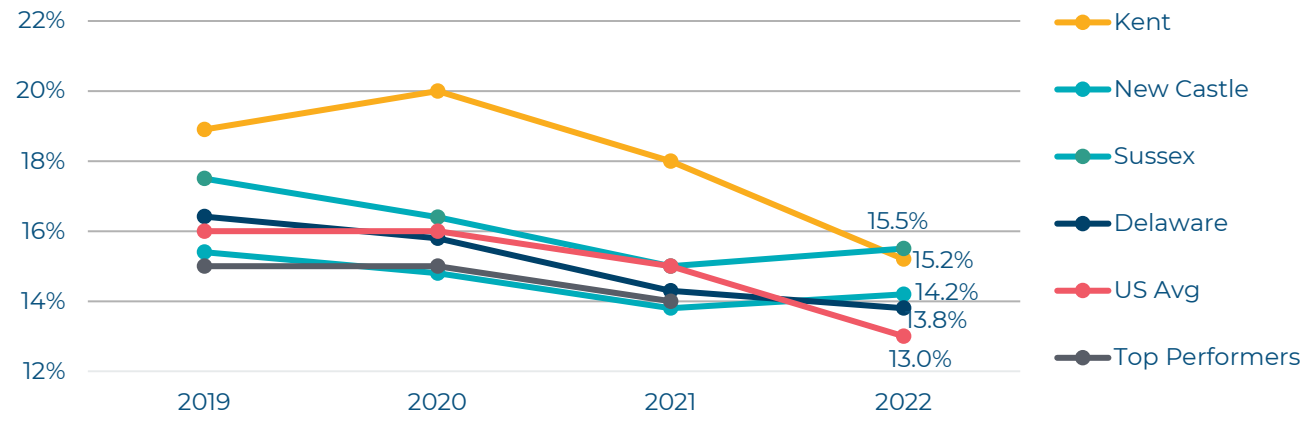
*For more health and safety information and resources tailored to parents, children and teens alike – visit www.kidshealth.org.

At Nemours Children's Hospital, Delaware — the state's only Level 1 Pediatric Trauma Center — **falls are the leading mechanism of injury** for our trauma program. In response, the Injury Prevention team actively engages with schools and community organizations to promote safety as a foundational element of child health and well-being. A hallmark of this approach is the **customized playground safety programming**, where our Injury Prevention Coordinator photographs each school's equipment and collaborates with staff to tailor curriculum to the specific structures, layout, and risk factors present at each site. This ensures safety guidance is not only relevant but actionable – grounded in the actual environment children engage with daily. Studies have shown that when supervision and education are adapted to the specific play environment, risk behaviors decrease, and injury rates decline.[435]

Tobacco Use

Tobacco use is another risk behavior that threatens safety and is one of the most significant preventable causes of disease and death in the United States. Adult cigarette smoking continues to contribute to heart disease, stroke, lung disease, and certain cancers. In Delaware, state (13.8%) and county-level smoking rates remain higher than the national average (13.0%) and the Healthy People 2030 target of 6.1%. These figures underscore that while adult smoking has declined over time, it persists at levels that maintain considerable health risk.

Figure 105. Percent of Adults Age 18 and Older Who Currently Smoke by County, Delaware, 2019-2022



Source: Behavior Risk Factor Sruveillance System (BRFSS), 2019-2022

> *Approximately 15.5% of residents in Sussex County smoke, followed by Kent at 15.2% and 14.2% in New Castle County.*

The impact of tobacco use extends beyond the individual smoker through secondhand smoke exposure in the home. According to the National Survey of Children's Health, 14.6% of Delaware children live in households where someone smokes, compared to 11.5% nationally. This falls short of the Healthy People 2030 goal to increase the proportion of smoke-free homes to 92.9%. Such exposure in early life increases the risk of respiratory illness, ear infections, and asthma exacerbations, creating a compounding burden for children already experiencing health inequities.[436]

[435] *Thompson, D., Hudson, S., & Olsen, H. (2002). ABC's of Playground Supervision. Educational Manual. Cedar Falls, Iowa: National Program for Playground Safety. https://playgroundsafety.org/research.*

[436] *U.S. Department of Health and Human Services, The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, 2006.*

Figure 103. Percent of Children Ages 0-17 Who Live in Households Where Someone Smokes, 2022-2023

Delaware	Nationwide
14.6%	11.5%

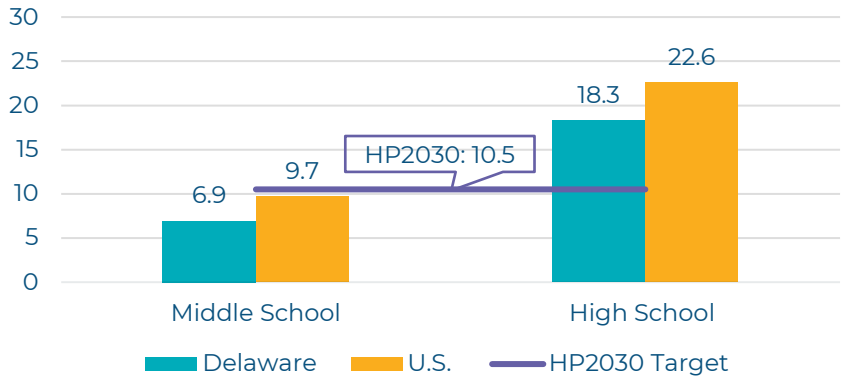
This does not meet the Healthy People 2030 goal of increasing the proportion of smoke-free homes to 92.9%.

Source: National Survey of Children's Health (NSCH), 2022-2023

Patterns established in childhood are critical, as people who start smoking at an early age are more likely to develop a severe addiction to nicotine than those who start at a later age.[437]. Vapor products or e-cigarettes are considered tobacco products because most of them contain nicotine as well as other harmful ingredients. Nicotine exposure during adolescence can cause addiction and harm to the brain. The use of these vapor products has grown over the past several years..[438]

In Delaware, 18.3% of high school students and 6.9% of middle school students reported current use of electronic vapor products in 2023. The Delaware and U.S. high school rates do not meet the Healthy People 2030 goal of reducing current e-cigarette use in adolescents to 10.5%.

Figure 106. Percent of Youth in Middle and High School Who Currently Use an Electronic Vaping Product*, Delaware, 2023



In 2018, **e-cigarette use was 19 times higher** in high school females (19%) and **11 times higher** in high school males (23%) than it was in 2011 (1%-2%).

Today, e-cigarettes are used **more often by high school students than by adults**.

U.S. Department of Health and Human Services, 2024

Source: CDC. Youth Risk Behavior Surveillance System. 2023

**Electronic vapor products include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs and hookah pens. Current use is defined as using the substance one or more times during the 30 days prior to the survey.*

While some declines in cigarette and combustible product use are evident, the rise of vaping products among youth reflects shifting trends rather than the elimination of risk.

Among **high school students**, **statistically significant declines** ($p<0.05$) occurred in current use of:

- **any tobacco product** (from 16.5% to 12.6%),
- **e-cigarettes** (from 14.1% to 10.0%),
- **cigars** (from 2.8% to 1.8%), and
- **any combustible tobacco product** (from 5.2% to 3.9%).

[437] *American Legacy Foundation. 2000. National Youth Tobacco Survey. 2001.*

438 Know the Risks: E-cigarettes and Young People, Get the Facts," U.S. Department of Health and Human Services, accessed May 26,2025, https://e-cigarettes.surgeongeneral.gov/getthefacts.html.

Among **middle school students**, **statistically significant increases** ($p<0.05$) occurred in current use of:

- **any tobacco product** (from 4.5% to 6.6%), and
- **multiple tobacco products** (from 1.5% to 2.5%).[439]

These data reinforce nicotine dependence during adolescence and increase the likelihood of continued use into adulthood, perpetuating cycles of risk and poor health outcomes.[440] Patterns that define physical health and lifestyle are deeply interconnected with long-term outcomes. While many factors are described as "modifiable," they are strongly influenced by circumstances such as food security, neighborhood safety, access to care, and socioeconomic stressors that shape whether healthy choices are possible. **Addressing these drivers requires not only individual education but also community and policy change that create environments where healthy living is realistic and sustainable**.

Tobacco use highlights the **bridge between physical and behavioral health**. Smoking and vaping are both biological risk factors for disease and behavioral responses shaped by stress, addiction, and social context. This overlap underscores that physical health cannot be fully separated from mental health, trauma, and substance use. The following section on Behavioral Health continues this progression, exploring how stress, mental well-being, and addiction intersect with the lifestyle and chronic disease patterns.

439 Birdsey J, Cornelius M, Jamal A, et al. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. MMWR Morbidity Mortal Weekly Rep 2023;72:1173–1182. DOI: http://dx.doi.org/10.15585/mmwr.mm7244a1.

440 U.S. Department of Health and Human Services, Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, 2012.

Behavioral Health

Behavioral health describes the interplay between emotions, thoughts, and actions, including mental health conditions, substance use, and the ways people cope with stress and trauma. For children and adolescents, behavioral health is foundational to learning, social development, and physical well-being. When these needs are unmet, the consequences can reverberate across school performance, relationships, and future health.

Research shows that one in five young people experiences a mental health disorder each year, and nearly half of all lifetime mental health conditions emerge by mid-adolescence.[441],[442] These challenges are not confined to the individual child—family dynamics, parental stress, and untreated adult behavioral health issues can profoundly shape a child's development and resilience.[443] Left unaddressed, behavioral health concerns in youth increase the likelihood of chronic disease, substance use, justice system involvement, and reduced opportunity later in life. Because adolescence is both a vulnerable and formative period, it offers a critical window for prevention and intervention. Addressing behavioral health in youth is therefore not just about treatment, but about creating pathways to healthier families and stronger communities across the lifespan.[444]

Mental Health

Mental health is inseparable from physical health and social development, shaping how children and adolescents learn, form relationships, and respond to challenges. For young people, it is the scaffolding on which future health and opportunity are built. The well-being of children is also profoundly tied to the well-being of their caregivers. Research demonstrates that when parents or guardians struggle with depression, anxiety, or other mental health conditions, the effects reverberate through the household. Children of parents with untreated depression are more likely to exhibit emotional and behavioral problems, to fall behind academically, and to experience long-term health risks that stretch into adulthood.[445],[446] Adult psychological distress is therefore not only a matter of individual burden but a key determinant of pediatric health.

Adults across the state of Delaware report high levels of psychological distress, with Kent County residents averaging 5.4 mentally unhealthy days in the past month—more than the national average and higher than the state's other two counties. This matters because children raised in households marked by caregiver distress often face disrupted routines, heightened stress, and diminished capacity for support at home.

[441] *Centers for Disease Control and Prevention (CDC). Youth Data: Mental Health. Atlanta, GA: U.S. Department of Health and Human Services, 2023. https://www.cdc.gov/healthyyouth/mental-health/index.htm.*

[442] *Kessler, Ronald C., et al. "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." Archives of General Psychiatry 62, no. 6 (2005): 593–602.*

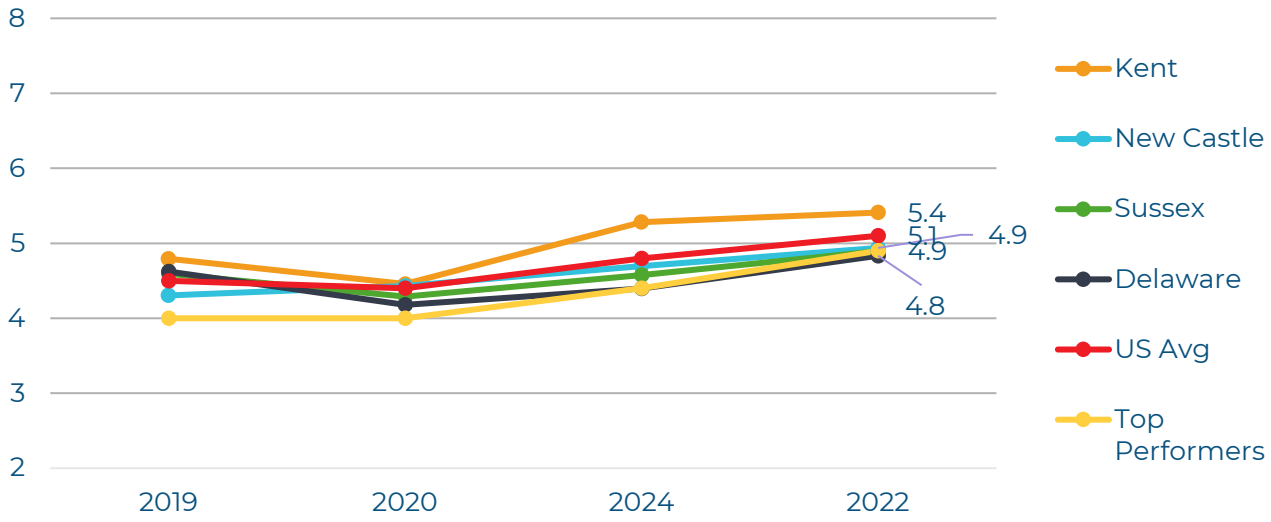
[443] *National Research Council and Institute of Medicine. Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington, DC: National Academies Press, 2009.*

[444] *U.S. Department of Health and Human Services. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, 2016.*

[445] *National Research Council and Institute of Medicine. Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington, DC: National Academies Press, 2009.*

[446] *Goodman, Sherryl H., and Ian H. Gotlib. "Risk for Psychopathology in the Children of Depressed Mothers: A Developmental Model for Understanding Mechanisms of Transmission." Psychological Review 106, no. 3 (1999): 458–90.*

Figure 107. Average Number of Mentally Unhealthy Days Reported in the Last 30 Days in Adults 18+by County, Delaware, 2019-2022

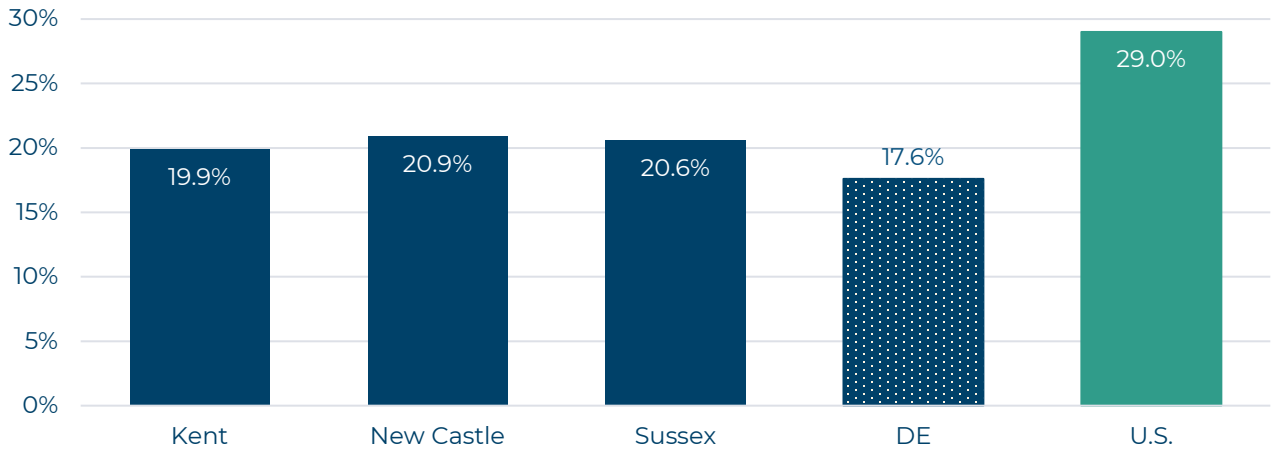


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2019-2022.

Kent County reported an average of 5.4 mentally unhealthy days in the past month—the highest in the state—followed by New Castle and Sussex Counties at 4.9.

One in five adults (17.6%) in Delaware report ever having been diagnosed with a depressive disorder, which is below the national average (29.0%). This gap between experienced distress and recorded diagnosis suggests that some adults—and by extension their families—may be living with unmet needs, shaped by barriers such as access, stigma, or lack of screening.

Figure 108. Percent of Adults Ever Diagnosed with a Depressive Disorder by County, Delaware, 2023



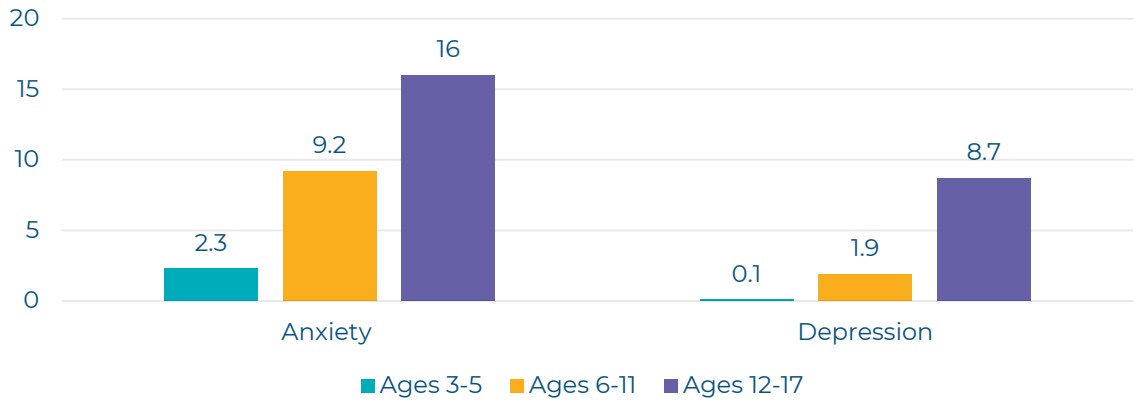
Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System (BRFSS), 2023.

As adult mental health challenges persist, childhood mental health concerns are rising nationally and locally. Anxiety is the most common diagnosis among children, affecting 11% overall, while depression affects 4%.[447] Both conditions become more common with age: by adolescence, nearly one in six teens

[447] *Child and Adolescent Health Measurement Initiative. National Survey of Children's Health (NSCH) 2022–2023. Data Resource Center for Child and Adolescent Health. https://nschdata.org.*

live with anxiety and nearly one in ten with depression.[448] Gender differences add another important dimension. Girls are more likely than boys to be diagnosed, with 12% of females and 9% of males experiencing anxiety, and 6% of females compared to 3% of males diagnosed with depression. These disparities suggest that biological, social, and environmental factors may shape how mental health concerns emerge and are recognized across childhood and adolescence.

Figure 109. Percent of Children Ages 3–17 With Anxiety and/or Depression, by Age, United States, 2022–2023



Diagnosis	Male	Female	Total
Anxiety	9%	**12%**	11%
Depression	3%	**6%**	4%

Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health (NSCH), 2022-2023

Rising rates of anxiety among children and adolescents are increasingly linked not only to trauma and household stressors, but also to the **pressures of overperformance** in school, sports, and extracurricular activities. Studies show that high-achieving students and competitive athletes are at elevated risk for anxiety disorders, with symptoms driven by perfectionism, fear of failure, and chronic stress from intensive schedules.[449,450]

The American Psychological Association reports that nearly **1 in 3 teens cite academic pressure as a major source of stress**, a burden that has been rising over the past decade.[451]

Research on *youth athletics* finds that **competitive pressure, long practice hours, and the pursuit of scholarships or elite performance can contribute to burnout, sleep disruption, and anxiety**, particularly when performance is closely tied to identity and family expectations.[452]

These findings suggest that while achievement can foster resilience and skill-building, the intensity of

[448] *Ibid*

[449] *Wood, Jillian J., et al. "Academic Performance and Anxiety in Children: A Meta-Analysis." Child Psychiatry & Human Development 50, no. 8 (2019): 1381–1402.*

450 Rice, Simon M., et al. "Sport-Related Pressure and Mental Health in Elite Young Athletes: A Systematic Review." International Review of Sport and Exercise Psychology 9, no. 1 (2016): 133–52.

[451] *American Psychological Association. Stress in America: The Impact of Stress on Youth. Washington, DC: APA, 2019.*

[452] *Gerber, Markus, et al. "Burnout in Young Athletes: Risk and Protective Factors." European Journal of Sport Science 13, no. 5 (2013): 499–508.*

modern youth environments may also be fueling the anxiety trends reflected in the data.

Community survey findings provide local context to the national data, with 8% of respondents reporting a stress or anxiety disorder in their child, and 6% revealing another mental/behavioral health diagnosis.

We asked community survey participants:
Have you ever been told by a doctor, nurse or other health professional that this **child*** has any of these conditions, diseases, or challenges?

8%
Stress or anxiety disorder

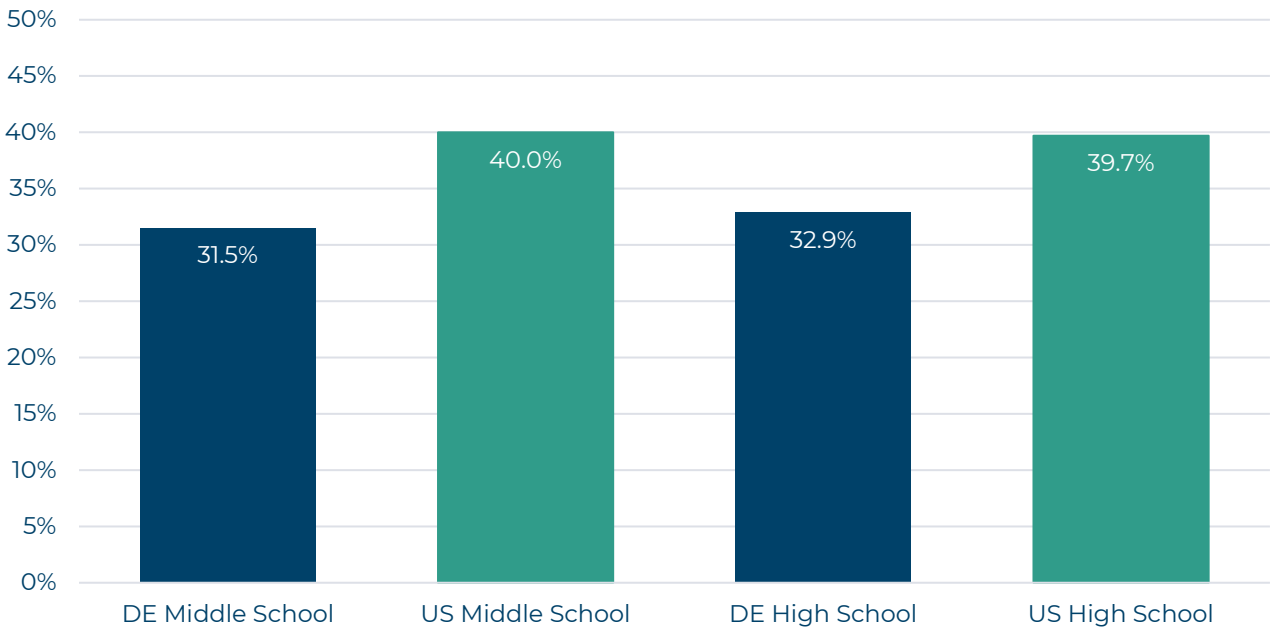
6%
Mental/Behavioral health condition
(excluding PTSD, anxiety, or eating disorders)

Children from the more densely populated ZIP code areas of **Wilmington City**, **Dover/Surrounding Area**, and **NE/SE Beaches** report higher rates of post-traumatic stress disorder (PTSD) than their peers in the remainder of each county (+2%).

Source: Nemours Community Survey, 2025

"This child" was used when asking the parent-proxy about the specific child from their household who was determined as the subject of all pediatric questions in the survey. Child subjects were randomly selected using the last-birthday (LB) method. This broader burden of mental health becomes more evident when looking beyond diagnoses to how young people describe their own experiences. Self-reported measures of sadness and hopelessness capture the depth of distress that may never result in a clinical diagnosis but still profoundly affect day-to-day functioning and long-term well-being – with sadness and hopelessness in adolescence serving as strong predictors of academic disengagement, substance use, and suicide risk, as well as linkages to chronic disease and diminished economic opportunity in adulthood.[453] Nearly 32% of middle school students and 33% of high school students in Delaware reported feeling sad or hopeless for two or more consecutive weeks over the past year. While the national percents are slightly higher (40% and 39.7% respectively), these proportions are still concerning.

Figure 110. Percent of Middle and High School Students Who Felt Sad or Hopeless for Two or More Consecutive Weeks in the Last Year, Delaware, 2023



Source: CDC. Youth Risk Behavior Surveillance System, 2023

What emerges from both the survey and national data is that **adolescence is a period of intensification**.

453 Fergusson, David M., and L. John Horwood. "Early Onset of Depression and Later Health Outcomes." Psychological Medicine 31, no. 6 (2001): 959–67.

Symptoms that may have been intermittent in childhood become more frequent and impairing as teens navigate academic pressure, social stress, and identity formation. Within these patterns there are disparities that sharpen focus. Nationally:

- Adolescent girls are far more likely than boys to report sadness and hopelessness, a gap that has widened in the past decade.[454]
- LGBTQ+ youth are significantly more likely to report persistent sadness, anxiety, and suicidal ideation than their peers, often reflecting the compounded stress of stigma, discrimination, and rejection.[455]
- Youth of color frequently experience disproportionate exposure to adversity, including racism, economic hardship, and community violence, which manifests as elevated rates of distress.[456]

These disparities underscore that youth mental health cannot be understood apart from the social and structural environments in which children live.

Youth also tell us how they cope. A 2023 Nemours KidsHealth poll found 86% of children worry; parents are the first line of support (67%), but help from peers, creative outlets, and online spaces is common, with uneven effectiveness.[457] These insights point to where to build capacity: families, schools, and youth-friendly community anchors.

86% Children report that they worry	Children most commonly turn to their parents in times of worry, but this appears to diminish with age.
67% Turn to parents for information or advice when they worry	More than 9 in 10 children who talk to someone or do something creative when they are worried, like paint or play music, say it makes them feel better.
55% Children worry about being bullied	Distracting oneself through social media and other technology is common — yet this often doesn't make children feel better.
36% Kids report being sad or miserable when they worry	More than half of children think adults don't really understand what they worry about.
	Some children feel like they worry more than peers and that no one usually notices when they do.

Source: Nemours KidsHealth. What's Worrying America's Kids: A National Survey, 2023.

**The research was conducted online from January 12–24, 2023, in the United States. The poll surveyed 504 youth ages 9–13, with permission to participate from their parent or legal guardian.*

[454] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey Data Summary & Trends Report, 2011–2021. Atlanta, GA: U.S. Department of Health and Human Services, 2023.*

[455] *Johns, Michelle M., et al. "Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students—Youth Risk Behavior Survey, United States, 2015–2019." Morbidity and Mortality Weekly Report 69, no. 1 (2020): 19–27.*

[456] *Alegría, Margarita, et al. "Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S." Journal of Adolescent Health 49, no. 5 (2011): 477–94.*

[457] *Nemours Children's Health, KidsHealth. What Kids Worry About: A National Survey, 2023.*

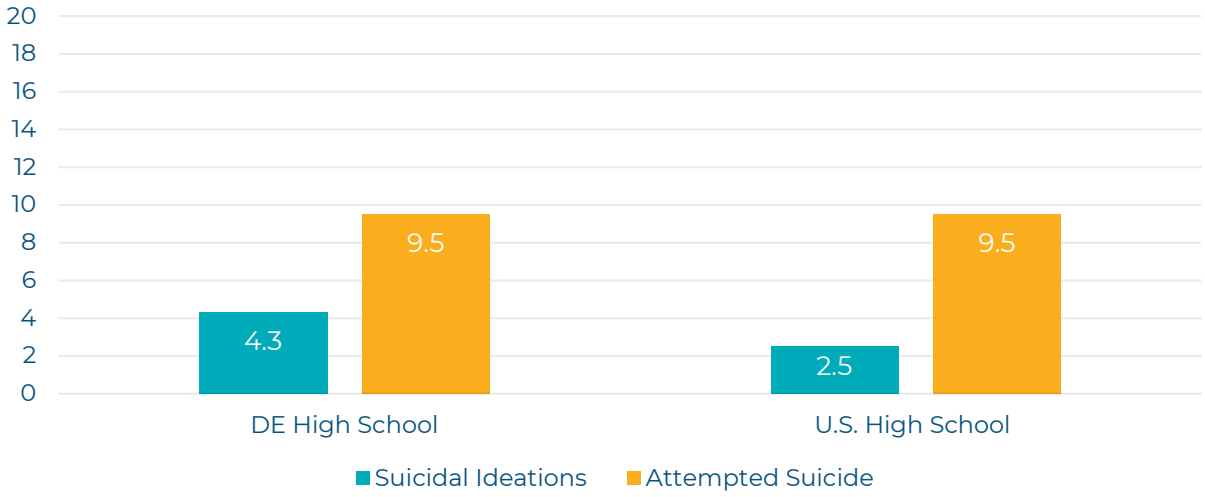
Understanding why kids worry, and the signs to look for, can help with prevention and early intervention – the most effective ways of creating long-term wellness.[458] It starts with recognizing how distress manifests in real life.

In kids, warning signs are often behavioral and functional (sleep changes, irritability or withdrawal, declining grades, school avoidance, somatic complaints, social conflict) rather than adult-style verbal reports of "depression."[459]

When parents, teachers, and pediatric clinicians are primed to notice these patterns and respond early with brief supports, safety checks, and warm handoffs, risk falls long before a crisis emerges. Large studies show that school connectedness—having even one trusted adult—protects against depression, substance use, and suicide-related behaviors,[460] and national recommendations endorse routine screening for adolescent depression and anxiety in healthcare settings when systems are in place for timely evaluation and follow-up, precisely to capture the many youths whose symptoms have not yet become diagnoses.[461] These approaches align with suicide-prevention evidence: earlier identification + immediate access to help (24/7) reduce distress[462] and can interrupt the pathway from persistent hopelessness to suicidal thinking and attempts.[463]Together, they translate what we hear from children into concrete, upstream prevention that reduces the probability of crisis and fatal outcomes.

Suicidal ideation demonstrates the urgency of timely identification and support. In 2023, 4.3% of Delaware high school students reported experiencing suicidal ideations, and nearly 10% reported attempted suicide. While the rate of attempted suicide is the same in Delaware as it is in the U.S. overall, suicidal ideations is almost twice as high among Delaware high school students than in their peers nationwide.

Figure 111. Percent of High School Suicide Attempts and Ideations *, Delaware, 2023



Source: CDC. Youth Risk Behavior Survey (YRBS), 2023

**Suicidal Ideation data includes the percentage of respondents who seriously considered attempting suicide.*

[458] *Nemours® KidsHealth®. (2023). What's Worrying America's Kids: A National Survey. Conducted by The Harris Poll. The Nemours Foundation. Retrieved from https://www.nemours.org/WhyKidsWorry. Accessed September 18, 2025.*

[459] *Alegría, Margarita, et al. "Disparities in Child and Adolescent Mental Health Services in the U.S." Journal of Adolescent Health 49, no. 5 (2011): 477–94.*

[460] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey Data Summary & Trends Report, 2011–2021. Atlanta, GA: U.S. Department of Health and Human Services, 2023.*

461 U.S. Preventive Services Task Force (USPSTF). Screening for Depression and Suicide Risk in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. JAMA 328, no. 15 (2022): 1536–44.

[462] *Hoffberg, A. S., et al. "Effectiveness of Crisis Line Services: A Systematic Review." Frontiers in Public Health 8 (2020): 190.*

[463] *Pfeiffer, Peggy N., et al. "Peer Support for Mental Health and Substance Use: Evidence, Challenges, and Future Directions." Psychiatric Services 72, no. 6 (2021): 601–07.*

Nationally, suicide is now the second leading cause of death for adolescents, and rates have been rising for over a decade.[464] In Delaware, nearly half of suicide deaths involve firearms, and many of those who die have a documented history of suicidal thoughts or prior attempts.[465] The evidence is clear: **access to lethal means, particularly firearms, dramatically increases the likelihood that an attempt will result in death**.[466]

In Delaware's recent violent death reporting, firearms were the most common mechanism (47%) among suicide decedents; nearly half had a documented mental health challenge; over one-third had a history of suicidal ideation; and 4 in 5 adolescent firearm suicides involved a gun belonging to a family member, highlighting the life-saving impact of secure storage.[467]

The rate of **suicide deaths** in Delaware is **13.5 per 100,000** population

Firearms were the most common mechanism (**47%**)

4 in 5 adolescent firearm suicides **involve a gun belonging to a family member**.

Nearly **half (45%) had a mental health challenge.**

More than **1 in 3** had a **history of suicidal ideations**

23% had a **history of attempted suicide.**

Source: Delaware Division of Public Health. Delaware Violent Death Reporting System (DVDRS),

Suicide and Overdose Data System (SUDORS). My Healthy Community, 2023. There is a growing body of evidence around crisis intervention. In addition to clinical inpatient and emergency department crisis stabilization, studies of community-based approaches demonstrate positive outcomes. For example, crisis hotlines show immediate reductions in distress during and after calls, with callers reporting greater feelings of safety and reduced hopelessness.[468] Peer support models, particularly those designed for teens and young adults, increase engagement because young people often prefer to talk first with someone close to their own age.[469] The availability of these services at all hours is critical, as mental health challenges can arise at any time and early connection can prevent escalation. In Delaware, community organizations like Sean's House – who provide 24/7 peer-led support for teens and young adults – offer a safe, welcoming space where young people can talk openly, receive guidance, and connect to resources that meet their needs.

Delaware's data and national evidence converge on one conclusion: **children's mental health is at once fragile and foundational.** It is influenced by the mental health of parents, shaped by social environments, and too often under-recognized until symptoms escalate. The persistence of sadness, the disparities across gender and identity, the reliance on informal supports, and the prevalence of suicidal ideation all underscore that **mental health in childhood is not a side issue but a central determinant of health and outcomes over the lifespan.**

Substance Use

Substance use among youth is both a behavioral health issue and a window into the deeper struggles children face. For many young people, early encounters with alcohol or drugs are not about recreation alone but about coping—with sadness, stress, trauma, or instability at

[464] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS): Leading Causes of Death Reports, 1981–2021. Atlanta, GA: National Center for Injury Prevention and Control, 2023.

[465] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance—United States, 2021. Morbidity and Mortality Weekly Report 72, no. 1 (2023): 1–50.*

[466] *Miller, Matthew, et al. "The Case for Firearm Access Prevention in Suicide Prevention." New England Journal of Medicine 380, no. 10 (2019): 895–97.*

[467] *Monuteaux, Michael C., et al. "Association of Increased Safe Household Firearm Storage With Firearm Suicide and Unintentional Death Among U.S. Youths." JAMA Pediatrics 173, no. 7 (2019): 657–62.*

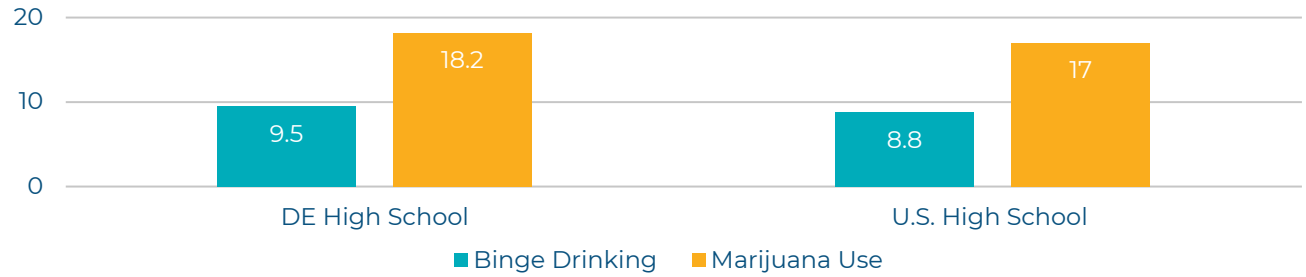
[468] *Gould, Madelyn S., and Anthony F. Kleinman. "Suicide Hotlines and Crisis Centers." Suicide and Life-Threatening Behavior 21, no. 2 (1991): 195–209.*

[469] *Pfeffer, Peggy N., et al. "Peer Support for Mental Health and Substance Use: Evidence, Challenges, and Future Directions." Psychiatric Services 72, no. 6 (2021): 601–07.*

home. The pediatric stakes are high: adolescent substance use can disrupt brain development, impair learning and memory, and increase the risk of accidents, chronic disease, and premature death.[470] And because substance use is closely interwoven with mental health, it both reflects and amplifies the distress already evident in Delaware's young people.

Delaware data show that alcohol and cannabis remain the most commonly used substances among teens. In 2023, 9.5% of Delaware high school students reported binge drinking which is above the national rate of 8.8%. Marijuana use was reported by 18.2%, higher than the U.S. average of 17%. Delaware high school students report **binge drinking and marijuana use at more than three times higher than the Healthy People 2030 goals for each indicator** (3.1%, and 5.8%, respectively).[471],[472]

Figure 112. Percent of Reported Current Binge Drinking* and Current Marijuana Use** in High School Students (Grades 9-12), Delaware, 2023



Source: CDC. Youth Risk Behavior Survey (YRBS), 2023

**Current binge drinking is defined as four or more drinks of alcohol in a row (if they were female) or five or more drinks of alcohol in a row (if they were male), within a couple of hours. **Current marijuana use is defined as having used marijuana one or more times during the 30 days before the survey.*

The data demonstrates a potential link to mental health burden. National YRBS analyses reveal:

Students experiencing persistent sadness or hopelessness are **twice as likely to drink alcohol and three times as likely to use marijuana** as their peers without such symptoms. Delaware-specific data reflects a similar correlation.[473],

How early use begins, or "early initiation", adds an additional layer of risk:

Approximately **14% of Delaware High School students said they had their first drink before age 13**, compared to 13.3% nationally.

Children who begin using alcohol who drugs before mid-adolescence (<age 15) are significantly more likely to develop a substance use disorder, have mental health problems, engage in risky sexual behaviors, and struggle academically. [474],[475],[476]

[470] *National Institute on Drug Abuse (NIDA). "Adolescent Substance Use and Its Impact on Brain Development." National Institutes of Health, 2020. https://nida.nih.gov.*

[471] *Healthy People 2030. "Reduce the Proportion of Adolescents Aged 12 to 17 Years Engaging in Binge Drinking—SU-10." Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, 2020. https://health.gov/healthypeople.*

[472] *Healthy People 2030. "Reduce the Proportion of Adolescents Aged 12 to 17 Years Who Use Marijuana—SU-09." Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, 2020. https://health.gov/healthypeople.*

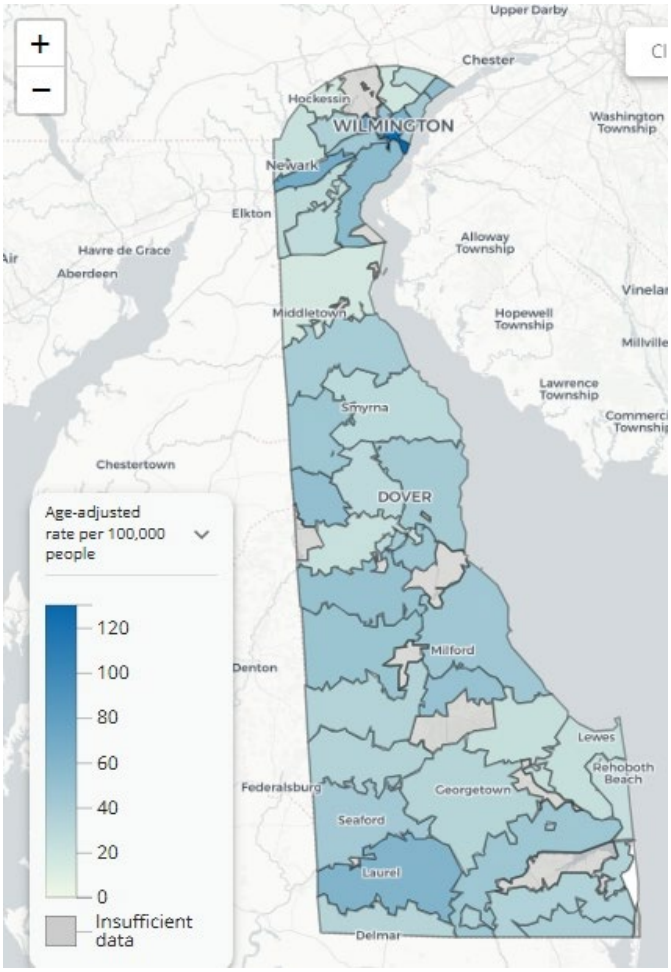
[473] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System (YRBSS): 2023 Results. U.S. Department of Health and Human Services, 2023.*

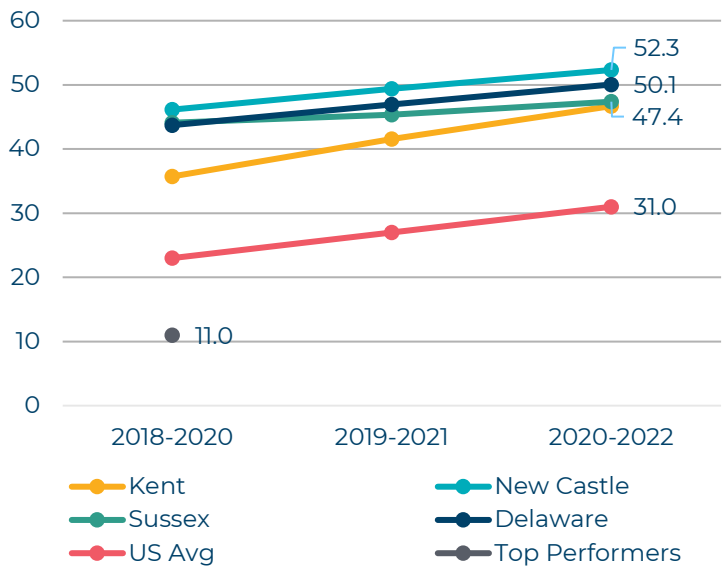
[474] *Hingson, Ralph W., and Aaron White. "New Research Findings Since the 2007 Surgeon General's Call to Action to Prevent and Reduce Underage Drinking: A Review." Journal of Studies on Alcohol and Drugs 75, no. 1 (2014): 158–169.*

[475] *National Institute of Drug Abuse (NIDA). Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. National Institutes of Health, 2020.*

[476] *Windle, Michael, and Richard W. Zucker. "Redefining Adolescent Substance Use: Developmental Perspectives." Psychological Science in the Public Interest 11, no. 3 (2010): 1–23.*

Figure 113. Rate of Unintentional Drug Overdose Deaths per 100,000 population by County and ZIP Code of Residence, Delaware, 2018-2022





Source: Delaware Department of Health and Social Services (DHSS), My Healthy Community, SUDORS: State Unintentional Drug Overdose Reporting System, 2018-2022; CHR, 2025; National Center for Health Statistics-Mortality Files, 2018-2022

**Figures show unintentional drug overdose deaths across all drug types.*

These implications are critically relevant when examining potential upstream factors related to Delaware's overdose rates. While most overdose deaths occur among adults, the relevance to pediatrics is evident. Children in households affected by parental substance use are at elevated risk of neglect, housing instability, and foster care entry. These exposures are strongly linked to higher rates of anxiety, depression, and substance use during adolescence, perpetuating an intergenerational cycle.[477,478] Thus, the overdose epidemic is not only an adult mortality issue; it is a pediatric health crisis reverberating through families and shaping children's futures.

Overdose mortality has been on an upward trajectory in Delaware and across the nation. The 2020-2022 Delaware two-year average of overdose deaths per 100,000 population (50.1) was significantly higher than the U.S. average (31) and **more than double the Healthy People 2030 target of 20.7.**

The map highlights ZIP-code hotspots—most notably Wilmington (19801, 19805, 19713) and parts of

[477] *Bridget, Maria, et al. "Parental Substance Use, Child Abuse, and Child Welfare Involvement: Findings from the National Survey of Child and Adolescent Well-Being." Child Maltreatment 24, no. 3 (2019): 26*

[478] *U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Relationship Between Substance Use Indicators and Child Welfare Caseloads. Washington, DC: HHS, 2021.*

Sussex County (19956, 19973)—where age-adjusted rates are highest, reflecting the dominant role of fentanyl in driving local fatalities. 2022 Data from Delaware's State Unintentional Drug Overdose Reporting System (SUDORS) show:

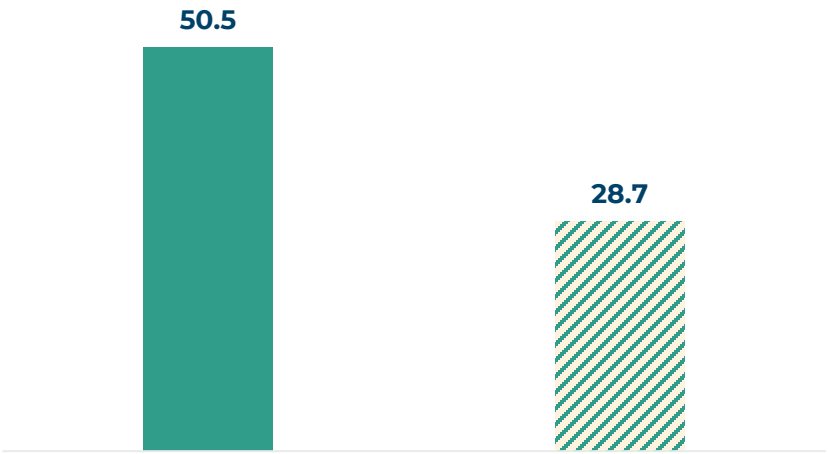
- Nearly one-third (32%) of overdose decedents had a documented mental health problem,
- One in four (25%) had experienced a prior overdose,
- 16% were in treatment for substance use, and
- 14% had recently returned to opioid use at the time of death.[479]

These patterns underscore that **overdose deaths cluster in identifiable communities and are often preceded by multiple contact points with health or social systems**, identifying opportunities for earlier intervention.

A young person's perception of the risk associated with a behavior can be a protective factor. In Delaware, only 55% of 11th graders and 43% of 8th graders reported perceiving "great risk" in using prescription drugs without a doctor's oversight.[480] This erosion of risk perception is alarming in an era when opioids and stimulants are potent, available, and deadly. Evidence shows:

Adolescents who minimize the risks of prescription misuse are more likely to initiate nonmedical use, to combine substances, and ultimately to experience overdose.[481] What begins as curiosity or casual misuse can evolve into dependence, especially when layered onto existing sadness, trauma, or family instability.

Rates of Overdose Deaths, DE and National, Any Opioids* (2022)



Source: SEOW, Opioid Use in Delaware, 2024.

Delaware's 2022 drug overdose mortality rate involving any opioid was 50.5 deaths per 100,000 residents, ranking second only to the District of Columbia among the 30 jurisdictions reporting. This is substantially higher than the national rate of 28.7 deaths per 100,000

**According to SUDORS, "Any Opioids" includes deaths that had at least one opioid listed as a cause of death. The "Any Opioids" category includes illegally-made fentanyl, heroin, prescription opioids, and any other opioids involved in overdose deaths.*

Prescribing Trends

The rate of people in Delaware filling an opioid prescription has declined since 2015, **decreasing from 20.4 to 11.6 people** per 100 residents by 2023.

Youth Misuse

In 2023, **3% of 11th grade students and 4% of 8th grade students** in Delaware reported they had ever taken pain killers to get high, and **~10% of high school students (grades 9-12) reported taking pain killers without a doctor's prescription** or differently than how a doctor told them to use it.

Perception of Risk

In 2023, **more than half (55%) of Delaware 11th graders** agreed there is "great risk" from using prescription drugs (including opioids) without a prescription, compared to **43% of 8th graders** who felt the same.

[479] *Delaware Department of Health and Social Services, Division of Public Health. State Unintentional Drug Overdose Reporting System (SUDORS), Delaware, 2018–2022. Dover, DE: Delaware Department of Health and Social Services, 2023.*
[480] *Delaware State Epidemiological Outcomes Workgroup (SEOW). Opioid Use in Delaware. Newark, DE: Center for Drug and Health Studies, University of Delaware; Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health; and U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), November 2024.*
[481] *Johnston, Lloyd D., et. al., Monitoring the Future National Survey Results on Drug Use, 1975-2022. Key Findings on Adolescent Drug Use. Institute for Social Research, University of Michigan, 2023.*

Large-scale reviews show that prevention programs anchored in schools—especially those that build social-emotional skills, involve parents, and deliver accurate information about risk—significantly delay initiation and reduce misuse.[482] **What protects most consistently, however, is connection**. Adolescents who feel close to at least one parent, teacher, or mentor are less likely to use alcohol, cannabis, or prescription drugs, even when exposed to adversity.[483]

Treatment

Timely access to treatment is critical in preventing a behavioral health concern from escalating into crisis. For children and adolescents, early treatment is especially dire: untreated depression, anxiety, or substance use not only disrupt daily life but can set a trajectory for chronic health problems, school failure, and even premature mortality later in adulthood.[484] Yet across the U.S.—and in Delaware—gaps in access remain wide.

National benchmarks show the scope of the challenge. According to the National Survey of Children's Health (NSCH), more than one in five U.S. children (ages 3–17) have a diagnosable mental, emotional, developmental, or behavioral disorder, yet only about half receive treatment from a mental health professional.

More than half (55%) of U.S. adolescents reported **discussing their mental and emotional health** with a health care professional.

Therapy and Medication

- **16%** of adolescents reported taking **prescription medication** to help regulate emotions, concentration, behavior, or mental health.
- **1 in 5** adolescents reported receiving **mental health therapy**.

20% of adolescents reported having **unmet mental health care needs**.

Source: National Center for Health Statistics. Interactive Summary Health Statistics for Teens. National Health Interview Survey—Teen. CDC, 2021-2023

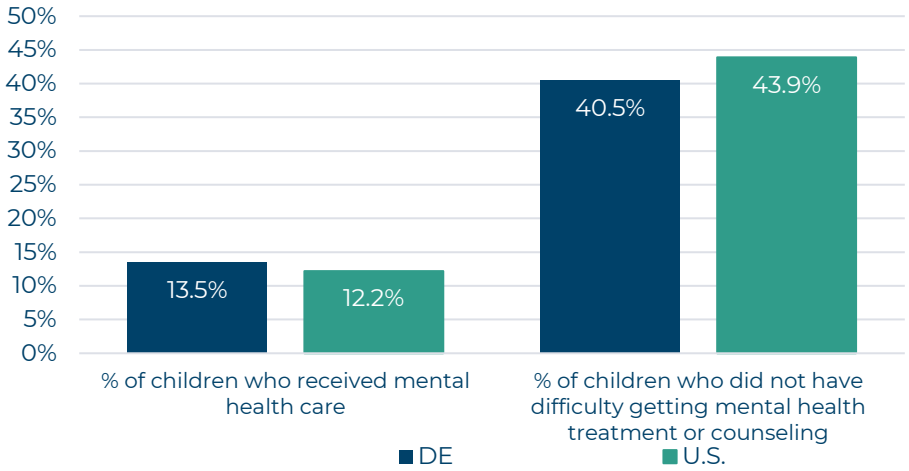
In Delaware, just 13.5% of children ages 3–17 received mental/behavioral health care when they needed it, compared to 12.2% nationwide. Fewer than half did not have difficulty getting treatment (40.5%), compared to 43.9% in the U.S. overall – further demonstrating that the U.S. and Delaware are falling short of providing accessible and equitable pediatric behavioral health care.

[482] *National Institute on Drug Abuse (NIDA). Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. Bethesda, MD: National Institutes of Health, 2020. https://nida.nih.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction*

[483] *Resnick, Michael D., et al. "Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health." JAMA 278, no. 10 (1997): 823–32. https://doi.org/10.1001/jama.1997.03550100049038*

[484] *National Institute on Drug Abuse (NIDA). Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. Bethesda, MD: National Institutes of Health, 2014. https://nida.nih.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction*

Figure 114. Percent of Children Ages 3–17 Who Received Mental Health Care When They Needed it, and Without Difficulty, Delaware, 2022-2023



"There are not nearly enough resources for mental health. And the places that are available are booked out months in advance, so people who really need to see someone can't be seen for quite some time."

– Community member

Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health (NSCH), 2022-2023

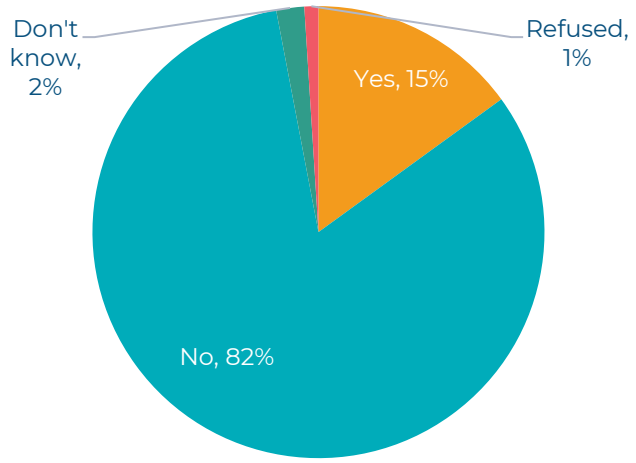
Healthy People 2030 set a target that 51.4% of children and adolescents who need mental health services receive them, but current estimates hover well below this benchmark. In addition, studies report the odds of unmet mental health care needs are even higher for children of color, children in low-income households, and those living in rural areas.[485,486]

To understand the perspectives behind these numbers, the Nemours CHNA community survey asked parents whether their child needed mental or behavioral health care in the past 12 months but did not receive it. Over 15% of families said yes. Among those respondents, the most common barriers were cost of treatment (28%), difficulty getting an appointment (22%), insurance barriers (17%), and the cost of care/diagnostics (16%). Families also noted stigma (5%), transportation (5%), and language or cultural barriers (2%) as obstacles.

[485] *Whitney, David G., and Mark D. Peterson. "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children." JAMA Pediatrics 173, no. 4 (2019): 389–91. https://doi.org/10.1001/jamapediatrics.2018.5399*

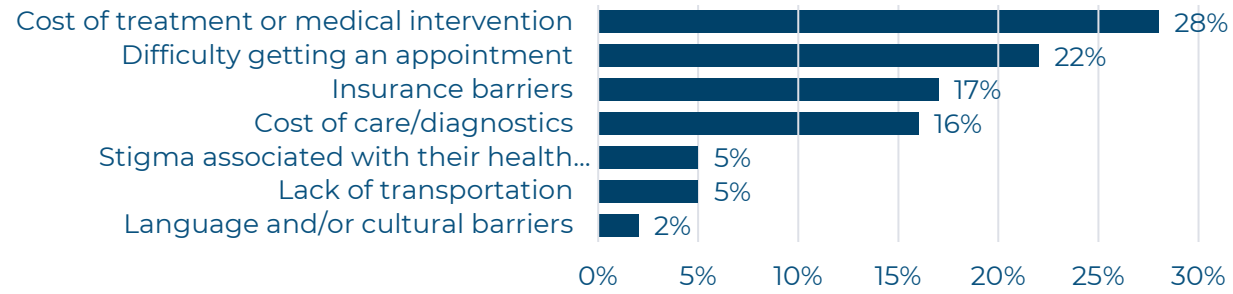
[486] *Perou, Ruth, et al. "Mental Health Surveillance Among Children — United States, 2005–2011." Morbidity and Mortality Weekly Report 62, no. 2 (2013): 1–35. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm*

Figure 115. Percent of Survey Respondent's with a Child that Did Not Get Receive Needed Mental and/or Behavioral Health Care and Primary Reason Why, Delaware, 2025



Community members described the frustration of knowing their child needed help but being unable to secure a timely appointment, noting that existing providers are often booked months in advance. Others emphasized how insurance limitations and out-of-pocket costs put services out of reach, even when children were in acute distress.

Source: Nemours Community Survey, 2025



These lived experiences echo what national studies have consistently shown: structural barriers—cost, wait times, and insurance coverage—outweigh individual reluctance in preventing children from accessing care.

When children's mental/behavioral health needs go unaddressed, the consequences extend well beyond the immediate crisis. Untreated conditions are linked to **poorer academic performance, higher rates of school dropout, and greater involvement with the juvenile justice system**. Over time, these unresolved challenges contribute to chronic health problems, and premature mortality in adulthood. Early intervention is therefore not only about reducing short-term distress but about protecting long-term trajectories for health, education, and social outcomes.[487]

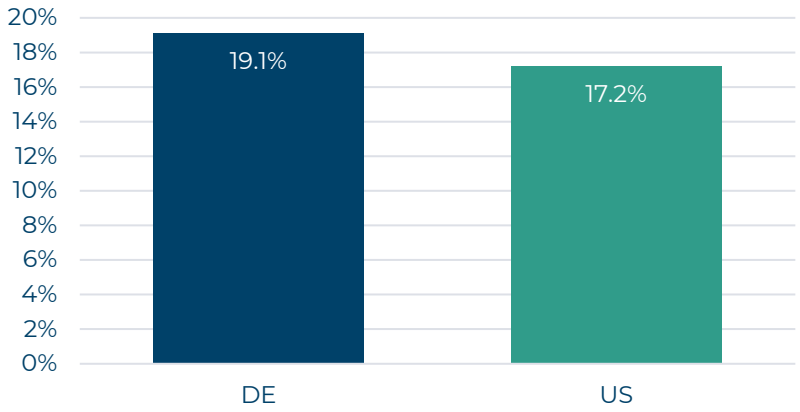
Trauma and Emotional Well-being Youth mental health challenges and early substance use are deeply connected to trauma and social-emotional wellbeing of children. Stressful and traumatic events in childhood create the conditions under which both mental health symptoms and substance use are more likely to take root. Conversely, when children have the supports to navigate adversity in healthy ways, they are more resilient and less likely to develop lasting behavioral health problems. Research in neuroscience and developmental psychology is clear: what happens to us in childhood shapes health across the lifespan. Experiences of adversity, especially when severe or prolonged, activate the body's stress response systems in ways that alter brain architecture, immune functioning, and hormonal

[487] *National Research Council and Institute of Medicine. Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities. National Academies Press, 2009. https://doi.org/10.17226/12480*

balance.[488]This "toxic stress" can impair emotional regulation, learning, and decision-making, leaving youth more vulnerable to depression, anxiety, and risky behaviors. Over time, the cumulative impact of trauma increases the likelihood of substance use and mental health disorders, chronic disease, and premature mortality.[489] In this way, the trauma of today's children is directly connected to the health and social outcomes we see in Delaware's adults tomorrow.

ACEs are generally grouped into three categories: (1) Abuse (2) Neglect, and (3) Household challenges. Studies show that ACEs are not rare, and more importantly, they are graded: the more ACEs a child experiences, the greater their risk for negative outcomes.[490] For example, children exposed to four or more ACEs are several times more likely to develop depression, misuse alcohol or drugs, or attempt suicide compared with those with none.[491] In Delaware, the scope of ACEs is significant. Nearly one in five children ages 0–17 (19.1%) has experienced two or more ACEs, compared to 17.2% nationally.

Figure 116. Percent of Children Ages 0–17 Having Experienced Two or More Adverse Childhood Events, * Delaware, 2022- 2023



Community members voiced concerns over trauma efforts in Delaware stating, "victims of trauma with criminal records [should be] given different opportunities for reform," and "[We need] trauma training in our schools and community, and holistic care for families who experience trauma."

Source: National Survey of Children's Health (NSCH), 2022-2023

**2 or more ACEs: Percent of children 0-17 having experienced two or more adverse childhood experiences out of a list of eleven ACE items: hard to get by on family's income (ACE1), parent or guardian divorced or separated (ACE2), parent or guardian died (ACE3), parent or guardian served time in jail (ACE4), saw or heard parents or adults slap, hit, kick punch one another in the home (ACE5), was a victim of violence or witnessed violence in neighborhood (ACE6), lived with anyone who was mentally ill, suicidal, or severely depressed (ACE7), lived with anyone who had a problem with alcohol or drugs (ACE8), treated or judged unfairly due to race/ethnicity (ACE 9), treated or judged unfairly due to sexual orientation or gender identity (ACE10), and treated unfairly because of health condition or disability (ACE11).*

Approximately
31%
of 8th and 11th graders
reported **3 or more ACEs**

The most commonly reported ACEs were:

- Living with someone with a mental illness
- Living with someone with SUD*
- Being bullied

Source: Delaware Department of Health and Social Services, Division of Public Health. Delaware School Survey: Student Health Behaviors, Grades 8 and 11, 2023. Newark, DE: Center for Drug and Health Studies, University of Delaware, 2023.

**SUD stands for substance use disorder.*

[488] *Shonkoff, Jack P., and Andrew S. Garner. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." Pediatrics 129, no. 1 (2012): e232–46. https://doi.org/10.1542/peds.2011-2663.*

[489] *Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine 14, no. 4 (1998): 245–58. https://doi.org/10.1016/S0749-3797(98)00017-8*

[490] *Merrick, Melissa T., Derek C. Ford, Katie A. Ports, and Angie S. Guinn. "Prevalence of Adverse Childhood Experiences from the 2011–2014 Behavioral Risk Factor Surveillance System in 23 States." JAMA Pediatrics 172, no. 11 (2018): 1038–44. https://doi.org/10.1001/jamapediatrics.2018.2537*

[491] *Bethell, Christina D., Narangerel Gombojav, Robert C. Whitaker, and Christina D. Johnson. "Adverse Childhood Experiences, Resilience, and Mindfulness-Based Approaches." Academic Pediatrics 19, no. 7 (2019): 793–801. https://doi.org/10.1016/j.acap.2019.05.003.*

The evidence supports an overlap between trauma exposure and intersecting behavioral health concerns: bullying increases the risk of depression, anxiety, and suicidality; parental substance use raises the likelihood of early initiation into alcohol or drugs; and family mental illness increases vulnerability to emotional distress.

> *"Parents don't know how to identify trauma. They don't see it." – Community member on the importance of parent/caregiver education around identifying trauma responses in their child.*

Without intervention, the impact of adverse childhood experiences persist into adulthood, driving higher rates of chronic disease, disability, and early death. Research shows that stable, supportive relationships with adults, early identification of distress, and access to safe environments can buffer the effects of trauma and equip children to thrive despite adversity.[492] **This makes ACEs not only a measure of harm, but also a clear call to action: reduce preventable trauma where possible, and surround children with protective factors where it cannot be avoided.**

The stressful life events reported by high school students can provide critical context for understanding patterns of behavior. More than one in five teens lived with a household member with mental illness (21.5%), and nearly one in five with substance use problems (17.5%). These two household conditions—mental illness and substance use—are among the most common exposures.

Teens aged 12-17 years reported experiencing the following stressful life events:

Divorced or separated parents: **31.7%**	Household member with mental illness: **21.5%**	Household member with substance abuse: **17.5%**
Discrimination: **18.0%** (race/ethnicity) **13.8%** (SOGI*)	Emotional abuse from Parent or guardian: **16.4%**	Victim or witness of community violence: **14.4%**
Incarcerated Parent(s): **10.9%**	Death of a parent or guardian: **7.3%**	Unmet basic needs: **6.9%**

Source: National Center for Health Statistics. Interactive Summary Health Statistics for Teens. National Health Interview Survey—Teen. CDC, 2021-2023

**SOGI stands for sexual orientation, gender identity)*[493]

Discrimination is another significant stressor, reported by 18.0% of teens for race/ethnicity and 13.8% for sexual orientation or gender identity (SOGI).

Research shows that **experiences of discrimination** predict higher rates of depressive symptoms, suicidal ideation, and substance use among youth, independent of household adversity.[494],[495]

This demonstrates that **trauma is both interpersonal and structural**—it comes from within homes, schools, and neighborhoods, but also from systemic inequities that leave children of color and LGBTQ+ youth carrying disproportionate risk.

[492] *Bethell, Christina D., et al. "Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample." JAMA Pediatrics 173, no. 11 (2019): e193007.*

[493] *GLAAD Media Reference Guide: 11th Edition. Glossary of Terms: LGBTQ. https://glaad.org/reference/terms. Accessed September 17, 2025*

[494] *English, Devin, et al. "Racial Discrimination, Mental Health Symptoms, and Substance Use in Adolescents." Cultural Diversity and Ethnic Minority Psychology 26, no. 2 (2020): 207–17.*

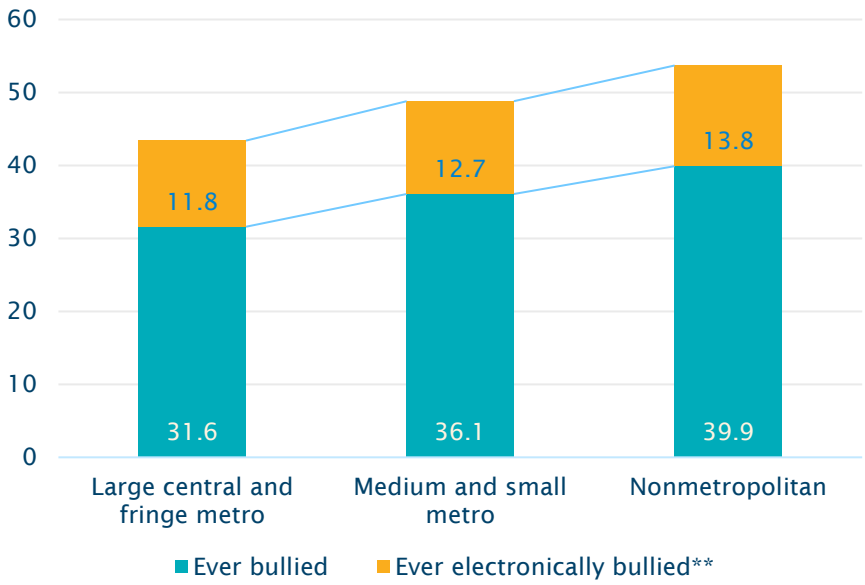
[495] *Johns, Michelle M., et al. "Disparities in Violence Victimization and Bullying among Sexual Minority Youth." MMWR 68, no. 11 (2019): 241–46.*

Within this broader landscape of stressors, bullying has continued to be a consistent and pervasive issue for youth. Unlike household adversity, bullying is peer-driven, repeated, and often public, undermining a child's sense of safety and belonging in environments that should nurture them**.**

Victims of bullying are at increased risk for **depression, anxiety, sleep disturbances, and suicidality**, while perpetrators show higher rates of **aggression, externalizing behavior, and substance use** later on.[496,497]

National data indicate bullying prevalence is higher in small towns and rural areas than in metropolitan schools, suggesting that community context—including access to prevention programs and supports—shapes risk.

Figure 117. Percent of Adolescents ages 12-17 Who Were Ever Bullied in the Past 12 Months by Urbanicity*, United States, 2021-2023



In the state of Delaware,
1 in 5
(20.7%)
high school students reported being bullied on school property and
16.3%
reported being electronically bullied.

Source: CDC: National Center for Health Statistics (NCHS), National Health Interview Survey (Teen), 2021-2023

**Urbanicity—Based on the 2013 NCHS Urban-Rural Classification Scheme for Counties which groups U.S. counties and county-equivalent entities into six urban-rural categories: large central metro, large fringe metro, medium metro, small metro, micropolitan, and non-core. For Interactive Summary Health Statistics for Teens, these six categories were collapsed into 3 groups: 1) Large central and fringe metros are defined as counties in Metropolitan statistical areas (MSAs) of 1 million or more population that contain the entire population of the largest principle city of the MSA, or have their entire population contained in the largest principle city of the MSA, or contain at least 250,000 inhabitants of any principle city of the MSA (large central) + counties in MSAs of 1 million or more population that did not qualify as large central metro counties (large fringe metro – New Castle County). 2) Medium and small metros are defined as counties in MSAs of populations of 250,000 to 999,999 (medium – Sussex County), + counties in MSAs of populations less than 250,000 (small metro – Kent County). 3) Nonmetropolitans are defined as counties in micropolitan statistical areas (micropolitan), + nonmetropolitan counties that did not qualify as micropolitan (noncore).[498] **Electronically bullied is defined as being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey.*

For Delaware, these geographical insights highlight the importance of addressing bullying both in urban districts like Wilmington and in smaller, rural schools across Kent and Sussex counties, where resources for prevention and response may be more limited.

Research shows that children and teens who feel hopeful about their future are more resilient against adversity and less likely to engage in risky behaviors.[499] In contrast, those who feel powerless or lack optimism are at higher risk of depression, disengagement from school, and substance use. The data

[496] *Gini, Gianluca, and Tiziana Pozzoli. "Association between Bullying and Psychosomatic Problems: A Meta-Analysis." Pediatrics 123, no. 3 (2009): 1059–65.*

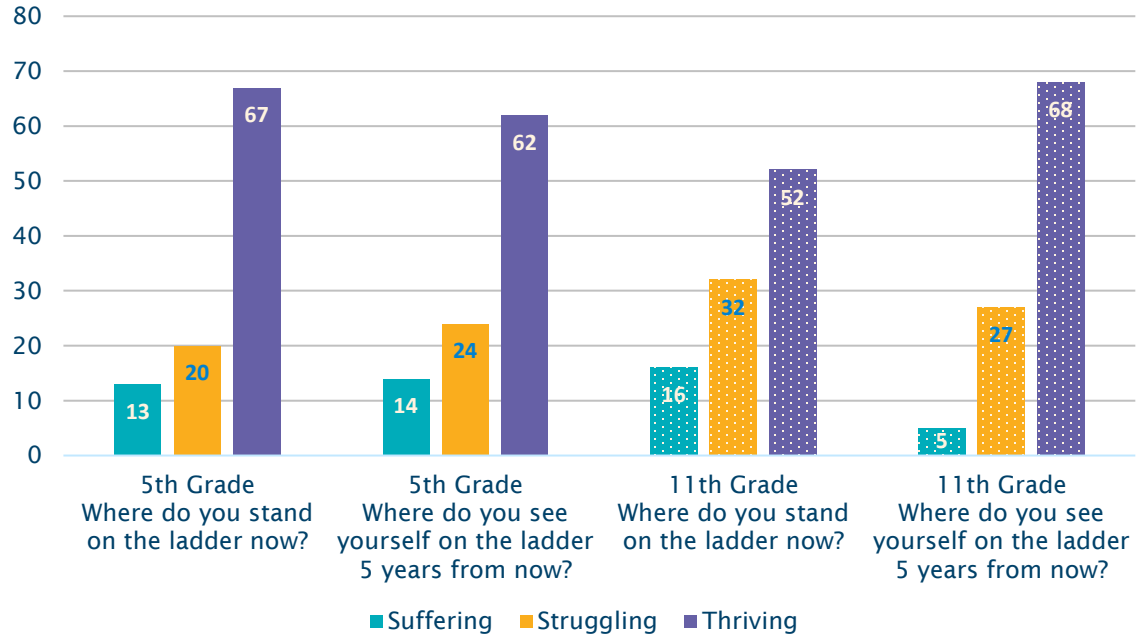
[497] *Holt, Melissa K., et al. "Bullying and Suicidal Ideation and Behaviors: A Meta-Analysis." Pediatrics 135, no. 2 (2015): e496–509.*

[498] *Ingram DD, Franco SJ. 2013 NCHS urban–rural classification scheme for counties. National Center for Health Statistics. Vital Health Stat 2(166). 2014*

[499] *Masten, Ann S. Orginary Magic: Resilience in Development. New York: Guilford Press, 2014.*

reveal important developmental differences in youth perception of well-being and optimism. Among 5th graders in Delaware, most (67%) report currently "thriving," but this drops by 15 points to 52% among 11th graders, with a notable rise in students who say they are "struggling" (32% from 20%). However, when asked to look five years ahead, optimism rebounds—62% of 5th graders and 68% of 11th graders expect to be thriving in the future. This suggests that while adolescent challenges grow with age, hope for future improvement remains strong, **pointing to a critical window for intervention to sustain optimism and prevent disengagement, depression, and risky behaviors.**

Figure 118. Percent Perceived Wellbeing, Now and Five Years in the Future Among 5th and 11th Graders, Delaware, 2023



Source: University of Delaware, Center for Drug & Health Studies. Delaware School Surveys, 2023

Nationally, disparities by race, ethnicity, and sexual/gender minority status reveal that **children from marginalized groups often report lower levels of hope and well-being**, reflecting the added burden of discrimination and inequity layered onto trauma.[500]

What children live through—at home, in their communities, and among peers—shows up directly in their health outcomes, risk behaviors, and overall wellbeing. Stressors such as household mental illness, substance use, divorce, discrimination, and bullying are not side issues; they are central determinants of whether children thrive. For Delaware, where youth already report concerning levels of sadness and hopelessness, these exposures carry heightened urgency. The evidence is clear that trauma is graded and cumulative—the more exposures, the greater the risk. But research also demonstrates that prevention and early intervention can bend the curve. Trauma-informed schools, anti-bullying initiatives, peer-led supports, and accessible 24/7 crisis response (such as 988 or youth-based peer crisis models) are evidence-based strategies that not only reduce acute distress but also build resilience that lasts into adulthood. Ensuring these supports are equitable, consistent, and embedded in the places children spend their time—homes, schools, and communities—is critical.

[500] *National Academies of Sciences, Engineering, and Medicine. The Promise of Adolescence: Realizing Opportunity for All Youth. Washington, DC: The National Academies Press, 2019. https://doi.org/10.17226/25388.*

Sexual and Reproductive Health

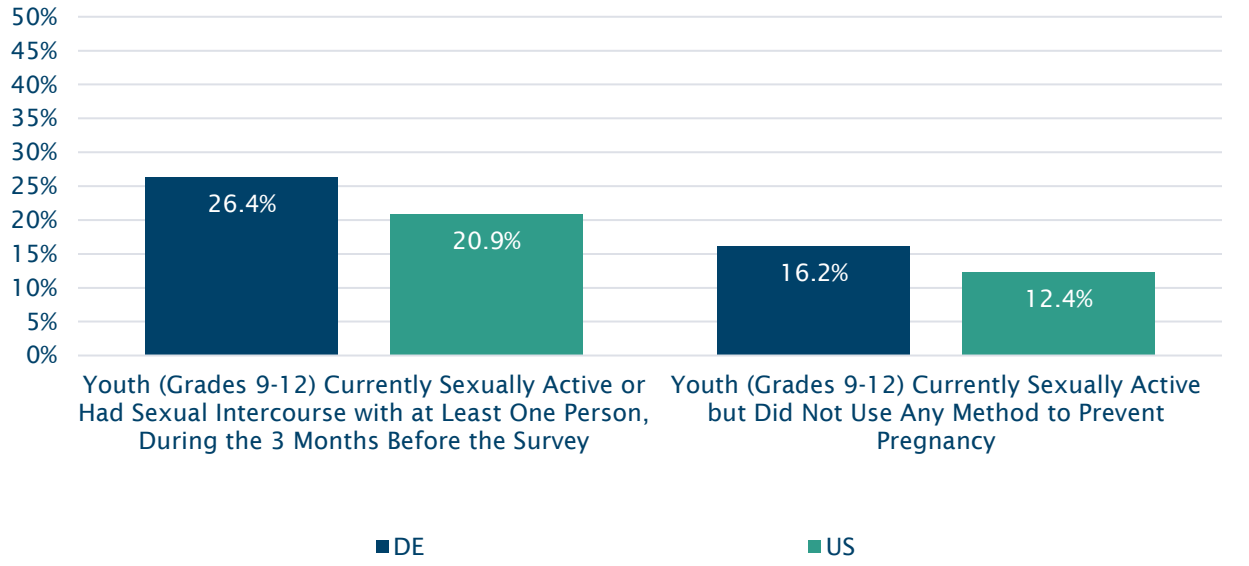
Improving sexual and reproductive health is crucial to eliminating health disparities, reducing rates of infectious diseases and infertility, and increasing educational attainment, career opportunities and financial stability.[501]

Sexual Wellbeing

Adolescence is a pivotal stage for developing lifelong patterns of sexual and reproductive health. For teens, sexual well-being means having the knowledge, resources, and support to make safe, informed choices about relationships, contraception, and prevention of sexually transmitted infections (STIs). Early experiences in this domain often shape health trajectories into adulthood, influencing future fertility, pregnancy outcomes, and overall well-being.[502] Preventive measures such as HPV vaccination, confidential and accessible contraception, and routine screening for STIs are especially important during adolescence, when experimentation and risk-taking behaviors can intersect with limited access to care or education.[503]

For adolescents who are sexually active, whether or not they use contraception has profound implications for sexual and reproductive health. Teens who do not use contraception remain at elevated risk for unintended pregnancy, which can disrupt educational attainment, increase economic hardship, and perpetuate cycles of poor health for both mother and child.[504] Approximately 26.4% of high school students (grades 9–12) in Delaware reported being sexually active in 2023, higher than the national average of 20.9%. Among those students, 16.2% reported using no method of contraception, compared to 12.4% nationally.

Figure 119. Percent Sexually Active and Birth Control Use in Youth Grades 9–12, Delaware, 2023



Source: CDC. Youth Risk Behavior Surveillance System, 2023

Method of choice also differs slightly from national patterns: 19.5% of sexually active Delaware high school students used birth control pills (similar to the U.S. at 20%), 52.8% used condoms (vs. 51.9% nationally), and

501 "Reproductive and Sexual Health," Healthy People 2020, accessed August 30, 2019, https://www.healthypeople.gov/2020/leading-health- indicators/2020-lhi-topics/Reproductive-and-Sexual-Health.

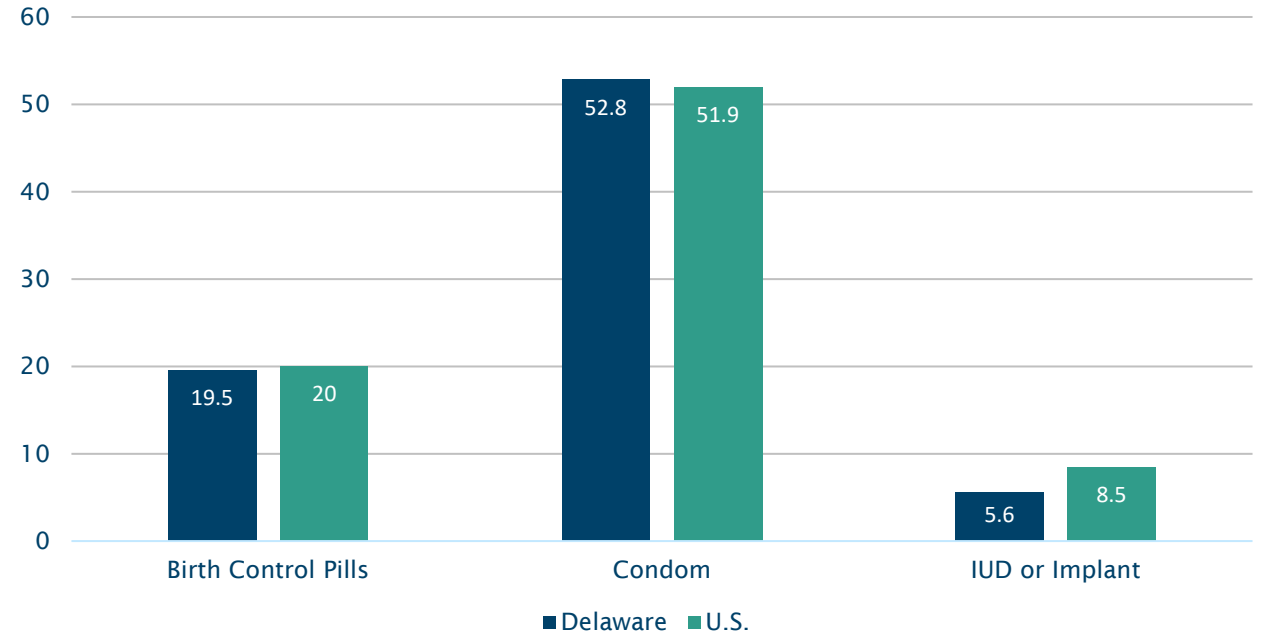
502 World Health Organization. Adolescent Health. Geneva: WHO, 2023. https://www.who.int/health-topics/adolescent-health.

503 Centers for Disease Control and Prevention (CDC). "Youth Risk Behavior Surveillance — United States, 2021." MMWR Surveillance Summaries 72, no. 1 (April 2023): 1–72. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.

504 Hoffman, Saul D., and Rebecca A. Maynard. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. Washington, DC: Urban Institute Press, 2008.

5.6% reported using an IUD or implant, compared to 8.5% nationally.

Figure 120. Percent Contraceptive Use of High School Students Grades 9-12 Before Last Sexual Intercourse with Opposite-Sex Partner* by Contraceptive Type, Delaware, 2023



Source: CDC, Youth Risk Behavior Surveillance System (YRBS), 2023

While Delaware teens demonstrate consistency with peers in condom and pill use, they lag in uptake of Long-Acting Reversible Contraception (LARCs)—the most effective methods of pregnancy prevention.[505]

Adolescents and young adults are at disproportionate risk for sexually transmitted diseases (STDs), accounting for nearly half of all new infections in the United States each year, despite representing only about one-quarter of the sexually active population.[506] Many of these infections, including chlamydia and gonorrhea, are often asymptomatic, making routine testing the only way to detect and treat them. Without early detection, untreated STDs can lead to serious long-term health consequences such as infertility, chronic pelvic pain, increased risk of HIV acquisition, and adverse pregnancy outcomes.[507] For youth, who may face barriers such as stigma, lack of confidential services, or limited access to healthcare, ensuring access to screening and treatment is essential to supporting both immediate and lifelong sexual well-being.[508]

Data suggests that Delaware's high school students are engaging with STD testing excluding HIV at slightly higher rates than their peers nationally. However, HIV testing, specifically, is lower than the U.S. comparison overall. Delaware youth may be somewhat more likely to access testing for STDs such as chlamydia and gonorrhea than the average high school student across the U.S., but the vast majority still go untested, leaving infections undetected.

[505] *Hoffman, Saul D., and Rebecca A. Maynard. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. Washington, DC: Urban Institute Press, 2008.*

506 Centers for Disease Control and Prevention (CDC). "STDs in Adolescents and Young Adults." Sexually Transmitted Disease Surveillance 2022. Atlanta: U.S. Department of Health and Human Services, 2023. https://www.cdc.gov/std/statistics/2022/figures/adolescents.htm.

[507] *Workowski, Kimberly A., et al. "Sexually Transmitted Infections Treatment Guidelines, 2021." MMWR Recommendations and Reports 70, no. 4 (July 2021): 1–187.*

[508] *American Academy of Pediatrics. "Condom Use by Adolescents." Pediatrics 138, no. 2 (August 2016): e20161896. https://doi.org/10.1542/peds.2016-1896.*

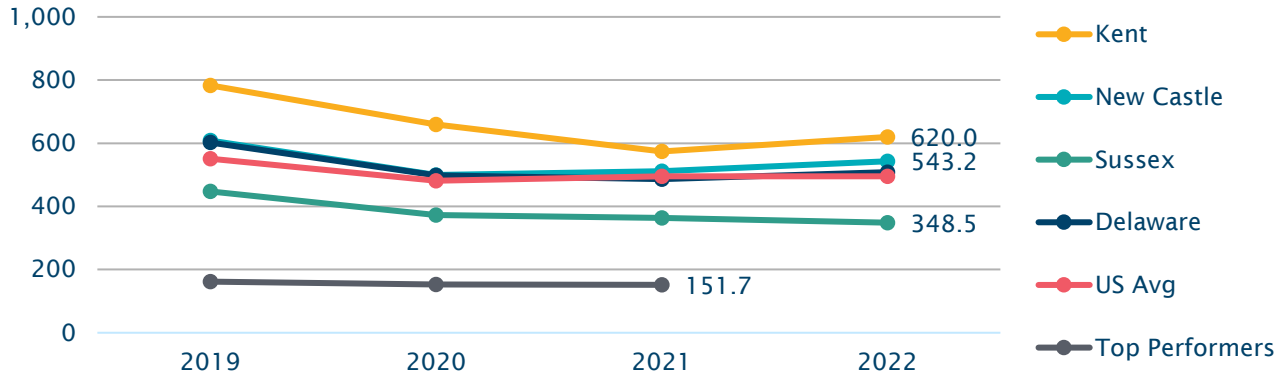
Just **7.5%** of high school students in Delaware **report getting tested for a Sexually Transmitted Disease (STD) other than HIV*** compared to **5.6%** **nationally.**

... and only **6.7%** **report ever getting tested for Human Immunodeficiency Virus (HIV)** in Delaware, compared to **7.1%** in the U.S.[509]

** Testing for sexually transmitted infections such as chlamydia or gonorrhea, during the 12 months before the survey.*

County-level data further underscore the need for routine testing. In 2022, Kent County (620 per 100,000) and New Castle County (543 per 100,000) had the highest rates of newly diagnosed chlamydia, while Sussex County (349 per 100,000) reported the lowest. Delaware's statewide rate (508 per 100,000) exceeded the U.S. average (495 per 100,000).

Figure 121. Number of Newly Diagnosed Chlamydia Diagnosed per 100,000 Population by County, Delaware, 2019- 2022

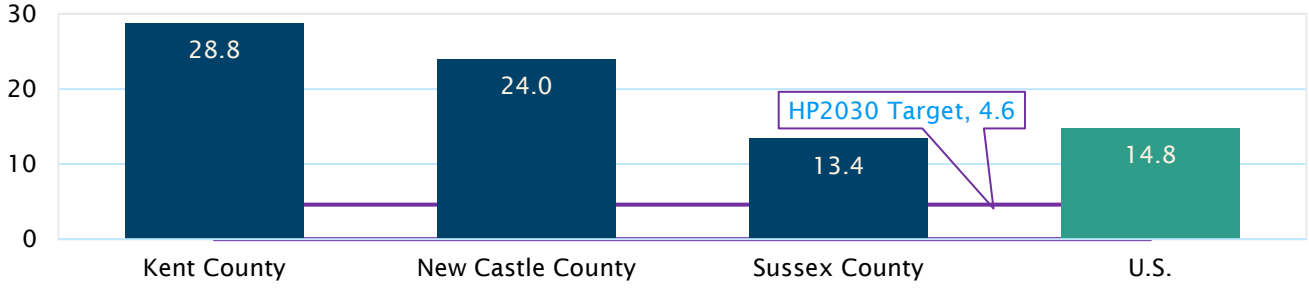


Source: CHR, 2025; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2019-2020

Kent County's rate of newly diagnosed chlamydia (620) is nearly double the rate in Sussex County (348).

Syphilis data show similar geographical disparities: among women aged 15–44, Kent County (28.8 per 100,000) and New Castle County (24.0 per 100,000) had much higher rates than Sussex County (13.4 per 100,000) and the U.S. average (14.8 per 100,000). Rates nationwide and in Delaware do not meet Healthy People 2030's goal of 4.6 per 100,000.

Figure 122. Rate of Primary and Secondary Syphilis Rates Among Women Aged 15-44 per 100,000 population, 2023.



Source: CDC STI Statistics, 2023

509 Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System (YRBSS): Delaware High School Results, 2023. https://nccd.cdc.gov/youthonline/app/results.aspx?LID=DE

These infections are particularly concerning given their link to congenital syphilis, which can **result in miscarriage, stillbirth, or severe lifelong complications for infants**.

For many people, the most significant risk factor for contracting an STD is living in a community with high rates of them. **Considering geographic risk in addition to individual behaviors can help reduce stigma and bias in screening**.

Expanding routine, confidential STD testing in adolescent care settings—whether pediatric clinics, school-based health centers, or community programs—is essential to addressing these risks early and promoting preventative behaviors across the life span.

Screening not only helps youth protect their own health but also interrupts transmission, reduces disparities, and aligns with Healthy People 2030 goals to reduce STD rates and expand access to preventive services for adolescents.[510]

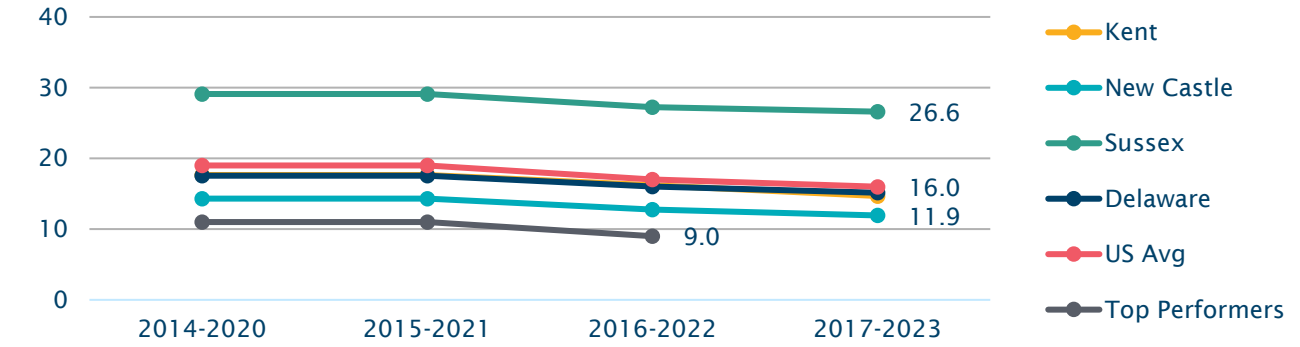
Maternal and Child Health

Sexual and reproductive health extends beyond contraception and STI prevention to encompass the health of women during and after pregnancy, as well as the profound interconnection between maternal health and child outcomes that directly shape a child's growth, development, and long-term well-being.

Teen pregnancy rates are a core marker of sexual and reproductive health, reflecting access to contraception, sexual health education, and preventative care. Teen pregnancy is not just an adolescent issue; it has ripple effects on maternal and child health outcomes. For example, young mothers are more likely to experience complications during pregnancy and birth, including preterm delivery and low birth weight, and are at higher risk for maternal morbidity.[511] Children of teen mothers face increased risks of infant mortality, developmental delays, and limited social and economic resources, linking teen birth rates directly to long-term child well-being.[512] Moreover, teen pregnancies often disrupt education and economic stability for young parents, reinforcing cycles of poverty and health inequity.

In 2023, the teen birth rate in Delaware was 15.1 per 1,000 live births among females ages 15–19, slightly lower than the national average of 16.0 per 1,000.

Figure 123. Teen Birth Rate per 1,000 Live Births in Females Ages 15–19 by County, Delaware, 2017-2023



Source: CHR, 2025; National Center for Health Statistics, National Vital Statistics System

[510] *Office of Disease Prevention and Health Promotion. "Sexually Transmitted Infections — Objectives." Healthy People 2030. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections.*

[511] *Chen, Xiaozhong, et al. "Teenage Pregnancy and Adverse Birth Outcomes: A Large Population-Based Retrospective Cohort Study." International Journal of Epidemiology 46, no. 1 (2017): 168–177.*

[512] *Hoffman, Saul D., and Rebecca A. Maynard. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy. Washington, DC: Urban Institute Press, 2008.*

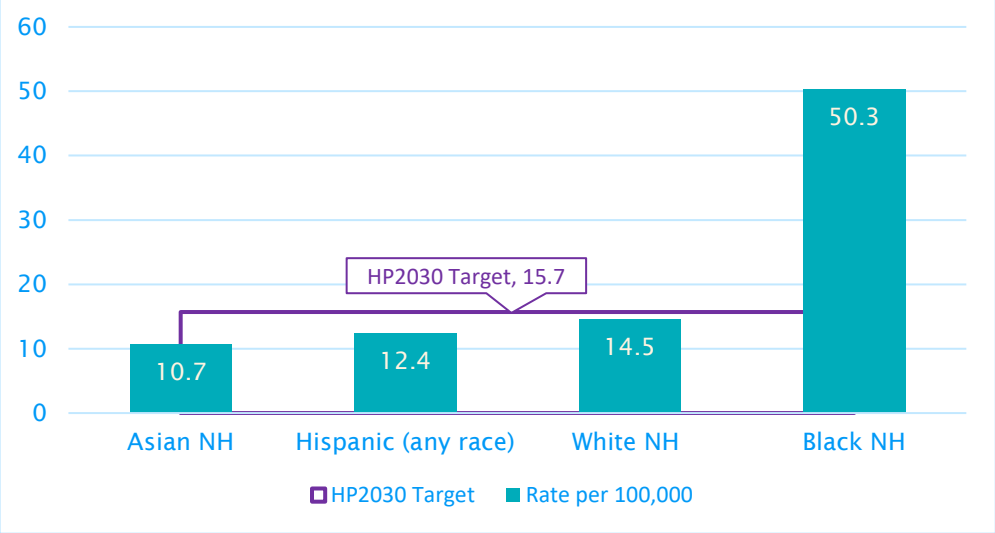
> *Sussex County reported a teen birth rate of 26.6 per 1,000 live births, nearly double the statewide average, while New Castle County had the lowest rate at 11.9 per 1,000.*

These geographic differences highlight how local conditions—such as healthcare access, socioeconomic opportunity, and community norms—shape adolescent reproductive outcomes. **Investments in prevention and support for adolescent parents advance equity by improving outcomes for mothers while laying stronger foundations for the health and stability of their children.**

Maternal morbidity and mortality are associated with preterm birth, infant mortality, and developmental delays in children, underscoring that **protecting women's health is inseparable from protecting child health**.[513] Despite advances, the United States continues to face serious challenges in maternal health. In 2023, the U.S. maternal mortality rate was 18.6 deaths per 100,000 live births, significantly higher than other high-income nations.[514] This rate fails to meet the Healthy People 2030 goal of reducing maternal deaths to 15.7 per 100,000.

Black women, in particular, experience disproportionate risk[515], with mortality rates (50.3 per 100,000) more 3-4 times that of White, Hispanic, or Asian women. These inequities reverberate into child health, as infants born to mothers with chronic illness, mental health challenges, or limited access to prenatal and postpartum care face increased risks of morbidity and mortality.

Figure 124. Rates of Maternal Mortality* per 100,000 Population by Race/Ethnicity, United States, 2023



In Delaware,

Black women account for about **28%** of **live births**, but **78%** of pregnancy-related **deaths**.

(CDRC, 2022)

Source: Centers for Disease Control and Prevention (CDC). Maternal Mortality Rates in the United States, 2023.

**Maternal mortality is defined as the death of a woman while pregnant or within 42 days of the termination of a pregnancy, from any cause related to or aggravated by pregnancy or its management, but not due to accidental or incidental causes of death.*[516]

Disparities in maternal mortality among Black women reflect multiple systemic factors. Research suggests that structural racism, chronic stress, inequities in access to quality prenatal and postpartum care, and implicit bias in the health care system all contribute to higher rates of severe complications and preventable deaths.

[513] *Venkatesh, Kartik K., and others. "Maternal Health and Child Outcomes: A Systematic Review." International Journal of Maternal and Child Health (2024).*

[514] *Tikkanen, Roosa, and Munira Z. Gunja. "Insights into the U.S. Maternal Mortality Crisis: An International Comparison." Commonwealth Fund, June 2024. https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.*

[515] *Child Death Review Commission. (2022). 2021 Annual Report. Delaware Department of Health and Social Services. Retrieved from https://cdrc.delaware.gov*

[516] *World Health Organization. International statistical classification of diseases and related health problems, 10th revision (ICD–10). 2008 ed. Geneva, Switzerland. 2009.*

These inequities persist even after controlling for income and education, underscoring that the disparity is not solely driven by socioeconomic status but also by differential treatment and barriers within the health system itself.[517]

Maternal mental health is another critical dimension of reproductive health. Untreated postpartum depression impairs mother-infant bonding and is linked to poorer child cognitive and emotional outcomes, as well as long-term stress within the caregiving environment.[518] Addressing maternal mental health therefore supports both maternal recovery and child development.

Nationally, as many as

1 in **7**

women **experience perinatal depression.**[519]

In Delaware,

10.4%

of mothers report **postpartum depressive symptoms.**[520]

Yet only **56-69%** of mothers in DE maternal death review cases **were screened**.[521]

Healthy People 2030 underscores the importance of screening and detection with a developmental objective (MICH-D04) to

Increase the proportion of women who are screened for depression during pregnancy and the postpartum period.[522]

This means the indicator is recognized as essential for public health progress, but standardized, reliable data to track progress are not yet available nationally.

Without universal or standardized screening, many **women experiencing depression symptoms go unrecorded.** revealing gaps in identification, and likely underrepresentation of high-risk groups.

Pediatrics provides a unique entry point for intervention, since mothers are consistently engaged in their child's care:

Pediatric well-child visits create multiple opportunities for providers to screen for maternal depression, inquire about postpartum hypertension, or share resources on contraception and preventive health services. Studies show that screening for maternal conditions during pediatric visits leads to **earlier detection and improved referral outcomes**.[523]

Nurse-Family Partnership programs and interconception care models demonstrate that integrating maternal health supports into pediatric systems **reduces unintended pregnancies, improves maternal health behaviors, and strengthens child outcomes**.[524, 525]

Even when pediatricians are not managing maternal conditions directly, they can act as liaisons of

[517] *Venkatesh, Kartik K. – A 2024 article in the International Journal of Maternal and Child Health that reviews maternal mortality inequities.*

[518] *Binda, Valeria, et al. "Effects of Postpartum Depression on Mother-Infant Bonding and Child Development." Lancet Regional Health – Americas 5, no. 4 (2021).*

[519] *O'Hara, Michael W., and Annette M. Wisner. "Perinatal Depression: Prevalence, Course, and Consequences." National Center for Biotechnology Information (NCBI) Bookshelf, 2022. https://www.ncbi.nlm.nih.gov/books/NBK519070/.*

[520] *Delaware Health and Social Services, Division of Public Health. Delaware Pregnancy Risk Assessment Monitoring System (PRAMS) Data Report: 2019–2021. Dover, DE: Delaware Department of Health and Social Services, 2023.*

[521] *Delaware Maternal Mortality Review Commission. Annual Report, 2023. Dover, DE: Delaware Department of Health and Social Services, Division of Public Health, 2023.*

[522] *Office of Disease Prevention and Health Promotion. Healthy People 2030: Increase the proportion of women who are screened for depression during pregnancy and the postpartum period (MICH-D04). U.S. Department of Health and Human Services. Accessed September 17, 2025. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-women-who-are-screened-depression-during-pregnancy-and-postpartum-period-mich-d04.*

[523] *Amro, Abeer, et al. "Maternal Evaluation During Pediatric Visits for Early Detection of Postpartum Preeclampsia." JAMA Network Open 7, no. 3 (2024).*

[524] *Olds, David L., et al. "Effects of Nurse Home Visiting on Maternal and Child Outcomes: A Randomized Trial." JAMA Pediatrics 168, no. 5 (2014).*

[525] *Children's Hospital of Philadelphia PolicyLab. "Improving Maternal and Child Health through Interconception Care." PolicyLab, 2024. https://policylab.chop.edu/project/improving-maternal-and-child-health-through-interconception-care.*

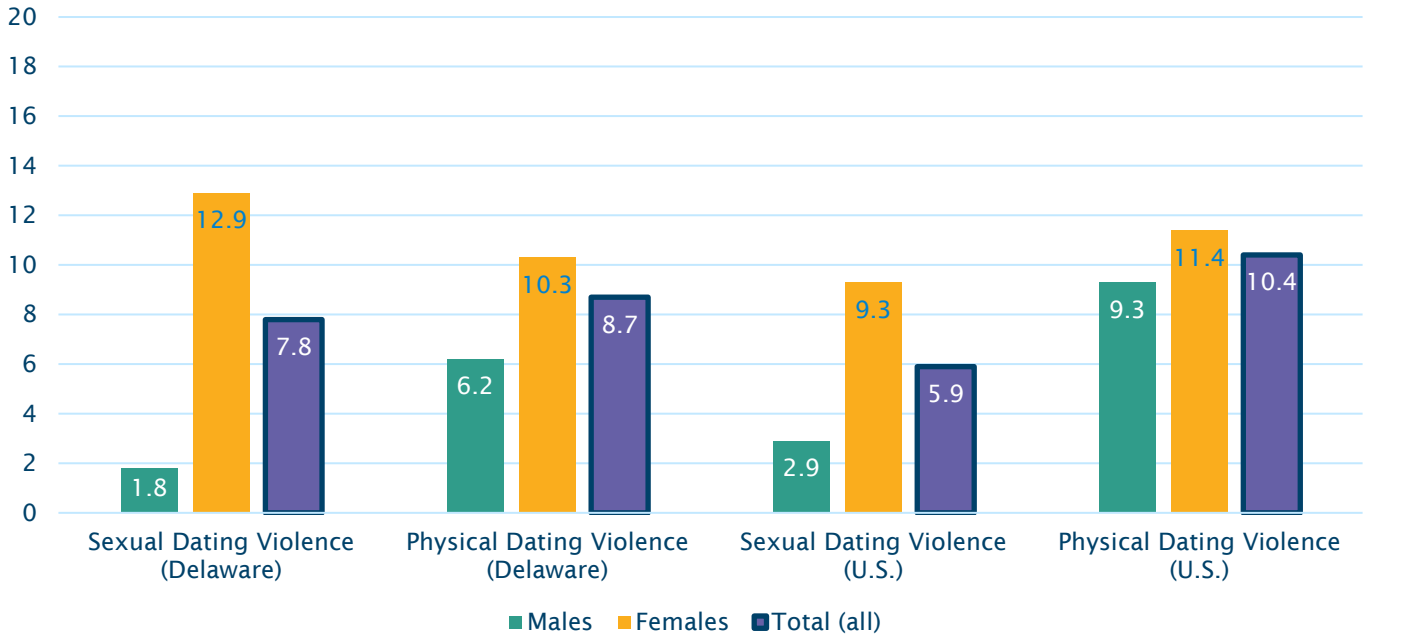
information and connection, linking mothers to primary care, obstetrics/gynecology, WIC, behavioral health, and community resources. **This role recognizes the mother-child dyad as a unit:** healthier mothers create healthier environments, and pediatric care settings are trusted hubs where both needs can be identified and addressed.

Sexual and Intimate Partner Violence

Violence in adolescent and young adult relationships—including physical dating violence, sexual dating violence, forced sex, sexual violence by anyone, reproductive coercion, and abuse in non-intimate settings—is a major sexual and reproductive health issue. These experiences are linked to increased risk of sexually transmitted infections (STIs), unintended pregnancy, adverse maternal outcomes, mental health disorders, and school disengagement. They disproportionately burden girls, LGBTQ+ youth, and other marginalized groups, underscoring equity concerns that extend beyond individual relationships to broader community health.[526],[527]

In 2023, 7.8% of Delaware high school students reported sexual dating violence, with striking gender differences: 12.9% of females compared to 1.8% of males. Nationally, the rate was 9.3% in females and 2.9% in males. Physical dating violence affected 8.7% of Delaware students overall (10.3% of females, 6.2% of males), just below the U.S. average of 10.4%.

Figure 125. Percent of Youth Grades 9–12 Who Experienced Sexual* and/or Physical** Dating Violence in the Previous 12 Months by gender, Delaware, 2023



Source: CDC. Youth Risk Behavior Surveillance System, 2023

** Sexual Dating Violence is defined as being forced to do sexual things (counting such things as kissing, touching, or being physically forced to have sexual intercourse) they did not want to do by someone they were dating or going out with, one or more times during the 12 months before the survey, among students who dated or went out with someone during the 12 months before the survey.*
***Physical Dating Violence is defined as being physically hurt on purpose (counting such things as being hit, slammed into something, or injured with an object or weapon) by someone they were dating or going out with, one or more times during the 12 months before the survey, among students who dated or went out with someone during the 12 months before the survey).*

[526] *CDC. "About Teen Dating Violence." Updated Jan 14, 2025. https://www.cdc.gov/intimate-partner-violence/about/about-teen-dating-violence.html.*

[527] *CDC. "About Intimate Partner Violence." Updated May 16, 2024. https://www.cdc.gov/intimate-partner-violence/about/index.html.*

Sexual violence—including being forced to engage in sexual acts against one's will and physically forced sexual intercourse—remains a serious threat to adolescent health and well-being. These experiences often occur outside of dating relationships, underscoring that risk extends beyond intimate partners. Such violence is strongly associated with immediate harms like injury and trauma, as well as long-term consequences.[528] For youth who experience these forms of violence at disproportionately high rates, the impacts can disrupt schooling, erode trust in relationships, and create lasting health disparities.[529]

Nationwide,

11.4%

of high school students experienced **sexual violence (by anyone)*** one or more times in the last year.

In Delaware,

9.9%

of high school students experienced **sexual violence** (by anyone) one or more days in the last year.

Approximately

8.6%

of high school students in the U.S. were ever **physically forced to have sexual intercourse***.

About

7.8%

of high school students in Delaware **report** having been **physically forced to have sexual intercourse.**

Females experience sexual violence at a rate

3x higher

than males, and LGBTQ+ students experience this at a rate

2-3x higher

than heterosexual/ Cisgender students.

Females and LGBTQ+ students experience forced sexual intercourse at a rate

3-4x higher

than male and heterosexual/ Cisgender students, respectively.

Source: Centers for Disease Control and Prevention (CDC). 1991-2023 High School Youth Risk Behavior Survey Data. Available at http://yrbs-explorer.services.cdc.gov/.

Sexual violence includes such things as kissing, touching, or being forced to have sexual intercourse that they did not want to do, one or more times during the 12 months before the survey. "Forced" is defined as "when they did not want to."*

Both sexual and physical dating violence are strongly linked to depression, anxiety, suicidality, substance use, and school disengagement—factors that shape long-term health and opportunity.[530] Survivors are more likely to experience inconsistent condom use, higher rates of STIs, and unintended pregnancies—often driven by reproductive coercion such as pregnancy pressure or sabotage of birth control.[531],[532] Pregnancies linked to violence carry higher risks of preterm birth, low birth weight, and maternal complications.[533]

"In ten years, the indicators for sexual violence haven't moved all the while we've been working to decrease it." - Stakeholder

[528] *Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey Results — United States and Delaware, 2023. Atlanta: U.S. Department of Health and Human Services, 2024. https://www.cdc.gov/yrbs/results/2023-yrbs-results.html.*

[529] *Clayton, H. B., et al. "Youth Risk Behavior Survey — United States, 2021." MMWR Supplements 72, no. 1 (2023): 1–20. https://www.cdc.gov/mmwr/volumes/72/su/su7201a8.htm.*

[530] *Clayton, H. B., et al. "Youth Risk Behavior Survey — United States, 2021." MMWR Supplements 72, no. 1 (2023): 1–20. https://www.cdc.gov/mmwr/volumes/72/su/su7201a8.htm.*

[531] *Miller, Elizabeth, et al. "Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy." Contraception 81, no. 4 (2010): 316–322.*

[532] *Willie, Tiara C., et al. "Reproductive Coercion and Unintended Pregnancy Among Adolescents and Young Adults." Journal of Interpersonal Violence (2019).*

[533] *Miller, Elizabeth, et al. "Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy." Contraception 81, no. 4 (2010): 316–322.*

Despite these risks, gaps persist in how sexual and intimate partner violence is addressed:

- **Screening and referral in pediatric, school-based, and community settings remain inconsistent**, and trauma-informed approaches are not universally implemented.
- **Services for youth are often fragmented**, with sexual health, behavioral health, IPV advocacy, and legal support operating in silos that can be difficult for young people to navigate.[534]

Prevention education (healthy relationship/consent curricula, digital abuse awareness) remains essential. **Promoting adolescent sexual well-being** provides opportunities to strengthen communication, model healthy relationships, and reduce stigma around seeking care.

- When **pediatric providers engage with teens on these issues**, they not only help protect against immediate health risks, but also lay a foundation for healthier futures—including healthier pregnancies and maternal outcomes later in life.[535]
- **Addressing disparities in access to sexual health resources** ensures that all young people, regardless of background, have the tools to thrive.[536]

[534] *CDC. "About Intimate Partner Violence." Updated May 16, 2024. https://www.cdc.gov/intimate-partner-violence/about/index.html.*

[535] *American Academy of Pediatrics. "Promoting Healthy Sexual Development and Sexuality in Children and Adolescents." Pediatrics 138, no. 2 (August 2016): e20161348. https://doi.org/10.1542/peds.2016-1348.*

[536] *Centers for Disease Control and Prevention (CDC). "Sexual Health of Adolescents and Young Adults in the United States." Atlanta: U.S. Department of Health and Human Services, 2022. https://www.cdc.gov/sexualwellness/data-research/adolescents-young-adults.html.*

Resource Awareness and Utilization

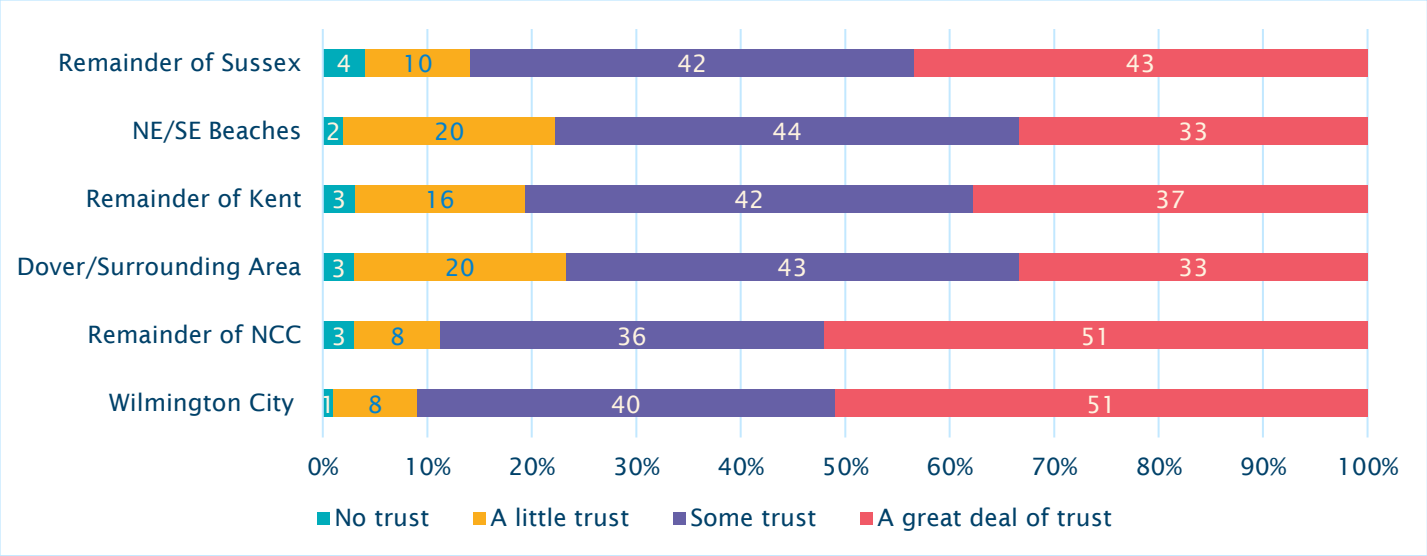
Institutional Trust and Care Utilization

Community perceptions of local hospitals, health centers, and clinics play a crucial role in whether people use them – and how they use them. Nationally, trust in physicians and hospitals in the U.S. fell from about 71.5% in April 2020 to 40.1% by January 2024,[537] with those reporting lower trust being significantly less likely to be vaccinated.[538] When patients and families believe providers are competent, responsive, and respectful, preventative care, treatment adherence, utilization increases; when trust erodes – because of past negative experiences, privacy concerns, cultural disconnects, or perceived inequities – people may delay or avoid care.[539]

In 2025, **Delaware ranked No. 1 in the nation for hospital quality (tied with HI) and No.5 for overall health care quality**. These rankings are driven by strong hospital performance, nursing home quality, reduced preventable admissions,[540] and indicators support community trust by reinforcing the perception of high standards of care. Patient experience scores echo this – with health systems reporting high ratings in teamwork, respect, and communication.[541] However, these positive scores coexist with safety concerns related to hand hygiene, post-surgical complications based on various external reviews of Delaware hospitals.[542]

Regional differences deepen perceptions. Hospitals in more urban areas tend to report stronger patient experience scores, while residents in rural communities are more likely to express lower satisfaction with the range of health and social services available locally. While the majority of survey respondents across the state (84%) reported "some trust" (40%) or a "great deal of trust" (44%) in their local hospital or health center to provide high-quality care, results vary by geography.

Figure 126. Percent Trust in Local Hospital or Health Center to Provide High-Quality Care by Level of Trust and Zip-code Region, Delaware, 2025



Source: Nemours Community Survey, 2025

[537] *Roy H. Perlis, Jon Green, Alexi Quintana, et al. "Trust in Physicians and Hospitals During the COVID-19 Pandemic." JAMA Network Open 7, no. 5 (May 6, 2024): e2411916. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821693.*
[538] *Vasiliki Souvatzi, Ioannis A. Kosmidis, Athanasios Mouratidis, and George Rachiotis. "Trust in Healthcare, Medical Mistrust, and Health Outcomes." Societies 14, no. 12 (2024): 269. https://doi.org/10.3390/soc14120269.*
[539] *Dereje Tefera, Yihenew Worku, and Habtamu M. Beyene. "Exploring Lack of Trust and Its Impact on Access and Utilization of Healthcare Services in Ethiopia: A Qualitative Study." BMC Health Services Research 24, no. 1 (2024): 11798. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11798-z.*
[540] *ChristianaCare Newsroom. "Delaware Ranked No. 1 in the U.S. for Hospital Quality." May 7, 2025. https://news.christianacare.org/2025/05/delaware-ranked-no-1-in-the-u-s-for-hospital-quality/.*
[541] *Newsweek and Statista. America's Best-in-State Hospitals 2025: Delaware. Newsweek/Statista Rankings, 2024, https://rankings.newsweek.com/americas-best-state-hospitals-2025/delaware. Accessed 15 Sept. 2025.*
[542] *Delaware Department of Health and Social Services. Healthcare-Associated Infections Annual Report 2022. https://dhss.delaware.gov/wp-content/uploads/sites/10/dph/pdf/HAIAnnualreport2022final.pdf.*

Residents in northern Delaware (Wilmington City + Remainder NCC) report the highest trust levels compared to other regions, with a majority (~51%) expressing a great deal of trust in local hospitals and health centers. Central regions of Kent County (Dover/Surrounding and Remainder Kent) have less overall confidence compared to Northern Delaware, with the largest majority reporting "some trust" (42-43%), and a larger share of respondents reporting "a little trust" (16-20% compared to 8% in NCC). Southern Delaware reports the lowest overall trust but also showed the most variation between regions below the county level. The NE/SE Beaches region showed 10% fewer respondents have a "great deal of trust" and 10% more respondents have little trust than the remainder of the county. These trends in fragmented trust suggest less certainty in local health care quality.

Hospitals across state, like many around the nation, are increasingly looking beyond their clinical walls to address the broader conditions that shape health. By engaging in community partnerships and programs that target root causes, health systems can **reduce preventable illness, lower readmissions, and improve long-term sustainability** while also strengthening trust and equity.[543]

In Delaware, many hospitals are major employers, landowners, purchasers of services, and have social reach which is why these efforts not only improve population health but also build community confidence in health care systems as responsive and relevant partners. **A broader, community-facing role is essential to ensuring hospitals are seen not only as providers of clinical care but as trusted champions of well-being**.

According to one stakeholder, "there is lots of good work going on with hospitals and not-for-profits. We have agencies and not-for-profit organizations that really care and have good intentions, time and energy."

Survey results show most respondents recognize Nemours Children's Health as playing an important role beyond the walls of the hospital.

More than half or

51%

of community survey respondents believe that Nemours works with the community "a great deal" to address broader issues such as *safety, food insecurity, education, and housing*.

... and another

36%

said the organization does so "somewhat" or "a little".

Source: Nemours Community Survey, 2025.

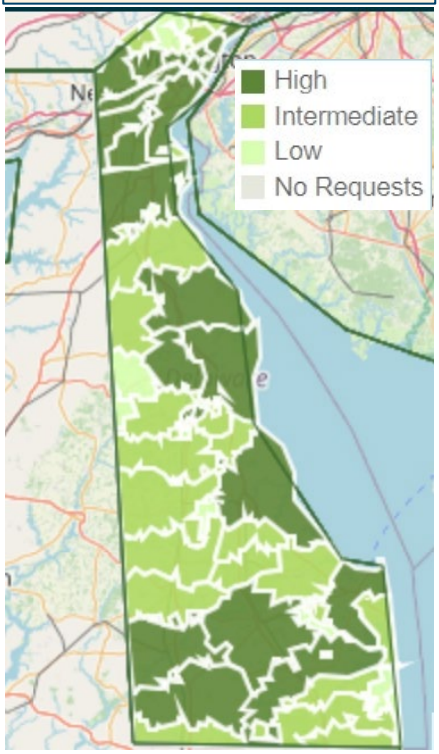
While these findings may point to the acknowledgement of Nemours' community presence from ~86% of survey participants, they also **demonstrate an opportunity to do better**. To truly serve as an anchor institution – a stabilizing force that extends beyond clinical care to strengthen the social and economic conditions that shape child health – Nemours remains dedicated to nurturing community-facing efforts and partnerships to achieve universal confidence in advancing health and equity, both inside and outside of clinical spaces.

[543] *Vasiliki Souvatzi, Ioannis A. Kosmidis, Athanasios Mouratidis, and George Rachiotis. "Trust in Healthcare, Medical Mistrust, and Health Outcomes." Societies 14, no. 12 (2024): 269. https://doi.org/10.3390/soc14120269.*

Referral Hubs

2-1-1 is a nationwide information and referral system that serves as a centralized access point for individuals and families seeking help with basic needs and community resources. By dialing the simple three-digit number, residents are connected with trained specialists who provide information on local services such as food assistance, housing and shelter, transportation, utilities support, childcare, employment, mental health resources, and crisis response. Operated locally but coordinated through United Way Worldwide, 2-1-1 covers more than 95% of the U.S. population and fields millions of calls annually, with demand increasing significantly during public health emergencies and natural disasters.[544]

Figure 127. Volume of Service Requests to Delaware 2-1-1 by ZIP Code, Delaware, 2024-2025



The darkest shading on the map in Figure 124 shows that the heaviest volume of 2-1-1 requests is concentrated in northern Delaware, particularly in and around Wilmington and the denser portions of New Castle County. That's consistent with population density, but it also reflects the concentration of low-income neighborhoods where reliance on social service referrals tends to be higher. Kent County shows a patchwork of intermediate volumes, with requests clustered around Dover and surrounding ZIP codes, which function as service hubs for the central part of the state. Sussex County has strikingly high activity as well, particularly in its western and southern ZIP codes, despite being far more rural. This suggests that 2-1-1 plays an important role in linking geographically isolated residents to housing, food, and health resources that are harder to access in low-service areas.

Equally important are the lightly shaded or white zones, especially along the eastern coastal strip and some inland rural ZIP codes, where there are few to no recorded requests. Those gaps could mean lower population, but they could also signal barriers—such as language, awareness, or digital access—that prevent residents from engaging with the 2-1-1 system. In other words, the map doesn't just show where needs exist, it also hints at where needs might be going unreported.

Tracking the types of services people request through 2-1-1 gives insight into what the most urgent needs in the community are, sometimes before they show up in other health data. By analyzing what people ask for, health systems can tailor their outreach, prevention, and support efforts, especially around social determinants of health, and better anticipate surges in non-medical needs that directly affect health.[545]

Between May 2024 and May 2025, Delaware's 2-1-1 system received more than 40,000 service requests, with needs overwhelmingly concentrated on the basics of daily survival.

[544] *United Way Worldwide. "211 Helpline Data Reveals Most Pressing U.S. Community Needs." United Way, 26 Mar. 2025, www.unitedway.org/news/211-helpline-data-reveals-most-pressing-us-community-needs.*

[545] *United Way Worldwide. "Americans Continue to Struggle with Housing and Utility Costs Post-COVID, According to New 211 Survey from United Way Worldwide." United Way, 16 Mar. 2023, www.unitedway.org/news/americans-continue-to-struggle-with-housing-and-utility-costs-post-covid-according-to-new-211-survey-from-united-way-worldwide-301774065.html.*

Figure 128. Top Service Requests to Delaware 2-1-1 by Category of Need, Delaware, May 2024-May 2025

Request Category	Total Count	% of Total	Top requested need in category (%)	Avg. % of all unmet requests in category	Highest unmet need in category (%)
Housing & shelter	**16,530**	**41.3%**	**Rent assistance** (39.4%)	29.5%	Mortgage assistance (42%)
Utilities	**5,958**	**14.9%**	**Bill assistance** (98.2%)	22.3%	Utility bill payment assistance (36%) ^
Food	**3,256**	**8.1%**	**Food pantries** (47.1%)	18.8%	Food pantries & Holiday meals (29% ea.)
Employment & Income	**2,508**	**6.3%**	**Job search** (48.6%)	18.5%	Job search (35%)
Healthcare & COVID-19	**2,429**	**6.1%**	**Health insurance** (25.2%)	15.2%	Medical providers (28%)
Clothing & Household	1,684	4.2%	Clothing (56.5%)	31.0%	Personal hygiene (57%)
Government & Legal	1,581	4.0%	Legal assistance (44.3%)	19.2%	Child and family law (24%) ^
Mental Health & Addictions	1,347	3.4%	Mental health services (43.4%)	27.8%	Marriage and family (43%)
Transportation	576	1.4%	Public transport (35.6%) *Medical transport (34.4%)*	17.0%	Ride share (23%)
Child Care & Parenting	559	1.4%	Family support services (49.9%)	26.8%	Parenting (50%)
Education	97	<1%	Adult education (42.3%)	19.1%	Tutoring (55%)
Disaster	23	<1%	Disaster relief (69.6%)	0.8%	Disaster relief (6%)
Other	3,476	8.7%	Special populations (19.0%)^	26.5%	Volunteering & donations (33%)^

Source: 2-1-1 Counts, Delaware. May 12, 2024- to May 11, 2025. https://de.211counts.org

**Percent of requests to 2-1-1 for which no help was available/need was unmet.*
^ "Other" had the highest percentage overall in this category and was replaced by the second highest percentage overall.

Housing and shelter alone accounted for over 41% of requests, most commonly for rent assistance, while mortgage support was unmet 42% of the time. Utilities (15%) and food (8%) followed, with residents struggling to keep up with energy bills and food pantry access—both carrying unmet needs in nearly one-third of requests. Beyond these essentials, employment and income support (6%), healthcare (6%), clothing and household (4%), government and legal (4%), and mental health services (3%) emerged as persistent challenges. Smaller categories such as child care, education, and transportation accounted for fewer total requests but revealed some of the highest unmet rates—parenting resources (50%), tutoring (55%), and ride share services (23%)—suggesting hidden gaps that intensify family instability. Even among basic goods, more than half of requests for personal hygiene items went unmet, reflecting unmet needs that impact dignity and health. Collectively, findings show that while housing, food, and utilities dominate demand, Delaware families also face critical service shortages in child care, education, and behavioral health, areas that directly shape long-term resilience and community well-being.

Overlaying geographic data and service type reveals community-level patterns of concentrated need:

Wilmington metro ZIPs dominate nearly **every service category**, underscoring the deep and persistent challenges tied to **housing, food insecurity, utilities, employment, legal aid, and basic goods.**	Suburban and industrial ZIPs of New Castle Co. **appear frequently**, reflecting how working-class and commuter communities experience parallel strains in **housing stability, healthcare access, childcare, and transportation.**	Dover ZIPs in Kent Co. surface across **housing, food, healthcare, employment, and education,** positioning the state capital as a consistent area of elevated need.	Rural ZIPs in Kent and Sussex Co. are **prominent in mental health, child care, disaster assistance, and transportation**—categories where service infrastructure is limited and barriers to access compound risk.
 **19801, 19802, 19805, 19804, 19807, 19809**	 **19720, 19713, 19706, 19730, 19731, 19702, 19703, 19717**	 **19901, 19904, 19977**	 **19936, 19941, 19943, 19946, 19950, 19952, 19953, 19960, 19962, 19967, 19970, 19979**

While Wilmington remains the epicenter of volume, high-need ZIPs are distributed across all three counties, reinforcing that solutions must be designed for urban, suburban, and rural realities alike.

Public Assistance

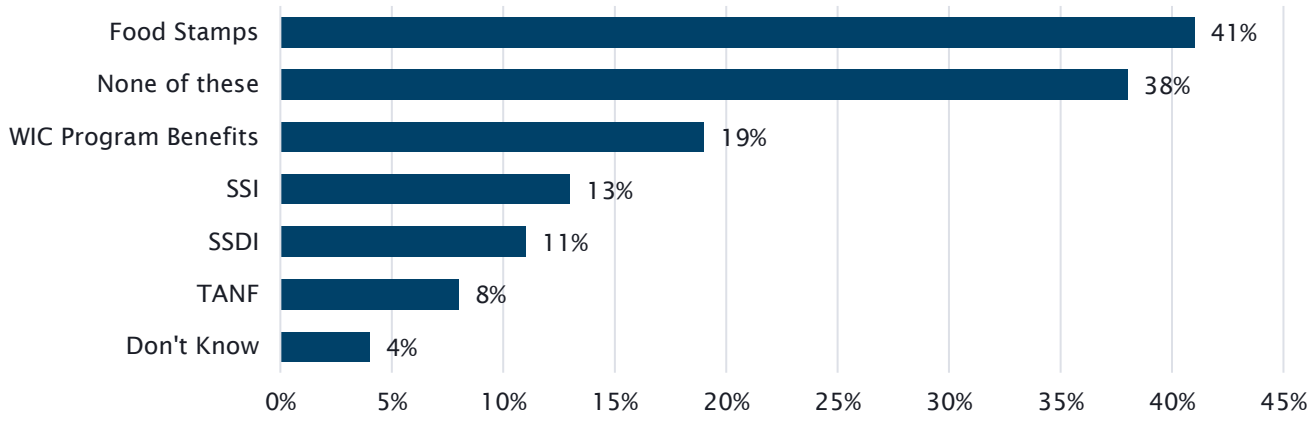
Public assistance refers to government-funded programs that help individuals and families meet basic needs such as food, housing, health care, and income support. Examples include the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), housing subsidies, and Medicaid supports. These programs are more than financial lifelines; they function as health interventions by reducing food insecurity, stabilizing housing, and improving access to medical care and medications. In Delaware, for instance, about 117,700 residents—11.2% of the state's population—received SNAP benefits in FY 2024, helping to offset household food insecurity.[546] Florida's Housing Assistance Waiver pilot, which connects up to 4,000 people annually to supportive housing and related services, has been shown to reduce overdoses by 57%, suicide ideation by 14%, and inpatient admissions by 29%.[547] Looking at public assistance in this way underscores its role as a determinant of health, shaping the conditions that allow families and children to thrive or, when absent, placing them at greater risk for adverse outcomes.

[546] *USAFacts. "How many people receive SNAP benefits in the U.S. every month? Delaware." Accessed September 2025. https://usafacts.org/answers/how-many-people-receive-snap-benefits-in-the-us-every-month/state/delaware/*

[547] *Florida Agency for Health Care Administration. "Housing Assistance Waiver." Accessed September 2025. https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/housing-assistance-waiver*

Survey results show that Delaware households rely on a range of public assistance programs. Food stamps (41%) were most commonly reported, followed by WIC program benefits (19%), SSI (13%), SSDI (11%), and TANF (8%). These findings indicate that families often draw on multiple supports to cover basic needs, **underscoring the interdependence of nutrition, income, and disability programs in promoting stability**. Nearly two in five households (38%) reported receiving none of these benefits, while 4% were unsure. This pattern highlights both the reach of public assistance and the proportion of households not connected to such supports despite potential eligibility.

Figure 129. Percent of Survey Respondents with a Household Member Currently Receiving Public Assistance by Type, Delaware, 2025

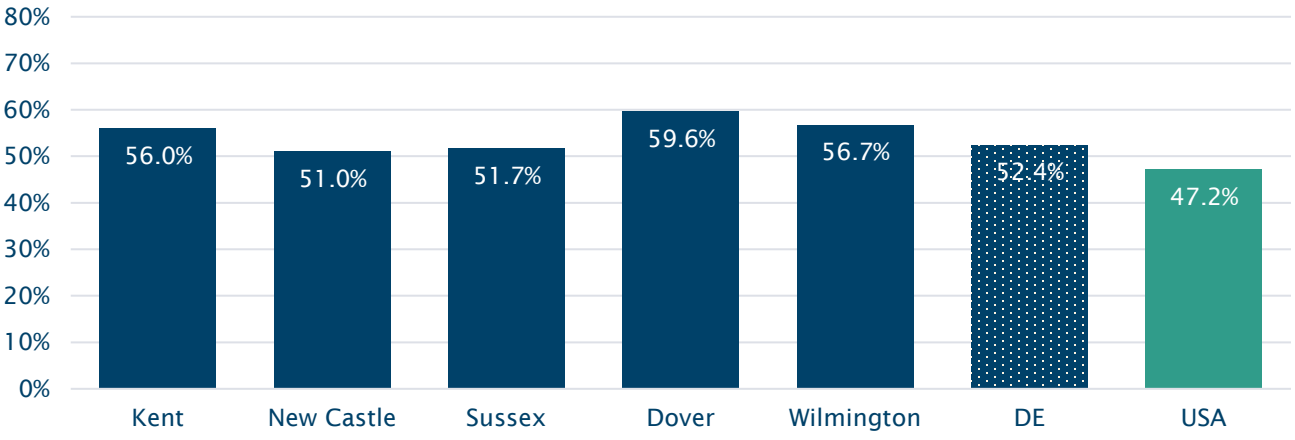


Source: Nemours Community Survey, 2025

The Supplemental Nutrition Assistance Program is the largest of the public assistance programs nationally, serving approximately 41–42 million people monthly, or about 12% of the U.S. population.[548] Nearly four in five SNAP households nationwide include children, older adults, or people with disabilities.

Approximately 52.4% of all households with children in Delaware participate in SNAP, compared to 47.2% nationally.[549]

Figure 130. Percent of Households with Children Under Age 18 Participating in the Supplemental Nutrition Assistance Program (SNAP) by County and City, Delaware, 2019–2023



Source: U.S. Census Bureau. American Community Survey. Five-year estimates

[548] *USDA Food and Nutrition Service. "Characteristics of Supplemental Nutrition Assistance Program Households, FY 2023." https://www.fns.usda.gov/research/snap/characteristics-fy23*

[549] *U.S. Census Bureau, American Community Survey 5-year estimates, 2019–2023.*

Rates are particularly high in Dover (59.6%) and Wilmington (56.7%). Kent County (56.0%) had the highest county-level participation, followed by Sussex (51.7%) and New Castle (51.0%) counties.

Alongside nutrition and income supports, Medicaid plays a pivotal role in ensuring access to health care. In Delaware, approximately 191,800 residents—about 20% of the population—are enrolled in Medicaid or CHIP, with nearly 96% of eligible children covered.[550],[551]

Medicaid and CHIP enrollment reached

78.1 million

people in the U.S., and nearly

1 in 2

of those enrollees are **children**.[552],[553]

Approximately

3 in 8

(37.5%) of all **children in Delaware** are enrolled in Medicaid/CHIP[554]

Medicaid not only expands access to primary and preventive care but also helps reduce uncompensated care costs and stabilizes health outcomes in low-income communities.

Community members were clear, when it comes to addressing affordable, accessible healthcare: "all hospitals, health systems, and Nemours must advocate to expand, not cut, Medicaid."

The future of public assistance programs remains uncertain. The 2025 federal budget reconciliation, known as the "One Big Beautiful Bill Act," proposed expanding SNAP work requirements, shifting a greater share of administrative costs to states, and introducing new income-verification requirements for Medicaid.[555],[556] The Congressional Budget Office has projected that these changes could reduce federal SNAP funding by nearly $300 billion through 2034, leading to narrower eligibility and fewer benefits.[557] For Medicaid, more frequent eligibility checks and new cost-sharing requirements may increase disenrollment among eligible populations, particularly children. Together, these policy shifts could weaken the protective role of public assistance programs and exacerbate inequities for families already vulnerable to food insecurity, unstable housing, and barriers to health care access.

Community Supports and Assets

Community survey responses highlight that families most often look for resources that meet basic needs such as meals or food programs (32%), activities and programs at community centers or clubs (24%), transportation services (18%), and prescription drug assistance (16%). Additional needs identified included housing services (12%) and helplines or referral lines (11%).

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[550] Delaware Insurance Media Guide, Medicaid/CHIP enrollment data (2022). https://healthjournalism.org/wp-content/uploads/2023/12/Delaware-Insurance-Media-Guide.pdf

[551] Senate Special Committee on Aging. "Delaware Medicaid Fact Sheet." https://www.aging.senate.gov/download/delaware-medicaid-fact-sheet?download=1

[552] Centers for Medicare & Medicaid Services (CMS). "May 2025 Medicaid & CHIP Enrollment Data Highlights." https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights

[553] Pew Research Center. "What the data says about Medicaid." June 24, 2025. https://www.pewresearch.org/short-reads/2025/06/24/what-the-data-says-about-medicaid/

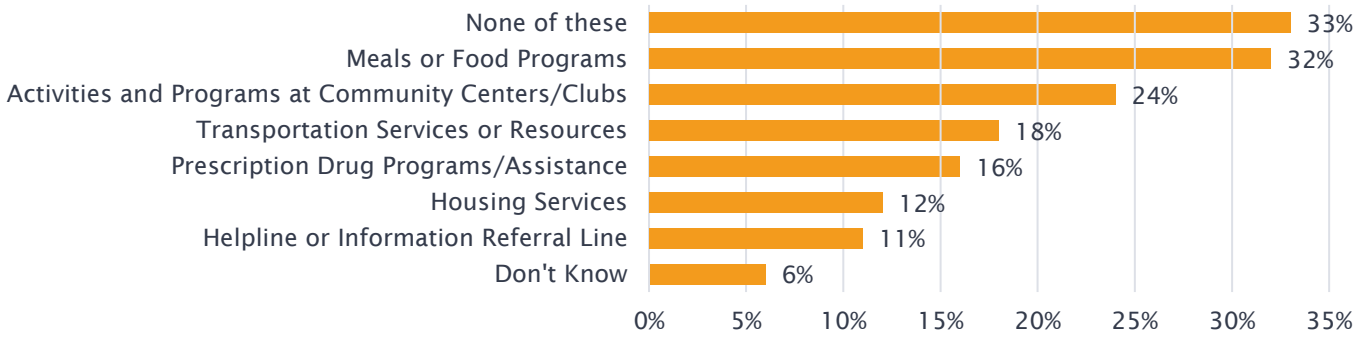
554 Delaware Public Media. "State Medicaid Program Requests $85.5 Million for Growth; Federal Program Cuts and Changes Loom." Delaware Public Media, 28 Feb. 2025, https://www.delawarepublic.org/politics-government/2025-02-28/state-medicaid-program-requests-85-5-million-for-growth-federal-program-cuts-and-changes-loom

[555] National Association of Counties. "The One Big Beautiful Bill Act and SNAP: What Counties Need to Know." https://www.naco.org/resource/one-big-beautiful-bill-act-and-supplemental-nutrition-assistance-program-snap-what

[556] Kaiser Family Foundation. "Tracking the Medicaid Provisions in the 2025 Budget Bill." https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

[557] Congressional Budget Office. "Budgetary Effects of Supplemental Nutrition Assistance Program Changes." 2024. https://www.cbo.gov

Figure 131. Percent of Survey Respondents with a Household Member who Has Utilized Community-based Supports in the Past Year by Resource Type, Delaware, 2025



Source: Nemours Community Survey, 2025

Finding emphasize that community-based supports—such as food pantries, after-school clubs, recreational centers, and transportation services—remain critical for families not only to manage immediate challenges but also to strengthen overall well-being. Moreover, community assets, including established networks of centers, faith-based organizations, and referral systems, are examples of existing infrastructure that can help meet their needs.

Figure 132. Community Assets by County, Delaware

	New Castle	Kent	Sussex	DE	U.S.
Average number of vehicles per meter of daily traffic, (2020)[558]					
Value	126	70	35	111	108
vs. DE avg.*	🔴	🟢	🟢	-	🟡
vs. U.S. avg.	🔴	🟢	🟢	🟡	-
Average number of annual library visits per person living within the library service area* , (2022)[559]					
Value	30.0	29.0	27.0	29.0	29.0
vs. DE avg.	🟡	🟡	🟢	-	🟡
vs. U.S. avg.	🟡	🟡	🟢	🟡	-
Percent of population who live close (</= 1/2 mile), to a local, state or national park, (2024)[560]					
Value	81	15	14	53	51
vs. DE avg.	🟢	🔴	🔴	-	🔴
vs. U.S. avg.	🟢	🔴	🔴	🟢	-
Number of childcare centers per 1,000 population under 5 yrs. old *, (2020-2022)[561]					
Value	9	7	6	7	7
vs. DE avg.	🟢	🟡	🟡	-	🟡
vs. U.S. avg.	🟢	🟡	🟡	🟡	-

**The library service area is the legal service area (LSA) for which the public library has been established to offer services and from which (or on behalf of which) the library derives revenue, plus any areas served under contract for which the library is the primary service provider. (Public Libraries Survey, 2022)*

**See Appendix A for a more comprehensive list of resources by county.*

By aligning identified resource gaps with existing assets, Nemours Children's and its partners can amplify

558 CHR 2025; Environmental Justice Screening and Mapping Tool (EJSCREEN, 2020

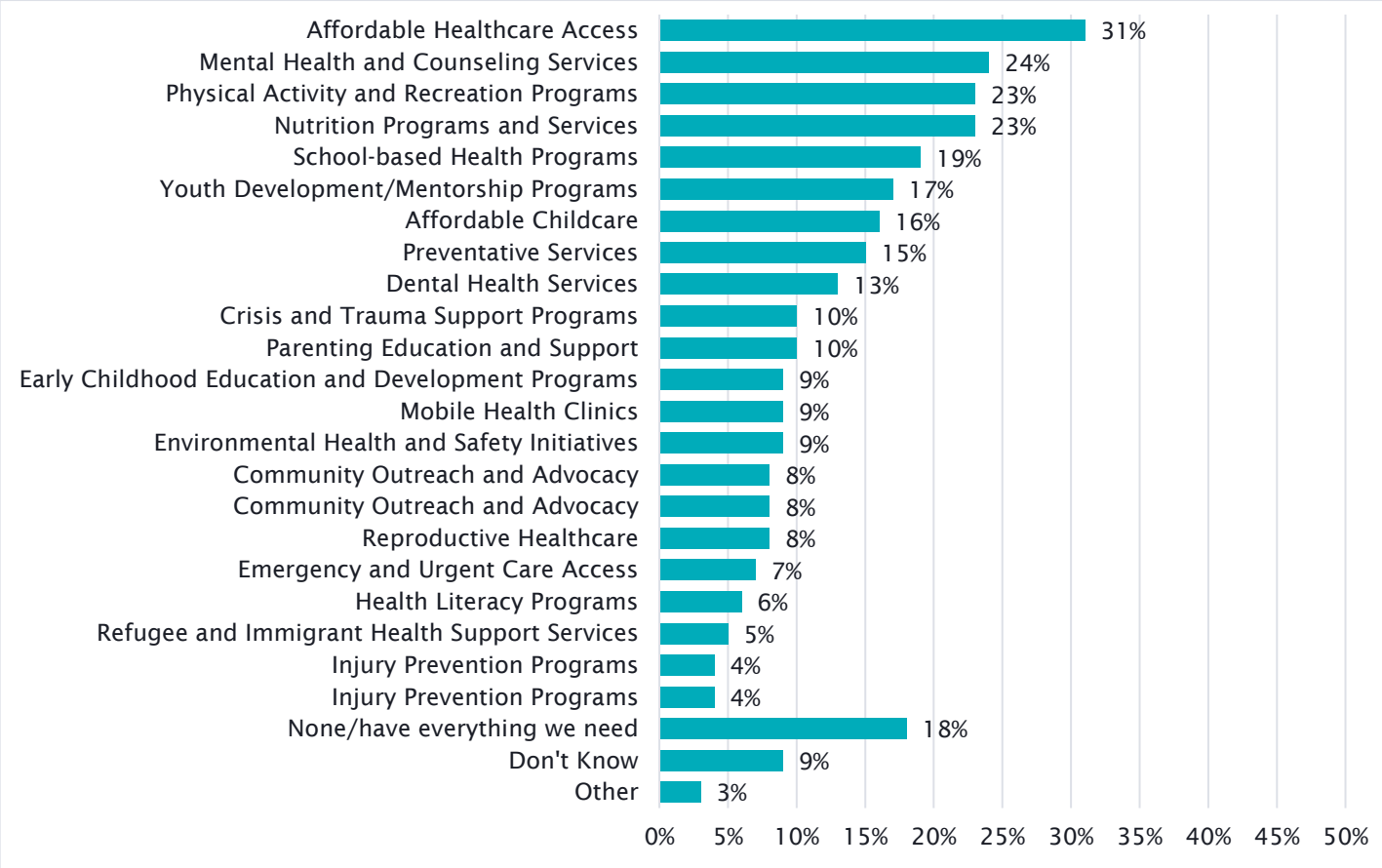
559 CHR 2025; The Institute of Museum and Library Services, 2022

560 CHR 2025; ArcGISPro Living Atlas, USA Parks Data, 2024

561 CHR 2025; Homeland Infrastructure Foundation-Level Data, 2020-2022

the impact of what is already working while addressing persistent barriers that limit equitable access to essential supports. We asked survey respondents to identify the healthcare, health education, or public health services or programs they'd like to see offered in their community. Their responses are reflective of assets that, to their knowledge, are not currently available or there is not enough of. Overall, the data points to strong community emphasis on affordable healthcare access, mental health and counseling services, physical activity and recreation opportunities, nutrition programs, school-based health, and youth supports.

Figure 133. Percent of Survey Respondents with Perceived Gaps in Healthcare, Health Education or Public Health Service or Program Needs in Their Community by Type, Delaware, 2025



Source: Nemours Community Survey, 2025

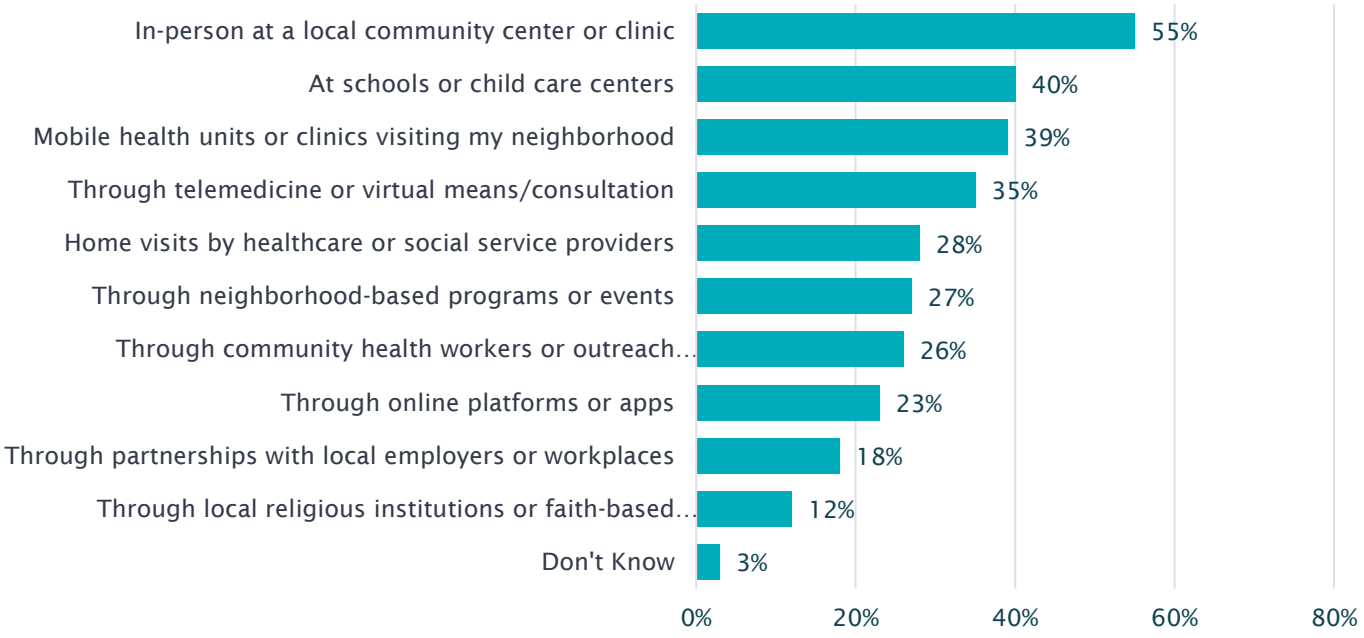
There is still a portion of respondents (18%) who feel their needs are already met, suggesting perceptions of access vary significantly across the population. This layered perspective underscores the importance of tailoring interventions to both universal and population-specific needs in order to build a more equitable health system.

Communication Preferences

Strategies for communicating and disseminating credible health and social services information in a way that community members prefer and understand are essential to expanding reach and improving outcomes. Meeting patient populations where they are is a key step to tailoring educational resources and information more effectively.

Overall, the majority of CHNA community survey respondents prefer to receive information about health and social services available in their community in-person at a local community center or clinic (55%), followed by at schools or childcare centers (40%), and via mobile health units or clinics visiting my neighborhood (39%). Through partnerships with local employers or workplaces and or local religion institutions were preferred the least by this group.

Figure 134. Percent of Survey Respondents Who Prefer to Receive Health and Social Service Information by Location or Platform, Delaware, 2025



Source: Nemours Community Survey, 2025

Communities in Delaware overwhelmingly prefer information and services be made available in the spaces they frequent most often in their daily lives – bridging gaps where they live, learn, and play.

The 2022 Community Health Needs Assessment: Implementation Plan and Progress

In response to the 2022 CHNA findings, Nemours Children's developed and formally adopted a three-year (2023-2025) Implementation Plan in April of 2023. The plan outlines initiatives that target violence prevention and food insecurity – the top two priority areas Nemours Children's selected from a list of community-identified health needs.

This section includes the most up-to-date information on implementation status from our 2024 Progress Report which is published annually on our website.

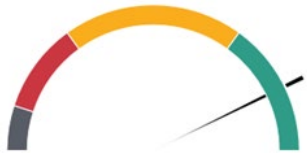
Implementation Plan

Violence Prevention: Initiative 1

Implement a referral pathway to an evidence-based violence intervention program that incorporates support services to patients who experience violence to promote healing and prevent future confrontation and death.

Goals, Metrics, and Progress

Status: Complete

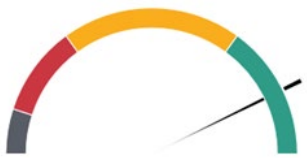


Goal: Establish a Hospital-Based Violence Intervention Program (HVIP) partnership with ChristianaCare Health System (CCHS) by the end of Y2, Q2 (6/30/24).

Metric:

- A fully executed Memorandum of Understanding (MOU) between Nemours Children's and ChristianaCare.
  - ✓ **Progress: Complete.** An MOU was fully executed and recorded in April 2024.

Status: Complete

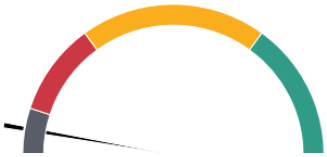


Goal: Develop a pathway that triggers patient referral to the CCHS HVIP program based on established eligibility criteria by the end of Y2 (12/31/24).

Metric(s):

- Expressed written approval of defined eligibility criteria for referral.
  - ✓ **Progress: Complete.** Leadership at both organizations reviewed eligibility criteria within the terms of the MOU and provided receipt of approval via the delivery and filing of an executed MOU signature page.
- Expressed written approval of the patient referral pathway.
  - ✓ **Progress: Complete.** Leadership at both organizations reviewed the HIPAA-compliant referral pathway, which utilizes the direct message inbox systems of EPIC (Nemours Children's) and CERNER (CCHS) to communicate pertinent patient information. Receipt of approval was provided via the delivery and filing of an executed MOU signature page. The pathway was adopted and fully operational by Q3 of 2024.

Status: Not Started



Goal: Refer at least 75% of eligible patients to the CCHS HVIP program in Y3 (1/1/25 – 12/31/25).

Metric(s):

- Total number of patients seen at Nemours Children's who meet eligibility criteria for EVOLV referral
  - ☒ **Progress: Not started.** Progress will be reported on in Y3.
- Total number of patient referrals to CCHS HVIP program.
  - ☒ **Progress: Not started.** Progress will be reported on in Y3.

Violence Prevention: Initiative 2

Identify opportunities in education for patients, families, and providers that promote evidence-based health and safety measures for the reduction of preventable death and injury due to gun violence.

Goals, Metrics, and Progress

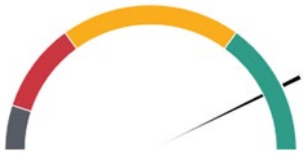
Status: In Process

Goal: Develop and disseminate parent/caregiver secure storage education materials in 12 Delaware practice locations and on at least one digital platform by the end of Y2 (12/31/24).

Metric(s):

- Receipt of final approval of the Nemours Children's brand-compliant education content and design from leadership
  - ✓ **Progress: Complete.** A safe storage education campaign was developed in partnership with Coalition for a Safer Delaware and submitted to the Nemours Children's MARCOM team to facilitate brand-compliant design. A final mockup was produced, reviewed, and approved by the appropriate governing bodies at each organization, and the joint campaign was published in October 2024.
- Secure storage education materials printed and delivered to all 12 Delaware primary care practices.
  - ⇨ **Progress: In Process.** Primary Care leadership underwent significant changes in 2024, placing our original distribution plan on hold. New governance has been named, and we've taken steps to ensure distribution in primary care practices in 2025. Community distribution has been consistent and successful since publishing.
- Secure storage education materials adapted and published on one or more digital platforms.
  - ✓ **Progress: Complete.** Materials were adapted to provide an interactive graphic on the Coalition for a Safer Delaware's Secure Storage landing page. Campaign materials link to this page via QR code. Webpage visitors can hover over elements of the graphic to learn more information or be directed to relevant tools and resources. We have also taken steps to break out the larger infographic format into their own respective blocks of text and visuals for social media distribution.

Status: Complete



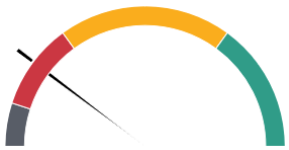
Goal: Operationalize a supply pathway for the distribution of universal gun locks to eligible patient families by the end of Y2, Q2 (6/30/24).

Metric(s):

- Identification of a gun lock repository.
  - ✓ **Progress: Complete.** A repository partner was identified in Q2 of 2024.
- Approval of a gun lock distribution pathway.
  - ✓ **Progress: Complete.** The Coalition for a Safer Delaware has agreed to intake/triage public requests for gun lock resources in partnership with Nemours Children's via their secure storage webpage. Their organization is experienced in gun-lock distribution in the community, and, therefore, well-positioned to take over this component while Nemours Children's works toward policy changes that will facilitate distribution in our care locations.

REVISION (2024): As stipulated in the 2023 Progress Report, the final two goals within the violence prevention focus area were placed on hold due to leadership changes in key areas of proposed implementation. In 2024, a revised strategy was developed that, both, preserves the original intent of delivering trauma-informed associate training and education, and aligns with other violence prevention efforts that require associate training and support. The following revised goal is anticipated for rollout in early 2025.

Status: On Hold



Goal: Identify an avenue to offer trauma-informed violence prevention training and education to Nemours Children's associates to support the implementation of secure storage screening and resource distribution in our care locations by the end of Y3 (12/31/25).

Metric(s):

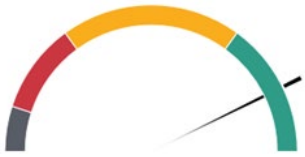
- Identify a content expert to develop and facilitate secure storage education/training to clinical and nonclinical associates.
  - Δ **Progress: On Hold.** Progress will be reported on in Y3.
- Determine at least three (3) associate groups to receive secure storage education/training in 2025.
  - Δ **Progress: On Hold.** Progress will be reported on in Y3.
- Complete at least three (3) training sessions with three (3) unique associate groups in 2025.
  - Δ **Progress: On Hold.** Progress will be reported on in Y3.

Food Insecurity: Initiative 1

Expand Nemours Cares Closets to additional primary care practice sites throughout the Delaware Valley.

Goals, Metrics, and Progress

Status: Complete

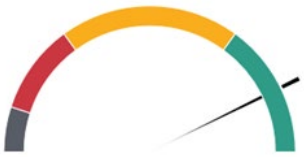


Goal: Identify at least two additional practice sites to host a Cares Closet at their location by the end of Y1, Q1 (3/30/25).

Metric(s):

- Total number of additional practices sites identified for the Cares Closet program
  - ✓ **Progress: Complete.** In the first quarter of 2023, a total of 10 additional practice sites were identified for expansion in the Delaware Valley, joining the two existing sites slated for transition. Only 4 of the 10 potential (new) sites were slated to move forward.

Status: Complete

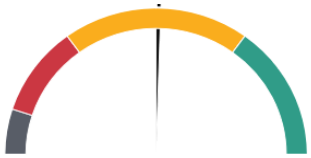


Goal: Stock Cares Closet food pantries based on need at each participating practice site by Y1, Q3 (9/30/23).

Metric:

- Total number of Cares Closet sites stocked with food
  - ✓ **Progress: Complete.** A total of 6 Cares Closet sites (4 new + 2 existing) were fully stocked as of May 2023.

Status: In Process



Goal: Monitor the Cares Closet program throughout the implementation period to provide recommendations for additional Cares Closet locations by the end of Y3 (12/31/25).

Metric:

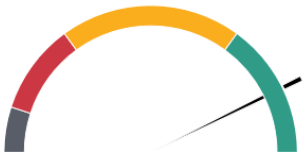
- Receipt of final approval from leadership of Cares Closet expansion plan
  - ⇨ **Progress: In Process.** This metric will be reported on in Y3.

Food Insecurity: Initiative 2

Partner with a mobile food pantry to coordinate regular stops at primary care practice locations across the Delaware Valley.

Goals, Metrics, and Progress

Status: Complete

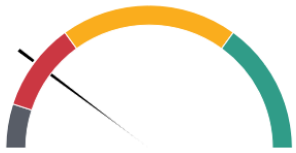


Goal: Identify at least two practice sites to receive regular mobile food pantry stops by the end of Y1, Q1 (3/31/23).

Metric(s):

- Total number of practices sites identified for mobile food pantry stops
  - ✓ **Progress: Complete.** In the first quarter of 2023, a total of two Delaware Valley practices were identified for pantry stops with the potential for additional expansion opportunities.

Status: On Hold

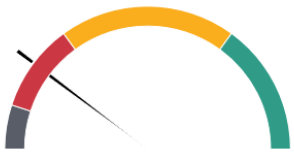


Goal: Finalize a Memorandum of Understanding (MOU) with the Food Bank of Delaware by the end of Y3, Q1 (3/30/25).

Metric:

- A fully executed MOU between Nemours Children's and the Food Bank of Delaware
  - Δ **Progress: On Hold.** In the first and second quarters of 2023, an MOU with the Food Bank of Delaware reached the final signature stage, and internal processes were established to aid pantry operations. However, in July 2023, the mobile food pantry program was placed on an indefinite pause.

Status: Removed

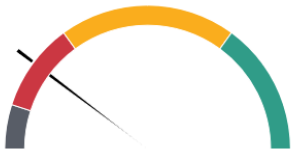


Goal: Partner with Nemours Children's Marketing and Communications (MARCOM) to distribute mobile food pantry promotional materials in at least two different modalities by the end of Y3, Q1 (3/30/2025).

Metric:

- Total number of modalities used to market mobile pantry marketing materials and messaging
  - Δ **Progress: Removed.** Due to anti-inducement laws, the Nemours Legal Department has advised against actively promoting the mobile food pantries or care closets. This goal has been removed as of May 2024.

Status: On Hold

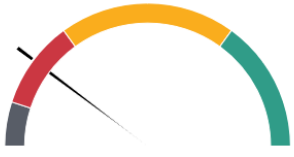


Goal: Implement the mobile food pantry program at identified Nemours Children's practice locations and begin tracking visit data by Y3, Q3 (9/30/25).

Metric:

- Total number of mobile food pantry visits at participating practice locations per month
  - Δ **Progress: On Hold.** As of July 2023, the mobile food pantry program has been placed on an indefinite pause.

Status: On Hold



Goal: Utilize mobile food pantry visit tracking data to assess the feasibility of expansion to additional practice locations across the system and provide at least five recommendations for spread and scale based on findings by the end of Y3 (12/31/25).

Metric:

- Total number of final recommendations for spread and scale of the mobile food pantry program systemwide
  - Δ **Progress: On Hold.** As of July 2023, the mobile food pantry program has been placed on an indefinite pause.

Additional Investments in 2022 Priority Areas

Nemours Children's continues to explore opportunities to support community priorities as we remain committed to advancing the physical, social, and emotional well-being of our patients with the same vigor applied to medical care.

In 2024, Nemours Children's established investment partnerships with several community-based programs and organizations engaged in violence prevention and food insecurity work across the region:

Violence Prevention

- **Community and Structural Violence:** The Center for Structural Equity (CSFE) empowers communities to overcome systemic barriers by promoting youth development, fostering meaningful community engagement, and advancing structural equity through programs that address the root causes of violence and inequity. Our 2024 partnership supported critical youth services and programs, workforce training, research and field testing, and outreach and education including CFSE staff serving on panels and hosting focus groups around violence, safety, and cultural competency.
- **Suicide and Self-Harm:** SL24: Unlocke the Light Foundation (Sean's House) is dedicated to supporting youth and young adults by providing free mental health education, 24/7 peer support, and safe spaces to reduce suicide, destigmatize mental illness, and promote emotional well-being. Our 2024 partnership sponsored two large fundraising events for the organization and provided additional support for a youth mental health summit, in addition to mental health workshops and seminars in the community that were developed and facilitated by Nemours Children's clinical psychologists.
- **Gun Violence:** Coalition for a Safer Delaware, alongside their sister organization the Delaware Coalition Against Gun Violence, works to end gun violence through education, community engagement, and policy advocacy, promoting responsible gun ownership, and supporting initiatives to prevent firearm-related injuries. In addition to the education campaign, our 2024 partnership supported the convening of a Violence Prevention x Public Health Summit, as well as the distribution of secure storage resources (i.e., cable locks) at community events and in other public spaces such as schools and libraries. Nemours Children's also attended various advocacy engagements.
- **Generational Trauma:** Partnerships with the Wilmington Alliance and The Hope Commission sponsored other evidence-based approaches to violence prevention in youth, such as safe spaces to engage in trauma-informed activities (i.e., Wilmington Alliances Art-O-Mat, or The Hope Commission's Dover Hope Zone) like art therapy, mentorship, juvenile justice programming, and positive youth and family events.

Food Insecurity

- **Food Kits:** The Food Bank of Delaware's Backpack Program fills a gap resulting from free and reduced-price lunch program when children do not have access to school meals, such as on weekends, school breaks, and over the summer. Nemours Children's partnered with the Food Bank of Delaware in 2024 to reach over 130 food-insecure children, providing them with food kits each week of the grant period. As a result of our financial commitment, approximately 7,000 packs were distributed, including nearly 28,000 meals (or 24,388 pounds of food).
- **School Gardens:** Healthy Foods for Healthy Kids (HFHK) is an initiative that aims to inspire healthier lives by providing youth with joyful school gardening experiences and opportunities to eat the garden-fresh vegetables they've grown. One element of this partnership was our adoption of school gardens (Adopt-a-Garden) at Carrie Downie Elementary School, Eisenberg Elementary School, Wilmington Manor Elementary School, and Read Middle School. Our 2024

partnership also supported HFHK's health and wellness program costs for each of the schools as well as planting costs for two seasons. This impacted over 1,300 students who harvested and consumed approximately 1,000 pounds of vegetables. Nemours Children's also sponsored a garden rebuild and program implementation at New Castle Elementary School which covered all supplies and program implementation costs impacting over 500 students. Nemours Children's associates participated in the garden builds at many of these locations across the state.

- **Community Food Pantry:** The Latin American Community Center (LACC) is a trusted hub offering culturally relevant programs and services that empower and support the Latino community across all ages. One specific element of our 2024 partnership with the LACC included supporting their Produce Pantry which provides essential groceries and household items to individuals and families in need. Through this, nearly 2,000 children and families received a total of 23,920 pounds of food – helping to combat food insecurity in the local Latino community in Wilmington, Delaware.

Building strong relationships with trusted pillars in the community allows us to champion efforts that address critical patient and family needs outside of our scope of care. Nemours Children's has leveraged this culture of engagement to transform our expertise into new opportunities that broaden our impact:

- The Trauma Center at Nemours Children's expanded their **Stop the Bleed (STB)** program footprint in 2024, hosting training at various community-based events such as the Latinos Unidos Student Summit, as well as at locations centrally located in neighborhoods that experience high rates of violent injury. STB instructors adapted the training to include front-line staff and other trusted adults in addition to the adolescents and teens that typically participate. By meeting communities where they are, Nemours Children's was able to expand access to, and knowledge of, key safety measures that save lives and empower young people and the support systems around them.

- Since 2020, Nemours Children's associates across the system come together annually to address food insecurity by providing thousands of meals to children and families in need. **Food Fight** is a two-week virtual food drive that provides our associates with the opportunity to donate to local food banks. Food banks supported in the Delaware Valley include the Food Bank of Delaware, Chester County Food Bank, Philabundance, and the Food Bank of South Jersey. This effort continues to grow through innovation and engagement and in 2024, our associates provided over 2,800 meals for families in need.

This information provides a snapshot of the comprehensive commitment Nemours Children's has made to address these community-driven priorities. By utilizing the CHNA as a vehicle for strategic development and action, we can invest back into the communities we serve in an informed and valuable way. This is how we go Well Beyond Medicine.

Appendix A – Community Assets

This section includes resources (programs, services, organizations, facilities) available in your community to support identified health and social needs in this report. This list should not be considered exhaustive or all-inclusive. The information is current as of September 2025.

At the top of many asset categories, you will notice that we have listed **directories** or resource hubs in **bold.** These comprehensive sources are meant to connect you to additional information about programs and providers that may not be individually named here, offering a broader entry point to support services. Following those, you'll find specific organizations by county to help you more easily identify local assets that meet your immediate needs.

Nemours Children's Health's main website and telephone number are listed in **bold** in the asset categories that match the wide range of services we provide at our hospital and satellite locations. Whether your child needs a check-up, follow-up care, therapy services, or a visit with an expert in areas like behavioral health, audiology, ophthalmology, allergy medicine, and beyond, our team is here to help. By calling the main number, you'll be connected with an operator who can guide you to the right department and help you schedule the care your child needs—quickly and easily.

NEW CASTLE COUNTY

Mental Health/Substance Use Disorder Services

Organization/Service	City	Website	Phone
Nemours Children's Health		**https://www.nemours.org/services/child-psychology.html**	**800.416.4441**
Promise Assessment Centers/ DSAMH – Statewide Directory	**Statewide**	**https://dhss.delaware.gov/dsamh/mental_health_cmhc/**	**855.649.7944**
Alcoholics Anonymous – Northern Delaware Intergroup	Wilmington	http://www.ndiaa.org	302.655.5113
American Red Cross of the Delmarva Region	Wilmington	https://www.redcross.org/local/dc-va-md-de/about-us/locations/delmarva.html	302.656.6620
Appoquinimink Counseling Services, LLC	Middletown	https://www.appocounseling.com/	302.898.1616
Aquila of Delaware	Wilmington	www.aquilaofde.com	302.999.1106
Brandywine Counseling and Community Services	Wilmington, Newark	https://brandywinecounseling.com/treatment/	302.225.9268
Broudy and Associates, Behavioral Health Counseling and Therapy	Wilmington	https://www.broudyassoc.com/request-an-appointment/	302.655.7110 ext. 221
Catholic Charities	Wilmington	https://www.ccwilm.org/	New Castle County Office: 302.655.9624. Bayard House: 302.654.1184
Child, Inc.	Wilmington	https://childinc.com/	302.762.8989
Children & Families First	Wilmington	https://www.cffde.org/	302.658.5177
Chimes Delaware	Wilmington	https://tinyurl.com/yc43fary	484.444.0412
Chimes Holcomb Behavioral Health System	Newark	https://chimes.org/holcomb-behavioral-health-systems	302.731.1504
Christiana Care, Rosenblum Adolescent Center	Wilmington	https://christianacare.org/us/en/care/behavioral-care	302.320.2100
Claymont Counseling Services	Claymont	https://claymontcenter.org/	302.792.2757
Claymont Treatment Center	Claymont	https://tinyurl.com/2uh8pvff	866.626.0133
Community Mental Health Center	Wilmington	https://dhss.delaware.gov/dsamh/	302.778.6900

Delaware Family Center	Wilmington	https://delawarefamilycenter.com/	302.995.9600.
Delaware Guidance Services, Counseling Program	Newark, Wilmington	https://www.delawareguidance.org/	302.262.9333, 302.652.3948
Delaware State Police, Victim Services and DE Victim Center	Statewide	https://www.delawarevictimservices.org/	
Delaware Psychiatric Center	New Castle	https://dhss.delaware.gov/main/maps/holloway/campsmap/	302.255.2700
Department of Veterans Affairs, Veterans Center	Wilmington	https://www.va.gov/wilmington-va-regional-benefit-office/	800.827.1000
Dept. of Correction, Baylor Women's Correctional Intuition Village	New Castle	https://doc.delaware.gov/views/R2Rprogram.blade.shtml	302.577.3004
Division of Prevention & Behavioral Health Services	Wilmington	https://kids.delaware.gov/prevention-and-behavioral-health-services/	302.633.2571
Division of Substance Abuse & Mental Health, Delaware Psychiatric Center	New Castle	https://dhss.delaware.gov/main/maps/holloway/campsmap/	302.255.2700
Gateway Foundation, Adult Residential Program	Statewide	https://www.gatewayfoundation.org/	877.505.4673
Gaudenzia, Fresh Start	Wilmington	https://www.gaudenzia.org/	833.976.4357
Hogar Crea International of Delaware	Wilmington	1126 Brandywine Street, Wilmington, DE, 19802	302.654.1158
Integrated Health and Wellness Services	Wilmington	https://integratedhealthwellnessservices.com/quick-call	New Patients: 302.428.9979, Existing Patients: 302.427.8000
Jewish Family Services	Wilmington, Newark	https://www.jfsdelaware.org/	302.478.9411
Kirkwood Detox Center	Wilmington	https://netcenters.org/listing_page/locations/	302.691.0140
Latin American Community Center	Wilmington	https://www.thelatincenter.org/	302.655.7338
Limen House For Men	Wilmington	https://www.limenrecovery.org/	302.655.1153
Limen House For Women	Wilmington	https://www.limenrecovery.org/	302.655.1153
MeadowWood Hospital	New Castle	https://www.meadowwoodhospital.com/	888.990.7146
Mental Health Association of DE	Wilmington	https://www.mentalhealthde.com/	302.654.6833
Middletown Counseling Services – Silver Lake Treatment Consortium	Middletown	https://kids.delaware.gov/prevention-and-behavioral-health-services/silver-lake-treatment-consortium/	302.378.5224. 8AM.4PM: 302.378.5238. 4PM.8AM: 302.464.3936/302.464.3925
Mobile Crisis Intervention Services, Northern Delaware	New Castle	https://dhss.delaware.gov/dsamh/crisis_intervention	302.577.2484
National Alliance on Mental Illness in Delaware	Wilmington	https://www.namidelaware.org/	302.427.0787
Oxford House	Wilmington, Newark, New Castle, Newport,	https://www.oxfordhouse.org/	
Pace Program	Wilmington	Pace Program	302.865.3565
Padre Pio House, the Ministry of Caring, Inc	Wilmington	115 East 14th Street, Wilmington, DE, 19801	302.658.6123
Rick VanStory Resource Centers	Wilmington	500 W 2nd St, Wilmington, DE 19801	302.691.7946
Rockford Center	Newark	https://rockfordcenter.com/	302.996.5480
Safe Harbor Christian Counseling	Hockessin, Newark, Newport, Wilmington	https://www.safeharbor1.com/	800.305.2089
Salvation Army, Adult Rehabilitation Center	Wilmington	https://easternusa.salvationarmy.org/eastern-pennsylvania/delaware-de/	302.472.0750

SODAT	Wilmington	625 North Orange Street, Wilmington, New Castle, DE, 19801	833.787.9718
Survivors of Abuse in Recovery (SOAR)	Wilmington	https://www.survivorsofabuse.org/	302.655.3953
Substance Abuse Counseling, Attack Addiction Foundation	Wilmington	https://www.attackaddiction.org/housing.html	302.365.5221
Supporting Kidds - Bereavement Support	Hockessin	https://supportingkidds.org/	302.235.5544
Survivors of Abuse in Recovery (SOAR)	Wilmington	https://www.survivorsofabuse.org/	302.655.3953
atTAck Addiction		https://www.attackaddiction.org/	302.365.5221
University of Delaware, Psychological Services	Newark	https://www.udel.edu/academics/colleges/cas/units/departments/psychological-and-brain-sciences/	302.831.2717
Wilmington Hospital, Partial Hospital Treatment Program	Wilmington	Wilmington Partial Hospitalization Program	302.733.1000
Wilmington Hospital, Psychiatric Department	Wilmington	https://christianacare.org/us/en/care/behavioral-care	302.320.2100
YWCA Delaware, Sexual Assault Response Center (SARC)	Wilmington, Newark	https://www.ywcade.org/	302.655.0039; 24Hr crisis helpline: 800.773.8570
YWCA, Domestic Violence Services	Wilmington	https://www.ywcade.org/sarc	302.655.0039; 24Hr crisis helpline: 800.773.8570

Medical Care

Organization/Service	City	Website	Phone
Nemours Children's Health	**Wilmington**	**https://www.nemours.org/locations.html**	**800.416.4441**
Advocare Brandywine Pediatrics	Wilmington	https://www.advocarebrandywinepediatrics.com/Wilmington-Office	302.478.2604
Advocare Delaware Pediatrics Wilmington	Wilmington	https://www.advocaredoctors.com/find-a-doctor	302.762.6222
Allergy Associates	Wilmington	https://www.wilmingtonallergy.com/	302.798.8070
Christiana Care Hospital	Newark	https://christianacare.org/us/en/facilities/christiana-hospital	302.733.1000
Concentra Urgent Care	Newark	Concentra Newark	302.738.0103
Delaware Modern Pediatrics	Newark	https://www.dmpkids.com/	302.392.2077
Delaware Ophthalmology Consultants	Wilmington, Middletown	https://www.delawareeyes.com/	302.479.3937
Delaware Public Health	Claymont, Middletown, Newark, New Castle, Wilmington	https://dhss.delaware.gov/dph/ofclocations/	302.283.7100
Dermatology Partners	Wilmington	https://www.dermpartners.com/	888.895.3376
ENT & Allergy of Delaware	Wilmington, Middletown, Newark	https://entad.org/	302.998.0300
Eye Care of Delaware	Newark	https://www.eyecareofdelaware.com/	302.454.8800
Glasgow Medical Center	Newark	https://www.trinityhealthma.org/location/glasgow-medical-center	302.832.1124
Go Care - Abby Medical	Newark	https://gocaredelaware.com/locations/	302.999.0003
Hearing Services of Delaware	Newark	https://www.heardelaware.com/	302.533.4217
Henrietta Johnson Medical Center	Wilmington	https://www.trinityhealthma.org/location/henrietta-johnson-medical-ctr	302.655.6187
Just Kids Pediatrics	Newark	https://www.justkidspediatrics.com/	302.918.6400
Nemours Children's Health, Becks Woods	Bear	https://www.nemours.org/locations/primary-care.html	302.595.0020
Nemours Children's Health, Foulk Road	Wilmington	https://www.nemours.org/locations/primary-care.html	302.655.3242
Nemours Children's Health, Jessup Street	Wilmington	https://www.nemours.org/locations/primary-care.html	302.576.5050

Nemours Children's Health, Middletown	Middletown	https://www.nemours.org/locations/primary-care.html	302.378.5100
Nemours Children's Health, Newark	Newark	https://www.nemours.org/locations/primary-care.html	302.836.7820
Nemours Children's Health, Pike Creek	Wilmington	https://www.nemours.org/locations/primary-care.html	302.239.7755
Nemours Children's Hospital, Saint Francis	Wilmington	https://www.nemours.org/locations/primary-care.html	302.421.9700
Nemours Children's Hospital, Wilmington	Wilmington	https://www.nemours.org/locations/primary-care.html	302.651.5245
Nemours Children's Health, Riverfront Fieldhouse	Wilmington	https://www.nemours.org/locations/specialty-care.html	302.416.4441
Newark Urgent Care Center	Newark	https://newarkurgentcare.org/	302.738.4300
Premier Pediatrics	Newark	http://www.premier4kids.com/	302.836.4440
PM Pediatric Urgent Care (Nemours preferred provider)	Newark	Nemours Urgent Care	302.576.5050
St. Francis Hospital	Wilmington	https://www.trinityhealthma.org/location/saint-francis-hospital	302.421.4100
Wilmington Audiology Services	Wilmington	https://wilmingtonaudiology.com/?utm_source=GBP&utm_medium=organic	302.654.1011
Wilmington Hospital	Wilmington	https://christianacare.org/us/en/facilities/wilmington-hospital	302.733.1000
Wilmington VA Medical Center	Wilmington	https://www.va.gov/wilmington-health-care/	302.994.2511
Planned Parenthood - Newark	Newark	Planned Parenthood	302.731.7801
Planned Parenthood - Wilmington	Wilmington	Planned Parenthood Wilmington Center	302.655.7293
Southbridge Medical Advisory Council, Inc. Henrietta Johnson Medical Center Homeless Health Care Access Program	Wilmington	https://nhchc.org/grantee-directory/southbridge-medical-advisory-council-inc/	302.428.3702
Westside Family Healthcare	Bear, Middletown, Newark, Wilmington	https://www.westsidehealth.org/	302.224.6800
Wilmington 1st Walk-In	Wilmington	https://wilmington1st.com/	302.407.5222

Dental Care			
Organization/Service	City	Website	Phone
Nemours Dental Program	**Wilmington**	**https://www.nemours.org/services/pediatric-dentist.html**	**800.416.4441**
DHSS Dental Guide	**Statewide**	Dental Resource Guide	
Christiana Care Health Service - Dental	Wilmington	https://christianacare.org/us/en/wellness/dentistry	302.320.4850
Delaware Technical Community College Dental Health Center	Wilmington	https://www.dtcc.edu/our-campuses/wilmington/dental-health-center/	302.571.5364
Henrietta Johnson Dental Program	Wilmington	https://www.hjmc.org/services.html	302.655.6187
Pediatric Dentistry of Middletown	Middletown	https://www.pediatricdentistmiddletown.com/	302.703.7864
Pierre Toussaint Dental Office	Wilmington	https://www.ministryofcaring.org/services/support-services/	302.6652.8947
Rawlins Orthodontics	Wilmington	https://www.rawlinsorthodontics.com/	302.239.3531
Wilmington Hospital Dental Clinic	Wilmington	https://christianacare.org/us/en/wellness/dentistry	302.320.4850
Wilmington Pediatric Dentistry	Wilmington	https://wpdde.com/	302.933.9900

Emergency Food/Food Pantry			
Organization/Service	City	Website	Phone
Food Bank of Delaware, List of Community Food Pantries in Delaware	**Wilmington, Newark, New Castle, Claymont,**	**https://www.fbd.org/get-help/community-food-pantries/**	**302.292.1305**
New Castle County Food Resources	**New Castle**	https://laborfiles.delaware.gov/main/dol/reentry/Food_Resources_NCC.pdf	302.761.8085
AIDS Delaware, Inc.	Wilmington	https://aidsdelaware.org/	302.652.6776
Appoquinimink State Service Center	New Castle	https://dhss.delaware.gov/main/maps/dsscmap/appoquin/	302.696.3125
Alpha Worship Center, Pantry of Hope	Bear	https://alphaworship.org/pantry-hope/	302.325.3930

Asbury's Food Pantry	Smyrna	https://asburysmyrnaumc.org/mission-team/	302.653.8415
Be Ready CDC	Wilmington	https://www.bereadycdc.org/	201.772.2031
Belvedere State Service Center	Wilmington	https://dhss.delaware.gov/main/maps/dsscmap/belvedder/	302.892.5977
Black Mothers in Power	Wilmington	https://www.blackmothersinpower.org/	302.932.6163
Blue Hen Bounty	Newark	https://bluehenbounty.weebly.com/	610.585.1238
Brandywine Counseling-Lancaster	Wilmington	https://brandywinecounseling.com/	302.504.5999
Canaan Baptist Church, Inc	New Castle	https://www.canaanbcde.org/home	302.354.9570
Catholic Charities, Basic Needs Program	Wilmington	https://www.ccwilm.org/child-and-adult-care-food-program/	302.655.9624
Christian Growth Ministries	Wilmington	https://www.facebook.com/christiangrowthministriesde/	302.494.5487
Churchman's Social Service Center	New Castle	https://dhss.delaware.gov/main/maps/other/chcorpctr/	302.498.5537
Claymont Community Center FC	Claymont	https://claymontcenter.org/	302.792-2757, ext.111
Community Collaboration of DE	Claymont	https://www.communitycollabde.org/	302.358.4482
Community Presbyterian Church-Community Eats	New Castle	https://www.facebook.com/compreschurch/	732.610.3683
Delaware Regional Dream Center	Newark	https://dreamcenterde.org/	302.286.7406
De La Warr State Service Center	New Castle	https://dhss.delaware.gov/main/maps/dsscmap/delawarr/	302.622.4500
Emergency Food Pantry (New Generation)	Wilmington	https://www.fbd.org/get-help/	302.353.1402
Expanded Branches Community Development Corporation	Wilmington	211 information	
Ezion – Mt. Carmel UMC	Wilmington	https://www.umc.org/en/find-a-church/church?id=001Um00000PFHcxIAH	302.654.3103
Faith Builders Churches of Jesus Christ, Inc.	Wilmington	https://www.fbep.org/	302.377.7945
Faith Chapel Community Outreach	Wilmington	https://www.rccgfaithchapel.org/	610.931.9795
First Presbyterian Church	Newark	https://fpcplayground.org/serve/food-for-success/	302.731.5644
FLOW – Falling Love Ones Wings, Inc.	New Castle, Wilmington	https://www.degives.org/orgs/flow-falling-love-ones-wings	
Food from Faith - Hope	Bear	https://www.fbd.org/get-help/	302.654.8886
Grace Church UM	Wilmington	https://gracechurchwilmington.org/outreach	302.655.8847
Hanover Presbyterian FC	Wilmington	https://hanoverchurch.org/weekly-activities/	302.584.0356
Holy Spirit Church, Food Closet	New Castle	https://delawareadrc.com/iresource/holy-spirit-church-food-closet/	800.223.9074
Holy Rosary Outreach FC	Claymont	https://www.hrparish.com/parish-outreach	302.798.1513
Hudson State Service Center	Newark	https://dhss.delaware.gov/main/maps/dsscmap/hudson/	302.283.7503
Immanuel Church	Wilmington	https://www.immanuelde.com/	302.652.3121
Joseph's Pantry of Congregation Beth Emeth	Wilmington	https://www.bethemethde.org/josephs-pantry/	302.753.2162
Kingswood Community Center, Community & Family Services	Wilmington	https://kgwcc.org/	302.764.9022
Kingswood United Methodist	Newark	https://www.kingswoodhope.com/food-closet.html	302.738.4478
Latin American Community Center Food Closet	Wilmington	https://www.thelatincenter.org/	302.654.8886
Love Fellowship CFD	Wilmington	https://www.facebook.com/LoveFFWBaptist/	367.973.7809
Love-In-Deed Food Closet	Wilmington	https://phdmde.org/love-in-deed-cdc/	302.842.3979
Lutheran Community Services Hope Lutheran	New Castle	https://lcsde.org/service/food-pantry-services	302 654.8886
Lutheran Community Services Choice Pantry	Wilmington	https://lcsde.org/service/food-pantry-services	302.654.8886
Lutheran Community Services St. Paul's Lutheran Church	Newark	https://lcsde.org/service/food-pantry-services	302.654.8886

Lutheran Community Services St. Stephen's Food Closet	Wilmington	https://lcsde.org/service/food-pantry-services	302.654.8886
Lutheran Community Services Unity Church Food Closet	Wilmington	https://lcsde.org/service/food-pantry-services	302.658.5288
Knollwood Community Center	Claymont	https://knollwoodcommunitycenter.com/services/	302.793.1627
Mt. Sinai Baptist Church	New Castle	https://www.mtsinaimissionarybc.org/	302.388.4212
Neighborhood House	Wilmington	https://www.neighborhoodhse.org/	302.658.5404
New Castle SDA Spanish Church Food Pantry	Wilmington	https://newcastlespanishde.adventistchurch.org/	718.600.9618
New Life Christian Church	Wilmington	https://www.newlifede.org/	267.992.1424
Newark Area Welfare Committee Food Pantry	Newark	https://www.newarkareawelfare.org/	302.368.8774
Northeast State Service Center	New Castle	https://dhss.delaware.gov/main/maps/dsscmap/northeas/	302.552.3501
Our Daily Bread	Middletown	https://www.ourdailybreadmot.com/	707.931.9964
Table of Plenty Food Pantry	Wilmington	https://tableofplentyde.org/	302.232.6610
Porter State Service Center	Wilmington	https://dhss.delaware.gov/main/maps/dsscmap/porter/	302.777.2814
Project 5000 (New Covenant Christian Fellowship)	New Castle	https://nccfde.org/project-5000/	302.528.5183
Resurrection Parish, Table of Plenty	Wilmington	https://resurrectionde.org/table-of-plenty	302.994.7867
Robscott Social Service Center	Newark	https://dhss.delaware.gov/main/maps/other/robscott/	302.368.6723
Rose Hill Community Center	New Castle	https://www.rosehillcommunitycenter.org/	302.656.8513
Saint Helena's Outreach	Wilmington	https://sainthelenas.org/social-ministries-2/	302.764.7545
Saint Patrick's Center, Emergency Food Closet	Wilmington	https://stpatrickscenter.org/programs/	302.652.6219
Saint Philips Food Pantry	Wilmington	https://www.stphilips.us/produce_distribution.html	
Salvation Army Food Closet	Wilmington	https://easternusa.salvationarmy.org/eastern-pennsylvania/delaware-de/	302.472.0720
St. Johns AM Church, Inc	Newark	https://www.facebook.com/stjohnamchurchInc/	302.530.7422
The Journey, LLC	Newark	https://yourjourney.tv/	302.312.4675
The Redeemed Christian COG	New Castle	https://www.facebook.com/abundantlifecenterdelaware/	302.256.3965
The Resurrection Center – Benevolence FC	Wilmington	https://www.trclive.org/	
UAW Local 1183 Food Pantry	Newark	https://region8.uaw.org/uaw-local-1183	302.738.4500
Victory Christian Fellowship, Blessings, Dressings and More	New Castle	https://victoryexperience.com/heart-for-humanity-blessings/	302.324.5400
West End Neighborhood House	Wilmington	https://westendnh.org/	302.658.4171
Wilmington Senior Center	Wilmington	https://wilmingtonseniorcenter.org/	302.651.3400
YMCA of Delaware – Central Branch Mission Market	Wilmington	https://www.ymcade.org/mission-market/	302.254.9622
YMCA of Delaware – Walnut Street Branch	Wilmington	https://www.ymcade.org/locations/walnut-street-ymca/	302.778.9009
YMCA Home Life Management Center	Wilmington	https://www.ywcade.org/housing	302.658.7100
Meal Services			
Organization/Service	City	Website	Phone
Meals on Wheels	**Statewide**	**https://mealsonwheelsde.org/**	**302.656.3257**
Ministry of Caring, Emmanuel Dining Room South	New Castle	https://www.ministryofcaring.org/services/emmanuel-dining-rooms/	302.577.2951
Ministry of Caring, Emmanuel Dining Room West	Wilmington	https://www.ministryofcaring.org/services/emmanuel-dining-rooms/	302.652.3228
Farmer's Market/ Produce Stand			
Organization/Service	City	Website	Phone
Bellefonte Farmers' Market	Wilmington	https://www.newcastlefarmersmarket.com/	302.588.8928

Belleview Farmer's Market	N. Wilmington	https://www.newcastlede.gov/2053/Bellevue-Farmers-Market	
The Brandywine Park Farmers Market	Wilmington	https://www.spreadgoodkarmafoundation.org/thebrandywineparkfarmersmarket	
Carousel Park Farmers' Market	Wilmington	https://www.newcastlede.gov/2051/Carousel-Park-Farmers-Market	
Co-op Farmer's Market	Newark	https://www.newark.coop/farmers-market	302.368.5894
Delaware Avenue Farmers' Market	Wilmington	https://www.facebook.com/p/Delaware-Avenue-Farmers-Market-100055354993755/	610.329.3936
Downtown Farmer's Market	Wilmington	https://downtownwilmingtonde.com/initiatives-blog/2015/8/4/farmers-market	302.425.0196
Glasgow Park Farmers' Market	Newark	https://www.newcastlede.gov/2052/Glasgow-Park-Farmers-Market	
Highland Orchards Farm	Wilmington	https://highlandorchardsfarmmarket.com/	302.478.4042
Harvest Outreach People's Project	Wilmington	https://thehopp.org/	888.323.HOPP
Middletown Farmers Market	Middletown	https://www.newcastlede.gov/2715/Middletown-Farmers-Market	
New Castle Farmers' Market	New Castle	https://www.newcastlefarmersmarket.com/	302.588.8928
Newark Farmers' Market	Newark	https://www.facebook.com/newarkfarmers/	302.894.0895
Route 9 Fresh Farm Stand	New Castle	3022 New Castle Avenue	
West Side Farmers Market at Cool Springs Park	Wilmington	https://www.westsidegrows.org/westside-farmers-market	302.888.5346
Willey Farms	Townsend	https://www.willeyfarmsde.com/	302.378.8441
Whitehall Sunday Market	Middletown	https://www.facebook.com/p/Whitehall-Sunday-Market-61571924781320/	

Healthcare Affordability and Financial Assistance

Organization/Service	City	Website	Phone
Nemours Children's Health Financial Assistance	Wilmington	https://www.nemours.org/patientfamily/financialassistance.html	844.551.2065
ACA Health Insurance Marketplace	Nationwide	Healthcare.gov	302.472.8655
ChristianaCare Financial Assistance	Wilmington	ChristianaCare Financial assistance	302.623.7440
Delaware Medicaid	Statewide	https://dhss.delaware.gov/dss/medicaid/	302.255.9500
Delaware Healthy Children Program	Statewide	https://dhss.delaware.gov/dss/dhcp/	800.996.9969
Delaware Medical Legal Partnership	Statewide	https://www.declasi.org/dmlp/	Wilmington 302.575.0666 Dover 302.674.8500 Georgetown 302.856.0038
Delaware Temporary Assistance for Needy Families	Statewide	https://dhss.delaware.gov/dss/tanf	302.255.8040
Delaware General Assistance Services and Programs	Statewide	https://dhss.delaware.gov/main/asistnce	302.255.8040
Delaware Health Care Connection & Voluntary Initiative Program	Statewide	https://dhss.delaware.gov/dph/dpc/chap/	
Delaware Screening for Life	Statewide	https://dhss.delaware.gov/dph/dpc/sfl/	
Medication Assistance	Nationwide	www.NeedyMeds.org	
The Assistance Fund	Statewide	https://tafcares.org/	855.845.3663

Stable Housing and Safe Environment

Organization/Service	City	Website	Phone
Delaware State Housing Authority	Statewide	https://www.destatehousing.com/find/	302.739.4263
Delaware Affordable Housing Hub	Statewide	https://delaware.affordablehousing.com/	855.301.5920
State Rental Assistance Program	Statewide	https://www.destatehousing.com/find/subsidized-rental-programs/	877.428.8844
Newark Housing Authority	Newark	https://newarkhousingauthority.net/	302.366.0826
New Castle County Housing Authority	New Castle	https://housing.nccde.org/	302.395.5600

Wilmington Housing Authority	Wilmington	https://whadelaware.org/	302.429.6701
US Department of Housing and Urban Development	Statewide	https://www.hud.gov/states/delaware	1.866.698.6155

KENT COUNTY

Mental Health/Substance Use Disorder Services

Organization/Service	City	Website	Phone
Promise Assessment Centers/ DSAMH – Directory	**Statewide**	**https://dhss.delaware.gov/dsamh/mental_health_cmhc/**	
Alcoholics Anonymous – Central Delaware Intergroup	Dover	http://www.cdiaa-de.org/html/home.html	302.736.1567
A Center for Mental Wellness	Dover	https://www.acfmw.com/	302.674.1602
Banyan Treatment Center	Milford	https://www.banyantreatmentcenter.com/facilities/milford	
Brandywine Counseling and Community Services	Milford	https://brandywinecounseling.com/treatment/	302.225.9268
Coras Wellness & Behavioral Health	Dover, Harrington	https://coraswellness.org/locations/	302.786.7800
Catholic Charities	Dover	https://www.ccwilm.org/behavioral-health-services/	302.674.1600
Child, Inc.	Dover	https://childinc.com/	302.762.6110
Community Mental Health Clinic – Williams State Service Center	Dover	https://dhss.delaware.gov/dsamh/tasc/	302.291.1821
Delaware Guidance Services, Counseling Program	Dover	https://www.delawareguidance.org/	302.678.3020
Delaware State Police, Victim Services and DE Victim Center	Statewide	https://www.delawarevictimservices.org/	
Dover Behavioral Health System	Dover	https://doverbehavioral.com/	302.560.0140
Dover Comprehensive Treatment Center	Dover	https://www.ctcprograms.com/location/dover-comprehensive-treatment-center	302.310.5073
Open Door	Dover	https://www.alcoholabuse.com/rehab-center/open-door-inc-2/	302.731.1504
Oxford House	Dover, Wyoming, Smyrna	https://www.oxfordhouse.org/	
People's Place	Milford	https://peoplesplace2.com/services/counseling-centers	302.422.8026
Psychotherapeutic Services	Dover	https://www.psychotherapeuticservices.com/	302.672.7159
Serenity Place	Dover	https://www.findserenity.org/	302.730.0800

Medical Care

Organization/Service	City	Website	Phone
Nemours Children's Health	**Wilmington**	**https://www.nemours.org/locations.html**	**800.416.4441**
ABC Pediatrics	Dover	https://www.abcpediatric.us/	302.674.0222
Bayhealth	Dover, Milford, Smyrna	https://www.bayhealth.org/	302.674.4700
Bayhealth Emergency Centers	Smyrna, Milton	https://www.bayhealth.org/	302.674.4700
Bayhealth Walk-In Medical Center	Dover, Milford	https://www.bayhealth.org/locations/walk-in-medical-care-blue-hen	302.678.1303, 302.430.5705
Burke Dermatology	Dover	https://burkedermatology.com/	302.734.3376
Camden C.A.R.E. Walk In	Dover	https://camdenwalkin.com/home	302.698.1100
ChristianaCare Go Health Urgent Care	Dover	https://www.gohealthuc.com/christianacare/locations/dover	302.546.5533
ChristianaCare Go Health Urgent Care	Dover	https://www.gohealthuc.com/christianacare/locations/dover-dupont-highway	302.857.0876

Christiana Care Smyrna Health and Wellness Center	Smyrna	https://christianacare.org/us/en/facilities/smyrna	302.659.4444
Delaware Dermatology, PA	Dover	https://www.bayhealth.org/find-a-doctor/joseph-f-andrews	302.736.1800
Delaware Public Health	Dover, Milford, Smyrna	https://dhss.delaware.gov/dph/ofclocations/	302.283.7100
Eden Hill Medical Center	Dover	https://www.edenhillmedicalcenter.com/	https://www.edenhillmedicalcenter.com/provider-directory/
Family Allergy and Asthma Care Consultants	Dover	https://www.faacconline.com/	302.734.4434
Hearing Services of Delaware	Dover	https://www.heardelaware.com/	302.487.1247
Hope Medical*Dental Clinic, Inc.	Dover	https://www.hopeclinicde.com/	302-735-7551
Kids and Teens Pediatrics	Dover	https://www.ktpdover.com/	302.433.6891
La Red Health Center - Milford	Milford	https://www.laredhealthcenter.org/	302-855-1233
Nemours Children's Health, Dover	Dover	https://www.nemours.org/locations/primary-care.html	302.672.5650
Planned Parenthood - Dover	Dover	https://www.plannedparenthood.org/health-center/delaware/dover	302.678.5200
Smyrna Health and Wellness Center	Smyrna	https://christianacare.org/us/en/facilities/smyrna	302.659.4444
Westside Family Healthcare	Dover	https://www.westsidehealth.org/	302.678.4622

Dental Care			
Organization/Service	City	Website	Phone
DHSS Dental Guide	**Statewide**	**https://dhss.delaware.gov/wp-content/uploads/sites/10/dph/pdf/dentalresourceguide.pdf**	302.318.8850
American Dental Care	Dover	https://www.americandentalsmiles.com/	302.734.7634
Care First Dental Team	Dover	https://www.carefirstdentalteam.com/	302.741.2044
Hope Medical*Dental Clinic, Inc.	Dover	https://www.hopeclinicde.com/	302.735.7551
Milford State Service Center	Milford	Milford State Service Center	302.424.7160
Westside Family Healthcare, Dover	Dover	https://www.westsidehealth.org/	302.678.4622
West Dover Dental	Dover	https://westdoverdental.com/	302.725.0044
Williams State Service Center, Children's Dental Clinic	Dover	Williams State Service Center	302.857.5120

Emergency Food/Food Pantry			
Organization/Service	City	Website	Phone
Food Bank of Delaware, List of Community Food Pantries in Delaware	**Statewide**	**https://www.fbd.org/get-help/community-food-pantries/**	**302.292.1305**
Blue Hen Social Service Center	Dover	https://dhss.delaware.gov/main/maps/other/bluhenml/	302.672.9500
Brandywine Counseling – Hope & Dreams	Dover	https://brandywinecounseling.com/hopes-dreams/	302.672.0425
Brandywine Counseling-Milford	Milford	https://brandywinecounseling.com/bccs-milford/	302.632.2469
Calvary Assembly of God	Dover	https://calvarydover.org/	302.697.7776, ext. 118
Catholic Charities, Basic Needs Program	Dover	https://www.ccwilm.org/child-and-adult-care-food-program/	302.674.1600
Do Care Doula Foundation, Inc.	Dover	https://www.docaredoulafoundationinc.org/	302.857.9026
First State Community Action Agency	Dover	https://www.firststatecaa.org/clientbasedservices	800.372.2240
Food Bank of Delaware	Newark	https://www.fbd.org/	302.292.1305
Frederica Senior Center	Frederica	https://fscguidinglight.org/	302.335.4555
Harrington Senior Center	Harrington	https://harringtonseniorcenter.org/	302.398.4224
Holy Cross FC	Dover	https://holycrossdover.org/living/social-concerns/samaritans	302.270.5875
Lake Forest Church Association	Harrington	https://sites.google.com/site/lakeforestchurchassociation/contact-information	732.600.1401
Mamie Warren Center FC	Smyrna	http://www.mamiewarren.org/	302.653.4078
Milford Community Pantry	Milford	Facebook Milford Community Pantry	302.422.8111

Milford State Service Center	Milford	https://dhss.delaware.gov/main/maps/dsscmap/milfordriverwalk/	302.424.7233
Orchard Kitchen	Magnolia	https://orchardchurchde.com/	302.335.3050
Prophetic Kingdom Ministries	Milford	https://prophetickingdomministries.com/	302.339.0380
Salvation Army Dover	Dover	https://easternusa.salvationarmy.org/eastern-pennsylvania/delaware-de/dover-corps/	302.678.9551
Smyrna State Service Center	Smyrna	https://dhss.delaware.gov/main/maps/dsscmap/smyrna/	302.514.4466
Solid Rock Church FC	Hartly	https://www.solidrockdover.com/services	302.423.3667
The Pentacostals of Dover	Dover	https://www.poddchurch.org/	302.566.5441
Whatcoat UM Church FP	Dover	https://www.pen-del.org/churchdetail/567426	302.270.1172
Williams State Service Center FC	Dover	https://dhss.delaware.gov/main/maps/dsscmap/williams/	302.857.5007
Meal Services			
Organization/Service	City	Website	Phone
Meals on Wheels		https://mealsonwheelsde.org/	302.656.3257
Dover Interfaith Mission for Housing	Dover	https://www.doverinterfaith.org/	302.736.3600
Modern Maturity Center	Dover	https://www.modern-maturity.org/	302.734.1200
Farmer's Market/ Produce Stand			
Organization/Service	City	Website	Phone
Fifer Orchards – Farm, Country Store & Community Supported Agriculture	Camden Wyoming	https://www.fifers.com/	302.697.2141
Harrington Farmer's Market	Harrington	https://www.visitdelaware.com/listing/harrington-farmers-market/6687/	302.519.2249
Riverwalk Farmers' Market	Milford	https://www.downtownmilford.org/riverwalk-farmers-market	302.393.6808
Tidal Market Delaware	Frederica	https://www.facebook.com/TidalMarketDE	
T S Smith & Sons/Orchard's Point	Bridgeville	https://www.orchardpointmarket.com/	302.727.1983
Healthcare Affordability and Financial Assistance			
Organization/Service	City	Website	Phone
See Healthcare Affordability and Financial Assistance section under New Castle County for statewide resources.			
Bayhealth Financial Assistance	Dover	https://www.bayhealth.org/patients/billing/financial-assistance-program	302.674.4700
Stable Housing and Safe Environment			
Organization/Service	City	Website	Phone
See Stable Housing and Safe Environment section under New Castle County for statewide resources.			
Dover Housing Authority	Dover	https://www.dhade.org/	302.678.1965

SUSSEX COUNTY

Mental Health/Substance Use Disorder Services

Organization/Service	City	Website	Phone
Promise Assessment Centers/ DSAMH	**Statewide**	**https://dhss.delaware.gov/dsamh/mental_health_cmhc/**	**302.255.9400**
Alcoholics Anonymous – Southern Delaware Group	Millsboro	https://sussexaa.org	302.856.6452
AMS of Delaware	Rehoboth Beach	https://www.amsdelaware.com/	302.227.1320
Beebe Behavioral Health	Georgetown, Lewes, Millsboro	https://www.beebehealthcare.org/	302.645.1099
Brandywine Counseling and Community Services	Georgetown	https://brandywinecounseling.com/treatment/	302.225.9268
Cape Integrated Wellness	Rehoboth Beach	https://www.capewellnesscenter.com/	302.213.3722
Caregiver Resource Center, Sussex	Georgetown		

Catholic Charities	Georgetown	https://www.ccwilm.org/child-and-adult-care-food-program/	302.674.1600
Child, Inc.	Georgetown	https://childinc.com/	302.762.6110
Children & Families First	Seaford	https://www.cffde.org/	302.658.5177
Chimes Holcomb Behavioral Health System	Seaford	https://chimes.org/holcomb-behavioral-health-systems	302.629.7900
Delaware Guidance Services, Counseling Program – Lewes	Lewes, Seaford	https://www.delawareguidance.org/	302.645.5338, 302.262.3505
Delaware State Police, Victim Services and DE Victim Center	Statewide	https://www.delawarevictimservices.org/	
Dover Behavioral Health System Georgetown	Georgetown	https://doverbehavioral.com/	302.747.1421
Hudson Health Services, Recovery Houses	Georgetown	https://hudsonhealth.org/	410.219.9000
La Esperanza	Georgetown	https://www.laesperanzacenter.org/	302.854.9262
Oxford House	Lewes, Georgetown, Rehoboth Beach, Millsboro	https://www.oxfordhouse.org/	301.587.2916
People's Place	Milford, Seaford, Millsboro	https://peoplesplace2.com/services/counseling-centers	302.422.8026
Re'klaim Treatment Center	Millsboro	https://www.reklaim.life/	302.858.7658
SUN Behavioral Health	Georgetown	https://sundelaware.com/	302.604.5600
Sussex County Comprehensive Treatment Center	Georgetown	https://www.ctcprograms.com/location/sussex-county-comprehensive-treatment-center	833.424.1441
Sussex County VA Clinic	Georgetown	https://www.va.gov/wilmington-health-care/locations/sussex-county-va-clinic/	302.994.2511
Trauma Specialists of Delaware	Lewes	https://traumaspecialistsofde.com/about/	
Treatment Access Center	Georgetown	https://dhss.delaware.gov/main/maps/other/tascgtwn/	302.856.5487
YWCA Delaware, Sexual Assault Response Center (SARC)	Georgetown	https://www.ywcade.org/what-we-do	302.273.1300

Medical Care

Organization/Service	City	Website	Phone
Nemours Children's Health	**Wilmington**	**https://www.nemours.org/locations.html**	**800.416.4441**
Beacon Pediatrics	Millville	https://www.beaconpediatrics.net/	302.537.0793
Altacare Urgent Care, Walk-in Clinic	Ocean View	https://atracare.com/services/walk-in-care/	302.745.7050
Altacare Urgent Care, Walk-in Clinic	Lewes	https://atracare.com/services/walk-in-care/	302.567.1500
Ambient Medical Care	Seaford	https://ambientmedicalcare.com/	877.629.2621
Bayhealth Hospital, Sussex	Milford	https://www.bayhealth.org/locations/bayhealth-hospital-sussex-campus	302.422.3311
Bayhealth Walk-in	Milford	https://www.bayhealth.org/locations/walk-in-medical-care-milford	302.430.5705
Bayhealth Emergency and Urgent Care Ctr	Milton	https://www.bayhealthtotalcare.org/our-location/bayhealth-total-care-24-7-er-and-urgent-care	302.725.3500
Bayside Audiology	Lewes	https://baysidehearingaids.com/	302.645.7603
Beacon Pediatrics	Rehoboth Beach	https://www.beaconpediatrics.net/	302.645.8212
Beebe Medical Center	Lewes	https://www.beebehealthcare.org/	302.645.3300
Beebe Healthcare Walk-in Care	Georgetown	https://www.beebehealthcare.org/locations	302.856.9729
Beebe Healthcare Walk-In Care	Millville	https://www.beebehealthcare.org/locations/beebe-walk-care-millville	302.541.4175
Beebe Healthcare Walk-In Care	Milton	https://www.beebehealthcare.org/locations	302.684.5635
Beebe Healthcare Walk-in Care	Millsboro	https://www.beebehealthcare.org/locations	302.934.5052
Beebe Healthcare Walk-in Care	Rehoboth	https://www.beebehealthcare.org/locations	302.645.3010
CAMP Rehoboth Community Center	Rehoboth	https://www.camprehoboth.org/camp-programs/	302.227.5620

Delaware Public Health	Frankford, Georgetown, Laurel	https://dhss.delaware.gov/dph/ofclocations/	
Delmarva Dermatology, LLC	Bethany Beach	https://www.beebehealthcare.org/locations/delmarva-dermatology-llc	302.402.3015
Eye Specialist of Delaware	Millville, Milford, Seaford	https://eyesde.com/	302.281.2620, 302.281.4893, 302.265.3962
La Red Health Center	Milford, Seaford, Georgetown	https://www.laredhealthcenter.org/	302.855.1233
Nemours Children's Health, Seaford	Seaford	https://www.nemours.org/locations/primary-care.html	
Nemours Children's Health, Milford	Milford	https://www.nemours.org/locations/primary-care.html	302.422.4559
Nemours Children's Health, Millsboro	Millsboro	https://www.nemours.org/locations/primary-care.html	302.629.5050
Nemours Children's Health at Beebe Healthcare Selbyville	Selbyville	https://www.nemours.org/locations/specialty-care.html	302.651.6660
Rainbow Pediatrics	Lewes, Georgetown	https://www.rainbowpediatrics.org/	302.856.6967
Sussex County Health Coalition	Georgetown	https://www.sussexcoalition.org/	302.858.4764
Sussex County VA Clinic	Georgetown	https://www.va.gov/wilmington-health-care/locations/sussex-county-va-clinic/	800.461.8262
TidalHealth Immediate Care	Laurel	https://www.tidalhealth.org/our-locations/tidalhealth-immediate-care-laurel	302.297.2579
TidalHealth Nanticoke	Seaford	https://www.tidalhealth.org/our-locations/tidalhealth-nanticoke	302.629.6611
Dental Care			
Organization/Service	City	Website	Phone
DHSS Dental Guide	**Statewide**	**https://dhss.delaware.gov/wp-content/uploads/sites/10/dph/pdf/dentalresourceguide.pdf**	
Delaware Pediatric Dentistry	Milford	https://delpd.com/	302.315.2019
La Red Health Center	Georgetown, Milford	https://www.laredhealthcenter.org/	302.855.1233
Shipley State Service Center, Children's Dental Clinic	Seaford	https://dhss.delaware.gov/main/maps/dsscmap/shipley/	302.628.6772
Thurman Adams State Service Center, Georgetown Dental Clinic	Georgetown	https://dhss.delaware.gov/main/maps/dsscmap/gtown/	302.515.3000
Emergency Food/Food Pantry			
Organization/Service	City	Website	Phone
Food Bank of Delaware, List of Community Food Pantries in Delaware	**Statewide**	**https://www.fbd.org/get-help/community-food-pantries/**	**302.424.3301**
Abundant Life Ministries	Ellendale	https://www.facebook.com/p/Abundant-Life-Ministries-CPC-100083129870905/	302.258.3854
Adams State Service Center FC	Georgetown	https://dhss.delaware.gov/main/maps/dsscmap/gtown/	302.515.3004
Agape Temple International Ministries, Inc.	Greenwood	https://www.facebook.com/AgapeTempleIntlMinistries/	302.331.1105
Bethel Tabernacle Church of God, Helping Hands Food Bank	Frankford	https://delawareadrc.com/iresource/bethel-tabernacle-church-of-god-helping-hands-food-bank/	800.223.9074
Blessings Unlimited Food Pantry	Millsboro	Blessings Food Pantry Facebook	302.238.7370
High Tide Church Food Pantry	Dagsboro	https://hightidechurch.org/ministries/the-pantry	302.727.1055
Bridgeville State Service Center	Bridgeville	https://dhss.delaware.gov/main/maps/dsscmap/bville/	302.721.7000
Cape Henlopen Food Basket	Rehoboth Beach	https://capehenlopenfoodbasket.org/	302.227.3528

Catholic Charities, Basic Needs Program	Georgetown	https://www.ccwilm.org/child-and-adult-care-food-program/	302.856.9578
Catholic Charities, Casa San Francisco Emergency Food Pantry	Milton	https://www.ccwilm.org/casa-san-francisco/	302.684.8694
Christian Storehouse-FC	Millsboro	https://www.christianstorehouse.org/about-us/food-pantry/	302.934.8151
Clarence Street Church of God	Seaford	https://clarencestreetcog.org/	302.604.8746
Community Lutheran Church	Frankford	https://bridgebuilder.church/	814.673.1255
Community Resource Center	Rehoboth Beach	https://www.rehobothcommunitycenter.org/	302.227.1340
Delmar Church of the Nazarene	Delmar	https://www.delmarchurchofnazarene.com/	302.752.5137
Delmarva Teen Challenge	Seaford	https://delmarvateenchallenge.org/	302.604.4668
Emmanuels House FC	Millsboro	https://www.emmanuelshouseinc.org/about-us	302.934.7186
Epworth UMC	Rehoboth	https://epworth.faith/	302.934.7186
First State Community Action Agency	Georgetown	https://www.firststatecaa.org/	800.372.2240
God's House of Deliverance	Millsboro	https://godshouseofdeliverance.org/	302.525.1608
Grace of God Grocery Club	Millsboro	https://www.goglcde.org/our-ministries.html	302.947.1044
Harvest Ministries, Inc. FC	Delmar	https://www.facebook.com/p/Harvest-Ministries-Inc-61574024128188/	302.945.3108
Higher Ground Outreach	Georgetown	http://highergroundoutreachinc.org/home/	302.470.7497
Home of the Brave	Milford	https://homeofthebravefdn.org/	302.424.1681
ICIAR-USA Temple Bethel Religious	Laurel	https://www.tbede.org/	302.569.7519
Joseph's Storehouse-Dagsboro Church of God FC	Dagsboro	No website	302.732.6550 ext 23
Laurel State Service Center	Laurel	https://dhss.delaware.gov/main/maps/dsscmap/laurel/	302.875.8404
Love Inc of Mid-Delmarva	Seaford	https://www.loveincofmiddelmarva.org/	302.339.5101
Milford State Service Center	Milford	https://dhss.delaware.gov/main/maps/dsscmap/milfordriverwalk/	302.424.7233
Millsboro SDA	Millsboro	https://www.millsborosda.com/	302.853.0957
Millsboro Bible Church	Millsboro	https://millsborobiblechurch.snappages.site/	302.519.7396
Milton Community Food Pantry	Milton	https://www.miltonpantry.org/	732.500.6154
Nanticoke Senior Center	Seaford	https://www.nanticokeseniorcenter.com/	302.258.3501
New Covenant Church	Lewes	https://www.ncpchurch.com/	302.344.8653
Philadelphia Pentecostal Holiness Church	Ellendale	http://philadelphiapentecostalholinesschurch.org/	302.344.8653
Promise Ministries Family Life Center, Inc.	Seaford	https://www.facebook.com/PromiseMinistriesDE	302.278.5273
Pyle State Service Center	Frankford	https://dhss.delaware.gov/main/maps/dsscmap/pyle/	302.732.1705
Saint John the Apostle Food Pantry	Milford	https://www.stjohnsmilford.com/ministries	302.854.8065
Saint Vincent De Paul Food Pantry	Seaford	https://ladyrosary.org/svdp	302.628.0630
Salvation Army Seaford	Seaford	https://easternusa.salvationarmy.org/eastern-pennsylvania/delaware-de/seaford-corps/	302.628.2020
Seaford Community of Hope	Seaford	https://www.cffde.org/scoh	302.551.9663
Shepherd's Office	Georgetown	https://www.shepherdsoffice.org/	302.907.3157
Stein Highway Church of God	Seaford	https://www.facebook.com/p/Stein-Highway-Church-of-God-Seaford-Delaware-100064874580697/	302.854.8065
The Life Center Church	Bridgeville	https://www.thelifecenters.net/	302.249.6416
Thurman Adams State Service Center	Georgetown	https://dhss.delaware.gov/main/maps/dsscmap/gtown/	302.515.3000
Unique Minds Changing Lives Inc.	Lewes	https://uniquemindscl.com/	302.943.1945
What is your Voice, Inc.	Lewes	https://whatisyourvoice.org/	302.682.20367
Meal Services			
Organization/Service	City	Website	Phone
Meals on Wheels Directory	**Statewide**	**https://mealsonwheelsde.org/**	**302.656.3257**
CHEER Senior Centers	Georgetown, Greenwood	https://www.cheerde.com/senior-centers/	302.515.0001

	Frankford, Lewes, Millsboro, Milton, Ocean View		
Farmer Gene's Market	Bridgeville		302.349.4121
Food Bank of Delaware - Milford	Milford	https://www.fbd.org/cafe/	302.424.3301
Love in the name of Christ	Seaford	https://www.loveincofmiddelmarva.org/gap-ministries	302.629.7050
Meals on Wheels of Lewes and Rehoboth	Lewes	https://www.mealsonwheels-lr.org/	302.645.7449
Farmer's Market/ Produce Stand			
Organization/Service	City	Website	Phone
Adams Fruit Market	Greenwood	https://www.adamsfruitmarket.com/	302.349.4924
Bethany Beach Farmers' Market	Bethany Beach	https://bethanybeachfarmersmarket.com/	
Country Living Produce	Millsboro	https://www.countrylivingproduce.com/	302.934.9045
Elmer's Market	Georgetown	https://www.elmersmarket.com/	302.337.8110
Fenwick Island Farmers' Market/Bennett Orchards	Fenwick Island	https://www.bennettorchards.com/maps/location/FenwickIslandDEFarmersMarket	
Historic Lewes Farmers' Market	Lewes	https://www.historiclewesfarmersmarket.org/	302.644.1436
Laurel Farmers' Auction Market	Laurel	https://www.facebook.com/LaurelFarmersAuctionMarket/	302.875.3147
Little Wagon Produce	Greenwood	https://www.littlewagonproduce.com/	302.349.5100
Milton Farmers' Market	Milton	https://www.facebook.com/people/Milton-Broadkill-Farmers-Market/100068649104011/	
Nassau Valley Vineyards Farmers' Market	Lewes	https://www.nassauvalley.com/farmers-market/	302.645.9463
Parsons Farms Produce	Dagsboro	https://parsonsfarmsproduce.com/	302.732.3336
Rehoboth Beach Farmers' Market	Rehoboth Beach	https://www.rbfarmersmarket.com/	302.249.7878
Riverwalk Farmers' Market Downtown Milford	Milford	https://www.downtownmilford.org/riverwalk-farmers-market	302.393.6808
Sea Colony Farmer's Market	Bathany Beach	https://seacolonyfarmersmarket.com/	
T.S. Smith Orchard Point Market	Bridgeville	https://www.orchardpointmarket.com/	302.727.1983
Willeys Country Market	Greenwood	https://www.facebook.com/willeyscountrymarket/?ref=bookmarks&_rdr	410.310.0519
Healthcare Affordability and Financial Assistance			
Organization/Service	City	Website	Phone
**See Health Care Affordability and Financial Assistance section under New Castle County for statewide resources.*			
Beebe Healthcare Financial Assistance	Lewes	https://www.beebehealthcare.org/patients-visitors/financial-assistance	302.645.3546
Bayhealth Financial Assistance	Milford	https://www.bayhealth.org/patients/billing/financial-assistance-program	302.422.3311
Stable Housing and Safe Environment			
Organization/Service	City	Website	Phone
See Stable Housing and Safe Environment section under New Castle County for statewide resources.			
Sussex County Housing	Georgetown	https://sussexcountyde.gov/community-development-housing	877.428.8844

Appendix B –Key Informant Representation

Key informants represented a cross-section of industries in our region, speaking to a broad range of experiences and perspectives within and across the systems that enable or inhibit the health and safety of children and families. Below is a list of key informant affiliations:

1. Healthy Communities Delaware
2. Delaware Housing Alliance
3. American Civil Liberties Union (ACLU-DE)
4. ChristianaCare Health System, Community Health: Food Is Medicine
5. Delaware School Nurse Association
6. Delaware Division of Public Health, Office of Health Equity
7. Children and Families First Delaware
8. Delaware Community Foundation
9. Delaware Department of Education, Career and Technical Education (CTE)
10. Delaware STEM Council
11. The Delaware Clinical and Translational Research (CTR) ACCEL Program
12. Delaware Council on Farm and Food Policy

Appendix C – Prioritized Results by Zip Code Region

Survey respondents selected their top three health needs and below are the areas that rose to the top broken out by zip code region. While the priorities related to general health status, behaviors and outcomes varied by region, the majority of the social determinants or root cause needs were consistent across geographies.

Figure 135. Prioritized List of Health Needs (Outcomes, Behaviors, Conditions) from The Community Survey by ZIP Code Region, Delaware, 2025

Ranked	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
1	Asthma	Mental/ behavioral health	Airborne and/or skin allergies	ADHD	Mental/ behavioral health	Stress or Anxiety
2	Mental/ behavioral health	Stress or Anxiety	Asthma & ADHD	Developmental delays/ disabilities	Food and/or medication allergies	Mental/ behavioral health
3	ADHD & Food and/or medication allergies	Asthma	Food and/or medication allergies	Mental/ behavioral health	Respiratory conditions other than asthma; asthma; stress or anxiety; developmental delays/ disabilities	ADHD

Source: Nemours Community Survey, 2025

Question: Thinking about the health and wellbeing of youth (ages 0-17) in your community, what are the top 3 most important health needs or concerns to prioritize?

Figure 136. Prioritized List of Health Needs (Social Determinants of Health) from The Community Survey by ZIP Code Region, Delaware, 2025

Ranked	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
1	Affordable healthcare	Affordable healthcare	Affordable healthcare	Affordable healthcare	Affordable healthcare	Affordable healthcare
2	Affordable health insurance	Affordable health insurance	Affordable health insurance	Affordable health insurance	Affordable health insurance	Affordable health insurance
3	Access to mental & behavioral health services/ providers	Access to mental & behavioral health services/ providers	Access to dental services/ dentists	Access to mental & behavioral health services/ providers	Access to dental services/ dentists	Access to mental & behavioral health services/ providers

Source: Nemours Community Survey, 2025

Question: Thinking about the root causes impacting top health needs or concerns among youth (ages 0-17) in their households and in the community, please select 3 critical social, economic, and/or environmental factors most important to address.

Appendix D –Community Survey Demographics

The results of the community survey demographic questions are below. At the end of the demographics, there is a link to the data tables for the remaining survey questions. . Table 1 shows the sample size for each ZIP code total number of surveys and surveys from each CHNA ZIP code region in Delaware, as well as the number of responses, the percent of total and any variation between values..

Difference between Proportions vs. Each

Each column is compared to the others in the same banner heading. Each column is identified by a letter shown under the banner. When the test shows that a column is significantly* different from another column, the other column's letter will appear below the data for the first column. An uppercase letter indicates the columns are different at the .01 significance level. A lowercase letter indicates the columns are different at the .05 significance level.

For example, if "ABd" appears in a Data Cell, it indicates that the Column Percent in this cell is significantly different from the Column Percents in banner columns A and B in the same Row at the 99% Confidence Level (since "A" and "B" are uppercase), and is significantly different from the Column Percent in Column D at the 95% Level (since d is lowercase).

*The 99% (.01) and 95% (.05) levels are defaults.

The mathematics behind this test also requires that the two groups being compared in each test be composed of separate people. Normally banner columns do show different groups of people, but if a banner variable allows multiple responses or you are using a multi-total banner in which the same people might appear in different columns, you should consider the test only a general indication, rather than a precise measure.

Nemours Children's Hospital, Delaware 2025
Table 1: SOURCE

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Web	884	210	241	106	112	104	111
	91%	93%	89%	91%	93%	88%	90%
Landline	13	2	2	0	2	4	3
	1%	1%	1%	0%	2%	3%	2%
Cell	78	15	27	10	7	10	9
	8%	7%	10%	9%	6%	8%	7%

Table 2: SEX

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Male	356	93	86	61	31	40	45
	37%	41%	32%	53%	26%	34%	37%
		bcD	aC	aBDEf	AC	C	c
Female	619	134	184	55	90	78	78
	63%	59%	68%	47%	74%	66%	63%
		bcD	aC	aBDEf	AC	C	c

Table 3: Q1: Which of the following ranges includes your age?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
18 to 24	175	47	48	17	17	26	20
	18%	21%	18%	15%	14%	22%	16%
25 to 34	240	68	61	23	31	29	28
	25%	30%	23%	20%	26%	25%	23%
35 to 44	319	63	80	51	40	49	36
	33%	28%	30%	44%	33%	42%	29%
		CE	Ce	ABf		Abf	ce
45 to 54	141	33	48	18	16	6	20
	14%	15%	18%	16%	13%	5%	16%
		E	E	E	e	ABCdF	E
55 to 64	75	14	29	7	11	6	8
	8%	6%	11%	6%	9%	5%	7%
65 to 74	24	2	4	0	6	1	11
	2%	1%	1%	0%	5%	1%	9%
		dF	dF	dF	abc	F	ABCE

Table 5: Q2: What county do you live in?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Kent, DE	241	0	0	116	119	0	6
	25%	0%	0%	100%	98%	0%	5%
		CDF	CDF	ABEF	ABEF	CDf	ABCDe
New Castle, DE	501	227	270	0	2	0	2
	51%	100%	100%	0%	2%	0%	2%
		CDEF	CDEF	AB	AB	AB	AB
Sussex, DE	233	0	0	0	0	118	115
	24%	0%	0%	0%	0%	100%	93%
		EF	EF	EF	EF	ABCDF	ABCDE

Table 8: Q4: What is your race or ethnicity? Select ALL that apply.

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Black or African-American	355	136	82	46	31	37	23
	36%	60%	30%	40%	26%	31%	19%
		BCDEF	Af	AdF	Ac	Af	AbCe
Asian or Pacific Islander	30	5	6	11	2	4	2
	3%	2%	2%	9%	2%	3%	2%
		C	C	ABDF	C		C
White or Caucasian	568	78	170	66	90	66	98
	58%	34%	63%	57%	74%	56%	80%
		BCDEF	AdF	ADF	AbCE	ADF	ABCE
Native American or Alaskan Native	18	4	8	0	3	2	1

	2%	2%	3%	0%	2%	2%	1%
Hispanic or Latino	85	23	28	5	4	17	8
	9%	10%	10%	4%	3%	14%	7%
		d	d	E	abE	CDf	e
Other	8	2	5	1	0	0	0
	1%	1%	2%	1%	0%	0%	0%

Table 9: Q5: How many children under the age of 18 live in this household?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	975	227	270	116	121	118	123
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
One	492	113	131	68	59	55	66
	50%	50%	49%	59%	49%	47%	54%
Two	295	67	91	28	28	41	40
	30%	30%	34%	24%	23%	35%	33%
			d		be	d	
Three	136	31	40	16	20	14	15
	14%	14%	15%	14%	17%	12%	12%
Four	29	7	3	4	10	4	1
	3%	3%	1%	3%	8%	3%	1%
		d	D		aBF		D
Five	17	8	3	0	2	4	0
	2%	4%	1%	0%	2%	3%	0%
		cf		ae		cf	ae
Six or more	5	1	2	0	2	0	0
	1%	0%	1%	0%	2%	0%	0%

Table 10: Q6: What is the primary language spoken in your household?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	974	227	270	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
English	943	221	263	110	120	110	119
	97%	97%	97%	95%	99%	93%	98%
			e	d	ce	bd	
Spanish	21	4	5	4	0	6	2
	2%	2%	2%	3%	0%	5%	2%
				d	ce	d	
Haitian Creole	4	0	0	1	0	2	1
	0%	0%	0%	1%	0%	2%	1%
		e	e			ab	
Other	6	2	2	1	1	0	0
	1%	1%	1%	1%	1%	0%	0%

Table 11.1: Q7: About the child who had the most recent birthday. How old are they?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	974	227	270	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
<1	21	8	5	1	2	3	2
	2%	4%	2%	1%	2%	3%	2%

1	56	16	14	4	9	8	5
	6%	7%	5%	3%	7%	7%	4%
2	65	14	21	7	9	5	9
	7%	6%	8%	6%	7%	4%	7%
3	68	12	21	2	10	10	13
	7%	5%	8%	2%	8%	8%	11%
			c	bdeF	c	c	C
4	57	14	15	10	2	6	10
	6%	6%	6%	9%	2%	5%	8%
				d	cf		d
5	70	20	16	18	6	7	3
	7%	9%	6%	16%	5%	6%	2%
		f	C	BDeF	C	c	aC
6	66	21	15	11	9	5	5
	7%	9%	6%	9%	7%	4%	4%
7	54	18	18	5	7	2	4
	6%	8%	7%	4%	6%	2%	3%
		e	e			ab	
8	41	8	14	4	7	4	4
	4%	4%	5%	3%	6%	3%	3%
9	48	7	19	4	6	8	4
	5%	3%	7%	3%	5%	7%	3%
		b	a				
10	40	9	12	5	6	3	5
	4%	4%	4%	4%	5%	3%	4%
11	47	12	9	3	6	12	5
	5%	5%	3%	3%	5%	10%	4%
			E	e		Bc	
12	63	15	13	6	13	9	7
	6%	7%	5%	5%	11%	8%	6%
			d		b		
13	58	8	18	9	4	6	13
	6%	4%	7%	8%	3%	5%	11%
		F			f		Ad
14	54	9	16	3	8	8	10
	6%	4%	6%	3%	7%	7%	8%
15	53	13	7	7	10	8	8
	5%	6%	3%	6%	8%	7%	7%
			de		b	b	
16	53	11	14	11	4	7	6
	5%	5%	5%	9%	3%	6%	5%
17	60	12	23	6	3	7	9
	6%	5%	9%	5%	2%	6%	7%
			d		b		

Table 12: Q7B: What is this child's gender?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Male	542	131	143	69	80	57	62
	56%	58%	53%	59%	66%	48%	51%
			d		bEf	D	d
Female	431	96	126	47	41	61	60
	44%	42%	47%	41%	34%	52%	49%
			d		bEf	D	d

Table 13: Q8: What is this child's race or ethnicity? Select ALL that apply.

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Black or African-American	395	150	97	46	36	41	25
	41%	66%	36%	40%	30%	35%	20%
		BCDEF	AF	AF	A	Af	ABCe
Asian or Pacific Islander	39	10	6	11	3	5	4
	4%	4%	2%	9%	2%	4%	3%
			C	Bdf	c		c
White or Caucasian	559	79	168	64	89	63	96
	57%	35%	62%	55%	74%	53%	79%
		BCDEF	AdF	ADF	AbCE	ADF	ABCE
Native American or Alaskan Native	22	2	13	2	3	1	1
	2%	1%	5%	2%	2%	1%	1%
		b	af				b
Hispanic or Latino	110	26	37	9	8	20	10
	11%	11%	14%	8%	7%	17%	8%
			d	e	be	cdf	e
Other	11	3	3	0	0	1	4
	1%	1%	1%	0%	0%	1%	3%
				f	f		cd

Table 52: Q47: Has your household utilized any of these resources in the past year?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Activities and Programs at Community Centers/Clubs	231	67	60	27	24	27	26
	24%	30%	22%	23%	20%	23%	21%
Meals or Food Programs	312	94	57	40	42	46	33
	32%	41%	21%	34%	35%	39%	27%
		BF	ACDE	B	B	Bf	Ae
Transportation Services or Resources	176	61	36	29	22	14	14
	18%	27%	13%	25%	18%	12%	11%
		BEF	AC	BEF		AC	AC
Prescription Drug Programs/Assistance	157	38	49	21	15	16	18
	16%	17%	18%	18%	12%	14%	15%
Helpline or Information Referral Line	108	32	24	22	10	12	8
	11%	14%	9%	19%	8%	10%	7%
		f	C	BdF	c		aC

Housing Services	121	42	24	14	11	13	17
	12%	19%	9%	12%	9%	11%	14%
		Bd	A		a		
None of these	325	56	115	23	44	41	46
	33%	25%	43%	20%	36%	35%	38%
		Bdef	AC	BDeF	aC	ac	aC
Other	1	0	0	0	1	0	0
	0%	0%	0%	0%	1%	0%	0%
Don't Know	59	15	17	8	5	5	9
	6%	7%	6%	7%	4%	4%	7%

Table 53: Q48: Has anyone living in your household received any of the following?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
SSI	129	34	24	14	21	20	16
	13%	15%	9%	12%	17%	17%	13%
		b	ade		b	b	
SSDI	110	40	26	10	14	9	11
	11%	18%	10%	9%	12%	8%	9%
		Bcef	A	a		a	a
Food Stamps	395	115	76	59	57	49	39
	41%	51%	28%	51%	47%	42%	32%
		BF	ACDe	BF	Bf	b	ACd
WIC Program Benefits	185	52	40	20	26	20	27
	19%	23%	15%	17%	21%	17%	22%
		b	a				
TANF	79	23	15	21	12	5	3
	8%	10%	6%	18%	10%	4%	2%
		cF	C	aBEF	f	C	ACd
None of these	371	59	141	25	40	48	58
	38%	26%	52%	22%	33%	41%	48%
		BEF	ACDe	BdEF	Bcf	AbC	ACd
Other	1	0	0	0	0	0	1
	0%	0%	0%	0%	0%	0%	1%
Don't Know	37	12	10	8	2	1	4
	4%	5%	4%	7%	2%	1%	3%
		e		de	c	ac	

Table 54: Q49: What is your current housing situation?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Own your home	494	84	158	43	79	55	75
	51%	37%	59%	37%	65%	47%	61%
		BDF	ACe	BDF	ACE	bDf	ACe
Rent your home	296	96	72	33	24	39	32
	30%	42%	27%	28%	20%	33%	26%
		BcDF	A	a	Ae	d	A
Stay with family/friends	120	24	24	25	14	21	12

	12%	11%	9%	22%	12%	18%	10%
		C	Ce	ABdf	c	b	c
Temporary housing	24	7	6	8	2	0	1
	2%	3%	2%	7%	2%	0%	1%
			c	bdEf	c	C	c
Unhoused	12	5	2	3	0	2	0
	1%	2%	1%	3%	0%	2%	0%
Other	2	1	1	0	0	0	0
	0%	0%	0%	0%	0%	0%	0%
Decline to answer	25	10	6	4	2	1	2
	3%	4%	2%	3%	2%	1%	2%

Table 55: Q50: What is the highest level of education that you have completed?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Less than high school	30	7	6	3	4	8	2
	3%	3%	2%	3%	3%	7%	2%
			e			bf	e
High school	255	73	51	27	36	34	34
	26%	32%	19%	23%	30%	29%	28%
		B	Adef		b	b	b
Trade or technical school or union apprenticeship	50	16	9	7	7	7	4
	5%	7%	3%	6%	6%	6%	3%
Some college	215	53	54	32	29	27	20
	22%	23%	20%	28%	24%	23%	16%
				f			c
College (associate's degree)	98	22	20	10	16	17	13
	10%	10%	7%	9%	13%	14%	11%
			e			b	
College (bachelor's degree)	177	29	64	20	16	17	31
	18%	13%	24%	17%	13%	14%	25%
		BF	Ade		bf	bf	Ade
Graduate school	127	19	58	15	12	6	17
	13%	8%	22%	13%	10%	5%	14%
		B	AcDE	be	B	Bcf	e
Other	0	0	0	0	0	0	0
	0%	0%	0%	0%	0%	0%	0%
Decline to answer	21	8	7	2	1	2	1
	2%	4%	3%	2%	1%	2%	1%

Table 56: Q51: Which of the following includes your annual household income?

AREA	Total	Wilmington City	Remainder New Castle	Dover & Surrounding	Remainder Kent Co	Remainder Sussex Co	NE & SE Beaches
Un-weighted Base	973	227	269	116	121	118	122
		23%	28%	12%	12%	12%	13%
		(A)	(B)	(C)	(D)	(E)	(F)
Less than $25,000	169	50	29	20	30	26	14

	17%	22%	11%	17%	25%	22%	11%
		Bf	ADE		BF	Bf	aDe
$25,000 to $49,999	201	65	43	17	32	25	19
	21%	29%	16%	15%	26%	21%	16%
		BCF	Ad	Ad	bcf		Ad
$50,000 to $74,999	177	40	45	19	17	32	24
	18%	18%	17%	16%	14%	27%	20%
		e	e	e	e	abcd	
$75,000 to $99,999	122	27	41	6	11	12	25
	13%	12%	15%	5%	9%	10%	20%
		cf	C	aBF	f	f	aCde
$100,000 to $149,999	131	17	47	17	20	11	19
	13%	7%	17%	15%	17%	9%	16%
		BcDf	Ae	a	A	b	a
$150,000 or more	115	13	46	29	5	5	17
	12%	6%	17%	25%	4%	4%	14%
		BCF	ADE	ADEf	BCF	BCF	AcDE
Decline to answer	58	15	18	8	6	7	4
	6%	7%	7%	7%	5%	6%	3%

*Data tables for the remaining survey questions are available upon request.

Appendix E –Community Survey Instrument

The 2025 CHNA community survey was conducted primarily online, in conjunction with a smaller sample of telephone surveys collected from both landline and cell phone outreach. The telephone survey instrument/guide is included below. The online survey was adapted from this tool with no changes to question content.

SCREENING

-	[RECORD GENDER of head of household, DO NOT ASK]
Male	
Female	

1	Which of the following ranges includes your age?
Under 18 [THANK & TERMINATE]	
18 to 24	
25 to 34	
35 to 44	
45 to 54	
55 to 64	
65 to 74	
75 or older	
Decline to answer	

2	What County do you live in? [DO NOT READ CHOICES]
Kent, DE	
New Castle, DE	
Sussex, DE	
Other	[THANK & TERMINATE]
Decline to answer	[THANK & TERMINATE]

3	What ZIP Code do you live in? [DO NOT READ CHOICES]
Enter zip code	
See spreadsheet for allocations	
Other	[THANK & TERMINATE]
Decline to answer	[THANK & TERMINATE]

4	What is your race or ethnicity? Select ALL that apply (bi-racial and Hispanic origin).
Black or African-American	
Asian or Pacific Islander	
White or Caucasian	
Native American or Alaskan Native	
Hispanic or Latino	
Other, please specify:	
Decline to answer	

5	How many children under the age of 18 live in this household?
One	
Two	
Three	
Four	
Five	
Six	
None (terminate)	
Refuse (terminate)	

6	What is the primary language spoken in your household?
English	
Spanish	
Haitian Creole	
Other, please specify:	
Decline to answer	

HEALTH STATUS

Your responses to these questions will be used by Nemours Children's Hospital, public health departments, and other community organizations to better serve the needs of our community's residents.

7	I would like to ask some questions about the health care of one of your children. In order to randomly select one, please answer the following questions about the child who had the most recent birthday. How old are they?
Enter age	
Decline to answer (terminate)	

8	What is this child's race or ethnicity? Select ALL that apply (bi-racial and Hispanic origin).
Black or African-American	
Asian or Pacific Islander	
White or Caucasian	
Native American or Alaskan Native	
Hispanic or Latino	
Other, please specify:	
Decline to answer	

9	Was there a time in the PAST 12 MONTHS when this child was sick or injured and needed medical care but could not get it?
Yes	
No	
Don't know/not sure	
Refuse	

Ask 10 if answer to question 9 is "Yes"

10	What would you say is the main reason this child was not able to get the care they needed?
Cost of care/diagnostics (includes costs of testing and diagnosis, hospital stays, office visits, follow-ups)	
Cost of treatment or medical intervention (includes surgical intervention, medications, medical devices, therapy, etc.)	
Lack of transportation	
Stigma associated with their health condition/challenge	
Language and/or cultural barriers	
Insurance barriers (no coverage, lack of coverage, intermittent coverage/loss of benefits)	
Difficulty getting an appointment (limited provider availability, inconvenient appointment hours, harsh policies)	
Other (specify)	
Don't know/not sure	
Refuse	

11	Was there a time in the PAST 12 MONTHS when this child needed mental and/or behavioral health care but did NOT get the care they needed?
Yes	
No	
Don't know/not sure	
Refuse	

Ask 12 if the response in question 11 is "yes"

12	What would you say is the main reason this child was not able to get the care they needed?
Cost of care/diagnostics (includes costs of testing and diagnosis, hospital stays, office visits, follow-ups)	
Cost of treatment or medical intervention (includes surgical intervention, medications, medical devices, therapy, etc.)	
Lack of transportation	
Stigma associated with their health condition/challenge	
Language and/or cultural barriers	

Insurance barriers (no coverage, lack of coverage, intermittent coverage/loss of benefits)
Difficulty getting an appointment (limited provider availability, inconvenient appointment hours, harsh policies)
Other (specify)
Don't know/not sure
Refuse

13	Does this child currently have any type of health care coverage or insurance?
Yes, private insurance (e.g., through an employer or purchased directly)	
Yes, public insurance (e.g., Medicaid, CHIP or other state-sponsored health insurance)	
No	
Don't know/not sure	
Refuse	

Ask 14 if response to question 13 is "no".

14	What is the main reason this child is not currently insured?
Cost is too high	
Ineligible due to income or other factors	
Waiting for coverage to begin	
Don't know/not sure	
Other, please specify:	

15	About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness or condition?
Within the past year (less than 1 year ago)	
Within the past 2 years (1 year but less than 2 years)	
Within the past 5 years (2 years but less than 5 years)	
5 or more years	
Never	
Don't know/not sure	
Refuse	

16	Have you ever delayed or skipped a recommended vaccination for this child?
Yes	
No (skip next question)	
Don't know/not sure	
Refuse	

Ask 17 if the answer to question 16 is "yes".

17	What is the main reason you have delayed or skipped a recommended vaccination for this child? (select 1)
Concerns about vaccine safety or side effects	
Belief that vaccines are not necessary	
Lack of information about vaccination schedules	
Cultural or religious beliefs	
Child was unwell at the time	
COVID-19 restrictions delayed the vaccine schedule, but we are caught up now.	
COVID-19 restrictions delayed the vaccine schedule, and we are still not caught up.	
Don't know/not sure	
Other, please specify:	

18	Has this child received a developmental screening(s) at or around the recommended ages of 9 months, 18 months, and 30 months?
Yes	
No	
Don't know/not sure	

Ask 20 if the answer to question 19 is "no".

19	What is the main reason this child did not receive developmental screening at or around the recommended ages of 9, 18, and 30 months? (Select 1)
They were screened, just not on this schedule	
Lack of awareness about recommended screenings	
Difficulty accessing healthcare services	
Concerns about the screening process	

Belief that screening isn't necessary
Scheduling conflicts or time constraints
The pediatrician never conducted the screening
COVID-19 restrictions prevented us from attending these visits and being screened
Don't know/not sure
Other, please specify:

Ask the following of those with children ages 11-17

20	The human papillomavirus (pap-uh-loh-muh virus), also known as HPV, is a common infection that can lead to several types of cancers later in life. It is recommended that children age 11 and older receive at least two shots of the HPV vaccine, sometimes called Gardasil (guard-uh-sil), or Cervarix (sir-vah-rix). The HPV vaccine is over 99% effective at preventing pre-cancer caused by HPV, which are linked to 70% of cervical cancers. Has this child had at least two shots of the HPV vaccine?
Yes	
No	
Don't know/not sure	
Refuse	

21	Have you ever been told by a doctor, nurse or other health professional that this child has any of these conditions or conditions, diseases or challenges? [READ LIST and *Select all that apply]*
Asthma	
Respiratory Condition other than Asthma (cystic fibrosis, RSV, tuberculosis)	
Meningitis (bacterial, viral, fungal)	
Airborne and/or Skin Allergy (Pollen, Dust Mites, Pet Dander, Mold/Nickel, Latex, Plants)	
Food and/or Medication Allergy (Nuts, Shellfish, Dairy/Sulfa Drugs, NSAIDs)	
Hearing Impairment/Deaf	
Visual Impairment/Blindness	
Cancer (all types)	
Neurodevelopmental Disorder (ASD, ADHD, etc.)	
Type 1 Diabetes	
Type 2 Diabetes	
Blood Disorder (sickle cell, anemia, etc.) High cholesterol	
Digestive Disorder (Celiac Disease, Lactose Intolerance, IBS, etc.)	
Eating Disorder	
Post-Traumatic Stress Disorder (PTSD)	
Stress or Anxiety Disorder	
Mental/Behavioral Health Condition Other Than PTSD, Anxiety, or Eating Disorder (Bipolar, Clinical Depression, OCD, Schizophrenia, Disruptive Behavior and Dissocial Disorders).	
Overweight or Obese	
Dental problems (gum disease, infection, abscess, etc.) Exclude: "cavities".	
Medical Complexity (multiple chronic conditions + other factors that make care more difficult)	
Vaccine-Preventable Disease (VPD) - including: Chicken Pox, Hepatitis (A&B), HiB, HPV, Measles, Mumps, Rubella, Tetanus, Rotavirus, etc.)	
Substance Use Disorder	
Sexually Transmitted Infection (STI)	
Other, please specify:	
None	
Decline to Answer	

Ask 22 if the answer to question 21 was any response EXCEPT "none" or "decline to answer".

22	Did this child receive treatment for their health condition(s)?
Yes	
No	
Decline to Answer	

Ask of ALL

23	Do you feel you have all that you need to manage this child's health?
Yes	
No	
Decline to Answer	

Ask 24 if the response to question 23 is "no".

24	What do you need in order to manage this child's health? [Do not read, *Select all that apply]*
More information/education about my child's condition(s) that is easy to understand, culturally relevant, etc.	

Financial assistance for basic needs (food, shelter, clothing, etc.)
Affordable healthcare/treatment options
Affordable Insurance coverage
Training/support for parents and caregivers on how to care for these condition(s) outside of the medical environment.
A better support system of family, friends, etc.
Better coordination of care across all points of care (school nurse, primary care doctor, specialists, etc.)
Increased appointment availability outside of work/school hours.
Reliable transportation to appointments/other services and supports
Multilingual services and resources
Trust in the healthcare system/providers
Don't Know
Other, please specify:

25	How often do you have difficulty understanding information or instructions from your doctor or healthcare provider?
Never	
Rarely	
Sometimes	
Often	
Always	

26	How confident are you in using health-related information (written or verbal) to make decisions about your health?
Very confident	
Somewhat confident	
Not confident at all	

27	How much trust do you have in your local hospital or health center to provide high-quality care to people in your community?
A great deal of trust	
Some trust	
A little trust	
No trust at all	
Don't Know	

28	How much do you think Nemours Children's Health (Delaware prompt only: Formerly AI DuPont Hospital for Children) works with the community to address broader issues such as safety, food insecurity, education, and housing?
A great deal	
Somewhat	
A little	
Not at all	
Don't know/ Not aware	

29	In the place you are currently living, are there any of the following problems? [Read, *Select all that apply]*
Leaking roof or ceiling	
Mold or mildew	
Inadequate heating and/or cooling	
Plumbing problems (e.g., leaks, no running water)	
Rodents or pests (e.g., mice, cockroaches)	
Overcrowding (e.g., too many people for the space)	
None of these	
Don't Know	
Other, please specify:	

30	How much do you agree with the following statements about your neighborhood or community? [*Strongly agree =1, Somewhat agree =2, Neither agree nor disagree =3, Somewhat disagree =4, Strongly disagree =5*]
People in my community can be trusted.	
I feel like I belong in my community/neighborhood.	
People in my community are willing to help each other.	
There are adults in my community/neighborhood I can count on to help me or my family if needed.	

My family has close friends or relatives nearby who we can rely on for support.

31	How safe do you feel this child is when: [*Very safe =1, Somewhat safe =2, Neither safe nor unsafe =3, Somewhat unsafe =4, Very unsafe =5*]
Playing outside during the day.	
Walking to or from school or a park.	
Being outside after dark.	

Ask 32 is the answer to question 31 "somewhat unsafe" or "very unsafe" in any of the 3 response categories.

32	What is the reason you feel this child is unsafe in your neighborhood or community?
Fear of crime (e.g., violence, theft, or harassment in the neighborhood)	
Traffic safety issues (e.g., busy streets, reckless driving)	
Lack of safe sidewalks, crossings, or pedestrian infrastructure like ___ and streetlights	
Lack of safe spaces to play or unsupervised public areas	
Lack of community support or presence of unsupervised youth	
Environmental hazards (e.g., abandoned buildings, unsafe playgrounds, trash)	
Risk of being approached or harmed by animals	
Concerns about weather or environmental conditions (e.g., extreme cold, heat)	
Presence of strangers or unfamiliar people in the area (e.g., tourism, transient populations, illegal activity, business/commerce traffic)	

33	In the past 12 months, how many times have you seen or heard violence in your home or community?
Never	
1-2 times	
3-5 times	
More than 5 times	
Don't know/not sure	
Refuse	

34	In the past 12 months, how many times has this child seen or heard violence at home or in their community?
Never	
1-2 times	
3-5 times	
More than 5 times	
Don't know/not sure	
Refuse	

Ask the following of those with children ages 6 and older

35	During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?
Enter 0-7	
Child unable to be physically active	
Don't know/not sure	
Refuse	

Ask the following of those with children ages 3-5

36	During the past 7 days, on how many days was this child physically active for a total of at least 3 hours per day or about 15 minutes every hour they are awake?
Enter 0-7	
Child unable to be physically active	
Don't know/not sure	
Refuse	

37	In the past 12 months, were there times when your family couldn't access enough food because of: (Read, check all that apply)
Cost of food	
Lack of transportation to get to a grocery store or food source	
Lack of stores that sell fresh or healthy food in your area	
Limited time to shop or prepare meals	
Other, please specify:	
Refuse	

38	In the past 7 days, how many days did this child eat the following foods?

	(Read, record the number of days 0-7)
Fresh fruits (e.g., apples, bananas, berries)	
Fresh vegetables (e.g., carrots, broccoli, leafy greens)	
Protein-rich foods (e.g., meat, eggs, beans, nuts)	
Whole grains (e.g., brown rice, whole-grain bread)	
Sugary snacks or desserts (e.g., candy, cookies, ice cream)	
Fast food or takeout meals	
My child is too young (under 1) or has a complex medical condition that impacts their diet (EXCLUDE)	

39	In the past 7 days, how often have you read books or stories to your child?
Every day	
A few times a week	
Once a week	
Never	

40	At what age did this child begin their earliest formal education program?
Before three years old (e.g., daycare, early learning program)	
3 years old (preschool)	
4 years old (preschool)	
5 years old (kindergarten)	
Child is not enrolled in school	

Ask 41 is the answer to question 40 is “child not enrolled in school”.

41	What is the reason this child is not enrolled in school?
Child is not old enough for school	
Not enough available spots in local kindergarten programs	
I prefer to homeschool or use alternative education methods	
Financial barriers (e.g., tuition, fees)	
Lack of transportation	
Other, please specify:	
Refused	

Community Health

Now, I would like to ask you some general questions about the health and well-being of your community.

42	Thinking about the health and wellbeing of youth (ages 0-17) in your community, what are the top 3 most important health needs or concerns to prioritize. If you think of a health need that is not listed here, please write it in under “other.” (Please choose only 3)
HEALTH NEEDS	
Asthma	
Respiratory Conditions Other than Asthma (RSV, cystic fibrosis, etc.)	
Airborne and/or Skin Allergies (Pollen, Dust Mites, Pet Dander, Mold/Nickel, Latex, Plants)	
Food and/or Medication Allergies (Nuts, Shellfish, Dairy/Sulfa Drugs, NSAIDs, etc.)	
Hearing and/or Vision Impairments	
Attention-Deficit/Hyperactivity Disorder (ADHD)	
Developmental Delays/Disabilities (including Autism)	
Type 1 Diabetes	
Type 2 Diabetes	
Stress and/or Anxiety	
Gender Wellness/Sexual Identity	
Eating Disorders	
Mental/Behavioral Health	
Suicidality (Suicide/Suicidal Ideations)	
Overweight/Obesity	
Dental Health	
Medical Complexities	
Vaccination/Immunization Adherence (common childhood vaccines)	
Accidental Injury (motor-vehicle crashes, risk-taking behaviors)	
Trauma/PTSD	
Inactive Lifestyle	
Unhealthy Diet	
Screen Time	

Alcohol Use/Binge Drinking
Drug/Substance Use
Vaping or E-Cigarette Use
Cigarette, Cigar, Cigarillo Use
Sexual and Reproductive Health (sexually transmitted infections, teen pregnancy, contraceptive use)
Infectious Diseases (including communicable diseases like Influenza or COVID-19 and non-communicable diseases like Tetanus or Lyme).
Cancer
Sleep Health (quality of sleep, quantity of hours)
Other (please specify):
Don't Know

43	Thinking about the root causes impacting top health needs or concerns among youth (ages 0-17) in their households and in the community, please select 3 critical social, economic, and/or environmental factors most important to address. If you think of a factor that is not listed here, please write it in under "other." (Please choose only 3)
	DRIVERS OF HEALTH
	Affordable health care
	Affordable health insurance
	Access to primary care services/providers
	Access to dental services/dentists
	Access to mental and behavioral health services/providers
	Crisis Intervention and Support
	Access to specialty care/providers
	Availability of care - office hours, accepting insurance/payment methods
	More urgent care or walk-in clinics, after hours care
	Access to Substance Abuse Services and Support
	Access to Physical and Occupational Therapy Services
	Services and programs for individuals with disabilities and special needs
	Food insecurity/Food Deserts
	Affordable Fresh/Natural Foods
	Affordable, Quality Education
	Positive Youth Development Programs and Activities
	Transportation
	Safe, Affordable Housing
	Employment/Economic Opportunity (jobs with living wage)
	Generational Poverty
	Social Media
	Bullying
	Walkable Communities (walking/bike paths and trails, well-lit, crosswalks, handicap accessible, covered bus stops and benches)
	Accessible, affordable, safe spaces for recreation (play, exercise, rest)
	Clean Air and/or Water
	Sexual Violence/Abuse (Sexual Abuse, Sexual Assault/Rape, Sexual Harassment, Exploitation/Trafficking)
	Child Abuse/Neglect (Excluding Sexual Abuse)
	Domestic and Intimate Partner Violence (Excluding Sexual/Child Abuse)
	Community Violence (violence in public spaces, gang violence, neighborhood violence, school shootings, violent crime - robbery/assault)
	Structural or Institutional Violence (racism, poverty, inequitable access to care, educational inequities, discrimination)
	Technology-Assisted Abuse (Cyberbullying/Stalking)
	Culturally and Linguistically Appropriate Health and Wellness Education and Information
	Access to affordable, reliable internet
	Disaster Preparation/Relief Resources and Support
	Other (please specify):
	Don't Know

RESOURCE UTILIZATION AND SUPPORT

44	What healthcare, health education or public health services or programs would you like to see offered in your community? Your answer should reflect services and/or programs that, to your knowledge, are not currently available or there is not enough of. [Do not read, *Select all that apply]*

None/have everything we need
Affordable Healthcare Access
Preventative Services (vaccination clinics, health screenings, etc.)
School-based Health Programs
Nutrition Programs and Services (food pantries, community gardens, nutritional education, etc.)
Mental Health and Counseling Services
Physical Activity and Recreation Programs (safe spaces to play, opportunities to be active).
Reproductive Healthcare (Sexual Health, Prenatal and Postnatal Care, etc.)
Dental Health Services
Youth Development/Mentorship Programs
Emergency and Urgent Care Access
Environmental Health and Safety Initiatives (Healthy Homes Programs, water and sanitation access programs, etc.)
Health Literacy Programs
Mobile Health Clinics
Early Childhood Education and Development Programs
Affordable Childcare (includes before and aftercare)
Parenting Education and Support (skill building, positive relationships)
Community Outreach and Advocacy (connection to services,
Injury Prevention Programs
Refugee and Immigrant Health Support Services
Crisis and Trauma Support Programs
Other, specify:
Don't know

Ask 45 if the response to question 44 is any answer EXCEPT "don't know"

45	How would you prefer these healthcare, health education or public health services or programs be delivered in your community? (Select all that apply)
In-person at a local community center or clinic	
Mobile health units or clinics visiting my neighborhood	
Through telemedicine or virtual means/consultation	
Home visits by healthcare or social service providers	
Through community health workers or outreach programs	
At schools or childcare centers	
Through online platforms or apps (for scheduling, resources, etc.)	
Through local religious institutions or faith-based organizations	
Through neighborhood-based programs or events (e.g., health fairs, community meetings)	
Through partnerships with local employers or workplaces	
Other, specify:	
Don't know	

46	Has your household utilized any of these resources in the past year? [*Select all that apply]*
Activities and Programs at Community Centers/Clubs	
Meals or Food Programs	
Transportation Services or Resources (ParaTransit, medical transportation, public transit discounts)	
Prescription Drug Programs/Assistance	
Helpline or Information Referral Line	
Housing Services (energy assistance programs, subsidized housing or home repair programs)	
None of these	
Other, specify:	
Don't know	

47	Has anyone living in your household received any of the following: [Select all that apply]
SSI (Supplemental Security Income)	
SSDI (Social Security Disability Insurance)	
Food Stamps (also known as SNAP benefits)	
WIC ("WICK") Program Benefits (Women Infant and Children Food Supplement)	
TANF ("Tan-if": Temporary Aid to Needy Families, formerly known as AFDC)	
None of these	
Other, specify:	
Don't know	

DEMOGRAPHICS

The last few questions are for classification purposes only. Be assured that your answers will remain confidential.

48	What is your current housing situation?
Own your home	
Rent your home	
Stay with family/friends (not paying rent)	
Temporary housing (e.g., shelter, motel)	
Unhoused (e.g., living in a car, tent, other)	
Other, please specify:	
Decline to answer	

49	What is the highest level of education that you have completed? (*Read choices*)
Less than High School	
High school	
Trade or technical school or union apprenticeship	
Some College	
College (associate's degree)	
College (Bachelor's degree)	
Graduate school	
Other, please specify:	
Decline to answer	

50	Which of the following includes your annual household income? (*Read choices*)
Less than $25,000	
$25,000 to $49,999	
$50,000 to $74,999	
$75,000 to $99,999	
$100,000 to $149,999	
$150,000 or more	
Decline to answer	

Those are all of my questions. Thank you for your time!

Appendix F –Key Informant Interview Instrument

The purpose of this interview is to understand how different sectors of the workforce across Delaware contribute to the health, safety, and well-being of our communities. Your insights will help identify strengths, gaps, and opportunities in the systems that support the everyday lives of children and families. The information gathered will be used to improve collaboration, services, and policies across the state.

While responses specific to the 0-18 population are appreciated, Nemours recognizes that people of all ages, and especially trusted adults, within a child/adolescent's environment play a significant role in their health and wellbeing – and, information collected on the community as a whole can serve as a powerful tool to inform the needs of the children we currently serve, as well as the needs we can anticipate across the lifespan. Therefore, interview questions are framed in a broader context, providing respondents the opportunity to tailor their answers based on the unique perspectives and expertise of their field (sector) and the population(s) they serve.

SECTION 1: Background & Role

1. Can you describe your role and how your work impacts the population(s) you serve?
2. What population(s) are most impacted by the work your (organization/agency/entity) does?

SECTION 2: Current Strengths & Challenges

3. What services, programs, or policies are currently working well to support the health and safety of the population(s) in your service area?
4. What challenges does your sector face that make it harder to meet community needs in your service area (e.g., workforce, funding, regulations, technology, coordination with others)?

SECTION 3: Addressing Community Needs & Equity

5. In your opinion, what are the top 3 challenges affecting the overall health, safety, and well-being in your service area?
6. What are the top 3 barriers community members in your service area face when trying to get the help or resources they need?

SECTION 4: Strengthening Systems for Health, Safety & Well-Being

The following questions are based on the 10 Essential Public Health Services (Revised, 2020), an evidence-based framework within which social determinants of health can be addressed through policies, systems, and overall community conditions that enable optimal health for all.

7. What information do you wish you had access to that would help you better serve the community?
8. How does your (organization/agency/entity) share important information with the community? Are there barriers to reaching certain populations (if so, please describe)?
9. How does your (organization/agency/entity) interact/partner with other entities to address issues affecting health, safety, and well-being of the community? Are there any gaps in or barriers to effective communication/collaboration?
10. How could the system be improved to ensure the population(s) in your service area have access to necessary resources and services when they need it?
11. What would help strengthen the workforce in your sector/field to better support overall health, safety, and well-being of the community?
12. What investments (such as more funding, new policies, or better technology) would make the biggest impact in your community/ the communities you serve?

SECTION 5: Closing & Recommendations

13. Do you have any final thoughts or suggestions on how we can work across sectors to make the community a healthier, safer, and more supportive place for children and families?

Appendix G – Community Health Summit(s) Results

At the two community health summits, the attendees prioritized the most significant health issues using Mentimeter. The attendees selected from a list of 20 health needs identified through the community health needs assessment process. After the needs were prioritized, the attendees formed groups around the top priorities and brainstormed how the community might address the health need by creating goals, actions, resources, and collaborators needed. After each group reported, the whole of the attendees discussed the need. Below is a recounting of the table groups' work. We hope all community organizations may benefit from the suggestions.

Summit 1 Priorities and Suggestions:

1. Affordable healthcare
2. (tie) Mental Behavioral health
2. (tie) Access to mental/behavioral health services
2. (tie) Access to primary care services/providers
5. Safe, affordable housing

Affordable health care

Goal 1: Best option is to have universal healthcare

Action 1 – All hospitals, health systems, and Nemours must advocate for universal healthcare

Resources/Collaborators Needed: Government support, community outreach

Action 2 – Nemours could offer a sliding scale for services

Goal 2: Expand do not cut Medicaid

Action 1 – Free children's clinic regardless of residency

Resources/Collaborators Needed: Department of Health, Nemours, All hospitals

Action 2 – Provide drive-up vaccine opportunities free vaccines COVID and flu for all takers

Resources/Collaborators Needed: All hospitals, Department of Health

Additional comments: It would be helpful if the school nurses could have a larger role in getting kids vaccinated – giving shots, reminders to parents

Mental health and access to providers

Goal 1: Increase providers for all ages

Action 1 – Incentivize providers to come to Delaware, particularly those who speak Spanish

Resources/Collaborators Needed: Colleges, universities who are matriculating providers, offer students loan assistance

Action 2 – Create partnerships for local training providers

Goal 2: Provide mental health prevention education and mental health management

Action 1 – Educate to erase the stigma with mental health issues and lethal means

Resources/Collaborators Needed: School districts, public health, local mental health providers

Action 2 – Organize community events that are more of a diversion

Resources/Collaborators Needed: School districts, public health, local mental health providers

Goal 3: Help people understand how to navigate the mental health system

Goal 4: Add post-partum depression support services

Goal 5: Provide culturally appropriate mental health services

Access to primary care services and providers

Goal 1: Improve transportation access

Action 1 – Provide funding for Uber health to assist in access to treatment

Resources/Collaborators Needed: State funding, organizations

Action 2 – Provide transportation between counties to services needed

Goal 2: Increase providers

Action 1 – Open a medical school and residency programs in DE

Action 2 – Outreach to nurse practitioners and physician assistant programs

Goal 3: Provide funding and scholarship opportunities for those in need

Action 1 – Additional funding for those in need and scholarships for medications and testing

Resources/Collaborators Needed: State funding, organizational funding, non-profits

Additional comments: Support the Governor in his efforts to start a medical school in Delaware

Safe, affordable housing

Goal 1: Standard assessment of homes for children with medical issues

Action 1 – Create standardized, statewide home assessments to create a scope of work and to be used by all providers/social workers

Resources/Collaborators Needed – State services, private funding

Action 2 – Community health care workers/housing repair service

Resources/Collaborators Needed: Medical providers, contractors

Action 3 – Provide data on houses that don't meet code and landlords. Provide data on physical housing conditions, fall hazards, mold, mildew, accessibility, overcrowding, plumbing and water facilities.

Action 4 – Provide home improvement resources for parents, elderly, anyone not meeting codes or needing increased accessibility in native language

Goal 2: Coordinate services and funding for better home inventory

Action 1 – Have one point of contact to coordinate all services

Resources/Collaborators Needed: Social workers, state services, private funding

Additional comments: Limit what people can charge for additional services such as pet rent and pet deposits. Provide information to all new parents on housing rights and options.

Summit 2 Priorities and Suggestions:

1. Safe, affordable housing
2. (tie) Affordable healthcare
2. (tie) Mental/behavioral health
3. (tie) Affordable, accessible, quality food
3. (tie) Access to mental health services/providers

Safe, affordable housing

Goal 1: Repair current housing stock for both renters and homeowners

Action 1 – Empower renters to know their rights

Action 2 – Ensure city enforces housing codes

Resources/Collaborators Needed – City of Wilmington, community legal aid, landlord, renters

Action 3 – Incentivize the purchase of older housing stock with home repair loans

Resources/Collaborators Needed – Banks

Goal 2: Create affordable housing in low-income communities

Action 1 – Provide tax credits to buy a house in a community where you're working

Action 2 – Provide income limited affordable housing with tax credits

Action 3 – Using local contractors, train students in carpentry, electricians, plumbers, etc., to build new housing stock

Resources/Collaborators Needed – Habitat for Humanity, Catholic Charities, weatherization credit, unions, private companies

Additional comment: Provide ways for renters to stay in place with constantly increasing rents

Affordable healthcare

Goal 1: Build trust and rapport

Action 1 – More community health workers; include CHW with different titles

Action 2 – Make community health worker services billable

Resources/Collaborators Needed- certification, funding, integration across organizations, whole family health, collaborations with FQHCs and community health centers,

Goal 2: Reduce fragmentation of care

Action 1 – Provide cross training and sharing of knowledge

Resources/Collaborators Needed – Diverse workforce, capacity, funding, willingness/trust, collaboration among organizations

Action 2 – Expand access and increase providers/clinics

Resources/Collaborators Needed – Cultural/language training, mobile health clinics, funding, target certain communities (Hispanic/Latino, newcomers who were not born here, Medicaid gap folks without health insurance)

Access to mental health services and providers

Goal 1: Workforce development

Action 1 – Conduct a needs assessment

Resources/Collaborators Needed – School data, funding

Action 2 – Support for providers needing supervised hours

Resources/Collaborators Needed – Possible preceptor model

Goal 2: Create a resource bank under one entity

Action 1 – Identify entities to create the resource bank

Action 2 – Acquire funding for the resource bank

Resources/Collaborators Needed – 988 surcharge 10% goes to the resource bank

Additional comments: Have representation of the community reflected in the providers. Hold more support groups in the community. Educate to reduce stigma and educate on what mental health and wellness is.

Affordable access to quality food

Goal 1: Increase nutrition education through community garden reaching 100 families per county

Action 1 – Provide education through hands on workshops provided seasonally to build knowledge

Resources/Collaborators Needed – local universities, DE master gardeners, DE center horticulture, Food bank of Delaware, NRPA

Action 2 – Generate community support by working with local universities, agriculture and nutrition departments or other organizations to educate families

Resources/Collaborators Needed – local elementary schools, locating gardening plots, funding

Goal 2: Build support for local school systems to provide families with a variety of produce

Action 1 – Provide access to fresh produce through youth engagement and family support

Action 2 – Provide families with fresh produce for their involvement in the program

Resources/Collaborators Needed – Funding

Other comments: Educate on what healthy food is. Treat culinary arts the same as music and art. Getting kids excited about making healthy meals.