COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

SUSSEX COUNTY, DELAWARE

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Key Health Priorities Identified

Based on community input and a comprehensive data analysis, the following health priorities have been identified for Sussex County. For a more detailed analysis Sussex County demographics and CHNA survey responses, see 2025 Bayhealth Community Health Needs Assessment, Sussex County document.

1. Access to Healthcare Services
Residents continue to face challenges including a shortage of healthcare clinicians and limited access to specialized care. Among survey respondents, 13% cited transportation barriers, 12% reported difficulty scheduling appointments, and others identified medical costs as key barriers that impede timely and effective care.

2. Mental Health and Substance Use Disorder
Demand for mental health and substance use services is rising, particularly in underserved and rural communities. Expanded access to behavioral health services and integrated treatment programs is essential. Children's mental health has emerged as a growing priority. Sixteen percent of respondents expressed concerns about the mental health of children ages 17 and under, while 21% identified bullying—which can cause serious emotional and psychological harm—as a significant issue.

3. Chronic Disease Prevention and Management
The high prevalence of chronic conditions—including diabetes, hypertension, and obesity—underscores the need for stronger prevention and disease management strategies. Survey results highlight key community concerns: 19% cited high blood pressure, 17% high cholesterol and 15% obesity.

4. Maternal and Child Health
According to the CDC, Delaware has the third highest infant mortality rate in the United States and Sussex County the second highest within the State.[i] Notably, Black and Hispanic infant mortality rates have increased in recent years.

5. Health Equity and Social Determinants of Health
Addressing disparities tied to income, education, housing, and food insecurity remains critical to achieving equitable health outcomes. Survey findings show that 10% of respondents experienced homelessness, while 30% reported having to choose between paying for medication, food, or household bills within the past 12 months.

Priority Areas, Goals & Measures of Success

1. Access to Healthcare Services

Goal: Improve access to timely, high-quality healthcare for all residents.

Strategies:

- Recruit and retain healthcare clinicans, with emphasis on primary care and specialty services.
- Expand community outreach health initiatives to reach underserved and rural areas.
- Reduce transportation barriers to care.
- Strengthen referral pathways between community-based organizations and healthcare providers.

Implementation Activities:

- Grow mobile health initiatives in rural areas.
- Partner with outside entities for ride vouchers and shuttles.
- Increase referral agreements with community-based organizations.
- Implement closed-loop referral tracking through Unite DE.

Measures of Success:

- Growth in provider workforce.
- Increase in health screenings in rural areas.
- Reduction in missed appointments due to transportation.
- Increase in referrals completed via Unite DE.

Involved Departments:
Executive Team, Medical Staff, Community Outreach, Graduate Medical Education, Information Technology, Patient Care Services, Emergency Department, Population Health, Care Management

Community Partners:

Unite DE, Food Bank of Delaware, DART

2. Mental Health and Substance Use Disorder

Goal: Expand access to behavioral health and substance use services.

Strategies:

- Integrate behavioral health into primary care and emergency settings.
- Partner with community organizations to expand peer support and recovery programs.
- Enhance crisis stabilization services.
- Strengthen prevention and support for children's mental health.

Implementation Activities:

- Embed behavioral health providers in ED and inpatient units.
- Increase Certified Peer Recovery Specialists in EDs.
- Partner with statewide crisis centers for referrals.
- Reduce reliance on contracted psychiatry services.
- Train ED staff on crisis stabilization protocols.
- Collaborate with high schools via Wellness Centers.

Measures of Success:

- Increase in behavioral health screenings in primary and inpatient care.
- Number of Certified Peer Recovery Specialists hired.
- Decrease in ED admissions for behavioral health crisis.
- Increase screenings of students in Wellness Centers and refer to appropriate agencies.

Involved Departments:
Executive Team, Medical Staff, Community Outreach, Graduate Medical Education, Information Technology, Patient Care Services, Emergency Department, Population Health, Care Management, Psychiatry

Community Partners:

Unite DE, Delaware Department of Health and Social Services

3. Chronic Disease Prevention and Management

Goal: Reduce the burden of chronic disease through prevention, education and coordinated care.

Strategies:

- Expand community education on nutrition, physical activity and prevention.
- Increase access to self-management programs for diabetes, hypertension and obesity.

- Further integrate Community Health Workers (CHWs) into clinical and community settings.
- Strengthen partnerships with schools, nonprofits and faith groups.

Implementation Activities:

- Offer monthly chronic disease education sessions in community centers.
- Develop digital modules for diabetes and hypertension management.
- Launch CDC-recognized Diabetes Prevention Program.
- Expand cardiac rehab and weight management services.
- Place CHWs in ED, focusing on high-utilizers.
- Train CHWs on chronic disease education and navigation.
- Collaborate with schools via Wellness Centers.
- Support health fairs with community partners.

Measures of Success:

- Number of participants in chronic disease self-management programs.
- Reduction in ED visits for uncontrolled diabetes and hypertension.
- CHW workforce embedded across Bayhealth.
- Increase in wellness screenings and prevention program participation.

Involved Departments:
Executive Team, Medical Staff, Community Outreach, Graduate Medical Education, Emergency Department, Population Health, Care Management, Diabetes & Endocrinology, Heart and Vascular Institute, Bariatrics

Community Partners:

Unite DE, Schools, Food Bank of Delaware, Sussex County Health Consortium

4. Maternal and Child Health

Goal: Improve maternal and child health outcomes and reduce infant mortality disparities.

Strategies:

- Expand access to prenatal and postnatal care.
- Strengthen partnerships with maternal and child health organizations.
- Increase awareness of safe sleep, breastfeeding and maternal health warning signs.
- Improve emergency response for postpartum patients.

Implementation Activities:

- Provide transportation vouchers for prenatal visits.
- Increase referrals to home-visiting programs (Nurse Family Partnership).
- Partner with Healthy Mothers, Healthy Babies and WIC.
- Expand outreach through Head Start and school programs.
- Distribute safe sleep kits and breastfeeding supplies.
- Launch maternal health awareness campaigns.
- Continue maternal bracelet initiative for ED risk alerts.
- Educate ED staff on postpartum patient identification.

Measures of Success:

- Increase in prenatal care attendance.
- Improvement in breastfeeding initiation rates.
- Reduction in infant mortality disparities.
- Increased participation in maternal classes.

Involved Departments:
Executive Team, Medical Staff, Mother Baby, Patient Care Services, Population Health, Care Management

Community Partners:

Delaware Perinatal Quality Collaborative, Fetal/Infant Mortality Review, Alliance for Innovation for Maternal Health

5. Health Equity and Social Determinants of Health

Goal: Address the root causes of health disparities and promote equity in all health initiatives.

Strategies:

- Continue SDOH screening across care settings.
- Strengthen partnerships with housing, education and workforce agencies.
- Improve cultural competency and health literacy among team members.
- Engage community leaders in planning and outreach.

Implementation Activities:

- Integrate SDOH screening questions and resources within EPIC.

- Automate referrals to Unite DE.
- Expand housing partnerships with Habitat for Humanity.
- Collaborate with workforce agencies for job placement.

Measures of Success:

- Number of SDOH screenings completed.
- Number of patients connected to housing/food resources.
- % of staff trained in cultural competency.
- Regular reporting of CBISA community benefit impact.

Involved Departments:
Executive Team, Medical Staff, Community Outreach, Graduate Medical Education, Information Technology, Clinical Practice and Professional Development, Population Health, Marketing

Community Partners:

Unite DE, Habitat for Humanity

Evaluation & Reporting

Progress will be tracked annually and shared with stakeholders and residents through the **Community Benefit Report**.

[i] https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm