



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Delaware**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.
An attachment is included in this section.

C. Assurances and Certifications

//2009/ Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Alisa Olshefsky, M.P.H, Director of Maternal and Child Health or Walter Mateja, Title V Program Administrator. //2009//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

//2009/ Public input into the Title V application and Delaware's Maternal and Child Health (MCH) Services is an ongoing process sustained through a number of advisory committees, public forums, and other associated workgroups and ad-hoc committees. These processes are coordinated and integrated through the State's Maternal and Child Health Director and her staff under the direction of the Division of Public Health's Senior Executive Team and Strategic Planning initiatives. Drafts of the entire document, summaries of relevant parts of the document, and supporting reports and documentation are available upon request and are made available either electronically, in hardcopy or through the world wide web. Each of the committees supporting MCH activities routinely holds public meetings, which are posted on the State's website. In addition, agendas and meeting minutes are also available either through the State website or upon request from the individual program manager.

The main committees which advise and review MCH activities include: the Delaware Healthy and Mothers Infants Consortium, a Governor appointed body with 5 working committees with wide ranging representation, including consumers; the Coordinating Council for Children with Disabilities; the Teen Pregnancy Prevention Advisory Board; the Early Comprehensive Childhood Systems Advisory Council; the Newborn Screening Advisory Council; the Newborn Hearing Advisory Council; the Traumatic Brain Injury Committee of the State Council for Children with Disabilities; and the Injury Prevention Coalition. Delaware actively solicits family involvement at health fairs and other events to participate on assorted Committees and planning bodies.

The MCH program recognizes that public input, with few exceptions over the years, has been limited. As part of its 2010 Needs Assessment, Delaware is actively seeking public input through two mechanisms. The first is the Education and Prevention Committee of

the Delaware Healthy Mothers and Infants Consortium. This committee is responsible for reviewing activities related to education and prevention and ensuring materials and messages are consistent with the CDC's Recommendations for preconception health care. The committee meets monthly and has several consumers as active participants. The Coordinating Council for Children with Disabilities, an advisory group for Children with Special Health Care Needs, will also be actively involved in needs assessment planning and interpretation of data. This group also has an active consumer involvement. Both of these groups can provide the resources for additional outreach to communities and the larger public throughout the state.

The state has also recently implemented a website, HealthyBabiesDe.com, which makes available assorted MCH related documents and reports. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ Based on the 2005 Title V MCH Needs Assessment, these are the identified priority needs:

- 1. Ensure nutrition services to children and adolescents.*
- 2. Improve dental health of children and adolescents.*
- 3. Ensure medical home and coordinated services to children with special health needs.*
- 4. Improve access to care in Kent and Sussex Counties and for black women throughout the state.*
- 5. Reduce teen births.*
- 6. Reduce preventable diseases in children and adolescents.*
- 7. Reduce preventable injuries to children and adolescents.*
- 8. Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment.*
- 9. Reduce black infant mortality.*
- 10. Reduce the barriers to delivery of care to pregnant women and women of child bearing years and reduce those risk factors resulting in infant mortality and congenital abnormalities in their infants.*

Based partially on these priorities, the state identified the following State Performance Measures:

- 1. Percent of women delivering live-born infants reporting any cigarette smoking during pregnancy.*
- 2. Percent of live births to women who have another live birth in less than 18 months.*
- 3. Percent of extremely low birthweight black infants among all live births to black women.*
- 4. Rate of children under age 1 who die as a result of Sudden Infant Death Syndrome.*
- 5. Percent of youth reporting any use of alcohol in the last 30 days.*
- 6. Percent of youth reporting feeling depressed in the past year.*
- 7. Percent of Medicaid children enrolled in a medical home.*
- 8. Hospital discharge rate for children with asthma.*
- 9. Percent of CSHCN who successfully transition to adult services.*
- 10. Rate of deaths to children 14-21 by motor vehicle crashes.*

The State's needs assessment process was conducted in a multi-faceted manner. Preventive and primary care services for pregnant women, mothers, and infants, and children were assessed by: 1) reviewing existing reports; 2) careful examination of data; and 3) discussions among professional and community leaders. A Steering Committee was established for the Maternal and Child Health (MCH) component. The needs assessment for MCH had been initiated with an evaluation of Delaware's Smart Start and Kids Kare programs.

The assessment process is ongoing and continuous. The major needs assessment function that continues occurred through the State's focus on MCH services as a result of the Infant Mortality Task Force which identified the following needs related to infant mortality reduction in Delaware:

- 1. Recognizing the signs of premature labor;*
- 2. Understanding the need for spacing pregnancies;*
- 3. Understanding the role of certain chronic illnesses during pregnancy;*

4. *Understanding the role nutritional advice or support plays during pregnancy;*
5. *Understanding how smoking can affect a baby during pregnancy;*
6. *Making sure women have access to services they need such as community outreach, transportation and medical and social services;*
7. *Understanding how stress affects a pregnancy.*

For the Children with Special Health Care Needs (CSHCN) component, the Coordinating Council for Children with Disabilities (CCCD) is the advisory committee and consists of over 40 agency representatives and other persons including parents. The MCH Steering Committee utilized consisted of various members from the Division of Public Health, Medicaid, the Department of Education, the Division of Child Mental Health, WIC, and the Department of Children, Youth and their Families and a parent/consumer.

The MCH Steering Committee initially reviewed the purpose of the specific Title V indicators, especially the National and State Performance measures. The data forms from the MCH Block grant provided a basis to determine progress towards stated objectives, the utility of performance monitoring, and an opportunity to study trends both positive and negative.

Other supplemental data and information were used to provide some qualitative explanations for the measures. The pyramid of services was introduced to compare what was currently in place in Delaware according to each level (resources and activities for direct health services, enabling services, population-based services and infrastructure-building services). The capacity to meet these needs through the MCH Block Grant funding alone was necessarily determined to be insufficient. The real capacity to meet the needs in the pyramid of services is found in the extensive and intensive partnerships and coalitions in Delaware.

Priority areas were selected by a two step process. First, the Coordinating Council for Children with Disabilities conducted a similar review of the pyramid of services with input from topic driven reports on issues related to CSHCN. The CCCD submitted the results of their discussions to the MCH Steering Committee. Three new state performance measures were negotiated at the meetings. The Council composed measures to be specific and time framed, based in hard data consistently collected, and that were connected to Healthy People 2010 objectives. Secondly, the MCH Steering Committee, which included three members of the CCCD, reviewed the three proposed new state performance measures during their needs assessment process. The MCH Steering Committee identified and reviewed the activities that addressed the priority areas including those listed in the block grant as related to each state and national performance measure.

Partnership building and collaboration is prominent within Delaware. MCH, with CSHCN collaborates with the following entities: including but not limited to the Delaware Mothers and Infants Consortium, Delaware Health Care Commission, Delaware Medicaid Office, Delmarva Health Initiative, Department of Education, Division of Developmental Disabilities, Division of Substance Abuse and Mental Health, Office of Emergency Medical Services for Children, Women, Infants & Children Program, The Fetal & Infant Mortality Review Project, the March of Dimes, and the Coordinating Council for Children with Disabilities.

Discussion of the needs assessment process was held during the MCH Steering Committee meetings over the past five years; during the numerous Infant Mortality Task Force (IMTF) meetings and subcommittee meetings from August, 2004 to the current time, and during the Coordinating Council for Children with Disabilities over the past four years. Relevant reports, data sets and literature were reviewed to determine the final priorities. Of

*note is that three of the ten State Performance Measures were changed in the process.
//2009//
An attachment is included in this section.*

III. State Overview

A. Overview

/2009/ Introduction

The designated Title V Maternal and Child Health (MCH) agency in Delaware is the Department of Health and Social Services (DHSS), Division of Public Health (DPH) directed by Jaime H. Rivera, MD., FAAP. Within DPH, the Family Health and Systems Management (FHSM) section is responsible for the planning, implementation, coordination and evaluation of maternal and child health programs. The section is headed by a Section Chief who is also the State MCH Director, Alisa Olshefsky, M.P.H. In addition to the Title V funded programs (which includes the Children with Special Health Care Needs [CSHCN] Program), the section is also responsible for a number of other MCH-related programs and activities including the Title X Family Planning Program, the Early Childhood Comprehensive Systems (ECCS) Program, the Newborn Metabolic Screening Program, the Newborn Hearing Program, the Adolescent Health Program, the Infant Mortality Program, the Center for Family Health Research and Epidemiology, the Birth Defects Registry, the Autism Registry, and the Health Systems Management Bureau (including program management of rural health, Federally Qualified Health Centers [FQHCs], the Conrad State 30/J-1 Visa Program - a recruitment program for physicians - and the State Systems Development Initiative [SSDI]).

The Title V MCH Block Grant funds field staff positions in community public health clinics for four key programs. These programs are Smart Start, Kids Kare, Child Development Watch (CDW), and the State's Oral Health Program. These field staff are under the direction of the State's Medical Director, Herman Ellis, M.D. Smart Start is a prenatal program addressing women at-risk for poor birth outcomes. Kids Kare is a case management program focusing on child health for children and adolescents from birth through 21 years of age. CDW is a program dedicated to CSHCN from birth through 3 years of age. In addition to Title V funds, state general funds also support field staff in these programs.

Title V MCH Block Grant funds are also used to fund positions within DPH's FHSM Section. These positions include the Bureau Director for Reproductive and Adolescent Health, a Management Analyst and an Administrative Assistant.

Each of the programs within FHSM is integrated with a common mission and strategic objectives. The mission of the FHSM section is to improve the health of families and provide leadership to communities in the development of health systems. FHSM accomplishes its mission by:

- developing, coordinating and evaluating programs and initiatives to improve the health of women, infants, children, adolescents and those with special health care needs;*
- monitoring health status through newborn screening (metabolic disorders and hearing), birth defects and autism registries;*
- eliminating disparities in maternal and child health outcomes, including infant mortality;*
- ensuring access to adolescent health care services through School-Based Health Centers (SBHCs) and implementing programs to reduce teen pregnancy;*
- applying epidemiology and research to improve delivery of quality health care to women, children and families;*
- enhancing reproductive health and ensuring access to family planning services;*
- translating evidence into practice to improve early childhood comprehensive systems of care; and*
- ensuring health systems across the state have the ability to meet Delawareans' health care needs by focusing on primary care, rural health, identifying and addressing*

health care provider shortages, and helping to improve access to data and health information.

In brief, FSHM's programs address the following areas. The Office of CSHCN works closely with CDW, the birth to three program, and other organizations throughout the State to coordinate services and address key issues including transition to adult services, family involvement and capacity building. Smart Start is the state's prenatal program for at-risk women and is available statewide through DPH Clinics and the Visiting Nurses Association. Smart Start is a collaborative effort between DPH and the state's Medicaid agency, the Division of Medicaid and Medical Assistance (DMMA). Kids Kare, a child health program, provides case management to children with serious medical issues and is available statewide through DPH clinic sites. Title X, the federal Family Planning Program, works closely with Title V on a wide range of issues including teen pregnancy prevention, preconception care and women's health issues. The ECCS Program partners with organizations throughout the state to plan, to develop and to implement partnerships to support child development and ensure that all Delaware's children are healthy and are ready to learn at school entry. The Infant Mortality Elimination Program funds contractual programs for at-risk pregnant women and preconception programs for women. The Infant Mortality Elimination Program's initiatives also include a research component (including the Pregnancy Risk Assessment Monitoring Surveillance survey) carried out through the Center for Family Health Research and Epidemiology and the State's Fetal Infant Mortality Review (FIMR) Program (through the Administrative Office of the Courts). The Newborn Metabolic Screening Program and Newborn Hearing Program screen newborns for metabolic conditions and hearing deficiencies, as well as maintain the state's Birth Defects and Autism registries. The State Systems Development Initiative works with Title V in building capacity for data analysis and the linking of MCH datasets. SSDI also is a key participant in the MCH needs assessment process and works closely with the Center for Family Health Research and Epidemiology on pilot studies.

Title V related activities throughout FSHM and DPH support the stated section mission across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) as detailed further throughout this application. The next section broadly describes the current system contexts, including some of the principal characteristics of the state's maternal and child health populations.

Population Characteristics

Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. Geographically, the state's area encompasses only 1,983 square miles ranking Delaware 49th in size among all states. Delaware is bordered by the states of New Jersey, Pennsylvania and Maryland, as well as the Delaware River, Delaware Bay and Atlantic Ocean. Wilmington, the state's largest urban center is within an hour's drive to Baltimore, MD and Philadelphia, PA and within two hours driving distance from New York City and Washington, D.C.

According to the latest population estimates, in 2008 the State of Delaware had about 863,800 residents, of which 75% were Caucasian and 22% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with 533,550 residents or about 61% of the state's total population.

New Castle County also has a large population of African-American residents (about 24%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 55 percent of the city's population). New Castle County also has the largest proportion of Hispanics. Kent County and Sussex County, located in the southern two-thirds of the state, are more rural than New Castle County. In 2008, the estimated population of Kent County was about 153,000 residents (75% Caucasian and 23% African-American). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2008 population was about 187,000 (85% Caucasian). Since 2000, the State's population has increased by about 9.8 percent.

Statewide, it is estimated that there are about 171,000 women of childbearing age (15-44 years of age) and 252,000 infants, children and adolescents aged 0-21 years of age. Annually in the state, about 13,000 infants are born. For the five year period 2001-2005, Delaware had an infant mortality rate of 9.2 per 1,000 live births with the highest rates (ranging from 13.9 to 19.0 per 1,000 live births) among African-American infants throughout the State's three counties and the city of Wilmington. Delaware's infant mortality rate remains one of the highest in the nation and infant mortality prevention is a main health priority in the state.

Economic Indicators

Delaware's top five employers are the State of Delaware, the Bank of America, the DuPont Corporation, Christiana Health Care Systems and Dover Air Force Base. Among Delaware's largest private employers are businesses in the insurance, pharmaceutical, telecommunications, health care and financial services sectors. Comparatively speaking, Delaware's unemployment rate is low at 3.8% (12th lowest in the nation) as of December 2007 when the Bureau of Labor Statistics reported a national rate of 5.0 percent.

Delaware's 2004 per capita income was \$35,728 and ranged from \$27,292 in Kent County to \$40,354 in New Castle County (Bureau of Economic Analysis). In 2005, approximately 14.5% of Delaware's children under age 18 were at or below 100% of the federal poverty level (U.S. Census Bureau).

Despite low employment, poverty remains a pervasive issue in the state with 13.8% of children 18 and under living at or below 100% of the Federal Poverty Level (FPL) and 33.9% of children 18 and under living at or below 200% of FPL. As in the nation at large, access to health insurance also remains a significant issue for many Delawareans. According to the University of Delaware's Center for Applied Demography and Survey Research, 14.8% of Delaware residents aged 0 to 64 years did not have health insurance in 2007.

In Delaware, 26% of households are headed by females with children and of these families, 26% are living in poverty. The median income of a 1 parent household in Delaware in 2007 was \$23,338 compared to a median income of \$67,492 for two parent households. The largest geographic disparity in the state, in this regard, is within the City of Wilmington, where 52% of households are headed by females. Statewide, only 5% of children with two parent households are living in poverty.

Geographic Disparities

Although the state is relatively small, disparities exist between the state's three counties as well as between rural and urban areas of the state with regard to healthcare access and utilization.

Statewide, the percentage of women accessing prenatal care in the first trimester is higher than the national average. For the 5 year period 2000-2004, 85.4% of pregnant women

received prenatal care in the first trimester compared to 77.6% nationally. Kent and Sussex Counties and the City of Wilmington, however, were all below the state five year average of 84.7% for period 2001 to 2005 for prenatal care in the first trimester (77.7%, 71.7% and 84.7%, respectively).

In terms of birth outcomes, Wilmington is the geographic area with the highest percentages of low birth weights (14.4% compared to 9.4% statewide) and very low birth weights (3.0% compared to 1.9% statewide). Kent County has a higher infant mortality rate than the state as a whole (10.0 infant deaths per 1,000 live births compared to 9.2 infant deaths per 1,000 statewide) as does the City of Wilmington (12.4 infant deaths per 1,000 live births).

Kent County, Sussex County and the City of Wilmington have the highest teen birth rates (47.6, 57.4, and 92.6 births per 1,000 females ages 15-19, respectively) compared to the state rate (44.3 births per 1,000), however only Sussex County and the City of Wilmington exceed the state percentages of births to single mothers (51% and 69.7%, respectively, compared to 41.8% statewide),

Sussex County has the highest rates of youth tobacco, alcohol and substance use. In 2006, 23% of Sussex County's 11th Grade students smoked cigarettes (compared to 17% statewide), 48% drank alcohol (compared to 41% statewide) and 26% smoked marijuana (compared to 22% statewide).

Kent County is the county with the highest risk of poverty ratio (2.5, comparing female headed households to male householder families). However, both Kent and Sussex Counties exceed the statewide percent of female headed household families living in poverty (30.2% and 31%, respectively, compared to 26.3% statewide).

The City of Wilmington, similar to many urban areas throughout the nation, has correspondingly high rates of social risks and poor health outcomes such as juvenile arrests, high school drop-outs, HIV/AIDS (with a high proportion attributable to needle sharing) and sexually transmitted infections.

Children with Special Health Care Needs

Based on rates from the 2005/2006 National Survey of Children with Special Health Care Needs (NSCHSN) of families of children to age 18, it is estimated that about 34,500 Delaware children (17.5%) younger than age 18 years may have a special health care need. The survey data suggest that CSHCN live in about one in four Delaware households.

Based on the 2005/2006 Survey data, around 7,000 (20.4%) of Delaware's CSHCN have health conditions that consistently and often greatly affect their daily activities with rates among Black children with special health needs (22.5%) higher than their White counterparts (17.9%) and rates among families with incomes less than 100% FPL (32%) and less than 200% FPL (30.5%) higher than other income groups (12%-18%).

The NSCSHN Survey data suggest that in 2005 about 4,900 (14.2%) of Delaware's CSHCN younger than age 18 years had one or more unmet needs for specific health care services. Rates were higher for Black (27.7%) and Hispanic children (33.2%), compared to Caucasian children (11.7%). Close to half of children living in families less than 100% FPL had unmet needs, 19.4% for those 100% to 200%, and 12.7% 200% to 400%. Those families with private insurance were half as likely to report unmet needs (9.8%), compared to those with public insurance (17.9%).

The Survey data also indicate that 29.7% of all Delaware CSHCN are without family-centered care. More than 50% of Hispanic (53.8%) and 47.5% Black CSHCN are without

family centered care (compared to 27.1% for Caucasian). About half of CSHCN living in families below 200% did not have family-centered care, compared to fewer than 30% at higher income levels.

This data on unmet needs, lack of family-centered care, and lack of a medical home indicates the increased needs of Black and Hispanic families and low-income families.

A recent survey of 15 pediatric practices throughout Delaware based on the Center for Medical Home Improvement's Medical Home index found 26.6% of these practices without elements required for partnering with families for care plan development (e. g. accessible office hours). In addition, one third (33.3%) of practices reported limited time and understanding of resources available to support transition to adult care.

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 67.6% of families with CSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. DuPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address their typical and specialized chronic health care needs? 2) To what types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. One-half of respondents did not have a specialist despite the perceived access and among those without a specialists, 39% reported they do know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in the process of transitioning to adult services.

Racial Disparities between Whites and Blacks

The Office of Minority Health for the Division of Public Health released a report on Health Disparities in Delaware in March of 2001. The following findings are significant:

- There were three indicators where the rate for Blacks was 3 times higher or more than the rate for Whites: HIV infection/AIDS death rate (10.66), homicide rate (4.3), and asthma hospitalization (3.3).*
- Five indicators showed a disparity ratio of greater than 2:1: teen birth rate (2.71), late or no prenatal care (2.55), percent of low birth weight births (2.08), infant mortality (2.75), and diabetes death rate (2.47).*
- Four indicators had a disparity ratio of greater than 1:1: alcohol-induced death rate (1.64), stroke death rate (1.62), cancer death rate (1.45) and heart disease death rate (1.20).*

Current Priorities and Initiatives

Current priorities and initiatives include those that were identified as part of the 2005 Title V Needs Assessment, and several additional ones that have emerged since. As the infant mortality rate remains high in Delaware, this issue remains one of the three health priorities of the current Governor (Reduce the Incidence of Cancer, Reduce Infant Mortality, and Reduce Health Disparities). The 2005 Needs Assessment contained three priorities related to infant mortality. These were:

- Improve access to care in Kent and Sussex Counties and for black women throughout the state;*

- **Reduce black infant mortality; and**
- **Reduce the barriers to delivery of care to pregnant women and women of child bearing years and reduce those risk factors resulting in infant mortality and congenital abnormalities in their infants.**

Currently, the Delaware Healthy Mothers and Infants Consortium (DHMIC) is in its third year of implementing 20 recommendations of a Governor's Infant Mortality Task Force to decrease infant mortality and improve maternal preconception health. The accomplishments of DHMIC are noted throughout this application and in the 2007 Annual Report that has been attached electronically to this section. The recommendations, at varying stages of implementation as they are phased in over a three year period are:

- **Conduct a comprehensive review of every fetal and infant death in Delaware.**
- **Create a monitoring system to increase understanding of the risks faced by pregnant mothers in Delaware.**
- **Establish the Delaware Healthy Mother and Infant Consortium (DHMIC) as successor to the current Perinatal Board.**
- **Create the Center for Excellence in Maternal and Child Health and Epidemiology within the Division of Public Health.**
- **Improve access to care for populations disproportionately impacted by infant mortality.**
- **Provide access to preconception care for all women of childbearing age with history of poor birth outcomes.**
- **Require that insurers cover services included in standards of care for preconception, prenatal and interconception care.**
- **Implement a comprehensive (holistic) Family Practice Team Model to provide continuous comprehensive care and comprehensive case management services to pregnant women and their infants up to two years post partum. Services will include comprehensive case management, trained resource mothers, outreach workers, nurses, social workers and nutritionists.**
- **Implement Federal Standards for Culturally and Linguistically Appropriate Services (CLAS).**
- **Create a cultural competence curriculum for providers.**
- **Improve comprehensive reproductive health services for all uninsured and underinsured Delawareans up to 650% of poverty.**
- **Fund an in-depth analysis of programs in Delaware that mitigate infant mortality and create and implement an ongoing process for continuous quality improvement for services and programs developed to eliminate infant mortality.**
- **Create an epidemiological surveillance system to evaluate and investigate trends and factors underlying infant mortality and disparity.**
- **Create a linked database system to meet data analysis and program assessment goals and improve health care and services provided to the public.**
- **Conduct a statewide education campaign on infant mortality targeted at high-risk populations.**
- **Expand the birth defect registry surveillance and make it proactive by broadening monitoring, early intervention and prevention programs.**
- **Continue to improve the statewide neonatal transport program.**
- **Evaluate environmental risk factors for poor birth outcomes.**
- **Promote oral health care, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal programs.**
- **Provide an annual report to the governor on current and future factors impacting the availability of obstetrical practitioners.**

Six of the priorities in the 2005 Needs Assessment were related to adolescent/teen health:

- **Ensure nutrition services to children and adolescents.**
- **Improve the dental health of children and adolescents.**

- **Reduce teen births.**
- **Reduce preventable disease in teens and adolescents.**
- **Reduce preventable injuries to children and adolescents.**
- **Improve the mental health of children and adolescents.**

Nutrition. Through the ECCS program, as well as other areas of MCH, DPH partners with Nemours Health and Prevention Services. In 2007, Nemours launched its 5-2-1 Almost None "formula for a healthy lifestyle". This program was adopted by the State Nutrition Action Program, which includes the Child and Adult Care Food Program, WIC and Food Stamps. These programs serve more than 75,000 persons in Delaware.

Other child nutrition related activities include:

- **The Newborn Screening Program distributes specialized formula to infants with PKU through the Specialty Formula Fund in Delaware;**
- **School-Based Wellness Centers provide dietary/nutrition assistance to students, in 2007. There were over 4,000 visits to School-Based Wellness Centers for nutrition issues.**
- **Smart Start, Kids Kare and Child Development Watch each have nutritionists as part of their case management teams.**
- **MCH program continue to partner with the Delaware WIC program to provide nutrition services statewide.**

Dental Health. The Oral Health program at DPH provides dental services to adolescents, children and children with special health care needs. In August 2007, the Bureau of Oral Health and Dental Services received a four-year, \$160,000 grant from the Health Resources and Services Administration (HRSA), the "Targeted State MCH Oral Health Service Systems (TOHSS) Grant." The grant will increase families' access to oral health care and prevent oral disease by improving the public oral health infrastructure. Project goals are for children to receive early and comprehensive oral health services; and for families to understand the importance of oral health and learn how to achieve optimal oral health status.

The Delaware Oral Health Coalition is a new group formed to help reduce the high level of dental disease among the state's children. The State Oral Health Collaborative Systems Grant funded the creation of this diverse group representing approximately 20 organizations. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health. It will also provide education about good oral health practices, and improve access to dental health providers.

The Oral Health Program also continues to further enhance and assure the dental services provided to underserved children in DPH's Seal-A-Smile sealant program, the Bureau of Oral Health and Dental Services has contracted with a private vendor to establish a case management referral system. Through the system, children identified through the sealant program are directed to a network of oral health providers who will accept them into their practices.

Reduce Teen Births. The Adolescent Health program, within the DPH FHSM section offers preventive health services for adolescents through school-based wellness centers and teen pregnancy prevention programming. In 2007 there were over 3,000 visits to School-Based Health Centers for pregnancy related issues. Also, the Infant Mortality Elimination Program supports teen pregnancy programming through a contract a mini-grant with Children and Families First.

Preventable Disease. School-Based Health Centers, Child Development Watch, Immunizations, the Office of Lead Poisoning Prevention, Kids Kare, Newborn Metabolic Screening, Newborn Hearing and the Family Practice Team Model programs provide preventive health services for children and adolescents statewide.

Preventable injury. Injury is one of the principal public health problems in Delaware. Between 1992 and 2001 injuries were the leading cause of death in the 1 to 44 year age group and the fourth leading cause of death over all age groups. From 2001 to 2003, an average of two people died from injuries, seven were hospitalized, and 190 suffered injuries that were severe enough to require emergency services each day in our state. Costs associated with these hospitalizations have increased from \$45 million dollars in 2001 to \$82 million dollars in 2003.

Strides have been made in Delaware to begin to reduce the number of injuries and resulting disabilities and premature deaths. For example, vehicle seat belt use in Delaware has increased from 64% in 1999 to 82% in 2004. In addition to the primary seat belt law, Delaware has passed other safety laws, and an Injury Prevention Coalition has been established to facilitate statewide injury prevention efforts.

A Strategic Plan for Injury Prevention (2005-2010) has been developed by expert work teams from the Delaware Coalition for Injury Prevention with guidance from the Division of Public Health's Office of Emergency Medical Services. The plan provides a framework to address nine core injuries: falls, motor vehicle injuries, traumatic brain and spinal cord injuries, suicide and suicide attempts, poisoning, fire injuries, dog bites, firearm injuries, and drowning and submersion injuries. The work teams used the public health approach to define each problem, identify risks and causes, and develop interventions to increase the public's awareness about the preventability of these injuries. The plan also seeks to reduce environmental risks, impact public policy and decision-making, and redirect the economic and social losses now caused by injury.

Mental health. Each of Delaware's MCH programs provides referral services for child and adolescent mental health issues. Additionally, School-Based Health Centers provide mental health counseling and referral. In 2007, there were over 36,000 visits to School-Based Health Centers for emotional and/or substance abuse issues.

The final priority from the 2005 MCH Needs Assessment was to ensure medical home and coordinated services to children with special health needs. The Office of Children and with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs. Emphasis has been on family-centered care coordination. The plan of care is family-driven and all aspects of the program seek to integrate cultural and linguistic competence principles and practices. Statewide training for all DPH staff has been held in areas such as active listening, community wrap around resource planning, and coaching families for early intervention. In addition, the Office of CSHCN actively supports the development of family-driven organizations such as the Delaware New Scripts, the Family Medicaid Panel, and the Delaware Family Network through stipend support of unpaid family time through a contract with the Coordinating Council for Children with Disabilities (CCCD).

Other areas of concern that continue to be addressed include immunizations, reducing tobacco use, preventing child lead poisoning, developing a comprehensive early childhood system to ensure every child is ready to learn at school entry, and eliminating health disparities for the broad MCH population.

The DPH Immunizations Program is responsible for preventing and controlling transmissible vaccine-preventable diseases. CDC recently recognized the Delaware Immunization Program as the fourth most improved state, with a 21.4 percent increase in

its childhood immunizations rate from 2003 to 2006.

Reducing tobacco-related illnesses and death is the goal of the Tobacco Prevention and Control Program. The team employs cessation and health communication interventions, surveillance and evaluation. Through sustained education, prevention and cessation strategies like the Quitline, the Tobacco Prevention and Control Program has successfully reduced smoking rates within the state. In 2007, Delaware recorded an all-time low smoking prevalence rate of 18.9% among its adults.

Unborn and young children who ingest lead can suffer permanent learning, hearing and behavioral problems, stunted growth and brain damage. The Office of Lead Poisoning Prevention (OLPP), within DPH, prevents childhood lead poisoning and promotes health among children (unborn through age six) through education, safe environments, universal screening and early intervention. OLPP promotes blood lead testing of all children at 12 months, and repeat testing children at high risk until age six. In homes of children with blood-lead levels exceeding the "level of concern" established by the U.S. Centers for Disease Control and Prevention (CDC), OLPP provides case management, education and inspection for lead hazards. Through the distribution of prevention materials, OLPP increases public awareness. The Office strives to prevent exposures by controlling lead hazards stemming from paint, dust, soil and lead-based elements in toys or ceramic dishware glazes.

The ECCS program is the lead in developing comprehensive early childhood systems. The program's scope of responsibilities include: 1) access to medical homes and health care coverage; 2) social-emotional development of young children; 3) early care and education; 4) parenting education; 5) family support; 6) Facilitate the Assuring Better Child Health and Development (ABCD) grant; and 7) providing early childhood technical assistance, trainings and resources.

The DPH Office of Minority Health is responsible for data collection and analysis relevant to minority health status and disparities. The Office ensures DPH programs are tailored to eliminate disparate morbidity and mortality rates of minority populations and works to strengthen community and government partnerships to solve key health concerns and prevent disease. The Office also works to promote workforce diversity and develop culturally competent Public Health systems. In 2008, the Office released a report, "DHSS/Delaware Division of Public Health Cultural Competence Assessment." The report's recommendations are currently under review for next steps.

How did the Title V administrator determine the importance, magnitude, value, and priority of competing factors upon the environment of health services delivery in the State?

The Maternal and Child Health Director and the Title V administrator, as well as other maternal and child health program staff work closely with a number of key constituents, committees and agencies to determine the priorities for allocation of resources that include funding, staff time, infrastructure development and partnering. Among these groups are the Delaware Healthy Mother and Infant Consortium, the Coordinating Council for Children with Disabilities, the Early Comprehensive Childhood Systems Advisory Council, the Early Hearing Detection and Intervention Advisory Committee, the Newborn Screening Advisory Committee, the Title X program, the Injury Prevention Coalition, the Emergency Services for Children program, the Teen Pregnancy Prevention Advisory Board, School Boards throughout the state, the Division of Medicaid and Medical Assistance, the Department of Education, the Department of Services for Children, Youth and Their Families, and the Division of Developmental Disabilities.

Title V administrators also work with staff in the Public Health clinics. In the past year a series of site visits were completed and currently the Title V program is conducting

environmental scans in preparation for the 2010 MCH Needs Assessment.

In 2006, House Bill 202 was signed into law creating the Delaware Healthy Mothers and Infants Consortium. As a health policy priority of the Governor, the reduction of infant mortality and associated morbidities has been a main thrust of many maternal and child health related efforts in Delaware.

Some of the priorities identified in the 2005 Needs Assessment overlap with current infant mortality reduction efforts; however, other issues have emerged, these include childhood obesity, autism, asthma, developmental screening among 0-5 year olds and repeat teen pregnancies. Each of these issues will be studied during the 2010 needs assessment process. //2009//

An attachment is included in this section.

B. Agency Capacity

/2009/ Preventive & Primary Care Services for Pregnant Women, Mothers and Infants
Currently, preventive and primary care services for pregnant women, mothers and infants are supported through Title V Maternal and Child Health Block Grant and state general funds in statewide programs for pregnant women, women of reproductive age, infants, children and adolescents. These programs include Smart Start, Kids Kare, home visits for first time mothers, the Family Practice Team Model, support for Resource Mothers, Newborn Metabolic Screening, Newborn Hearing Screening, and the Preconception Health program.

Smart Start is a prenatal case management program for at-risk women throughout the state. Pregnant women are referred to the program through primary care practices, hospitals, WIC, Family Planning, Public Health clinics, Medicaid and other partner agencies. Women are screened for risk factors in three domains: nutrition, social and medical. Once enrolled pregnant women are seen at least monthly throughout their pregnancy and depending on their risk factors, provided information and education on topics including domestic violence, reproductive health, labor and delivery, alcohol, substance and tobacco use, and post partum issues. In 2007, over 1,200 women were enrolled in Smart Start and over 4,600 visits were completed by staff including nurses, social workers and nutritionists.

Kids Kare provides support for families with children who are at risk for delayed development, providing education and support to families with children. Nurses, nutritionists and social workers provide support and education to parents. Parent education emphasizes the importance of routine and preventive medical care. It helps parents to know: when and where to seek medical attention; when and where to get children immunized ; how to identify signs and symptoms of illness; what to expect as a child grows and develops, how to prevent injuries; how to develop healthy eating practices and how to strengthen parenting and coping skills.

The Family Practice Team Model (FPTM) program, a clinic/health center based holistic prenatal care program provides social support to women before birth and to women and infants up to two years after birth. Currently, 7 sites offer the FPTM located throughout the state. The FPTM was developed based on an identified need for services among women who delivered infants that were premature and/or low birth weight. The targeted groups of women for this program include African Americans, Hispanics and women with a history of previous pregnancy complications or poor birth outcomes. For example, 18% of the women served in 2007 had a history of prematurity, low-birthweight or infant death and 27% were coping with a chronic disease such as diabetes, hypertension or heart disease. The program's services include nutritional counseling, mental health services, community outreach, social services through case management and increased

postpartum care which may, in part, prevent future poor birth outcomes. According to 2007 data, only 3 infant deaths occurred out of 1,292 pregnancies served through FTPM. This occurrence was 67% lower than expected among the at-risk group of women served by the program. Additionally, only 10 percent of pregnancies resulted in a premature birth and only 5% resulted in a low-birthweight infant, both indicators below the expected proportions of these outcomes.

The Preconception Care program, a new initiative under the Infant Mortality Elimination Program, is designed to help women plan their reproductive life course. The program offers education and information related to healthy diets, exercise, stress, chronic disease, reducing and eliminating risky behaviors such as alcohol, substance and tobacco use and understanding how previous pregnancies may affect subsequent pregnancies. Initial data suggest a positive impact in terms of birth spacing with 87% of women waiting more than 18 months before becoming pregnant again.

As part of the research completed in the design and implementation of both the FTPM and Preconception Care programs, the State of Delaware created a Registry for Improved Birth Outcomes. The registry, compiled from all births in Delaware occurring over during the past two decades, has helped to identify key risk factors associated with poor birth outcome (prematurity, low-birth weight and infant mortality). These factors include smoking, maternal weight (either too low or too high), chronic disease and short intervals between pregnancies.

The Newborn Metabolic Screening Program offers initial and confirmatory (second) screening for 37 conditions for every infant born in Delaware. The Newborn Metabolic Screening program also offers follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services. In 2007, 12,666 infants were screened. The program also distributes specialized baby formula to infants with metabolic conditions.

The Newborn Hearing Screening Program offers universal screening. Currently, the program screens over 93% of infants born in the state. The program also manages a hearing aid loaner program for children until a source is identified to obtain their own hearing aid. Two new pieces of legislation were passed this year. The first law expands the age limit for those eligible for hearing aid loaners from three to eighteen years of age. The second law requires insurers to cover up to \$1,000 per hearing device per ear every three years for children with hearing loss up to 18 years of age.

Services for CSHCN

In Delaware, Children with Special Healthcare Needs (CSHCN) are served by the Birth to Three program for infants and toddlers aged 0-3 and by Kids Kare for children to age 21. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with, or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. CDW is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children working together to provide early intervention to young children with special health care needs and their families. The average monthly number of children participating in CDW during 2007 was 1,559. During the year, over 4% of children aged 0-3 years, received early intervention or periodic assessment and tracking through CDW.

CDW is evaluated on an ongoing basis. One of the evaluative tools is the annual Family Survey which is conducted via telephone with a stratified random sample of families based on geographic region, ethnicity and length of time in the program. The 2007 survey found:

? 97% of families indicated that they had overall satisfaction with the services they received;

? 94% of families perceived the program as accessible and receptive;

? 93% of families perceived change in themselves and their family;

? 93% of families perceived change in their child;

? 93% of families reported a positive perception of family decision-making opportunities;

? 92% of families reported a positive family-program relationship with CDW staff; and,

? 92% of families reported a positive perception of their quality of life.

The Office of Children with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs.

Child Development Watch utilizes a community team model. The CDW team includes members from the Division of Family Services, the Division of Management Services, the Department of Education, the Division of Developmental Disabilities Services and contractual staff to ensure children and families are linked with the appropriate array of services. The model also includes specialized community services provided in early education centers and daycare settings, where CDW provides outreach to care providers for educational purposes and follow-up services for Children with Special Health Care Needs.

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition Initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008. In addition, the Office of CSHCN also supports expansion of Internet based tools for families and youth with special health care needs. Through a contract with the University of Delaware's Center for Disability Studies, Delaware's website for transition information continues to be updated to include specific contact information for medical and social needs.

State Statutes Signed into Law in the Past Year

SENATE BILL 78, AMENDED: PKU INSURANCE -- This bill provides that certain medical formulas and food expenses in the on-going treatment of phenylketonuria (PKU) and other inherited metabolic diseases shall be covered in health insurance contracts and also in group and blanket health insurance policies, effective July 1, 2008. Untreated PKU can result in severe mental retardation, complicated medical conditions, extensive health care costs, or death. Such outcomes can be prevented by following a very strict, medically prescribed diet.

HOUSE RESOLUTION 29: WOMEN'S HEALTHY HEART TASK FORCE -- House Resolution 29 establishes a Task Force for Women's Healthy Heart Issues. The task force will study the issues of women's heart risk and develop a comprehensive strategy to encourage healthy heart activities. The bill notes that cardiovascular disease claims more women's lives than the next six causes of death combined - nearly 500,000 women's lives a year, nearly twice as many as all forms of cancer. Unlike men, women may not suffer chest pain or discomfort as the first symptoms of a heart attack.

HOUSE SUBSTITUTION 1 FOR HOUSE BILL 194: MERCURY IN VACCINE BILL - This Bill

allows the use of mercury containing vaccines for children less than eight years of age or to pregnant women when an emergency occurs as declared by the Director of the Division of Public Health, or when there is no mercury-free vaccine manufactured or available for a specific disease.

HOUSE BILL 178, AMENDED: HEARING AID LOAN BANK - *This Act re-authorizes the Hearing Aid Loan Bank to ensure that all eligible children have access to hearing aids.*

HOUSE BILL 355, AMENDED: DELAWARE CODE RELATING TO HEALTH INSURANCE CONTRACTS -- *This Bill requires insurers to provide coverage of up to \$1,000 per individual hearing aid, per ear, every three years for children up to 18 years of age.*

HOUSE BILL 286, AMENDED: THE DELAWARE CODE TO ASSIST ENROLLMENT IN THE DELAWARE HEALTHY CHILDREN PROGRAM -- *This Bill requires school districts to report to the Delaware Department of Health and Social Services (DHSS) the name, eligibility status, family income level, address and phone number of each child eligible for free and reduced price meals through programs subsidized by the National School Lunch Program, the School Breakfast Program, or the Special Milk Program for Children. DHSS, in turn, will use the information to seek to enroll children in the State's CHIP and Medicaid programs.*

TOBACCO EXCISE TAX WITHIN BUDGET BILL - *The Budget Bill increased the state tobacco excise tax by 60 cents, effective Aug. 1. It is more than the 45 cents that tobacco prevention advocates were pushing through HB49. The increase is expected to decrease youth tobacco initiation and adult consumption of tobacco.*

SB 222. *This bill creates Delaware Stars for Early Success, a quality rating and improvement system for early childhood and care programs. This legislation directs the Department of Education to develop and give oversight to Delaware Stars for Early Success, a quality rating and improvement system, to benefit young children and their families served by early care and education programs. This legislation was a part of the Governor's and the Kids Caucus' agendas. The Office of Children with Special Health Care Needs and the Early Comprehensive Child Systems program have been involved in efforts to support this legislation including the ECCS Advisory Committee, the Family Support Coordinating Council and New Scripts. One of the measures used in the Delaware Stars rating system is the number of children enrolled with special health care needs.*

HB 472. *This bill is awaiting the Governor's signature and creates a procedure by which the Child Death, Near Death, and Stillbirth Commission will perform reviews of maternal deaths occurring in Delaware. The review is to provide meaningful, prompt, system wide recommendations in an effort to prevent future deaths and to improve services to pregnant women. This bill also extends the timeframe from 3 months to 6 months for expedited reviews of all child abuse and neglect deaths and near deaths and provides for compliance with the Federal Child Abuse Prevention and Treatment Act requirements pursuant to 42 U.S.C. SS 5106 a(b)(2)(A)(x).*

Cultural Competence

In 2007, the Delaware Division of Public Health (DPH)/DHSS contracted with the Center for Health Equality (CHE) at Drexel University's School of Public Health to conduct a cultural competence assessment of the division. The primary project objective was to apply a health care cultural competence protocol that was adapted, with the assistance of DPH staff, to the priorities and characteristics of the division. The process called for interviewing administrative, management and program personnel identified by the DPH, obtaining and ordering cultural competence-related materials across programs, and

scoring and scaling the division according to the assessment's five-point "Spectrum of Cultural Competence."

Findings of this initiative included the following:

Ethnic/cultural characteristics of staff and clients of DPH. The composition of employees of DPH is approximately as follows: 74% Caucasian, 18% African American, 4% Hispanic and 3% Asian. A descriptive analysis by pay grade and race/ethnicity indicated that there are relatively little difference in representation among Caucasians, African Americans and Hispanics (72%, 86%, 91%, respectively) in entry level positions, however, representation in the middle levels of the organization are reflective of less diversity with the exception of Asian employees, substantially represented in these positions (65%). Finally, in the upper levels of DPH, there is no difference by race/ethnicity.

Mission, management and program priorities. The organization has identified cultural competence as an organizational concern and has included it as part of periodic assessments of community/client needs, although those assessments tend to vary by program. Administration understands the importance of diversity and cultural competence in the context of public health mission and programs and this is reflected in the strategic plan.

DPH has made efforts to incorporate diversity into its administration/management. However, there is a general sense that formal strategies are more likely occurring at the service/program level.

Direct service staff stated that they were working to design culturally and linguistically appropriate interventions related to their programs, including consideration of related outcomes, and soliciting advice from clients. Some were working to reflect a long term commitment to cultural competence.

Diversity education and training. Interviewees generally acknowledged that DPH offers some training and education for providers and administrative staff, usually through orientation. Some programs acknowledged formal cultural competence training (including internet) or direct service education (for providers).

There has been some effort to formally identify related resources. For example, Task Force Recommendations for the Delaware Department of Health and Social Services (DHSS) workforce development include "Workforce Diversity and Cultural Competence Tool Kits for health care providers and consumers, which is accessible from their website. Included within these recommendations are talking points on the importance of funding projects to reduce disparities, and documenting how DHSS has already worked to start reducing disparities for cancer, maternal and child health, and diabetes.

Resources and Materials. A review of internal and external reports, brochures, protocols and other written resources was completed as part of the cultural competence analysis of the DPH. Overall DPH has addressed cultural competence-related issues through various methods such as trainings, internal communications, public and private reports, forms and educational brochures. Internal documents illustrate that DPH has planned inclusion of strategies to address working with diverse populations to insure they receive the array of services offered by the organization. For example, a strategic plan for special populations in public health related emergencies outlines how the needs of non-English speakers, people with disabilities, homeless people, pregnant women and children should all be integrated into preparedness programs. In addition, a list based on populations served by the Southern Health Services illustrates the state's great diversity in DPH serves clients from 45 different countries.

DPH Links to Community. The Division of Public Health has a number of important and established links to the community with a substantial number of these links formed with programs and personnel employed within the service arm of the organization. Through

their work with clients, direct service staff have taken the lead to partner with community based organizations which include community advocacy groups, local service programs, numerous faith-based institutions (i.e., primarily churches), schools (i.e., colleges and universities) and community advisory groups. Many of the direct service personnel indicated that there were "too many community partners" to list. This speaks to the efforts on the part of DPH programs to be interactive, integrative and responsive to their communities. This was evident given the extensive list of organizations that DPH has worked with over the past two decades. Many of the staff that has worked with the community has indicated that "keeping a strong community connection is vital." The connections and work with the community organizations have included outreach support, mass media campaigns, educational opportunities and referral sources. The effectiveness of working with the community in these activities was rated very high.

Direct service staff have made substantial efforts to incorporate the community into programs that target a specific racial/ethnic group. Educational programs for breastfeeding and HIV were mentioned as models that linked to communities but also incorporated the needs of diverse clients (i.e., hiring bilingual staff). Direct service staff commented that the success of community partnerships is based on the recommendation of managers on the direct service side to encourage employees to participate in community meetings. A provider resource guide was also developed for clients that identified language spoken among health care providers in the community.

Addressing the language and communication needs of clients. Assessments from administration and direct service staff indicated that 25-50% of client base speaks Spanish. In addressing the needs of this group the direct service as well as administrative staff have had many successes. Management has been responsive to client language needs by hiring bilingual staff in the clinic. Client language needs are identified on enrollment applications, most materials for clients are available in Spanish (e.g., consent forms, client rights and responsibilities form, HIPAA forms and educational materials) and there are also Spanish messages on direct service phone lines. In addition, videos in clinic waiting rooms are in Spanish; and complaints about services can be taken in Spanish. Finally, service providers have access to the AT & T language line for interpreter services.

In addition to the relative strengths of DPH in striving for cultural competence, the report identified areas for improvement. These areas include:

- *Services tend to operate independently of each other and, as a result, there was little opportunity to engage across them or to learn from their experiences or initiatives.*
- *Insufficient resources to provide important cultural competence services, including restrictions and requirements regarding dollar allocations, limit scope and reach and make it difficult to prioritize cultural diversity given other pressing needs.*
- *From staff in administration and direct service there was very little to no information gathered related to a formal process for collecting and monitoring client based race and ethnic data. Direct service staff do not have a formal mechanism for capturing client language needs in electronic databases. Although individual programs have added this information to their intake questionnaires, these data are not captured for administration to observe trends in demographic shift of clients.*
- *Although, there were many connections to the community, most of the work to incorporate community was project specific and oriented toward direct service personnel.*

To address these challenges, the DPH Office of Minority Health, along with other staff from DPH are in the process of developing action steps to further advance the cultural competence capacity of the Division. Among the recommendations that are under consideration are:

- *Use the Workforce Development group to take a lead on diversity.*

- **Expand resources for recruiting a diverse workforce.**
 - **Implement a cultural competence training program with a common content core but also with tailoring to specific service needs.**
 - **Advancing language assistance programs and initiatives.**
 - **Adapt, expand and centralize data and data system to more fully integrate diversity.**
 - **Review office/environmental opportunities for addressing or featuring diversity.**
 - **Establish a DPH resource for ongoing cultural competence activities.**
 - **Provide a web-based source for discussing cultural competence, and diversity-related issues.**
 - **Extending the community based resource into management and administration.**
- //2009//*

C. Organizational Structure

/2009/ Governor Ruth Ann Minner heads the executive branch of Delaware's state government. Governor Minner is in her final year of a second four year term. The Delaware Department of Health and Social Services (DHSS) is among the cabinet-level agencies in the executive branch. DHSS is led by Secretary Vincent Meconi. Within DHSS, there are 12 divisions, the largest of which is the Division of Public Health (DPH). Jaime Rivera, MD, FAAP is the Division Director for DPH.

In Delaware, there are no county/local health departments. DPH administers both state and local public health programs. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. The Title V Maternal and Child Health (MCH) Block Grant program and the Children with Special Health Care Needs (CSHCN) program are part of the Family Health and Systems Management Section (FHSM), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH. Alisa Olshefsky, M.P.H. is the section chief for FHSM, as well as the state MCH Director. The MCH program includes components of four bureaus within FHSM, as well as linkages to other programs within DPH. Within FHSM, the Bureau of Maternal & Child Health is led by the MCH Deputy Director. This position is currently vacant due to a hiring freeze for state funded positions. The Bureau includes the Title V Block Grant, the Newborn Screening program, the Newborn Hearing program, the Genetics program, Early Childhood Comprehensive Systems and Children with Special Health Care Needs. The Bureau of Adolescent and Reproductive Health, under Gloria James, Ph.D. includes the Adolescent Health Program (which includes School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Bureau of Health Planning & Resources Management, led by Judith Chaconas includes the Offices of Primary Care & Rural Health and the State Systems Development Initiative. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program. Research functions of this Center, including the Pregnancy Risk and Assessment Monitoring (PRAMS) survey, are led by a Centers for Disease Control and Prevention (CDC) MCH Epidemiologist, Charlan Kroelinger, Ph.D., who serves as the Science Director.

Nurses, social workers and nutritionists within the Smart Start, Kids Kare, and Child Development Watch Programs are directed by Herman Ellis, MD and Kristin Bennett, RN., MSN.

Beyond the FSHM section, several other critical programs are part of the MCH array of services and programs. These include Oral and Dental Health Services: led by Greg McClure, DMD; Northern Health Service Clinics, led by Anita Muir, M.S.; and Southern Health Clinics, led by Sherry Eshbach. Northern and Southern Health Services Clinic sites are the providers of three primary programs funded by Title V funds: Smart Start, Kids Kare and Child Development Watch.

DPH also includes a number of other programmatic areas which work closely with the MCH array of programs and activities. These programs are located throughout the strands of DPH and include Immunizations, Sexually Transmitted Diseases, Emergency Medical Services for Children and the WIC program.

The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes \$1,690,998 for 26.4 FTEs. State general funds and appropriated special funds from Oral Health program revenue will pay for 73.5 FTEs (a total of \$5,580,193) and programs under the Infant Mortality Elimination program (a total of \$4,468,500).

**Attached are the organizational charts for the state government, DHSS, DPH, and Family Health and Systems Management Section. //2009//
An attachment is included in this section.**

D. Other MCH Capacity

/2009/ Title V federal funds directly support 26.4 FTEs. A majority of these positions are clinic based positions (throughout the state) supporting Smart Start (a prenatal program for at-risk women); Kids KARE (a children's health services program); and Child Development Watch (a case management program for Children with Special Health Care Needs). The positions include: a Public Health Physician (.4 FTE); 3 Advanced Practice Nurses, 2 Nursing Supervisors, 2 Registered Nurses, 1 Licensed Practical Nurse, 3 Senior Medical Social Workers (2.5 FTEs), 3 Medical Records Technicians, a Senior Child Development Specialist, a Social Service Specialist, a Trainer/Educator, a Public Health Administrator, a Public Health Program Administrator, a Management Analyst, a Dental Assistant, a Health Program Coordinator (.5 FTE), Community Relations Officer (.5 FTE), a Health Program Coordinator (.5 FTE), and 5 Administrative Support Staff. Of these positions, the Public Health Administrator (Bureau Chief for Adolescent and Reproductive Health), the Public Health Program Administrator (Director, Children with Special Health Care Needs), an Administrative Assistant and a Management Analyst are centrally located and serve in an administrative capacity supporting MCH programs throughout the state.

In addition to the federally-funded positions, there are 73.5 FTEs that are state funded (66.5 FTEs) or funded through appropriated special funds (Oral Health Program Revenue). These positions include:

- **6 Administrative Specialists**
- **7 Advanced Practice Nurses**
- **1 Section Chief (MCH Director)**
- **1 Clinic Aide**
- **4 Clinic Managers**
- **7 Dental Assistants**
- **7 Dentists**
- **1 Genetics Coordinator**
- **5 Nursing Supervisors**
- **1 Public Health Program Administrator**
- **13 Registered Nurses**
- **1 Senior Child Development Specialist**
- **2.5 Senior Medical/Social Work Consultants**
- **1 Public Health Physician**
- **1 Social Worker**
- **3 Social Service Specialists**
- **8 Social Service Technicians**
- **1 Teacher**
- **1 Teacher's Aide**

- 1 Trainer

The Division of Public Health employs a parent who serves in an advisory capacity to the CSHCN program and is also the AMCHP family delegate for the state of Delaware. This family member works with the Children with Special Needs Alert Program (SNAP) within the Emergency Medical Services for Children Program. SNAP is a program designed to notify emergency medical personnel of a child's special needs in advance. DPH also has parents of Children with Special Health Care Needs that are among the staff within the Child Development Watch program. //2009// An attachment is included in this section.

E. State Agency Coordination

/2009/ As a small state, Delaware has many benefits, one of which is close collaboration between private and public agencies to address the maternal and child health needs of the state. Title V staff work with all agencies and constituency groups to assure that women, infants, children and adolescents, and children with special health care needs and their families have access to needed services.

At the highest organizational levels, the Delaware Health Care Commission provides an objective and informed forum for all stakeholders, including patients, insurers, employers, legislators, government agencies, health care providers and others. The Secretary of Delaware Health and Social Services, represents DPH and the MCH program on the Commission. The Commission serves as a policy-setting body and is designed to allow creative thinking across agency lines and across the public and private sectors. In recent years, the Commission has focused its efforts on health care access, cost and quality and oversees five major initiatives to meet its mission and goals. These initiative are:

- Uninsured Action Plan -- The Commission explores strategies to reserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care through the Community Healthcare Access Program.*
- Information & Technology - The Commission is working to develop a statewide clinical health exchange through the Delaware Health Information Network (DHIN).*
- Health Professional Workforce Development -- The Commission assures an adequate supply of health care professional through the State Loan Repayment Program and the Health Workforce Data Committee and expanding educational opportunities for Delawareans through the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER).*
- Research and Policy Development -- The Committee performs ongoing research and provides accurate information for state policy makers.*
- Specific Health Care Issues -- The Commission addresses specific health care conditions that are prevalent and warrant special attention and works in cooperation with other bodies within the State for this purpose.*

Coordination of services and programs within the Title V MCH Block Grant program is accomplished through a number of committees and advisory boards with wide ranging representation. Programs partnered with Title V include the State's Early and Periodic, Screening, Diagnosis, and Treatment Program (EPDST), WIC, Part C IDEA, programs administered through the Department of Services for Children, Youth and Their Families, Division of Child Mental Health Services and Office of Early Prevention and Intervention, the Division of Visually Impaired, the Division of Developmental Disabilities Services, infant mortality initiatives (including the Family Practice Team Model and Preconception programs), and Family Planning programs.

Partners in the community include Nemours Health and Prevention Services, A.I. DuPont Hospital for Children, the Children's Hospital of Philadelphia, Johns Hopkins, and the

State's hospitals (Christiana Care Health Systems, Bayhealth, Nanticoke, and Beebe). These and additional agencies (March of Dimes, Easter Seals for example) are typically represented on a number of Maternal and Child Health Committees including the Delaware Healthy Mothers and Infants Consortium.

Additional current advisory and coordinating committees include the Coordinating Council on Children with Disabilities (an advisory committee to the Children with Special Health Care Needs programs), the Teen Pregnancy Advisory Board (an advisory committee to the Director of Public Health), the Early Childhood Comprehensive Systems Advisory Council, the Newborn Screening Advisory Committee, the Newborn Hearing Advisory Committee, the State Systems Development Initiative Advisory Committee, the Birth Defects and Autism Registries Advisory Committee, the State Council for Persons with Disabilities (which includes the Traumatic Brain Injury Committee), the Developmental Disabilities Council, the Interagency Coordinating Council (an oversight committee for PART C), the Family Support Coordinating Committee, the Emergency Services for Children Advisory Board, the Trauma System Advisory Board, Healthy Delawareans with Disabilities 2010 (a committee that strategically plans preventing secondary health conditions among persons with disabilities, see attached Delaware Health Status for Children with Disabilities and Special Health Care Needs [April, 2008]), and the MCH Needs Assessment Working Group.

EPSDT, part of the State's Medicaid Program, is administered through the Division of Medicaid and Medical Assistance (DMMA), a sister division to DPH. Staff from DMMA and DPH routinely meet to discuss crosscutting issues related to outreach, enrollment and services utilization. DMMA is the lead agency for the State's Assuring Better Childhood Development (ABCD) initiative, in which a pilot program to implement standardized screening in pediatric practices is underway.

The Delaware WIC Program is located within DPH. Title V programs and WIC staff routinely work together at the state's public health clinic sites and referrals to WIC are made from each of the state's MCH programs. The PART C IDEA program is administered through the Division of Management Services, also a sister agency of DPH. The Office of Children with Special Health Care Needs and Child Development Watch work closely with PART C to provide services to Children with Special Health Care Needs (birth to 3 years of age). Additionally, the Early Comprehensive Childhood Systems program works with PART C to ensure all Delaware Children are ready to start school.

The Department of Services for Children, Youth and Their Families is the primary agency in Delaware responsible for child mental health services (administered by the Division of Child Mental Health Services). The ECCS program, Adolescent Health Program and CSHCN program each collaborate on initiatives related to MCH and child mental health. Additionally, each of these programs have advisory committees with representation from the Division of Child Mental Health Services. This year, the Division of Child Mental Health Services and the DPH Title V Maternal Child Health Program were co-applicants in a grant application to the Substance Abuse and Mental Health Services Administration to integrate physical and behavioral health preventive services for children 0 to 8 years of age.

The Division of the Visually Impaired and the Division of Developmental Disabilities Services are both partners with the Title V, Children with Special Health Care Need Program. Both of these Divisions are within the same cabinet-level department as the Division of Public Health. The Delaware Healthy Mothers and Infants Consortium (DHMIC) is a Governor appointed body consisting of academics, neonatologists, a hospital director, nurses, department secretaries, consumers, the faith-based community and legislators. In addition to these

appointed members the Consortium includes statewide representation from numerous stakeholders in each of its five committees (Data & Science, Education & Prevention, Health Disparities, Standards of Care and Systems of Care). The Consortium, now in its third year of work, is a key body for coordinating maternal and infant health issues in the state, especially issues related to infant mortality.

The Title X Family Planning Program within the same section as the Title V Maternal and Child Health program, works in close partnership with many MCH related initiatives including teen pregnancy prevention, women's health and infant mortality. Title X also supports staff located throughout the state in both contractual programs and Public Health Clinics. Referrals are routinely made between the Title V programs and Title X programs, as well as WIC.

The State Systems Development Initiative (SSDI) includes an advisory committee with representation from each of the key agencies with MCH related data. The Committee consists of the SSDI Coordinator, the Title V Program Administrator, the WIC Director, the Bureau Chief of Health Systems Management, the Newborn Screening Director, an Information Technology representative, representatives from School-Based Wellness Centers, staff from Northern Health Services and Southern Health Services (the regional offices for Public Health Clinics), representatives of the CSHCN, ECCS, Family Planning, Genetics programs, epidemiologists from the Center for Family Health Research and Epidemiology, and a representative from the Delaware Medicaid Program. The committee meets routinely to discuss ideas for linking data, identifying appropriate research questions for pilot studies and advising the SSDI coordinator on systems related issues.

The MCH Needs Assessment workgroup, initially formed in March 2008 includes representatives from each area of DPH's maternal and child health programs. In the coming year this group will be expanded, as needed, to include representation from other public/private agencies.

Federally Qualified Health Centers (FQHCs) and the state's rural health program are also closely related to the MCH program. Administrators overseeing these efforts are under the supervision of the state's MCH Director. Additionally, the Office of Oral Health and Dental Services, within DPH collaborates closely with the MCH program, including the Office of Children with Special Health Care Needs. //2009// An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

In FY 2007, the Division of Public Health implemented a Center for Excellence in Maternal and Child Health Epidemiology. The primary responsibility of this unit is to conduct and collaborate on research initiatives related to Maternal and Child Health with an emphasis on Infant Mortality and Poor Birth Outcomes. The Center works closely with the State Vital Statistics Office and Medicaid to study and monitor measures related to maternal and child health and associated health systems capacity indicators. Center staff provides expertise on research, data and statistics and share information internally with other Title V staff, as well as with numerous other partners in the Division, State and larger community.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	66.2	69.1	69.1	69.1	69.1
Numerator	1742	378	378	378	378

Denominator	263274	54668	54668	54668	54668
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

At the time of submitting the 2009 MCH Block Grant application, the latest available hospital discharge data is 2004.

Narrative:

The 2004 final rate, 2005 provision rate and 2006 provision rate are one-year rates for children hospitalized for asthma. The rates in 2002 and 2003 are five year moving average rates.

In August 2005, the Division of Public Health and the Department of Natural Resources and Environmental Control released a report, "The Burden of Asthma in Delaware. The report provided an overall description of asthma in Delaware that included prevalence statistics, a profile of persons affected by asthma, health care utilization among persons with asthma and economic and social costs of asthma.

The Department of Education, as part of its School Improvement Initiative incorporates guidelines concerning school health. Asthma is one of the topics addressed. Among the strategies stated are: Obtaining written action plans for each student with asthma; supporting access to appropriate health care for students with asthma; integrating asthma and lung disease education into the classroom; participating in the YRBS and Delaware School surveys and offering Asthma Awareness Days to educate family and community members.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	70.7	74.6	88.1	88.1	88.1
Numerator	3902	4370	5421	5421	5421
Denominator	5522	5857	6154	6154	6154
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

In 2007, Delaware was successful in starting a Assuring Better Child Health & Development (ABCD) initiative. This process will enable the State to access technical assistance to improve early screening systems.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	NaN	NaN			
Numerator	0	0	0	0	0
Denominator	0	0			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Final

Notes - 2007

All infants are eligible for Medicaid and therefore do not get SCHIP

Notes - 2006

All infants are eligible for Medicaid and therefore do not get SCHIP

Notes - 2005

All infants are eligible for Medicaid and therefore do not get SCHIP.

Narrative:

All infants are eligible for Medicaid and therefore are not enrolled into SCHIP until after 12 months of age.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	78.3	80.6	80.6	71.3	71.3
Numerator	8880	9150	9150	8450	8450
Denominator	11337	11358	11358	11857	11857
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

2007 data are not available at this time.

Notes - 2005

2005 data will be available in 2007.

Narrative:

In State Fiscal Year 2007, Delaware implemented a Comprehensive (Holistic) Family Practice Team Model. This program is a direct services model targeting disparity in access to care, specifically among minority and lower income populations. The Family Practice Team model is a community-based model aimed at increasing access to supplemental care among targeted populations through combining prenatal and medical care with social services, nutrition services, and other components of health services coordinated by a case management system. The program is funded to cover areas of care not typically paid for by insurance providers and to provide care during time periods where insurance coverage is limited or for identified gaps in service.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	96.2	94.8	94.8	93.8	94.2
Numerator	71589	78004	78004	81133	89704
Denominator	74384	82292	82292	86503	95253
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

The percent of potentially Medicaid-eligible children who have received a service paid by Delaware's Medicaid Program is reported in Table 7A.

The Kids Kare, Smart Start and Child Development program refer families to Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	39.2	41.1	42.8	84.9	84.9
Numerator	5622	6107	6743	13990	13990
Denominator	14348	14870	15756	16474	16474
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

In 2007, the Delaware Healthy Children Program (DCHP) began offering dental coverage for all of its members. The legislation authorizing these services will enable approximately 500 additional children to have the opportunity to obtain regular dental care by providing comprehensive benefits, competitive reimbursement fees, and streamlined claims processing. Under the benefit, modeled after those available under the State's Medicaid program, services include oral exams, x-rays, cleanings, fluoride applications, fillings, and restorative and specialty services. Orthodontic care is also available.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	3825	3756	3334	3334	2927
Denominator	3825	3756	3334	3334	2927
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

The percent of the State's SSI beneficiaries less than 16 years old receiving rehabilitative services from the State's Children with Special Health Care Needs Program is reported in Table 8. 2006 data are provisional at this time.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	11.3	8	9.5

Narrative:

During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	payment source from birth certificate	9.8	8.6	9.1

Narrative:

During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	71.1	89.4	81.4

Notes - 2009

National Performance Measure 18 is based on 2006 Delaware Vital Statistics preliminary data. The data reported on Form 18 are from 2005 final Vital Statistics data. At the time this application was completed the 2006 final Vital Statistics data were not available.

Narrative:

During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	69	83.7	77.1

Notes - 2009

At the time this application was completed the 2006 final Vital Statistics data were not available. The values reported for Form 18 HSCI 05D "All" are based on 2005 final Vital Statistics data. The value reported for HSCI 04 are based on 2006 preliminary Vital Statistics data.

Narrative:

During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)		

Notes - 2009

Infants are Medicaid eligible.

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants are reported in Table 6A.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19)	2007	133 100

(Age range to)		
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	200

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for children are reported in Table 6B.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2009

Pregnant women are Medicaid eligible.

Narrative:

The percent of poverty level for eligibility in the State's Medicaid program for pregnant women is reported in Table 6C. Pregnant women do not receive SCHIP.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC	1	No

eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Two notable accomplishments in FY 2007 have improved the State's MCH program's access to policy and program relevant information. First, the Center for Excellence in Maternal and Child Health Epidemiology was created and fully staffed. This Center, within the State's Maternal and Child Health Branch, is composed of three full time staff dedicated exclusively to collecting, generating, and analyzing data in MCH. The staff provides current updates of local, state and national data to the Division of Public Health, the Department of Health and Social Services, collaborative and partnering agencies and the Delaware Healthy Mother and Infant Consortium. The goals of the Center are to impact all programs that provide services in MCH, provide expertise in applications for federal and other supplemental funding opportunities, and facilitate evaluation of all MCH-related programs. In FY 2007, the Center will implement the statewide PRAMS survey. Additionally, the Center is collaborating on research initiatives with a number of partners including the University of Delaware, the State Medicaid Office, Christiana Care Health Systems and Johns Hopkins University. The second accomplishment has been an internal reorganization that has placed the state's State Systems Development Initiative within the same section as the Maternal and Child Health Branch. During FFY 2007, a new SSDI Program Director was hired and a SSDI committee has been formed and has met several times to prioritize data set linkages and research questions.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2009

Narrative:

According to the Campaign for Tobacco-Free Kids, Delaware ranks 2nd in the nation among all states in funding tobacco prevention programs. Delaware is currently only one of three states that funds tobacco prevention programs at or above the minimum amounts recommended by the Centers for Disease Control and Prevention.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2009/ Delaware continues to monitor progress on each of the State's priorities, performance measures and program activities, however some data sources present significant barriers for timely assessment. Two years ago, Delaware transitioned to an Electronic Vital Statistics Record System (EVRS). Since this transition, staff in the Health Statistics Section of DPH have continued to provide Vital Statistics and Hospital Discharge data as soon as possible. For this year the latest Vital Statistics data that are available are for 2006. The Vital Statistics data that are reported throughout the application's forms for 2007, therefore, are provisional. The latest hospital discharge data that are available are for 2005. The Hospital Discharge data-based indicators for 2006 and 2007 are also provisional.

DPH also maintains a dated information system the Community Health Information System (CHISYS). CHISYS was originally designed for billing purposes about 15 years ago. Presently, the system continues to be used for billing and payment purposes. In the past two years, a working group has been formed to study issues related to CHISYS for the purposes of reporting client utilization of DPH services. This working group has identified a number of issues related to the consistency of data entry across programs throughout the State.

Two important additions have been made to the State's capacity to monitor performance through indicator data. First, the Center for Family Health Research and Epidemiology was funded in 2006 and made operational in 2007. This Center provides important analyses of trends in women's, infant and family health. Two main accomplishments of this Center in the past year have been the establishment of a Registry for Improved Birth Outcomes and the implementation of the Pregnancy Risk Assessment Monitoring System. The Registry for Improved Birth Outcomes has informed policy makers about risk factors of women with repeated poor pregnancy outcomes such as low-birth weight, preterm birth and fetal/infant death. The initial year of PRAMS data is expected to be ready for analyses sometime in the Fall of 2009. In addition to the Center for Family Health Research and Epidemiology, the State System Development Initiative (SSDI) has made important gains in identifying pertinent questions to be addressed with respect to linking databases. This year the SSDI project provided an analysis of birth defects using Newborn Screening/Birth Certificate data. This analysis is being used by a Birth Defects Registry working group to make recommendations for enhancing Delaware's Birth Defects Registry. The objective is to move from a passive registry to an active registry in 2009. //2009//

B. State Priorities

/2009/ As depicted in the attached schematic diagram, the Delaware Maternal and Child Health programs address priorities, national performance measures and state performance measures across each level of the MCH pyramid (direct health services, enabling services, population-based services and capacity/infrastructure activities. Though not inclusive of all the activities supporting these outcome measures, this section briefly addresses the linkages and activities that point to the capacity and resource capability within the State's MCH programs.

Direct health care services are provided by Public Health Clinics in support of National Performance Measure (NPM) 4, "the percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need." These services are made available through pediatric services in the clinics, as well as the Child Development Watch and Kids Kare programs. State Performance Measure (SPM) 5, "Percent of women delivering live-born infants reporting

any cigarette smoking during pregnancy" and NPM 15, "Percentage of women who smoke in the last three months of pregnancy" are addressed through DPH's smoking cessation programs and health education and counseling in Smart Start and the Family Practice Team Model. Family Planning Services, Smart Start, Preconception Healthcare Services and the Family Practice Team Model each teach women the importance of adequate birth spacing (SPM 7). Together these efforts address the stated priorities of medical homes and coordinated care for CSHCN, access to care, reducing preventable disease, reducing disparities in the Black:White infant mortality ratio and reducing barriers to care.

Enabling services are offered as part of the case management efforts within Smart Start, Kids Kare, Child Development Watch and the Family Practice Team Model. These services are wide-ranging wrap around services for women, infants and children, as detailed throughout this application. Enabling services within these programs support each of the state's priorities. Adolescent enabling services are provided through School-Based Health Centers which provide referral for mental health, substance abuse and physical health issues.

Population Based Services address a number of State and National Performance Measures. These services include Newborn Screening (NPM 1), Newborn Hearing (NPM 12), WIC's Breastfeeding promotion efforts (NPM 11), the Infant Mortality Elimination Program's Education Campaign to raise awareness of preconception health (numerous indicators), youth injury prevention through Delaware's Emergency Medical Services for Children and the Injury Prevention Coalition (NPM 10) and many other efforts. Together, these programs and activities provide support for all the state's priority needs as identified in the 2005 MCH Needs Assessment.

Capacity/Infrastructure activities are also wide-ranging. These include a number of ongoing surveys (such as PRAMS, the Primary Care Physician Survey, the Youth Risk Behavior Survey, the CSHCN Family Satisfaction Survey), DPH's efforts to involve families in program planning and evaluation, and support for assorted committees, task forces and work groups throughout the state, as detailed throughout this application. Capacity building also includes the work of the Early Comprehensive Childhood Systems program, the Conrad/J-1 Visa program and the State Systems Development Initiative. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	11337	11337	12293	22	35
Denominator	11337	11337	12293	22	35
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012

Annual Performance Objective	100	100	100	100	100
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Notes - 2006

2006 data are for positive screens that receive appropriate follow-up clinical management. Prior year data are for all newborns receiving screening services (Delaware Newborn Screening Program).

Notes - 2005

The number actually screened is 12,392. The total occurant births are 12,293. The additional screens result when babies receive screens in Delaware, but were born elsewhere, including adoptions and tranfers to A.I. duPont Hospital for Children.

a. Last Year's Accomplishments

The Division of Public Health's Newborn Screening Program (expanded in 2003) currently screens for 37 disorders including amino acidopathies, organic acidurias, fatty acid oxidation disorders, hemoglobinopathies, and endocrinopathies. Additionally, repeat screens are performed on all infants. The initial screen is completed at least 24 hours after the infants first feeding and the repeat screen is completed 7 to 28 days after birth. Delaware offers a fee exemption in the event that a parent cannot pay for the screening.

In 2007, the Division of Public Health's Newborn Screening Program completed analyses of 24,426 specimens (12,666 initial specimens, 11,592 repeat specimens and 168 other specimens. Annually, approximately 15-30 infants are identified with one of the metabolic conditions detectable through newborn screening. The screens that were completed included over 300 medical providers and 10 birthing facilities and hospitals.

Staff from the Newborn Metabolic Screening Program continued to provide follow-up services when initial screens were not completed at the birthing facility and for confirmatory (second) screens. When initial or confirmatory screens are not completed at a hospital, referrals are made to Public Health Nurses for a home visit.

Newborn screening staff also continued to provide quality assurance visits at birthing facilities and hospitals and to provide education presentations to medical professionals throughout the State.

The Newborn Screening Program Director, Betsy Voss, was selected as one of the Division of Public Health's Employees of the Quarter for her work in coordination of functions for families with an infant with PKU. Newborn Screening staff is instrumental in supporting the efforts of the Delaware Chapter of the Mid-Atlantic Connection for PKU and Allied Disorder (MACPAD).

The Newborn Screening program is also responsible for administration of the Specialty Formula Fund in Delaware. This fund provides specialty formula for infants in need.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. On June 21, 2008, the Second Annual PKU Picnic for the Delaware Chapter of the Mid-Atlantic Connection for PKU and Allied Disorders was held.				X
2. The DPH Newborn Screening program includes initial and second screens for 37 metabolic conditions.			X	
3. Newborns are followed until repeat screens are completed and infants are referred for appropriate treatmentj.			X	

4. Delaware Formula Fund provides specialized formula for infants in need.	X			
5. Newborn Screening Program provides Quality Assurance monitoring to hospitals and birthing centers to ensure consistency and timeliness in the screening process.				X
6. Newborn Screening data system supports the Birth Defects and Autism Registries enhancement initiatives.				X
7.				
8.				
9.				
10.				

b. Current Activities

In addition to the on-going administration of the Newborn Screening Program, current year activities include planning and implementing enhanced Birth Defects and Autism Registries. These registries are housed within the Newborn Screening program. A workgroup has been formed to identify partners and stakeholders and to plan for notification of specialty medical providers within Delaware's child health network. A process for routinely updating the registries with standardized data is being formulated that will enable the registries to provide valuable information for surveillance, needs assessment and program planning in future years.

The Newborn Screening program is also currently investigating the feasibility of increasing fees to increase revenue. In recent years the revenue funding stream has been adequate to address ongoing needs. However, it is anticipated that a new Tandem Mass Spectrometry MS/MS machine may be more cost effective than maintaining an aging machine.

c. Plan for the Coming Year

Within the Family Health and Systems Management Section, there has been a focus of closer integration of all maternal and child health related activities. In Federal Fiscal Year 2009 this integration will continue. As improved Birth Defects and Autism registries are available, the Newborn Screening program will be a key partner in further integration of data (with the State Systems Development Initiative and the Center for Family Health Research and Epidemiology.

The Newborn Screening program will also continue to identify possible sources of revenue to further expand the core screens available for Delaware's infants.

A priority across MCH programs in Federal Fiscal Year 2009 will also be strengthening family involvement. Newborn Screening will continue to work closely with programs such as Newborn Hearing, which will implement a Delaware Hands and Voices chapter this year and to market the screening program and opportunity for family involvement at health fairs and other conferences throughout the state.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	60	60	65	65
Annual Indicator	56.9	56.9	56.9	56.9	61.1
Numerator					

Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Child Development Watch (CDW), the primary program for Children with Special Health Care Needs (ages 0-3 years), conducts an annual Family Survey (See attached). In 2007, 52.6% percent of families surveyed (N=158) strongly agreed with the statement "You felt that you receive up-to-date information about your child's needs so that you can make decisions for him or her. An additional 38.5% of families agreed with the statement and only 9% disagreed or disagreed very strongly. Almost all families (98.2%) strongly agreed or agreed with the statement "You are included in all planning and decisions for your child's programs and services." This level of expressed satisfaction regarding families' perception of decision-making opportunities within CDW points to one of the many successes of the program. CDW involves families in decision-making at all levels. Families continued to be active participants in monitoring, reviewing and developing standards of care, as well as participating in the development and monitoring of Individualized Family Services Plans. The programs advisory board, the Coordinating Council for Children with Disabilities, has a strong level of active family representation. In state fiscal year 2007, about 1,450 children were referred to CDW. The average monthly caseload was about 1,370 children.

Family Voices of Delaware was successful in obtaining a HRSA grant to fund family--run health information resource centers. These centers are designed as one-stop sources of support and information for families of children with special health care needs.

The project is designed to accomplish the following.

1. Share information with families and professionals about CSHCN topics and provide technical support by operating a toll free telephone line, establishing an FTF website, sending email alerts and operating a listserv, producing a newsletter and including relevant information in partner newsletters, distributing informational materials through doctor's offices, health clinics, and other health care and relevant settings and through state conferences and local health fairs.
2. Provide training to families and professionals about CSHCN issues by offering family-led, family-professional collaboratively led, and professional-led workshops, trainings, and educational experiences. These learning opportunities will be offered throughout the state to reach as many families and professionals as possible.
3. Help improve the services CSHCN and their families receive by:
 - a. Collaboratively working with families and professionals to identify/develop effective family-health care professional partnership models for Delaware.

- b. Staying abreast about best practices for serving CSHCN and their families and working with families and professionals to identify effective practices being used in Delaware.
- c. Sharing best practice and partnership model information with families, professionals, policy makers, and insurers.
- d. Providing a consistent and well informed family voice about CSHCN issues by serving on relevant state councils, committees, and other advisory groups and advocating to policy makers and insurers about service and system improvements.

In addition (and as required by MCHB), the FTFC will collect information about center users, training participants, and center activities and will conduct an annual survey of families to help determine if FTFC activities have helped families of CSHCN make effective health care decisions leading to improved care. Also, the FTFC will work to reach underserved and Spanish speaking populations by working with partner organizations that serve these populations.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch has a strong level of family involvement in standards development, system monitoring and Individualized Family Services Plans development.		X		X
2. The Division of Public Health conducts an annual Family Survey of families with Children with Special Health Care Needs.				X
3. Family to Family Centers will provide health information to families of Children with Special Health Care Needs.		X		
4. The Center for Disabilities Studies, at the University of Delaware, maintains a website of resources related to Children with Special Health Care Needs.		X		
5. The Coordinating Council for Children with Disabilities provides coordination and communication for issues related to Children with Special Health Care Needs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CDW continues to operate on an on-going basis throughout the State of Delaware. Through May, 2008, 1,466 children were referred to the program with an average monthly caseload of about 1,350 children.

The Office of Children with Special Health Care Needs maintains contracts with the Coordinating Council for Children with Disabilities (CCCD) and the University of Delaware's Center for Disabilities Studies. The Office of CSHCN, through the CCCD contract provides education and mentoring for Council members, professional management of the Council (including support functions), broadening the advisory role of the Council (through the facilitation of communication of issues, grants, projects, etc. and collaboration with private/public agencies with goals consistent with the CSHCN program) and research activities. Through the Center for Disabilities Studies contract, the CSHCN program supports the Centers initiatives to:

- 1) Research medical transition resources.
- 2) Conduct a survey of healthcare providers in Delaware.
- 3) Compile a list of healthcare providers and allied health specialists including current contact

information, scope of practice and accessibility for adults with disabilities.

- 4) Compile a list of resources to help youth in their transition process to adult medical services.
- 5) Share this information and resources electronically with the public in Delaware.

c. Plan for the Coming Year

The DPH MCH Program will work collaboratively with the University of Delaware, Center for Disabilities Studies on the Family to Family project and continue to identify new opportunities for integrating and enhancing services for Children with Special Health Care Needs and their families.

In January of 2008, the Office of Children with Special Health Care Needs convened a day long initial planning session ("pre-meeting") to begin work on identifying goals and objectives. The purpose of the meeting was to inform members of the Coordinating Council for Children with Disabilities about key steps that need to be reviewed. These steps include defining and identifying the CSHCN population, how they are currently served, what are the unmet needs and what is the vision for the future. Over the next year, this planning process will be part of the overall Delaware MCH 2010 Needs Assessment effort.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55	55	55	60	60
Annual Indicator	52.8	52.8	52.8	52.8	48.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	50	50	50

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Child Development Watch includes each child's primary care physician as a member of a multidisciplinary assessment team.

Since 2001, Delaware's Medicaid Program has provided enhance reimbursement for case management services for children with special health care needs medical home providers. Smart Start, Kids Kare and Child Development Watch refer families to medical Homes and Medicaid and SCHIP-based insurance.

The Delaware Chapter of the American Academy of Pediatrics hosted provider trainings on newborn screening, cystic fibrous screenings, linking families to community resources, and family-centered care in each of Delaware's 3 counties for medical personnel who provide primary care to children birth to five.

The Division of Public Health's ECCS project partnered with the Delaware Chapter of the American Academy of Pediatrics to conduct a medical home survey. The survey included both pediatricians and family participants.

The Division of Public Health and the Division of Medicaid and Medical Assistance successful in their efforts to initiate a systems improvement project under the Assuring Better Child Health and Development (ABCD) project. This project, in cooperation with the Delaware Chapter of the American Academy of Pediatrics, launched a pilot program in two pediatric practices in Delaware. This pilot seeks to implement policies and practices that move the use of standardized screening tools as part of well child care to a "standard of practice."

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch includes the child's Primary Care Physician as a member of a multidisciplinary team.		X		
2. Children in Kids Kare and Child Development Watch are connected to a medical home and primary care physician.		X		
3. The ABCD project supports policies to expand the use of standardized screening tools as part of well child care.				X
4. The current Delaware Primary Care Physician Survey includes an item to establish baseline information on the understanding of the AAP's medical home criteria.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Delaware Medicaid, Early Comprehensive Childhood Systems, Nemours Health and Prevention Services, the Autism Society of Delaware and Child Development Watch are collaborating on a statewide policy development pilot related to developmental screening of young children.

A question was added to the Delaware Primary Care Physician Survey based on based on the Center for Medical Home Improvement's Medical Home. This question, "How familiar/knowledgeable are you about the concept of a medical home as defined by the American Academy of Pediatrics?" will establish a baseline indicator of need for training on issues related

to medical homes in Delaware.

c. Plan for the Coming Year

A team from Delaware, including representatives from the Health Care Commission, the Delaware Chapter of the American Academy of Pediatrics, the Division of Medicaid and Medical Assistance and the MCH Director applied for an opportunity to attend a Medical Home Summit in July 2008. This summit sponsored by the National Academy for State Health Policy (NASHP), the Patient Centered Primary Care Collaborative, and The Commonwealth Fund is designed to help state policymakers improve the quality and availability of medical homes for Medicaid and State Children Health Insurance Program (SCHIP) beneficiaries.

The absence of a medical home for all children in Delaware remains a critical issue. Under the Ready Child section of Delaware's state plan for early childhood, Early Success II, the need for all children to have access to a medical home where they receive developmentally appropriate, coordinated care is essential to the optimal health of all children. To address the lack of a consistent medical home model in Delaware, the ECCS grant is providing opportunities to collaborate among agencies, medical providers, community stakeholders and policy leaders.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	67	67	67	70	70
Annual Indicator	66.7	66.7	66.7	66.7	63.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

As the number of uninsured Americans continues to grow, some states are striving to create a health system "safety net" that provides affordable and appropriate care to uninsured citizens. CHAP is Delaware's health system "safely net" and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology, and laboratory services offered at reduced cost. Patients with incomes below 200 percent of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance are matched with doctors at hospitals, private practices, and community health centers throughout the state. The target population for CHAP is comprised of approximately 20 percent of the state's uninsured population, about 20,720 adults. Since the inception of the program in 2001, and as of September 30, 2007, CHAP has served over 13,487 uninsured patients and enrolled 2,893 in other state and federal medical assistance programs like Medicaid and the Veteran's Administration. In 2006 a health risk assessment and disease management component was added to CHAP, allowing the program's focus to shift to those enrollees with chronic conditions and the highest medical need. In 2007 evaluation began, which demonstrated some success of CHAP in improving personal health outcomes. In 2008, evaluation will continue as well as recruitment of uninsured participants and, when appropriate, enrollment of eligible citizens in other medical assistance programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New Delaware Legislation requires the Department of Education to report contact information for children enrolled in reduced cost/free breakfast/lunch programs for the purpose of enrollment in Medicaid/SCHIP.		X		
2. CHAP, Delaware's health safety net program, connects low-income, uninsured children to physicians and health care resources.		X		
3. The Delaware Health Commission will continue to promote policies that preserve existing coverage, expand coverage (in the short term), and provide universal coverage in the long-term.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year, HB 286 was signed into law by the Governor. The Bill requires school districts to report to the Delaware Department of Health and Social Services (DHSS) the name, eligibility status, family income level, address and phone number of each child eligible for free and reduced price meals through programs subsidized by the National School Lunch Program, the School Breakfast Program, or the Special Milk Program for Children. DHSS, in turn, will use the information to seek to enroll children in the State's CHIP and Medicaid programs.

c. Plan for the Coming Year

The State Planning Program, launched in 2001 after securing funding from the U.S. Health Resources and Services Administration (HRSA), permits continued analysis of health insurance coverage options for Delaware. Over the course of the Planning Grant period, the Delaware Healthcare Commission has rigorously reviewed and analyzed over twenty short term and long

term options. In 2007, Planning Grant funds expired, but after extensive consideration, two strategies have been analyzed and the Commission concluded that these were most appropriate for Delaware moving forward: Preserve and Expand Coverage- The Commission has defined a two-pronged strategy addressing the issue of access to health care: preservation of existing insurance coverage; and expansion of insurance coverage to the uninsured. Preservation will include more aggressive enrollment of eligible children into the SCHIP and Medicaid programs. The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2007 a contract was signed with Jonathan Gruber, PhD to conduct econometric simulation and analysis of two models: traditional single-payer and a "building block" model that makes use of existing systems and other state reforms. Results from this study are due to the Commission no later in the summer of 2008.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	75	75	75	80	80
Annual Indicator	72	72	72	72	88.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	90	90	90

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The Delawareans with Disabilities 2010 project implemented a childhood survey to study the needs of parents and guardians and the health needs of their children aged 0-17. the survey includes physical, intellectual, sensory, genetic and chronic health conditions and is based on the CDCs Behavioral Risk Factor Surveillance System.

The demand for Child Development Watch (CDW) services continues to grow. In 2007, CDW followed over 2,800 children in the program. Federal and local monitoring ensures that state

programs comply with regulations related to timeliness of multidisciplinary assessments, development of Individualized Family Service Plans for eligible children, and transition planning for children aging out of the program. This year, CDW's Northern Health Services (NHS) staff achieved a 92% compliance with transition planning and 96% with service timelines.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Children with Special Health Care Needs supports web-based information on resources for families with Children with Special Health Care Needs.		X		
2. Delaware annually surveys families of Children with Special Health Care Needs to track family satisfaction and their perceptions of service availability and accessibility.				X
3. Title V partners with Delaware's Family to Family Center Grant utilizing family-practitioner partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CDW/NHS completed its first year of outcome measurement, a project involving a significant system change. Preliminary data for 75 children show the following outcomes:

- 62.7% are achieving or have emerging ability to achieve milestones in social emotional skills;
- 56% are achieving or have emerging ability to achieve milestones in skill acquisition; and
- 56% are achieving or have emerging ability to achieve milestones in meeting their own needs.

Child (CDW) statewide implemented a Delaware Building Block Outcomes Project to better define the progress of Delaware's children with special health care needs. The project tracks functional abilities versus simply skills assessment and deficit-based evaluations. Southern Health Services (SHS) CDW staff was trained to enhance their evaluation abilities and skills. Outcome measurements verify quality of service provision and increased accountability of service providers, increasing family participation in the process.

An attachment is included in this section.

c. Plan for the Coming Year

Family Voices of Delaware (FV DE), with support from the Center for Disabilities Studies (CDS) at the University of Delaware was awarded a Family to Family Center (FTFC) Grant. The FTFC will be run by family members and governed by a Family to Family Leadership Council, composed mostly of family members.

Delaware's FTFC will do the following:

- share information with families and professionals about CSHCN topics and provide technical support;
- provide training to families and professionals about CSHCN issues by offering family-led, family-

professional collaboratively led, and professional-led workshops, trainings, and educational experiences: and

- help improve the services CSHCN and their families receive by: collaboratively working with families and professionals to identify/develop effective family-health care professional partnership models for Delaware; staying abreast about best practices for serving CSHCNs and their families and working with families and professionals to identify effective practices being used in Delaware; sharing best practice and partnership model information with families, professionals, policy makers, and insurers; and providing a consistent and well informed family voice about CSHCN issues by serving on relevant state councils, committees, and other advisory groups and advocating to policy makers and insurers about service and system improvements.

In addition, the FTFC will collect information about center users, training participants, and center activities and will conduct an annual survey of families to help determine if FTFC activities have helped families of CSHCN make effective health care decisions leading to improved care. Also, the FTFC will work to reach underserved and Spanish speaking populations by working with partner organizations that serve these populations.

FV DE is the lead agency in this application and will provide the expertise, leadership, and family staffing needed for the FTFC to be successful. FV DE assists families of CSHCN and the professionals who serve them through: direct information and referral, parent matching, support groups, conferences, topical calls, resource guides, listservs, newsletters, and surveys. FV DE monitors legislative action that will impact families and works closely with other families and Delaware Medicaid to improve services for CYSHCN. FV DE is funded by the DE Maternal and Child Health Program, DE Emergency Medical Services for Children (EMSC), Easter Seals, and the DE Early Intervention Program. FV DE has worked to engage a variety of partners for the proposed center, especially those who are doing substantial and important work related to CSCHN issues.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	20	20	20	20	25
Annual Indicator	5.8	5.8	5.8	5.8	42.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	45	45	45	45	50

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the

sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 67.6% of families with CYSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CYSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. DuPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To what types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. One-half of respondents did not have a specialist despite this perceived access and among those without a specialists 39% reported they do know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in the process of transitioning to adult services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A.I. DuPont Hospital has established an Office of Transition to meet the needs of youth transitioning into adult care.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In April 2007, the Coordinating Council for Children with Disabilities held a Symposium on Transition at A.I. DuPont Hospital for Children. The day's schedule included a Pediatric Grand Rounds and keynote from Dr. Albert C. Hergenroeder from the Texas Children's Hospital. The sessions also included a parent pane featuring several parents of young adults with disabilities who discussed their successes and frustrations as they help their young adults navigate into adulthood. A.I. DuPont has created a full time position to improve the transition process for CSHCN.

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008.

c. Plan for the Coming Year

The Office of Children with Special Health Care Needs and the Coordinating Council for Children with Disabilities will continue to focus on initiatives to enhance transition to adult services. The efforts will include: continuing to explore existing adult community services for individuals with medical conditions and disabilities for gaps in services delivery; continuing to educate adult health care providers on the needs of transitioning youth and their families; beginning the process of exploring collaborative efforts between pediatric and adult physicians; and beginning the process to explore ways to provided needed transition resources to families and youth who are in the transition process.

The Office of Children with Special Health Care Needs will continue its strong partnership with the Bridging the Gap project. The Project focuses on:

1. Creating a state office that focuses on health issues of persons with disabilities;
2. Developing a statewide strategic plan for health promotion and prevention of secondary health conditions in individuals with disabilities;
3. Maintaining an advisory council that represents agencies and organizations from the health and disabilities communities as well as self-advocates and family members;
4. Building and maintaining partnerships with health and disabilities organizations to address health and wellness issues of individuals with disabilities;
5. Maintaining and improving Delaware's ability to monitor health and wellness for people with disabilities;
6. Providing technical assistance, consultation, and training, either directly or through partnerships with state agencies and community organizations.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	80.3	83.5	82.6	76	76
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012

Annual Performance Objective	80	80	80	80	80
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Notes - 2007

2006 National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware 4:3:1:3:3. Data released February 2008 (Corrected).

Notes - 2006

2006 National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware 4:3:1:3:3. Data released February 2008 (Corrected).

Notes - 2005

2005 National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware, 4:3:1:3:3.

a. Last Year's Accomplishments

Families enrolled in Smart Start and Kids Kare are educated regarding the importance of childhood immunizations in order to protect their children from vaccine preventable diseases.

WIC staff checks the immunization registry and discuss the importance of vaccine preventable diseases. Children are referred to a Primary Care Physician or Child Health Clinic.

Family Planning staff utilize the immunization registry to determine if a client is eligible for the Hep B series. If eligible the client receives education, counseling and the injections.

DPH staff seeks to meet this objective through an unwritten policy - "Do not miss an opportunity to vaccinate." To support this intention, DPH staff strives to ensure all vaccinations are performed in the fewest number of visits possible. All required vaccinations are given during an appointment as long as no contraindications are present. Follow-up appointments are scheduled at the time the client is seen. Clinics routinely display posters and distribute literature to reinforce the need to ensure vaccinations are kept up to date.

The Immunization Coalition of Delaware has expanded the focus from seasonal influenza vaccine promotion to a broader mission to include children and teens for all vaccine preventable diseases.

The membership has grown to include school nurses, physicians, colleges, infection control nurses and various community agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Northern and Southern Health Services (Public Health Clinic sites) provide immunizations at Well-Child visits. These services are primarily targeted to the under- and uninsured.	X			
2. The Division of Public Health participates in the Immunization Coalition of Delaware. This group identifies need and addressess system-wide issues regarding immunizations.				X
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b. Current Activities

The Immunization Program joined the Family Health Services and Systems Management Section to offer the FDA-approved HPV vaccine Gardasil that prevents four strains known to cause cervical cancer. The Immunizations Program established the Adult HPV Program for women 19-26 years who are uninsured or under-insured, or without a private provider. Eligible girls 9-18 can receive Gardasil through the Vaccines for Children program.

The Immunization Coalition of Delaware, chaired by Northern Health Services Section Chief Anita Muir, has significantly increased its collaborative partnership outreach from about 10 members a few years ago to 77 current members. The group meets monthly in person and via teleconference. Partners include the DPH Immunization Program Office, Southern Health Services, Northern Health Services, several drug manufacturer representatives, the University of Delaware Health Services, the Delaware Medical Society and a cross-section of community partners. Discussions, information presentations, and communication collaborations are strengths.

The African American Access Initiative (AAAI) convened to address issues specific to the health of the African American population. To increase by 10 % the number of African Americans receiving influenza shots from Southern Health Services, six churches allowed vaccination clinics to coincide with their Sunday services. The AAAI committee will consider other specific interventions to reduce the health disparities gap.

c. Plan for the Coming Year

DPH is in the process of drafting a new Memorandum of Agreement with the Division of Medicaid and Medical Assistance, the State's Title XIX Medicaid Agency. A main purpose of this agreement is to provide for the sharing of information and education on pediatric vaccinations and delivery of immunization services.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	30	29	28	27	26
Annual Indicator	34.1	24.6	22.2	22.0	22.0
Numerator	387	412	381	386	386
Denominator	11337	16740	17170	17572	17572
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	20	20	20

Notes - 2007

2007 data are not available at this time.

Notes - 2006

2006 Data are not available at this time. The rate reported is provisional and based on the 2005 final rate.

Notes - 2005

Teenage births from 2005 Delaware Vital Statistics Live Births. Population estimates computed from Delaware Population Consortium estimates for 15 - 19 year old females.

a. Last Year's Accomplishments

Teen pregnancy prevention services are available through the Adolescent Health Program's School Based Health Centers, Alliance for Adolescent Pregnancy Prevention and teen pregnancy prevention programs, such as Teen Hope. The Teen Pregnancy Prevention Advisory Board provides guidance on implementing and evaluating these efforts. The Board advises the Division Director.

Family Planning Clinics provide teen pregnancy prevention services throughout the state. In 2007 these clinics served 7,665 teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health provides Teen Hope programming at six high schools with high risk populations. This program teen pregnancy prevention education and case management to participating teens.	X			
2. The Division of Public Health provides Wise Guys programming at high schools throughout the State. Wise Guys is a male responsibility, teen pregnancy prevention program.	X			
3. Title X Family Planning provides reproductive health and pregnancy prevention services to teens at sites throughout the state.	X			
4. The Infant Mortality Elimination program provides funding in the form of mini-grants for teen pregnancy prevention. The program also provides preconception health services.	X			
5.				
6.				
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b. Current Activities

The Maternal and Child Health team developed outcome-based, data driven programs for the Alliance for Adolescent Pregnancy Prevention program. The team introduced two programs: "Making a Difference," which targets at-risk students ages 11 through 13; and "Wise Guys," which targets at risk students ages 14 through 18 and uses a mentor approach.

c. Plan for the Coming Year

In the coming year, the data collected through the Making a Difference, Wise Guys and Teen Hope programs will be analyzed for program effectiveness.

The rate of repeat teen pregnancies has been identified as a potential priority issue to be

explored in the 2010 Needs Assessment. The issue of repeat teen pregnancies has surfaced at several forums this year, including the Delaware Healthy Mothers and Infants Annual Summit where the problem -- and its relation to inadequate birth spacing, has been linked to poor birth outcomes.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	35	35	35	35	40
Annual Indicator	30.7	21.4	34	34	34
Numerator	464	286			
Denominator	1512	1338			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	35	35	37	37	40

Notes - 2007

The 2007 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Notes - 2006

The 2006 indicator is based on a 2002 statewide survey of third grade children. Prior year indicators were obtained from CHCIS & Medicaid and only represent a select subset of the population. The statewide survey is scheduled to be repeated in 2007. The 2010 annual performance objective has been revised to reflect the HP2010 objective of 50%.

In the 2006-2007 School Year, the DPH Dental Program reported placing 1400 sealants.

Notes - 2005

The 2005 indicator is based on a 2002 statewide survey of third grade children. Prior year indicators were obtained from CHCIS & Medicaid and only represent a select subset of the population. The statewide survey is scheduled to be repeated in 2007. The 2010 annual performance objective has been revised to reflect the HP2010 objective of 50%.

a. Last Year's Accomplishments

Children active in Kids Kare, Child Health and WIC are referred to the Dental Clinic and/or private dental providers accepting Medicaid payments. Services include preventive and emergency services.

Tooth care and nutrition are discussed at each physical exam performed. Clients are referred to state-sponsored medical programs as possible sources of free or low-cost dental care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health's Dental program provides dental screening for the Special Olympics Program.	X			
2. Public Health Dental Clinics offer comprehensive dental treatment for those in need.	X			
3. The Dental Loan Repayment program continues. This program is an attempt to attract dentists to underserved areas of the state.				X
4. The Dental program's Seal a Smile program provides sealants and dental screening at elementary schools throughout the state.	X			
5.				
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b. Current Activities

The Bureau of Oral Health and Dental Services Sealant program completed the following activities:

- 34 schools were visited out of 37 scheduled;
- 561 students were screened;
- 395 student received sealants (70% of those screened), and a total of 1,348 sealants were placed;
- 231 students were referred for regular dental services (41% of those screened);
- 43 students were referred for urgent care;
- 15 students were referred for urgent care under Medicaid (34% of students in need of urgent care)
- A total of 171 (30% of those screened) were covered under Medicaid.

In 2007, the Bureau of Oral Health and Dental Services received a four-year, \$160,000 grant from the Health Resources and Services Administration (HRSA) for the Targeted State MCH Oral Health Service Systems (TOHSS) Grant. Project goals are for children to receive early and comprehensive oral health services; and for families to understand the importance of oral health and learn how to achieve optimal oral health status.

An attachment is included in this section.

c. Plan for the Coming Year

The Delaware Oral Health Coalition is a new group formed to help reduce the high level of dental disease among the state's children. The State Oral Health Collaborative Systems Grant funded the creation of this diverse group representing approximately 20 organizations. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health. It will also provide education about good oral health practices, and improve access to dental health providers.

The Oral Health Workforce Activities Grant will support the Department of Education's Oral Health Curriculum, a Case Management Referral System, and a pilot project, the "Mobile Dentistry Program."

The TOHSS Grant will provide Primary Care Physician Oral Health Trainings, support a pediatric residency in Oral Health, complete an oral health needs assessment and implement oral health surveillance.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	3.2	3.2	2.5	2.5	2.5
Annual Indicator	3.0	2.2	1.8	1.8	1.8
Numerator	25	11	9	9	9
Denominator	821990	499038	500732	500732	500732
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2007

This indicator is provided through Hospital Discharge data. Data for 2006 and 2007 Hospital Discharges is not available at this time.

Notes - 2006

2006 data are not available. The reported rate for 2006 is provisional and based on the 2005 three year average rate.

Notes - 2005

This is a three year rate (2003-2005). Source: Delaware Vital Statistics, Deaths to Children from Motor Vehicle Crashes.

a. Last Year's Accomplishments

Emergency Medical Services for Children and Delaware Safe Kids hosted the seventh annual "Preventing Childhood Injury in the 21st Century" Conference in Dover, DE. There were 79 attendees from across the state.

Children in approximately 1000 classrooms statewide are participating in the Risk Watch Program. The program now reaches over 28,000 students in Delaware schools. The students gain knowledge to prevent injuries through the Risk Watch injury prevention program.

Parents of all children active in Kids Kare, Smart Start, WIC and Child Health receive education regarding the importance of car seat safety and Delaware state law. If the family is unable to afford a car seat, they are linked to community-based organizations that provide car seats at low or no cost.

The Office of Highway Safety coordinated an education and enforcement initiative during this national Child Passenger Safety Awareness Week. Fourteen law enforcement agencies conducted 830 hours of enforcement, and made 87 child restraint and over 650 seatbelt arrests during saturation patrols and child restraint checkpoints. In addition, OHS purchased radio advertisements to highlight the state's fitting stations as well as CPSAW enforcement activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Emergency Medical Services for Children and the Injury Prevention Coalition continue to address motor vehicle related injuries and deaths among children as a priority area in their programming efforts.				X
2. Smart Start, Kids Kare and Child Development Watch complete safety assessments at clinic and home visits.		X		
3. State Service Center locations offer child safety seat loaners to parents who cannot afford to purchase one.		X		
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b. Current Activities

Motor vehicle deaths are being analyzed in greater detail through the Crash Outcome Data Evaluation in Delaware. This system links state police crash data with EMS run reports and hospital discharge data to provide greater detail about motor vehicle crashes in Delaware. This information can help determine what prevention and awareness raising would be most effective in reducing these deaths.

The Emergency Medical Services for Children Program has published a new report, "2008 Childhood Injury in Delaware" which reports injury related data for Motor Vehicle Injury and Death, as well as economic costs.

c. Plan for the Coming Year

Delaware's highway safety objectives related to occupant safety include:

- To increase seat belt use from 87% in 2007 to 88% in 2008. In order to achieve an 88% seat belt use rate, Delaware must convert 8% of its current non-seat belt users into seat belt users.
- To reduce alcohol-related fatalities from 36% in 2006 to 33% in 2008 and to reduce the alcohol fatality rate per hundred million vehicle miles traveled from .61 in 2006 to .58 in 2008.
- Aggressive Driving -- To reduce fatal crashes resulting from aggressive driving behaviors from 52% in 2006 to 49% in 2008.

In support of these objectives, the state's police agencies will overtime enforcement to arrest violators of the state's seat belt/child restraint-, impaired driving- and aggressive driving laws on days of the week and times of the day when aggressive driving-related crashes have occurred. Officers will be directed to conduct enforcement at locations where aggressive driving-related

crashes have occurred.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12	36
Annual Indicator			10.6	35.7	35.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	36	36	36	36	36

Notes - 2007

2007 data are not available. 2007 reported percentage is provisional and based on the 2004 National Immunization Survey, Geographic-specific Breastfeeding Rates for Children 6 months of age born in 2004.

Notes - 2006

2006 data are not available. 2006 reported percentage is provisional and based on the 2004 National Immunization Survey, Geographic-specific Breastfeeding Rates for Children 6 months of age born in 2004.

Notes - 2005

2005 data is an estimate from the CDC's 2004 National Immunization Survey.

a. Last Year's Accomplishments

WIC supports breastfeeding rooms where any breastfeeding mom can pump or breastfeed in comfort and privacy. Each room has a glider and ottoman, an electric, hospital-grade pump, a refrigerator for storing expressed milk and breastfeeding literature.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V is supporting a pilot program "Best Start", an enhancement to Smart Start. The goal of the program is to have at least 80% of program participants breastfeeding their infants at 6 months of age.		X		
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b. Current Activities

The Women, Infant and Children (WIC) Program realized a noticeable increase in breastfeeding initiation and continuation rates among enrollees. In 2007, 36% of Delaware WIC women breastfed their infants, compared to 34% in 2005. Twenty-nine percent of them are not supplementing with formula: a 27% jump over 2006 statistics.

WIC provides support to lactation consultants and peer counselors. Lactation consultants are experts in the field of breastfeeding. They are licensed, trained professionals who are available to provide support and assistance to pregnant and nursing mothers. Peer Counselors are women who have breastfed at least one infant for a minimum of four months. Peer counselors receive intensive training in breastfeeding support. WIC clients can reach a peer counselor by phone or through WIC clinics.

To increase the number of women who breastfeed their infants, the Milford Health Unit hired an RN as a "Certified Lactations Consultant." The RN provides weekday case management and consultative services to Smart Start and Kids Kare cases for breastfeeding mothers. The Title V Program provided funding support for the Public Health Nurse to attend lactation training.

c. Plan for the Coming Year

The WIC Program is supporting the Annual World Breastfeeding Week Celebration. An event is scheduled during August as the Chase Center in Wilmington, DE.

One of the 2008 goals for the Health Promotion and Disease Prevention Section is to increase breastfeeding in at-risk populations. Southern Health Services has also identified a 2008 goal to assure support for breastfeeding women at Kent and Sussex health care agencies, SHS clinic sites, and in family settings using a variety of strategies.

DPH recently implemented a Breastfeeding Policy to allow employees who are exclusively breastfeeding mothers to have their infant brought to the Division of Public Health's facilities by the infant's care provider for the purpose of breastfeeding during working hours.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	99	99	100	100	100
Annual Indicator	98.0	98.1	98.2	98.4	93.7
Numerator	10861	11889	12098	12147	11864
Denominator	11083	12121	12324	12342	12666
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

The Newborn Hearing Screening program is currently reviewing 2007 information to ensure all records have been entered accurately into the data system. The data reported for 2007, therefore, is provisional at this time.

Notes - 2006

2006 Delaware Newborn Hearing program data.

Notes - 2005

2005 Delaware Newborn Hearing program data.

a. Last Year's Accomplishments

The Newborn Hearing Screening Program tracked and followed all babies who do not pass the newborn screening and diagnostic testing. The birthing facilities and DuPont Hospital for Children are currently screened about 98% of babies prior to discharge. Currently, the program locates all babies born in the state on the electronic birth certificate to ensure all babies receive a screen. All pediatric audiologists were informed of the Hearing Aid Loaner Bank. Pediatric Audiologists were also sent information on medical homes as described by the AAP. The program also identified a contractor to oversee the development of a family support network and provide program evaluation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In June 2008, the first meeting of a statewide chapter of Hands and Voices was held. Hands and Voices is a parent support organization for children who are deaf and hard of hearing.				X
2. On March 12, 2008, the 3rd Annual Conference on Hearing Loss, "Delaware's Still Listening", was held at the Dover Downs Conference Center in Dover, DE. The conference included sessions: Navigating the System, an update on a study of family focus gro				X
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4.				
5.				
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b. Current Activities

A family focus group study was completed. The study gathered information about perception and satisfaction with hearing loss related services in Delaware. The study will help the Hearing Program's Advisory Board to determine which efforts are working well, understand the needs of families with hearing loss, and determine gaps in- and barriers to services. The report also contained recommendations to enhancing existing hearing services in several domains including schools and education, staffing, information dissemination, and access to resources.

A Hands & Voices Chapter is in its initial stages for formation. The first meeting was held in June 2008.

According to preliminary data for 2008, the percentage of hearing screens performed prior to hospital discharge among newborns continues in the range of 97-98 percent.

Legislation was signed into law mandating insurance companies to cover \$1,000 per hearing aid per ear for children up to 18 years of age.

Additional legislation was introduced to expand Delaware's Hearing Aid Loaner Bank Program (from 3 years of age up to 18 years of age).

The 3rd Annual Conference on Hearing Loss, "Delaware's Still Listening,": was held on March 12, 2008.

c. Plan for the Coming Year

The Newborn Hearing Program will continue to support the formation of a Hands & Voices Delaware Chapter for parents of children with hearing loss.

The Newborn Hearing Program will support the annual Conference on Hearing Loss.

The Hearing Program will continue to ensure that hearing screening is performed on every infant in Delaware and provide follow-up case management to ensure that screens not performed prior to hospital discharge are completed.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.2	8.2	8.2	8	8
Annual Indicator	8.5	8.5	12.6	12.3	12.3
Numerator	17090	17045	25484	24992	24992
Denominator	201054	200527	202255	203188	203188
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	11	11	10

Notes - 2007

Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

Notes - 2006

Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

Notes - 2005

Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

a. Last Year's Accomplishments

As the number of uninsured Americans continues to grow, some states are striving to create a health system "safety net" that provides affordable and appropriate care to uninsured citizens. CHAP is Delaware's health system "safely net" and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology, and laboratory services offered at reduced cost. Patients with incomes below 200 percent of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance are matched with doctors at hospitals, private practices, and community health centers throughout the state. The target population for CHAP is comprised of approximately 20 percent of the state's uninsured population, about 20,720 adults. Since the inception of the program in 2001, and as of September 30, 2007, CHAP has served over 13,487 uninsured patients and enrolled 2,893 in other state and federal medical assistance programs like Medicaid and the Veteran's Administration. In 2006 a health risk assessment and disease management component was added to CHAP, allowing the program's focus to shift to those enrollees with chronic conditions and the highest medical need. In 2007 evaluation began, which demonstrated some success of CHAP in improving personal health outcomes. In 2008, evaluation will continue as well as recruitment of uninsured participants and, when appropriate, enrollment of eligible citizens in other medical assistance programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Community Health Access Program (CHAP) CHAP helps provide access to primary care doctors, medical specialists, and other health resources. Medical services are provided in the community through Community-based Health Care Centers and private doc	X	X		
2. MCH Programs provide SCHIP and Medicaid eligibility determination referral.		X		
3.				
4.				
5.				
6.				
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b. Current Activities

This year, HB 286 was signed into law by the Governor. The Bill requires school districts to report to the Delaware Department of Health and Social Services (DHSS) the name, eligibility status, family income level, address and phone number of each child eligible for free and reduced

price meals through programs subsidized by the National School Lunch Program, the School Breakfast Program, or the Special Milk Program for Children. DHSS, in turn, will use the information to seek to enroll children in the State's CHIP and Medicaid programs.

c. Plan for the Coming Year

The State Planning Program, launched in 2001 after securing funding from the U.S. Health Resources and Services Administration (HRSA), permits continued analysis of health insurance coverage options for Delaware. Over the course of the Planning Grant period, the Delaware Healthcare Commission has rigorously reviewed and analyzed over twenty short term and long term options. In 2007, Planning Grant funds expired, but after extensive consideration, two strategies have been analyzed and the Commission concluded that these were most appropriate for Delaware moving forward:

Preserve and Expand Coverage- The Commission has defined a two-pronged strategy addressing the issue of access to health care: preservation of existing insurance coverage; and expansion of insurance coverage to the uninsured. Preservation will include more aggressive enrollment of eligible children into the SCHIP and Medicaid programs. The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2007 a contract was signed with Jonathan Gruber, PhD to conduct econometric simulation and analysis of two models: traditional single-payer and a "building block" model that makes use of existing systems and other state reforms. Results from this study are due to the Commission no later in the summer of 2008.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				33	33
Annual Indicator			34.0	27.8	20.2
Numerator			2141	2712	2075
Denominator			6296	9763	10264
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	18	18	17

Notes - 2006

2006 Delaware WIC program data.

a. Last Year's Accomplishments

The Division of Public Health's Health Promotion and Disease Prevention section hired a Physical Activity Program Administrator. This begins a comprehensive statewide approach to help reduce major health problems, cardiovascular disease, diabetes, and cancer caused by lack of physical activity and obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Division of Public Health MCH programs partner with Nemours Health and Prevention Services on child health issues including obesity.				X
2. The DPH Health Promotion and Disease Prevention Section has obesity prevention as a strategic objective.				X
3. Nutritionists are part of the MCH programs' staff. These programs include Smart Start, Kids Kare, the Family Practice Team Model and Preconception Health Care.	X			
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6.				
7.				
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b. Current Activities

The Office of Women's Health held its first symposium for clinicians and program managers at Delaware State University. Clinical Medical Director Dr. Jacqueline Christman organized "The Challenges of Overweight, Obesity and Weight-Control among Women in Delaware."

Through the ECCS program, as well as other areas of MCH, such as School-Based Health Centers, DPH partners with Nemours Health and Prevention Services. Nemours launched its 5-2-1 Almost None "formula for a healthy lifestyle". This program was adopted by the State Nutrition Action Program, which includes the Child and Adult Care Food Program, WIC and Food Stamps. These programs serve more than 75,000 persons in Delaware.

c. Plan for the Coming Year

Health Promotion and Disease Prevention's Physical Activity Program Administrator held a comprehensive planning summit on nutrition, physical activity and obesity prevention in the Summer of 2008. These preliminary discussions will lead to the development of a coalition that can begin and implement a state plan.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				11	10.9
Annual Indicator			11.2	6.8	6.8
Numerator			1272	814	814
Denominator			11337	11898	11898
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	6.5	6	6	5.5	5.5

Notes - 2007

2007 data are not available at this time.

Notes - 2006

2006 data are not available. 2006 reported rate is based on 2005 Delaware Vital Statistics, "Women who smoked during pregnancy."

Notes - 2005

The latest available data is from 2003. 2004 data will be available in Fall 2006. 2005 data will be available in 2007.

a. Last Year's Accomplishments

Counseling and education regarding smoking cessation continued to be provided during all Smart Start and Family Practice Team Model visits.

Counseling regarding smoking cessation is provided at Family Planning pregnancy test visits.

Based on need, clients are also referred to the Delaware Quitline, a 24-hour, toll-free number resource. Callers access a smoking cessation program that combines expertise with local knowledge and services. Those who enrolled received referral to trained pharmacists and community groups. Vouchers are provided to low-income residents obtain effective pharmaceutical cessation products.

More than half of the pregnant women in the state are enrolled in WIC. Program participants are encouraged to stop smoking and are referred to cessation services.

Preventing infant mortality and associated risks is a primary objective of the Delaware Division of Public Health and the Delaware Healthy Mother and Infant Consortium. Accordingly, counseling and referral to smoking cessation services are included in each of the Infant Mortality programmatic initiatives to date. These include the preconception health programs that were implemented in FY 2007 and the prenatal Comprehensive Family Team Practice programs that were expanded in FY 2007.

In May 2007, the Delaware Healthy Mother and Infant Consortium held a one-day conference "Pursuing Motherhood." The morning sessions were targeted to women at risk for low-birth weight and other adverse pregnancy outcomes. Lifestyle risks were highlighted during the sessions including the risks of smoking. Informational binders were distributed and community resources were made available.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation continues to be a main risk factor reduction priority in each of the Maternal and Child Health programs. Women are counseled and provided education materials that assist in smoking cessation.	X	X		
2. The MCH programs refer women to the Delaware Quitline, a statewide resource that offers support, counseling and vouchers	X	X		

for pharmaceutical products.				
3. Smoking during pregnancy continues to be monitored through the Registry for Improved Birth Outcomes.				X
4. The Delaware Healthy Mothers and Infants Consortium partners with community agencies to address the reduction of tobacco use among pregnant women and women of childbearing age.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Smoking continues to be a primary risk factor that is included in the State's Registry for Improved Birth Outcomes. Data from the registry suggest that about 20% of women with poor birth outcomes (low birthweight, preterm birth or infant mortality) smoked during pregnancy. As part of the Preconception Health Program, smoking cessation, before pregnancy is a primary objective.

c. Plan for the Coming Year

Delaware plans to expand its services through the Family Practice Team Model (a prenatal health program) and the Preconception Health Program.

The Delaware Healthy Mothers and Infants Consortium will continue to partner with key organizations throughout the state, including the Cancer Consortium and the Delaware Lung Association to advance policies and services targeted to the reduction of smoking and its associated morbidity and mortality.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.6	5.5	5.5	5.5	5.4
Annual Indicator	8.3	8.4	5.8	5.8	5.8
Numerator	23	14	10	10	10
Denominator	276711	166957	170943	170943	170943
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012

Annual Performance Objective	5.4	5.4	5.4	5.4	5.4
------------------------------	-----	-----	-----	-----	-----

Notes - 2007

This indicator is provided through Hospital Discharge data. 2006 and 2007 Hospital Discharge data are not available at this time.

Notes - 2006

2006 data are not available. 2006 reported rate is provisional based on 2005 data.

Notes - 2005

2005 reported rate is a three year rate (2003-2005). Source: Delaware Vital Statistics, Deaths by Suicide, 15-19 year olds.

a. Last Year's Accomplishments

School-Based Health Centers continued to provide mental health prevention and early intervention services throughout the State. In 2007, over 36,300 visits were completed for mental health emotional issues, substance abuse issues and suicidal ideation.

In an ongoing attempt to reduce suicide the Delaware Health and Social Services, Division of Substance Abuse and Mental Health sponsored the 2nd Annual Suicide Prevention Conference, "The Golden Link, Creating Pathways for Survival" at the University of Delaware in April 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DPH clinic based services provide referral for depression and other mental health conditions.		X		
2. School-based Health Centers provide mental health counseling and referral to students.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The goals of school-based health centers in Delaware are to provide primary prevention and early intervention for health problems among the student population by providing preventive care through Licensed Clinical Social workers who work with Students and families as needed to:

- detect signs of emotional stress and psychosocial problems for counseling and/or referral;
- reduce the incidence of high risk behaviors through health education and risk reduction efforts; and
- reduce the mental health and psychosocial problems of adolescents.

Service are provided through Individual and family counseling in a variety of settings including group sessions and where topics are a function of identified needs (including drug and alcohol abuse, stress management, etc. including referral for long- term counseling and evaluations.

c. Plan for the Coming Year

Through the Early Comprehensive Childhood Systems initiative, DPH will continue to focus on enhancing available mental health services for the birth to 8 years old population. One of the the Delaware Early Childhood Council's 2008 recommendations includes supporting "the development of a comprehensive approach in Early Childhood Mental Health services for behavior problems for families and early childhood programs."

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	82.6	79.7	79.7	79.3	79.3
Numerator	195	145	145	188	188
Denominator	236	182	182	237	237
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	82	82	82

Notes - 2007

2007 data are not available at this time.

Notes - 2005

The latest available data is from 2003. 2004 data will be available in Fall 2006. 2005 data will be available in 2007.

a. Last Year's Accomplishments

As one of the recommendations from the 2005 Governor's Infant Mortality Task Force, the Delaware Healthy Mothers and Infants Consortium was charged with continuing to improve the statewide neonatal transport system. Delaware only has 1 Level III facility, Christiana Care, in New Castle County. Babies in need of level III care must be transported to Christiana Care. The Task Force called for an ongoing evaluation of the neonatal transport system to understand the issues affecting neonatal transport and how improvements in this system could result in better access to care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Delaware Healthy Mothers and Infants Consortium, Standards of Care Committee monitors neonatal transport issues regarding transportation to the Level III facility.				X
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Delaware Healthy Mothers and Infants Consortium's Standards of Care Committee reviewed the standards of care, which included the American College of Obstetricians and Gynecologists state and national recommendations. These standards were determined to be adequate. The committee also reviewed the statewide Neonatal Transport Program. The program was determined to be adequately functioning in its current structure.

c. Plan for the Coming Year

The Standards of Care Committee will continue to evaluate current practices and promote optimum care standards of all women of childbearing age. Additionally, the committee will focus on reviewing standards of preconception care in the coming year.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88	88	90	90	90
Annual Indicator	83.9	84.7	83.2	73.9	73.9
Numerator	9508	9615	9450	8796	8796
Denominator	11337	11358	11358	11898	11898
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	75	75	77	77	80

Notes - 2007

2007 data are not available at this time.

Notes - 2006

2006 data are not available. 2006 reported percentage is provisional and based on the 2005 data.

Notes - 2005

2005 Delaware Vital Statistics: Prenatal Care by Trimester.

a. Last Year's Accomplishments

The primary goal of Smart Start is to link all pregnant women to early prenatal care. In 2007 over 1,200 women were enrolled in Smart Start.

DPH clinics offer pregnancy. Positive pregnancies are referred to a local obstetrician. Negative tested clients are referred to a gynecologist or local reproductive and sexual health clinic. DPH community health nurses accept referrals on positive pregnancy tests to assure early entrance into prenatal care and the Smart Start program.

The Family Practice Team Model programs served over 1,200 women in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smart Start and the Family Practice Team Model engage women in early pregnancy, and provide case management and follow-up services to ensure prenatal care is available and accessible.		X		
2. Prenatal programs provide translation services to non-English speaking women to reduce barriers to care.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Improving access to care for populations disproportionately impacted by infant mortality remained a priority. Under the Infant Mortality Elimination Program, increasing enrollment in Medicaid and providing additional access to care for pregnant women are focal points. In support of this goal, the program has enhanced translation services for medical visits, provided prenatal vitamins to women in need and initiated a statewide education campaign on improving birth outcomes targeted to high risk populations.

Smart Start and the Family Practice Team Model programs continue to enroll at-risk women and facilitate access to prenatal care.

c. Plan for the Coming Year

In the coming year the Family Practice Team Model programs will establish community partnerships by conducting outreach, promoting participation in the program and raising awareness of the benefits of participation. The model will also be evaluated for effectiveness.

A related program, the Preconception Care Program, will continue to work with women to educate them about what they can do to maintain their health. The program will be expanded and new contracts will be awarded. An evaluation process will be established.

D. State Performance Measures

State Performance Measure 1: *Percent of women delivering live-born infants reporting any cigarette smoking during pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11.5	11	11	10	10
Annual Indicator	11.3	11.8	11.6	6.8	6.8
Numerator	1286	1340	1346	814	814
Denominator	11337	11358	11603	11898	11898
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	10	10	10	10	10

Notes - 2006

This is the number of women who reported smoking in the last three months of pregnancy. 2006 data on any smoking during pregnancy is not available at this time.

Notes - 2005

2005 Delaware Vital Statistics, "Women who smoked during pregnancy."

a. Last Year's Accomplishments

Counseling and education regarding smoking cessation continued to be provided during all Smart Start and Family Practice Team Model visits.

Counseling regarding smoking cessation is provided at Family Planning pregnancy test visits.

Based on need, clients are also referred to the Delaware Quitline, a 24-hour, toll-free number resource. Callers access a smoking cessation program that combines expertise with local knowledge and services. Those who enrolled received referral to trained pharmacists and community groups. Vouchers are provided to low-income residents obtain effective pharmaceutical cessation products.

More than half of the pregnant women in the state are enrolled in WIC. Program participants are encouraged to stop smoking and are referred to cessation services.

Preventing infant mortality and associated risks is a primary objective of the Delaware Division of Public Health and the Delaware Healthy Mother and Infant Consortium. Accordingly, counseling and referral to smoking cessation services are included in each of the Infant Mortality programmatic initiatives to date. These include the preconception health programs that were implemented in FY 2007 and the prenatal Comprehensive Family Team Practice programs that were expanded in FY 2007.

In May 2007, the Delaware Healthy Mother and Infant Consortium held a one-day conference "Pursuing Motherhood." The morning sessions were targeted to women at risk for low-birth weight and other adverse pregnancy outcomes. Lifestyle risks were highlighted during the sessions including the risks of smoking. Informational binders were distributed and community resources were made available.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Smart Start provides smoking cessation counseling, education and referrals to pregnant women who use tobacco.	X	X		
2. Family Practice Team Model programs provide smoking cessation counseling, education and referrals to pregnant women who use tobacco.	X	X		
3. Preconception Care programs provide provide smoking cessation counseling, education and referrals to women of childbearing age who use tobacco.	X	X		
4. Family Planning programs provide smoking cessation counseling, education and referrals to women of childbearing age who use tobacco.	X	X		
5. Registry for Improved Birth Outcomes tracks smoking during pregnancy as one of the key risk factors for poor outcomes (including low-birth weight, preterm birth and infant mortality).				X
6. Public Health clinics refer clients to Delaware's smoking cessation program, the Delaware Quitline, a 24 hour toll-free number staffed by trained tobacco cessation counselors.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Smoking continues to be a primary risk factor that is included in the State's Registry for Improved Birth Outcomes. Data from the registry suggest that about 20% of women with poor birth outcomes (low birthweight, preterm birth or infant mortality) smoked during pregnancy. As part of the Preconception Health Program, smoking cessation, before pregnancy is a primary objective.

c. Plan for the Coming Year

Delaware plans to expand its services through the Family Practice Team Model (a prenatal health program) and the Preconception Health Program.

The Delaware Healthy Mothers and Infants Consortium will continue to partner with key organizations throughout the state, including the Cancer Consortium and the Delaware Lung Association to advance policies and services targeted to the reduction of smoking and its associated morbidity and mortality.

State Performance Measure 2: *Percent of live births to women who have another birth in less than 18 months*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	9.2	9.2	9	9	9
Annual Indicator	9.2	11.0	11.0	11.0	11.0
Numerator	616	741	741	741	741
Denominator	6691	6766	6766	6766	6766

Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	9	9	9	9	9

Notes - 2005

2005 data will be available in 2007.

a. Last Year's Accomplishments

Based on findings from the State's pilot Fetal Infant Mortality Review interconception care, and birth spacing more specifically, were found to be significant factors in birth outcomes. The study recommended:

- Putting into place interconception care services that target high risk women and provide wrap-around services such as: nutritional counseling, family planning, genetic counseling, general health checks, bereavement support and psychosocial intake; and
 - Case management is needed for some women at high-risk for subsequent poor pregnancy outcomes. This case management could be provided through OB offices, DPH or insurance companies. The case management may be tiered for level of risk.
- To address these recommendations, the Family Practice Team Model was implemented to address high risk women.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning, Smart Start, Family Practice Team Model and Preconception Care programs emphasize the importance of adequate birth spacing for optimal birth outcomes.		X	X	
2. The Registry for Improved Birth Outcomes tracks birth intervals as one of the key risk factors for poor birth outcomes.				X
3. Teen pregnancy prevention programs work to address the issue of repeat teen pregnancies.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Since both short and long intervals between pregnancies has been identified as a risk factor for poor birth outcomes in Delaware, the Delaware Healthy and Mothers Infant Consortium continues to study the how to deliver a consistent message on birth spacing to women of childbearing age. The research and terminology (18 vs. 24 months, what constitutes the interval -- birth to conception, conception to conception, birth to birth, for example) are confusing to the lay public and it is not clear that "one recommended interval" is appropriate for all socio-demographic groups. The issue is particularly a concern for women who experience a loss and desire to become pregnant as soon as possible.

The State's Fetal Infant Mortality program continues to review infant mortality cases for risk factors and maintains a database of the information reviewed.

In 2008, a statewide information campaign was initiated designed to raise awareness of the

importance of preconception health. As the campaign progresses and awareness of "What is preconception health?" increases, different segments of the population will be targeted with different messages (risks such as smoking, chronic disease management, planning for adequate time between pregnancies, etc).

Each of the programs (Smart Start, Family Practice Team Model, Family Planning) provide education to clients regarding the importance of adequate spacing between pregnancies.

c. Plan for the Coming Year

In 2008, a statewide information campaign was initiated designed to raise awareness of the importance of preconception health. As the campaign progresses and awareness of "What is preconception health?" increases, different segments of the population will be targeted with different messages (risks such as smoking, chronic disease management, planning for adequate time between pregnancies, etc).

State Performance Measure 3: *The percent of extremely low birth weight black infants among all live births to black women*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	1.5	1.5	1.4	1.4	1.4
Annual Indicator	2.0	1.6	1.6	3.1	3.1
Numerator	266	224	224	442	442
Denominator	13571	13777	13777	14257	14257
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2007

The indicator is provision based on 2000-2004 reported percentage of very low birthweight black babies (<1,500) g. and total births of black infants.

Notes - 2006

2006 data are not available at this time.

Notes - 2005

2005 data will be available in 2008.

a. Last Year's Accomplishments

The primary goal of Smart Start is to link all pregnant women to early prenatal care. In 2007 over 1,200 women were enrolled in Smart Start.

DPH clinics offer pregnancy. Positive pregnancies are referred to a local obstetrician. Negative tested clients are referred to a gynecologist or local reproductive and sexual health clinic. DPH community health nurses accept referrals on positive pregnancy tests to assure early entrance into prenatal care and the Smart Start program.

The Family Practice Team Model programs served over 1,200 women in 2007.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smart Start and Family Practice Team Model prenatal programs throughout the state serve women at-risk of poor pregnancy outcomes with enhanced case management services. The Family Practice Team Model eligibility extends to two years post delivery.		X		
2. Delaware's Preconception Care Programs educate women about important health issues related to achieving an optimal pregnancy. The programs are targeted to women in high-risk zip codes throughout the state.		X		
3. The Registry for Improved Birth Outcomes continues to provide surveillance of subpopulations and risk factors for poor birth outcomes.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Improving access to care for populations disproportionately impacted by infant mortality remained a priority. Under the Infant Mortality Elimination Program, increasing enrollment in Medicaid and providing additional access to care for pregnant women are focal points. In support of this goal, the program has enhanced translation services for medical visits, provided prenatal vitamins to women in need and initiated a statewide education campaign on improving birth outcomes targeted to high risk populations.

Smart Start and the Family Practice Team Model programs continue to enroll at-risk women and facilitate access to prenatal care.

c. Plan for the Coming Year

In the coming year the Family Practice Team Model programs will establish community partnerships by conducting outreach, promoting participation in the program and raising awareness of the benefits of participation. The model will also be evaluated for effectiveness.

A related program, the Preconception Care Program, will continue to work with women to educate them about what they can do to maintain their health. The program will be expanded and new contracts will be awarded. An evaluation process will be established.

State Performance Measure 4: *The rate of children under age 1 who die as a result of Sudden Infant Death Syndrome*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	87	83	60	60	60

Annual Indicator	62.6	92.5	92.5	72.0	72.0
Numerator	41	49	49	40	40
Denominator	65545	52994	52994	55571	55571
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

This is a five year rate, based on 2000-2004 data.

Notes - 2005

2005 data will be available in 2007. The rate is a five year rate (1999-2003).

a. Last Year's Accomplishments

Back-to-Sleep continues to be promoted in the MCH programs including Smart Start, and Kids Kare. Educational sessions are offered and brochures are made available to program participants.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Back-to-Sleep is promoted in Delaware's MCH Programs through Smart Start, Kids Kare and Child Development Watch.		X		
2. Community Action Teams, as part of Delaware's Fetal Infant Mortality Review, continues to monitor and review SIDS deaths.				X
3. Co-sleeping has been identified as an emerging SIDS related issue in Delaware, both by the Child Death, Near Death and Stillbirth Commission and the Delaware Healthy Mothers and Infants Consortium.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Co-sleeping has been found to be related to infant deaths in Delaware. The Child Death, Near Death and Stillbirth Commission has taken action to develop a plan for addressing the issue of co-sleeping. The Commission has established a community action team to evaluate programs, task forces and educational awareness campaigns around safe sleeping practices education in Delaware and make recommendations for creation improvement or merging of initiatives to address the current number of SIDS deaths with safe sleeping practices factors.

c. Plan for the Coming Year

As recommended by the Child Death, Near Death and Stillbirth Commission, the Delaware Healthy Mothers and Infants Consortium will include, as part of a statewide educational campaign on improving birth outcomes, safe sleeping practices information and specifically target that information to minority community. The Consortium will coordinate its efforts in this regard with community organizations such as the Delaware SIDS Affiliate, the SIDS Alliance of the Mid-Atlantic, the Resource Mothers Program, Nemours Health and Prevention Services, Christiana

Health Care Systems and other hospitals and birthing centers throughout the state.

The Fetal Infant Mortality Review Community Action Teams have been directed to research national outcome studies on the "Campaign for Cribs" programs and develop and implement a Delaware Campaign for Cribs program if national data suggests this is an effective strategy.

State Performance Measure 5: *The percent of youth reporting any use of alcohol in the last 30 days.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	45	45	44	44	43
Annual Indicator	45.4	45.5	44.4	44.4	45.6
Numerator	1384	1324	1142	1142	1096
Denominator	3048	2910	2572	2572	2402
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	43	43	43	43	43

Notes - 2007

Data are from the 2007 YRBS, any alcohol use in the past 30 days for 9th - 12th grade students. Numerator and Denominator are based on survey responses. Weighted rate is 45.2% for those students reporting any alcohol use in the past 30 days.

Notes - 2006

Data are from the 2005 YRBS, any alcohol use in the past 30 days for 9th - 12th grade students.

Notes - 2005

Data are from the 2005 YRBS, any alcohol use in the past 30 days for 9th - 12th grade students..

a. Last Year's Accomplishments

School-Based Health Centers provided individual counseling for alcohol prevention and for children of alcoholics. The staff also worked with parents to improve their ability to speak to their children about alcohol issues. School-Based Health Centers also referred individuals to the Division of Child Mental Health Services, within the Department of Services for Children, Youth and Their Families, an to other available services.

Division of Public Health Staff, both at clinic visits and home visits, assess alcohol use during each client contact. Resources for cessation are suggested. The Division's trainers/educators provide education and information regarding alcohol use to the communities throughout Delaware.

During the 2006-2007 school year, over 1800 visits to the School-Based Wellness Center Clinics were identified as at-risk of alcohol or other drug abuse and/or dependence. Of the 14,802 students enrolled in the SBWCs, about 12.2% were identified as at-risk of alcohol or other drug abuse and/or dependence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Youth Risk Behavior Surveillance (YRBS) data is monitored and results are disseminated throughout the state.				X

2. School-Based Health Centers provide mental health and substance abuse counseling and referral to students.		X		
3. The Division of Public Health partners with the Division of Child Mental Health Services (the Single State Agency for child mental health and substance abuse prevention and treatment).				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

School-Based Health Centers continue to provide individual counseling for alcohol prevention and for children of alcoholics.

The Division of Public Health monitors youth alcohol use trends through the Youth Risk Behavioral Risk Factor (YRBS) survey. Results are shared with agencies and organizations throughout the State.

c. Plan for the Coming Year

School-Based Health Centers will continue to provide individual counseling for alcohol prevention and for children of alcoholics.

State Performance Measure 6: *Percent of youth during the last 12 months who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	23	23	23	23	23
Annual Indicator	27.4	27.8	28.3	28.3	26.6
Numerator	831	842	757	757	688
Denominator	3034	3034	2677	2677	2584
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	23	23	23	23	23

Notes - 2007

Data are from the 2007 YRBS. Numerator and denominator are based on survey responses. Weighted rate is 26.9% for 9th - 12th grade students reporting feeling sad or hopeless for two weeks or more during the past 12 months.

Notes - 2006

Data are from the 2005 YRBS.

Notes - 2005

Data are from the 2005 YRBS.

a. Last Year's Accomplishments

School-Based Health Centers provide mental health counseling and referral.

The Division of Public Health monitors the prevalence of youth depression through the Youth Risk Behavioral Factor Surveillance System (YRBS). Results of this survey are shared with Child Mental Health professionals and school staff throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Youth Risk Behavior Surveillance (YRBS) data is monitored and results are disseminated throughout the state.				X
2. School-Based Health Centers provide mental health and substance abuse counseling and referral to students.		X		
3. The Division of Public Health partners with the Division of Child Mental Health Services (the Single State Agency for child mental health and substance abuse prevention and treatment).				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The School-Based Wellness Center Director, Fred MacCormack, is a current Mid-Atlantic Scholar. The Division of Public Health, Mid Atlantic Scholars this year are working to develop a family health navigator model to work with the Sussex County Child Health Promotion Coalition. This model will include mental health services. The goal is to provide a model to the Sussex County Child Health Promotion Coalition for development of a Robert Wood Johnson Grant. The reason for this action is a disparity in life expectancy in Sussex County. The primary population to be served by this project is the large Hispanic population in Sussex County which has several barriers to care including economic, geographic, linguistic, cultural and Health care financing.

c. Plan for the Coming Year

The Division of Public Health clinics will continue to provide depression screening during any contact with youth regardless of the primary reason for the visit.

Students enrolled in the School-Based Wellness Centers will continue to be eligible for mental health counseling.

State Performance Measure 7: *The percent of Medicaid children, including children with special health care needs, under age 21 who receive coordinated, ongoing, comprehensive care within a medical home.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				90	90
Annual Indicator			89.6	93.8	94.2
Numerator			64586	81133	89704
Denominator			72064	86503	95253
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	95	95	95

Notes - 2007

Indicator for this performance measure is based on active enrolled clients in Medicaid under age 21 for calendar year 2007. Numerator are those clients enrolled in a HMO.

Notes - 2006

2006 data from Division of Medicaid and Medical Assistance

Notes - 2005

2005 data from Division of Medicaid and Medical Assistance.

a. Last Year's Accomplishments

The absence of a medical home for all children in Delaware remains a critical issue. Under the Ready Child section of Delaware's state plan for early childhood, Early Success II, the need for all children to have access to a medical home where they receive developmentally appropriate, coordinated care is essential to the optimal health of all children. To address the lack of a consistent medical home model in Delaware, the ECCS grant is providing opportunities to collaborate among agencies, medical providers, community stakeholders and policy leaders. The Division of Medicaid and Medical Assistance (DMMA) recognizes a medical home as a primary care provider. While this is one operational definition, a primary care provider may or may not embrace the AAP definition of a medical home model. By the American Academy of Pediatrics (AAP) definition, the majority of Delawareans do not have access to coordinated, comprehensive, client-centered care that is culturally competent. DMMA reports high usage of emergency room use for routine care among its 150,000 recipients. A survey conducted by DMMA in 2005, showed that many on Medicaid had never visited their stated primary care office and preferred to use the emergency room out of convenience. In 2007, ECCS and the Delaware Chapter of the American Academy of Pediatrics (DE-AAP) conducted a medical home survey of pediatricians and families of young children. The analysis of results indicates that the participating families were uncertain as to what is meant by a medical home, but were satisfied with the care received from their provider. The majority of providers who participated in the survey reported that they felt they were adequate in providing a medical home, but acknowledged that they could not meet all of the criteria defined under a true medical home concept. The DE-AAP has partnered with the ECCS grant project and the Division of Public Health's (DPH) Newborn Screening Project (NBS) to provide ongoing learning collaboration on a variety of maternal and child health issues, including medical homes, family-centered care, the role of the pediatrician in preventive oral health care developmental and mental health screenings, early detection and treatment of cystic fibrosis, phenylketonuria (PKU), and the linking to community resources and family engagement. During the past year, this partnership braided ECCS funds with NBS revenue to provide the funding for these learning collaboratives for medical providers and residency programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware's Learning Collaborative features Parent-				X

Professional Partnerships with an emphasis on continuing advancement of the Medical Home concept in Delaware.				
2. Public Health Maternal and Child Health Programs refer clients to appropriate resources including Medical Homes.		X		
3.				
4.				
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b. Current Activities

Delaware utilizes a learning collaborative model to sponsor a variety of early childhood family-centered health care topics, seminars, and forums statewide. This model encourages the participation of both the physician and their staff members in a more holistic approach. Additionally, the format of the learning collaborative model offers a pathway to include families and other early childhood stakeholders allowing for maximum participation and the sharing expertise.

On April 2-3, 2008, the Delaware Chapter of the American Academy of Pediatrics hosted a Parent-Professional Partnership, "Keys to Practice Improvement and Excellent Health Care." The forum was part of the continuing effort to advance the Medical Home concept in Delaware.

c. Plan for the Coming Year

A question was added to the Delaware Primary Care Physician Survey based on based on the Center for Medical Home Improvement's Medical Home. This question, "How familiar/knowledgeable are you about the concept of a medical home as defined by the American Academy of Pediatrics?" will establish a baseline indicator of need for training on issues related to medical homes in Delaware. Medical Homes will be included in the 2010 Needs Assessment as an area of interest.

State Performance Measure 8: *Hospital discharge rate for children from five through 17 years with asthma*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	20.3	19.3	17	17	17
Annual Indicator	19.7	18.5	18.5	18.5	18.5
Numerator	288	272	272	272	272
Denominator	146338	146652	146652	146652	146652
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	17	17	17	17	17

Notes - 2007

2007 Hospital Discharge data is not available at this time. The rate reported is provisional and based on 2004 Hospital Discharge data. This measure is similar to HSC #1, which reports Hospital Discharges for asthma for children under age 5. SPM Measure #8 is asthma related discharges for children aged 5 through 17.

Notes - 2006

2006 rate is provisional and based on 2004 data.

Notes - 2005

2005 rate is provisional and based on 2004 data.

a. Last Year's Accomplishments

The Division of Public Health does not have a "dedicated" Asthma program at this time. However, A number of environmental factors--cigarette smoke, particulate matter, ground-level ozone--impact people with asthma. Surveillance for these factors include the Delaware Behavioral Risk Factor Survey, the Division of Public Health's Youth Tobacco Survey, and The Department of Natural Resources and Environmental Control (DNREC) which tracks and reports airborne pollutants that can cause increased distress for asthma sufferers.

The Division of Public Health released a report in 2005, "The Burden of Asthma in Delaware." The report noted the following possible disparities regarding the prevalence of asthma in Delaware:

- The prevalence rate appears to decline with increase in income.
- The low-income--\$15,000 to \$24,999--category, when considered with other variables, may represent a key intervention target, given the spike in both lifetime and current rates for this group.
- The prevalence profiles of both Delaware men and women very closely track national patterns.
- In Delaware, as in the nation, women have higher prevalence rates -- both for lifetime and current asthma.
- The lifetime prevalence rate is quite consistent across all three counties.
- The current rate is highest for Kent County, followed by New Castle.
- A conservative estimate is that 23,400 children in Delaware suffer from asthma.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health collaborates with the American Lung Association and the A.I. DuPont Hospital and Pediatric Clinics on asthma reduction efforts.				X
2.				
3.				
4.				
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b. Current Activities

Delaware's Department of Education supports a Coordinated School Health Model which addresses students with Asthma. This model stipulates:

- Accommodating all students for full participation in physical activity;
- Obtaining a written action plan for every student that has asthma;
- Integrating asthma and lung disease education into the classroom via other subjects;
- Providing nutritious and safe alternative foods for children with asthma or allergies;
- Enforcing regulations that prohibit tobacco use on school grounds, school transportation and all school sponsored events;
- Offering Asthma Awareness Days/Nights to educate family members and communities;
- Providing and coordinating social services for students with Asthma; and
- Conducting asthma education opportunities for school staff.

c. Plan for the Coming Year

Delaware continues to seek external funding to support an Asthma program within the Division of Public Health. The Office of Children with Special Health Care Needs, in collaboration with the Early Comprehensive Childhood Systems Program will initiate an Asthma planning process in the coming year. Asthma will be one of the areas considered in the 2010 Needs Assessment process as well.

State Performance Measure 9: *The percent of young adults with special health care needs cared for in Delaware who transition appropriately to adult health and social services when they reach their 18th bi*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator		7	7	7	42
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	0	0	0	0	0

Notes - 2007

National Survey of Children with Special Healthcare Needs, 2005-2006

Notes - 2006

This information is based on the SLAITS Survey.

Notes - 2005

This information is based on the SLAITS Survey.

a. Last Year's Accomplishments

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 67.6% of families with CYSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CYSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave

pediatric medical care at A.I. DuPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To what types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. One-half of respondents did not have a specialist despite this perceived access and among those without a specialists 39% reported they do know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in the process of transitioning to adult services.

In April 2007, the Coordinating Council for Children with Disabilities held a Symposium on Transition at A.I. DuPont Hospital for Children. The day's schedule included a Pediatric Grand Rounds and keynote from Dr. Albert C. Hergenroeder from the Texas Children's Hospital. The sessions also included a parent pane featuring several parents of young adults with disabilities who discussed their successes and frustrations as they help their young adults navigate into adulthood. A.I. DuPont has created a full time position to improve the transition process for CSHCN.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Children with Speical Health Care Needs and the Coordinating Council for Children with Disabilities work closely with the A.I. DuPont Hospital for Children and its newly created Transition Office.				X
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3.				
4.				
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b. Current Activities

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008. In addition, the Office of CYSHCN also supports expansion of Internet based tools for families and youth with special health care needs. Through a contract with the University of Delaware's Center for Disability Studies, Delaware's website of transition information will be updated to include specific contact information for medical and social needs.

c. Plan for the Coming Year

The Office of Children with Special Health Care Needs and the Coordinating Council for Children with Disabilities will continue to focus on initiatives to enhance transition to adult services. The efforts will include: continuing to explore existing adult community services for individuals with medical conditions and disabilities for gaps in services delivery; continuing to educate adult health care providers on the needs of transitioning youth and their families; beginning the process of exploring collaborative efforts between pediatric and adult physicians; and beginning the process to explore ways to provide needed transition resources to families and youth who are in the transition process.

The Office of Children with Special Health Care Needs will continue its strong partnership with the Bridging the Gap project. The Project focuses on:

- Creating a state office that focuses on health issues of persons with disabilities;
- Developing a statewide strategic plan for health promotion and prevention of secondary health conditions in individuals with disabilities;
- Maintaining an advisory council that represents agencies and organizations from the health and disabilities communities as well as self-advocates and family members;
- Building and maintaining partnerships with health and disabilities organizations to address health and wellness issues of individuals with disabilities;
- Maintaining and improving Delaware's ability to monitor health and wellness for people with disabilities;
- Providing technical assistance, consultation, and training, either directly or through partnerships with state agencies and community organizations.

State Performance Measure 10: *Decrease the rate of deaths from 33 to 30 to children ages 14 years through age 21 caused by motor vehicle crashes.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator					
Numerator	33	27	27	27	27
Denominator	90423	90331	90331	90331	90331
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	0	0	0	0	0

Notes - 2006

Data are provisional and based on 2004 rate.

Notes - 2005

Data are provisional and based on 2004 rates.

a. Last Year's Accomplishments

The Division of Public Health and the Injury Prevention Coalition worked to develop a Delaware Strategic Plan for Injury Prevention, 2005-2010.

Delaware continued its graduated driver's license requirement for all drivers under age 18.

Emergency Medical Services for Children and Delaware Safe Kids hosted the seventh annual "Preventing Childhood Injury in the 21st Century" Conference in Dover, DE. There were 79 attendees from across the state.

Children in approximately 1000 classrooms statewide are participating in the Risk Watch Program. The program now reaches over 28,000 students in Delaware schools. The students gain knowledge to prevent injuries through the Risk Watch injury prevention program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Emergency Medical Services (OEMS) supported safer driver discussions underway through presentations and publications. OEMS staff produced information for an aggressive driving study.			X	
2. OEMS accomplished many Crash Outcome Data Evaluation System (CODES) projects: linking 2004 CODES data; preparing hospital hospitalization data; and generating fact sheets to support state and local agencies.				X
3.				
4.				
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b. Current Activities

Motor vehicle deaths are being analyzed in greater detail through the Crash Outcome Data Evaluation in Delaware. This system links state police crash data with EMS run reports and hospital discharge data to provide greater detail about motor vehicle crashes in Delaware. This information can help determine what prevention and awareness raising would be most effective in reducing these deaths.

The Emergency Medical Services for Children Program has published a new report, "2008 Childhood Injury in Delaware" which reports injury related data for Motor Vehicle Injury and Death, as well as economic costs.

c. Plan for the Coming Year

Delaware's highway safety objectives related to occupant safety include:

- To increase seat belt use from 87% in 2007 to 88% in 2008. In order to achieve an 88% seat belt use rate, Delaware must convert 8% of its current non-seat belt users into seat belt users.
- To reduce alcohol-related fatalities from 36% in 2006 to 33% in 2008 and to reduce the alcohol fatality rate per hundred million vehicle miles traveled from .61 in 2006 to .58 in 2008.
- Aggressive Driving -- To reduce fatal crashes resulting from aggressive driving behaviors from 52% in 2006 to 49% in 2008.

In support of these objectives, the state's police agencies will overtime enforcement to arrest violators of the state's seat belt/child restraint-, impaired driving- and aggressive driving laws on days of the week and times of the day when aggressive driving-related crashes have occurred. Officers will be directed to conduct enforcement at locations where aggressive driving-related crashes have occurred.

E. Health Status Indicators

//2008//The Health Status Indicators, similar to the Health Systems Capacity Indicators, provide a succinct description of the unique issues facing Delaware's Maternal and Child Health Population. Several of the measures regarding live birth weight are key indicators in Delaware's efforts to reduce infant mortality. As mentioned throughout this application, the Delaware Healthy Mothers and Infants Consortium, the legislated outgrowth of the Governor's Infant Mortality Taskforce, is charged with implementing 20 recommendations to improve maternal and infant health thereby reducing infant mortality. The Consortium and its 5 workgroups are periodically briefed on progress on each of these measures through the work of the Center for Excellence in Maternal and Child Health Epidemiology.

Beyond the target objectives of the Division of Public Health under the Governor's priority health areas, Title V staff use these indicators to identify trends and monitor progress under Title V toward improved performance of multiple systems. Emergency Medical Services for Children and the Division of Public Health's Family Planning and STD programs are key partners of the overall MCH effort in Delaware.

Note: The previous year application's language for this section has been deleted. Another section was erroneously duplicated here in last year's application.//2008//

F. Other Program Activities

//2009/ In addition to the identified priority needs, National Performance Measures and State Performance Measures, DPH addresses a number of additional priority MCH health issues. These include HIV/AIDs, Cancer and Women's Health.

African American make up 65 percent of AIDS cases even though they are only 17 percent of Delaware's population. More than 50 percent of Delaware's HIV cases occur in Wilmington. This disparity is addressed by several programs.

DPH's Office of Minority Health has implemented a capacity building program in the African-American Community and Hispanic Communities, providing technical assistance to organizations, helping to establish effective HIV/AIDS outreach, education, counseling and testing programs.

DPH's HIV counseling and testing program places special emphasis on meeting the needs of the African-American community. The program targets youth, injected drug users, their partners, men who have sex with me and heterosexual women. Testing is provided in locations throughout the state.

Delaware has made great strides in reducing Delaware's cancer incidence and mortality rates. DPH offers a comprehensive program to educate residents and prevent cancer, monitor the number of cases, offer access to cancer testing and treatment and establish legislation that protects the public from risks. As mentioned earlier, in addition to infant mortality, health disparities and the reduction of cancer incidences are main priorities of the Governor. Delaware maintains an established cancer registry to report incidence and deaths by race, gender and age group. Education and prevention are offered through a nationally recognized anti-tobacco program and the Delaware Quitline, a smoking cessation resource available statewide. The Screening for Life Program provides payment for cancer screening tests to qualified adults which includes office visits, mammograms,

pap tests, colorectal cancer screening tests and health education and help with coordinating associated care. Over 40% of women receiving pap tests through the Screening for Life Program are Hispanic which speaks to the success of the program in reaching a disparate population. Care coordination is available to every person diagnosed with cancer in Delaware to find medical and support services. The Delaware Cancer Treatment program pays for treatment for any uninsured Delawareans diagnosed with cancer that are below age 650 percent of the federal poverty level (an amount equal to an income of \$122,525 for a family of four.

The DPH Office of Women's Health sponsors an annual Women's Health Expo annually. This yearly event has been a successful due to partnerships with numerous organizations throughout the State. In 2007, over 700 people attended the Expo. The Office of Women's Health is charged with:

- Formulating and implementing a women's health agenda with community leaders and organizations;*
- Creating and strengthening partnerships to address key women's health concerns and promote disease prevention;*
- Providing outreach and education regarding health promotion, disease prevention and management for women;*
- Performing leadership development and community capacity building;*
- Disseminating data and research relating to gender-specific health care and treatment outcomes; and*
- Recognizing women's multiple, overlapping and sometimes conflicting social roles, and their knowledge and right to make decisions. //2009//*

G. Technical Assistance

//2009/ While the past State's needs assessment process has been conducted in a multi-faceted manner (i.e., reviewing existing reports, surveys, careful examination of data, discussions with professional and community leaders and groups and clients), there is a need to more fully examine overall program capacity. The state is asking for technical assistance at this time to determine optimal staffing patterns in each of the state's Public Health Clinics' Maternal and Child Health Programs. As noted in the budget, there are currently 26.4 FTEs that are supported with Title V federal funds and an additional 71.5 funded either through state general funds or appropriated special funds. As part of this request, the state is seeking technical assistance in designing an efficient system for tracking personnel hours and activities performed in the following maternal and child health areas: Pregnant Women, Mothers, and Infants, Children and Adolescents, and Children with Special Health Care Needs. Technical assistance would include identification of best practices, exploration of options for creating a system, development, implementation, and testing/evaluation of the system.

A second topic for technical assistance is the needs assessment. Currently, we are in the early stages of the 2010 Needs Assessment and have convened an internal working group which will expand in the near future. We have begun using the CAST V instrument in our initial environmental scans. We are investigating several avenues of needs assessment related technical assistance - these include assistance through either an MCH related consulting firm or through the Centers for Disease Control and Prevention (which may have such assistance available later in the year). At this time, a formal proposal for technical assistance has not been completed, however we anticipate such a request may be developed and submitted by December 2008. The primary purpose of the assistance would likely be to assist the State's stakeholders in a process of prioritization and ensuring priorities and selected indicators are not duplicative of existing/required measures. //2009//

V. Budget Narrative

A. Expenditures

//2009/ Title V Maternal and Child Health Block Grant funding has historically funded staff positions within the Division of Public Health's clinic-based MCH programs, including Smart Start, Kids Kare, Child Development Watch and the Oral Health program. As noted in the Technical Assistance section, Delaware is in need of an efficient tracking mechanism to report staff time and effort across programs and populations. The Delaware system that is used for financial reporting is scheduled to be replaced within the next two years and this presents a good opportunity to address this need.

An initial factor in fluctuations that may be apparent is that two years ago (for the FFY 2007 Block Grant Application), MCH staff reviewed staffing patterns and assigned positions' effort according to level of service and population. This resulted in some variation in the amounts reported by level of service and population from year to year over the time period this methodology was applied and adopted.

A second factor contributing to fluctuations from year to year across service types and populations served is an increase in state spending for MCH programs. In 2006, the State significantly increased its funding, primarily due to a 2005 task force report on infant mortality in Delaware. Since 2006, the state funds allocated to infant mortality has increased each year. Hence, there has been corresponding increases in the amount of funding reported targeted to pregnant women and infants. Over this same time period, the Division of Public Health has reduced some of its funding targeted to teen pregnancy prevention programs. So fluctuations/decreases in the amount budgeted/expended for children 1-22 are apparent. It should be noted, however, that Delaware does not include School-Based Health Center funding in the amount reported in the MCH-State Partnership. This annual budget from state funds is over \$6 million per year. Additionally, some of the funding that has been traditionally reported for the Kids Kare program for children 1-22, has been reallocated to Children with Special Health Care Needs in the budgeted funds/expenditures noted. This is not an actual shift in funds, but a recognition that Kids Kare also serves Children with Special Health Care Needs, as well as other children.

Form 3 reports 2007 funds were expended as budgeted, a total of \$12,458,136 in State and Federal partnership funds. The decrease in other funds from 2007 to 2008 was a result of the State no longer including Newborn Screening Revenue as part of the State Maintenance of Effort and shifting to Infant Mortality state funds. Form 4 reports the amount budgeted for infants increased significantly from 2007 to 2009. This is mainly an effect of state infant mortality funds and the result of reallocating staff salaries in the Smart Start and Kids Kare programs to this population.

Form 5, shows a decrease in the amount allocated to Direct Health Care Services from 2007 to 2009. This is mainly attributable to a review of program activities and allocating staff time accordingly, a recognition that some direct services were enabling services or population based services. //2009//

B. Budget

//2009/ The maintenance of effort remains the same with the State of Delaware continuing to provide an amount that exceeds the baseline maintenance of effort (MOE) established in Federal Fiscal Year (FFY) 1989. The baseline MOE was \$5,679,738. For FFY 2009, the State MOE is \$10,048,693. This amount consists of salaries and fringe for 73.5 staff (administrative, KIDS Kare, Child Development Watch, the Dental Program and Smart Start) totaling \$5,580,198 and funds budgeted for the State's Infant Mortality program totaling \$4,460,500.

The budget amount for federal funds includes an estimated FFY 2009 allocation of \$1,962,811 (based on level funding and the FFY 2008 estimated allocation) and an estimated \$485,507 remaining in FFY 2008 funds on October 1, 2008. These remaining funds are mainly due to staff vacancies.

Of the total \$2,448,318 federal dollars that are budgeted, \$1,690,998 are for salaries and fringe for 26.4 FTEs (Smart Start, Kids Kare, Child Development Watch, Oral Health and administrative staff). The balance of the federal portion of the budget includes: \$10,000 for travel expenses, which include the annual MCH Partnership and AMCHP meetings, as well as additional MCH training related opportunities; \$3,000 for supplies and materials (pamphlets, brochures and other media for programs); a required \$188,615 in indirect cost (calculated 16.47% of federal supported salaries); \$56,576 for other required expenses (state computer charges/federal staff, postage, phone lines, malpractice insurance, copies); and a state audit fee of \$3,296. The remaining funds will be used for several ongoing and new initiatives:

\$30,000 -- renewal of a contract with the Coordinating Council for Children with Disabilities. This contract provides education and mentoring for Council members, professional management of the Council (including support functions), broadening the advisory role of the Council (through the facilitation of communication of issues, grants, projects, etc. and collaboration with private/public agencies with goals consistent with the CSHCN program) and research activities.

\$20,000 -- These funds will support a new initiative, sponsored by the Children with Special Health Care Needs Program to distribute the new edition of Bright Futures to field staff throughout the state. A series of forums will be held to learn about the types of screening (developmental and physical health-related) that are being carried out throughout the state and to provide educational opportunities to learn about best practices in screening.

\$10,000 -- These funds will support a planning process to develop services for the prevention of obesity.

\$20,000 -- These will support a planning process to enhance the state's coordination of services related to Autism Spectrum Disorders.

\$29,000 -- These funds will support the Special Needs Alert Program (SNAP) for Children with Special Health Care Needs. The purpose of the program is to identify a special needs child when placing a 911 call. Parents/guardians enroll children in the Special Needs Alert Program (SNAP), by completing the following forms:

- **The Enrollment Form**
- **The Home Visit Information (or Home Information) Form**
- **The Emergency Information Form (This must be completed and signed by the child's physician. This is the form developed by the American Academy of Pediatrics.**
- **The Consent Form**

To better serve children with special health care needs in Delaware once again and encourage growth of the SNAP program we will hire an Administrative Specialist II for 24 hours (three days) per week through a contract with the Easter Seals of Delaware.

\$19,000 to enhance a pilot program, "Best Start." This demonstration project is funded by the Division of Public Health (DPH) Women, Infants and Children (WIC) Program Office and staffed by Milford Public Health Unit staff. Staffing includes the Nursing Supervisor, two Registered Nurses, and a Senior Medical Social Work Consultant. One nurse is an ILBC certified lactation consultant.

The project began on May 1, 2008 with the receipt of the WIC funded breastfeeding supplies available for use by the Smart Start "Best Start" mothers. The target population for the project is 35 prenatal clients interested in breastfeeding their infant for minimum of 6 months. The goal is to achieve 80% of mothers continuing to breastfeed their infants at 6 months. The MCH funds will support the purchase of educational materials for staff and clients, an opportunity for a RN to attend a lactation consultant course and a Breastfeeding Conference to be held in Spring, 2009. //2009//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.