



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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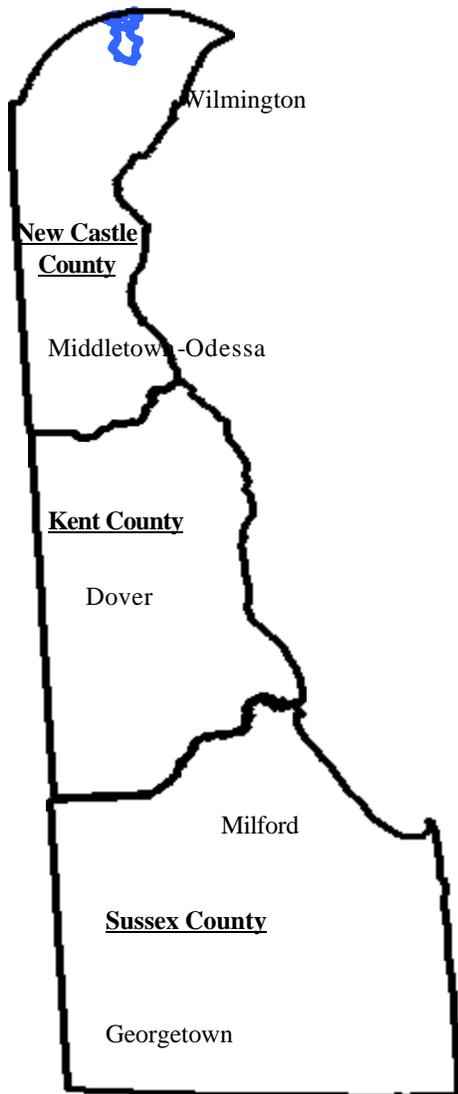
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1.4 Overview of the State



The State of Delaware is located on the eastern seaboard of the United States. A small state encompassing just 1,983 square miles, Delaware ranks 49th in area among all states. Three counties, New Castle, Kent, and Sussex, cover only 96 miles in length and 35 miles in width. The states of New Jersey, Pennsylvania and Maryland, as well as the Atlantic Ocean and Delaware Bay, border the State of Delaware.

Delaware's total population is approximately 730,000. The majority (57%) of the population is between the ages of 20–59. The population aged 0-19 account for another 27% and, finally, those aged 60 and up constitute the remaining 16%.

The top five employers, starting with the largest, include the State of Delaware, DuPont E.I. du Pont de Nemours and Company, MBNA Corporation, Christiana Health Care Systems and the Dover Air Force Base. The median income across the state is \$40,009 with the per capita income at \$15,854. According to an Urban Institute analysis of the most recent Population Surveys from 1995 to 1996, 11% of Delaware's population can be considered poor (less than 100% of the Federal poverty guidelines) and 18.9% are near-poor (between 100% and 199% of the federal poverty guidelines). 15.1% of all Delaware's children under 18 are poor. 23.9% of all poor Delawareans are minorities.

Although the state is relatively small, disparities exist across the counties with regard to access to quality health care services. Some of the problems are predominantly found in certain areas while others are common in each of the counties. For example, while it takes less than three hours to drive from one end of the state to the other, transportation is among the worst of problems in each of the counties. Coupled with the spatial distribution of primary care physicians and dentists, this results in critical access issues. Racial, cultural and language barriers lead to access problems and place added burdens on the system. The disparity in infant mortality, diabetes, and heart disease between blacks and whites is significant. Additional problems associated with limited access to quality health care services will be expanded on in the Needs Assessment portion of this application. The state is fortunate to have the involvement of its seven hospitals in not only ongoing and preventive care, but capacity building as well.

Most of them are participating in a variety of community based activities. (See the Needs Assessment: Infrastructure Building section for more detail.)

What are the State Health agency's current priorities and initiatives? The mission of the Division of Public Health (DPH) is to protect and enhance the health of the people of Delaware by:

- Addressing issues that affect the health of Delawareans
- Keeping track of the State's health
- Promoting positive lifestyles
- Responding to critical health issues and disasters
- Promoting availability of health services

Current DPH MCH related priorities include:

- Decrease infant mortality with a special effort to eliminate the disparity between white and black infant mortality
- Prevent teen pregnancy
- Improve the rate of immunizations
- Reduce the use of tobacco
- Implement service integration
- Prevent of childhood lead poisoning
- Improve in child care providers understanding of health and safety issues
- Address adolescent needs through school based health centers

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 Title V administrator used a variety of sources to analyze the competing factors which affect health services delivery. In particular, a needs assessment was completed based on parent surveys and focus groups, community needs assessments, discussions with key stakeholders, reviews of reports and analyses. The draft was shared with several community groups (Delmarva Rural Initiative, Perinatal Board, Part C Interagency Coordinating Council, Healthy Start, etc.) and interested persons. After the draft was distributed, meetings were held one in the southern part of the state and another in the north and recommended changes were incorporated into the document.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Delaware's public health system includes both the state and local functions in the same state agency administered as a single unit--the Division of Public Health (DPH). The Division is one of 11 divisions under the umbrella agency Delaware Health and Social Services (DHSS). The DHSS Secretary, Dr. Gregg Sylvester, reports directly to the Governor. Below are the organizational charts for the state government, DHSS and DPH.

DELAWARE HEALTH AND SOCIAL SERVICES



Secretary
Gregg Sylvester, M.D.
Deputy Secretary
Steve Boedigheimer

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DIV. OF MANAGEMENT SERVICES

William Love
577-4515 (237.5)

OFFICE OF THE CHIEF MEDICAL EXAMINER

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DIV. OF ALCOHOLISM DRUG ABUSE & MENTAL HEALTH

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DIV. FOR THE VISUALLY IMPAIRED

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DIV. OF MENTAL RETARDATION

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DIV. OF LONG TERM CARE RESIDENTS PROTECTION
Mary McDonough
Director

(16.0)

DIV. OF PUBLIC HEALTH

Ulder J. Tillman, M.D.
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DIV. OF SOCIAL SERVICES

Elaine Archangelo
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DIV. OF CHILD SUPPORT ENFORCEMENT

Karryl D. Hubbard
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DIV. OF STATE SERVICE CENTERS

Anne M. Farley
577-4961 (127.6)

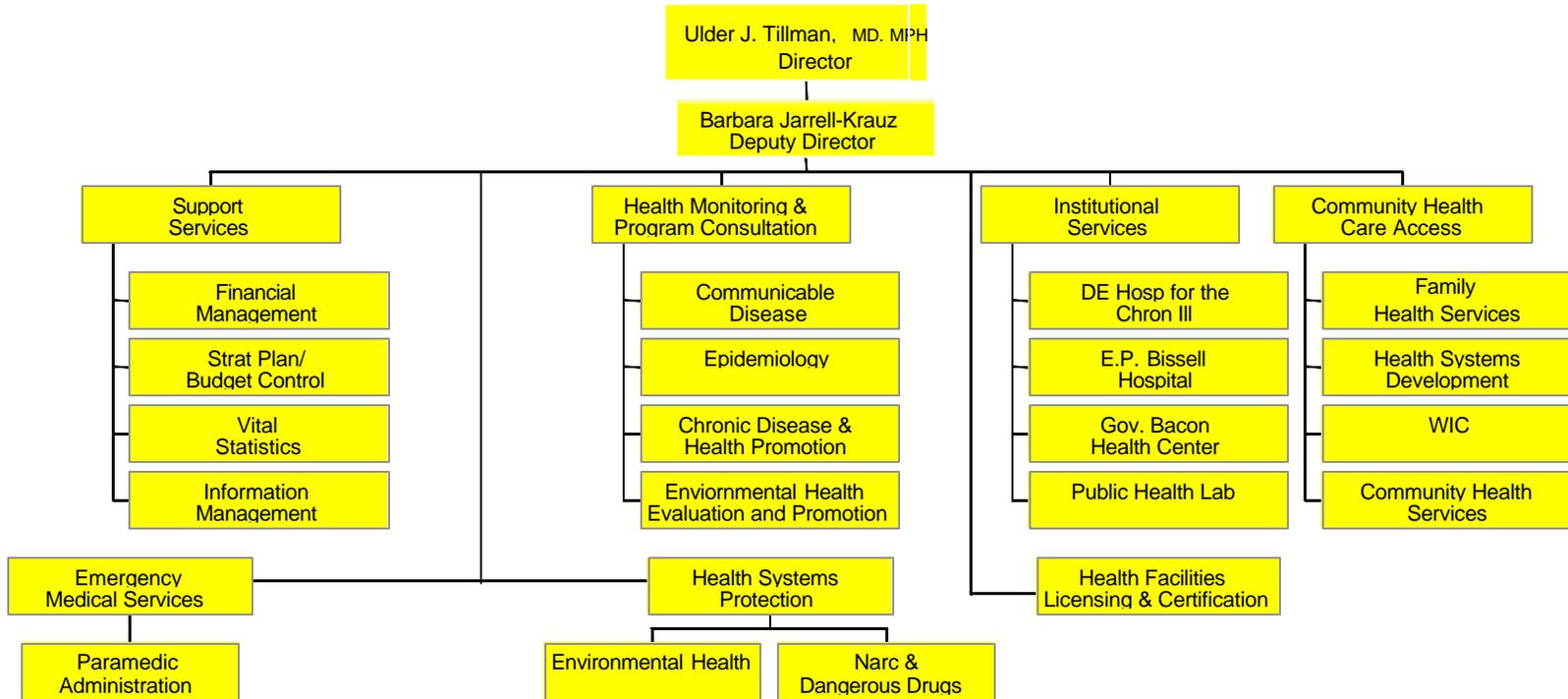
DIV. OF SERVICES FOR AGING & ADULTS WITH PHYSICAL DISABILITIES

Eleanor L. Cain
577-4660 (101.2)

Revised July 6, 1998

Position complements are as specified in the SFY '98 Budget Act (HB 375) Gregg C. Sylvester, M.D., Secretary

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH



It is important to point out that in Delaware, the MCH Block Grant is used almost exclusively to support staff positions that are assigned to work out of the local health units. All but 3-4 of those positions are assigned to the two local health units, Northern and Southern Health Services, and are responsible for service provision at the local level. As evidenced by Delaware's overmatch of its Title V funds, funding from a variety of sources including revenue, State funds and other Federal dollars, provide the majority of support for the State's maternal and child health programs. Other maternal and child health related programs such as immunizations, breast and cervical cancer, and childhood lead poisoning are located in other sections of Public Health making them further removed from the Title V program. Consequently, it is very difficult to describe the Title V funded efforts as distinct from the many maternal and child health efforts and programs being offered statewide.

Administration of Maternal and Child Health and Children with Special Health Needs programs are provided through the Community Health Care Access Section's Family Health Services Branch. This branch also includes infant mortality issues, child health including child care, and school based health centers. Family planning and adolescent health (primarily teen pregnancy prevention) are part of the Women's and Reproductive Health Branch.

In Delaware, statutory authority exists for the following services:

- Child safety seat legislation
- Seat belt legislation (effective January 1, 1992)
- Immunization requirements for entrance to schools and day care centers (enacted 1983)
- Birth certificates
- Trauma Registry
- Federal Omnibus Budget Reconciliation Acts of 1989 and 1990
- Mandatory reporting of certain notifiable disease, including lead poisoning
- Title XIX Medicaid EPSDT Federal Regulations
- Delaware Code for Optometry Services for Children
- Delaware Code for Services to Children with Handicapping Conditions
- Bike safety helmet legislation
- Newborn Screening
- Childhood Lead Poisoning Screening
- Mandated insurance coverage for PAP tests, mammography, immunizations and blood lead screening
- Birth Defects Registry documenting every diagnosis or treatment, or both, of any birth defect in any child under age 5 in the state.
- Infant and Toddler Early Intervention Services Act authorizing Part C of the Individuals with Disabilities Education Act
- State Children's Health Insurance Plan

1.5.1.2 Program Capacity

The Division has been attempting to move away from providing direct health care services and back to the basic functions of public health: assessment (collecting and analyzing information on the health and health needs of communities), policy development (developing public health policies based on sound scientific knowledge and principles), and assurance (committing to constituents that services needed to achieve health goals are available). Theoretically, the affect of managed care and increased involvement of the private sector (i.e., du Pont Pediatrics, Healthy Start) should have made it possible for Maternal and Child Health leadership to reemphasize the core values by supporting infrastructure building and population based services. However, since Title V funding has organized to provide direct services provided by the counties and has been tied to personnel, it has been extremely difficult to reallocate those resources. Finally, Title V has just started to closely examine services for CSHCN. The state has only had a Director for the last two years and is still in the infancy states when it comes to assessing needs.

1.5.1.3 Other Capacity

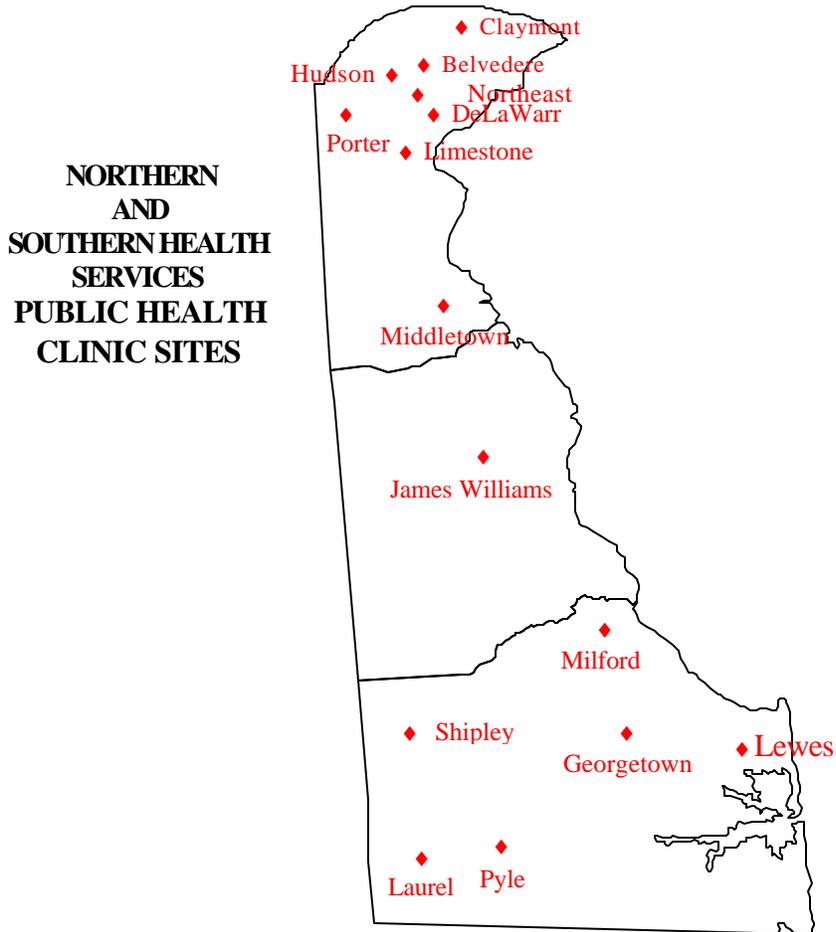
Joan Powell was appointed the Family Health Services Director (Title V MCH Director) in December 1997. (See Supporting Documents for information related to Ms. Powell and all pertinent personnel.)

The Children with Special Health Care Needs Director has resigned as of June 15, 2000. This position has a dual role of administering both the Part C early intervention program for the Division of Public Health and the Children with Special Health Care Needs responsibilities under Title V.

All the branches of the Community Health Care Access section have an effect on maternal child health for the state but particularly the Women's & Reproductive Health and Health Systems Development Branches. Supporting Documents include vitae on JoAnn Baker, Women's & Reproductive Health and the Section's Administrator, Prue Albright. The Health Systems Development Branch Director position is also currently vacant.

The Health Systems Development Branch has appointed a Primary Care Coordinator, Eileen Guerke, funded through Title V funds. She has the responsibility to work with other DPH programs to plan, develop and implement MCO prevention partnerships; develop an evaluation plan relating to Public Health core functions; coordinate and oversee the development of an annual report of services paid for by DPH under Medicaid managed care; work to problem solve MCO billing issues; work with the FQHCs regarding managed care issues; promote DPH specialty services in the private sector; and oversee biannual capacity studies of primary care physicians, dental services and specialist physicians.

There are close to 40 positions that are funded through Title V. Most of these positions are those working in the local health units, Northern and Southern Health Services. Leadership for the local health units is provided by Shirlee Kittleman for Northern Health Services and Barbara DeBastiani for Southern Health Services. Below is a map of the public health clinics.



1.5.2 State Agency Coordination

Delaware as a small state has many benefits, one of which is the greater ease of collaboration with a number of private and public agencies to address the maternal and child health needs of the state.

Title V, Division of Public Health works with all agencies, foundations, and constituency groups to assure that pregnant women, mothers, infants, children, adolescents and children with special health needs and their families receive the best quality service available.

Delaware Health Care Commission: The Delaware Health Care Commission is an independent public body that reports directly to the Governor and the General Assembly. It was established by the General Assembly in 1990 to develop a “pathway to basic, affordable health care for all Delawareans.” Serving on the Commission are the Secretaries of Finance; Health and Social Services; Children, Youth and their Families; the Insurance Commissioner and six private citizens appointed by the Governor; the Speaker of the House and the President ProTempore of the Senate. The Commission has administrative jurisdiction over the Delaware Institute of Medical Education and Research which allows Jefferson Medical College to function as Delaware’s medical school and over the Delaware Health Information Network which promotes an integrated health information network. The Director of the Health Systems Development Branch in the Community Health Care Access section provides support for the Commission.

The Family Service Cabinet Council: The Governor’s Family Service Cabinet Council is composed of Secretaries from Departments of Health and Social Services; Children, Youth and their Families; Education; Public Safety; Labor and Corrections; the Budget Office and Governor’s Office. The Family Service Cabinet Council established a plan called the *Services Integration Initiative*, which established a set of key indicators that could serve as benchmarks to reflect the extent to which the state is achieving its mission to strengthen and support Delaware families and help children achieve their full potential. Title V staff led or participated in several maternal and child health initiatives which include: adolescent pregnancy prevention, early intervention service delivery system supporting DPH’s Child Development Watch, the Home Visiting Program for first time parents, the Service Integration Initiative, reduction of infant mortality and low birth weight, and screening prevention for childhood lead poisoning.

Department of Health and Social Services: The Division of Public Health (DPH) resides in the Delaware Health and Social Services. Included in the Department are several agencies, which work closely with DPH. They are:

- Division of Social Services, Medicaid Office. Medicaid Managed Care organizations, First State and Delaware Care, contracts with DPH to provide services and works closely with Medicaid on a variety of issues including the Delaware Healthy Children Program (Delaware’s SCHIP), Child Development Watch operations, and the Transdisciplinary Pilot Project.
- Division of Mental Retardation (DMR). DPH collaborates with DMR on Traumatic Brain Injury issues, respite care, and Child Development Watch operations.

- Division of Alcoholism, Drug Abuse and Mental Health. DPH has worked with this agency on women's health issues and most recently in planning for a women's health conference.
- Division of State Service Centers. DPH has worked with this agency to improve Delaware Helpline, the toll free number used across the state for all programs. Several of our clinics are also housed within the Division of State Service Centers' locations and it has collaborated with DPH to give away child safety seats.
- Division of Management Services. This agency provides human resources, budget development, and evaluation services to other DHSS divisions. It also houses the Birth to Three Office which provides administration for Part C.
- Division for the Visually Impaired. DPH Child Development Watch works with DVI to provide service coordination for children with visual impairments or who are deaf and blind.
- Division for Aging and Adults with Physical Disabilities. DPH has worked with this division on a variety of initiatives for older women.

Department of Services for Children, Youth and Their Families: The Department of Services for Children, Youth and Their Families (DSCYF) was created in 1983 to consolidate child protective (Division of Family Services, DFS), child mental health, and juvenile correction services within a single agency. CHCA has maintained a cooperative relationship with this agency for joint planning of services. A Memorandum of Understanding (MOU) between the DPH and DFS establishes uniform criteria for responding to reports of abuse and neglect and delineates the responsibilities of DPH and DFS personnel. The MOU has just been revised to address the need for ongoing, collaborative training and joint case planning between personnel in each agency. DFS and DPH are co-located at several local sites where direct services are provided. DFS staff is housed at both sites of Child Development Watch and are fully incorporated into the multidisciplinary assessment team. In addition, DPH has collaborated with the Office of Child Care Licensing to improve the training and support for child care providers in the areas of health and safety.

Department of Education (DOE): The Delaware Health and Social Services and the Department of Education work collaboratively on developing and implementing EPSDT in the school setting and in providing support for school based health centers. The Department of Education has pulled together a Coordinated School Health Coalition which includes several commissions or task forces which include DPH participation. Some of the commissions are Health Education, Health Services, Nutrition Services and Counseling Services. The Department of Education has also collaborated with DHSS in development of the Part C early intervention efforts. Staff are also housed and incorporated into the CDW team and serve as liaisons for transition and Individuals with Disabilities Education Act (IDEA B and C) issues. (More information appears in the Population-Based Services section of the Needs Assessment.)

Federally Qualified Health Centers: The Office of Primary Care (in the Health Systems Development Branch) is co-located with the Title V administration (Family Health Services Branch) in the Community Health Care Access Section. The Health Systems Development Director assists as a facilitator to the Federally Qualified Health Centers and coordinates with the Family Health Services Director to ensure a variety of primary and preventive maternal and child health services.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures (See Forms 3, 4, 5 in section 5.8 Forms)

2.2 Annual Number of Individuals Served (See Forms 6,7, 8, and 9 in section 5.8 Forms)

2.3 State Summary Profile (See Form 10 in section 5.8 Forms)

2.4 Progress on Annual Performance Measures

Title V or their match dollars are used to support many of the activities and thus the accomplishments related to both the national and state performance measures. While most of the dollars go to the county health units to provide direct and enabling services, some of the dollars are used to support infrastructure and capacity building and population based services in both the central Title V office or those activities performed by the county units. As already described, it is difficult to separate Title V from other DPH initiatives, plans, and programs. Furthermore, it is equally hard to separate out a DPH role, for even when not taking a lead, DPH is usually an active participant.

Although these performance measures and their relationship with the Maternal Child Health Block Grant were just established in 1998, the Division of Public Health and its collaborating agencies have a long history of supporting interventions that will help us to effectively meet our goals.

Services for Children with Special Health Care Needs (CSHCN)

Title V provides leadership and some funding for services having to do with children with special health needs in the state. There are other private and public agencies which also have a lead role which impacts this population. Among them are other agencies in DHSS, specifically Medicaid, the Birth to Three Office in the Division of Management Services, the Division for the Visually Impaired, and the Division of Mental Retardation. The Department of Services for Children, Youth, and Their Families has the primary lead on child mental health issues. The Department of Education ensures that CSHCN are provided with a free appropriate public education. A major private provider is the duPont Hospital for Children, which also administers pediatric clinics. There are also numerous private therapy providers. Goals for children with special health needs cannot be met without the collaboration of these groups.

In reviewing Title V's ability to meet the performance measures for CSHCN, despite the efforts made to conduct a needs assessment, we still do not have all the data necessary to determine if we are meeting the measures. Since DPH does not actually have a CSHCN program which provides services, it was difficult to find a population to survey and the response did not meet our goals. While we are able to collect some information on those whom DPH serves and those served by Medicaid, it is impossible to know whether we are meeting the needs of the population that we do not serve.

Performance Measure 1 (The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State (CSHCN) Program.)

Infrastructure Building

The percent of State SSI beneficiaries less than 16 who receive rehabilitative services from the Division of Public Health is 0. It has not been necessary for DPH to provide direct services to this population because all SSI eligible children are automatically eligible for Medicaid. Under Medicaid they are eligible for EPSDT services which includes rehabilitation such as occupational therapy, speech therapy, physical therapy and any durable medical equipment needed to support such therapies. DPH Title V staff have worked with Medicaid to establish EPSDT standards for all children. These standards are part of the Managed Care RFP and contracts.

Performance Measure 2 (CSHCN program provides or pays for specialty and subspecialty services):

Direct Services

DPH offers diagnostic and short term treatment services for some special needs for children especially in Kent and Sussex Counties where geographic access is limited. These services include cardiac, genetics, audiology and ophthalmology. DPH participates as part of the cleft palate/oral-facial clinical team in conjunction with duPont Hospital for Children. The oral facial clinic covers orthodontic treatment if needed. The genetic services include genetic counseling for families in Southern Delaware. Last year, the neurologist moved out of state removing availability of pediatric neurologists in the southern two counties, until October 1999 when a new contract began.

The Preschool Diagnostic Developmental Nursery (PDDN) provides early intervention services to infants and toddlers, age birth to three, and their families under the direction of Child Development Watch. Service delivery reflects a multidisciplinary team approach, and includes services such as special instruction, physical therapy, speech therapy, social work, and consultation services.

Enabling Services:

The Division of Public Health has the operational responsibility for Child Development Watch which screens, assesses, determines Part C eligibility, provides service coordination and ensures completion and

implementation for the Individualized Family Service Plan (IFSP). There are four locations: Milford, Kent/Sussex Counties; Limestone Road and Middletown, New Castle County; and Christiana Care in the City of Wilmington.

DPH provides services for at-risk children through its' Kids Kare Program. This program provides assessment, counseling and education by nurses, nutritionists and social workers to children who are biologically, nutritionally, psychosocially or environmentally at risk, factors that are highly correlated with a probability of delayed development. Enhanced services are available to Medicaid eligible and low income uninsured families of children up to age 21. However, a high priority is placed on the birth to six years of age children of this population. If there is a need for further intervention for infants born to mothers in the Smart Start Program, the enhanced care program for high risk pregnant women, they become eligible for Kids Kare services. Title V supports several positions that are responsible for providing the assessment and case management services under the auspices of Kids Kare as well as program administration.

Performance Measure 3 (CSHCN who have a Medical Home):

Since 1996, Medicaid has provided its services through the Diamond State Health Plan, a managed care method of coverage. The premise of the Plan is that all children served by that plan have a medical home. This is also a premise of the state's SCHIP program (Delaware Healthy Children Program) and the premise that we used to determine if children with special health care needs have a medical home. Also considered in the count were children served by the Division of Public Health and one small clinic at the duPont Hospital, the CSHCN Clinic. We had to use a rough estimate for the number of CSHCN (8.5%) which was based on a brief by Dr. Henry Ireys, "Applying Concepts and Data from the NHIS Child Disability supplement to State CSHCN Program Planning." At this time, the estimate for CSHCN with a medical home is 52%, an increase since last year's estimate of 43.2% and over our targeted 47%.

Although data is difficult to find, there are accomplishments related to medical homes for children, which are addressed in the following section.

Enabling

Child Development Watch has made great efforts to include each child's primary care physician (PCP) as a member of the Child Development Watch (CDW) multidisciplinary assessment team. If the family does not have a medical home the CDW service coordinator works with the family to obtain one. Children receiving Kids Kare services are also referred to a PCP for a medical home.

Infrastructure Building

DPH has developed a system to ensure that children are linked with a medical home. DPH nurse liaisons with St. Francis Hospital and Christiana Care Health Systems, Inc. receive referrals for at risk infants and children and where necessary, refer to pediatric providers. DPH nurse liaisons are also stationed in private

physicians' offices and DuPont Pediatric Clinics in addition to hospitals. The Home Visiting Program for first time parents requires the first visitor to assess the family for a "medical home." Again, if necessary, referrals are made. To support this effort, all referrals into Central Intake are checked within several databases to determine if the child has a medical home or regular provider.

Performance Measure 11 (CSHCN in DPH programs with a source of insurance for primary and specialty care): The 1998 information shows that 64.9 % CSHCN in DPH have Medicaid or private insurance which is about the same as last year. Private insurance was included this year but we did not have the information for 572 children. Included in the count were children in Child Development Watch (CDW), Specialty Clinics and the Kids Kare program. Our target of 80% was not met but we expect this may be a data entry problem rather than an insurance access one.

While most of the children are insured, many may be uninsured for certain specialty care services such as therapies. Although Medicaid covers these services, many private providers do not. Part C dollars are used for Part C eligible children in Child Development Watch.

Enabling

Child Development Watch staff have been particularly instrumental in helping children to enroll in Medicaid, the Delaware Healthy Children Program and Medicaid's Disabled Children's program which waives parental income when a child meets certain disability criteria.

Performance Measure 14 (assuring family participation in CSHCN program and policy):

The Title V program has more work to do to involve families of special needs children.

Enabling

Child Development Watch (including Title V staff) has included the family in every step of their process. Families are integral members of the Child Development Watch team through participation in standards development, monitoring plans, and monthly family forums. CDW has also coordinated with Partners in Policy Making to ensure that their families are aware of available advocacy training and that the training provided includes information about CDW.

Infrastructure Building

Parents have been invited to serve on the Needs Assessment Advisory Task Force. However, few actually came to meetings. To address this lack of participation, the CSHNC Director phoned each parent to assess how they might participate. Parents reported a sense of being over-whelmed with their child's activities of daily living and having no time during their hectic lives which include child care for a child with special needs plus other children, work, house, physician and therapy appointments. Several parents who

participate in other state committees stated that they pick and choose which committees they participate in because they get called upon to participate in every state and community special needs committee. Active parents state that they feel many other parents of special needs children are intimidated to be at a meeting with professionals and that meetings are not held at locations and times that are accommodating to special needs families. The CSHCN Director tried other tactics to solicit participation such as, including having parents review minutes and share comments; additional phone calls and letters, and working lunches for parents in their community. All received poor responses.

Parents are included in review of the block grant. Drafts were shared with both the Perinatal Board and the Interagency Coordinating Council for Part C, which include parents as members. The Chair of the ICC is also the State Coordinator of Family Voices in Delaware.

One problem that Delaware faces in involving parents is an inability to pay them. Since funds are limited, it is unlikely that the state will be able to hire a family member consultant or provide much financial support for parent activities.

Preventive and Primary Care Services for Children

The provision of preventive and primary care services for children is another joint public private partnership. Since the advent of Medicaid Managed Care and the introduction of the duPont Pediatric Clinics in the last few years, the DPH role in direct care has decreased substantially. However, as stated previously, DPH has liaisons at each clinic site to ensure continuity of service delivery. Finally, this accomplishment allows DPH staff to be more involved in population based and capacity building endeavors.

Performance Measure 5 (Children through age 2 who have been immunized):

The data for this application came from the Center for Disease Control and Prevention's National Immunization Program annual surveys to determine the estimated vaccination coverage (National Immunization Survey). For the fiscal year 1999, Delaware's completion rate was 75.4% (plus or minus 6.3%) much higher than the original baseline data of 51% in 1990. However, this represents a substantial drop from 81% as was reported last year and the target of 83% was not met. Reasons for this drop are not clear. Some opinions are that physicians are not consistently tracking. Last year when DPH reviewed records for a Combined Vaccine Assessment, records showed that 79.7% of children under 2 in day care centers were up to date with their immunizations and 78.3% of children at Head Start Centers were up to date. These figures are consistent with the survey data. This analysis found that only 36.2% of the children in Public Health clinics were up to date with their immunizations. This record review is consistent with the fact that Public Health does not serve as the primary care provider and when a child comes to the clinic he

or she is often not up to date. After receiving a vaccination, he or she is referred to their PCP for subsequent vaccinations.

DPH is addressing this issue on several fronts. See Annual Plan for new initiatives.

Direct Services

Southern Health Services has a contract with Delmarva Rural Ministries, funded by the immunization grant to support immunization activities provided on a mobile treatment health van, called the MATCH van. The van travels to many small rural low-income communities through Kent/Sussex. Outreach workers help to identify persons in need of immunizations, which they can then obtain on the van. This year they hired an additional staff person to handle immunizations for their Match Van clients.

Population Based Services

All children are screened for immunizations as part of their visit in the remaining Well Child Clinics. Southern clinic staff have sent letters to school nurses regarding immunization requirements and are participating in a variety of health fairs. Emphasis is placed on special populations, such as the Amish in Kent County. Client volume remains high at the Amish Clinic despite the loss of a pediatrician. This loss, and the resulting lack of provision of sick care, has not affected immunization and well child check-ups which are provided by a Pediatric Nurse Practitioner.

Performance Measure 7 (third grade children who have received protective sealants on at least one permanent molar tooth):

During the past three years, Delaware, through its Health Care Commission, Delaware Health and Social Services and Southern Delaware partnerships, has been working to improve dental care. Some successes include: hiring a state dental director, raising Medicaid reimbursement rates and recruiting more dentists accepting Medicaid patients, and legislation requiring fluoridation of all municipal water supplies.

The Division of Public Health has tried several initiatives to support an oral health needs assessment for children. DPH requested Primary Health Care funding to conduct an oral health needs assessment of 500 children, ages 5-18 years old, in targeted areas throughout the state. Region III staff proposed to utilize University of Pennsylvania dental students, Christiana Care dentists and others to carry out a needs assessment. Both proposals were rejected. Until a needs assessment can be accomplished this performance measure data will continue to be a very rough estimate. A needs assessment is planned for the fall of 2000 that will use SSDI dollars. (See Annual Plan for more information.)

The data provided regarding this performance measure is based on those Medicaid clients receiving services through Public Health dental clinics. Our estimate is that 14.6% of third graders receive protective

sealants. Because this year's data was so different than last year's we further analyzed the results and determined that there was a reporting error last year. Only 15.4% had sealants in 1998. Data sheets have been revised to show that there have been relatively few changes during the last three reporting years. One of our concerns with reporting this data as reflective of all third graders is that the children seen in the clinics have very poor dental health and for most of them it is too late for sealants.

Direct Services

As will be described in the needs assessment, Public Health Dental Clinics continue to be the primary source of dental care for Medicaid eligible children. Children are scheduled for appointments in the dental clinic by school nurses and brought to and from the dental clinic by state drivers. They are returned to school following their appointment.

In Southern Health Services, Dental hygienists provide cleanings, scaling, x-rays, prophylaxis, sealants, and oral hygiene education which free the dentists to perform extractions, fillings, stainless steel crowns, sealants, etc.

Performance Measure 8 (Reduction of number of deaths from motor vehicle crashes for 1 to 14 year olds):

During the periods 1994-1998, the rate dropped to 3.3% from 4.2% in 1993-1997. Since Delaware's numbers are small, even looking at five year rates trends are difficult to determine. This total death rate for children 1 to 14 due to motor vehicle crashes was 23, which was 6 less than the prior period. Delaware's target was 4.1%, therefore we exceeded the target.

Infrastructure Building

The Delaware Emergency Medical Services for Children (EMSC) program used federal funds to administer childhood injury prevention subcontracts in 1999 and 2000. Three of the funded programs addressed this performance measure. One program targeted teen drivers and graphically describes the consequences of not wearing seatbelts and other responsible driving behaviors to high school students. The other two programs were child safety seat education and distribution to low income populations. One in particular revitalized a defunct safety seat loaner program in the State Service Centers.

The DPH Office of Emergency Medical Services also provides support to the Delaware Safe Kids Coalition. There is a .6 position to provide staff support and direct service for the Delaware Safe Kids Coalition funded through the Prevention Block Grant. This year General Motors awarded a Chevy van to the Safe Kids Coalition to promote child passenger safety in our state. This van travels throughout the state so that certified Child Passenger Safety Technicians can educate parents and caregivers regarding child

safety seat installation and seat belt use. The Safe Kids Coalition also gives child safety seats to those recipients in need who do not have a seat or whose children are riding in an unsafe seat.

Performance Measure 12 (increase numbers of children with health insurance):

The estimate for uninsured children 0 to 18 as provided by the University of Delaware's Center for Applied Demography and Survey Research is 15% which is a little higher than last year's estimate of about 13% .

Infrastructure Building

As described earlier, the Health Systems Development Branch Director (Community Health Care Access section) has been part of the planning process for Delaware Healthy Children's Program. Also described in the Needs Assessment section, is the Robert Wood Johnson grant received by the Division of Public Health to provide coordinated outreach to families without insurance into the program.

Performance Measure 13 (potentially eligible Medicaid children who have received a service paid by Medicaid):

According to the most recent Medicaid data, about a third of potentially eligible children have received Medicaid services. A careful review of the data provided during the last two years showed that this data was incorrect. Since the change to managed care, encounter data has not been accurate and is not distributed. We suspect that the 33% estimate is much lower than the amount of children actually getting served. During the last few years, we used an approximation of about 8.9% of potentially eligible children who did not enroll. This estimate has decreased to 7.5% based on the increased number of children being enrolled.

Enabling

Title V supported clinic and field staff all refer to Medicaid when they determine that a child may be eligible. However, since DPH is providing less direct services, there are fewer opportunities for referral. DPH continues, however, to provide liaisons with duPont Pediatric Clinics which refer potentially eligible children to Medicaid and refer children through Child Development Watch and the WIC program.

Performance Measure 16 (suicide deaths among youths aged 15-19):

As with other data, we have had to look at the number of suicide deaths through a five year period. Fortunately, these rates are low in comparison to U.S. data. The rates have been generally rising. However, between the years 1994 and 1998, the total number dropped to 17 for a rate of 7.3 per 100,000. This rate is not close to our target of 6.0 per 100,000. This was lower than the previous year when the rate was 7.9 with a total of 18 suicides reported. No suicides occurred in 1998, although six occurred in 1997. Because these numbers are so small and fluctuate greatly from year to year, it is difficult to provide any analysis.

Infrastructure Building

DPH both staffs and serves on the Child Death Review Committee which is described in the Needs Assessment portion of this document. A child death is considered preventable if one or more interventions (e.g. medical, social, legal, psychological) might reasonably have averted the child's death. Since the situations were so different for each suicide reviewed, it was impossible to pinpoint one or two specific systems recommendations.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

DPH, including Title V staff, have had a lead role in several efforts related to pregnant women, mothers, and infants. Other funding has supported a variety of initiatives such as Title X, Medicaid, and General Fund state Title V match dollars. Partners in these efforts are the Perinatal Board, Medicaid, the Alliance for Adolescent Pregnancy Prevention (AAPP), hospitals, etc. There have been many accomplishments and activities. (Others are noted in the annual plan.)

Performance Measure 6 (Lowering the birth rate among teenagers):

These statistics for this measure will seem quite different than those reported last year specifically because the denominator for the rate has changed with a new population estimate. The numbers look much better for Delaware than what was previously reported. Although Delaware has a long way to go before it meets its goals, it is definitely going in the right direction.

Delaware's teen birth rate for 15 to 17 year olds shows that the rate has dropped slightly from 43.6% per 1,000 teens for years 1993 to 1997 to 39.2 for years 1994 to 1998. Delaware has exceeded its target of 43%. Furthermore, preliminary data for 1999 shows that this downward trend is continuing with a birth rate of 37.2%.

Direct Services- Teen Hope

There are two major components of this program. First, this initiative has provided additional social work hours to provide intense one-to-one counseling to identify "at-risk" teens based on the Transtheoretical Behavior Change Model (TTM) at seven SBHCs. Social workers working on a one-to-one basis with at-risk students will determine the readiness of each student to chose abstinence or where sexually active, condom use.

Teen Hope also includes community sites and a specific youth development project modeled after the Carrera Model. Community work has included:

1. Southern Health Services:

- Contract with the two Boys & Girls Club to provide structured after school activities to at-risk high school students. Topics such as self-esteem and peer pressure are covered.

- Contract with social worker to provide services at a housing project and targeted areas for follow-up, case management, and referral for at-risk teens and their families. Services are provided singly and in group sessions.

2. Northern Health Services

- Contract with the Claymont Community Center providing counseling/social work services and a variety of group activities. The Center takes advantage of being collocated with the Children and Families First/ARC (A Resource Center) which has provided teen sexuality education since the 1970's.
- Carrerra Model project: The state will be initiating an official Dr. Michael Carrerra/Children's Aid Society replication project in the Riverside/East Lake communities of the Northeast in Wilmington. The model offers academic assistance including tutoring, family life/sexuality education, individual/lifetime sports, medical/mental health services, entrepreneurial/job skills, and self-expression through creative arts. Currently, the state has opened a program at the Kingswood Community Centers that offers components of the Carrerra model as described. The program will recruit seventh and eighth grade students.

Direct Services: Family planning services

Public Health oversees all Title X family planning services for the state. DPH and private agencies provide these services some of which are specifically aimed at teens during teen specific time frames. 50% of all clients are teenagers. No teen is charged for services. In 1999, 5,549 teens received services.

Population Based

DPH population based efforts include both broad-based statewide initiatives and local efforts. Both Southern and Northern Services have established Teen Pregnancy Prevention work groups and there is a statewide group as well. School based health centers are very active in addressing this problem through population-based services such as Lunch and Learn series and other group activities.

DPH supports the Alliance for Adolescent Pregnancy Prevention which is described in the Needs Assessment-Population Based Services section of this document. This alliance of a variety of agencies has the lead for most of the state's population based initiatives focusing on teen pregnancy.

Performance Measure 15 (Reducing very low birth weight live births):

There were 886 infants born with very low birth weights between 1994 to 1998. The five-year average has remained at 1.7 for the period of 1994-1998. This is higher than our target of 1.6 which was the rate in six prior five-year periods.

Population Based Services

The Perinatal Board's Community Outreach Committee is addressing this performance measure as well as related measures by working with the March of Dimes, Healthy Start, and Perinatal Association to implement pre-conceptual counseling "Think Ahead Train the Trainer Programs" to approximately 45 health care providers, educators, outreach workers and public health nurses. This program not only reached its goal to teach a minimum of 1000 women of childbearing age about pre-conceptual health care but went beyond the goal and reached 1200 women.

Performance Measure 18 (Increasing percent of infants born to women receiving care in first trimester):

Healthy Delaware 2000 set a goal of 85% for women entering care in the first trimester. Since the period between 1987-1991 where Delaware had a rate of 78%, the number entering into care has slowly risen to a high of 82.6% between 1994-1998. Our target has been reached for this time period. Kent County has the lowest percentage (68.3%) entering into care during the first trimester, followed by Sussex County (74.5%) and the City of Wilmington (79.9%). The rest of New Castle County had the highest level of early entry into care of 91.1%. There is also a disparity in entry into care with 86.5% whites entering care during the first trimester as opposed to 71.5% of blacks. Hispanic women had the lowest rate of early entry into care (67.8%).

Enabling

Smart Start is a prevention program designed to address the factors, which may negatively influence pregnancy outcomes. After the initial assessment, a basic package of education and counseling is provided to cover the main components of prenatal and child birth education and postpartum care of both the mother's and infant's needs. Based on an assessment of the client's needs and identified risk factors, interventions specific to the risk factors, to include teaching and counseling sessions, as well as referrals to other agencies and resources are incorporated into the care plan. Each family is provided with one care manager. The care manager is a person who has knowledge about health, nutrition, social services and community resources for pregnant women and their families.

Enabling: Addressing Kent and Sussex Entry into Care Issues

Women who make an appointment do not always have a Medicaid card in hand, and are being turned away and rescheduled. To help solve this, the Division of Public Health has worked with the Medicaid Office to develop a receipt program by which pregnant women can request at the time they submit their Medicaid application a form that verifies that they have submitted an application. The doctor's offices are willing to accept this form in lieu of a Medicaid card and will allow them two visits to give Medicaid time to process and send out the card.

The Division of Public Health also supports a voucher program in Sussex County where DPH provides vouchers to cover initial and revisits for patients with no insurance and who are under 250% FPL. Of

course, those who are at 185% of poverty and less qualify for Medicaid. This voucher program was initiated in 1998 after the closing of DPH prenatal clinics in Lewes, Pyle, and Milford precipitated by the advent of Medicaid Managed Care and presumptive eligibility for pregnant women. If clients turn out not to be eligible for Medicaid and fit the other above guidelines, DPH will provide vouchers until they qualify for Medicaid. Vouchers require participation in the Smart Start program to ensure appropriate follow-up with physician, keeping appointments, and applying for Medicaid when they become eligible. A recent review of data for FY 1999 showed that at the time of delivery, 97% of the clients had some type of insurance. Birth records for 60 clients were reviewed and it was determined that 72% initiated care in the first trimester and 63% of those had 10 or more prenatal visits. Plans are underway to expand this program into Kent County.

Performance Measure 4 (Newborns in the State with at least one screening):

Delaware has been very successful (99.7% in calendar year 1999) in meeting its goals for newborn screening. In addition, there are approximately 112 children screened by the Newborn Screening program who were not born in Delaware.

Direct Services

To ensure that all newborns are screened, DPH nursing staff conduct one home visit for residents who have delivered at home. In addition, the First Time Parents Home Visiting program ensures that newborns of new parents receive all necessary screens.

Performance Measure 9 (Increasing mothers who breastfeed):

Unlike a lot of states, Delaware collects this data when it collects newborn screening data. Despite the efforts initiated by several programs, the number of mothers breastfeeding upon leaving the hospital remains about the same at 60%.

Direct Services

The WIC program, a unit under the Community Health Care Access Section, has one of the lead roles for encouraging and enabling mothers to breastfeed their babies. One initiative administered by WIC has been the Breastfeeding Peer Counselor Program. As of June 30, 2000, this program will be disbanded because data has shown that it has not been effective. Instead the WIC program will be expanding its lactation consultant program to the community by locating them at Northern and Southern Health Services' clinics. These consultants will provide support to staff as well as to WIC clients.

Performance Measure 10 (increase percentage of newborns who have been screened for hearing impairment before discharge):

At this point, 72.6% of the infants born in Delaware hospitals received screens. This is an increase of over 10% from last year and exceeds the target of 60%. Christiana Care, where the majority of the births take place has a rate of 99.2%. St. Francis Hospital, in New Castle County just started providing screens for high-risk infants in 1999 and implemented full screening in April 2000. Nanticoke Hospital just started screening in May 2000. The Amish Community and the Birthing Center do not have access to hearing screens which affects about 200 babies per year.

Infrastructure Building

The CSHCN Director and neonatologist, from Christiana Health Care co-chair the UNBS Committee comprised of audiologists, nurses, public health staff, teachers, medicaid managed care representatives, and pediatricians, whose goal is to implement a state-wide Universal New Born Hearing Screening (UNBHS) initiative. The role of the CSHCN Director is to facilitate a statewide approach to screening, early intervention, data collection, quality management and evaluation. Still needed are a formal method of data collection, analysis, and reporting.

Performance Measure 17 (Very low birth weight infants delivered at facilities for high-risk deliveries and neonates):

The data reported this year includes both VLBW infants who were born in nearby Level 3 facilities (Crosier-Chester Medical Center) and those transferred to a Level III facility. Prior years data only included those VLBW infants born in Christiana Care. Therefore our numbers will look higher and are 83.3% for 1998 and 81% for 1997. We have exceeded the target of 81%.

Infrastructure Building

In 1997, the Perinatal Board worked with the delivering hospitals to establish the Perinatal Classification System, which designated Christiana Care Health Services as its Level III facility. All at-risk deliveries are referred to Christiana Care. If necessary, mother and/or infant are transported by ambulance or helicopter from the southern part of the state to the nearest facility. (See needs assessment section regarding infant mortality which points to Delaware having quality and availability of neonatal intensive care as reflected in high survival rates for the very low birth weight babies.)

STATE PERFORMANCE MEASURES

Children with Special Health Care Needs

State Performance Measure 10 (Hospital discharge of asthma patients): According to Healthy Delaware 2000, asthma affects about 28,000 Delawareans based on national prevalence rates. Hospital

discharge rates have been increasing rapidly in the child population. Two years ago when Delaware decided to use asthma as a performance measure, the decision was to follow the rates for children one through seventeen. However, since that point the MCH Bureau has requested that through the Health Status Indicators, we track children with asthma under five. In order to make this data more useful, we decided to track five through seventeen as a performance measure and of course, report the under five data in the Health Status report. In addition, in reviewing the data, we determined that instead of basing the denominator on total hospital discharges, it was more beneficial to base it on the total population. Therefore, our data for this category will change this year but we did go back for the last three previous years and recalculate. For both age groups, hospitalizations for asthma are decreasing. The rate of hospitalizations for children under 5 is higher at 45.2 per 10,000 children. However, this is a large drop from 59.3 per 10,000 in 1997. The discharge rate for older children seems to slightly fluctuate from year to year with rates of 21.2 in 1996, 22.7 in 1997 and 20.3 in 1996.

Enabling Services

The improvements to the DPH's Kids Kare program (i.e., standards, protocols) has enhanced our ability to provide enabling services for these children. The program offers teaching, monitoring of medications and medical follow up for children having asthma that were referred to the program. In addition, referrals are made to community services for any developmental needs or for medical supplies. In addition, the Child Development Watch program for infants and toddlers with disabilities and delays provides services. About 9% have asthma or are suspected of having asthma. DPH provides liaison activities at hospitals to assure linkage with a primary health care home and other needed resources in the community (i.e., Medicaid, Delaware Lung Association, Public Health Nursing, Home Health Care Agencies).

In addition, Medicaid managed care providers all have asthma case management programs and school nurses in each district monitor children with asthma. Every public school in the state of Delaware has a school nurse. The American Lung Association has received a grant providing nebulizers in every school and nurses have been trained in their use. The state School Board also just amended the Drug Free School policy so that children with asthma may carry a quick relief inhaler provided that they have permission of their physician and parent.

Adolescent health

Data presented regarding risk behaviors (except teen pregnancy) comes from the Youth Risk Behavior Survey which was administered to youth in 24 public high schools. Although this data does help the state to target areas of need, there are some drawbacks to using it. First of all, the survey is only taken every other year. Secondly, it cannot necessarily be generalized to other non-public high school students or non-students. However, these results are helpful in understanding current teen behavior and are the only benchmarks that we now have.

State Performance Measure 1 (Tobacco use by Teens):

Smoking clearly has an affect on infant mortality. Smoking around young children has a known relationship with SIDS and incidence of asthma. The best way to prevent tobacco use at all is to prevent people from even starting while they are young. The Healthy Delaware goal was to reduce the initiation of cigarette smoking so that no more than 15% of adolescents from ninth to twelfth grades smokes. The 1999 Behavioral Risk survey found that 23% of the responding teens smoked at least two cigarettes per day on those days that they smoked, a good indicator for a smoking habit. This percentage has decreased from 26% since 1997 when the last survey was completed. Despite the drop, we have a long way to go before we can achieve this goal but on many fronts the State has already initiated numerous activities to prevent tobacco use by teens. With the addition of the Tobacco funds garnered as a result of the nationwide lawsuit, the efforts are expected to intensify.

Population Based Services

There are a variety of tobacco prevention activities aimed at youth that are funded through DPH mini-grants. Two of these grants are:

- A University of Delaware/Cooperative Extension project provides the "Free for Life!" (National 4H Council) smoking prevention program to youth ages 8-12 enrolled in after-school programs in Wilmington/New Castle County sites. Each site receives at minimum 10 one hour lessons from the curriculum.
- The Boys & Girls Clubs in Newark and Wilmington provide the "Smoke Screamers" tobacco prevention program at two school-based after-school programs. This program is combined with educational and fitness activities.
- Another Boys and Girls Club in Wilmington provides a nutrition education and fitness program aimed at increasing knowledge about good nutrition, increasing physical activity, and decreasing obesity. They are currently planning to recruit youth in planning and production of eight 1/2 hr cable TV shows which send a strong anti-smoking message while informing the viewers of the unhealthy effects of tobacco. Each show will feature a different negative outcome of tobacco use, examine what factors lead youth to use or refrain from tobacco, and include a panel of youth who will field questions from the co-hosts and provide feedback on the topic from their perspective.

Infrastructure Building

The DPH Tobacco Prevention and Control Program along with Tobacco Free Delaware produced a plan to eliminate tobacco use in Delaware. In addition, this program is funding community-based organizations to develop and or expand programs for youth. Tobacco Free Delaware is a project of the IMPACT Delaware Tobacco Prevention Coalition which uses Robert Wood Johnson grant funds to support community programs and to develop and expand youth tobacco prevention efforts. This Coalition is supporting Teens

Against Tobacco Use groups in a number of high schools with plans to expand in the future. In February 2000, over 100 high school and middle school students attended the Governor's Youth Tobacco Conference. The event gave active students an opportunity to come together to plan for a statewide prevention and cessation effort.

State Performance Measure 2 (Alcohol Use by Teens):

The reduction of alcohol use for all is a strategy to reduce AIDS, motor vehicle injuries, poor pregnancy outcome, etc. According to the latest YRBS report, 47% of all high school students drank once a month. This is a small increase from the 1997 survey where 46.7% stated that they had at least one drink in the prior 30 days and it is not close to our goal of 37%.

Direct Services

One initiative that has a positive effect on all teen at-risk behaviors are the School Based Health Centers. To stem the tide of alcohol abuse, they provide individual counseling for alcohol and for children of alcoholics. They also work with parents so that parents can speak to their children about this topic.

Population Based Services

DPH provides some mini-grants that support alcohol prevention initiatives. These include:

- The Police Athletic League (PAL) provides the SLAM (Students learn About Mortality) program, aimed at reducing the number of teens driving, or riding with a driver, under the influence of alcohol in New Castle County. These activities include social events at which 40 youth leaders will distribute alcohol/substance abuse awareness promotional items and guide their peers to stay away from dangers of alcohol.
- The "Start Smart" program is aimed at prevention of tobacco and alcohol use. Pre-teens and teens meet each week. They take part in a variety of activities such as the use of the pulmonary function screen with simultaneous visual (laptop screen) and instantaneous graphing and participation in health fairs.

State Performance Measure 3 (Condom use by sexually active teens):

This measure will be replaced by a new State Performance Measure 3 addressing adolescent mental health concerns. See needs assessment for more detail on mental health and annual plan for specific information on the new performance measure.

While the state's goal is always abstinence, it recognizes that there are some adolescents who will engage in sexual activity despite abstinence interventions. The goal for the Healthy Delaware 2000 was to increase to 63%, the percentage of adolescents who report using a condom during their last sexual intercourse. In 1999, 62% of those responding to the Youth Behavioral Risk Survey (YRBS) stated that they used a

condom. This was a major increase from the last time the survey was done in 1997 when 53% of the students engaging in sex reported condom use. Clearly, we are making headway in reaching this goal.

The Needs Assessment Steering committee has recommended that this performance measure be eliminated based on the following:

1. This measure is clearly improving.
2. It is reported in other venues such as the Title V abstinence grant.
3. Its' effect is seen through the teen pregnancy measure.
4. Mental health issues have been identified as an over-riding need which affects youth and their behavior including sexual activity.

Direct Services

All teens receive basic contraceptive and disease prevention counseling when seen in STD clinic or when obtaining pregnancy tests through Family Planning clinics. Free condoms, including female condoms, are distributed in STD clinics. In other clinics, when appropriate, condoms will be provided (i.e., pregnancy testing.) Counseling on the need for the use of condoms is a clear message in both Family Planning and STD clinics. All are encouraged to make a gynecological appointment.

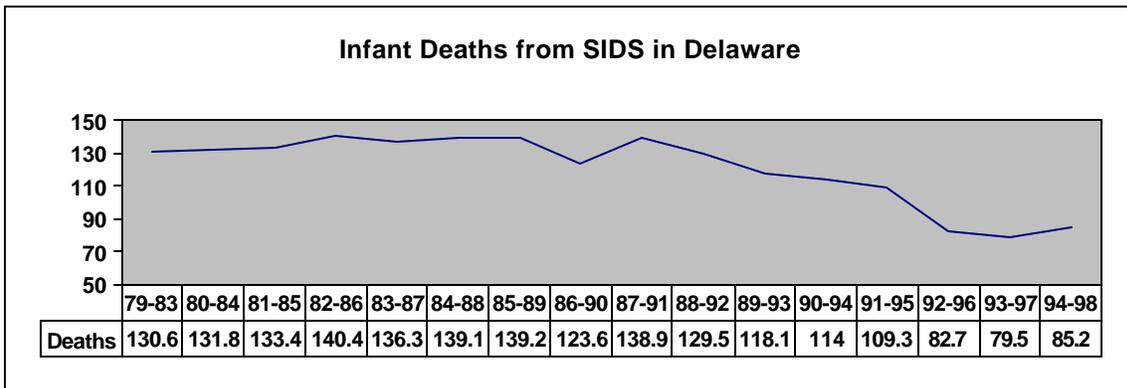
State Performance Measure 4 (Increase numbers of Medicaid eligible children under 3 receiving lead screens)

The state Lead Screening Program and Medicaid staff continue to be concerned that children in the Medicaid program are not getting screens as they should. This problem exists although all DPH staff are expected to link children to screening and PCPs are supposed to provide screens for all children under 6. These are some of the most vulnerable children in the state often living in older homes where lead may be a problem. The state has set a goal that in five years at least 50% will be screened. After a couple of percentage point drop between 1997 and 1998, the percent screened has increased to 33%. However, we have not met our target of 40% for 1997.

To continue to increase these numbers the Lead Screening Program has revised the DPH lead screening protocols to reflect HCFA requirements of lead testing for all Medicaid eligible children at 12 and 24 months and any child not previously tested. They are also working more closely with the Medicaid Managed Care agencies to ensure that the need for lead screening is communicated to primary care physicians and health benefits counselors.

State Performance Measure 9 (Decrease numbers of deaths from SIDS):

The Perinatal Board’s Scientific Committee completed a study which showed that if 75% of infants were placed on their back during the years 1990-1994, an estimated 28 infants could have been saved. In the spring of 1998, the Board set decreasing deaths caused by Sudden Infant Death Syndrome (SIDS) as its focus for year 1999. The Board worked diligently along with other organizations such as the March of Dimes, Public Health, Child Death Review Commission, Office of Child Care Licensing and others to get the word out. Unfortunately, the most recent statistics shows an increased rate of SIDS between 1993-1997 and 1994-1998. At this time it is unclear why the rate has risen.



Population Based

The Perinatal Board made this problem a top priority during the past couple of years. Current successes include 1) “Back to Sleep” stickers have been distributed and are secured on the isolettes in birthing facilities throughout the state to inform new parents that they should place their babies on their backs to sleep and 2) presentations to Kiwanis Clubs throughout the state to prevent SIDS information and to engage their support resulting in the Kiwanis making SIDS prevention their priority. Plans are underway which will involve education and communication to families and professionals. (See Annual Plan for more detail.)

All WIC sites and all duPont Pediatric Clinics received the “Back to Sleep” campaign literature. All DPH clinics have SIDS education brochures and show SIDS informational videotapes.

In addition, the Back to Sleep brochure is placed in the “Growing Together” portfolio given to all new parents upon discharge from Delaware hospitals and the Birthing Center. Peer education has been developed for nurses, physicians, and midwives.

Infrastructure: Further study is needed in the area of disparity and cultural competency issues. There are indications that the Back to Sleep message might not be reaching minority populations. The Division of Public Health will work with the Perinatal Board and its committees to address this issue.

State Performance Measure 5 (Percent of pregnant women using tobacco):

The number of women reporting tobacco use during pregnancy has been increasing slightly each year from 13.9 in 1996 to 14.2 in 1997 and again in 1998 to 14.9 despite the fact that the risks of smoking have been widely disseminated. Delaware has not met the target of 12% for 1998. The rate, however, is still lower than the 19.7 that it was in 1989. Goal 2 in the State Tobacco Control Plan is to increase the proportion of smokers who attempt to stop smoking. One of the objectives under that goal is to enhance smoking cessation efforts for pregnant women at both Public Health clinic and other health providers to ensure that advice and targeted quit-smoking materials are available to all pregnant women who smoke.

The Scientific Committee of the Perinatal Board determined that infant mortality is 1.57 higher for smokers. If exposure to smoking cessation programs increases the quit rate to 14.3% and 17.4% of smokers reduced their activity, 5 infant deaths in over 5 years could be saved. In addition to the crucial infant mortality issues, if the mother remains non-smoking there will be reduced respiratory problems such as asthma for their children and incidence of SIDS. Finally, changing anyone's smoking habits will have an affect on their risk factors for other diseases (i.e., cancer, high blood pressure). Public Health has initiated a variety of activities to affect this measure.

Enabling

Counseling regarding smoking is provided during all Family Planning and Pregnancy test visits. Once a woman is determined to be pregnant and, if at risk, receives services through Smart Start she receives additional counseling to quit. Other staff also offer health teaching to families who are receiving services.

Former State Performance Measure 6 (Adequate prenatal care for black women in Kent and Sussex Counties):

During the last 10 years, the state has used the Kessner Index as a method of determining adequacy of prenatal care. This Index looks at a combination of trimester of first visit, weeks of gestation and number of prenatal visits to determine whether women in Delaware are getting adequate prenatal care.

When the performance measures were developed in 1998, the participants in the process, noted that although Kent County had the worst adequacy of care rates, Sussex County also was behind the rest of the state. The most current data for 1998 shows that 47.5% (a decrease from 54.3% in 1997) of black women in Sussex and Kent Counties combined get adequate prenatal care as compared to 61% white women from Sussex and Kent Counties. There was a corresponding drop in adequacy of care for white women who had received adequate care at a rate of 66.6% this year. Further examination showed a reporting problem for

one of the hospitals which would account for the sudden drop. This primarily affected the data from Kent County.

New State Performance Measure 6 (Adequate prenatal care for black women):

National data experts seem to be using the Kotelchuck Index and the MCH Bureau is now requiring that we track access to care using the Kotelchuck. In addition, the Kotelchuck provides more accuracy in reviewing access because it takes into account number of prenatal care visits, month of first prenatal care visit, gestational age (date of birth minus date of last menstrual period, birth weight (in grams), and sex. Therefore, we have decided to use the Kotelchuck for this measure instead of the Kessner Index.

The Needs Assessment Steering Committee, after a careful review of the data, is recommending that we establish access to care for all black women as a performance measure while continuing to address the issue of access to care in the southern two counties. The rate for adequacy of care for all black women using the Kotelchuck index is 63.2% as compared to 71.3% for all white women. The widest disparity between the two races occurs in Sussex County where only 54.5% of black women receive adequate care as compared to 72% of white women. Kent County has an overall problem for pregnant women entering care as is discussed in the needs assessment. Data entry for visits also was incorrect for 1998, which affects the overall rate.

Enabling

As the result of the closing of Kent County Hospital's maternity center, DPH, through its Southern Health Services Administrator, took a lead role with a transition committee which worked to ensure that private doctors were ready to take additional patients and to ensure that the uninsured receive services. Clinic leadership in Dover's Williams State Services Center worked with the largest private OB/GYN practice in Kent County, OB/GYN Associates to enhance their available services. The practice renovated their current offices to provide space to DPH. A social worker and nutritionist are on site two days per week to do psychosocial assessments, nutritional counseling, WIC certifications, and to facilitate referrals to the Smart Start program.

Revised State Performance Measure 7 (Increase birth interval to more than 18 months):

The Perinatal Board's Scientific Committee studied data between 1990 and 1994 and determined the infant mortality rate for birth intervals of less than 24 months was over two times higher than when the interval was over 24 months and that reducing the short birth interval by 50%, an estimated 33 deaths would be prevented during a five year period.

However, in December 2000, the Title V Director requested that this issue be reviewed again because she had noted that most indicators were tracking birth interval between 18 months, not 24 months. The

Scientific Committee reviewed the available information and recommended that the state use 18 month intervals between births as a performance measure. This decision corroborates the findings of the Centers for Disease Control and Prevention which concluded that the wait between birth pregnancy is best between 18 to 23 months. A review of previous years shows that between 1992-1996 and 1994-1998, the rate of women giving birth 18 months after a previous birth has dropped from 9.9% to 9.4%.

Population Based

DPH staff provides counseling regarding this risk factor through its family planning clinics, first time home visiting program, Smart Start and Kids Kare.

Infrastructure Building

Public Health's Home Visiting program co-sponsored two workshops with Parents As Teachers on dealing with teen sexuality issues. Parent educators from a variety of agencies attended the two half day workshops. The goal was to increase the skills of those who work with teen first-time moms in order to help them better address the sexuality issues and impact on delaying a second pregnancy.

Former State Performance Measure 8 (Decrease percent of low birth weight black infants):

Unfortunately, the rate of low birth weight births to black women rose slightly from 13.5% between 1993 and 1997 to 13.6% between 1994 and 1998. This compares to a rate for white women of 6.6%, also a slight rise from 6.5%. This rate has fluctuated very little for both races in recent years.

Revised State Performance Measure 8 (Decrease percent of extremely low birth weight black infants)

The biggest single causes of infant death are disorders related to low gestational age or birth weight, and congenital anomalies. While congenital anomalies is the most prevalent cause of death for whites, the first cause of death for black infants is disorders related to low gestational age or birthweight. An analysis completed for the City Match Data Institute project by the Office of Health Statistics determined that the high-risk birth weight-gestational age categories are less than 28 weeks, and less than 1000 grams. More than twice as many black infants as white infants are born in the high-risk birthweight-gestational age categories. Because of these facts, we have decided to track data for and place the emphasis on extremely low birth weight of 1,000 grams or less. In the years 1994-1998, 1.7 of all births to black mothers were extremely low birth weight. This rate is almost three time higher than for births to white mothers where the rate was .6.

Infrastructure Building

Additional efforts are being made to address concerns regarding the disparity between white and black infant mortality rates. In September the Division of Public Health and the Perinatal Board hosted a series of meetings addressing the issue of the disparity between white and black infant mortality. The main speakers

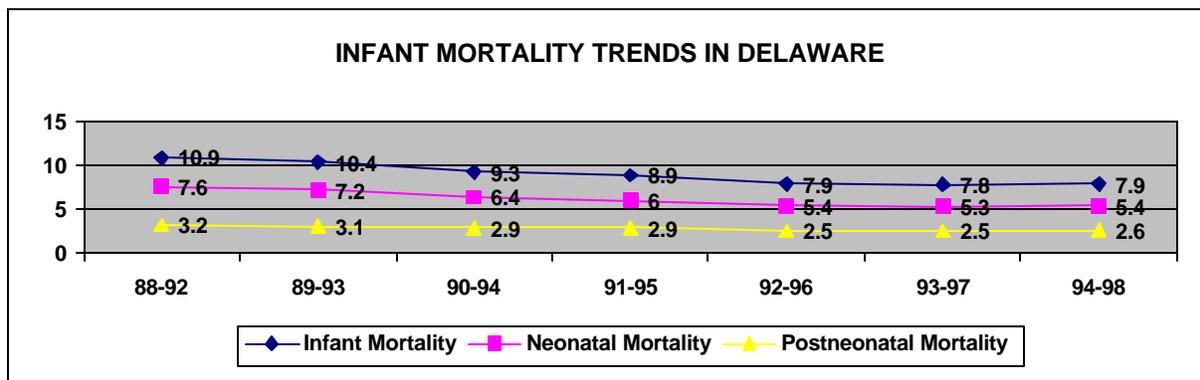
were Dr. Henry Spring, Acting Deputy Commissioner of New Jersey’s Health and Senior Services Department, Ilise Zimmerman, Director of the Northern New Jersey Maternal/Child Health Consortium and Yvonne Wesley, Director of Research and Development for the Consortium. The series of meetings included opportunities for community members and professionals to learn about New Jersey’s efforts to address the disparity problem. These meetings brought awareness of the issue to the state and renewed attention by the Board and other health professionals to tackle the issue. (See Annual Plan for future plans.)

DPH has collaborated with Christiana Care Health Services on several fronts in addressing this issue. DPH staff serve on the Executive Board for the Wilmington Healthy Start grant which is targeted to Wilmington which has a high minority population.

2.5 Progress on Outcome Measures

In reviewing Form 11, the reader will note that 1998 targets were not set for most of the outcomes measures because the data that we have depicts events from 1994 to 1998, a period of time prior to the establishment of the measures. As noted in the discussion on performance measures, the state’s efforts have been successful in gradually decreasing the rate from those that were significantly higher than the national rate (10.4 between 1989-1993) to the current rate of 7.9 per 1000 live births between 1994 to 1998.

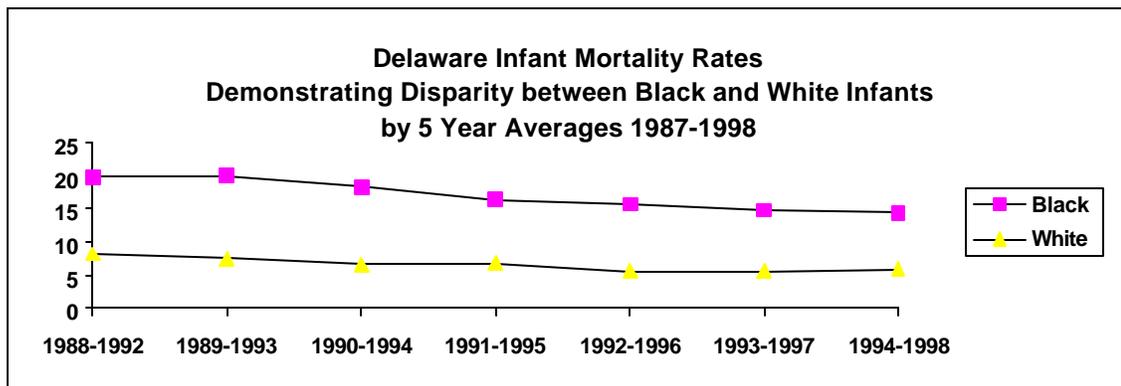
However, this represents a slight increase as compared to 7.8 during 1993-1997. The postneonatal five-year rate is now 2.6 per 1,000, also slightly higher than last period's rate of 2.5. The neonatal five-year rate shows a steady decrease from 8.1 per 1,000 between 1989-1993 to 5.3 per 1,000 between 1993-1997. As with the other rates, this rate has also risen slightly to 5.4. In the years 1991-1995 the rate was 10.2, dropped to 9.2 in 1992-1996, and to 9.0 in 1993-1997. (Please note: The figures shown here may be a little different than Form 12. These are the figures reported by the Delaware Office of Health Statistics, which rounds the numbers off a little differently than the format in the Grant application package.)



Since the Perinatal Board was just established in November 1995 and the most recent data is from 1994-1998, it would be difficult to attribute much of the overall decrease to its establishment. However, the fact that the Board

was established clearly demonstrates a concern about the rate by the state including the Governor, health officials and other leaders. Efforts by both DPH, other agencies, and the private sector have been in operation for several years. These efforts include DPH's program Smart Start and efforts by hospitals such as Christiana Care Health Services (formerly Medical Center of Delaware) in caring for neonates through its neonatal intensive care unit, the introduction of surfactant therapy, and the attention given to ensuring appropriate care for at-risk births. Finally, the rate for the United States is dropping and Delaware is in step with this drop.

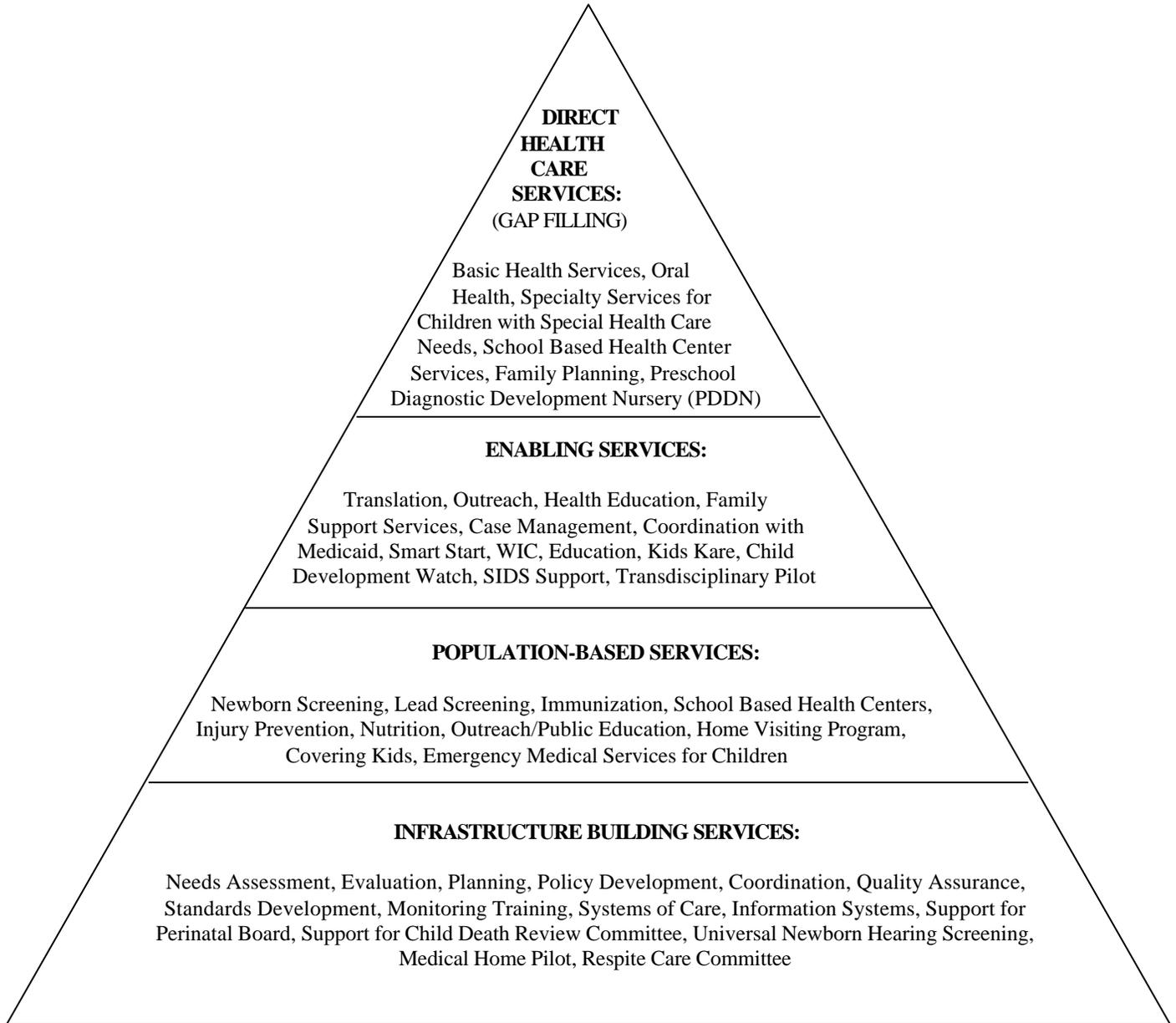
Besides the overall infant mortality rate, the state shares a concern with the rest of the nation regarding the disparity between the black and white infant mortality rates. In Delaware the compilation of the last five year averages since 1987-1991 show that the disparity has never been less than a rate of 2.2. It is currently 2.4 for 1994-1998, a slight drop from 2.6 for 1992-1996. This slight drop and the overall drop in infant mortality during the last period was based on a decrease in black infant mortality from 14.7 to 14.4 and unfortunately an increase in white infant mortality.



The five-year rates for child deaths 1 to 14 show a small decrease in the last five-year period from 23.5% in 1993-1997 to 22.1% in 1994-1998. This decrease comes after slight increase for each of the five-year periods prior to 1993-1997. The total deaths were 156 a drop from 162.

III. REQUIREMENTS FOR APPLICATION

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY:
Delaware's Division of Public Health**



3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

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 the reports and surveys as listed in the Supporting Documents section; 2) a careful examination of data with sources as listed; and 3) discussions with both professional and community leaders and groups and clients. For both the MCH component and the CSHCN component, Steering Committees were established.

The MCH Steering Committee consisted chiefly of the Division of Public Health, Medicaid, and Department of Education. In addition, discussions were held with Northern and Southern Clinic Managers, the Delaware School Nurses Association, the Robert Wood Johnson Local Coalition for the Covering Kids Southern Pilot, and clients. Drafts were shared with the Perinatal Board, Healthy Start leadership; Delmarva Rural Initiative; and Part C Interagency Coordinating Council and other interested individuals.

The State also held meetings that helped to further define health needs. Particularly as health care pertains to pregnant women, mothers, and infants and children, the MCH Steering Committee determined that much work had already been accomplished during the last couple of years in assessing needs. Delaware is a small state and concerns were raised that citizens not be oversurveyed. For these reasons and cost factors, primary data was not gathered particularly for this grant application and needs assessment. Surveys that were already in the planning stages were utilized such as the Hispanic Survey, and provider surveys. Community needs assessments also played a major role in determining state priorities. Data used included Vital Statistics Reports; Hospital Discharge Data; Youth Risk Factor Behavior Survey (YRBS); Behavioral Risk Factor Surveillance survey (BRFSS); Newborn Screening Data; Division of State Police; Reportable Disease Data; and School Based Health Center data. The State also reviewed the Needs Assessment Indicators as well, and incorporated this information into the overall plan.

In the future, Delaware will have data from the Pregnancy Risk Assessment Monitoring Surveillance Survey, which the Division of Public Health has decided to implement using its own state and federal dollars. There is some data that is not available to Public Health such as emergency room visit data, nonfatal injuries when not hospitalized, and Medicaid encounter data. To retrieve some Medicaid data such as for prior years required new programs to be devised that would have been costly.

Another long-range goal is to have the resources to administer a Fetal Infant Mortality Review (FIMR) program. Although Christiana Care had hoped to implement this program through its Healthy Start funds, plans were faced with roadblocks including personnel and liability issues. Recently Christiana Care and the Division of Public Health have begun discussions that may lead to a contract to undertake the process. This would enable FIMR to work more closely with the Child Death Review Commission.

The CSHCN Steering Committee consists of parents; physicians; school nurses; social workers; service providers; representatives from the Division of Public Health, Division of Mental Retardation, Division of Management Services, and the Division of Social Services (Medicaid), in the Department of Health and Social Services; Division of Mental Health in the Department for Children, Youth, and their Families; Division of Vocational Rehabilitation in the Department of Labor; Department of Education; duPont hospital for Children; University of Delaware; March of Dimes; Interagency Coordinating Council; Family Voices; and the Ecumenical Council.

The Children with Special Health Care Needs population is inclusive of children with varying levels of care and services. Children with special health care needs who reside in Delaware receive care and services from numerous programs and agencies. It was difficult to identify and assess the health care needs of all Delaware's special health care needs children since there is no one program that maintains a comprehensive data base. The Needs Assessment Steering Committee determined that the focus for this year would be children who have already been identified as CSHCN.

The state's CSHCN needs assessment process was conducted in a four-prong approach utilizing focus groups, a telephone survey, key informants, and review of national and state CSHCN surveys, reports and data.

The focus groups were conducted in January 2000 and were comprised of parents of children, ages 8 to 15 who attend a Delaware Specialty School. All children were described as caregiver dependent, developmentally delayed and physically challenged. Most of the children experience medical problems. A total of three focus groups were conducted, one in each of the state's three counties at the John J. Leach School, in New Castle County; Charlton School in Kent County; and the Howard T. Ennis School in Sussex County. The projected number of focus group members was 30; however, only eleven parents participated.

The CSHCN telephone survey was conducted in February 2000. Participants were parents of children ages 4 to 7 who received services from the state's Child Development Watch Program, Delaware's Part C early intervention program. The projected number of participants for the telephone survey was 500. One hundred and sixteen parents participated, a 23% response rate. One of the other surveys used during this process was conducted by Family Voices. Entitled *Your Voice Counts: The Survey of Health Care Experiences of Families of CSHCN*, the survey was conducted in 20 states. Within each state the goal was to survey 300 families. In Delaware 43 families participated, a 15% response rate. Nationally, there were 2,220 respondents with a 41% response rate.

Because of the complexity of the needs assessment process and the needs of our target populations, the State cannot feasibly cycle through the phases from analysis to development of plans in one year. The process needs to be an ongoing one with needs consistently being reviewed and programs constantly monitored, evaluated and revised based on determined need. As has been discussed in the Annual Report, Delaware's Title V program faces some specific difficulties in implementing programmatic changes because most of the available funds are tied up in

personnel allocation, which by its nature, determines and sometimes constricts program implementation. Nevertheless, despite these inhibiting factors, the state is able to make incremental program changes based on identified needs.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Status

MAJOR HEALTH ISSUES, STRENGTHS, AND WEAKNESSES OF THE SERVICE SYSTEM

ACCESS TO CARE

The Delaware Health Care Commission, as described in the Annual Report, was formed to address health access issues. It was recognized at the time that while uninsured individuals were able to access health care through hospitals, that care was uncompensated. Hospital emergency care, however, cannot take the place of preventative and primary care managed by a primary care physician.

Health Care Costs: In June 1998, a report prepared by the University of Delaware for the Delaware Health Care Commission, *The Total Cost of Health Care in Delaware*, reported that Delaware was “essentially in the mainstream with respect to personal health care expenditures.” The cost per person may be slightly higher but that is commensurate with the per capita income. Another point made was that payments for Medicare and Medicaid have continued to rise at a faster rate than payments by the private sector. Chief reasons for the rise in government payments are increases in the elderly population and efforts to increase health care access for the poor and specifically children.

Insurance Coverage: Another report completed in 1998 (and repeated again in 1999) by the University of Delaware for the Delaware Health Care Commission identified populations without health care coverage in Delaware. One identified reason for problems with health care access is no health insurance. The tables below list characteristics of this population from both reports.

Delawareans without Health Insurance 1996-1998	
70% are over the age of 17	80% are above the poverty line
57% are male	20% have household incomes over \$50,000
66% are white	78% are single
6% are Hispanic	51% are working
70% are over the age of 17	4% are self-employed.
66% own or are buying their home	14% live alone

Center for Applied Demography and Survey Research, University of Delaware 1998

Delawareans without Health Insurance 1997-1999	
65% are over the age of 17, 35% are children	75% are above the poverty line
49% are male, 51% are female	23% have household incomes over \$50,000
66% are white	72% are single
5% are Hispanic	40% are working
20% live alone	6% are self-employed.
66% own or are buying their home	

Center for Applied Demography and Survey Research, University of Delaware 1999

The characteristics of the uninsured change through the years. Between 1996-1998 and 1997-1999, the proportion of uninsured children increased; the proportion of uninsured women increased; the proportion of the working uninsured decreased; the proportion of those above the poverty line decreased; while the race and Hispanic proportions remained the same. These findings show that the approach to improving access to insurance must be multi-faceted. The Delaware Healthy Children Program could help to enroll children if their income is low enough, under 200% of the federal poverty level. However, it will not help those children whose parents are periodically unemployed or working but not covered by their employer and cannot afford coverage on their own. Significantly, 40% of those who are uninsured are working, although this per cent has decreased from 51% during the last period.

As with so many other health indicators, there are definite disparities in insurance coverage between racial groups. According to the study, black respondents have almost a 50% higher risk of being without insurance than white respondents do. Since Delaware's Hispanic population is low, data for Hispanics is subject to fluctuations. However, this study found that slightly less than 24% of Hispanics were without health insurance coverage which is double that for non-Hispanics.

Enhancing Communication: The New Castle County Perinatal Board Outreach Committee, the Delaware Ecumenical Council, and the Division of Public Health's Northern Health Services held a series of community meetings to assess the needs of the northern county. Statements of participants were in line with many of the other studies and analyses that have been completed such as need for dental care, child care, transportation, mental health, and insurance. Furthermore, it was recommended that Delaware could improve health care access by enhancing communication between community services via a central clearinghouse for health-related information. The clearinghouse could be accessed by telephone and by electronic mail. Participants also recommended that the state develop a "comprehensive, coordinated, community-friendly but scientifically based program of health promotion and disease prevention." Although the report acknowledged some excellent programs, participants believe that these programs are fragmented and "not accessible from a single source." Findings also led to a recommendation that a "large-scale program of community health advisors be supported." These individuals would function as outreach workers to the community to help individuals better access existing services. Finally, hearing leaders heard again and again comments from community members that we not address "maternal and child health" or "aging" issues but family issues since we function within families and what happens to one member affects the whole family.

Access to care on many fronts is of great concern in Delaware. This topic will be addressed throughout the document in discussions on racial and geographic disparities and access to prenatal care.

DISPARITIES

There are disparities throughout the health system in access and for specific populations. Below are the most significant of those disparities.

Racial Disparities between whites and blacks:

Infant mortality: As already described in the Annual Report, Delaware is concerned about its disparity in infant mortality. Delaware's Office of Health Statistics has been working with the Perinatal Board and the Division of Public Health to analyze causes for the disparity. One City Match Data Institute project analysis determined that on the basis of the available data, there should have been 68 black infant deaths in 1993-97 to equal the white rate. However, since the actual number of deaths is 163, there is an excess of 95 black deaths in this period. This analysis also showed that over half of all black infant deaths occurred during the first 6 days. There were some clear differences with cause of death. For white infants, congenital anomalies were the chief cause of death and for black infants the chief cause of death were disorders relating to short gestation and low birth weight. It was also determined that more black babies than white babies are born at extremely low birth weight.

HIV: As of April 30, 2000, Delaware ranks 5th in the nation for reported AIDS cases per capita. AIDS is the second leading cause of death among persons 25-44. One out of every 185 Delaware citizens is infected with HIV. It is a particular problem for minorities with 61% of the total cumulative case count African-American and 5.35% Hispanic. Currently, out of the 19 children receiving services through Ryan White, 16 are African-American. These numbers exceed the total percentages of those groups in the total population.

Diabetes: Data shows that Diabetes is high in Delaware particularly among African-Americans. In 1997, the Behavior Risk Factor Surveillance System (BRFS) reported that 6.4% Delawareans have diabetes. 6.9% of women reported having it as opposed to 5.9% men. However, 9.5% non-white females reported having diabetes. Mortality rates are also high, particularly in Sussex County. The five-year annual average 1993-1997 age adjusted mortality rate per 100,000 was 53.7 for black females in Sussex County. The overall average for black females in Delaware was 38.9. The overall rate for white women was 11.8 and 13.3 in Sussex County. According to birth certificate records, 3.7% of the births in 1997 were to mothers who had diabetes. Data does not break down the numbers according to whether the diabetes was gestational or preexisting. Also, since there were concerns with the consistency of reporting from the state's hospitals, this data is no longer reported.

To address Delaware's high rate, the state House of Representatives created a Diabetes Task Force. This group identified four barriers: education and awareness; access to coverage/obstacles to benefit coordination; labor intensive navigation of the system; and psychosocial factors. The Division of Public Health's Diabetes Control Program has developed seminars, support services and training for families and community leaders on current treatments for diabetes management and disease prevention strategies. Also the Division has provided free health screening and assessment for participants in the community intervention. The initial target population was African-American adults 35 and older in Sussex County. The Division has worked with a group of community leaders to form the Delaware Diabetes Coalition that is dedicated to reducing the burden of diabetes and its complications in Delaware. The coalition in collaboration with three managed care organizations developed a patient and provider

flow sheet to promote the use of quality standardized care. The flow sheets identify for both the patient and the provider routine procedures, tests and specialists visits that are necessary to reduce the complications of diabetes.

Asthma: Asthma can be considered as an indicator for primary care and overall child health in that with proper case management and adherence to proper regimen, occurrences can be minimized. This is another area where disparities between whites and blacks is very evident. Asthma (including bronchiolitis) is the number one cause of hospitalization for all children 1 to 9. However, while these diagnoses represent 15% of hospitalizations for white children 1 to 4, they are the reason for 23% of the hospitalizations for black children. This difference is more pronounced for 5 to 9 at 11% for whites and 24% for blacks. For white children 10 to 14 who are hospitalized, mental health issues become more evident. (See section on mental health gaps.) However for black children 10 to 14, asthma is still the chief cause for hospitalizations with a discharge rate of 13%.

Hispanics:

Delaware's estimated Hispanic population grew from 15,348 in 1991 to 31,158 in 1998, an increase of 103 percent. New Castle County had the largest estimated Hispanic population in 1998 (18,896) followed by Sussex County (9,672) and Kent County (2,590). Because the number of Hispanics is so small in Delaware, data is often not reported because of its lack of statistical significance. This population, however, is growing at tremendous rates. Sussex County showed the greatest percent increase in Hispanic population at over 262 percent. Estimated growth was also significant in New Castle County (84.2 percent), whereas growth in Kent County was relatively small (7.1 percent). Of the over 15,800 Hispanics added to the State's population over the period, Sussex County accounted for over 44 percent (7,004) of the total. According to the U.S. Census Bureau, Delaware's total population is expected to increase by 144,000 people, at a rate of change of about 20.1%. In comparison, the Hispanic population is expected to increase by 138.3%. These changes have already had an impact on health care in the state, particularly as it relates to cultural competency and access to care.

The rapidly growing Hispanic population in Sussex County prompted a specific survey effort conducted in 1999. DPH in conjunction with La Esperanza/La Red interviewed 482 Hispanic residents of Sussex County using a structured questionnaire. Respondents represented 961 individuals as members of their household, and this total represents between 5-6 percent of the estimated Hispanic population (approximately 17,000 residents and migrant workers). In addition to the survey, confirmatory and clarifying interviews with representatives of both La Esperanza/LaRed and local poultry plant health center staff were conducted.

80% of the respondents had incomes of less than \$20,000, but 77% had not applied for any type of public assistance. One issue that was noted was that adults are forced to convince program officials that they are "legal" in order to obtain employment or assistance. Of those that are employed, most work in a high-risk environment, usually the poultry plants.

As stated most were uninsured and only 10% of reported children were covered by Medicaid. Dental care was noted as a significant problem with 38% of survey respondents not having seen a dentist in more than one year. Of note, 47% reported being denied medical care, or avoiding seeking that care during the past 12 months. Approximately 25% of respondents reported needing medication or dental care but could not obtain these services because of cost.

Nearly 88% of the population surveyed speak Spanish only, which clearly shows a need for bilingual providers. In summary, transportation and reduced financial barriers were the primary needs identified following bilingual services.

Other information regarding needs of the Hispanic population were obtained in preparation for Christiana Care Health System's application for a Healthy Start extension grant in Southern Delaware. Christiana Care and Title V leadership held community meetings which identified several needs of the Hispanic population. Identified were translation needs, substance abuse treatment, inadequate housing, poor distribution of medical services, and lack of continued, appropriate health care once a pregnancy was determined.

Geographical Disparities: Access to Care

Overall health services in the rural part of the state are more limited in availability when compared to the northern New Castle County.

Sussex and Kent Counties: Sussex County is the poorest in the state with an estimated 30% of its residents below 200% of the federal poverty level as compared to 23% for the rest of the state. The unemployment rate is also higher and the average income about \$4,000 less than the state average. Key informants note several communities in Western Sussex and south of Georgetown that have particular difficulties in accessing care including Frankfort, Clarksville, Selbyville, Hickory Tree, Seaford, Laurel and Bridgeville.

The Office of Rural Health, in the Community Health Care Access section of DPH, in conjunction with the Delmarva Health Initiative contracted with a consultant to develop the Delaware Rural Health Plan for Sussex County. A draft of the plan has been distributed but it will not be finalized until the end of June 2000. The plan was developed by reviewing available data and reports and interviewing key stakeholders. The result was an environmental analysis of the county's multiple resources including sufficiency, quality, and gaps. Regarding the MCH population, the plan noted some of the following gaps in resources:

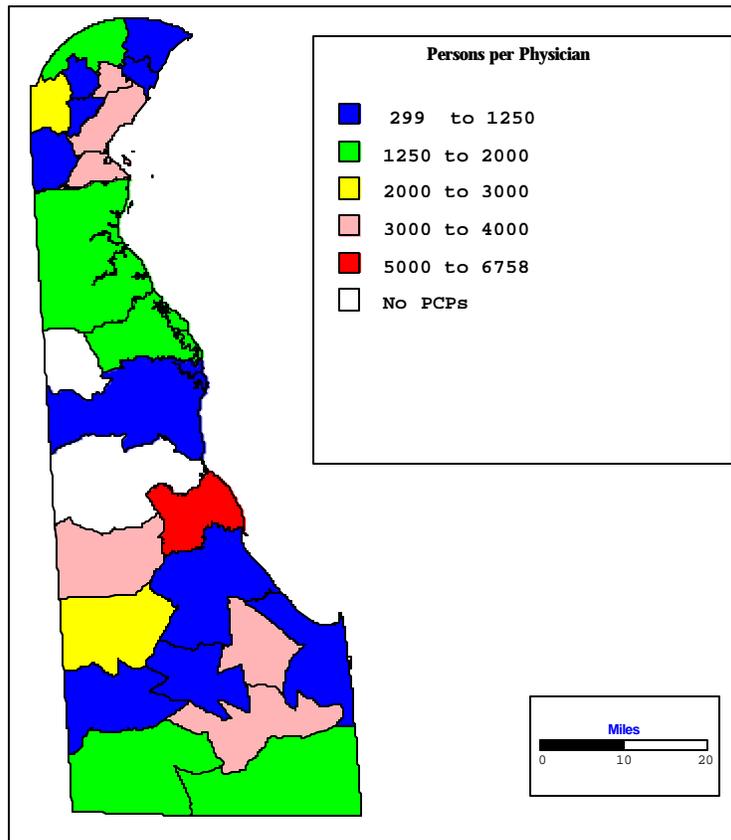
- Monitoring of outcomes is limited.
- Provider to provider communication is sporadic.
- More bilingual capacity is needed.
- Services for CSHCN are limited in that there are not enough specialists and providers
- Transportation limits access.
- Adolescent access into family planning services is problematic due to lack of transportation and availability of clinic hours.

The Division of Public Health contracted with the University of Delaware's Center for Applied Demography and Survey Research to survey primary care physicians in the state. The resulting report, *Primary Care Physicians in Delaware 1998*, included responses from approximately 82% of the primary care physicians. Primary care physicians (PCP) include the following specialties: family practice, general practice, internal medicine, pediatrics, and obstetrics/gynecology. The current findings are that there are probably sufficient primary care physicians in Delaware although their location and specialty may not be optimal. According to the report, "Primary care physicians are sufficient and are reasonably well distributed throughout Sussex County with two exceptions." These exceptions are the Milton census tract district which is close to high PCP served areas and Millsboro which has a small population. The authors note that this area is growing and has a significant transient population as do other areas in Sussex County such as Lewes and Selbyville.

Other than the city of Dover, Kent County, while much smaller than Sussex County, is also mainly rural. Because of its population size, the county has been precluded from the benefit of federal designations necessary for eligibility into many federal programs. Kent County has had the lowest access rate to prenatal care in Delaware. Kent County has areas with no primary care physicians: Kenton, Central Kent and Felton. On the other hand, these areas have low population rates. The most populated district, Central Kent, is in close proximity to Dover. Because numbers are so small in many of these census tracts and because PCPs are accessible if a person has transportation, these numbers can be deceiving. For those living in the rural areas, accessing a physician is very difficult.

Number of Persons per Primary Care Physician by Census County Division

Source: Center for Applied Demography & Survey Research, University of Delaware



There also seem to be some problems attracting new physicians into Southern Delaware which may lead to a shortage as the current group ages and as the population grows, particularly in Sussex County. Slightly more than 80% of primary care physicians are accepting new patients but the proportion accepting new Medicare and Medicaid patients is significantly lower. This also varies by practice specialty. In Kent County, there is a difference of over 44 percentage points between those PCPs currently treating Medicaid patients and those willing to accept new ones. Sussex County fairs slightly better with a difference of about 28 percentage points. One reason for this difference is that more time is necessary for these patients. Statewide, about 24% of overall physician time are spent on Medicaid patients. However, only 12% of the total population are Medicaid eligible. The difference in physician time is not unexpected, since most eligibles are children. Above is the map showing the distribution of primary care physicians in the state of Delaware.

Another area of need in Southern Delaware is mental health. As a study done under the auspices of the Developmental Disabilities Planning Council by Elwyn, Inc. *Mental Health Study for Delaware, Population Ages Birth to 24* reported that key informants in the mental health communities in Kent and Sussex Counties pointed to a lack of services providing behavioral health care in either the private or public sectors. The draft Rural Health Plan lists other concerns:

- Ambulatory chemical dependency and substance abuse services appear to be insufficient;
- Child and adolescent services are insufficient;
- Wellness Center staff report significant access problems for mental health services for children and adolescents
 - No formal process is available for adolescent behavioral health referrals or for linkages between primary care and behavioral health resources
 - There is 0.5 FTE child psychiatrist in the county, located on the coast; there are no pediatric or adolescent behavioral health units or hospital services in Sussex County
 - Knowledge of, and linkages between resources (communication), in the child and adolescent population are lacking

New Castle County: There are pockets throughout New Castle County where access to health care is a problem. In addition to Wilmington, the largest city in the state, there are other areas where poverty, lack of transportation, cultural barriers, etc. are common. These areas include the Rt. 40 corridor, the Middletown-Odessa-Townsend (MOT) area, and Claymont.

The MOT area needs mental health services, services for cancer patients, and transportation. This area has gone through remarkable growth in the last 10 years with many middle and upper middle class families building homes in the MOT area. It has one of the few school districts that are adding new schools. It added a new high school a few years ago and plans to add a new kindergarten and grade school. However, services have not kept pace with the growth. Physicians who come to the area to practice have no trouble filling their waiting rooms. Despite the influx of the well-to-do families, there are economically disadvantaged areas in all three towns where joblessness, alcohol, and drugs have been the norm.

The Route 40 corridor is an area of small developments inhabited by the working and non-working poor. Not only is transportation not routinely available, but there are no stores or activities that are in walking distance. In fact, walking on Route 40 is dangerous because there are no sidewalks and the traffic moves quickly.

Claymont in Northern New Castle County is an urban area where there are pockets of poverty and transportation is more difficult than in the city. Using public transportation, it can take as much as a full day for a person living here to get to and from a clinic.

City of Wilmington: The city of Wilmington is like most urban areas throughout the nation and has correspondingly high rates of teen fertility rates, infant deaths, children born to single mothers, juvenile arrests and AIDS cases. Although Wilmington does not have a city health department, it has recently focused more on the health needs of its population and has recently hired a Public Health Officer.

DPH and Wilmington worked together to assess need through a Health benchmarking project. Key informants (about 40 people) were interviewed throughout the city of Wilmington to identify the key areas of need in the city.

The results were summarized into seven main focus areas:

- Improving youth and adolescent health
- Supporting Healthy Behaviors
- Improving Access to health care
- Environmental Health
- Monitoring Wilmington's Health
- Creating a Health Structure for the City
- Improving the health of older adults

Although Wilmington has major hospitals and available physicians, access to care remains a problem in the following areas:

- Locations and service times which are not convenient
- Transportation which is not accessible or affordable
- Too few culturally competent health care providers, preferably bi-lingual
- Lack of pharmacy services for the uninsured and under-insured
- Lack of Dental care
- Few Ancillary services
- Lack of health insurance coverage

As a result of creating a health structure group, the city created a Public Health Officer position. The Public Health Office has recently created a vision also based on findings of the Benchmarking process. Of note in regards to the MCH population are:

- To coordinate with the state agencies the flow of information pertaining to health issues including, but not limited to, diabetes, sexually transmitted diseases, mental health, infant mortality, and lead contamination.
- To help with the educational effort promoting responsible sexual behavior tending to reduce teenage pregnancy.
- To help find answers to the problem of substance abuse which must include alcohol and tobacco agendas and addressing the tobacco use among adolescents.

- To help community organizations formulate programs addressing the issues of physical activity and obesity/overweight
- To help promote healthy communities.

In addition, the city created the Physician Advisory Board for the Mayor, which the Director of Public Health co-chairs. As a result of the monitoring health work group, the city contracted with Kids Count and the University of Delaware to produce Wilmington Counts.

In October 1999, the City of Wilmington and Wilmington Healthy Start held a Housing Roundtable for Pregnant and Parenting teens. Needs identified were: domestic violence programs, child care and after school care, case management, emergency assistance, transportation, coordination and collaboration between lead agencies, health insurance, substance abuse services, health services near housing, safe environments, budgeting and lifeskills training, stress management, and parenting.

STRENGTHS AND WEAKNESSES OF SYSTEM SERVING CSHCN

Strengths

Overall, key informants, interviewed for the assessment, believed the state's birth to three system which provides services through Child Development Watch (CDW) is an effective delivery system for that age group. CDW service coordination provides a central point of contact for families by linking health care, education, social services, and family support services. Once children turn three, most of the children are served through the educational system where the links to the health care system are not as clear. Most CSHCN are mainstreamed throughout the various school districts. Some are served through the educational system's specialty schools. These schools are also named as a strong resource for families.

Primary care needs are generally taken care of and, particularly with the introduction of duPont Pediatric Clinics, access has improved throughout the state. DuPont CSHCN Clinic and Specialty Clinics have also been noted as being of high quality. (See discussion on providers.) However, for families living in southern Delaware, services are a great distance.

Those interviewed also felt that insurance provided through the state with Medicaid and the Delaware Healthy Children Program was adequate. On the other hand, numerous parents pointed out how difficult it is obtaining approval for some specific services or equipment such as in-home health care assistants, certain wheelchairs, or pull-up diapers. Parents are also more pleased with Medicaid coverage than with that of private managed care companies. In addition, there are other issues of concern such as parent's lack of awareness of available services. (See section on Direct and Enabling Services.)

Most obvious in assessing the CSHCN system is the fact that service delivery is fragmented. After the age of three there is no central contact point. Once a child turns three, service coordination is no longer offered by the state. While some service providers offer case management, the assigned managers generally focus on one area of need instead of a holistic approach to child and family. The provision of service coordination would also help to address other identified needs such as better communication between the public school, primary care physicians and health care insurers; lack of one source of reliable information; and improvement in parents' understanding of health care coverage and SSI. (More details on gaps are found in the sections on Enabling and Infrastructure Building Services.)

SERVICE GAPS

Transportation: Community leaders and consumers have identified transportation as a major problem in accessing health care throughout the state. Even for Wilmington residents, transportation is cited as a problem with long waits for buses, "non-accommodating schedules", and difficulty in handling several children. Highlights from these discussions are:

- Medicaid requires 48 hours notification and no emergency transportation is available.
- Transportation is only provided for the child being treated and one parent making it difficult for a mother with more than one child.
- Even if a parent gets transportation to a doctor's office, she may not be able to get transportation to a pharmacy to pick up a prescription.

Lack of Telephones: Although we do not keep a count of families who do not have a telephone, public health nurses report that many of their clients lack a phone. It is often the case that when a woman calls for an appointment, she cannot make the appointment right away and is told to leave a message. The problem is that the office cannot call back if the patient is calling from a pay phone.

Oral Health: The Division of Public Health, Delaware Health & Social Services contracted with the University of Delaware's Center for Applied Demography and Survey Research to conduct a dental survey which was completed in 1998. One important finding was that Delaware suffers from a serious maldistribution of dentists, which leaves Sussex County with a severe shortage and Kent County far from optimal to meet the needs of the growing population. This finding was based on the industry standard of one FTE dentist for 2000 persons. Most of the shortage in Sussex County appears to be in the western, more rural part, from Bridgeville to Laurel. These are a few highlights from the report: 1) Although 97% of general dentists in New Castle County are accepting new patients, only 84% in Kent and 81% in Sussex are accepting new patients. 2) Wait times for non-emergency patients in Kent County are more than double those for New Castle County patients. 3) Almost 20% of Delaware's dentists will either not be active in five years or are unsure. 4) Younger dentists are more likely to locate in New Castle County. This situation affects all Delawareans particularly those in the lower socioeconomic category. The affect on women, particularly on pregnant women is devastating since lack of dental care can lead to infections that are dangerous to the mother and her fetus.

MAJOR HEALTH ISSUES AFFECTING ENTIRE MCH POPULATION

Violence: As in many other states, Delaware is concerned with the apparent increase in violence. However, deaths as a result of domestic violence decreased substantially between 1996 (a total of 26), to 1997 (a total of 13) and 1998 (a total of 9). In 1998, there were 26,884 combined criminal and non-criminal domestic incident reports and 36.6% had a child present at the time of the report. Delaware started collecting this data for the first time in 1998; therefore this information provides good baseline information but trends cannot be determined. Another area of concern is child abuse. Substantiated reports of child abuse to the Delaware Department of Services for Children, Youth, and their Families stayed approximately the same at about 25% during the last three years.

MORBIDITY AND MORTALITY: WOMEN AND INFANTS

Hospital Discharge data was reviewed for the needs assessment. 66% of all admissions for women of child bearing ages 15 to 44 was for reproductive related reasons such as birth, sterilization, D&C, etc. Diagnoses related to mental disorders including psychoses, depression, and Bipolar disorder were the general category for hospitalization at 9%.

Vital Statistics Cause of Death data reveals that 818 women between 19 and 44 died in the years 1994 to 1998. A disparate number of these women were black, 395 as compared to 495 white women. The number one cause for all was cancer followed by unintentional injury. However, the number one cause for black women was AIDS (73 women) followed by cancer (42 women) and hypertension (41 women). Health disparities are also clear in the areas of suicide and homicide. White women were much more likely to commit suicide during the period studied (24 whites as compared to 2 blacks). Black women were proportionately more likely to be victims of homicide (20 blacks as compared to 24 whites.)

Breast and cervical cancer: In 1998, Delaware released its strategic plan for breast and cervical cancer control. The plan targets different groups based on cancer risk. The high-risk target groups for breast cancer were identified as women 60 and older, women 50 and older with less than a high school education and young black women especially those with family history of breast cancer. For cervical cancer the high risk groups were identified as women 18 years and older living in Sussex County, women 18 years and older who did not graduate from high school, older women generally especially black women over 40, and women with pre-cancerous conditions detected by screening pap smears.

Infant mortality: The Office of Health Statistics listed a series of key facts as they relate to infant mortality rates. These facts can be used to pinpoint where Delaware would want to expend its efforts over the next five years. These facts are as follows:

- Infants born to mothers who received inadequate prenatal care had a higher mortality rate (22.0) than infants born to mothers who received adequate prenatal care (6.3).

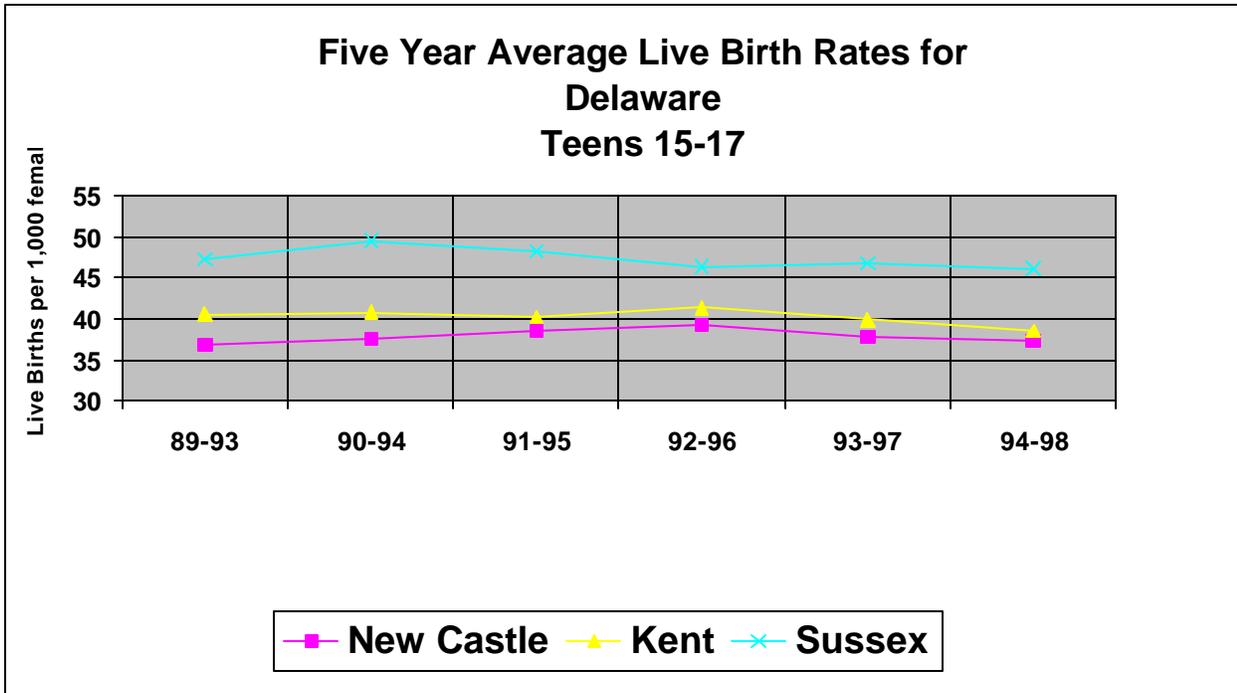
- Infants born to mothers who had another live birth less than 18 months earlier had a higher mortality rate (16.2) than infants born to mothers whose last live birth was 18 months ago or more (5.2).
- Infants born weighing less than 1500 grams (3 lbs. 5 oz) had a mortality rate of 255.2 compared to 2.3 for infants born weighing 2500 grams (5 lbs. 8 oz).
- Infants born to mothers under 20 years of age had a higher mortality rate than infants born to mothers 20 years of age and older.
- Infants born to single mothers had a higher mortality rate (12.0) than infants born to married mothers (5.1).

Delaware struggles with some of the same types of problems that other states are battling. According to an article in *Pediatrics*, "Annual Summary of Vital Statistics- 1998", "state-by state difference in IMR (*infant mortality rates*) reflect racial composition, the percentage LBW, and birth weight-specific neonatal mortality rate for each state." This article compared states' rates for LBW and infant mortality and VLBW and neonatal mortality. According to the writers "Differences in LBW and IMR by state reflect, in part, differences in the racial, ethnic, and socioeconomic composition of their populations." On the other hand, the writers state that the neonatal mortality rate for 500 to 1499 grams is more closely related to the "quality and availability of neonatal intensive care." Although this analysis shows that Delaware's LBW and IMR data reveals the overall racial and socioeconomic situation in the state; it has one of the highest success rates when it comes to saving babies between 500 and 1499 grams. This is reflective of the successes of Christiana Care Health Services' Special Care Nursery (neonatal intensive care unit).

Teen pregnancies and fertility

Governor Carper has made the goal of lowering teenage birth rates one of the chief priorities of his administration. Likewise, the Delaware Health and Social Services FY2000-2002 Strategic Plan has established the following goals:

- To reduce the rate of births among teenage girls ages 15 to 19 years old by 5% each year.
- To achieve a birth rate of 36.0 births per 1,000 females ages 15-17 by FY2002, and
- To decrease the number of teen pregnancies in high-risk communities by FY2002.



The Division of Public Health was given the lead to ensure the carrying out of these activities. Delawareans are also "solidly behind" teen pregnancy reduction efforts as reported by Doble Research Associates to the Division of Public Health. This contractor conducted surveys and a series of focus groups for the Governor's Family Services Cabinet Council which resulted in the following recommendations: 1) initiation of a series of discussions for teens to deliberate about pregnancy and its consequences; 2) promotion of additional group discussions for parents to discuss the difficulties in talking to children about sexuality; and 3) support for proceeding with all teen pregnancy reduction efforts because not only does the public support these efforts but wants the state to do more.

The most recent vital statistics data regarding teen pregnancy for teens 15 to 17 shows that Delaware's numbers are decreasing but only slightly since an overall Delaware high during the period of 1990 to 1994. It is clear from the chart above that Sussex County's rate of 46.2 is the highest rate in the state as compared to 37.3 for New Castle and 38.5 for Kent County.

We do not have the birth data 15-17 from Wilmington, but we suspect that those figures also might be high since the rate in Wilmington for teens 15 to 19 is much higher than the rest of the state. Wilmington's rate was 147.6 from 1994-1998 as compared to an overall teen pregnancy rate of 57.1 for teens from 15-19. On the other hand, this number has dropped from 152.3 between 1993-1997. Another concern is the disparity in these rates between white and black teens. Overall in Delaware, the black teen birth rate is 110.6 as compared to 40.4 for whites.

Furthermore, Delaware just started reporting pregnancy data last year. This data includes live births, fetal deaths, and induced terminations and is helpful in understanding sexual activity in teens. These statistics show that the two-year average pregnancy rate for 15 to 17 year olds is also highest in Sussex County, with 66.7 for Sussex, 61.7 for New Castle County and 48.9 for Kent County. Comparing this information with fertility rates shows that New Castle County has a much higher pregnancy rate than the fertility data showed. In a two year period, induced terminations occurred in 45.7% of the reported pregnancies for this age group in New Castle County; 35.6% in Kent and 29.7% in Sussex.

MORBIDITY AND MORTALITY: CHILDREN

Causes of Child death: Tables below show that in Delaware, unintentional injuries are the prime cause of death for both young children from 1 to 4 years and those 5 to 14. 45% of these injuries were caused by motor vehicle accidents.

Leading Causes of Death for Children 1-4 years		
Delaware 1994-1998		
Cause of Death	Deaths	
	Number	Percent
Unintentional Injuries	19	28.8
Homicide and Legal Intervention	10	15.2
Congenital Anomalies	9	13.6
Diseases of the Heart	5	7.6
Malignant Neoplasms	3	4.5
All Other Causes	20	30.3
Total	66	100.0

Leading Causes of Death for Children 5-14 years		
Delaware 1994-1998		
Cause of Death	Deaths	
	Number	Percent
Unintentional Injuries	32	35.8
Malignant Neoplasms	14	15.6
Diseases of the Heart	6	6.7
Homicide and Legal Intervention	6	6.7
Pneumonia&Influenza	5	5.8
All Other Causes	27	30.0
Total	90	100.0

Source: Delaware Health Statistics center

Injuries: According to the Delaware State Police, in 1999, the non-fatal injury rate for children ages 14 and younger was 895.87 per 100,000. This represents a drop from the 1998 rate of 927.72. Delaware does not separate out teens from injury or death figures. The rate for ages 15 to 24 was 3,232 per 100,000 in 1999 as compared to 3,368 per 100,000 in 1998. This high rate of injuries for teens and young adults corresponds with Delaware Health Statistics Center's reported number of deaths due to unintentional injuries of 188 in 1994-1998 making up 52.7% of all deaths

in that age category. These rates compare to 13% from suicide, 10.6% from homicide or legal intervention, 5.3% from malignant neoplasms, and 2.2% from heart disease.

Head injuries and resulting disabilities has recently surfaced as an issue in Delaware. The statewide Trauma System Registry is able to provide data on those children birth to 21 who have had head injuries requiring hospitalization. According to this data, in 1998 there were 370 children in this age group who were hospitalized with some degree of head injury. There were 22 fatalities, 201 additional children with serious, severe, or critical head injuries, and another 147 with minor head injuries in this group. 15% of the group were under the age of 5 years, another 15% were 5 to 9 years old, another 15% were 10 to 14 years old, 41% were 15 to 19 years old, and the other 13% were 20 to 21 years of age. The majority of these injuries, including 19 of the 22 deaths, were caused by highway crashes, including motor vehicle, motorcycle, bicycle, and "pedestrian-related incidents."

Seatbelt and car safety seats have been a focus for Delaware in the last few years. Information obtained from Delaware's Department of Public Safety's Office of Highway Safety shows that the usage rate for the State is 64%. A survey was also conducted to determine misuse of car seats at a variety of checkpoints throughout the state. Misuse has improved. In 1998 about 93% of the car seats examined at the checkpoint were not used correctly. In 1999, this number had dropped to about 89%. As has been pointed out, there is a high number of deaths for 15 to 24 year olds due to unintentional injuries. Lack of seat belt use is a definite problem for high school students. About 34% of students answering the Youth Risk Behavior Survey stated that they either never, rarely, or only sometimes used a belt. Only about 40% stated that they used a seatbelt all the time.

Delaware Health and Social Services has not been able to work out a plan with the state's hospitals to obtain emergency department data. As a result, hospital discharge data is the only data available in regards to hospitalizations. For children between one and nine, the number one cause for hospitalization is asthma followed by pneumonia, hypovolemia and electrolyte disorders, Nonbacterial gastroenteritis and abdominal pain, and seizure. As the chart below shows as a child gets older (5 to 9) the less prevalent causes of hospitalization change. Mental disorders and appendectomies begin to appear and poisoning and toxic effects and fever are no longer in the top 10 reasons for hospitalization.

Delaware Hospital Discharge Data for Children 1 to 4 years		
1996-1998 Top Ten Discharges	Frequency	Percent of age
Asthma & Bronchiolitis (76% Of This Category For 1-4 Are Asthma Diagnosis)	806	18
Simple Pneumonia	559	12
Hypovolemia & Electrolyte Disorders	549	12
Nonbacterial Gastroenteritis & Abdominal Pain	296	6
Seizure	249	5
Epiglottitis, Otitis Media, Uri & Laryngotracheitis	205	4
Poisoning & Toxic Effects Of Drugs	93	2
Respiratory System Signs, Symptoms & Other Diagnoses	84	2
Chemotherapy	62	2
Fever Of Unknown Origin	61	1
Others	1616	35
Total	4594	100

Source: Office of Health Statistics

Delaware Hospital Discharge Data for Children 5 to 9 years		
1996-1998 Top Ten Discharges	Frequency	Percent of age
Asthma & Bronchiolitis (98% Due To Asthma)	447	15
Simple Pneumonia	227	8
Hypovolemia & Electrolyte Disorders	223	7
Nonbacterial Gastroenteritis & Abdominal Pain	143	5
Seizure	102	3
Childhood Mental Disorders	88	3
Appendectomy	83	3
Cellulitis	69	2
Epiglottitis, Otitis Media, Uri & Laryngotracheitis	65	2
Chemotherapy	62	2
Others	1477	49
Total	2986	100

Source: Office of Health Statistics

As children get older (10 to 14), reasons for hospitalizations vary more so that the highest ranked discharge, Childhood Mental Disorders was 9% of the total. (See section on gaps and mental health.) Also as noted, asthma hospitalizations are higher for black children and still the number one hospitalization cause for 10 to 14 year olds.

3.1.2.2 and 3.1.2.3 Direct Health Care Services and Enabling Services

Pregnant Women, Mothers, and Infants

Access to Care: Of great concern in Delaware has been access or early entry into care for pregnant women in Kent County. Delaware uses the Kessner Index to determine access to care and just this year used the Kotelchuck Index as well. Both show an across the board reduced access to care. A further analysis of 1998's data showed that there was a reporting problem in Kent County, which explains the ten point drop in access between 1997 and 1998. However, reporting does not account for the overall drop in access for all populations irrespective of race, age, insurance coverage or education. Since there is some questions about visit data, it is most beneficial to look at entry into care. As already reported in the Annual Report, Kent County had the lowest percentage (68.3%) entering into care during the first trimester, followed by Sussex County (74.5%) and the City of Wilmington (79.9%). Below are listed other pertinent data relating to entry into the first trimester are:

- 59.7% of women under 20 in Kent County enter in the first trimester as compared to 69.7% of all Delawarean women under 20.
- 71.2% of women between 30-34 in Kent County enter in the first trimester as compared to 88.9% of all Delaware women between 30-34.
- 71.7% of white women in Kent County enter in the first trimester as compared to 86.1% of all white Delaware women.
- 59.4% of black women in Kent County enter in the first trimester as compared to 73.2% of all black Delaware women.

There are no clear-cut answers to this situation. The Division of Public Health and the Office of Health Statistics are working closely with the Perinatal Board and Kent County providers to determine root causes and to address them. Initiation of the PRAMS survey may help.

Financial Access

Impact of Medicaid and managed care

Satisfaction with Health Care Plans: Satisfaction with health care plays a large role in accessing care. If an individual is dissatisfied with her doctor, she may not enter into care as soon as she should. If she is unaware of what her health care plan pays for, she may not attempt to access a needed service. The Delaware Health Care Commission funded a Consumer Assessment of Health Plans Study (CAHPS) in Delaware. A major component of the study was a survey of adults, age 18 and above, about their experiences with their health plan and medical care during the previous six months. At the time of the survey, 74% of Delaware's non-elderly adults were enrolled in some form of managed care.

This survey followed one that had been conducted in 1997 but more people were surveyed allowing for more detailed comparisons. One key finding was that Delawareans are more satisfied with their health plans than they were in the prior year. The 1998 findings also showed a statistically significant difference in satisfaction between

managed care and fee for service enrollees. Fee for service enrollees were more satisfied. This was a change from the previous year when there is no statistically significant difference. Interpretations for this gap are that the enrollees remaining in fee for service are likely to be the most satisfied with their plan; survey sample increase; deteriorating managed care quality which seems unlikely that it would drop so much in one year; and the “bashing” of managed care in the media. On the other hand, overall ratings of health care and ratings of specialists show no significant differences between managed care and fee for service. For most of the specific measures used by the survey, there was no difference between managed care and fee for service.

There were a couple of measures where there was clear preference for fee for service plans and they were found in the ratings for health plans and personal doctors. These ratings may be a result of consumers having to pick their doctor from a managed care restricted list. Other concerns were that under the managed care plans, physicians did not stress diet and exercise and that the enrollees didn't get needed tests and treatments. However, analysis of overall ratings of health care and ratings of specialists pointed to the fact that recipients of managed care were not less satisfied than those of fee for service. Further, out of 17 specific measures, plan type had no significant effect on the ratings.

On the other hand, there were findings that may explain some county differences in access to care. Kent County residents had the greatest difficulty finding a doctor, which can be understood by the fact that there are fewer physicians per capita than in the other two counties. Kent County residents were more likely to report that their doctors never listen to them carefully (17%); showed no respect for what they had to say (6%); and did not spend enough time with them (15.7%). Sussex County residents reported the greatest satisfaction with their physicians. Similar patterns were repeated when questioned about office staff.

Benefits: The Medicaid managed care plans (Diamond State Health Plan) cover all of the basic Medicaid services as well as enhanced care for pregnant women called Smart Start and comprehensive EPSDT services. Post partum home visits are also required under the plans. Family planning benefits are extended for all women with Medicaid for two years after they lose eligibility for comprehensive coverage. Freedom of choice for family planning services is still protected so that a woman may go to any qualified provider for family planning services regardless of the plan in which she is enrolled.

As Medicaid participants begin utilizing their medical homes and primary care providers, there is much less demand upon public health to provide direct medical services at public health clinics, although this varies in each county. All pregnant women, regardless of insurance status, identified as “at-risk” may obtain Smart Start services that are currently provided through three agencies including DPH. Because of the new stricter federal regulations, Medicaid cannot pay for Smart Start services to undocumented immigrants, although Medicaid funds can pay for basic treatment. Funding for DPH Smart Start services is provided through Title V, Medicaid and revenue dollars.

The switch from fee-for-service Medicaid to managed care, has limited some of the opportunities for DPH to come into contact with these women and enroll them in programs such as Smart Start. However, other methods have been developed such as co-locating DPH staff in OB-GYN offices. Another area of concern is that managed care companies have established authorization procedures that are cumbersome and difficult to track. They also have had difficulty in retrieving reliable encounter data from physicians. Public Health staff have recently been meeting with the MCOs to share some of their experiences with establishing encounter data systems, tracking clients, and ensuring that patients receive follow-up check-ups. In addition, one of the two remaining managed care providers has recently switched to fee-for-service for its enrolled physicians which may help to provide the necessary data to track program success.

Further, more clients enrolled in DPH's Smart Start in 1999 than in the previous two years. From a low of 1,402 in 1998, clients served have increased to 1,943. As can be expected, 70% of DPH's Smart Start clients are from the southern two counties where there are few services and fewer opportunities for access to care. On the other hand, there are anecdotal indications that PCPs are not referring to other providers or DPH as frequently as needed.

Impact Of A Better Chance

A Better Chance (ABC) welfare reform program was implemented in October 1995. It was among the earliest state reforms to embody full-family time limits, strong work incentives and services, and a comprehensive array of family responsibility requirements. The family responsibilities that are particularly relevant from a public health standpoint are attending parent education classes, obtaining family planning information, ensuring that children are immunized and participating in substance abuse assessment and treatment when necessary.

The Division of Social Services, Delaware Health and Social Services is the agency responsible for administering the program. To ensure ongoing evaluation of the program it has contracted with a private agency Abt Associates to conduct a series of evaluations. In March 1999, an installment entitled *The ABC Evaluation Enrollment of Families in Delaware's A Better Chance Program: A Report on the First Three Years* was completed which examined enrollment and distribution of ABC clients. This report analyzed the total population of 17,694 who were enrolled in ABC sometime during the first three years. This number is much larger than the number enrolled at any given time. For instance, as of November 1, 1999, 6,318 were enrolled. This data is indicative of the fact that for the most part, families come and go from the rolls and do not remain for a substantially long time. 6% of all households in Delaware participated in ABC sometime during the first three years.

Another report completed by this group in May 1999 was *The ABC Evaluation Carrying and Using the Stick: Financial Sanctions in Delaware's A Better Chance Program*. By June 1998, 43% of all 16,602 families enrolled in ABC had received at least one sanction. Two of the three most common reasons were failure to attend parenting education classes and failure to prove that all children were satisfactorily immunized. A variety of reasons were pointed out for these failures including family circumstances such as the program placing greater burdens on large

families, failure to understand the program requirements as a result of less education, and being less equipped to offset losses through earnings as a result of a spotty work record, longer welfare dependence, and lower levels of education. The report also pointed out that practices in local offices probably had an influence since rates differed across offices even when the data was controlled for caseload intensity.

The evaluators made several recommendations including: 1) Limit the number of sanctions to a few behaviors; 2) Provide clear policy guidance and training to workers; and, 3) Change the current penalty structure which costs the state in missed opportunities to work with the families to a one-tier, partial benefit approach.

Another component of the evaluation was the conduct of a survey to determine what Delawareans think of ABC and its effects on welfare recipients. Some of the findings determined that: 1) Most Delawareans know very little about welfare; 2) The majority believe that poverty results from lack of effort by individuals; 3) Most support time limits but believe that they should vary according to circumstance; 4) Attitudes toward work requirements differ from current policy in that most respondents believed that welfare reform needs to concentrate more on education and job skills and that mothers with young children should not be required to work full time; and 5) The public supported continued provision of cash assistance to teen parents although the state stopped cash benefits in December 1998. The public supported giving teens better social and economic opportunities, encouraging abstinence and family planning. As a result of the early evaluation findings, legislative changes were made to support clients engaging in secondary education, post-secondary education, and vocational training as part of the work activity requirement.

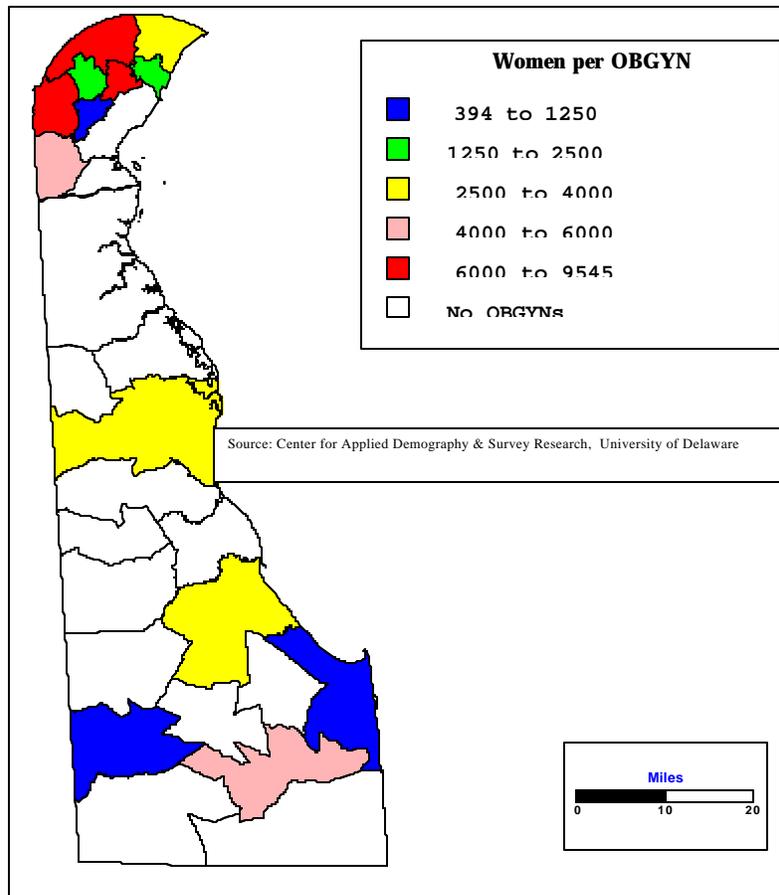
Availability of Health Care Providers and Programs for Women and Infants

OBGYNs: OB-GYNs tend to be more partially concentrated than other primary care physicians are. Practice sites were usually associated near a hospital. The Physicians Survey, in its 3rd year, has found a smaller proportion of OB-GYNs in Kent County. Almost all (95%) OBGYNs are accepting new patients but the wait tends to be longer as compared to other primary care physicians. Established patients usually wait more than 20 days. New patients will wait about 35 days to see an OB-GYN. Further analysis of the survey shows that the racial distribution of OB-GYNs is anything but diverse. 8% of OB-GYNs were African-Americans with none in Sussex and Kent Counties. Only one Hispanic OB-GYN was in Sussex at the time and only 2 were in New Castle County with none in Kent County.

Primary care physicians have available to them resources to extend their own abilities to serve patients. The advanced practice nurse (APN), the certified nurse midwife (CNM), and the physician's assistant (PA) are the most typical such resources. There are significant differences between the specialties where the OBGYN and pediatric primary care physicians are far more likely to employ all of these alternative resources. (See below for more detail.)

In June 1998, the Governor’s Advisory Council on Minority Health produced a report that recommended that the state explore the use of certified nurse-midwives and certified OB-GYN’s Nurse Practitioners in rural areas. The Council was concerned that African-American women were not getting prenatal care because of a lack of OB-GYNs and difficulty in finding transportation. As can be seen by the map below, in the words of the Primary Care Physicians Report “ women requiring the services of an OB-GYN can expect to travel.”

**Number of Women (15-64) per OBGYN
by Census County Division**



Primary Care Non-Physician Clinicians: The Division of Public Health just released a report by the University of Delaware's Center for Applied Demography and Survey Research on the availability and characteristics of individuals in these disciplines who provide primary care: nurse practitioners, certified nurse-midwives, and physician assistants (*Primary Care Non-physician Clinicians in Delaware 1998*). Since this was the first year of the survey, this data will serve as baseline data and the goal for coming years will be to have more participation than the 61% who responded to this first survey. Findings included:

- For 5 primary care physicians, there is one primary care clinician. This distribution will vary throughout the state.

- There are more advanced nurse practitioners than physician assistants by about five to one.
- Respondents believe that they are underemployed and that physicians do not understand their training.
- Delaware does not have a physician assistant training program but does have three college programs offering masters degrees in nursing with advanced practice specialties.
- About 40% of both groups work for physicians in private practice. Physician assistants tend to work in emergency rooms. Advanced practice nurses work in hospitals but generally not in emergency rooms. They are also more likely to work in public health clinics and to specialize in the areas of women and children's health.

Midwifery: There are less than 20 midwives in Delaware. The Birthing Center in northern New Castle County employees the services of midwives who deliver about 80 babies a year. A few years ago, Kent General Hospital closed its maternity center which included midwife services. The Division of Public Health participated on a transition committee which worked to ensure that private doctors were ready to take additional patients and to ensure that the uninsured receive services. OB/GYN Associates worked with the state to enhance their available services.

Alcohol and drug abuse programs: According to a study completed by the University of Delaware for the Division of Alcoholism, Drug Abuse and Mental Health, *Prevalence and Need for Treatment of Alcohol and Other Drugs Abuse Among Women in Delaware*, lack of research regarding drug abusing women has made it difficult to develop programs specifically geared to women. However, studies have shown that female-specific programs have a higher success rate.

Reflections, the substance abuse center at Governor Bacon located in Delaware City, New Castle County, has a capacity of 12 mothers and 4 infants. Infants must be under 6 months when the mother enters treatment, as the facility is not functional for toddlers and older children. This is the only residential treatment center available exclusively to women.

What are the cultural acceptability issues? Cultural issues often present barriers in providing health services. Throughout the state a major issue is the language barrier. Languages spoken include numerous Spanish dialects, Pakistani, Chinese, Creole, Haitian, Korean, Vietnamese, and several African dialects. Even AT & T's third party translation program faces difficulties with the Spanish language because there are so many dialects that exact translation is impossible and the translators do not know how to translate medical terminology. Such translation also takes a lot of time and receptionists say they do not have time to use the service. Hospitals have only sporadic translation services. Often they call upon a family member without a health background and in many cases children. In at least one instance, a child attended the birth of his sibling so he could translate for his mother.

Other cultural differences exist which present other problems. For instance, some cultures object to a man coming into the home to give a child therapy if the man of the house is not home. Although he may request a woman therapist, the agency may not have one. Also women coming from other countries, such as Guatemala, have not had a physical exam. Some of these women have come to family planning clinics and have been shocked that they would need to be examined. These issues require not only sensitivity from staff but time to work with the woman to help her achieve a comfort level with the exam.

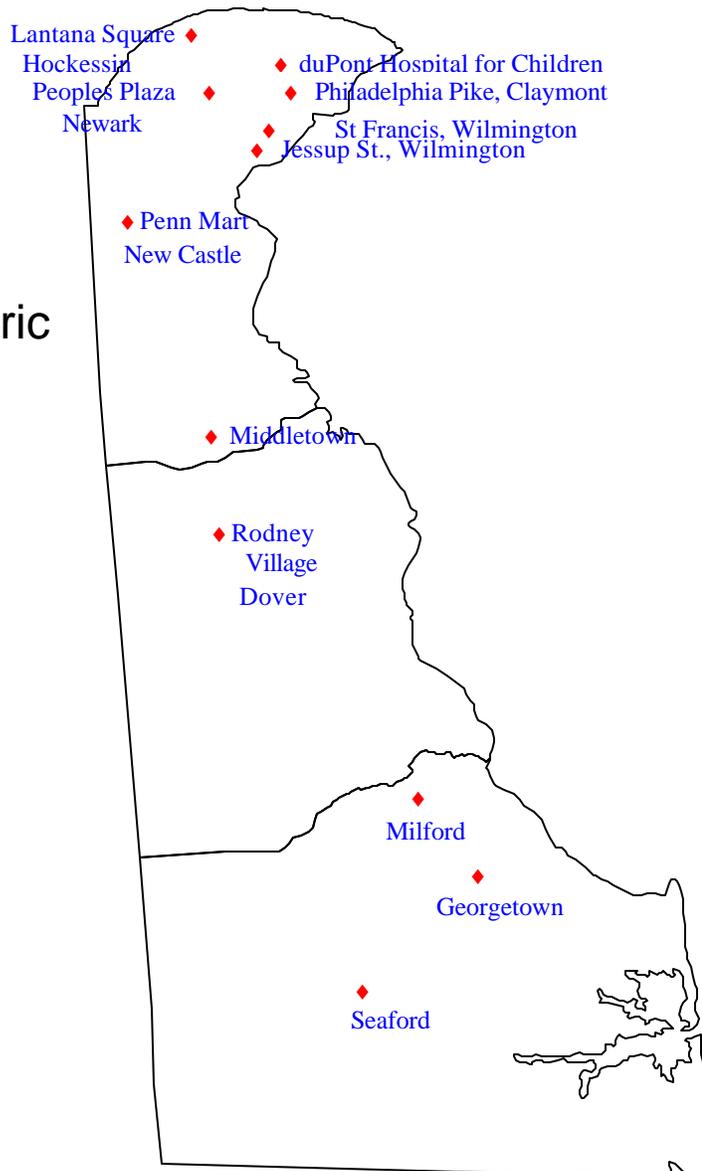
Primary and Preventative Services for Children

Financial Access

Impact Of Medicaid And Managed Care

The MCHBG continues to support the provision of direct child health services (EPSDT, immunizations, counseling, TB screening, lead screening and health education). These services are provided primarily to the uninsured, under-insured and a small number of Medicaid clients when referred by their primary care physician. However, with the implementation of Medicaid managed care and the duPont Pediatric Clinics, there is less of a need for DPH to provide these direct services. There are 12 of these Clinics situated throughout the state. Seven are in New Castle County. The other four are in Dover, Milford, Seaford and Georgetown. The hospital served over 80,000 outpatient clients at the hospital and 120,000 in the primary care sites. See below for map of specific locations.

Delaware DuPont Pediatric Clinics



Impact Of SCHIP

The Delaware Healthy Children Program began on January 1, 1999. It is being administered by the Medicaid Office, Division of Social Services, Delaware Health and Social Services. Coverage includes well visits for babies and children, immunizations, prescription drugs and vision care and other routine services. It also includes services for children with special health care needs such as therapies and home health where medically necessary. Non-emergency transportation, dental benefits, and eyeglasses are not covered under the program. There is a nominal monthly premium of 10, 15, or 25 dollars depending upon income.

Recent analysis shows that enrollment in this program has slowed down. The point between the initial application and the time when an individual picks her provider and pays is a critical one and some individuals are not following through to enrollment. Those who have been asked to pay a premium of \$10.00 seem to be having greater difficulty in making payments. This situation may be a result of the "buy-in" not being there; eligible families believing that

they cannot afford the expense; or for families cycling on and off between coverage by the Delaware Healthy Children Program and Medicaid, causing differing payment policies and resulting confusion.

The Division of Public Health has been awarded a Robert Wood Johnson Covering Kids Project grant to coordinate and enhance outreach efforts connected with implementation of this program. It has been estimated that 10,500 uninsured children may be eligible for the program. By March 2000, 2,590 children had been enrolled.

Shortages of Health Care Providers

Oral health: As already stated in the Needs Assessment Overview, there is a severe shortage of dentists in Sussex County and a less than optimal situation in Kent County and in some sections of the city of Wilmington. Throughout the state, most dentists serve pediatric patients. About 25% of dentists will serve a child under three years of age. However, a recent report by the Delaware Health Care Commission, *Dental Care Access Improvement Committee Report and Recommendations to the Delaware Health Care Commission* noted that while there has been some progress made, there are some issues that still need to be addressed. Some of these as they particularly relate to children are:

- School nurses report severe access problems particularly for those from low-income families.
- Although Public Health has hired additional hygienists, wait time for a clinic visit is extremely long (after initial diagnosis 5 to 6 months) and used to fix existing problems rather than for preventative care.
- The number of Medicaid eligible children being served is much too low because of the overall dental access problems. These problems have prevented Delaware from including dental services in its Delaware Healthy Children Program.

Most dental care provided to Medicaid recipients under the age of 21 has been provided in the Public Health dental clinics. Four sites in Kent and Sussex Counties employ two full-time dentists, contractual dentists equal to one full time equivalent, and three part-time hygienists. The four sites in New Castle County employ four full-time dentists. As the Delaware Health Care Commission reports, if the clinics served the whole population that would mean a ratio of one dentist to 5,000 patients. An estimate of Medicaid eligible children served at the clinics is 29% in New Castle County, 18% in Kent County, and 25% in Sussex County. Although more private practice dentists are participating in Medicaid, about 50%, in 1998 Medicaid patients, including adults were served by only 3.6% of general private practice physicians. An estimate of children served by private practice dentists is less than 3%.

The Dental Care Access Improvement Committee recommended the following strategies to improve dental care in Delaware:

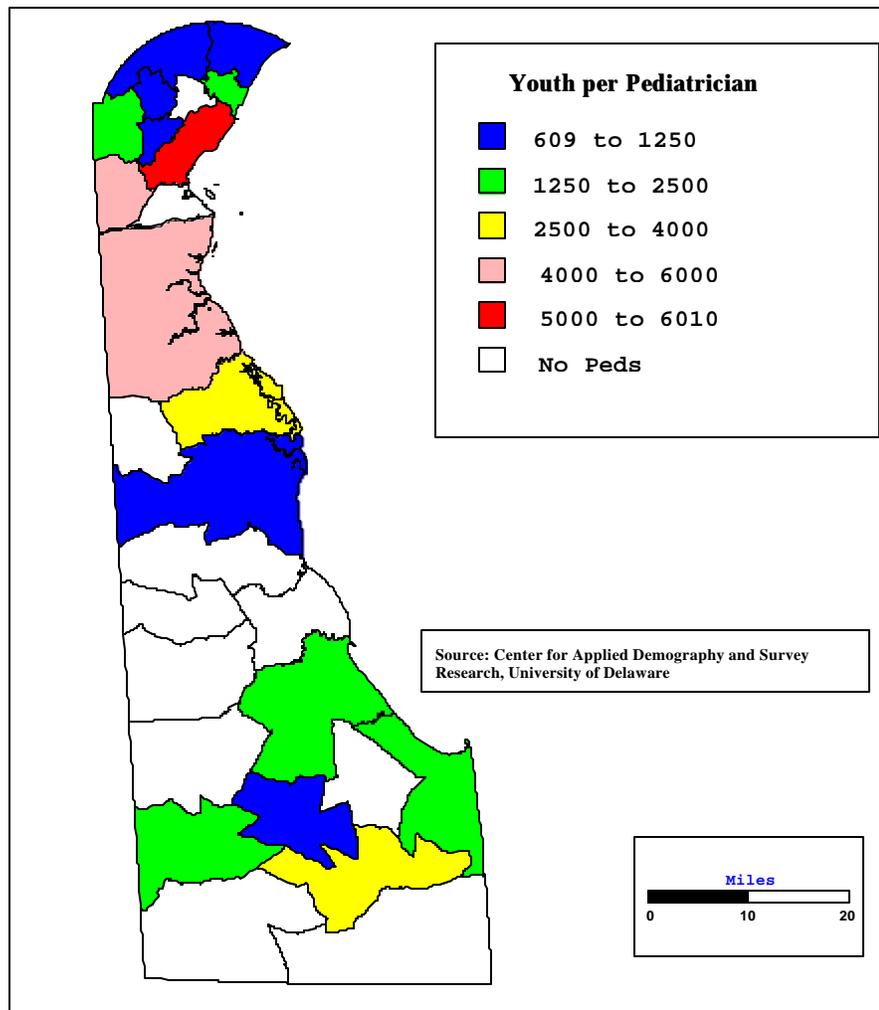
- Marketing the benefits of practicing in Delaware with consideration given to racial and cultural composition of the targeted population

- Education loan repayments or other financial assistance for capital costs for dentists establishing a practice in an underserved area
- Implementing a reciprocity program offering provisional licensure for dentists serving in underserved areas instead of a one-year general practice residency requirement
- Implementing a preceptorship program available to dentists who are Board eligible in Delaware if they practice under direct supervision of a licensed dentist in an underserved area
- Licensure changes to make it easier to attract qualified dentists and hygienists such as allowing dental hygienists to work in schools, mobile health vans and other settings under state dental director supervision and reducing practice experience required.

If dental services for Medicaid eligible children are lacking, it is expected that for children whose families are uninsured or underinsured, accessibility would be worse. This data was not available but it is interesting to note that an average of about 7.5% of general dentists' gross fees was not reimbursed as a result of charity care. According to the University of Delaware's *Dentists in Delaware-1998* report about 40% of dentists provide some charity care outside of the offices. Proportions providing charity care are less in Kent and Sussex Counties but this probably reflects their greater workload.

Primary Care Physicians in Delaware reported that pediatricians are almost 20% of the total primary care physician population. As with OB-GYNs, they are generally located nearer hospitals. The most underserved areas are southern Kent County and southern Sussex County. Georgetown in Sussex County, Dover in Kent and northern and western New Castle County has the highest rates of pediatricians per the number of youth. One problem that has been noted is the low number of Hispanic pediatricians. Survey responses showed no Hispanic pediatricians in either Kent or Sussex counties. However, there was a surprising number, 48%, who could speak Spanish, most located in New Castle County. See below map for distribution of pediatricians.

Number of Youth (0-19) per Pediatrician by Census County Division



Gaps in mental health for young children and adolescents: Both existing data and perceptions by providers and consumers point to gaps in mental health services for children. A study completed under the auspices of the Disabilities Planning Council identified several gaps in mental health services for adolescents. They are: 1) too few adequate alternatives for special living arrangements such as structured residential settings; 2) not enough vocational rehabilitation and continuing education opportunities; and, 3) not enough one-on-one support for severely mentally ill or depressed adolescents. This study also noted that there are not enough trained therapists for very young children.

As already stated, hospital discharge data for 10 to 14 year old children shows that childhood mental disorders are the number one cause (9%) for hospitalizations for this age group. Other mental health related diagnoses include:

depression (ranked 2nd at 8%), psychoses (ranked 3rd at 8%), neuroses except depressive (ranked 8th at 3%). Black children 10-14 are not hospitalized as frequently for mental disorders as the rest of the population. However, childhood mental disorders are ranked 2nd at 6%, depression (ranked 3rd at 6%), psychoses (ranked 5th at 5%). For teens 15 to 19, discharges related to birth are the most prevalent rate. After birth, however, psychoses ranks 3rd (6%), depression ranks 4th (4%) and childhood mental disorders ranks 6th at 2%. Again black children are not hospitalized at the same frequency for mental problems. Instead after birth related hospitalizations, diabetes and sickle cell are the prime causes.

Much of the data that we used to understand mental health issues (i.e., hospital discharge data) was too new to get a sense of whether the adolescent mental health problems were new. However, client count data from the Division of Child Mental Health shows an increase from 1,785 clients in fiscal year 1998 to 1,919 in fiscal year 1999. This number has jumped to 2,264 in the first nine months of fiscal year 2000.

The Department of Education recently conducted the Youth Risk Behavior Survey. Data from this report shows a clear need for mental health intervention. Although the survey does not cover all of the state's adolescents, nor does it take place in all schools, it is broad enough in its coverage to raise concerns. The following statistics are of particular interest:

- Almost 27% of the respondents said that during the past 12 months they felt so sad or hopeless for almost every day for two weeks in a row that they stopped doing usual activities.
- About 17% seriously considered attempting suicide for during the past 12 months.
- 3.7% stated that they had actually attempted suicide.
- 2.4% had to be treated by a doctor or nurse for depression.

SBHCs serve as an important resource of teens with emotional concerns. In FY 1999, there were 12,652 visits (30%) where emotional concerns were the primary diagnosis. Thirty-four of these visits were for suicide ideation. Fortunately, during the past year, none of these children actually succeeded in taking their life.

There have been some major efforts to address mental health issues through prevention. The Department of Services for Children, Youth, and their Families and 10 of the 20 state's school districts established the K3 Early Intervention Program. Additional funding was provided for social workers "to reduce classroom disruptions and encourage long-term academic success" and for some programs "to mitigate negative effects of conduct disorder." Unfortunately during the time that this program was evaluated only 11 students actually completed the program. 82% of the cases had closed because of reasons such as the student had moved. 57% of the children in the program had child behavior inventory scores below the conduct disorder intensity threshold score. This score dropped for most of the children who completed the program.

Gaps in drug and alcohol counseling:

There is also clearly a need for more help for teens who abuse drugs and alcohol. The Youth Risk Behavior Satisfaction survey showed that:

- 23% had at least one drink of alcohol between 40 and 100 or more days.
- 32% had their first drink between 8 or younger and 12 years old.
- 27% had consumed five or more drinks of alcohol in a few hours at least once during the last 30 days.
- 49% had tried marijuana at least once.
- 7% have used cocaine at least once and 1.3% have used it 40 or more times.
- 12% have at least once sniffed glue, breathed the contents of aerosol spray cans or inhaled paints or sprays to get high and .5% have done this 40 or more times.
- 1.3% have tried heroin at least once.

A collaborative effort between Children and Families First, elementary schools and parents, Families and Schools Together (FAST) is an early intervention/prevention program designed to reduce factors associated with school failure, juvenile delinquency and substance abuse in adolescence. Together with nonprofit mental health clinics and assessment clinics for substance abuse, the schools' and parents' participation is geared to result in enhancing family functioning and decreasing child problem behaviors. A total of 845 of the families across the state completed the process and graduated from FAST. Parents reported a 14% reduction in behavior problems, while teachers reported an 11% reduction

Nutrition counseling for Adolescents: The latest YRBS data also provides some understanding of any nutritional problems faced by adolescents. Although there are a small number that have severe nutritional problems, addressing those problems is a critical need. Some of the more serious problems are:

- 11.5% of the respondents stated that during the past 30 days they went without eating for 24 hours or more to lose weight or to keep from gaining weight.
- 4.7% took diet pills, powders or liquids without a doctor's advice during the last 30 days for the purpose of losing weight.
- 3.2% vomited or took laxatives to lose weight or to keep from gaining weight.

On the other hand, 55% exercise to lose weight or to keep from gaining weight. 54.4% participated in physical activities for at least 20 minutes for at least 4 or more days. Following nutritional guidelines also seems to be a problem for adolescents. For instance, only 26.5% reported eating vegetables other than carrots at least 1 time per day during the past 7 days. Only 28.7% had fruit at least once a day during that time period and only 38.2% had fruit juice at least once a day.

One source of nutritional counseling for school students in public schools is the school based health centers. During the fiscal year 1999, there were 2,534 (6% of total) visits where nutrition needs were the primary diagnosis and 3,165 visits where the concern was a secondary diagnosis.

Children with Special Health Care Needs

Financial Access

Impact Of Medicaid and Managed Care

State and private health care insurance plays a pivotal role in meeting the needs of all CSHCN. Medicaid's benefits are more generous than the benefits of many private health plans, and include access to basic and ancillary care that are vital for these children.

Medicaid has established standards for access to care and the availability of primary care providers for its Managed Care Organizations (MCOs). In the last Request for Proposal, Medicaid added several requirements for the MCOs to provide adequate access to specialists for children with special health care needs even if it means they need to authorize specialists outside of their contracted provider network. However, most standards are not specific to children with special health care needs such as standards related to waiting time for appointments, service approval time, and travel distance to a provider.

Since the inception of Medicaid Managed Care in Delaware, two of the Managed Care Organizations (MCOs), Blue Cross /Blue Shield and Amerihealth, decided to terminate their Medicaid managed care agreement. Many parents of CSHCN were left to identify a new MCO that provided the same primary care physicians, specialists, care, services, and durable medical equipment. Even if the services were provided by the new MCO, each child had to be reevaluated for their current services. The process of choosing and obtaining a new MCO and retaining current service modalities was challenging to CSHCN and their parents.

Title V used several sources to analyze the impact of Medicaid and overall managed care on children with special health care needs and their families including: the Office of CSHCN's survey completed by the University of Delaware; the focus groups conducted for the Office of CSHCN, the survey conducted by Family Voices; and comments from a variety of key informants.

Medicaid Managed Care Organizations provide networks of care and services for CSHCN including primary, secondary and tertiary care. The designated services and service providers are not always family-centered and community based and those living in the south have long distances to travel to obtain necessary services.

However, the Title V sponsored survey of parents of CSHCN showed a fairly high level of satisfaction with their children's primary care physician with 84.1% stating that they were very satisfied and 13.3% stating that they were somewhat satisfied. This level of satisfaction was not carried over to satisfaction with their health care plan. 58.8%

were very satisfied and 31.6% were somewhat satisfied. In the CAHPS survey (described in the Needs Assessment section on Direct Health Care Services and Enabling Services for Pregnant Women, Mothers, and Infants) which surveyed adults, satisfaction with the health plan was only slightly less than with physicians. The correlation with adult experience and experience with service for their children should be high. However, it seems as if the demands placed on their health plans are greater given the needs of their children. On the other hand, per the Family Voices survey, parents of children covered by Medicaid give higher performance ratings and are more satisfied with their health plans than parents of children in private health plans.

This survey also identified many of the same problems as the focus groups and Title V sponsored survey respondents identified. The most common complaints include hassles in obtaining needed care, inability to obtain accurate and clear information about available services, and unsatisfactory coordination of services. Families of children whose health conditions are more unstable report less satisfaction with their child's primary health plan and considerable problems coordinating their child's care, accessing needed services, and locating providers with the skills and experience necessary for their children.

Parents need clear information about health plan benefits and ways to access services for their CSHCN. Managed care plans provide Health Benefits Managers to work with parents of CSHCN. However, parents are not always aware of what is available. In addition, the responsibility for the provision of therapeutic services-mental health, speech, physical and occupational therapy needs to be clarified for parents because they are often unsure whether these critical services will be provided by their child's health plan or the local school system. They are also unsure as to which health plan, Medicaid or private, will pay for the services. More effective methods to link these systems together and to provide information and support to families are needed. Improved coordination of care and communication among providers of care is essential. For children with complex needs served by many different providers and agencies, greater emphasis on coordinated care is imperative.

Shortages of Health Care Providers

As already described in the Annual Report section, DPH offers diagnostic and short-term treatment services for some special needs for children especially in Kent and Sussex Counties where geographic access is limited.

Specialty Care Physicians: The majority of this state's pediatric specialists are housed in the duPont Hospital for Children. CSHCN and their families who live down state can travel as much as 2 hours or more for a doctor's appointment and then have to go to their local network lab for prescribed blood work and x-rays. A second visit to duPont Hospital may be needed for lab and x-ray follow-up. This process is time consuming and debilitating for a medically fragile child and family.

Dental Care: Delaware's lack of dental providers particularly affects children with special health needs. For instance, providers working with children with Cleft Palate have noted that lack of Delaware dentists and

orthodontists has been a particular challenge since it is imperative that they receive good dental care to combat the sequelae of their birth defect. At least one parent interviewed during the focus group sessions expressed concerns that most dentists do not want to touch her severely disabled child and she is forced to travel a long distance to du Pont Hospital for needed dental care. The survey of parents of CSHCN showed that while most needed specialty services were provided, a lower proportion of those needing dental services actually received them (77.6%). Since this sample was very small (116 respondents), this problem might not extend to the larger population. However, given Delaware's overall problem providing dental care the results were not surprising.

Physical Therapy, Occupational Therapy, and Speech: School-aged children with special health care needs are often limited to therapeutic interventions in the school setting. Therapies are usually provided in the consultative modality in a group setting by the teacher who consults with the therapists. However, parents have not been included. Therefore, carry over of therapies is a challenge to parents and other caregivers who are not present for the intervention. Parents see a need for additional therapeutic interventions in the home in addition to the functional therapies received in the school. In most cases, they are denied. Parents are not sure if the denial is from the school, primary care physician, and/or their health care insurance.

The duPont Hospital for Children has instituted Specialty Clinics particularly to address the needs of CSHCN in Kent and Sussex Counties. The need for Specialty Clinics outside of the hospital is made known through reviews of clinic appointment books. The hospital has established standards regarding how long a child should wait for an appointment and how far (there has to be a certain number) a child should travel to an appointment. Once a need is identified a clinic is established (i.e., Cleft Palate Clinic at the Williams State Service Center three times a year and Orthopedic Clinic in Seaford). Plans are underway for a Cardiac Clinic in Seaford and Hematology Clinic somewhere in Sussex County. Clinics are held every month unless the need indicates otherwise. The specialty clinics provide many service providers (MD, RN, Nutritionist, Social Workers, and Dentists) at one location and at the same clinic visit for a child to receive comprehensive services.

Respite Care: Respite services are provided in a limited capacity to CSHCN who do not require skilled nursing. It is more difficult to find service providers for technology dependent children than for children with fewer medical needs. Typically, private and public health care insurance does not support respite care. However, there are some available sources of funding. The Division of Mental Retardation (DMR) receives state funds for respite. DMR provides two weeks of respite care to their clients. Children, who demonstrate a 25% cognitive delay, are eligible to receive services through DMR. Parents are given the option to obtain their own respite care provider or the DMR will designate a provider. The United Cerebral Palsy (UCP) offers several state- wide choices of respite care such as, center- based weekend day care; summer day camp; and center –based weekend care. UCP provides services to children with physical disabilities who do not require skilled nursing. The State's minor league baseball team, the Blue Rocks, has recently endorsed UCP, as their designated charity. Donations from the Blue Rocks will help support respite care. The Easter Seal Society provides respite for all children 6 to 14 with a disability. The

population served includes families of children with cognitive and physical disabilities (including ventilator dependent). The respite services include weekends and over-night summer camp all in Maryland. The family must pay for the weekend services although there is limited financial assistance from Easter Seals for the summer camp. The state Autistic Program also provides services to families of its students. Families are entitled to 24 hours of monthly respite care, plus an additional 7 days per year. Parents provide some payment and the State Department of Education subsidizes the rest. The Ecumenical Council represents Delaware's faith communities and also provides "low end" respite care to the families of children with special health care needs.

The Office of Children with Special Health Care Needs recently recruited a respite advisory committee to address the respite care needs of Delaware's CSHCN. During this time the CSHCN Director discovered the existence of another group working on respite issues. At this point, it has not been determined whether this group is the best vehicle to address this issue or if Title V lead is needed. The focus of this group is on children with severe medical needs who are in most cases institutionalized or would meet the criteria for institutionalization. One of the goals is to establish a group home for these children with a few extra beds to serve as respite beds. There have been discussions regarding enlarging the already established committee to address the issue for the total population but no decisions have been made.

Linkages That Promote Provision Of Services And Referrals Between Primary Level Of Care, Specialized Secondary Level Care And Tertiary Level Care

As a small state, Delaware is in an optimal position to link health services. There are several efforts affecting direct service delivery that should be noted.

State Service Centers: The Division of State Service Centers within Delaware Health and Social Services administers a statewide network of service centers. These centers, 14 in total, serve as multi-service facilities in which various public and private agencies are co-located, with the goal of promoting access to Delaware's health and human service system. The goal is to provide client support services that promote increased accessibility, enhanced service integration and efficient service monitoring. Annually, more than 600,000 visits are made to State Service Centers throughout Delaware. Each service center provides a mix of services appropriate to the communities that it serves. There are over 160 programs and services delivered through state service centers.

The Division of Public Health locates many of its clinics at the centers including several very large operations such as Hudson in Newark, Northeast in Wilmington (New Castle County), Williams in Dover, Milford State Service Center (Kent County), and Bridgeville, Pyle, Laurel, Georgetown and Shipley, all in Sussex County. Refer to map of clinics for more detail. In addition to Public Health, services can include probation and parole, mental health, social services, and Medicaid.

Christiana Care's Perinatal Behavioral Health Program: All women of child bearing years within the Christiana Care Health System perinatal obstetrical catchment region are eligible to participate in this pilot program aimed at maternal depression. This program spans the continuum of care and coordinates universal screening, education, and treatment efforts as the patient moves through different stages of her life and different parts of the health care system. The goal is to provide seamless care that integrates with pre-existing perinatal and behavioral health pathways. The key components of the program include early identification through universal screening of all pregnant women, assessment/triage to the appropriate level of intervention, and ongoing case management with serial assessments. Services may include social service referrals to community agencies, education and support groups, infant development classes, lactation consultation, perinatal bereavement consultation for previous losses, psychiatric evaluation and counseling, and crisis intervention.

Child Find: Under the Individuals with Disabilities Education Act (IDEA), Delaware has established a *Comprehensive Child Find* System to locate children with disabilities. The Supporting Documents include the Part C flowchart, which shows the design for the Part C or Birth to Three System. The system was designed in a manner to build upon and expand those programs in place prior to Part C. The flow chart shows how the various referral sources feed into Central Intake. Central intake allows for the tracking and referral linkages for infants and toddlers who are at risk and are not eligible under Part C. Included as an integral part of the Central Intake process is the Home Visiting program.

Medical Home: The Office of Children with Special Health Care Needs in partnership with the Medicaid Office, Family Voices, and the local chapter of the American Academy of Pediatrics is developing a medical home model to meet the care coordination needs of CSHCN. In the medical home model a child's primary care physician will be designated as the medical home to ensure that service delivery is family-centered, community-based, culturally competent, coordinated, comprehensive, cost-effective, and compassionate. (More information is provided in the section describing the constructs.)

3.1.2.4 Population-Based Services

There are several population-based services that are managed directly by the Division of Public Health. Most are achieved in cooperation with other programs. Described below are those specifically population based programs related to meeting Title V objectives.

Population-Based Services for Women and Infants

Newborn Screening

As described in the Annual Report, the state screens for Phenylketonuria (PKU); Congenital Hypothyroidism (CH); Galactosemia; Hemoglobinopathies; Biotinidase Deficiency; and Maple Syrup Urine Disease (MSUD). Results of testing are provided to the Delaware Newborn Screening Program by electronic data transfer, to the hospital of birth in writing for inclusion in the medical record and to the primary care provider of record in writing. During the past

year, the state has allotted Specialty Formula funds to help to fund special formulas needed as a result of disorders such as PKU. The Division of Public Health administers these funds.

Funding mechanism: Newborn Screening dollars are generated through revenue.

Geographic availability/distribution: Delaware has an outstanding record in meeting this need. Every birthing hospital participates.

Universal Hearing Screens

Delaware's Universal Newborn Hearing Screening Initiative falls under the auspices of the Delaware Infant Hearing Assessment and Intervention Program (DIHAIP) of the Delaware Chapter of the American Academy of Pediatrics. DIHAIP serves as a statewide steering committee to support the establishment of a universal infant hearing assessment and intervention program for all infants born in Delaware. The DPH CSHCN Director serves on this committee in addition to Child Development Watch (CDW) service coordinators; Medicaid representative; school representative; other experts in the field of newborn hearing; and representatives from the 6 birthing hospitals and DuPont Hospital for Children. The role of the CSHCN Director is to facilitate a statewide approach to screening, early intervention, data collection, quality management and evaluation.

Funding mechanism: Funding for screens is provided through the private sector. For the state component, DPH is reviewing a variety of sources chiefly federal dollars.

Geographic availability/distribution: The six birthing hospitals are now providing universal hearing screens. St. Francis Hospital in Wilmington and Nanticoke Hospital in Sussex County just started in the spring of 2000.

Breastfeeding promotion

Education regarding breast feeding is provided within public health clinics and recommended to all clients except when a client is HIV positive. As already described the WIC program has the lead in DPH for promoting breastfeeding. It has collaborated for years with the Delaware Breastfeeding Advisory Board to conduct an annual Breastfeeding conference. WIC also works with the Perinatal Board to distribute information on breastfeeding.

Funding mechanism: Funding depends on the specific program. WIC is a federally funded program. The Perinatal Board used March of Dimes and Healthy Start state dollars to support the development and distribution of its' "Breast is Best" brochure.

Geographic availability/distribution: Promotion is available throughout the state.

Folic Acid

Under the leadership of the March of Dimes, the Folic Acid Coalition was formed last year. The Division of Public Health participates with this group and along with the March of Dimes and Happy Harry's Pharmacies is leading a folic acid awareness campaign. A key component of this effort is the distribution of vitamin vouchers to women entering family planning clinics and who discover that they are not pregnant. These vouchers are provided at the courtesy of Happy Harry's. Other efforts have included distributing *B-Attitude* bookmarkers in bookstores throughout the state as giveaways to promote folic acid.

Funding mechanism: Funding for these efforts have come from the March of Dimes and Happy Harry's. The Division of Public Health has provided in-kind support.

Geographic availability/distribution: This effort is a state-wide campaign.

Home Visiting Program

The State of Delaware offers the Home Visiting program to all first time mothers of newborns. Home visits are conducted by several home health agencies. If a second home visit is needed, these can be undertaken by a variety of agencies based on identified needs. Second visitor agencies include Baby Steps, Parents as Teachers, Public Health's Second Visitor programs, and Community-Based Parent Education and Support.

Funding mechanism: Funding is provided through state General Funds.

Geographic availability/distribution: Services are provided to all new mothers. During the last 3 years, 10,426 have taken advantage of this service. Percentage of participation increased from 69% in 1997, to 86% in 1998 and to 91% in 1999.

Population-Based Services for Children and Adolescents

Immunizations Program

The goal of public health is to ensure that children receive services through their medical home. However, DPH clinics continue to provide immunizations even for children who are Medicaid eligible because primary care physicians do not always provide immunizations or there are long waiting lists. Unfortunately, the rate of immunizations for two-year-olds has dropped since last year from 81% to 75.4%. (See Progress report.) More needs to be done in this area and the program is carefully reviewing programming options.

Funding mechanism: Funding for immunizations comes from state and federal dollars.

Geographic availability/distribution: The Division also makes an extra effort to reach special and rural populations by providing specific immunization clinics to the Amish population and to the rural residents in southern Sussex

County. For instance, there is an Immunization clinic that is held at the Laurel Flea Market in rural Southern Delaware.

Lead Poisoning Prevention

The DPH Office of Lead Poisoning Prevention staff currently provides the following services:

- Nurse review of all blood-lead test results from all duPont Pediatrics, DPH and Claymont Family Services providers, including written recommendations for appropriate follow-up blood-lead testing to those providers, based on current CDC guidelines;
- Medical history to monitor developmental progress and referral to an early intervention program for further assessment if there are delays or lags; environmental history to identify exposure sources;
- Determination of nutritional status and recommendations to parent/guardian regarding correction of nutritional problems;
- In-home assessment by a nurse and social service specialist to educate families about the causes and both the short- and long-term repercussions of a child's elevated blood-lead level; and
- In-home assessment by a certified lead inspector or risk assessor to identify sources of exposure and to recommend lead hazard reduction alternatives.

Appropriate chelation therapy is performed by a licensed M.D. Lead hazard reduction of the child's primary residence is provided by a certified lead worker under the supervision of a certified lead contractor supervisor. Temporary or permanent relocation of the family to lead-safe housing is provided through community resources.

Funding mechanism: Federal funding sources include Centers for Disease Control, Childhood Lead Poisoning Prevention; Environmental Protection Agency, Office of Pollution, Prevention and Toxics; and the Department of Housing and Urban Development, Lead Hazard Control Program.

Geographic availability/distribution: Delaware has a mandatory blood-lead screening law, requiring all children to be blood-lead tested at or around 12 months of age. Children are identified with elevated blood-lead levels in Delaware by blood-lead testing primarily through their primary health care provider. Screening is also provided through the DPH clinics but since managed care, referrals to DPH have decreased. Ten statewide duPont Pediatrics sites perform about half of all blood-lead testing that occurs in the state, with DPH providing each duPont Pediatric site with blood-lead screening supplies and DPH laboratory analysis of their blood-lead specimens, free of charge. In FY '99, 64 children (out of 9958 blood lead tested, or 0.6%) under the age of 72 months were identified with lead poisoning (at or above the CDC action level of 15 mcg/dL).

Emergency Medical Services for Children

In November 1999, the state's office of Emergency Medical Services issued its first annual report on the EMSC program in Delaware which was started in 1997. The goals of the EMSC program are:

- To ensure state-of-the-art emergency medical care for children,

- To integrate EMSC into existing EMS systems,
- To establish and maintain links with children's primary care providers, and
- To provide primary prevention of illness and injury education to children and youth.

The program focuses on four areas: system development, injury prevention, data collection, provider training, and equipment standardization. Successes have included a comprehensive needs assessment of the pediatric emergency care system in the state and development of Basic Life Support and Advance Life Support treatment protocols.

Injury Prevention

In addition, the EMSC program has placed a specific emphasis on injury prevention programs. An integral component of the EMSC program is to stimulate community awareness about the need for EMS-based injury prevention activities. One way of stimulating interest was to hold a competitive application process which awarded thirteen contracts to local programs during the first year. Efforts addressed car seat distribution, safe sitter training, all terrain vehicle injury prevention, bicycle injury prevention, poison prevention and a smoke detector program.

Risk Watch is a broad-based injury prevention program developed by the National Fire Protection Agency and a coalition of Northern America's most authoritative injury prevention professionals. Targeted are children from pre-kindergarten through eighth grade for the eight major risk areas that kill or injure children every year. These include motor vehicle safety; fire and burn prevention; choking, suffocation and strangulation prevention; poisoning prevention; falls prevention; firearms injury prevention; bike and pedestrian safety; and water safety. The EMSC program has worked with the Department of Education to establish *Risk Watch* training programs in several schools as a pilot program. To help with implementation, the EMSC program bought ten training units for schools and community groups. As of May 2000, there are seven schools committed to the program throughout the state.

Funding mechanism: The state receives federal dollars for this program from the Federal Department of Health and Human Services for development of EMSC and from the National Fire Protection Association specifically for Risk Watch.

Geographical Distribution: The program itself is statewide but not every component is offered in every part of the state. The Risk Watch program is offered in selected schools.

Teen Pregnancy Prevention Programs

Throughout this document, the reader will note reference to numerous programs aimed at preventing teen pregnancy. They cover all levels of the MCH pyramid.

The state has placed much of its' population-based efforts in the hands of the *Alliance for Adolescent Pregnancy Prevention (AAPP)* of Christiana Health Services which has a contract with DPH. The mission of the AAPP and its board is to decrease the teen fertility rates in Delaware by promoting increased education of teens, parents, and the

general public. Much of the effort has been to increase media attention to this concern. Messages have been placed on billboards such as "Talk with Your Kids About Sex...Everyone Else Is!" In addition a radio advertisement was aired on a local radio station that reaches adolescents statewide. In addition to the main Resource Center in the Wilmington hospital, 11 additional mini-resource centers have been established in Boys and Girls Club facilities in the state. These centers are stocked with brochures, books, videos, curricula, posters, games, activity kits and other materials for children of all age levels. Some materials are designed specifically for adults to help them to communicate with their children about sexuality, risky behavior and teen pregnancy prevention. Other approaches have included participation in Health Fairs and public speaking, workshops and training sessions for more than 1,800 adults and youths, and SLAM '99 (Students Learning, Adults Mentoring) conferences geared to improving communications between adults and teens.

Funding mechanism: The AAPP receives \$430,000 annually through the Division of Public Health and the federal abstinence education grant

Geographic availability/distribution: These programs are statewide.

School Based Health Centers

School-Based Health Centers (SBHCs) operate in 27 of the 29 public high schools and are available for any student with parental approval. SBHCs are administered in the Division of Public Health's Family Services Branch (also including Title V) and carried out by medical vendors who are contracted to staff and operate the centers. They offer health care services, mental health services and nutrition services to enrolled students. However, they also offer numerous population based services such as Lunch and Learn sessions.

Focus groups were conducted during spring of 1999. The focus groups are part of an evaluation plan to assess whether Delaware School Based Health Centers (SBHCs) make a difference in the health care of students. Although the total evaluation is not yet completed, findings from the focus groups are:

- Students, parents and staff focus groups believed that SBHC services/activities contributed to reductions in adolescent risk taking behaviors students;
- Parent and staff focus groups felt that center services/activities assisted in improving adolescent health care decision making;
- Female group/male group indicated that health-related, "problem solving" services as a major reason for SBHC usage; and
- Both student and parent focus groups indicated that SBHCs promote active parental involvement in adolescent health care.

This study illustrates that the School Based Health Centers have had a positive impact on individuals, family units, high schools and the community-at-large. In addition, students, parents and school staff strongly support expanding school-based center services (i.e., middle schools) and increasing mental health hours.

Funding mechanism: SBHC receive most of their funding through state general fund dollars. One center receives \$130,000 from the MCHBG.

Geographic availability/distribution: One of the schools that does not have a center is in northern New Castle County and the other is in Dover.

School Health Programs

Delaware has an organized, effective system of school nurses managed by the Department of Education (DOE) which places a nurse at every state public school. Other collaborative efforts extend from very young children up to and including high school students. Together DOE and CHCA have collaborated in the operation of the scoliosis screening program, the hearing conservation program, and the optometry program. DOE works with DPH's EMSC Program. In addition to Risk Watch, the EMSC program provides training to school nurse on preparing for and managing school emergencies. The DPH and DOE have collaborated to ensure that school based health centers are in any public school that wants one. Together they developed a position statement on School-Based Health Centers, which clarifies the wellness centers' role and scope of services, which can be delivered in the school setting.

Funding mechanism: School programs have a variety of funding sources including state, school district, and federal funds.

Geographic distribution: In addition to 21 public school systems throughout the state, there are numerous private and parochial schools throughout the state the majority in New Castle County.

3.1.2.5 Infrastructure Building Services

Statewide and Local Partnerships Addressing Needs Of Total MCH Population

Delaware has many of the building blocks of a comprehensive health system and numerous partnerships addressing health needs.

Delaware Institute of Medical Education and Research (DIMER)/Health Care Commission and Division of Public Health access to care initiative: The purpose of this collaboration is to attract physicians to underserved areas of Delaware by offering funding to repay student loans. Plans are underway to provide payments incrementally after every 6 months of service and will increase with each payment to physicians agreeing to serve in Delaware. The service obligation for physicians receiving loan repayment will be 3 years. Physicians and organizations looking to hire physicians register for the program and are matched based on compatible criteria. Physicians may also serve

their loan repayment obligation by opening a solo practice. Targeted are physicians with student loan debt and organizations looking for physicians to practice in high need areas.

Health Care Commission application for a Community Access Program (CAP) grant: This request is a collaborative effort of the Commission, DPH, the Federally Qualified Health Centers (FQHCs), Delaware Foundation for Medical Services, the Medical Society, Delmarva Health Initiative, hospitals, Chamber of Commerce, Perinatal Board, Call-A-Nurse, EDS, etc. The grant will provide for implementation to assist states with developing systems of care for the uninsured. Delaware's approach is to develop a single fee scale among participating agencies for all uninsured, including primary care and specialty and ancillary services. An information management system will be developed that links all "network" providers so that patients can be case managed and demographic information is available at all points of service.

Central Delaware Community Health Partnership and the Southern Delaware Community Health Partnership: These two organizations are collaborative partnerships consisting of numerous agencies and professionals, the former serving Kent County and the latter serving northern Sussex County. Members include but are not limited to: Public Health, Chambers of Commerce, Delmarva Rural Ministries, Bayhealth, American Red Cross, Child Inc., Social Security Administration, Dover Air Force Base, Blue Cross Blue Shield of Delaware, senior centers, and both private practice physicians and retired physicians. They are steered by a Board of Directors, which includes the Division of Public Health, and each has obtained 501 (c) 3 status. Their missions are similar: to promote better health for all residents by enlisting the help, cooperation, and commitment of individuals, organizations and businesses that together will pool resources, leverage other dollars and implement programs and state-level policies that advance the community's good health and well being.

These two organizations have worked to address needs identified in needs assessments conducted by Kent General Hospital in 1995 and Milford Memorial Hospital in 1996. (These two hospitals eventually joined to become part of Bay Health Medical Center.) Needs identified continue to be of concern. They are: 1) access for underserved, uninsured and underinsured populations, 2) knowledge of the existing health care delivery system and resources, 3) access to services for the elderly, 4) opportunities and activities for youth to counteract the risk of typical adolescent health disparities, and 5) development of infrastructure to focus on family-centered care for women and children.

As a result of the needs assessment, the Central Delaware Community Health Partnership and the Division of Public Health established the Kent Community Health Center for migratory farm workers. The goal is to develop the Center into a full time comprehensive provider of primary and preventive health services that serve as a medical home under various managed care plans.

Delmarva Health Initiative: Four community partners, including three hospital systems (Beebe Hospital, Bayhealth, and Nanticoke) and the Division of Public Health Office of Primary Care, have joined forces to identify those

without a medical home and to provide information to help them to access services. This partnership is responsible for developing and implementing the Rural Health Plan.

La Red: LA Red, translated to mean "the network," is currently in phase I of its mission to improve access to primary and preventative health services for vulnerable populations of Sussex County. At present La Red is a bilingual health service referral Hotline with plans to become a comprehensive health care center. This group has just been approved for a Rural Health Outreach Grant. La Esperanza, Inc., in Georgetown will operate the program. The network of organizations that will be contributing include Nanticoke Health Services, a number of rural private physicians, Division of Public Health, and the Episcopal Diocese of Delaware. The target population of this project is primarily the minority populations and the underinsured and uninsured of Sussex County. Services will include both primary medical care and preventative care to include prenatal care, immunizations, well baby checks, development screening, and adult chronic disease screenings.

Strong Communities: The Delaware Family Services Cabinet Council initiated the Strong Communities Initiative in 1994 to address the needs of Delaware communities, relative to the provision of services and to provide a vehicle for collaborative community building activities. There are two Strong Communities Initiatives, one in Kent and another in Sussex. The Division of Public Health Southern Services provides support to both. In Sussex County, using Preventative Health Block grant funds, DPH funds two projects: a youth prevention initiative focusing on alcohol, tobacco and nutrition and a grant writing workshop to enable community leaders to obtain skills and knowledge necessary to seek additional funding for after school and adult programs. The state also provides funding for teen pregnancy prevention after school group. DPH health educators provide programs on STDS, reproductive health, and self-esteem to adolescents in these communities. In Kent County, state teen pregnancy prevention dollars are used to fund several programs. The Kent County Strong Communities have been working to establish their priorities which will be announced in a few months. Expected to top the list is community policy and crime reduction and infrastructure issues such as street lights and water/sewer issues.

Medicaid and Public Health: Public Health has contracts with the two Medicaid Managed Care contractors to provide services for Medicaid eligibles. Contracts include Kids Kare, Smart Start and Family Planning. Currently Medicaid also pays directly for assessments at Child Development Watch but these will be eventually incorporated into managed care plans. The Public Health Managed Care Steering Committee is developing Prevention Partnerships with MCOs. The focus is expected to be on pregnancy prevention and tobacco control.

SSDI

The SSDI program is part of the Health Systems Development Branch within the Community Healthy Care Access (CHCA) section that houses Title V. The SSDI Coordinator serves on the MCH Needs Assessment Steering Committee. Other activities, both planned and completed, include the completion of an inventory of resources available in Sussex County and the barriers experienced by the Hispanic population in accessing health care;

completion of an oral health care needs assessment of pre-school and elementary school-aged children throughout the state; completion of a Community Health Profile for every community in Delaware and presentation of those profiles to community leaders; and collaboration with state and community stakeholders in developing strategies for addressing identified needs derived from the MCH needs assessment.

Women's, Infants, and Children Program (WIC) Title V and the WIC program are administratively in the same DPH unit, the Community Health Care Access Section, and have many opportunities to consolidate policies and services. WIC also works with other agencies to provide services and ensure quality. For instance, WIC was instrumental in the formation of the Delaware Breastfeeding Advisory Board, which now operates under the Perinatal Association of Delaware. WIC also works closely with teen pregnancy prevention programs to prevent additional pregnancies, with the Immunization Program to ensure compliance by their recipients, and with the March of Dimes Program to provide information about folic acid.

Statewide And Local Partnerships Addressing Needs Of Women and Infants

Perinatal Board: In November 1995, Governor Carper signed Executive Order Number 37 establishing the Delaware Perinatal Board. Its purpose is to:

- provide oversight for the infant mortality problem
- assess, define and prioritize problems
- assist in the development of an approach
- establish appropriate standards
- assess the state's need for services on a community-by-community basis
- evaluate the effectiveness of initiatives
- coordinate and manage relevant data.

The Director of Public Health sits on this Board and it is staffed by the Title V Director. Further, each Perinatal Board Committee has a DPH staff person including the Directors of the Women's and Reproductive Health Branch and Family Planning and the Chief of the Health Monitoring and Program Consultation Section.

March of Dimes: The Family Health Services Director (Title V) serves on the Program Services Committee of the March of Dimes. This committee which is made up of representatives of many of the agencies described in this application is devoted to developing plans for March of Dimes programs particularly the *Train the Trainer* preconceptional health counseling, application for national program funding, and development of fund raising activities. (See Population-Based Services for detail on Folic Acid Campaign.)

The Perinatal Association: The Perinatal Association of Delaware (PAD) which supports community Resource Mothers. PAD and DPH work as a team on shared client cases and work to provide each client with the most comprehensive care without duplication of activities. Resource mothers are paraprofessionals from the community who identify and assist mothers, their infants and families with accessing needed resources. They serve as

mentors/role models by teaching and demonstrating skills in a variety of areas including menu planning, budgeting, parenting, etc.

Statewide And Local Partnerships Addressing Needs Of Children and Adolescents

Head Start and Early Childhood Assistance Program (EAP): Head Start is administered by seven community-based organizations throughout the state. Early Childhood Assistance Programs (ECAP) are state funded programs administered by the Department of Education and operated by seventeen community based organizations throughout the state, including existing Head Start grantees, school districts, and other early education agencies. Approximately 1,571 children between three and five are served by the traditional Head Start program. 843 four year olds are served by EAP and 36 are served in Migrant Head Start. All programs followed the federal Head Start Performance Standards. The Division of Public Health participates on the Head Start Collaboration project which was established to develop state level partnerships for planning and policy development for Head Start eligible children and their families. Priority areas include welfare reform, health access, childcare, disabilities, educational opportunities, volunteerism, literacy, and homelessness. In addition, Child Development Watch staff work with local Head Starts and other providers on the Sequence in Transition to Education in Public Schools (STEPS) Committee which concentrates on transition issues for 3 year olds.

Early Success: In the spring of 1998, a special committee, Early Care and Education Steering Committee, was established to address child care in Delaware. The administrator of the Community Health Care Access section served on the committee. The committee was made up for business representatives, the University of Delaware, social service agencies, school districts, child care providers, Head Start, state and federal legislators or their staff, community centers, parents, etc. In February 2000, it issued a plan, *Early Success creating a quality early care and education system for Delaware's Children*. This plan has three goals for all Delaware's children and their families:

- Ensure safety while parents work
- Ensure full preparation for school.
- Ensure quality, continuity, and efficiency in an early care and education system.

Recommendations of the plan are the establishment of a Steering Committee to oversee its implementation including the responsibility to "Coordinate the delivery of early care and education services; and link such services to health, education, and social service systems." Quality programs are described as those who pay attention to the child's total development including mental and physical health. These programs support access to state and community services, for example "meeting health and safety concerns by linking child care programs with nurse consultation." If Early Success receives the expected support from the Governor and state legislature, it will be governed by an interagency council composed of the secretaries of the related departments.

Child Death Review Commission: The Child Death Review Commission was signed into Delaware law on July 19, 1995. The Commission oversees the work of the two Child Death Review Panels, one for New Castle County and another for Kent and Sussex Counties. The Commission is composed of leaders from state agencies, police, nurses,

physicians, attorney general's office, social workers, and child advocates. The Commission has the power to investigate and review the facts and circumstances of all deaths of children under 18, which occur in Delaware. Furthermore, it has the power to administer oaths and compel the attendance of witnesses. Its purpose is not to act as an arm of the police, but to look at systems to determine if the death was preventable. A death is considered to be preventable if one or more interventions might have averted it. Title V provides some staffing.

Major Providers Of Health And Health-Related Services (Including Collaborative Efforts)

Christiana Care Health System, Inc.: Christiana Care Health System (CCHS) is the largest provider of health care in the state. By both enlarging and developing its original services and incorporating other agencies into its operations, Christiana Health Care now provides a vast array of services. These include home health care, surgery, rehabilitation from an illness, including a cancer center, heart center, women's health, emergency care, rehabilitation center and patient services, and Call-a-Nurse program. It has the only Level 3 neonatal intensive care unit (Christiana Care Special Care Nursery) in the state. In addition, services include preventative services through their Preventive Medicine and Rehabilitation Institute (PMRI). These include cooking and exercise classes, relaxation workshops, support groups and assessment clinics. The system also includes two health insurance programs: First State Health Plan providing Medicaid coverage and Mid-Atlantic Health Plan.

The Division of Public Health collaborates with CCHS on many issues. DPH social workers and WIC nutritionists help to staff CCHS Obstetrical practice at the Wilmington Hospital. CCHS and the duPont Hospital for Children collaborate with the DPH and other state agencies on providing assessment services for Child Development Watch (CDW). High-risk follow-up for premature infants is also provided through a collaborative agreement between the hospitals and CDW. It also administers the Healthy Start grant and has contracts with DPH to administer several School Based Health Centers. The CCHS's PMRI has been awarded a grant for the last three years by DPH for its Alliance for Adolescent Pregnancy Prevention program. The Chairpersons of the Perinatal Board and its Standards of Care Committee are also CCHS physicians.

In addition, Claymont Community Center, located north of Wilmington, provides services in conjunction with the Division of Public Health and Christiana Care Health Services. Services provided include: adult ambulatory care, HIV testing and counseling, WIC nutrition and counseling, well child clinic, immunizations and selected screening programs. Christiana Care has recently entered into an agreement with the community center "to provide medical directorship" and provides pediatric and prenatal care on an "on call" basis.

Healthy Start: In 1997, Christiana Care Health Services, Inc. took the lead in applying for and receiving the Healthy Start grant for Delaware which focuses on several at-risk areas in Wilmington. The overall goal is to improve perinatal outcomes and minimize those stressors impacting infant mortality in the city through a vehicle of community collaboration. Three strategies are being implemented to accomplish this goal: 1) strengthen community collaboration efforts and involvement, 2) enhance client recruitment to reach those clients most difficult to reach,

and 3) avail to clients more services that will reduce stressors impacting infant mortality. This project includes outreach through the efforts of Resource Mothers and Outreach workers at 8 community centers. The Northern Health Services Administrator serves on the Board of Directors and several staff are active in Healthy Start Committees of the Consortium.

Bayhealth Medical Center: This center incorporates both Kent General in Dover and Milford Memorial Hospital in Sussex County. It is the second largest health care system in the State of Delaware. Services include a continence center, comprehensive cancer care, consumer health, diagnostic testing services, outpatient including community testing sites, emergency department, maternity, neonatal intensive care, pediatrics, audiology, rehabilitation services, respiratory care, surgery, women's health and transitional care. Bayhealth works on a variety of community initiatives such as the *Central Delaware Community Health Partnership*. And like Christiana Care, it also contracts with DPH to provide oversight for sixteen school based health centers.

DuPont Hospital for Children: The duPont Hospital for Children, located north of Wilmington, with funding from the Nemours Foundation, serves as a full-service regional pediatric medical center offering a complete range of clinical programs. As already described, it has established a system of pediatric clinics throughout the state to provide primary health care for unserved and underserved children. DuPont Pediatric Clinics provide check-ups; physicals; sick visits; vision, hearing, and lead screening; immunizations; referrals to specialists, and a 24-hour medical advice hotline for parents.

Nanticoke Memorial Hospital: Nanticoke Memorial Hospital with 120 beds includes extended care, outpatient services, psychiatric and chemical dependency services, and preventive medicine and health education programs. An affiliation agreement with Johns Hopkins Hospital and University and duPont Hospital for Children provides access to their specialists. Public Health works closely with Nanticoke to ensure early entry into prenatal care. DPH Nurses, social workers and nutritionists are housed at the Nanticoke Maternity Center so that they may refer eligible at-risk clients right into Smart Start. Nanticoke also manages three school based health centers.

Beebe Medical Center: Beebe is a small hospital located in Lewes, Delaware. It holds several contracts with Public Health to operate a school based health center and to provide x-ray services. It also collaborates with other agencies on access issues. (See below.)

Beebe Hospital and Delmarva Rural Ministries: Beebe hospital located in Lewes, Delaware and Delmarva Rural Ministries have established a pilot program to provide medical care and links to social services for underserved populations of Sussex County through the MATCH van in targeted areas.. The project called Shore-Match is targeted for uninsured residents in Selbyville and Frankford. A case worker and a nurse practitioner travel on the van which parks in specific locations throughout the county. The case worker checks on the patient's insurance, helps to determine eligibility and refers to a physician in the Beebe network. The nurse practitioner provides on site

treatment. Payment is based on a sliding fee schedule. Plans are underway to provide a card that would establish eligibility for designated programs.

St. Francis Hospital: St. Francis Hospital is part of a nation-wide Catholic health system, located in the center of Wilmington. They are involved in community health outreach projects including health fairs and wellness days. The hospital is working with the West End Neighborhood House to transition its housing into property available for purchase by low and moderate-income buyers. They operate the St. Claire van which provides medical mobile outreach services to the homeless and uninsured. Finally, they provide Tiny Steps which is a comprehensive maternal fetal care program which uses family physicians to provide prenatal, intrapartum, postpartum, and newborn care at three locations: Westside Health Center in Wilmington, Family Practice Center at the hospital, and the Center of Hope in Newark. This program centers around the family practice residency program offering intense case management and follow-up to predominately Hispanic and African-American women.

American Academy of Pediatrics: Over the last several years, Public Health has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of Pediatrics (AAP). The AAP, Medicaid, and CHCA have participated on the vaccine committee, EPSDT implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality. They have offered their assistance with the Healthy Child Care America 2000 grant application and in the development of health care consultants for child care providers.

Federally Qualified Health Centers (FQHCs) There are three Federally Qualified Health Centers (FQHCs) in Delaware. Two are community health centers (CHCs) funded under Section 330 of the Public Health Service Act, and one is a migrant health center (MHC) funded under Section 329 of the Public Health Service Act. The CHCs are located in Wilmington (New Castle County). Henrietta Johnson Medical Center primarily serves African-Americans. Westside Health Services serves mostly Hispanics. The MHC, Delmarva Rural Ministries, has sites in Dover (Kent County) and in Sussex County serving the eastern shores of Delaware, Maryland and Virginia. Delmarva Rural Ministries services are targeted to farmworkers, underserved, uninsured, pregnant women and children. Its mission is primarily to meet a variety of needs of migrant and seasonal farmworkers and the low income rural resident.

Statewide And Local Partnerships Addressing Needs Children with Special Health Care Needs

Four Constructs of a CSHCN System

1. State Program Collaboration with Other State Agencies and Private Organizations

***Based on the above, Delaware is giving itself a score of 2= *mostly met* on the scale describing the Service System Constructs of Children with Special Health Care Needs. This scale states that *the state has established and maintained an ongoing interagency collaborative process for the assessment of needs with respect to the*

development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

Children with special health care needs (CSHCN) and their families who live in Delaware receive care and services from state and community agencies. The Office of Children with Special Health Care Needs in the Division of Public Health is responsible to ensure access to services and coordination of those services for children with special health care needs birth to 21.

Children Three Years and Over

Delaware does not have a comprehensive CSHCN program for children three to twenty-one. The responsibility for providing direct care and services for children past three years old falls to more than one agency. An assessment was undertaken to determine needs of families with children with special needs. Public Health conducted the recruitment of a diversified steering committee who provided guidance in the development of a needs assessment plan. The primary goal was to concentrate on determining the needs for older children and adolescents via the implementation of a survey and use of focus groups. (See Needs Assessment Process.)

Preliminary data from the needs assessment indicate for the most part there are services for CSHCN three to twenty-one; however, a holistic and family focused approach is lacking. Parents as life long advocates for their children need to be empowered to challenge inappropriate and inadequate services. Parents of CSHCN need continuous and repetitive information regarding access to care and services for their children. Over all, a state/community service delivery model is needed to ensure services for children three to twenty-one are coordinated, comprehensive, compassionate, family-centered, culturally-competent, and continuous.

Coordinated service delivery: There is little coordination of service delivery within the present system. There are numerous providers involved and communication is not consistent. The Division of Public Health as described below has established the Kids Kare program, which does provide comprehensive coordination for families of children with special needs.

The Department of Education and the local school districts provide services to the child (not the family) via the Individual Education Plan that by its very nature has an education focus. The school nurse and/or homeroom teacher may provide coordination. If a child needs therapy, these services often don't start until late October and then end in early June. Since parents are not present for therapies, there is no carry over to the home. The Division of Vocational Rehabilitation (DVR) is another agency that is involved once a child turns 14. However, services are limited to children with higher cognitive abilities. The Division of Mental Retardation (DMR) serves children of all ages with a 25% cognitive delay. They provide limited case management with some coordination with community agencies and resources such as the schools. DMR also provides respite care

Primary care physicians (PCPs) may provide care as single providers or as part of large practices. The duPont Pediatric Clinics, as already described, are a major provider in the state who take Medicaid eligible and some uninsured children. Families raise a concern that primary care providers are not always aware of available state and community programs that support children and families. Coordination between schools and PCPs is limited. This lack of knowledge greatly affects their ability to provide coordination. In addition, referrals are restricted to designated network providers, which limits the families' choice of a primary care physician and specialists.

Other resources are private therapy providers such as Easter Seal Society and Delaware Curative Workshop. However, for the most part, they do not work with other state agencies or schools to provide coordinated services. Parents also state that the transition of older kids to the Division of Vocational Rehabilitation in the Department of Labor is not clear to them particularly with respect to which agency is responsible and for what services. They also are concerned that coordination of services between agencies is often weak and fragmented.

Coordinated financing of services: There is some coordination of financing for services particularly through Medicaid. Disabled Children's Medicaid is a comprehensive health care insurance plan for CSHCN. Case management is limited to the medical needs of the child. In many cases case managers do not meet the child or family and are unaware of community resources. Approved services are based on professional documentation and not family input. The needs assessment has shown that parents have difficulty understanding the role and responsibilities of Medicaid versus the school. For the most part, however, private insurance does not offer any additional case management for CSHCN.

Coordinated Data Collection, Standards and Program Monitoring, and Polices:

There have been attempts through establishment of the Integrated Services Information System (ISIS) to establish a tracking system for children at risk from birth through eight but ISIS never became the tracking system that it was intended to be. (See below.) Standards, program monitoring and polices are not coordinated for this population.

Part C Infants and Toddlers Birth to Three

The Division of Public Health works closely with several state agencies to ensure collaboration in the continuation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for infants and toddlers with disabilities and/or developmental delays who are eligible under Part C of the Individuals with Disabilities Education Act (IDEA). Delaware Health and Social Services (DHSS) is the lead agency for Part C in Delaware. Included in a written agreement are the Department of Health and Social Services (DHSS) and its Divisions, Public Health (DPH), Management Services (DMS), Mental Retardation (DMR), Visually Impaired (DVI), and Social Services (DSS) Medicaid Program; the Department of Education (DOE) and the Department of Services for Children, Youth and Their Families (DSCYF) and its Divisions (Family Services (DFS) and Child

Mental Health (DCMH)). Although system administration is carried out through DMS, the program operations are the responsibility of the Division of Public Health's Child Development Watch (CDW) program.

Coordinated service delivery: The Child Development Watch teams have primary responsibility for the assessment, evaluation and service coordination components. The actual early intervention services delivered under the Individualized Family Service Plans (IFSPs) are provided through a network of approximately 43 different private and public providers across the state. The Program continues to recruit additional providers whenever possible.

Coordinated Policies: The teams of professionals who work in this program are staffed from all three departments and by pediatricians and pediatric subspecialists. There is a strong, ongoing commitment to work together among the agencies. One approach to collaboration has been active participation with the Interagency Coordinating Council (ICC). The Title V Director represents the Division of Public Health on the ICC. Participating are parents, physicians, the Departments of Education and Services for Children, Youth, and Their Families, Division of Mental Retardation, Medicaid Office, Delaware Insurance Office, among others. The ICC makes recommendation to the state regarding all Part C activities including programming, eligibility, and financing.

Another approach has been the development of internal interagency memoranda of understanding with Child Development Watch in the Division of Public Health and other agencies having staff on the teams. These are not in place of the Interagency Agreement, but in addition, with an emphasis on operational issues. Such an agreement with the Division of Mental Retardation is in place, as well as one with the Division of Family Services of the Department of Services for Children, Youth and Their Families (including eligible children in foster care), and with the Department of Education to outline the team participation of the Education Field Agents, and their role in service coordination, training, and transition to Part B (Birth mandate and School District) programs. These agreements are reviewed annually, and quarterly meetings are held in order to address intra and inter agency issues that arise.

Coordinated financing of services: In January 1996, the State of Delaware Medicaid Program instituted a managed care system. The Lead Agency works with Medicaid and the Medicaid Managed Care Organizations (MCOs) to assure coordinated care for Part C eligible families who are eligible for Medicaid or eligible for the Delaware Healthy Children Program, (also known as CHIP). CDW Clinic managers attend monthly meetings with the MCOs in order to discuss system issues of access, coverage, and timeliness.

Coordinated Standards and Program Monitoring: Procedural safeguards are in place that were developed with input and review by public and private providers, parents, ICC members and community advocates. Through the Interagency Agreement, all state-participating agencies have agreed to abide by these safeguards, and all vendors wishing to participate in the program must agree to abide by them as well. In 1997, DPH led another interagency team, the Quality Management Committee, in developing standards for the operations of the CDW clinics and its providers as they pertain

to services for children under three. These are the standards that are used to monitor the system and have served as the model for Kids Kare and Smart Start standards.

Part C's Interagency Coordinating Council is represented on the state-wide Department of Education's Parents Council for Children with Disabilities Committee, with professionals from state agencies, private providers and higher education. This group provides ongoing input to ensure that personnel necessary for implementing the Part C system are appropriately and adequately trained using established standards. The Part C Training Administrator is a member of a new group, New Scripts, and will be working with institutions of higher education to promote adequate curriculum development for disciplines working towards a career in early intervention.

In order to avoid duplication, monitoring systems already in place in the participating agencies are used, to the greatest extent possible. In addition, the Director of Children with Special Health Care Needs in Public Health chairs the Quality Management Committee that oversees the promulgation of standards and management of all quality assurance initiatives. Serving on the committee are several ICC members, parents, representatives from higher education, line staff from Child Development Watch and representatives from provider agencies. A monitoring sub-committee is developing a self-continuous monitoring plan, based on the program's standards, and the indicators for successfully meeting those standards. This year's focused monitoring was a parent telephone interview in the area of transition from Part C to Part B programs.

CDW participated in the interagency evaluation process developed through the University of Delaware's Center for Disabilities Studies. There are two components: an annual family survey and a child change initiative. The third Family Survey instrument was developed three years ago and has been distributed every year since to a representative sample of families eligible for Part C. The second component has been evaluating child change as a result of intervention. In addition, a measurement of family functioning is included in the process as an additional method for viewing child change. Last year, the Child Change Committee completed Phase I of the evaluation model to test the process of measuring child change under the direction of the interagency evaluation process. Phase II was completed at the end of 1999 and results have just been finalized. As a result of the study, the University recommends that 60 children be tracked on a continuous basis; no service coordinator have more than 3 children being tracked at any one time; and that the Play Based Assessment Scale (PAS) and the Home Observation Measurement of the Environment (HOME) instruments serve as the child change tools. Furthermore, at this point the study is showing that there are positive changes occurring in the development of these children which may be related to their participation in CDW.

Coordinated Data collection: The Coordinating Council for Children with DisAbilities was organized in 1963 to help to provide coordinated efforts for children with one or more "handicapping conditions." In the late eighties, it was asked to take on a new role of administering a new information system to track children at risk ages birth to eight. As part of the Interagency Agreement, all participants in the Part C system agreed to participate in and provide information, on a timely basis, to the state ISIS (Integrated Service Information System) data system. Participants agreed that ISIS would serve as

the data system for the early intervention system. Information regarding screening, assessments, and services for all children referred to Child Development Watch are entered into ISIS. This tracking system, however, never reached its full potential because most of the participating agencies did not want to ask their workers to enter into more than one system. Therefore, although it is possible to find some detailed information about children served in the CDW program, once a child leaves the system there is no way to keep up the data entry. Furthermore, the efforts made to extend ISIS to other agencies diluted the original purpose of the Council. In February, the Executive Committee of the Council (which includes the Title V Director) voted to go back to the Council's original purpose, which was based on coordination and advocacy. As this Council seeks to reorganize, it holds the possibility of becoming the Council that Title V looks toward to help its structure its mandate to serve CSHCN.

2. State Support for Communities

***Based on the above, Delaware is giving itself a score of 2= *mostly met* on the scale describing the Service System Constructs of Children with Special Health Care Needs. This scale states that *state programs emphasize community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.*

The State provides support for the development of community-based service programs for CSHCN through the 1) Transdisciplinary/Consultative (TD) Pilot Project, 2) the Medical Home Demonstration Project and 3) Partners in Policy Making. Service delivery is to be family-centered, community-based, culturally competent, coordinated, comprehensive, cost-effective, and compassionate. The Office of Children with Special Health Care Needs in the Division of Public Health facilitates the TD and Medical Home initiatives through technical assistance, consultation, education and training, and financial resources.

Transdisciplinary/Consultative Service Delivery model: The model that provides early intervention services in Delaware has been based on a one-to one or per child system of service delivery which does not always allow for the provision of care in an integrated, holistic way. Since the interaction takes place primarily between the child and therapist, the therapy is not usually integrated into a child's daily activities and service provision from several therapists can be confusing for both the child and family. To address these concerns, the Division of Public Health working with the Interagency Coordinating Council, Medicaid, and its managed care organizations piloted the transdisciplinary consultative pilot project. The model used offered the opportunity to expand access, offer flexible and coordinated care in natural environments, such as at home and at child care centers, and generally support families' needs while improving outcomes. The purpose of the transdisciplinary consultative intervention is to strengthen developmental processes and increase functional skills by integrating strategies into one inclusive plan. Another important aspect was providing a method of financing these consultative services and to ensure that costs would not be higher. Both Medicaid, through its managed care organizations, and Delaware Health and Social Services, through its Part C dollars, funded the services provided through the pilot.

A steering committee was recruited to facilitate the development, training, monitoring, and evaluation of the pilot. The TD steering committee is chaired by the CSHCN Director and is composed of CDW Clinic Managers; Part C Coordinator; Part C Fiscal Agent; Service Providers (Easter Seals of Del-Mar Inc and Christiana Care), and representatives of Medicaid and Managed Care Organizations. Committee members meet monthly to discuss and review the pilot progress and make recommendations.

The Division of Public Health received a grant from the Delaware Disability Planning Council to support TD training and evaluation. Thus far program evaluation shows that the children have demonstrated progress in their functional skills and parents are satisfied with service delivery. Communication has been enhanced between the Child Development Watch Program, service providers, and MCOs. Moreover, a cost analysis indicates a cost savings in overall service delivery. Although this project has been initially for children under three, it may serve as a useful model for providing services to older special needs children.

Medical Home: The Office of Children with Special Health Care Needs in partnership with the Medicaid Office, the Delaware Chapter of the American Academy of Pediatrics and Family Voices is developing a Medical Home Model to provide care coordination for CSHCN. The model is in its infancy stage and will continue to be developed throughout the year.

The inception of the Medical Home Model was the result of the June 1999, *Tri-Regional Work Shop, Children with Special Health Care Needs in Managed Care, Strengthening Partnerships to Assure Quality Services in a Changing Managed Care Environment*. The CSHCN Director recruited a delegation comprised of representatives from Family Voices; State Medicaid Office; Medicaid Managed Care Organizations; and the Delaware Chapter of American Academy of Pediatrics. The Work Shop promoted the development of a State Action Plan to ensure CSHCN are identified and Medicaid services are family-centered, community-based, culturally-competent, coordinated, comprehensive, cost-effective, and compassionate in the framework of a Medical Home. The President of Delaware's Chapter of the American Academy of Pediatrics applied for and was awarded a Community Access to Child Health-Planning (CATCH) Grant. The CATCH Grant will provide funding for training of State and community service providers in the Medical Home Model. It is projected that starting December 2000, the Medical Home Model will be piloted in one pediatrician's office in each county, New Castle, Kent, and Sussex.

The Medical Home Model for children with special health care needs is a State/Community effort to address the medical and social needs of children with special health care needs. Pediatricians and parents will act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. Medicaid-eligible children with specific physical, functional, and/or developmental deficits, or those with multiple factors placing them at risk for specific deficits are eligible. A medical home would provide the comprehensive primary care services, care coordination, and other medical and

social support services needed by these children. State agencies are designated to provide “wraparound” support services that complement the medical case management and medical home components provided by the primary care physician.

Partners in Policymaking: The state also provides community leadership training for parents of CSHCN through Partners in Policymaking. Partners in Policymaking is a leadership training project of the Delaware Developmental Disabilities Council that teaches people to be community leaders. The program is designed for parents raising young or school-aged children with a developmental disability or young adult with developmental disability. Partners provides up-to date information, education and skill building activities about the legislative process and local, state and national issues that affect individuals with disabilities. The overall goal of the program is to foster a partnership between people who need and use services for disabilities and those who make public policy.

3. Coordination of Health Components of Community-Based Systems

***Based on the above, Delaware is giving itself a score of 2= *mostly met* on the scale describing the Service System Constructs of Children with Special Health Care Needs. This scale states that *a mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.*

In addition to information provided under construct #1, there are two DPH programs that help to coordinate health and community-based systems for CSHCN, Kids Kare and the Ryan White Program.

Kids Kare: The Division of Public Health provides a multi-disciplinary support program for vulnerable families with children who have been found to be biologically, nutritionally, psychosocially, or environmentally at risk, factors that are highly correlated with a probability of delayed development. A care plan is developed based on the needs of the family determined by risk factors identified at an initial home visit assessment. The families receive support, teaching and coordination of services in their home from Public Health nurses, social workers, and /or nutritionists. Services are available for low-income families who have Medicaid or who are uninsured. Children up to the age of 21 may be referred but priority is given to those children who are between the ages of birth to six. Children referred to this program may show signs of developmental delay but do not meet the eligibility requirements for the Part C program.

Ryan White HIV program: The Division of Public Health also manages Ryan White Grant funds which provide case management to a small number of HIV infected children (19 children). The case manager is housed in the duPont Hospital. Case management is focused on the health care needs of the child to ensure that medical services are provided through an infectious disease specialist, primary care physician, and dentist. There is also an AIDS

Medicaid Waiver provided to children who are AIDS diagnosed (total 9 children). The Wavier provides case management, respite, and medication to children with AIDS.

Some coordination is offered for mental health services as described below:

Mental Health: Children and adolescents under the age of eighteen who receive Medicaid or are uninsured are served by the Division of Child Mental Health Services (DCMHS) in the Department of Services for Children, Youth, and their Families (DSCYF DCMHS offers essentially all types of mental health and substance abuse treatment options. These services include: early intervention, crisis services, outpatient, wraparound, intensive outpatient, partial day treatment, day treatment, day hospital, residential treatment, and psychiatric hospital services. In order to promote incorporation of mental health services into primary pediatric care, and to discourage early referrals and institutionalization, private organizations paid for by MCOS furnish 30 units of non-residential mental health services for children. After the 30 units have been exhausted, or on passing a DCMHS assessment for acuity, clients can enter service with DCMHS.

DCMHS also offers extensive services to homeless children. Referrals come from the Division of State Service Centers, Public Health clinics, Head Start, and schools.

The Division also has worked with hospitals to provide on-site emergency room training in appropriate response to mental health emergencies. Specific interrelationships with education include: Membership in the Interagency Collaborative Team (ICT) for funding rare and complex students, participation in Interagency Coordinating Councils to develop a model of integrated services between mental health and education, provision of mobile crisis services to the school and training in using the crisis services. In addition, the School/ Agency Collaboration, a new initiative, uses a team approach to identify and develop solutions around specific children and families. The initiative calls for school based student support teams that are responsible for case planning and management for service delivery. The team leader serves as a direct liaison to a district level support team and to the Family Services Cabinet Council agencies. The district level support teams assist the school based teams, state and community agencies in resolving problems, coordinate training, develop policy to ensure consistency across the district, appoint a single point of contact between the district and the agencies, and assess effectiveness.

4. Coordination of Health Services with Other Services at the Community Level

***Based on the above, Delaware is giving itself a score of 2= *mostly met* on the scale describing the Service System Constructs of Children with Special Health Care Needs. This scale states that *a mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.*

See information for early intervention services through Child Development Watch under construct #1.

Special Education:

About 6 months prior to turning three, the Part C eligible child is referred to a school district Child Find. Referrals with parental permission can come from the CDW service coordinator, primary care physician, relatives, childcare providers or other professionals. CDW service coordinators work with the school district, parents, and private service providers to establish a transition meeting. The purpose of the transition meeting is to discuss how a child is doing in his current program; review past and present services; discuss the adequacy of those services in meeting the child's needs; explore the possibilities for future services, both short and long term; and determine what if anything needs to be done (site visits, immunizations, etc.) to prepare for preschool.

Delaware carries out Public Law 94-142, Public Law 99-457, and Title 14 of the Delaware Code through its Administrative Manual: Programs for Exceptional Children. This manual states that all eligible students with disabilities are entitled to a free, appropriate public education. A free, appropriate public education is defined as specialized instruction and services, including related services that are designed to enable persons with disabilities to benefit from education. The majority of the schools provide services for 3 to 21 year olds; however, by legislative mandate, four categories have been given special status and receive services at birth. " Birth mandate services" are provided from birth to 21 for children are autistic, deaf-blind, deaf, and blind. Each school district has a Multidisciplinary Team (MDT) which initially determines a child's eligibility for special education services. Based on the results of evaluations, they decide whether or not the nature and severity of a child's disability meets the criteria established in the Administrative Manual for a handicapping condition that requires special services. Within 30 days of the MDT decision, the school district must schedule a meeting to develop the child's Individualized Education Program (IEP). The IEP Team determines the program that will meet the child's unique needs. This placement must be based on the child's IEP, and consider the least restrictive environment, age-appropriateness, proximity to the child's home and capability to provide opportunities to be educated with typical children.

In some cases a child is referred to one of 15 Specialty Schools found throughout the state. As their name denotes, some of the schools target special populations such as, Autistic Program and the Sterck School for the Hearing Impaired. The children who attend the Speciality Schools in most cases have cognitive and physical disabilities and require a host of related services in addition to the educational component. Others are mainstreamed into regular classes. As already described the CSHCN needs assessment included focus groups of parents of students attending speciality schools. Concerns they raised were a limited amount of therapies provided in a group/class room setting as opposed to individual therapies; therapies not being offered in the home with no carry over; and therapies being discontinued due to no progress. Delaware Specialty Schools facilitate parent support groups within their school setting. Principals and/or school nurses invite all parents to attend and participate in the monthly meetings. Parents are encouraged to participate in the development and presentation of the monthly agenda. Monthly meetings provide a forum for parents to verbalize concerns regarding their child's educational needs as well as related services.

Family Support:

Family Forums offer a way to reach out to families statewide, and include monthly meetings throughout the state and address a variety of issues. Typical topics presented this past year include a series of sibling workshops, several sessions on parenting and coping skills, and a session on sensory integration. These Forums are open to families with children birth to kindergarten, and over 250 families have participated this year. Outreach to families is coordinated with the Parent Information Center of Delaware, Delaware's Parent to Parent Center. Family Resource Rooms have been set up at each Child Development Watch site as a resource to both staff and families. User-friendly manuals, including listings of books, videos, parent-tips and handouts, are available. This year 56 books and 20 videos were added to the current collection. The Program also developed an Internet Guide titled, "Children with Special Needs, Internet Guide for Parents and Professionals".

Delawareans with Special Needs: Medicaid Managed Care Panel is a group of parent advocates who meet on a monthly basis with members of the Delaware State Medicaid Office, representatives from the Health Benefits Managers Office, and the two Managed Care Organizations who make up Medicaid's Diamond State Health Plan. Each month a variety of issues are addressed. The meetings are designed to provide a place where people can come to address specific issues or complaints about Delaware's Medicaid Managed Care programs and its providers; give members assistance in learning about the different types of plans available through the Diamond State Health Plan; and give participants opportunities to learn about Medicaid and keep up with changes.

Parent Information Center provides state wide services that include educational advocacy training for parents of children with disabilities; individual technical assistance for families and professionals; information on special education laws and processes; information on the rights and entitlements of persons with disabilities; information on various disabilities; information and training for professionals working with children and youths with disabilities and their families; and disability awareness training and events for schools and community. Resources available at the Center include books, news articles, and videos. The Parent Information Center also provides programs that include individual technical assistance programs; parent educational advocacy programs; and parent to parent support.

The Development and Implementation of Standards of Care and Guidelines

In September 1997, The Standards of Care Committee of the Board developed the *Delaware Perinatal Care Classification* which categorizes state hospitals into 5 levels of appropriate perinatal care. A joint venture, undertaken by two hospitals in the state, Christiana Care Health Services, Inc. with duPont Hospital for Children, was named to provide care to the highest risk mothers and highest risk neonates. This effort has succeeded in ensuring that those women and infants with the greatest need are treated at the most specialized hospital. As already stated, Christiana Care is the only Level 3 neonatal hospital in the state, although women may be referred out of state.

Following the development of the classification system, the Perinatal Board established a series of guidelines aimed at providers. However, these recommendations have served as guides not as specific standards and are to be used “at the discretion of the attending physician.” Guidelines include: Preconception Counseling; Gestational Diabetes; Group B β -Hemolytic Streptococcus: Screening and Treatment; Drug-Exposed Neonates; Postpartum Care/Discharge Planning; Postpartum Education; and Sudden Infant Death Syndrome. Other guidelines, developed by other organizations have been supported and disseminated by the Board such as ACOG’s *Premature Rupture of Membrane* and *Vaginal Birth After Previous Cesarean Delivery* guidelines and St. Francis Healthcare Services’ *Guidelines for Scheduled C-Section*.

Evaluation of Care, Monitoring of Program Effectiveness, Continuous Quality Improvement and Community-Based Service Systems

Since October 1988, Delaware Health and Social Services (DHSS) has had a policy that mandates the evaluation of its programs “as an essential activity ... to re-design operations so that they more effectively meet client needs.” The policy is administered by the Evaluation Coordinator in the Division of Management Services (DMS). Since FY ‘89, 219 formal evaluations of Department programs have been completed.

Some evaluations are conducted by independent consulting firms hired by the Division which house the programs being evaluated. Other evaluations are conducted in-house by Division staff, and a few (evaluations of programs which cross Divisional lines) are conducted by the Evaluation Coordinator. The Evaluation Coordinator also provides evaluation technical assistance and training to Department staff and tracks each evaluation within the Department.

The following evaluations pertaining to the maternal child population were undertaken during the years 1997 to 1999. Most of the results are discussed throughout this document.

Evaluations affecting Women and/or Infants

- Conducted under the auspices of the Division of Public Health: *Referral System Evaluation of Child Care Licensing and the Lead Program*
- Conducted under the auspices of the Division of State Service Centers: *Statewide Case Management/Family Development Services*
- Conducted under the auspices of the Division of Social Services: *Welfare Reform: The Early Economic Impacts of Delaware’s; “A Better Chance” (ABC) Welfare Reform Project; Delaware’s Strengthening Young Parent Families Initiative: Pilot Assessment*
- Conducted under the auspices of the Division of Alcoholism, Drug Abuse and Mental Health: *Reflection House Final Evaluation (Abandoned Infants Grant - Year 4)*

Evaluations affecting Children and Adolescents

- Conducted under the auspices of the Division of Public Health: *Childhood Lead Poisoning Prevention - 1996 Surveillance Report; Referral System Evaluation of Child Care Licensing and the Lead Program; Evaluation Of Targeted Screening Activities in New Castle County; Teen Pregnancy Prevention: What the People of Delaware Think (Doble Report); School-Based Health Centers (Lewin Report)*
- Conducted under the auspices of the Division of Social Services: *Delaware Child Care Market Rate Study*

Evaluations affecting Children with Special Health Care Needs

- Conducted under the auspices of the Division of Public Health and the Division of Management Services: *1998 Child Development Watch (CDW) Family Survey*

Evaluations Covering More Than One Population

- Conducted under the auspices of the Division of Alcoholism, Drug Abuse and Mental Health *Needs Assessment of the Statewide Prevalence of Substance Abuse: Includes 8 separate reports some of which are: 1) Delaware Alcohol and Drug Treatment Need Telephone Surveys; 2) Prevalence and Need for Treatment of Alcohol and Other Drug Abuse among Women in Delaware; 3) Alcohol, Tobacco, and Other Drug Abuse among 5th, 8th and 11th Graders in Delaware; 4) Substance Use and Abuse Patterns of Delaware Youth: Implications for Treatment Service Planning*
- Conducted under the auspices of the Division of Management Services: *Service Integration: “No Wrong Door” Pilot*
- Conducted under the auspices of the Division of Social Services *Diamond State Health Plan - 1997 Consumer Assessment Survey Results*
Diamond State Health Plan (External Quality Review) included Six clinical quality of care studies which provided baseline data and include: (1) alcohol and drug abuse, (2) breast cancer, (3) childhood asthma, (4) childhood immunizations, (5) mental health, and (6) prenatal care and infant outcomes.

Evaluations currently being conducted

- Conducted under the auspices of Division of Social Services: *Delaware Healthy Children Program* by HCFA , in-house and consultant
- Conducted under the auspices of Division of Public Health: *School-based Health Centers*
Results have already been released from the focus groups but the total evaluation will not be completed until the summer of 2000. The evaluation, based on the program’s original position statement will answer the overall question “Do SBHCs make a difference?” Specific data will provide answers to the following questions:
 1. Have SBHCs provided preventive health care?
 2. Have SBHCS detected signs of emotional stress and psychosocial problems for counseling and/or referral?

3. Do SBHCS facilitate student use of health care systems by establishing links with health care providers?
4. Do SBHCs promote ongoing, comprehensive health care for students?
5. Do SBHCs work toward the improvement of the student's knowledge of the importance of preventive health care and assist in developing health-promoting behaviors?
6. Do SBHCs provide early detection of chronic conditions?
7. Do SBHCs provide early detection, diagnosis and treatment of acute and minor conditions?
8. Do SBHCs encourage parent involvement in health care for adolescents?
9. Do SBHCs improve responsible decision making about health matters?
10. Do SBHCs reduce risk-taking behaviors?

- Under the Divisions of Management Services and Public Health: *Child and Family Change Evaluation - Phase II*
- Conducted under the auspices of the Division of Social Services: *A Better Chance - Welfare Reform; "Do Welfare Recipients' Children Have a School Attendance Problem"?*; *Diamond State Health Plan*

Interagency Evaluations

Home visiting program recommendations: Still in the planning stages are recommendations that an evaluation for the second visitor stage of the Home Visiting program be initiated with the University of Delaware's Center for Disability Studies which has conducted a variety of interagency evaluations. The recommendations are to develop a short-range evaluation plan and a long-range three-year plan that will:

1. Assess the implementation of recommended practices within the follow-up home visiting system.
2. Assess the current capacity of the agencies within the system to collect common data elements.
3. Develop an overall evaluation system that can be implemented across programs.
4. Report on the preliminary results of selected evaluation indicators that can be used to assess whether families are benefiting from the services.

3.2 Health Status Indicators

3.2.3.1 Priority Needs

Most of these needs were identified two years ago when the new grant performance measures went into effect. For the most part, overall priority needs have not changed since the last full needs assessment five years ago. On the other hand, improved data collection and the numerous community assessments have provided more information for specific program planning. Only one priority was revised during this year's assessment process. Those listed here are not by priority but are numbered for ease of discussion.

Based on the above assessment, below is the list of identified needs:

1. Ensure nutrition services to children and adolescents.

2. Improve dental health of children and adolescents.
3. Ensure a 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.

These needs are addressed in a variety of programs throughout the state and served to help us to establish performance measures. The following brief summary outlines some of the needs assessment data which lead the state to confirm its commitment to the above priorities.

DIRECT

Ensure nutrition services to children and adolescents. The latest YRBS showed there are a small number of adolescents that have severe nutritional problems such as bingeing and purging. On the other hand, over half are not eating vegetables on a regular basis or exercising. Although data was difficult to obtain, there do not seem to be enough nutritionists available to children in any consistent way and only to adolescents in a limited way through school based health centers. While children do learn about the basic food groups, this may be an academic exercise and not part of their lifestyle.

Improve dental health of children and adolescents. The lack of dental services for all poor Delawareans is self-evident. There is a severe shortage of dentists in Sussex County and a less than optimal situation in Kent County and in some sections of the city of Wilmington. Although Medicaid covers dental health for children, there are not enough dentists who will take Medicaid patients or can take enough to keep up with the demand. The Delaware Healthy Children Program does not cover dental services but if it did, there wouldn't be enough available dentists to provide coverage. By the time children come to the public health clinics, their teeth have too many cavities for sealants. When adolescents reach adulthood, dental services are even worse in that Medicaid does not pay for services for pregnant women.

ENABLING SERVICES

Ensure a medical home and coordinated services to children with special health needs. It is clear from this needs assessment that coordination of services for CSHCN over three years is needed. Although there are numerous

high quality services in Delaware, delivery is often fragmented and families and other providers are unaware of other services. A disconnect between education and medical providers has also been noted.

POPULATION BASED SERVICES

Improve access to care in Kent and Sussex Counties and for black women throughout the state. Access to care remains a problem in both Kent and Sussex counties and for black women throughout the state. 86.5% whites enter care during the first trimester as opposed to 71.5% of blacks. Further the rate for adequacy of care for all black women using the Kotelchuck index is 63.2% as compared to 71.3% for all white women. Although Title V has decided to focus on care to all black women as a performance measure, we will continue to carefully review access in the southern part of the state where transportation and cultural barriers are significant. Using the Kotelchuck index, the widest disparity between the two races occurs in Sussex County where only 54.5% of black women receive adequate care as compared to 72% of white women.

Reduce teen births. Although teen birth rates have dropped a little, our rate continues to be one of the highest in the nation. Delaware's teen birth rate for 15 to 17 years olds is now 39.2. Sussex County's rate of 46.2 is the highest rate in the state as compared to 37.3 for New Castle and 38.5 for Kent County. This is another area where there is a large racial disparity with the black teen birth rate at 110.6 as compared to 40.4 for whites for those between 15 and 19.

Reduce preventable diseases in children and adolescents. *Asthma* may not be totally preventable but in some cases it may be. For instance, roaches, smoking and kerosene heaters are linked to childhood asthma. Although we do not have prevalence data, we have hospital discharge data, which shows that asthma is the number one cause of hospitalization for all children 1 to 9. This is also another area where disparities between whites and blacks is very evident. Proportionately, black children have a higher rate of hospitalization for this disease. *SIDS* deaths had been decreasing but have recently started to rise again. Although not all are preventable, putting the baby on the back and not using overstuffed blankets can prevent many *SIDS* deaths. Finally, the state continues to be concerned that children are not getting lead screens, as they should. This problem is particularly noticeable in examining Medicaid data. These are some of the most vulnerable children in the state often living in older homes where lead may be a problem.

Reduce preventable injuries to children and adolescents. The leading cause of death for children 1 to 14 in the state of Delaware is unintentional injuries. Motor vehicle crashes are the number one leading cause of unintentional injury death in 1-19 year olds in 1997-1998. YRBS data also show that the majority of high students do not always wear a seat belt. Poisoning and toxic effects of drugs are the 7th most prevalent reason for hospitalizations for children 1 to 4. Although safety seat use and seat belts have increased, many drivers do not know how to adjust them correctly. Alcohol use by adolescents remains a serious problem. YRBS data shows that almost one half of all students drink. Alcohol use is directly related to injuries to adolescents particularly in motor vehicle accidents but in other injuries as well.

INFRASTRUCTURE BUILDING

Reduce black infant mortality. The disparity between the rates of black infant deaths and white infant deaths has remained about the same for the last ten years. The state's City Match Data Institute team has identified extremely low birth weight and prematurity as the chief direct causes. The state is also considering stress and racism as factors that underlay the problem since both Delaware and national data show that educated black women and those that have accessed care early are still in more danger of losing their infants than white women.

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. Reducing the barriers has been identified has a high priority to delivery of care. Identified barriers include access to care problems such as cultural, transportation, and insurance issues. Risk factors include lack of early care, substance abuse including tobacco use, lack of good nutrition, being unmarried, giving birth again after less than an 18-month interval, and the age of the mother.

Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment. Mental health issues were raised in many venues: in preparation for the Rural Health Plan, by the Developmental Disabilities Planning Council, by parents in SBHC focus groups, and in review of SBHC data, DCMH client visit YRBS data, and hospital discharges. After the age of ten, mental health problems were one of the chief causes for hospitalization for white children. While early intervention and prevention have been noted as crucial, there is clearly a gap in providers particularly in southern Delaware. Lack of insurance coverage has been raised as a problem. The Division of Child Mental Health only supports services to children who are on Medicaid or uninsured, which does not include the underinsured.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms (See Forms section in 5.4 for Form 2, Form3, Form 4 and Form 5.)

3.3.2 Other Requirements

3.3.2.1 The maintenance of effort remains the same with the State of Delaware continuing to provide an overmatch of which is much greater than its maintenance of effort of. "Other" dollars are from the Newborn Screening Program. Other federal funds include the Community Integrated Services Child Care grant. The fact that this grant has been level funded for many years presents a problem for Delaware in that most of the grant is allotted to positions. When state workers get a raise so do federally funded workers.

3.3.2.2 The FY2001 budget includes: for salaries, and another for fringe for 33.40 employees; \$1,567,077.35 in salaries, fringe and health insurance; \$54,470 for casual seasonal employees; \$130,000 to help to support one school based health center; \$179,063 for indirect; \$10,000 for travel and fleet services for in state travel; \$24,930 for supplies, duplication costs, registration, enrollment, dues, audit, etc. More detail is provided in Forms 3, 4, and 5 appearing in the Supporting documents section of this application.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures See section 5.5.

3.4.1.1 Five Year Performance Targets Form 11 is found in the Forms section in 5.8.

3.4.2 State “Negotiated” Five Year Performance Measures See section 5.6.

3.4.2.1 Development of State Performance Measures

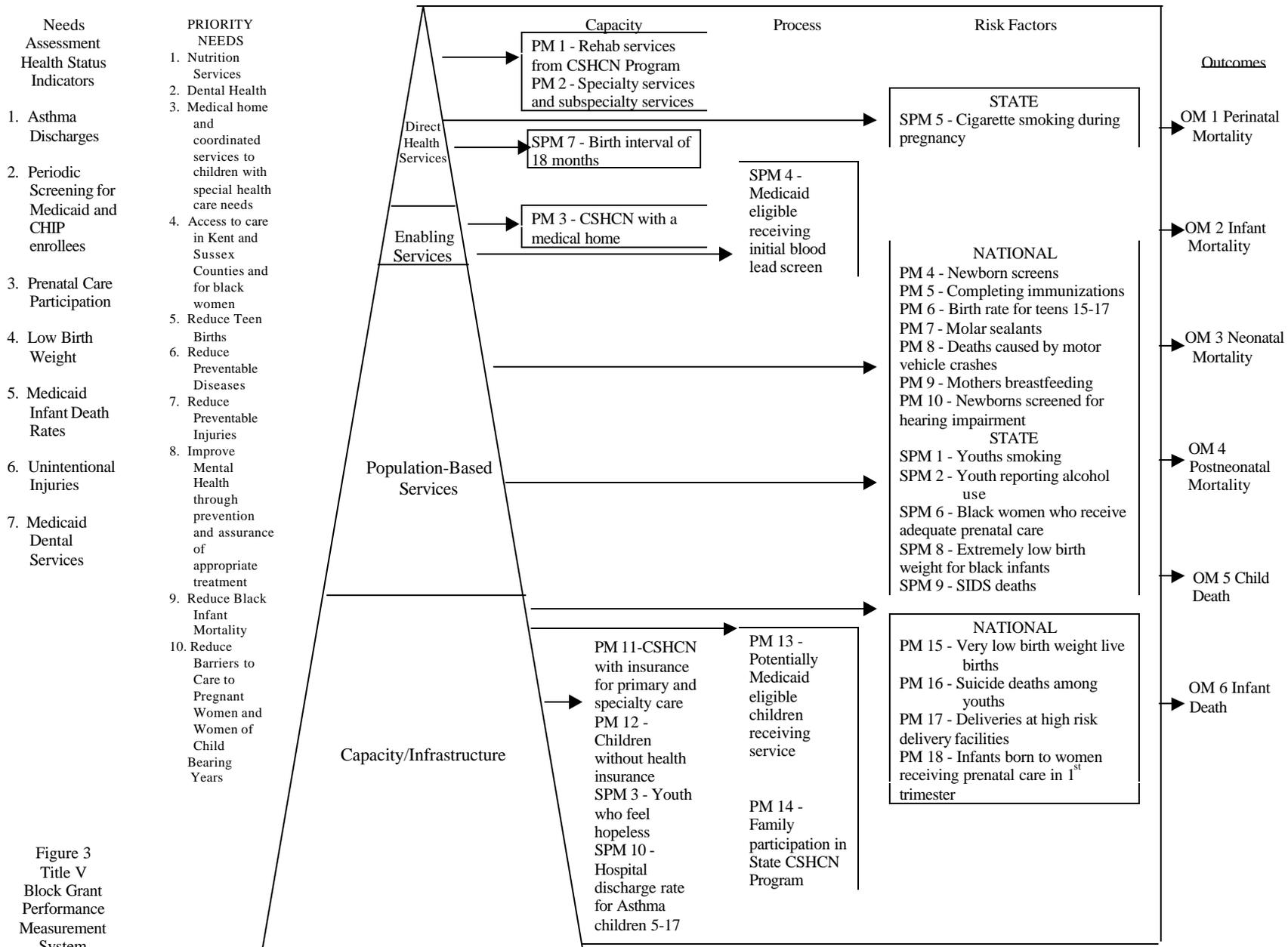


Figure 3
Title V
Block Grant
Performance
Measurement
System

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of youth reporting smoking 2 or more cigarettes per day on the days they smoke.			X				X
2) The percent of youth reporting any use of alcohol in the last thirty days.			X				X
3) 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				X	X		
4) The percent of Medicaid eligible children under 3 years that received an initial blood lead screen.		X				X	
5) The percent of pregnant women delivering live-born infants reporting any cigarette smoking during pregnancy.	X						X
6) The rate of infants born to pregnant black receiving adequate prenatal care.			X				X
7) The rate of live births to women who have had another birth at less than 18 months.	X						X
8) The percent of extremely low birth weight black infants among all live births to black women.			X				X
9) The percent of children under age 1 who die as a result of Sudden Infant Death Syndrome.			X				X
10) Hospital discharge rate per 10, 000 children (5 years through 17 years of age) for Asthma (ambulatory care sensitive diagnosis).				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

The Needs Assessment Steering Committee has reviewed the state performance measures and recommends some changes based on the assessment. Revisions were shared with the Perinatal Board and Part C's Interagency Coordinating Council (ICC), County clinic managers, DPH program managers, Delmarva Rural Initiative, Healthy Start, our federal Maternal Child Health Bureau regional representative and a variety of other groups.

Services For Children With Special Health Care Needs

State Performance Measure #10 Hospital Discharges for Asthma (Ambulatory Care Sensitive Diagnoses for Children with Special Health Needs)

Hospital discharge rate per 10,000 children (5 through 17 years of age) for Asthma

Why was the measure chosen? According to Healthy Delaware 2000, asthma affects about 28,000 Delawareans based on national prevalence rates. Hospital discharge rates have been increasing rapidly in the child population. If these patients get proper care and are not exposed to hazards such as smoke, they would not need to be hospitalized. In addition, this group, by the nature of its size and its sensitivity to quality care, makes it a prime example for tracking of care to all CSHCN. The performance measure was revised from tracking children from 1 through 17 to tracking children 5 through 17 because of the new federal requirement that the state report a health status indicator related to the asthma discharge rate for children under five. In this way we can continue to track the older children and adolescents while tracking the younger children.

Level of Placement on the Pyramid: Infrastructure Building

Relationship to need: 1. Ensure a medical home and coordinated services to children with special health needs. 2. Reduce preventable diseases in children and adolescents.

Link to outcome: Reduce the child death rate

Preventive And Primary Care Services For Children

State Performance Measure #1 Use of Tobacco by Youth

The percent of youth reporting smoking cigarettes in the last thirty days.

Why was this measure chosen? Smoking clearly has an affect on infant mortality. Smoking around young children has a known relationship with asthma and other respiratory problems. The best way to prevent tobacco use at all is to prevent people from even starting while they are young. If a female teen chooses to smoke, she will be more likely to smoke as an adult and to continue when pregnant.

Level of Placement on the Pyramid: Population-Based

Relationship to need: 1. Reduce black infant mortality. 2. 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. 3. Reduce preventable diseases in children. 4. Improve dental health of children and adolescents.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the number of neonatal deaths. 3. Reduce the number of postneonatal deaths. 4. Reduce the perinatal mortality rate. 5. Reduce the child death rate.

State Performance Measure # 2: Use of Alcohol by youth

The percent of youth reporting any use of alcohol in the last thirty days, by age.

Why was this measure chosen? The reduction of alcohol use for all is a strategy to reduce AIDS, motor vehicle injuries, unintended pregnancy, poor pregnancy outcome, etc. According to the latest Youth Risk Behavior Survey, 47% high school students drank once a month.

Level of Placement on the Pyramid: Population-Based

Relationship to need: 1. Reduce teen births. 2. Reduce preventable injuries to children and adolescents. 3. Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment. 4. Ensure nutrition services to children and adults. 5. 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. 6. Reduce preventable diseases in children and adolescents.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the number of neonatal deaths. 3. Reduce the number of postneonatal deaths. 4. Reduce the perinatal mortality rate. 5. Reduce the child death rate.

State Performance Measure #3: (youth feeling so sad or hopeless)

Why was this measure chosen? The needs assessment identified mental health services as being limited. The Youth Risk Behavior Survey and other data showed some severe mental health issues for adolescents. 26.9% of the students taking the YRBS survey stated that during the last 12 months they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities, a clear indicator for depression. Depression is linked to suicide attempts and suicide itself. Also, depression has been known to cause other risky behaviors such as substance abuse and sexual acting out.

Level of Placement on the Pyramid: Infrastructure Building

Relationship to Need: 1. Reduce teen births. 2. Reduce preventable injuries to children and adolescents. 3. Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the number of neonatal deaths. 3. Reduce the number of postneonatal deaths. 4. Reduce the perinatal mortality rate. 5. Reduce the child death rate.

State Performance Measure #4: Child Health/Lead Levels

The percent of Medicaid eligible children under 3 years that received an initial blood lead screen.

Level of Placement on the Pyramid: Enabling

Why was this measure chosen? Poor, undernourished, or homeless children run a greatly increased risk of poisoning from even small doses of lead because of the increased lead absorption rates associated with fasting or undernourished conditions. Symptoms in the most severe cases can cause convulsions or death.

Relationship to need: 1. Reduce preventable diseases to children and adolescents. 2. Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment. 3. Ensure a medical home and coordinated services to children with special health needs.

Link to outcomes: 1. Reduce the child death rate.

Preventive And Primary Care Services For Pregnant Women, Mothers And Infants

State Performance Measure #5 Use of Tobacco by Pregnant Women

The percent of pregnant women delivering live-born infants reporting any cigarette smoking during pregnancy

Level of Placement on the Pyramid: Direct Services

Why was this measure chosen? Infant mortality is higher for smokers. In addition to the crucial infant mortality issues, if the mother remains non-smoking there will be reduced respiratory problems such as asthma for the children. Finally, changing anyone's smoking habits will have an affect on their risk factors for other diseases (i.e., cancer, high blood pressure).

Relationship to need: 1. Reduce black infant mortality. 2. 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. 3. Reduce preventable disease in children and adults. 4. Ensure nutrition services for children and adults.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the number of neonatal deaths. 3. Reduce the number of postneonatal deaths. 4. Reduce the perinatal mortality rate. 5. Reduce the child death rate.

Revised State Performance Measure #6: Adequate care for black pregnant women in Delaware

The rate of infants born to black women in Delaware receiving adequate prenatal care

Level of Placement on the Pyramid: Population-Based

Why was this measure chosen? Adequate care has a positive affect on infant mortality, neonatal mortality, perinatal mortality, and postneonatal mortality. Access to care is a critical problem for black women throughout the state.

Relationship to need: 1. Reduce black infant mortality 2. Improve access to care in Kent and Sussex Counties and for black women throughout the state. . 3. 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.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the disparity between white and black infant mortality. 3. Reduce the number of neonatal deaths. 4. Reduce the number of postneonatal deaths. 5. Reduce the perinatal mortality rate.

Revised State Performance Measure #7: Births of infants less than 18 months after last live birth The rate of live births to women who have had another birth within the last 4 months to 18 months. This measure was revised per the advice of the Perinatal Board's Scientific Committee. This decision collaborates the findings of the Centers for Disease Control and Prevention which concluded that the wait between birth pregnancy is best between 18 to 23 months.

Level of Placement on the Pyramid: Direct Services

Why was this measure chosen?

Relationship to need: 1. Reduce black infant mortality. 2. 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.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the disparity between white and black infant mortality. 3. Reduce the number of neonatal deaths. 4. Reduce the number of postneonatal deaths. 5. Reduce the perinatal mortality rate.

State Performance Measure # 8: Birth of extremely low birth weight black infants

The percent of extremely low birth weight black infants among all live births to black women.

Level of Placement on the Pyramid: Population-Based

Why was this measure chosen? It is well known that low birth weight is associated with infant mortality and morbidity. The Health Statistics Office has recently analyzed data for the City Match project and determined that a much greater number of extremely low birth weight infants are born to black mothers.

Relationship to need: 1. Reduce black infant mortality. 2. 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. 3. Improve access to care in Kent and Sussex Counties and for black women throughout the state.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the disparity between white and black infant mortality. 3. Reduce the number of neonatal deaths. 4. Reduce the number of postneonatal deaths. 5. Reduce the perinatal mortality rate.

State Performance Measure #9 Infant Mortality as a result of SIDS

The percent of children under age 1 who die as a result of Sudden Infant Death Syndrome

Level of Placement on the Pyramid: Population-Based

Why was this measure chosen? The Perinatal Board's Scientific Committee completed a study which showed that if 75% of infants were placed on their back during the years 1990-1994, an estimated 28 infants could have been saved.

Relationship to need: 1. Reduce black infant mortality. 2. Improve access to care in Kent and Sussex Counties and for black women throughout the state. 3. Ensure a medical home and coordinated services to children with special health needs. 4. Reduce preventable diseases in children and adolescents. 5. Reduce preventable injuries to children and adolescents.

Link to outcomes: 1. Reduce infant mortality. 2. Reduce the disparity between white and black infant mortality. 3. Reduce the number of neonatal deaths. 4. Reduce the number of postneonatal deaths.

3.4.2.3 Five Year Performance Targets

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures (See Form 12 in section 5.7.)

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

As is already described and well known to those familiar with the block grant, it has been level funded for several years. The state also pays for a little over 33 FTEs with the grant. Every time salaries are raised, there is a decrease of available dollars. We have not just matched the dollars allotted through the grant but provide an overmatch. Another way that we have addressed needs is to partner with other agencies, both public and private.

Children with Special Health Care Needs

Overall the Title V needs assessment has confirmed a need for more service coordination support for families. Although Delaware offers numerous services to these families, they are fragmented and families are often unaware of them. Moreover, providers are not always aware of what other providers are doing. There are also several councils which meet to address needs. During the next year, the Office of Children

with Special Health Care Needs will investigate the most logical organizations to serve as the focal point for bringing some of these parties together. The Coordinating Council for People with DisAbilities has discussed the development of a conference to make available current information on programs and other advocates have also expressed interest in a consortium or conference. The purpose would be not only to provide updated information on a variety of programs but to renew the networking process as well. The Office will also review other mechanisms for providing information such as through the internet, schools, primary care physicians, Delaware Health & Social Services kiosks, etc.

Performance Measure 1 (The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State (CSHCN) Program:

As described in the Annual Report, it has not been necessary for DPH to provide direct services to this population because all SSI eligible children are automatically eligible for Medicaid. Under Medicaid they are eligible for EPSDT services which includes rehabilitation.

Performance Measure 2 (CSHCN program provides or pays for specialty and subspecialty services):

Plan

DPH will continue to provide some services, which are not available to children with special health needs.

Direct Services:

As described in the Annual Report, DPH offers diagnostic and short-term treatment services for some special needs for children especially in Kent and Sussex. These services include neurology, cardiac, genetics, audiology, and ophthalmology.

Public Health provides special formulas for children with inborn errors of metabolism such as PKU and women of child bearing age. This program has been expanded this year with additional dollars and includes both uninsured and underinsured children.

Enabling Services:

As described in the Annual Report and Needs Assessment section, the Division of Public Health administers Child Development Watch and Kids Kare which provide service coordination for early intervention services and children at risk. Kids Kare has been discussed as one program that might be further expanded if a need is identified.

Performance Measure 3 (CSHCN who have a Medical Home):

Plan

Infrastructure Building

DPH will continue to work to ensure a medical home for all children. The Delaware Healthy Children program and the outreach program funded through a Robert Wood Johnson Foundation grant (described below) will help to insure all children and ensure them of a medical home. The Office of Children with Special Health Care Needs in DPH will continue to work with the Delaware Chapter of the American Academy of Pediatricians to develop the medical home pilot project. (See Needs Assessment.)

Brain injury is the most frequent cause of disability and death among children in the United States. As pointed out in the needs assessment, the incidence of injuries is high in Delaware as well and head injuries are a chief factor. Delaware is currently investigating the needs of children with traumatic brain injury. The Director of the Division of Mental Retardation is leading a group that is looking at the issue. The Administrator for the Community Health Care Access section participates. The problem is that there is not a designated agency that is responsible to coordinate care and services for these children. Lack of follow-up after hospital and emergency room discharge has been noted. On the other hand, these are some of the same issues identified for other children with special health care needs. Title V will partner with other agencies during the next year to help to determine needs and develop a system for these and other CSHCN.

Performance Measure 11 (CSHCN with a source of insurance for primary and specialty care):

Plan:

The Community Health Care Access section through its Health Systems Development Branch was awarded Robert Wood Johnson Covering Kids grant, *A National Health Access Initiative for Low-Income, Uninsured Children* in March 1999. The funds are being used to support outreach to enroll children into both Medicaid and the State Children's Health Insurance Plan (SCHIP).

Enabling

Referrals are made to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, all DPH programs (CDW, Kids Kare, immunizations etc.) work to ensure that children under their care are referred to Medicaid when it is determined that they do not have a source of insurance. Child Development Watch also ensures that Part C dollars are available for early intervention services when there is no source of insurance. DPH staff will also refer and help with applications to private insurance where applicable.

Infrastructure - Child Care Outreach

The Healthy Child Care America 2000 grant will help support outreach initiatives to child care providers.

Performance Measure 14 (assuring family participation in CSHCN program and policy):

Plan: Infrastructure Building

Involvement of parents has been a priority for the past year. As described in the Annual Report, CSHCN Steering committee was formed including parents, and parents have been appointed to the Child Development Watch Quality Management Committee. However, parent attendance at meetings has been poor. Parents seem reluctant to provide input.

Prior to leaving, the CSHCN Director was exploring several national and state resources to help identify methods to effectively recruit and retain parents of CSHCN in committees. A literature and research review was in process but will have to be put on hold until a replacement is hired. Key informants such as, specialty school principals have shared successful parent involvement strategies. The CSHCN director contacted several other state CSHCN directors to solicit their experiences and recommendations for parent involvement in CSHCN advisory boards and workgroups. Possible funding sources to support parental contracts as well as, financial support to help alleviate some of the parental barriers (transportation, child care, compensation for lost work time) to committee membership was being explored. Collectively, all information regarding parent involvement will be shared with the CSHCN Steering Committee. The committee will make recommendations to the Director of Public Health.

Another opportunity for parent participation is with The Delawareans with Special Needs/Medicaid Managed Care Panel. Representatives of the State's Medicaid Office and the Managed Care Organizations meet monthly to discuss health care insurance issues presented by parents of CSHCN. To afford these parents an opportunity to work with private health insurers, the Office of Children with Special Health Care Needs plans to enhance this group by inviting MCO representatives. In addition to meeting current needs, the focus will also encompass anticipatory mental and physical needs for CSHCN and the family.

Preventive and Primary Care Services for Children

Performance Measure 5 (Children through age 2 who have been immunized):

Title V does not have direct responsibility for immunizations. However, we have a strong role in ensuring that immunizations are provided.

Plan:

Population Based:

Through its Immunization Grant, Public Health will undertake renewed efforts to ensure immunizations. Plans include: teaching provider assessments in the private sector as to MCOs and American Academy of Pediatrician Delaware Chapter; developing and implementing programs to educate public and private providers to ensure compliance with immunization standards; and developing and disseminating information for parents.

Infrastructure Building:

The Title V agency applied for a Healthy Child Care America 2000 grant. One of the major goals of this grant will be to develop an infrastructure that will provide more training to those already providing services to child care providers (i.e., Department of Services for Children, Youth, and their Families' Office of Child Care Licensing) and to child care providers. Information regarding immunizations will be provided as part of the grant.

The Primary Care Coordinator, funded through Title V dollars has just been appointed to serve on the Quality Improvement Initiative Task Force which will collaborate with Medicaid managed care to utilize a multi-agency approach to address and, where possible, resolve issues/opportunities for improvement identified during previous quality review activities. A benchmark recently set by the group was to increase the immunization rate to 80% through awareness, education, and specific interventions to coordinate efforts and resources.

Performance Measure 7 (third grade children who have received protective sealants on at least one permanent molar tooth):

Title V does not have direct responsibility for this measure although Title V dollars support a dental assistant position for Southern Health Services. However, the Division of Public Health has taken a lead role in planning the improvement of services to the Medicaid population. As described in the Needs Assessment, dentists are in short supply.

Plan/Infrastructure Building

The Division of Public Health plans to use SSDI funds to complete a comprehensive intraoral screening of elementary school children, and hopefully junior high and high school student. It will also include a survey on determinants and behavioral characteristics. The scope of the project will depend on possible volunteer effort, particularly utilizing dental school students.

Performance Measure 8 (Reduction of number of deaths from motor vehicle crashes for 1 to 14 year olds):

Title V provides support to the Child Death Review Commission and its review panels. It also is working closely with the Emergency Medical Services for Children (EMSC) Coordinator to ensure that motor vehicle injury prevention efforts are coordinated.

Plan

This support and activities listed below will continue.

Enabling

The DPH clinic staff supply car safety seats to their clients through a program coordinated with the Division of State Service Centers. Home visit and clinic staff advise and provide education to families regarding use of car seats and seatbelts. Child Development Watch includes information about car seats and air bag dangers in all intake packets.

Population Based

The Child Death Review Commission recommended that Municipal Court and Justice of the Peace refrain from waiving the motor vehicle fine for failing to have a child in a safety seat when the driver produces a safety seat at the time of the hearing. Legislation was drafted by the Department of Justice to remove the discretion from the statute; however, the legislation did not pass during the last two-year General Assembly session. It was offered for introduction during this legislative session which will last until June 30, 2000. At this time, it remains in a legislative committee and will probably not be addressed forcing the bill to be reintroduced next year.

Performance Measure 12 (increase numbers of children with health insurance):

This is also not an area for which Title V in Delaware has direct responsibility. Increasing the numbers with insurance coverage depends on a variety of factors such as implementation of SCHIP and Medicaid enrollment.

Plan: Infrastructure Building

As described, DPH has received a Robert Wood Johnson grant. Funding supports two Community Relations coordinators who participate within the county health units. These individuals serve as liaisons with the pilot coalitions of community agencies. Project objectives were developed by the coalitions based on community needs. The Kent and Sussex Counties pilot project includes the following objectives: 1) Utilize a partnership of agencies and organizations to funnel referrals and build appointment schedules for a mobile application and enrollment site (van); 2) Engage the private sector retail community in hosting events at high-traffic family

locations which will create interest and opportunity for enrolling children; 3) Monitor application and enrollment data from the van, events, and community organizations; 4) Utilize the partnerships' cumulative experience with the application and enrollment process to indicate special marketing needs and method for hard to reach clients and 5) Evaluate the feasibility of implementing finder's fees for community based organizations.

New Castle County's pilot project has set the following objectives: 1) Create a network of agencies and organizations who have established and possibly overlapping relationships with children and families, which will collaboratively assist clients throughout the health insurance application and enrollment process; 2) Reconfigure the caseload of a Medicaid eligibility worker to manage the network of organizations instead of managing a caseload of individual clients; 3) Monitor application and enrollment data from members of the Network; 4) Reframe education programs into a culturally appropriate training program to stress value of health insurance for families within the target area; and 5) Utilize the partnerships' cumulative experiences with the application and enrollment process to indicate special marketing needs and methods for hard to reach clients in New Castle County.

Enabling

Referrals are made to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, all DPH programs (CDW, Kids Kare, immunizations etc.) work to ensure that children under their care are referred to Medicaid and to the state's new health insurance program when it is determined that they do not have a source of insurance. DPH staff will also refer and help with applications to private insurance where applicable. Better coordination with child care providers is also planned for the next couple of years as a result of the Healthy Child Care America 2000 grant.

Performance Measure 13 (potentially eligible Medicaid children who have received a service paid by Medicaid):

What has been said regarding insurance coverage for special needs children and Non-Medicaid coverage applies for this measure as well.

Performance Measure 16 (suicide deaths among youths aged 15-19):

As with most other measures, meeting this measure is not a sole Public Health responsibility. In fact, the Department of Children, Youth, and their Families through its Division of Child Mental Health has the lead responsibility. However, DPH, through its school based health centers and its support for the Child Death Review Committee has a major role to play as well.

Plan

Current plans are to continue to support activities under SBHCs and the Child Death Review Commission.

Direct Services

School Based Health Centers will continue to provide counseling for students as needed. Additional funds were provided last year to each center specifically targeted for mental health services.

Population Building

A Title V funded position provides staff support to both review panels of the Child Death Review Committee and assists in the preparation of their annual report.

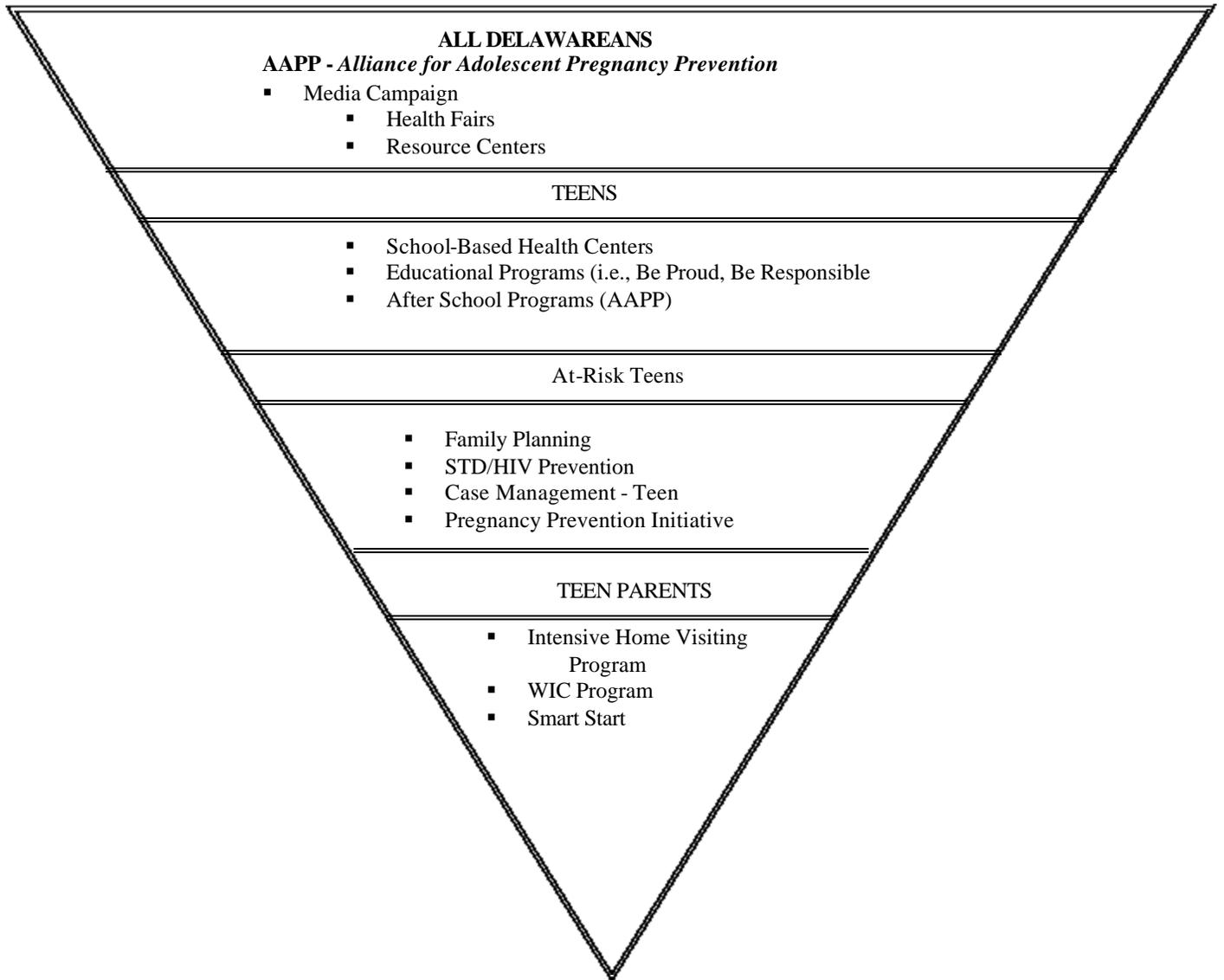
Preventive and Primary Care Services for Pregnant Women, mothers and infants

Performance Measure 6 (Lowering the birth rate among teenagers):

Although the Community Health Care Access section has been given the lead responsibility for this measure, we cannot be successful without the support and involvement of the schools, parents, and the community.

Plan

The chart below serves as a graphic description of Delaware's strategy for reaching all Delawareans through public awareness efforts, all teens through school based health centers and educational programs, at-risk teens through family planning, STD prevention and case management, and teen parents through the intensive home visiting program, WIC and Smart Start.



Enabling Services

Public Health family planning services, 50% of which are teenagers will continue to provide services specifically aimed at teens. No teen is charged for services at the Title X funded sites.

The Division’s STD clinics will continue to treat every teen as a priority by offering extra counseling following their encounter with the nurse practitioner. The counselor may be the HIV Counselor, a Disease Intervention Specialist, or another nurse. This “high risk counseling” is a straightforward discussion of the client’s reported risk behaviors and their potential consequences. Follow-up calls or visits may be provided based on the teen’s interest. A behavior change “contract” is developed.

As already described in the Annual Report, School-Based Health Centers (SBHCs), supported by state and Title V funding, operate in 27 of the 29 public high schools and offer health care services, mental health services and nutrition services to enrolled students. In addition six of the centers have funding for the intensive Teen Pregnancy Program initiative, (Teen Hope).

The state has initiated an official Dr. Michael Carrera/Children's Aid Society replication project at the Kingswood Community Center in Wilmington. (described in Annual Report).

Population Based

Other activities are:

- To better serve this population, the DPH clinics profile teens who come in for pregnancy tests by gathering additional data.
- There are outreach programs to teens at a variety of sites such as dental clinics and WIC.
- DPH staff participate in the Healthy Start Program by linking and coordinating with Resource Mothers and outreach workers in community centers.
- DPH staff participates in the Be Proud/Be Responsible curriculum provided in community centers, Boys and Girls Clubs, etc. throughout the year.
- Emergency contraception is available in all public health clinics. Education regarding emergency contraception has been incorporated into all new patient visits.
- Health Educators provide presentations on teenage pregnancy and sexuality to teen groups at teen shelters, schools, colleges, churches, and community events. They also provide educational materials through community health fairs and private businesses.

Performance Measure 15 (Reducing very low birth weight live births):

The Perinatal Board has been given the lead responsibility of reducing infant mortality. However, DPH is responsible for staffing the Board and Title V staff perform this role. DPH also supports the Smart Start program. Neither group, however, can affect this measure alone. We need a concerted effort by insurers, physicians, hospitals and other state agencies to be able to affect change.

Plan

The Title V plan is to continue to support the Board and support current activities. This includes promoting Smart Start to community physicians so that they are aware of the services provided by DPH.

Enabling:

Smart Start, which has been described, is a program that addresses the needs of at-risk pregnant women.

Infrastructure Building. As described, Title V will continue to support the Perinatal Board's efforts to address black infant mortality whose direct cause is extremely low birth weight and prematurity. (See State Performance Measure 8 for additional plans.)

Performance Measure 18 (Increasing percent of infants born to women receiving care in first trimester):

See Performance Measure 15 above regarding the Perinatal Board.

Plan:

See Performance Measure 15 above regarding Smart Start.

Enabling:

Southern Health Services will continue the voucher program in Sussex and is working to establish the process in Kent County.

Infrastructure Building

The Division of Public Health and the Office of Vital Statistics are reviewing data to help to determine the reasons for poor access to prenatal care data in Kent County. Findings are not expected to be released until the next fiscal year.

Performance Measure 4 (Newborns in the State with at least one screening):

We would like to maintain our support for this measure as described in the Annual Report.

Population Based

DPH county field staff support the screening program by providing follow-up in the home when screenings have not occurred in the hospital (i.e., home births) or a repeat screen is needed. While most repeat screens are completed in the hospital, a referral is made to Public Health Nursing for a home visit if an infant with an abnormal HMD cannot be located.

Performance Measure 9 (Increasing mothers who breastfeed):

Plan

Title V staff will continue to collaborate with WIC staff and hospitals to promote breastfeeding.

Population Based

Education regarding breast feeding is provided within public health clinics and recommended to all clients except when a client is HIV positive. In particular, pregnant women accessing Smart Start services are informed of the benefits of breastfeeding. Postpartum visits also provide support for the nursing mother. Public Health nurses have received training in the March of Dimes Train the Trainer program and now have the capability of training additional staff as well as providing information to clients and community groups.

Performance Measure 10 (increase percentage of newborns who have been screened for hearing impairment before discharge):

This is a performance measure which is the prime responsibility of hospitals. However, Title V staff may provide some collaborative support in the area of data collection and public awareness. DPH also provides audiology services.

Plan

We will continue to provide the activities described below and will work with the hospitals on addressing this issue.

Direct Services

DPH provides a full range of audiology services in Kent and Sussex Counties. The audiology program provides screening, diagnostic, and rehabilitative, and referral services to children and their families with known or suspected hearing loss. Included are testing for children with risk factors for hearing impairment; coordination of services for children with hearing impairments; provision of support for hearing aid needs when families are financially eligible (under 200% of poverty); and family training and rehabilitation services such as auditory training when indicated. It provides screening and referral services to community preschools and child care providers and assists with the difficult to screen in community schools and early intervention programs. The program serves as a community information and referral source for all ages, providing telephone guidance to individuals who need to know more about hearing loss and how to access services.

Infrastructure Building

Title V will continue to work to develop the system for screening newborns for hearing impairments. The CSHCN Director has served as a co-chair of the committee investigating the options. When the position is filled, the individual will continue this role. Three remaining questions are 1) what electronic data system is needed to support the screening system? 2) who will provide follow-up in the case of positive screens? and 3) what new resources are necessary?

Performance Measure 17 (Very low birth weight infants delivered at facilities for high-risk deliveries and neonates):

Plan: Infrastructure Building

DPH Title V will continue its support for the Perinatal Board and its activities.

STATE PERFORMANCE MEASURES

Children with Special Health Care Needs

State Performance Measure 10 (Hospital discharge of asthma patients):

Plan

Title V staff have a leadership role to play in this area through 1) education regarding second hand smoke and asthma; 2) the development of a needs assessment to determine needs for this population; 3) support for Kids Kare; 4) collaboration with duPont Pediatric Clinics and the American Lung Association on their efforts; and 5) continual support for medical homes.

Enabling

DPH provides liaison activities at hospitals to assure linkage with a primary health care home and other needed resources in the community (i.e., Medicaid, Delaware Lung Association, Public Health Nursing, Home Health Care Agencies).

DPH also provides Kids Kare services as described in the Annual Report and needs assessment.

Infrastructure - Training on child care

During the last year the state of Delaware's technical assistance support for the Community Integrated Service Systems grant for child care, Health Systems Research, Inc. issued a *report Healthy Child Care Delaware: Findings of an Assessment of the Health and Safety Practices of Delaware's Child Care Providers*. According to this report, 59% of all facilities serving CSHCN provided child care to a child with asthma. After allergies, it was the second most common health condition faced by the child care centers. As a result of this information, DPH will be working with the Office of Child Care Licensing in the Department of Services for Children, Youth, and their Families to provide more information about asthma to providers.

Child Health

Adolescent Health activities:

The following activities address the state measures relating to teens.

State Performance Measure 1 (Tobacco use by Teens):

Like all adolescent health measures, while DPH can help to lead this effort, it cannot address these issues alone. Instrumental are the schools, the legislature, SBHC contractor agencies (i.e., Christiana Care Health Services, Bay Health), and parents. In addition, Title V is not the lead DPH agency regarding this issue but is a collaborator with Health Monitoring and Program Consultation, another DPH section.

Plan

Title V will continue the current emphasis on eliminating use of tobacco through the development and support of SBHC. We will also continue to incorporate this measure in other programs such as Smart Start, Kids Kare, etc. Title V will continue to support the work of the Tobacco Coalition as already described in the Annual Report.

Population Based

- The school based health centers sponsor a number of activities such as lunch and learn series on the hazards of tobacco use, yoga and smoking cessation, coordination with the *Great American Smoke Out* and have implemented the *Too Smart to Start Program*.
- Smart Start advises all clients including teenagers to stop smoking.
- Pamphlets regarding the dangers of smoking are placed in all clinics such as dental, STD, and Child Health clinics. Posters and bookmarks are placed at most clinics.
- DPH provides several grants to community agencies including: HD 2000 Mini-Grants; prevention/peer education grants; cessation, reduction, health education and stress management.

Infrastructure Building

During the year 2000, Delaware became a recipient of funds received from the Master Settlement Agreement with the tobacco companies. To determine how to best use these funds, the legislature established the Delaware Health Fund Advisory Committee which is mandated to make recommendations to the Governor and the General Assembly each year for appropriating these funds. The Secretary of Delaware Health & Social Services was appointed as chair and the committee was charged with recommending only health related activities for funding. At this point, the final decisions have not been made regarding allotment of funds but the Committee has recommended a mix of activities. Funding will probably be directed to a variety of initiatives aimed at teens including media activities and community based programs.

State Performance Measure 2 (Alcohol Use by Teens):

Plan

Direct

School Based Health Centers provide individual counseling for alcohol and for children of alcoholics. They also work with parents so that parents can speak to their children about this topic.

Clinics provide dangers of alcohol consumption at the same time that they provide physicals to children.

Population Based

School Based Health Centers include activities such as a play on substance abuse; “Prom Promise”, and discussions with teens regarding substance free lifestyles.

Infrastructure Building

During the next year, the Title V program will work with the local public health units and school based health centers to determine other ways of incorporating an alcohol prevention message into its programs.

State Performance Measure 3 (youth feeling so sad or hopeless)

Plan:

Infrastructure Building

After much discussion the Needs Assessment Steering Committee recommends that a new performance measure be added. The measure is based on a question posed to students taking the Youth Risk Behavior Survey which is “During the last 12 months have you felt so sad or hopeless almost every day for two weeks or more in a row that you stopped doing usual activities?” As already reported in the needs assessment portion of this application, 26.9% of youth answering the survey said yes. A further breakdown of the numbers shows that 33.3% of the females said yes and 21.1% of the males said yes. There were other performance measures that were considered particularly those seriously considering attempting suicide (17.2%); those making a serious plan (12.5%) and actual suicide attempts requiring medical attention (2.4%). All of these measures will be continue to be carefully tracked.

There are many programs and plans in place to address children who are at risk. However, they are fragmented and not available to reach all children and adolescents in need. For instance, the K-3 Early Intervention Program (described in the needs assessment) is only in 10 of the state’s school districts and each worker can only carry a caseload of 15. The schools are undertaking other initiatives such as the development of a Wellness Workshop Conference which will provide an

opportunity to involve school nurses in discussions on counseling techniques and how they can help with early intervention. There are other school climate initiatives which will identify at-risk students and those in need of interpersonal skills development, suicide intervention and prevention, etc. The Division of Child Mental Health, as already described in the needs assessment, is mandated to provide or ensure services to Medicaid eligible or uninsured children. The DCMH also has a variety of programs and initiatives underway to address those children who are already facing crises.

This is another measure for which Title V is not the sole agency responsible for ensuring progress. At this time SBHCs have been the sole mechanism by which we are addressing adolescent mental health concerns. This issue was raised by many informants, other reports, and data.

Although we gathered numerous pieces of information from a variety of sources, there may be resources of which we are not aware. During the next year, Title V will work with other agencies to put these concerns on the table and to develop a plan to start addressing them.

Under Three

State Performance Measure 4 (Increase numbers of Medicaid eligible children under 3 receiving lead screens)

Plan

Enabling

Although they are not funded through Title V, the Disease prevention team tracks non-compliant and delinquent elevated tests, provides case management protocol for elevated leads; and inspects homes for lead. Finally, all DPH programs are expected to determine if there is a need to screen such as WIC staff who ask about lead screening at the 12-month recertification.

Population Based

On October 28, the U.S. Department of Housing and Urban Development awarded the State of Delaware a \$2.7 million grant to implement a Lead-Based Paint Hazard Control program. DPH will use the grant for lead-based paint intervention services as part of an overall rehabilitation strategy. The interventions will include intensive preventive cleaning to remove lead dust, window replacement, and abatement. DPH will partner with the Latin American Community Center on these initiatives.

Infrastructure Building

A new DPH lead poisoning screening protocol will require that all children be blood-lead tested at 12 and 24 months of age or between the ages of 36 and 72 months, if not tested before. The screen will be based on all those who receive Medicaid or WIC services; reside in one of 20 priority ZIP Codes; or whose parent or guardian answers "yes" or "don't know" to any question on a lead Risk Exposure questionnaire.

Women's and Infant's

State Performance Measure 5 (Percent of pregnant women using tobacco):

Plan:

Direct Services

Counseling regarding smoking is provided during all Family Planning and Pregnancy test visits. Once a woman is determined to be pregnant and, if at risk, she receives services through Smart Start and additional counseling to quit. Other staff also offer health teaching to families who are receiving services.

Northern Health services staff have trained Resource Mothers and a Christiana Care Health Services social worker on the new American Cancer Society program "Make Yours a Fresh Start Family." It is targeted at pregnant women and mothers of young families to help them stop smoking. It uses the Prohaska model (the trans-theoretical model of behavior modification.) A "sample" session for insurance vendors was also provided.

Wilmington Healthy Start is working with the American Cancer Society to offer smoking cessation sessions to all of their clients. This effort is part of their overall healthy lifestyles initiatives which include nutrition instruction, enrollment in WIC, substance abuse and psychological counseling, and dental care.

Infrastructure Building

When the state's Tobacco Program started, its' objectives were mostly related to teens. However, plans are underway to either create or expand cessation programs. Pregnant women will be one of the major target groups. CDC grant funding has been set aside for these activities. If as expected the Division receives Tobacco Settlement funds, some of that money will be dedicated to expanding cessation services.

State Performance Measure 6 (Adequate prenatal care for black women):

Plan:

DPH is working to ensure that Smart Start services are provided to all women needing them. As discussed earlier, staff has been stationed in private provider offices to ensure early enrollment.

Infrastructure Building

As already described, the Perinatal Board has the lead to address infant mortality and has been paying close attention to addressing the disparity issue. It has made reducing the disparity a top priority and will be addressing this issue through the work of its committees. One focus is likely to be cultural competency and its effect on women entering care.

Christiana Care Services through its Healthy Start grant is working to address this issue in Wilmington. It has recently revised its program by replacing some Resource Mothers with Outreach Workers who will be stationed at 8 community centers. These agencies have adopted the "one-stop shopping" concept encouraged by the City of Wilmington's Enterprise Community. Location of the workers at these community centers will allow them to have easier access to referrals and programs at each center. Outreach workers and Resource Mothers have plans to canvass the neighborhoods to recruit clients door-to-door and distribute fliers and doorknob hangers. The goal is to increase the accessibility of perinatal health care for 500 at-risk pregnant women. The Healthy Start program also plans to promote community health education classes concerning racial disparity issues through health educators and social service agencies.

The Division of Public Health is also addressing disparity. Its Office of Minority Health has pulled together a committee of DPH staff to develop plans for addressing disparity as it affects the total population and a variety of health problems. There is another committee that has begun to gather data affecting related to access to care in Kent County.

Revised State Performance Measure 7 (Increase birth interval to more than 18 months):

Plan:

Support for family planning, Smart Start and Home Visiting program activities will ensure that the role of birth interval and infant mortality will be communicated. DPH Title V will continue to support the Perinatal Board as it investigates this concern.

Direct Services

Family Planning staff counsel clients about potential dangers in having babies at close intervals. They provide other information through pamphlets.

Health teaching is provided by all DPH programs such as Smart Start where families are informed that short birth interval is a risk factor for SIDS (taught in relation to the "Back To Sleep Program").

A contract went into effect on March 1, 1999 with a consortium of parent education agencies to provide home visiting services for first-time teens enrolled in DPH Home Visiting Program. The contract is managed through the Department of Services for Children, Youth, and their Families' Office of Prevention. The lead agency is Children and Families First, a private agency and they collaborated with Child, Inc. and the Perinatal Association of Delaware. The program called "Baby Steps" is targeted to teens who have given birth to their first child. In addition to parent education and support, the goal of the services is to delay a subsequent pregnancy for at least 18 months. Families receive weekly visits for the first three months and then the visits taper to once a month based on need.

State Performance Measure 8 (Decrease percent of extremely low birth weight black infants)

Plan

Addressing this measure are activities outlined below.

Infrastructure Building

The Northern Health Services Unit applied for a CityMatch Urban Data Use Institute project which was approved in June 1999. NHS is collaborating with the, Christiana Care and the Title V Director on a project that will develop a perinatal health profile for the city of Wilmington. The project will focus on clarifying and communicating racial disparity in infant mortality rates among populations in the city of Wilmington. The first goal was to develop a **profile** of the risk factors related to racial differences in birth outcomes. The team is still developing the project but has narrowed its focus to low birth weight and particularly preterm birth. This study will continue through the next year.

The Perinatal Board is planning a conference in June 2000 that is funded by Healthy Start state funds. The goal is to address black infant mortality. Since low birth weight and prematurity are the main cause of the disparity, these issues will certainly be raised. A rough outline for the conference includes: an opportunity for participants to hear what is known about the issue and what is not known; an "open space" process which provides an opportunity for participants to convene their small group working sessions; and opportunities for stakeholders to gather in their own groups to discuss some possible actions. The target audience will include physicians and other medical professionals, social service and public health agencies, minority community leaders, educators, and black mothers. The Title V Director as staff to the Board serves on the Conference Design Team.

State Performance Measure 9 (Decrease numbers of deaths from SIDS):

Plan:

Title V and other DPH staff will continue to support the Perinatal Board and the Child Death Review Commission in their efforts to decrease SIDS deaths. The Perinatal Board has made the *Back to Sleep* campaign a top priority during the past year.

Direct Services

Title V (MCH) provides home visits to families who have experienced SIDS to offer support, counseling and follow-up referrals as needed. Referrals come from the Medical Examiner's office. Provided is information regarding community resources, short-term support and referral to other resources and responses to questions and concerns the family may have. Northern Health Services has just finalized formal procedures for support of families faced with SIDS. These procedures will be shared with Southern Health Services for possible statewide implementation.

Population Based

The Perinatal Board enlisted the help of the local Kiwanis organization that agreed to make SIDS prevention a top priority last year. The Kiwis Clubs can also help with outreach and the actual grassroots campaign to take the information to local communities. However, despite these plans, some of the communication with the Kiwanis has diminished and this effort has not moved as quickly as planned. The issue here has been lack of resources for the Board and the very fact that both are essentially volunteer organizations. Renewed efforts will be undertaken during the coming year.

Infrastructure Building

DPH staff link with the Medical Examiner's Office to receive all referrals statewide with pending SIDS diagnosis. DPH supports the Child Death Review Commission by providing any client information. DPH provides some funding, staff support, and communication support for the Perinatal Board.

Although the disparity is not as high as it is in some states, there are some indications that SIDS has not decreased as much for the black population. The City Match Data Institute project team intends to look further into the data. Recommendations may need to be made concerning cultural competency and the message used to disseminate SIDS prevention information.

4.2 Other Program Activities

In February 1997, the state launched an expanded partnership with the Delaware Helpline, a non-profit information and referral service administered by United Way. The toll-free service employs fully trained specialists to provide current information about and referrals to state and non-profit services. Included in Helpline information are details on services regarding maternal and child health programs.

The Community Health Care Access section operates another toll free line which provides up-to-date health information for teens and adults. An individual can call *In Touch* 24 hours a day, 7 days a week and listen to pre-recorded information on over 300 topics in the following categories: AIDS, Family Planning, Reproductive Health Care, Pregnancy/Options/Prenatal Care, Rape/Sexual Harassment, Sexuality, STDs, Safety, Messages for Older People, Alcohol, Cocaine, Marijuana, Other drugs, Reasons for Young People to say No, Tobacco, Mental Health, Stress, and Depression, Health and Fitness, Nutrition, Diet and Weight Control, Parenting, School Issues, Self-Esteem, Assessment and Help, and Personal Growth.

Coordination

EPSDT is administered through Medicaid. Services are now delivered through Medicaid's MCOs. DPH provides some EPSDT services and works with Medicaid to ensure access to care.

Title V and the WIC program are administratively in the same DPH unit, the Community Health Care Access Sections and have many opportunities to consolidate policies and services. Several common objectives and joint activities have already been listed.

IDEA is implemented through DPH's Child Development Watch program. Grant administration is through the Division of Management Services, which is part of Delaware Health and Social Services.

Family Planning (Title X) as discussed is part of the Community Health Care Access Section. The Family Planning Director reports to the Women's and Reproductive Health Director in the Community Health Care Access section.

DPH has many opportunities for coordination and collaboration with providers of services to identify pregnant women and infants who are eligible for Title XIX to assist them in applying for services. As described earlier, we actually have stationed staff in hospitals and physician's offices. Included in collaborative efforts are outreach efforts for Medicaid and the Delaware Healthy Children program, and marketing plans to enroll clients into services such as Smart Start and Kids Kare.

A representative from the Division of Vocational Rehabilitation, Department of Labor was assigned to serve on the CSHCN Needs Assessment Steering Committee but never attended any meetings. By including this

perspective, we had hoped to be able to plan for adolescent transition issues. We have had little contact with the Social Security Administration and the State Disabilities Determination Services unit.

4.3 Public Input

Drafts of this document were shared with several groups including the Interagency Coordinating Council, the Perinatal Board, the Delmarva Rural Initiative and other key individuals including parents. There were two meetings held to discuss the grant application and findings from the needs assessment. Recommendations from those meetings and individual comments were incorporated into the document.

4.4 Technical Assistance

No technical assistance is requested for the next year.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. [Title V Sec. 501(b)(4)]

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. **(For planning and systems development)** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health

including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;

- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the **Federal** Title V Block Grant allocation, the **Applicant's** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the **State** funds (the total matching funds for the Title V allocation - match and overmatch), **Local** funds (total of MCH dedicated funds from local jurisdictions within the State), **Other** Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and **Program Income** (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis -Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-

- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.3a

REFERENCES

Alfred I. DuPont Hospital for Children, *Guide to Programs and Services*

Christiana Care Corporate Communications; *The Alliance for adolescent pregnancy prevention, Annual Report, July 1, 1998 - June 30, 1999.*

Christiana Care, *Perinatal Behavioral Health Program, MOMA (Multi-centered Ongoing Monitoring Algorithm)*

City of Wilmington and Wilmington Healthy Start, *Pregnant and Parenting Teens Meeting Minutes, October 22, 1999*

Delaware Head Start Association, *Delaware Directory of Head Start and Early Childhood Assistance Programs*

Delaware Health and Social Services, *Delaware Vital Statistics Annual Report 1998, Winter 2000.*

Delaware Health and Social Services, *Proposal for the Evaluation and Support of the "Second Visitor" Phase of the Home Visiting Program*

Delaware Health and Social Services, Delaware Office of Emergency Medical Services and Emergency Medical Services for Children; *Emergency Medical Services for Children (EMSC) Needs Assessment, Summer 1998.*

Delaware Health and Social Services, Division of Public Health; *Comprehensive Breast and Cervical Cancer Program Grant, 1999*

Delaware Health and Social Services, Division of Public Health; *Title X Family Planning Grant Application FY 00, 1999*

Delaware Health and Social Services, Division of Public Health, Delaware Tobacco Control Program; *Life Can Be Beautiful Don't Let it Go Up In Smoke - A Plan for a Tobacco-Free Delaware, January 2000*

Delaware Health and Social Services, *Delaware Core Diabetes Program Application*

Delaware Health and Social Services, *Delaware REACH 2010 Program Application*

Delaware Health and Social Services, Division of Public Health, Health Monitoring and Program Consultation; *Strategic Plan for Breast and Cervical Cancer Control in Delaware*, 1998

Delaware Health Care Commission, *Dental Care Access Improvement Committee Report and Recommendations*, March 2, 2000

Delaware Health Care Commission, *Health Care Policy: Balancing Needs and Viewpoints, A Decade of Focus, Annual Report and Strategic Plan*, January 15, 2000

Dental Care Access Improvement Committee, *Dental Care Access Improvement Committee Report and Recommendations to the Delaware Health Care Commission*, March 2000

Division of Child Mental Health Services, Department of Services for Children, Youth and Their Families; *State of Delaware FY2000 State Mental Health Plan Child and Adolescent Services*

Doble Research Associates, *Teenage Pregnancy: What the People of Delaware Think*, June 1998.

Family Planning Council Research Department, *Children with Special Health Care Needs Focus Groups Final Report*, January 2000

Guyer, Bernard, MD, MPH; Donna L. Hoyert, Ph.D.; Joyce A. Martin, MPH; Stephanie J. Venture, MA; Marian F. MacDorman, Ph.D.; and Donna M. Strobino, Ph.D.; *PEDIATRICS, Annual Summary of Vital Statistics - 1998*, December 1998 Vol. 104, No. 6.

Health Systems Research, Inc., *Healthy Child Care Delaware: Findings of an Assessment of the Health and Safety Practices of Delaware's Child Care Providers*, January 18, 2000

Latino Agenda 2000, December 21, 1999 DRAFT

The New Castle County Perinatal Outreach Committee, *Proposal to the Health Advisory Committee Delaware Health Fund*, October 1999.

Ratledge, Edward C., *Delawareans Without Health Insurance 1998*, University of Delaware, Center for Applied Demography and Survey Research, College of Human Resources, Education and Public Policy, May 1999

Ratledge, Edward C., *Primary Care Physicians in Delaware 1998*, University of Delaware, Center for Applied Demography and Survey Research, College of Human Resources, Education and Public Policy, 1998

Ratledge, Edward C., University of Delaware, Center for Applied Demography and Survey Research, College of Human Resources, Education and Public Policy; *The Total Cost of Health Care in Delaware (1998 version)*, June 1998

Ratledge, Edward C., University of Delaware, Center for Applied Demography and Survey Research, College of Human Resources, Education and Public Policy; *Children with Special Health Care Needs*

Ratledge, Edward C. University of Delaware, Institute for Public Administration, Center for Applied Demography and Survey Research, College of Human Resources, Education & Public Policy; *Consumer Assessment of Health Plans in Delaware*, May 1999.

Ratledge, Edward C. University of Delaware, Center for Applied Demography and Survey Research, College of Human Resources, Education and Public Policy; *Delawareans Without Health Insurance*, 1999

5.3b Curriculum Vitae

Prudence Albright

EMPLOYMENT HISTORY

August 1996 – Present: Delaware Division of Public Health, Public Health Nursing Director, Community Health Care Access Section Administrator - Supervise, direct and guide the Branch Directors responsible for Family Health, Special Populations, Women's and Reproductive Health and Health Systems Development; Plan and direct section efforts to support Governor, Department and Division priorities, currently Teen Pregnancy Prevention, School-Based Health Centers, DPH role in Managed Care; Participate in Section, Division and Department planning efforts; Develop and manage appropriated state funds, federal and other grant funds, and other revenues to assure optimum use of resources to carry out work plans; Develop standards of care, clinical protocols and practice guidelines; Provide advice and technical assistance on policies and procedures for implementation of services; Manage PHN collective bargaining agreement for the Division in conjunction with the County Administrators; Represent Delaware and the Division with nursing groups in the state and nationally.

December 1992 – August 1996: Sussex Technical High School, Instructor - Developed and taught health professions curriculum to high school students; Served as manager for health & human services cluster; Served as club advisor/coach for Vocational Industrial Clubs of America (VICA), Key Club, and field hockey team; Selected as 1996 State VICA Advisor of the Year.

August 1991 - December 1992: Delaware State College, Department of Nursing, Instructor - Instructor for Community Health Nursing and Fundamentals of Nursing; Various college and department committees, including curriculum revision.

October 1989 - August 1991: Children's Bureau of Delaware, Project Director - Coordination of Sussex Tech's Wellness Center; Supervise multidisciplinary team providing service to enrolled students; Provide nursing assessment, education and counseling to students; Coordinate services with school nurse, counselors, and administration; Participate in health education planning within the school district.

March 1972 - October 1989: Division of Public Health, Various Positions

Nurse Consultant - Coordinate multidisciplinary team clinics for at risk infants and toddlers; Nursing responsibilities in special clinics; Central referral/intake nurse for high risk pregnant women and infants and toddlers.

Chief of Administration - Managed budget process for the Division; Assistant to the Division Director; Supervised Vital Statistics, Personnel, and Fiscal Offices.

Public Health Nursing Assistant Director - Assisted in the hiring of Public Health Nurses; Management consultation to Public Health Nursing Supervisors; Developed and implemented quality assurance tools; Coordinated statewide Nursing inservice programs; Adjunct Professor, Wesley College - Instructor for the Community Health Nursing; Co-chair the Division of Public Health/Division of Child Protective Services Task Force to revise the working agreement

between the agencies; Assisted with implementation of policy for PHN's; Agency Representative to Division of Nursing Research Project with the Visiting Nurse Association of Omaha.

Nursing Supervisor, Milford & Southern New Castle County Health Units - Implemented all Division programs at this unit; Supervised public health nursing field and clinic activities, community assessment and participation - Interagency Council on Child Sexual Abuse, Interagency Council for Services to High Risk Infants and Children.

Special Project Assignment - development and implementation of client tracking system.

Public Health Nurse II, Kent County Health Unit - Case management of home health, pregnant women, infants and children; Pediatric assessments and health teaching in clinic services.

Cancer Screening Project Director - Developed and implemented a statewide screening program for cervical and breast cancer; Coordinated activities with nonprofit agencies.

Public Health Nurse, Kent County Health Unit - Case management infants, children, home health clinic services, child health, prenatal, communicable disease.

September 1971 - March 1972: Delaware State College, College Health Service, Nurse - Provided nursing assessments and treatment per standing orders of students seeking assistance from the college health service.

OTHER EXPERIENCES - Adjunct Professor - Wilmington College, Nursing Leadership; Foster Care Review Board - February 1989 - May 1996; Association of State and Territorial Directors of Nursing, 1996-present; Attended Duke Executive Education for State Government, March 1999.

EDUCATIONAL BACKGROUND - May 1984, Widener University, M.S. Nursing, Chester, PA, Nursing Service, Administration; May 1971, University of Delaware, B.S. Nursing, Newark, DE

PUBLICATIONS - *THE OMAHA SYSTEM: APPLICATIONS FOR COMMUNITY HEALTH NURSING*, By Karen S. Martin and Nancy J. Sheet for The Visiting Nurse Association of Omaha "*Using the Omaha System in a State Health Department.*"

5.3b Curriculum Vitae

Biographical Sketch - Jo Ann Baker

Name (Last, first, middle initial) Baker, Jo Ann, M	Title Director, Women's & Reproductive Health		Birth Date 9/7/55
Education (begin with baccalaureate or other initial professional education and include postdoctoral training)			
Institution and Location	Degree	Year Completed	Field of Study
Wilmington College	MSN	1997	Nursing; Family Practice Nurse Practitioner
Wilmington College	BSN	1991	Nursing; Supervisory Management
Milford Memorial Hospital School of Nursing	Diploma	1976	Nursing (RN)
HONORS: Cum Laude Sigma Theta Tau			

RESEARCH AND PROFESSIONAL EXPERIENCE List in reverse chronological order previous employment and experience. List in reverse chronological order most representative publications.

9/98-Present Division of Public Health: Director, Women's & Reproductive Health Branch
9/99-Present Department of Corrections consultant: medical chart audit reviewer
7/98-Present Family Practice Nurse Practitioner; Private-Practice (part-time)
10/94-9/98 Division of Public Health: Family Planning Program Administrator
9/93-10/94 School Nurse (grades K-8)
6/95-9/93 Kent General Hospital: Nurse Manager Perinatal Department (Certified Childbirth Educator)
9/83-9/93 Kent General Hospital: Nurse Manager Dialysis/Medical Surgical Unit
2/78-9/93 Dover Dialysis Unit: Staff RN; CAPD Coordinator; Transplant Coordinator
6/76-2/78 Milford Memorial Hospital: Critical Care Staff RN

Publications:

Abstract on collaborative program with ACOG/MCH/PH, New York Journal of Medicine and the Public Health Collaborative Program Pocket Guide; Summer 1998

Presentations:

12/95 News Conference: HIV/AIDS 076 Project
10/96 Prevention Conference: HIV/AIDS; Delaware Technical and Community College
1997 & 1998 Contraceptive Options; Wilmington College Nurse Practitioner Program
9/98 Role of the NP with Adolescent Populations; Wilmington College Nurse Practitioner Program
10/98 Women's Health Issues; University of Delaware Women's Issues Forum Class
4/99 Region II Conference: Lessons Learned: Family Planning and Medicaid Waivers; University of Chapel Hill
11/99 AWHONN Annual Meeting: Reaching Teens with High Risk Behaviors: Teen Pregnancy Prevention
1/00 Delaware State University: Women's & Reproductive Health Statistics & Services Available

Activities/Committees/Memberships:

State Family Planning Administrators Regional Delegate 1995-1999
State Family Planning Administrators Executive Board 1996-present; Chair 1998-99
Advisory Board: Planned Parenthood OB/GYN Nurse Practitioner Program (Region III)
Advisory Board: Wilmington College Nurse Practitioner Program
Perinatal Board Standards of Care Committee
Perinatal Association of Delaware
Kent County Board: American Cancer Society
American Academy of Nurse Practitioners
Sigma Theta Tau International
Domestic Violence Coordinating Council

5.3b Curriculum Vitae

Barbara C. DeBastiani

Division of Public Health, 544 S. Bedford St., Georgetown, DE 19947

Phone 302.856.5355

Fax 302.854.2856

Email bdebastiani@state.de.us

Education	1989	Wilmington College, Georgetown, De M.S. Human Resource Management Thesis: A Proposal for the Reorganization of Community Health Services in the Delaware Division of Public Health
	1971	Alderson Broaddus College, Philippi, WV BSN, cum laude Major: Nursing
Honors/Awards	1993	Delaware State University Nursing Honor Society Community Leader
	1989	Richard Campbell Ponsell Award for highest academic average in Master's program
	1971	Allied Paramedical Sciences Writing Award
	1971	Silver Key Honorary Society
Experience	1976-present	State of Delaware, Division of Public Health County Health Administrator, Kent & Sussex Counties, 1990 - present Public Health Nursing Supervisor, Milford Health Unit, 1986-1990
	1974-75	Public Health Nurse I, II, III, Team Leader and Nursing Supervisor, Sussex County Health Unit, 1974-1975, and 1976-1986
	1975-76	Montgomery County Health Department, Silver Spring MD, Community Health Nurse
Professional Affiliations		National Association of County and City Health Officials American Public Health Association Delaware Public Health Association

Publications/Presentations

- Presenter "Medicaid Managed Care: The Delaware Experience", American Public Health Association, New York City, November, 1996
- Presenter "Tackling Tuberculosis in Sussex County: A Public/Private Partnership. Presented at regional meeting of the Delaware, Pennsylvania, and New Jersey Public Health Associations, Philadelphia PA April, 1996
- Contributor "An Outbreak of Tuberculosis in Rural Delaware", American Journal of Epidemiology, February, 1989
- Coauthor "Public Health Nursing Today", Delaware Medical Journal, December, 1988
- Coauthor "Hepatitis Outbreak in Sussex County", Delaware Morbidity Report, November, 1983

5.3b Curriculum Vitae

Shirlee Kittleman

Professional Experience

Division of Public Health

1988 to Present

2055 Limestone Rd., Suite 300, Wilmington, DE 19808

Position Held: County Administrator

Responsibilities include: Administrative responsibility for local Public Health Program, needs assessment, local policy development, community planning, collaboration, budget development

Division of Public Health

8/84 to 7/88

501 Ogletown Rd., Newark, DE 19711

Position Held: Supervisor

Responsibilities: Supervision of Public Health Nurses and support staff. Implementation of programmatic policy, maintenance of standards of nursing practice, including quality assurance. Management of two clinic sites which included child health, women's health and adult health. Recruitment, hiring, and termination of employees

Division of Public Health

10/83 to 8/84

3000 Newport Gap Pike, Wilmington, DE

Position Held: PHN II

Responsibilities: PHN Liaison for St. Francis Hospital, A.I. duPont Institute. Initiated PHN liaison role between St. Francis Hospital and Division of Public Health. Duties included establishment of referral criteria for new Obstetrical Unit at the hospital, maintenance of communication and collaboration between the hospital and Division of Public Health.

Cecil County Health Department

4/77 to 9/77

Position Held: Consultant

Served as consultant of implementation of problem oriented record for county health department.

University of Delaware

2/82 to 2/83

Newark, Delaware

Position Held: Part-Time Lecturer

Clinical instructor for community field experiences for Senior Nursing Students

University of Delaware

1973 to 1977

Newark, Delaware

Position Held: Instructor

Responsibilities: Clinical instructor for MCH and Community courses in BSN program. Planned clinical experiences, supervised students, lectures.

Wake County Health Department

1971 to 1972

Raleigh, North Carolina

Position Held: Public Health Nurse

Visiting Nurse Association of Cincinnati and Northern Kentucky 1969 to 1971

Cincinnati, Ohio

Position Held: Staff Nurse & Supervisor

Education

University of Iowa

Iowa City, IA

1964 to 1966

Degree/Achievement - None

Wayne State University

Detroit, Michigan

9/66 to 12/66

Degree/Achievement - None

University of Cincinnati

Cincinnati, OH

1967 to 1969

Degree/Achievement - BSN

University of North Carolina

Raleigh, NC

1972 to 1973

Degree/Achievement - MPH

University of Delaware

Post-Grad - No Degree

Strategic Leadership for State Executives, Governor's Center at Duke University, 1998

Organizations

National Association of County Health Officers, Membership Committee, 1996

American Nurses Association

American Public Health Association

Delaware Nurse Association

Delaware Public Health Association

Delaware Perinatal Association

Delaware Health Care Alliance

Presentations

Regional facilitator, Advancing the Strategy for Suicide Prevention, Reno Nevada, Oct. 14-18, 1998

Guest lecturer, "Community and Public Health Nursing, Educator and Provider Perspectives", University of Delaware, October 1997

Co-Presenter, "The Delaware Experience: Medicaid Managed Care", American Public Health Association, New York, NY, November 15, 1996

Presider, "Childhood Lead Poisoning Issues", American Public Health Association, San Francisco, CA, October 27, 1991

Guest Lecturer, "Administrator's View of Advance Practice Roles/Accessing Power", Department Advanced Nursing Science, University of Delaware, December 1, 1992

Guest Lecturer, Introduction to Family & Community Services - Role of Public Health, Individual & Family Studies, University of Delaware; November 14, 1989, March 20, 1990, November 13, 1990

Awards

Northern Health Services recipient of NACCHO (National Association of County & City Health Officials)

Runner-up for the 1997 Award for Multicultural Health for Home Visiting Program

5.3b Curriculum Vitae

Eileen K. Guerke
400 Quail Run
Wyoming, DE 19934

Phone: H (302) 678-9043
W (302) 739-4735

PROFESSIONAL EXPERIENCE

- June 1999 to Present Primary Care Coordinator - (Public Health Treatment Program Administrator)
Health Systems Development Branch, Community Health Care Access Section,
Div. of Public Health, Dept. of Health & Social Services, State of Delaware
Jesse Cooper Building, P.O. Box 637, Dover, Delaware.
Major Responsibilities: Management of Primary Care Cooperative Agreement. Responsible for writing, monitoring and completing workplan activities and grant expenditures. Meets quarterly with Federally Qualified Health Centers in Delaware to problem-solve and provide technical assistance regarding primary care and systems building. Participates on a variety of community partnerships to address access to care issues. Develops state capacity reports that compare the state's health care needs with available resources. Staffs meetings and coordinates activities of the DPH Managed Care Committee. Assists with the implementation of the Delaware Covering Kids Program. Participates in negotiations with MCOs and monitors compliance. Plans and implements MCO prevention partnerships related to DPH disease management. Develops strategies for improving public health goals among MCOs.
- November 1998 to June 1999 Allocations Associate, United Way of Delaware, Orange Street, Wilmington, Delaware and 365 United Way, Dover, Delaware
Major Responsibilities: Responsible for staffing Management and Program Review Teams that include United Way Allocations Volunteers. Conducts management audits of non-profit agencies in Wilmington and Kent County. Recommends funding amounts based on program outcomes and ensures sound management practices. Staff leadership also given to Count Issues Committee - *representatives from New Castle, Kent and Sussex counties.*
- February 1992 to September 1998 Executive Director, Central Delaware YMCA, 1137 South State Street, Dover, Delaware
Major Responsibilities: Supervision of total branch operations including planning, financial development, marketing, program and membership services, facility management of two pools, fitness center, daycare room, two multi purpose rooms, youth center and twenty-five extension sites; fiscal year 1998 operating budget of \$ 1,964,480.
Staff Supervision: Sixteen full time staff, two hundred part time staff.
Volunteer Leadership Relationships: Board of Managers, Executive Committee, Leadership Development Committee, Contributing Campaign Committee, Annual Golf Tournament Committee; Delegation of staff as aides to Program & Membership Committees. More than 300 volunteers.
- August 1987 to Feb. 1992 Director of Fitness & Physical Education, Central Delaware YMCA, 1137 South State St.
Dover, Delaware

5.3b Curriculum Vitae

Joan S. Powell

Public Health, Planning and Evaluation Experience

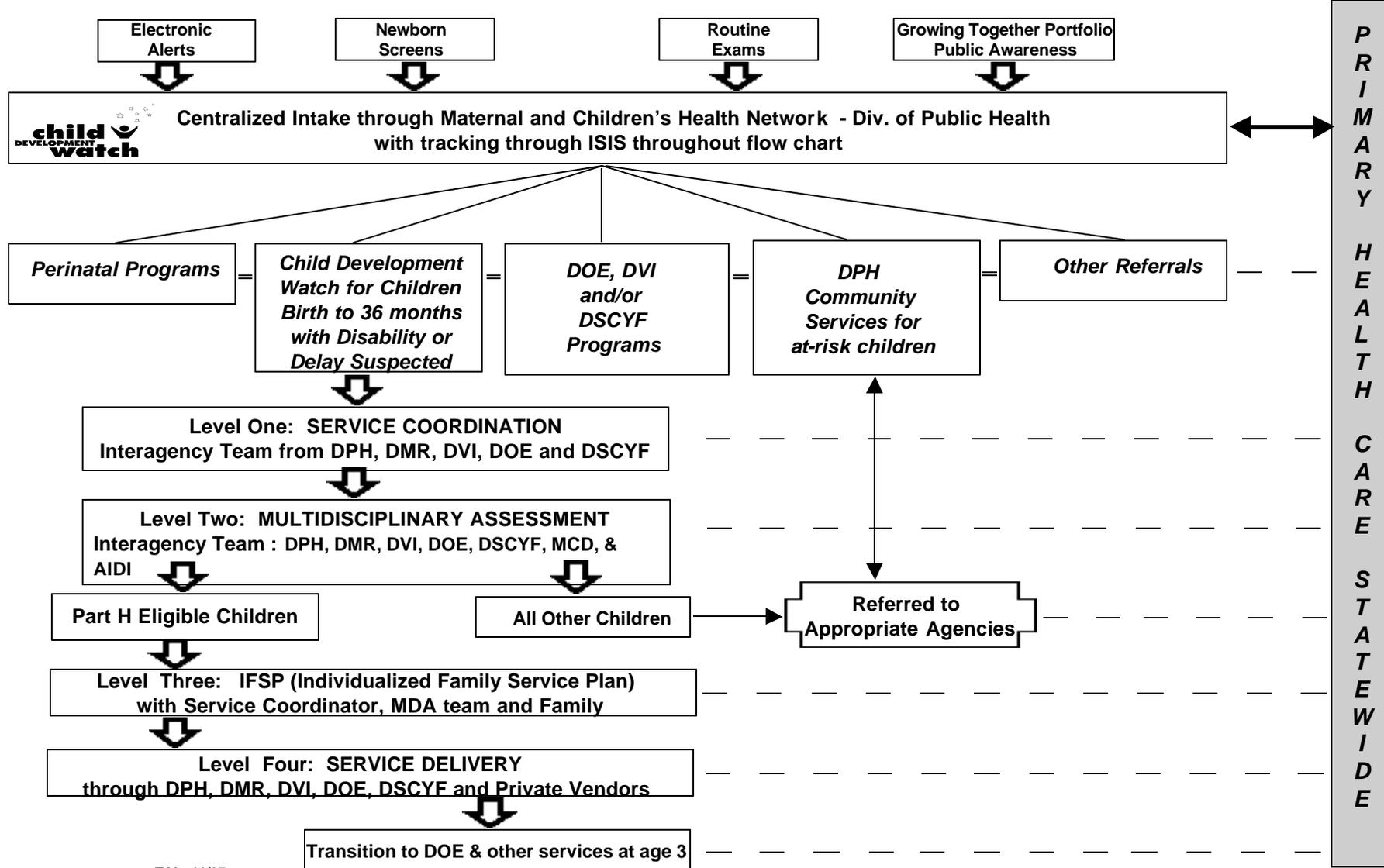
January 1998 to Present	<p><u>Family Health Services Director</u>, Div. of Public Health, Delaware Dept. of Health and Social Services</p> <p>Responsibilities include: 1) Family Health Services Branch Director including supervision of School Based Health Centers and Children with Special Health Needs and Early Intervention; 2) Administration of the Maternal Child Health Block Grant; 3) Serve on Community Health Care Access senior management team; 4) Implementation of child care/public health efforts; 5) Support for Perinatal Board and infant mortality reduction; 6) Project Director for the Pregnancy Risk Assessment Monitoring System (PRAMS).</p>
October 1994 to January 1998	<p><u>Early Intervention Services Director</u>, Div. of Public Health, Delaware Dept. of Health and Social Services</p> <p>Major Responsibilities included: 1) Management of early intervention services budget; 2) Program planning and development; 3) Development of quality management and evaluation efforts; 4) Data management; and 5) development of needs assessment for children with special health care needs from birth to 21.</p> <p>Successes included: 1) Developed program standards and evaluation plans; 2) Collaborated with Medicaid and other agencies to ensure the continued provision of services for children with special health needs under Medicaid Managed Care. 3) Developed and implemented plans for meeting data collection needs.</p>
February 1992 to Sept. 1994	<p><u>Assistant Part H Coordinator</u>, Div. Of Management Services, Delaware Dept. of Health and Social Services</p> <p>Major responsibilities included: 1) Planning for and developing a system for a federally funded early intervention program; 2) Expanding funding options; 3) Establishing procedural safeguards; 4) Building service capacity; 5) Planning for timely reimbursement of providers; 6) Coordinating all public awareness activities; 7) Managing data.</p> <p>Successes included: 1) Established case management as a Medicaid reimbursable activity; 2) Established procedural safeguards for children and families served; 3) Developed contractual agreements; 4) Developed and managed centralized billing system; 5) Collaborated to develop and implement a case management system for infants and toddlers birth to three.</p>
December 1989 to Feb. 1992	<p><u>Senior Human Services Planner</u>, Div. Of Planning, Research and Evaluation, Dept. of Health and Social Services</p> <p>Major responsibilities included: 1) Evaluations of designated interdivisional programs and polices and 2) serving as a liaison between Departmental administrative unit and the Division of Public Health.</p>

Education

Master of Public Administration, University of Delaware

Bachelor of Arts, Sociology, West Chester University

Part C Model Flow Chart within Delaware Health Network



TAL, 11/97



DPH = Div. of Public Health
 DOE = Dept. of Education
 DMR = Div. of Mental Retardation

DSCYF = Dept. of Services for Children, Youth & Families
 DVI = Div. for the Visually Impaired
 ISIS = Integrated Service Information System

AIDI = duPont Hospital for Children
 MCD = Christiana Care Health System
 MDA = Multidisciplinary Assessment

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