

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **DE**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Dennis Rubino, Director of Children with Special Health Care Needs (CSHCN).

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Drafts of this document were shared with the Maternal Child Health Block Grant Steering Committee, which is composed of representatives from Medicaid, Department of Education, Department of Services for Children, Youth and Their Families, Division of Child Mental Health, and the Division of Public Health. It was also reviewed by the Coordinating Council for Children with disAbilities. Since there were few major changes this year and the Title V office did not have the up to date data until the middle of June, the application was not widely disseminated. When the needs assessment was completed in 2000, it and the grant were shared with several groups including the Interagency Coordinating Council, the Perinatal Board, the Rural Health Initiative and other key individuals including parents. After the grant is transmitted, it will be shared with a variety of key partners again including the ICC, the Perinatal Board, March of Dimes, etc.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

III. State Overview

A. Overview

[See attachment] 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 783,600. The majority (55%) of the population is between the ages of 20--59. The population aged 0-19 account for another 28% and, finally, those aged 60 and up constitute the remaining 17%. It is interesting to note that since 1990, children ages 10 to 14 have increased by 28%.

//2005/ The population estimate for Delaware in 2002 was 807,385; at three percent increase. New Castle County increased by 2.4%, Kent County by 3.5%, and Sussex County by 47%. //2005//

The top five employers, starting with the largest, include the State of Delaware, A.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 the U.S. Census Bureau, in 1999, 10.4% of Delaware's population can be considered poor (less than 100% of the Federal poverty guidelines). 16.6% of all Delaware's children under 18 are poor.

//2003/ New data from Census 2000 has just been released. It shows that the state's median income grew by almost 5 percent to \$47,381 from 1989 to 1999. New Castle County had the highest median income at \$52,419, followed by Kent County at \$40,950 and Sussex at \$39,208. The median income in Sussex rose by 12.3 percent because an influx of older, wealthier and better-educated retirees moved into beach areas. Overall the data show significant gains in well-paying professional jobs because of the growth of service industries such as banking. But the data also show that not everyone benefited from the decade's growth. The number of families living in poverty rose and the gap between the poor and the well-to-do widened. The number of families in poverty grew by 23 percent to 13,306 between the 1990 and 2000. The number of single mothers in poverty grew by 24 percent to almost 7,000 women. The percent of people in service occupations grew from 12.6 percent in 1989 to 14.6 percent in 1999. People in manufacturing jobs dropped by about 21 percent to about 12.5 percent. But the new census figures show that the number of people in upper incomes grew in the past decade while the percentage of families in poverty also increased. In 2000, 63,663 Delaware households, or 21 percent, reported an annual income between \$50,000 and \$74,999, making that income group the largest. In 1989, the largest percentage of the state's households - 20 percent - fell into the \$35,000-to-\$49,999 range. When adjusted for inflation, that range translates to Census 2000's \$45,425-to-\$64,892 bracket.

Between 2000 and 2001, the Division of Public Health pulled together a statewide partnership of over 150 Delawareans from business, community, health care, education, and government organizations to create the Healthy Delaware 2010 Initiative. A multi-sector steering committee established the vision and goals for the initiative and a collaborative process to develop measurable health improvement objectives for the decade. At the end of the process, over 60 private and public sector partners agreed to become "Prevention Partners" to involve their organizations, staff and members in the development and promotion of Healthy People 2010; work towards the achievement of health for all Delawareans; and be active partners in the initiative. Several of the objectives and strategies are in the MCH plan.

Geographic Disparities

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 the problems in each of the counties. Coupled with the geographic 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.

/2003/ 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 \$8,000 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.

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

The city of Wilmington is like most urban areas throughout the nation and has correspondingly high rates of teen pregnancy rates, infant deaths, children born to single mothers, juvenile arrests and AIDS cases. Although Wilmington does not have a city health department, it hired a Public Health Officer a couple of years ago.

/2004/ Kids Count is working on community profiles that will target the above by September 2003. //2004//

/2005/ Kids Count produced a fact book for the City of Wilmington and for the State of Delaware with a volume of data and trends related to Maternal Child Health. Discussion has also been initiated on conducting some type of assessment of all the personnel funded by the grant in order to enhance our knowledge of the variety of work effort made, relating to Maternal and Child Health. The assessment may be by direct observations, or random telephone surveys. //2005//

Racial Disparities between whites and blacks:

The Office of Minority Health for the Division of Public Health released a report on Health Disparities in Delaware in March of 2001. A Spanish version of the document was released in the fall of 2001.

The following findings are significant:

SS There were three indicators where the rate for blacks was 3 times higher or more than the rate for whites: HIV Infection/AIDS Death Rate (10.66), Homicide Rate (4.3), and Asthma Hospitalization (3.3).

SS Five indicators showed a disparity ratio of between 2 and 4: Teen Birth Rate (2.71), Late or No Prenatal Care (2.55), Per cent of Low Birth Weight Births (2.08), Infant Mortality (2.75), and Diabetes Death rate (2.47).

SS Four indicators had a disparity ratio between 1 and 2: Alcohol-Induced Death rate (1.64), Stroke Death rate (1.62), Cancer Death Rate (1.45) and Heart Disease Death rate (1.20).

The Office also analyzed trends and determined that long-term downward trends were significant for late or no-prenatal care and alcohol-induced death rate. Trends have decreased in the short term for low birth weight births and teen birth rates. However, for all other indicators the disparity ratios have either changed or worsened.

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
- ? Develop a support system for CSHCN
- ? Prevent childhood lead poisoning
- ? Improve understanding of health and safety issues for child care providers
- ? Address adolescent needs through school based health centers
- ? /2004/ Develop a comprehensive early childhood system. //2004//
- ? /2004/ Establish an emergency preparedness system //2004//

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, and 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 in all counties and recommended changes were incorporated into the document. For this year's application, the Title V administrator requested updates from the key participants who contributed to the development of the needs assessment.

B. AGENCY CAPACITY

Steps Taken by the CSHCN Program to Ensure a Statewide System of Services:

State Program Collaboration with Other State Agencies and Private Organizations;

The state collaborates 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.

As described in the application, 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. There is little coordination of service delivery within the present system. There are numerous providers involved and communication is not consistent. For children 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). The Director of CSHCN is responsible for the Part C operations in the Division of Public Health.

/2004/ The Coordinating Council for Children with disAbilities (CCCD) has been active as an advisory committee for the CSHCN program. This has increased both the formal and informal interagency collaboration statewide. In addition the CCCD has received technical assistance from Health Systems Research, Inc. who has initiated a technical assistance plan for the CCCD with a focus on interagency, collaboration, communication, and assessment. //2004//

/2005/ A final needs assessment as an outcome of the Technical Assistance Plan is expected to be completed by Helath Systems Research, Inc. and will be used as a basis for the Maternal Child Health required needs assessment process. //2005//

Numerous representatives from the Division of Public Health participated in Delaware's Continuous Improvement Monitoring Process. The Office of Special Education Programs (OSEP) of the U.S. Department of Education is responsible for assessing the impact and effectiveness of State and Local efforts to implement the mandates of the Individuals with Disabilities Education Act (IDEA) amendments of 1997. "The Continuous Improvement Monitoring Process" is the title given to the process by which impact and effectiveness are determined. As part of this process, Delaware was chosen as one of 16 states to conduct a statewide self-assessment regarding the provision of Early Intervention and Special Education services in the state. The self-assessment was intended to identify both strengths and areas of improvement and compliance issues of the State's Part B and Part C programs for children birth to 21. There were three phases of the self-assessment process, which began in June 2000: 1) Review of the data and the development of the draft self-assessment; 2) The Validation Process; and 3) Review of the public input and finalization of the self-assessment report. Part C strengths were noted in the areas of outreach, collaboration, personnel development, and family satisfaction. Areas of improvement include issues around natural environment, system evaluation, access to services, and tracking. Future plans include utilizing the existing committees to work on areas of improvement while maintaining the current strengths of the system, and utilizing the outcomes when developing a State Improvement Plan. The Director of CSHCN chairs the Quality Management Committee for Child Development Watch. This Committee oversees the promulgation of standards and management of all quality assurance initiatives. The Committee will have a lead role in ensuring the implementation of the federal recommendations made as a result of Delaware's Continuous Improvement Monitoring Process.

/2004/ The Quality Management Committee has developed and implemented a system of formal on-site provider monitoring. For the first time, in the State of Delaware, the Child Development Watch Part C service providers are being monitored. Monitoring began in September 2003. //2004//

/2005/ The Quality Management Coordinator position was frozen due to the State's freeze on hiring and has not yet been recovered. This position has conducted provider monitoring for Part C services. As a result, the responsibility for provider monitoring was assigned to Northern and Southern Health Services within the Counties. //2005//

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 that also have a lead role that 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 Developmental Disabilities Services. The Division of Child Mental Health, Department of Services for Children, Youth, and Their Families has the primary lead on child mental health and substance abuse 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. The Delaware Department of Education in collaboration with numerous other agencies and departments, including the DHSS and the DSCYF sponsored a statewide Early Childhood Summit in March of 2002. The summit initiated a strategic planning process to address the emotional wellness in young children inclusive of CSHCN.

/2004/ On January 24, 2003 a Speech Summit was held to raise the awareness and to formally continue the discussion on the appropriate and effective use of the dwindling of speech and language therapy services in Delaware. The National Early Childhood Technical Assistance Center facilitated the process. A strategic plan is being formulated to address the future needs of the CSHCN and their families. //2004//

/2005/ A strategic plan was implemented as a result of the Speech Summit. New guidelines were created and approved under a program called "Enhanced Watch and See". The program addresses speech and language therapy services statewide. //2005//

State Support for Communities:

State programs strive to 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:

1) the Transdisciplinary/Consultative (TD) Project, 2) the Medical Home Demonstration Project, 3) the Traumatic Brain Injury Project, 4) the Delaware/Maryland Autism project, and 5) Partners in Policy Making.

//2004/ 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 has developed a Medical Home Model to provide care coordination for CSHCN. A Community Access to Child Health Planning (CATCH) Grant provided funding for training of State and community service providers in the Medical Home Model. In addition, the concept of the medical home has been added to the Medicaid Request For Proposals for managed care organizations. A small CATCH grant was submitted by the Delaware AAP in conjunction with the CSHCN program and was approved. The grant plans to implement a "certification" process for medical homes focusing on pediatrician and family practice offices.//2004//

//2005/ The Medical Home project has partnered with the Medical Home subcommittee of the State Early Childhood Comprehensive Systems planning grant. The merging of the two committees has enhanced its membership and its productivity. //2005//

//2004/ Traumatic Brain Injury: The Director of Children with Special Health Care Needs has provided active representation on the statewide Traumatic Brain Injury (TBI) Steering Committee. The Steering Committee was chaired by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). A strong partnership with the DSAAPD had heightened the awareness of the needs of children from birth to twenty-one as related to traumatic brain injury and acquired brain injury. The DSAAPD had focused previously on adults only. A Pediatric Subcommittee of the TBI Steering Committee had met to review the specific needs of the birth to twenty-one population and had formulated a position paper on the issues, needs of the population, and gaps in service delivery. During this past year the state support for TBI has shifted systemically to the State Council for Persons with Disabilities. There now exists a Brain Injury Committee of the council, which coordinates the efforts related to TBI/ABI. The Director of CSHCN remains an active member of the committee which addresses both treatment and prevention efforts.//2004//

Maryland/Delaware Autism Surveillance Project: The Autism Surveillance Project complements the work of the CSHCN Advisory Committee. The data that the project will obtain and analyze will be used to contribute to the formulation of a state policy on autism, inform discussion of the fiscal resources needed and possible funding mechanisms, facilitate service planning and implementation and allow for the evaluation of the service program. The surveillance project will measure the population prevalence of these disorders, breaking down surveillance by subtype, and tracking the prevalence over time. Maryland will compare its population and experience with that of Delaware. The Director of CSHCN is on the Autism Project Advisory Committee.

//2005/ The Maryland/Delaware Autism Surveillance Project has expanded into a Center of Excellence called the "Center for Autisms and Developmental Disabilities Epidemiology". Currently under its monitoring activities, we do not know how many children living in Maryland and Delaware have an ASD. However, we do know that during the 2002-03 school year 278 children, ages 3-11, in Maryland, we classified as having autism under the Individuals with Disabilities Education Act (IDEA). There are additional children with ASDs who are classified in other disability categories under IDEA or who do not receive special education services.

The center will use multiple sources to obtain more accurate estimate of the number of children in the study area with an ASD. The center will study whether ASDs are more common in some groups of children than in others and whether the number of children with ASDs is changing over time. The monitoring activities will focus on children 8years old. The center

anticipates posting the results of the 2000 study year on its website by the end of 2004. //2005//

? Coordination of Health Components of Community-Based Systems

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.

//2005/ The Kids Kare program is currently undergoing an evaluation, statewide. //2005//

Ryan White HIV program:

//2004/ The Division of Public Health also manages Ryan White Grant funds, which provide case management to a small number of HIV infected children (29 children). The case manager is housed in the A.I duPont Hospital for Children. 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. HIV positive and negative children are also provided services if they live in a family unit where at least one of the parents is HIV infected. These may include, case management, food, housing, emergency financial, transportation and other forms of assistance. There is also an AIDS Medicaid Waiver provided to children who are AIDS diagnosed (total 12 children). The Waiver provides the full range of Delaware Medicaid services along with Waiver specific services of case management, respite, and nutritional supplements. //2004//

//2005/ there is about a 10% increase in persons who access the services overall, but there is not the same increase as related to children. There are very few HIV infected children born anymore, due to testing activities at the OB-GYN offices. //2005//

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.

//2005/ Most referrals have originated from shelters to the Crisis Services of DCMHS. //2005//

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.

? Coordination of Health Services with Other Services at the Community Level

Various mechanisms exist 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.

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 who 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 Specialty 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 specialty 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.

State Statutes Relevant to the Title V Program

Below are the state statutes relevant to children and families served under Title V:

/2002/ Child restraint and bicycle safety laws help to support the Title V priority need to reduce preventable injuries to children and adolescents.

? Every person transporting a child under the age of 4 years in a motor vehicle is responsible to secure a child in a child passenger restraint system.

? Children between the ages of 4 and 16 are required to wear a fastened seat belt or child passenger restraint system at all times while in a motor vehicle.

? No child who is 65 inches or less in height and who is under 12 years of age shall occupy the front passenger seat of any vehicle equipped with a passenger-side airbag that has not been deliberately rendered inoperable.

? Children under 16 years of age must wear a properly fitted and fastened bicycle helmet when operating, riding upon or riding as a passenger in any bicycle.

Immunization requirements for entrance to schools and day care centers support the Title V performance objective of averting cases of vaccine- preventable morbidity and mortality.

? All children enrolling in the public schools should have at least begun the series of immunizations not later than the time of enrollment.

? The Department of Health and Social Services is authorized to prevent and control the spread of vaccine-preventable diseases in children, including regulation of nonpublic elementary and secondary schools and child care and other preschool facilities.

? /2004/ The Department of Education regulations have been updated to require varicella for entry into kindergarten. //2004//

Birth certificates -- The registration of all births in Delaware is required by law. Confidentiality is ensured. The data collected helps to support the Title V data requirements and objective tracking.

Trauma Registry helps the Title V agency to better plan for services for children with disabilities caused by trauma. Acute care facilities which transfer trauma patients with moderate or severe injuries to Trauma Centers contribute data to the Delaware Trauma System Registry and Quality Improvement Program.

Mandatory reporting of certain notifiable diseases to the Division of Public Health affect all providers including Title V providers such as School Based Health Centers and Public Health Clinics. Included are several laws pertaining to the reporting of STDS and lead poisoning

Childhood Lead Poisoning Screening supports the MCHBG state performance objective #4 to ensure that all Medicaid eligible children are screened for high lead levels.

? Every health care provider who is the primary health care provider for a child is required to order screening of that child, at or around 12 months of age, for lead poisoning.

? This law requires that all group and blanket insurance policies that provide a benefit for outpatient services shall also provide a benefit for a baseline lead poisoning screening test for children at or around 12 months of age. Benefits are also to be provided for lead poisoning screening and diagnostic evaluations for children under the age of 6 years who are at high risk for lead poisoning.

Establishment of Birth Defects Registry documenting every diagnosis or treatment, or both, of any birth defect in any child under age 5 in the state.

? The intent of the General Assembly is to provide financial assistance for the treatment of children with birth defects and to require the establishment and maintenance of a birth defects surveillance system and registry for the State. This is the law that established the provision of the Special Formula fund.

? Certain health care practitioners and all hospitals and clinical laboratories are to make available to the Department of Health and Social Services information contained in the medical records of patients who have a suspected or confirmed birth defect diagnosis.

? Although this law has been in effect for several years regarding the actual reporting of the birth defects, the registry is still in the process of being established as a data tracking system.

Services for Children with Disabilities are also established through the Delaware Code. The Department of Health and Social Services is designated as the agency to administer a program of services for indigent children who are "crippled or who are suffering from conditions which lead to crippling." This program is minimally funded but has helped to support the Specialty Clinics in Southern Delaware.

Mandated insurance coverage for PAP tests, mammography, immunizations and blood lead screening supports preventive health goals of Title V.

Infant and Toddler Early Intervention Services Act authorizes Part C of the Individuals with Disabilities Education Act (IDEA). This Act ensures services for birth to three-year-old infants and toddlers who have developmental delays or disabilities or a high probability of delays under our Child Development Watch program.

The Child Death Review Commission is also established through law. This Commission reviews deaths of children under the age of 18 to provide recommendations to alleviate those practices or conditions, which impact the mortality of children.

The State's Title V 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 was originally targeted to provide direct services provided by the counties and tied to personnel, it has been extremely difficult to reallocate those resources.

Maternal Child Health issues are administered through the Community Health Care Access (CHCA) section. Dr. Jacqueline J. Christman was appointed Section Chief in November 2000. This position had been vacant for about four years. CHCA includes Family Health Services, Special Populations (WIC), Women and Reproductive Health, Health Systems Development, and Northern and Southern Health Services, our local health units.

/2004/Northern and Southern Health Services (our local health units) no longer are part of the Community Health Care Access Section. They are now the Community Health Services Section. //2004//

/2005/ Based on this year's realignment, Northern Health Services and Southern Health Services are now in the Bureau of Clinical and Field Services in the Community and Family Health Section and work under the direction of a medical director (position currently vacant). Also Special Populations (WIC) and Health Systems Development have been moved to the Health Promotion and Disease Prevention Section. //2005//

Title V is administered by the Family Health Services Branch of the Community Health Care Access section. Joan Powell was appointed the Family Health Services Director (Title V MCH Director) in December 1997.

/2005/ Joan Powell resigned her position as the Family health Services Director (Title V MCH Director) in May 2004. //2005//

As of October 2000, Dennis Rubino assumed the role of Children with Special Health Care Needs Director. 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.

JoAnn Baker is the Director of the Women's & Reproductive Health Branch, which includes newborn screening, family planning, and teen pregnancy prevention.

/2003/ During the summer of 2001, Kae Johnson joined the section as the Health Systems Development Branch Director that had been vacant since June 2000. The Health Systems Development Branch includes a Primary Care Coordinator, Kathleen Collison, 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.

/2004/ The Division of Public Health has received technical assistance from the National Center for Cultural Competency related to cultural and linguistic competency. As follow up to a kick-off event in October of 2003, discussions are continuing with a goal of conducting an organizational self-assessment for certain programs within the division including CSHCN. In addition, the Community Health Care Access Section is continuing with a series of trainings and discussions around cultural and linguistic competency. //2004//

/2005/ Due to reorganization, Community Health Care Access (CHCA) no longer includes Special Populations (WIC) and Health Systems Development. This reorganization does not preclude the sections coordination and cooperation on MCH issues. //2005//

C. 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, Vincent Meconi, reports directly to the Governor. Delaware began year 2001 with a new administration under Governor Ruth Ann Minner. Several officials were replaced and since the current fiscal situation is not as positive as in past years, there are few new initiatives.

/2003/ The budget situation has deteriorated since last year. The Governor ordered a freeze on hiring for most state jobs other than those providing essential services, such as police, prison guards or nurses. Federally funded positions have also been frozen. At the time that this grant request was written, the state estimated that it either had found or cut \$50 million from the proposed budget to make it balance. As a result of this situation, there are few new initiatives. The most important initiative, however, is a result of September 11. Anti-Bioterrorism efforts have been initiated and are receiving the major emphasis for DPH over and above last year's emphasis on cancer.

/2004/ The Governor lifted the hiring freeze on federally funded positions with a required justification for each position before it can be filled. //2004//

/2004/ The hiring freeze continues for state funded positions and some federally funded position. The small Title V unit in the Family Health Services Branch has two vacancies. The Quality Management position will not be filled soon since the Part C dollars funding that position are now supporting direct services. If Delaware is awarded the Early Childhood Comprehensive Systems grant, we will use that funding along with the Healthy Child Care America dollars to fill the other vacant position. Some state positions have been eliminated from the budget and will not be restored. These include public health nursing staff. Bioterrorism and cancer prevention continue to be the foci. //2004//

/2005/ The Quality Management position remains vacant. The second vacant position has been filled as of February 2004, with Norma Everett, who will be coordinating the transition of the Healthy Child Care America (HCCA) grant and implementing the State Early Childhood Comprehensive Systems grant (ECCS). //2005//

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 5 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 is 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 early childhood, and school based health centers. Family planning and adolescent health (primarily teen pregnancy prevention) are part of the Women's and Reproductive Health Branch.

Below are the organizational charts for the state government, DHSS, DPH and Family Health Services Branch.

[See Attachments for Organizational Charts]

D. OTHER MCH CAPACITY

Direct and population based services are primarily provided through Northern and Southern Health Services. Services for CSHCN are coordinated through Northern and Southern Health Services but are primarily focused on children birth to three and those at-risk. There are close to 35 positions that are funded through Title V. Most of these positions are those working in the local health units.

Leadership for the local health units is provided by Anita Muir for Northern Health Services and Barbara DeBastiani for Southern Health Services. Below is a map of the public health clinics.

/2003/ This map will look different this year. Lewes Public Health Clinic just closed as a result of a drop in clients accessing its programs.

/2004/ The Community Health Care Access section split this year. Northern and Southern Health Services are now part of the Community Services section with Dr. Ulder Tillman as the section chief. Northern and Southern Health Services leadership remains the same. /2004/

/2005/ Based on this year's realignment, Northern and Southern Health Services are now in the Bureau of Clinical and Field Services in the Community and Family Health Section and work under the direction of a Medical Director (yet to be hired). In addition, Laurel SSC is no longer a service location, but it does house the offices for the Southern Health Services Prevention team. //2005//

[see attachment for Northern & Southern Clinic Site Map]

Managing Data: The capacity to manage data and evaluation is limited within the Title V state office. To address this limited capacity, we work very closely with the Office of Health Statistics to obtain the needed data for our programs. Personnel from this office serve as the AMCHP Data contact, serve on the MCH Block Grant Steering Committee, and are key contributors to the Pregnancy Risk Assessment Monitoring System (PRAMS) process. /2003/ During the past year, this Office has lost three of its most seasoned employees. Although one FTE has been filled, one position has been frozen and the other has been moved to another section. These losses have greatly impacted the data capacity for the Family Health Services Branch (FHSB). The Office does not have the capacity to analyze the PRAMS data, which has been contracted out to the University of Delaware. In addition, the release of vital statistics data has been delayed and the FHSB has lost its AMCHP data contact.

/2004/ The capacity in the Office of Health Statistics has declined even further than reported last year. Another individual has left state employment. These positions will not be filled. The Health Systems Branch in the Community Health Care Access Section will take over doing some of the work, specifically the geomapping. However, most of the MCH data collection will not be completed or will be less timely. //2004//

/2005/ ***the Health Systems Development branch is no longer part of Community Health Care Access section. The office of Health Statistics has been subsumed by the health Information and Epidemiology section. //2005//***

Other DPH sections: Two other sections which impact on MCH issues are Disease Prevention & Consultation (DP&C) and Health Systems Protection (HSP). DP&C are responsible for prevention programs such as Cancer, Diabetes, Tobacco, HIV, etc. HSP is responsible for environmental health, which includes lead poisoning prevention.

/2005/ The DP&C is now under the Health Promotion and Disease Prevention section (see DPH organizational chart. //2005//

Title V also works with Delaware's Office of Emergency Medical Services, particularly with its Emergency Medical Services for Children program.

E. 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 Delaware Health and Social Services Secretary serves as the Chair. 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. /2004/ The Lt. Governor now serves as the Chair. While the Director of the Health Systems Development Branch attends meetings and provides public health information as needed, she no longer is providing policy support.

Department of Health and Social Services: The Division of Public Health (DPH) resides in 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. The Medicaid Managed Care organizations (MCOs), First State and Delaware Care contract with DPH to provide services, DPH works closely with Medicaid on a variety of issues including the Delaware Healthy Children Program (Delaware's SCHIP), Child Development Watch operations and early childhood systems development.

/2003/ As of July 1, 2002, Delaware Care will no longer be a Medicaid MCO.

/2004/Diamond State Partners, a managed care organization operated by Medicaid, replaced Delaware Care. //2004//

/2005/ First State Health Plan is no longer a Medicaid Managed Care (MMC) provider. They have been replaced by Shaller Anderson/Delaware Physicians Care, Inc. //2005//

? Division of Developmental Disabilities Services (DDDS). DPH collaborates with DDDS on Traumatic Brain Injury issues, respite care, and Child Development Watch operations.

? Division of Substance Abuse and Mental Health (DSAMH). DPH has worked with this agency on women's health issues, planning a women's health conference, and Pregnancy Risk Assessment Monitoring System (PRAMS),

/2004/ Delaware decided to discontinue PRAMS as a project with the Centers for Disease Control but will continue to review the data. //2004//

? Division of State Service Centers. DPH has worked with this agency to improve the 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 they have 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. This Division has the lead for Traumatic Brain Injury issues in the state. The CSHCN Director works closely with the Division to ensure that the needs of children are addressed. DPH has also worked with this division on a variety of initiatives for older women.

/2004/ Although the Division for Aging and Adults with Physical Disabilities maintains the lead for the adult TBI issues in the state, the Division of Public Health, CSHCN, is working through a Subcommittee of the Council for Person with Disabilities to address the pediatric TBI/ABI issues.//2004//

/2005/ The Division for Aging and Adults with Physical Disabilities has gained approval for a Traumatic Brain Injury Medicaid waiver for the adult population. //2005//

Department of Education (DOE): The Delaware Health and Social Services and the Department of Education work collaboratively on developing programs to promote the health of children. Examples include the delivery of EPSDT services in the school setting and in providing support for school based health centers. The Department of Education initiated a Coordinated School Health Coalition in 1999 that includes several commissions or task forces, based upon the CDC Coordinated School Health Model which include DPH participation. Currently there are three commissions: Health Education, Health Services, and Physical Education. Future commissions will include Nutrition Services, School Climate, Staff Wellness and Counseling Services. /2003/ Thus far standards have been developed for health education that can be used in other curricula such as reading or social studies. The Coordinated School Health Program Team is composed of a variety of health and education related agencies, private, and public including parents. They recruited school applicants to participate in a needs assessment of health needs in their respective schools. After identifying the specific needs, plans were developed to target those needs. The Department of Education (DOE) 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. This year the Office of Health Services, DOE, partnered with the DPH to provide training to school nurses on teen pregnancy prevention, lead poisoning, tuberculosis, immunizations and public health resources. Delaware has a comprehensive system of school nurses, with one in each school and most private schools /2004/ There are over 300 full and part time school nurses in Delaware that serve students in public and private schools. The Department of Education and the Division of Public Health have also partnered to provide training to the school nurses on bioterrorism. //2004// /2004/ The Department of Education's Early Care and Education Office is a key collaborator with the Division of Public Health on the early childhood comprehensive systems effort. //2004//

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 also 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 and in the development of the early childhood comprehensive systems planning. The Division of Child Mental Health has a working relationship with School Based Health Centers and works closely with center coordinators to ensure appropriate referrals and obtain training for staff and has contributed to the development of the Maternal and Child Health grant.

/2004/ Finally, the Title V Director was just appointed to serve on the Division of Child Mental Health Advisory Council. This appointment will provide an opportunity to coordinate public health and mental health issues. //2004//

/2005/ The Title V Director resigned effective May 2004. The appointment of the Division of Child Mental Health will be relayed to the Director of Children with Special Health Care Needs (CSHCN). //2005//

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.

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 Disease Prevention and Control 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.

//2003/ We expect to collaborate with The March of Dimes new focus for next year on prematurity.

The Perinatal Association: The Perinatal Association of Delaware (PAD) 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.

//2005/ The Perinatal Association merged with Children and Families First (CFF); These partners share a similar mission. Children and Families First conducts counseling, foster care, and the Resource Mother's Program. There are 9 Resource Mothers (RMs), 3 down state, and 6 upstate. CFF will continue the tradition of targeting women least likely to seek services and the uninsured. The majority of the staff is bilingual. Their role includes, but is not limited to; prenatal, postpartum, and newborn education, transportation to prenatal and pediatric office visits, and assistance with obtaining appropriate resources including insurance, housing, and jobs. The program receives \$200,000 annually from the Tobacco Settlement Funds. //2005//

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.

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.

//2004/ Administration for this Commission has moved to the Department of Services for Children, Youth and Their Families. Public Health continues to provide members for the local review panels.//2004//

The state is fortunate to have the involvement of its hospitals in not only ongoing and preventive care, but capacity building as well.

Christiana Care Health System, Inc.: Christiana Care Health System (CCHS) is the largest provider of health care in the state. It has the only Level 3 neonatal intensive care unit (Christiana Care Special Care Nursery) in the state. The Division of Public Health collaborates with CCHS on many issues for instance; high-risk follow-up for premature infants is provided through a collaborative agreement between the hospitals and CDW.

//2003/ Christiana Care was the administrator for the Healthy Start project which lost its funding this year. However, the Division continues to work with CCHS to support the Healthy Start consortium. CCHS also 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.

//2004/ Christiana Care also has representation on the Early Childhood Comprehensive Systems Steering Committee.//2004//

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. Bayhealth works on a variety of community initiatives such as the Central Delaware Community Health Partnership. Like Christiana Care, it also contracts with DPH to provide oversight for school based health centers.

//2005/ Bayhelth is also the lead for the Kent Prenatal Task Force, a group of representatives of public and private agencies who seek to improve systems of care in Kent County that impact on early entry into prenatal care. //2005//

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. 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.

//2005/ The Nemours Foundation established a Division of Helath Prevention Services (HPS). The division will focus on child health promotion and disease prevention. The mission of the division is to improve chilfren's health over time through an intergrated community-based model that includes:

*** Developing and implementing effective prevention programs, building on existing community resources.**

*** Evaluating programs, while also contributing to the national landscape on children's health prevention research.**

*** Providing business support sevicess and technical assistance to non-profit and health related organizations.**

The Division of Public Health Title V has collaborated with HPS on their first two initiatives, focused on diabetes and obesity. //2005//

Nanticoke Memorial Hospital: Nanticoke Memorial Hospital works closely with Public Health to ensure early entry into prenatal care. A social worker 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.

/2004/ Two members of the Perinatal Board are also employed by the Nanticoke Memorial Hospital. //2004//

/2004/ Nanticoke Maternity Center is scheduled to close June 30, 2003. The La Red organization will absorb some of the prenatal patients through a contract physician. //2004//

/2005/ Nanticoke Maternity Center did close on June 30, 2003. La Red Health Center has absorbed some of the prenatal patients who would have previously used the maternity center. There is no longer social workers or nutrition services housed at Nanticoke. //2005//

Beebe Hospital and Delmarva Rural Ministries: Beebe Hospital 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. Beebe Hospital manages one school-based health center.

/2005/ Beebe and Delmarva are no longer collaboration through the MATCH van. The program has been discontinued. //2005//

/2005/ Beebe Medical Center manages three School-Based Health Centers. //2005//

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. They provide Tiny Steps, which is a comprehensive maternal fetal care program, which uses family physicians to provide prenatal, intrapartum, postpartum, and newborn care in Wilmington and Newark.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Data and information are reported on Forms 17,18, and 19.

#01: The rate of children hospitalized for asthma (10,000 children less than five years of age). The asthma hospitalization rate has stayed relatively the same over the last three years.

#02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen. The percentage of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen has fluctuated over the past three years. The fluctuation could possibly be contributed to the change in Medicaid MCOs twice during that three year period.

#03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. All infants are eligible for Medicaid and therefore do not get SCHIP. For CY 2001 there were 5047 children under 1 receiving Medicaid; CY2002--5425; CY2003---5648.

#04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The percent of women (15-44) for this indicator has remained generally the same over the last three data years.

#05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. The comparison is reflected in Form 18.

#06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women. The comparison is reflected in Form 18.

#07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. The percent of EPSDT eligible children aged 6 through 9 who have received dental services during the year has increased from 24.9 to 39.2. The maternal & child health program

has coordinated efforts with the oral health program over the past two years, which may account for the increase. Greater entry into the school system has been effective.

#08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program. 3,825 children less than 16 years of age are receiving services through the state CSHCN .

#09-A: The ability of States to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data. The state through the SSDI grant is working towards linking data systems, especially when the electronic birth certificate is completed. Delaware had been participating in PRAMS but made a decision to not continue two years ago.

#09-B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. Delaware does not participate in PedsNSS.

#09-C: The ability of States to determine the percent of children who are obese or overweight. MCH does have access to WIC program data and YRBS data. The Division is cooperating with a new Division of Prevention Services through the Nemours Foundation. Their two major foci are diabetes and obesity in children.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities as measured by the 18 National Performance Measures and the 10 state performance measures are depicted in the following two graphic displays.

[see Attachments]

B. STATE PRIORITIES

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 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.

Based on the past needs 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 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 Services

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 would not 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 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. 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. The widest disparity between the two races occurs in Sussex County.

Reduce teen births. Although teen birth rates have dropped a little, our rate continues to be one of the highest in the nation. This is another area where there is a large racial disparity between the black teen birth rate and that for whites.

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 a disparity 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 years 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. YRBS data also show that the majority of high school 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 years. 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 underlie 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 supports services to children who are on Medicaid or uninsured, which does not include the underinsured.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Enabling Services:

The State of Delaware Guideline for the Management of Sickle Cell Disease has been established. This guideline is a tool that assists primary care practitioners in the management of Sickle Cell Disease for patients from birth until the end of life. Children birth to three with sickle cell are eligible for Delaware's Part C Program, Child Development Watch, and receive comprehensive service coordination for those families who agree to participate in the program. Others are assisted through the Kids Kare program.

Population-Based Services:

The state continues to screen for Phenylketonuria (PKU); Congenital Hypothyroidism (CH); Galactosemia, Hemoglobinopathies, Biotinidase Deficiency, and Maple Syrup Urine Disease (MSUD).

Expanded newborn screening has been implemented. The needed equipment was purchased last year for the public health lab. Because of ethical considerations, only those problems that can be treated are tested. They are Homocystinuria, MSUD, Tyrosinemia, Urea cycle disorders, other aminocidopathies, MCAD, other Fatty acid oxidation, Methylmalonic academia, Propionic academia, Isovaleric academia, Glutaric aciduria 1, other organic aciduria, and G6PD deficiency.

b. Current Activities

Enabling Services:

The Specialty Formula Fund is funded with state dollars in order to pay for specialty formula, prescribed by a provider, for metabolic disorders not covered by insurance companies. In 1996, this fund was established and regulations developed to cover the cost of specialty formula for under and uninsured citizens based on a sliding fee scale and on household income. Due to the lack of funding requests for specialty formula, the committee, which manages this fund, recommends regulation revisions governing the use of the fund resources. The committee recommends the following:

- * The funds be maintained at current level,
- * Rebate assistance be provided for required food for those families who apply,
- * The excess funds be available to offer one to three scholarships to children with PKU or other metabolic disorders to attend specialty camp where they will have the opportunity to learn more

about their disorder and be among peers, learn more about their diet and treatment options.

Population Based:

DPH county field staff continues to 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 when the family of an infant with an abnormal HMD is not responsive to follow up visits

c. Plan for the Coming Year

Enabling:

The Specialty Formula Fund Committee will be deciding on potential revisions to the regulations governing the fund. The recommendation to be voted upon is maintain funds at the current level and to provide rebate assistance for required foods for those families who apply.

Population Based:

DPH county field staff will continue to 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.

The state will continue to screen for Phenylketonuria (PKU); Congenital Hypothyroidism (CH); Galactosemia, Hemoglobinopathies, Biotinidase Deficiency, and Maple Syrup Urine Disease (MSUD).

The Expanded newborn screening will continue, however, because of ethical considerations, only those problems that can be treated are tested. They are Homocystinuria, MSUD, Tyrosinemia, Urea cycle disorders, other aminocidopathies, MCAD, other Fatty acid oxidation, Methylmalonic academia, Propionic academia, Isovaleric academia, Glutaric aciduria 1, other organic aciduria, and G6PD deficiency.

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

a. Last Year's Accomplishments

Enabling:

Child Development Watch continued to engage the family in each step of the process. The family orientation was specifically focused on the natural environment of the client. Families were encouraged to participate in standards review and development, monitoring of IFSPs, and monthly forums. The forums were advertised more widely, which increased attendance.

The Delawareans with Special Health Care Needs Medicaid Managed Care Panel met monthly with a consistent attendance of parents and their children attending. The panel held alternate monthly meetings upstate and downstate with alternate times either late afternoon or evening. The variety of times accommodated families and encouraged participation.

Infrastructure Building:

Involvement of parents was a priority for the past year. Previously, the CSHCN Steering committee was formed including parents and the parents were appointed to the Child Development Watch Quality Management Committee. However, parent attendance at meetings

had been poor.

The CSHCN Office engaged the Coordinating Council for Children with disAbilities (CCCD), a private not-for-profit corporation, to enhance the original Advisory Task Force. Discussions were held to enroll interested parents into the process. One problem that Delaware faced in the involvement of parents was the inability to offer a stipend. Since funds were limited, it was unlikely that the state would hire a family member consultant or provide financial support for parent activities.

However, several new initiatives encouraged parent participation. The Child Development Watch program started Spanish-speaking support groups where families met monthly to network and receive relevant information related to their CSHCN. Conferences made available enhanced parent participation. These included "Faith Communities and Building Healthy Communities", and "Grandparents and Relative Caregivers Program". Similar programs are scheduled for the future.

Another opportunity for parent participation was with the Delawareans with Special Needs/Medicaid Managed Care Panel. Representatives of the State's Medicaid Office, the Director of Children with Special Health Care Needs, and the Managed Care Organizations met monthly to discuss health care insurance issues presented by parents of CSHCN. The parents' issues were reviewed at the meeting, minutes were taken, and the resolutions to the problems were discussed at the following meetings. The Medicaid and MCO representatives were very cooperative in addressing all issues in a timely manner. In addition to meeting needs, the focus encompassed anticipatory mental and physical needs for CSHCN and the family.

b. Current Activities

Enabling

Child Development Watch continues to involve the family in their process. Families remain active in monitoring standards review and development. They also continue to participate in the development and monitoring of IFSPs. The monthly forums continue to be held with special topics of family interest to be presented.

The Delawareans with Special Health Care Needs Medicaid Managed Care Panel continues to meet monthly. A videoconference link between two sites, one upstate, and one downstate increases communication and participation among families.

A Family Survey Report conducted by the University of Delaware was completed. The topics that emerged from the discussion with families regarding their experiences with Child Development Watch were: awareness of CDW; assessment and evaluation; coordination of services; interactions with service coordinator; delivery of services; family support; and transition from Part C.

The results of the National Survey of Children with Special Health Care Needs with a focus on family participation was reviewed by the Coordinating Council for Children with Disabilities as a result parents present at the CCCD determined to recruit these parents as members.

Infrastructure Building:

The Coordinating Council for Children with disAbilities continues to be a forum for family participation in policy planning and development. The Director of CSHCN continues to provide staff to the Council with an outstanding partnership with the A.I.duPont Hospital for Children.

c. Plan for the Coming Year

Enabling:

Child Development Watch will continue to involve the family in their process at every level possible. Families will continue to be supported to participate in standards review and development and in the development and monitoring of IFSPs. The monthly forums will continue with special topics of family interest to be presented.

The Delawareans with special Health Care Needs Medicaid Managed Care Panel will continue to meet monthly with videoconference links between two sites, one upstate, and one downstate.

The results of the Family Survey Report conducted by the University of Delaware will be reviewed and analyzed with possible changes made relating to the issue of family participation.

Infrastructure:

The Coordinating Council for Children with disAbilities will continue to be a forum for Family participation in policy planning and development. The Director of CSHCN will staff the Council.

Parents will be included in review of the block grant. The needs assessment will be shared with both the Perinatal Board and 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. The Family Voices Coordinator is also a parent representative and has been quite active with the CSHCN program. The CSHCN office will continue to provide financial support for Family Voices mailings.

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

a. Last Year's Accomplishments

Enabling

Child Development Watch remained the catalyst for including each child's primary care physician as a member of the CDW multidisciplinary assessment team. The April, 2003 CDW Statewide Report reflected that cumulative to date from July 1, 2002 they have processed through Central Intake a total of four thousand, eight hundred, twelve (4,812) referrals for children ages from birth to twenty-one (0-21). Over 1300 children, ages 0-3 were assessed for eligibility under Part C. All of these children and families were linked to a medical home, if one had not been established. This function remains the responsibility of the CDW Service Coordinator. Children receiving Kids Kare were also linked to a medical home.

Infrastructure Building

DPH continued work ensuring medical homes for all children. The Delaware Healthy Children program and the outreach program funded through a Robert Wood Johnson Foundation grant helped to insure all children and provide them access to a medical home. The Office of Children with Special Health Care Needs in DPH has continued to work with the Delaware Chapter of the American Academy of Pediatrics in the development of the medical home project. The committee met monthly to focus on the implementation of the medical home concept.

A written plan was developed addressing emergency medical services specific to CSHCN. A parent, who is also a paramedic, chaired the workgroup, with staffing and direction from the EMSC Director and the Director of CSHCN. The plan involved a 'flagging' of the CSHCN during a 911 call and included training and education components connecting the CSHCN and their families to medical homes. The program was officially named Special Needs Alert Program (SNAP).

Brain injury continues to be the most frequent cause of disability and death among children in the United States. The Director of CSHCN has served as the lead for a Pediatric Subcommittee of the statewide Traumatic Brain Injury (TBI) Steering Committee. There exists a lack of resources to coordinate care and services for these children. The formal Steering Committee and the Pediatric Subcommittee disbanded. In its place a new subcommittee of the State Council for Persons with Disabilities was formed with a mission statement to "improve the lives of Delawareans with brain injury." The twenty-member Brain Injury Committee (BIC) included four persons with TBI. The Director of CSHCN has been one of the key people in the development of the BIC to raise the TBI/ABI to a new level in the state.

Another project initiated through Title V technical assistance funds was a small research project conducted by Dr. Jane Crowley of the A.I.duPont Hospital for Children. The topic of the research was brain concussions in high school sports. Dr. Crowley has gathered information and data through discussions with the schools' directors of athletics, the athletic trainers, and the state associations with which they are affiliated.

b. Current Activities

Enabling:

The Child Development Watch Service Coordinators continue to maintain the function of linking the children to a medical home and including the physician as part of the multidisciplinary assessment team, especially through the IFSP process with the family. The ISIS computer based system tracks the number of children served and the number of children linked to a medical home. Kids Kare also continues to link children and their families to medical homes. Discussion will continue on the possible expansion and enhancement of the Kids Kare program beyond the zero through age six current priority of the program. This will allow further enhancement of the medical home concept to include all at-risk children ages 0-21.

Infrastructure Building:

The Division of Public Health continues to support a medical home for all children. The Medical Home Planning Committee has arranged for technical assistance to be accessed through the CATCH grant on the implementation of the medical home approach and for the 'certification' of pediatric and family practices offices to be medical homes. Collaboration is planned with the Medical Society of Delaware who received a Robert Wood Johnson grant, which includes objectives related to medical home.

The SNAP project is conducting a pilot project with selected families through the A.I.duPont Clinics located throughout the state. Once the pilot project is system tested, a fully implemented SNAP will be established, along with the appropriate education, training and marketing for the program.

The Brain Injury Committee is scheduled for monthly meetings throughout the year to address the issues of TBI/ABI. Linking those children with TBI/ABI with medical homes is part of the agenda for the BIC. A legislative amendment was approved to address the inclusion of a TBI category within the Department of Education so that children with TBI will better be able to be tracked, as well as to receive the appropriate special services within the school system. The BIC as part of the Governor's appointed State Council for Persons with Disabilities remains an advocate to CSHCN with TBI/ABI for links to appropriate and effective medical homes.

c. Plan for the Coming Year

Enabling:

The Child Development Watch Service Coordinators will continue to maintain the function of linking the children to a medical home and to include the physician as part of the multidisciplinary assessment team, especially through the IFSP process with the family. The

ISIS computer based system will track the number of children served and the number of children linked to a medical home. Kids Kare will also continue to link children and their families to medical homes. Discussion will continue, regarding the possible expansion and enhancement of the Kids Kare program beyond zero (zero) through age six (6), which is the current priority of the program. This will allow further enhancement of the medical home concept to include all at-risk children ages zero through twenty-one (0-21).

Infrastructure Building:

The Division of Public Health will continue to ensure a medical home for all children. Collaboration is planned with the Medical Society of Delaware, who received a Robert Wood Johnson grant that includes objectives related to medical home.

The SNAP project will complete the pilot project with selected families through the A.I.duPont Clinics located throughout the state. Once the pilot project works through the system, a fully implemented SNAP will be established, along with the appropriate education, training, and marketing for the project.

The Brain Injury Committee (BIC) has scheduled monthly meetings throughout the year to address the issues of traumatic brain injury (TBI) and accidental brain injury (ABI). Linking those children with TBI/ABI with medical homes is part of the agenda for the BIC. The legislative amendment for the inclusion of a TBI category within the Department of Education, so that children with TBI will be able to be tracked, will be implemented. The BIC as part of the Governor's appointed State Council for Person with Disabilities will remain an advocate to CSHCN, with TBI/ABI for links to appropriate and effective medical homes.

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

a. Last Year's Accomplishments

According to the annual 2003 Kids Count in Delaware report, Medicaid coverage for children increased for the first time in four years from 20% to 23%, which was the highest level since 1995. The percentage of children with private insurance decreased to 68% from 71%. Although Medicaid in Delaware covers only about 23% of the entire population of children, it covers 62% of poor children.

Enabling:

According to the Kids Count report, 15,702 applications for the Delaware Healthy Children Program (DHCP) were mailed to families through November 2003. The total children currently enrolled are four thousand eight hundred sixty-eight (4,868). There remains the close link between the DHCP and Medicaid as children transition between the two programs when family incomes fluctuate.

Delaware took steps towards working with the immigrant populations around the issue of child health coverage; many immigrants fear that applying for health insurance for their children could affect their immigration status. Application forms for both Medicaid and DHCP were revised to contain a statement that alien verification information did not affect immigration status or lead to deportation.

Referrals were made to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, all DPH programs, such as CDW, Kids Kare, immunizations etc., worked to ensure that children, under their care, were referred to Medicaid when it was determined that they do not have a source of insurance. Child Development Watch also

ensured that Part C dollars are available for early intervention services when there was 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 childcare providers.

b. Current Activities

Direct Services:

The Division of Public Health continues to offer diagnostic and short-term treatment services for children with special needs in Kent and Sussex Counties where geographic and health access is limited. These services continue to include cardiac, genetics, and ophthalmology. DPH also continues to participate on the Cleft Palate/Oral Facial Clinical Team in conjunction with the A.I.duPont Hospital for Children. The genetic service includes genetic counseling for the families in Southern Delaware. A pediatric neurologist continues to provide services in Kent and Sussex Counties.

The Preschool Diagnostic Developmental Nursery continues to provide early intervention services to the birth to three populations with a multidisciplinary approach and with the appropriate services.

Enabling Services:

The Division of Public Health continues the operational responsibility for the Part C Birth to Three program under Child Development Watch (CDW).

The DPH provides services for at-risk children through the Kids Kare Program. Discussions continue on the possibility of expanding and enhancing the Kids Kare Program beyond the current priority to serve the birth to six years of age population in Delaware. Title V will continue to support positions that are responsible to provide the assessment and case management services under the auspices of Kids Kare as well as program administration. In the most rural Southern Delaware, the Amish Community is assisted by the team of public health nursing and social work to provide resources for special care needs. An evaluation of the Kids Kare program is underway with a final report due within six (6) months.

Referrals continue to be submitted to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, referrals to Medicaid and the Delaware Healthy Children Program are made by all DPH programs (CDW, Kids Kare, immunizations etc.) when it is determined that the children under their care lack insurance or are underinsured. Child Development Watch also ensures that Part C dollars are available for early intervention services when there is no source of insurance. DPH staff also refers and help families with applications to private insurance when applicable.

c. Plan for the Coming Year

Direct Services:

The Division of Public Health will continue to offer diagnostic and short term treatment services for children with special needs in Kent and Sussex Counties where geographic and health access are limited. These services will include cardiac, genetics, and ophthalmology. DPH will also continue to participate on the Cleft Palate/Oral Facial Clinical Team in conjunction with the A.I.duPont Hospital for Children. The genetic services will include genetic counseling for the families in Southern Delaware. A pediatric neurologist will continue to provide services in Kent and Sussex Counties.

The Preschool Diagnostic Developmental Nursery will continue to provide early intervention services to the birth to three populations with a multidisciplinary approach and with the appropriate services.

Enabling Services:

The Division of Public Health will continue the operational responsibility for the Part C Birth to Three programs under Child Development Watch (CDW).

The DPH will continue to provide services for at-risk children through the Kids Kare program. Title V will support positions that are responsible to provide the assessment and case management services under the auspices of Kids Kare as well as program administration. In the most rural Southern Delaware, the Amish community will be assisted by the team of public health nursing and social work to provide resources for special care needs.

Referrals will continue to the A.I.duPont Pediatrics Clinics when a child does not have insurance or a medical home. In addition, all DPH programs (e.g. CDW, Kids Kare, immunizations etc.) will 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 will also ensure that Part C dollars are available for early intervention services when there is no source of insurance. DPH staff will refer and help with applications to private insurance where applicable.

The recently released "Kids Count in Delaware Fact Book; 2004" will be reviewed and analyzed. A section of the report dedicated to health insurance shows that through November 2003, 15702 SCHIP applications were mailed to families. The total current enrollment is 4,868. In addition, noted in the report that less than nine percent (9%) of Delaware's population was without health insurance in 2002, down from almost fourteen percent (14%) in 1999. Other findings will be reviewed.

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

a. Last Year's Accomplishments

Enabling:

The Medical Home Planning Committee met monthly to establish and maintain at the community level the development of the medical home system. Several pediatric practices met biweekly to enhance their medical homes for CSHCN.

Infrastructure:

Four major councils within the state that addressed: needs assessment, policy development, and systems of care. The Interagency Coordinating Council (ICC) continued to build awareness among a variety of public and private institutional representatives. The Director of CSHCN maintained a standing agenda item for the quarterly meetings that focused on system coordination. The MCH Director remained the Division of Public Health's appointed representative on the ICC.

The State Council for Persons with Disabilities also addressed coordination of efforts for the population. One of its subcommittees focused solely on Traumatic Brain Injury. This involved policy development and research for preparation of legislation. The MCH Director remained the appointed representative on this state council, with the Director of CSHCN as an active member of the brain injury committee.

The Governor's Advisory Council for Exceptional Citizens (GACEC) addressed the coordination of efforts for the children receiving special education in the school system. The Policy and Legislative Committee addressed the development of systems of care and services for the children and their families. The Director of CSHCN remained the appointed representative on the GACEC.

The Coordinating Council for Children with disAbilities (CCCD) met monthly to address a major statewide needs assessment for the birth to 21 CSHCN population. The Council continued to build the capacities of the public and private agencies that faithfully attended the meetings. The CCCD has worked with CompCare for technical assistance on both a survey of agencies serving CSHCN in the state, and on Focus Groups in the community for the purpose of assessment of services and the ease of service access by the families.

The Developmental Disabilities Council also addressed coordination, policy development and needs assessment for persons with disabilities across the lifespan. The Council worked to increase the capacity of agencies in the development of community based systems of services. Small grants were offered to conduct trainings, to establish pilot projects, and to research coordination of transportation needs.

b. Current Activities

Enabling:

The Medical Home Planning Committee merged with the Medical Home Subcommittee of the Early Childhood Comprehensive Systems Committee (ECCS) The Medicaid office is a part of the planning process in addition to the Delaware AAP, Family Voices, Child Development Watch, A.I.duPont Hospital for Children, and the CSHCN program.

Infrastructure:

Representation on the four councils continues. The ICC is reviewing and commenting on the IDEA reauthorization, along with the Governor's Advisory Council for Exceptional Citizens. The Coordinating Council for Children with disAbilities continues with CompCare to complete the needs assessment and to facilitate the focus groups with families who have CSHCN of adolescent age. Recommendations out of the needs assessment will be related to the performance measure to make systems of services organized in a way that would benefit the families. An analysis of the needs assessment should also be able to site gaps in the service system.

The results of the National Survey of Children with Special Health Care Needs will were shared with agencies and families. In addition, the Family Survey Report completed by the University of Delaware will be completed, reviewed, and shared with agencies and families.

c. Plan for the Coming Year

Enabling:

The Medical Home Planning Committee will continue to meet as a subcommittee of the Early Childhood Comprehensive Systems Committee. The co-chairs are Dr. Linda Cabellero of A.I.duPont and Dennis Rubino, Director of Children with Special Health Care Needs. The Medicaid office will continue to be a part of the planning process in addition to the Delaware AAP, Family Voices, Child Development Watch, and A.I.duPont Hospital for Children, and families

Infrastructure:

Representation on the four councils will continue. The ICC is reviewing and commenting on the

IDEA reauthorization, along with the Governor's Advisory Council for Exceptional Citizens. The Coordinating Council for Children with disAbilities will continue with ComCare to complete the needs assessment and to facilitate the focus groups with families who have CSHCN of adolescent age. Recommendations out of the needs assessment will be related to the performance measure to make systems of services organized in a way that would benefit the families. An analysis of the needs assessment should also be able to site gaps in the service system. The Family Survey Report completed by the University of Delaware will be analyzed and shared with agencies and families.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Enabling:

The topic of transition has been in the forefront recently through a major project undertaken by the A.I.duPont Hospital for Children. The Transition Subcommittee of the executive committee has met monthly to focus on transition systems issues. The CSHCN Director was an active member of the committee. Dr. John Reiss of the Institute of Child Health Policy presented at grand rounds for three major hospitals in Delaware to increase awareness. The Coordinating Council for Children with disAbilities co-sponsored the event. In addition, a Stakeholders Meeting was held to encourage others to participate. Approximately 40 persons attended.

b. Current Activities

Enabling:

The topic of transition has been in the forefront recently through a major project undertaken by the A.I.duPont Hospital for Children. The Transition Subcommittee of the executive committee has met monthly to focus on transition systems issues. The CSHCN Director was an active member of the committee. Dr. John Reiss of the Institute of Child Health Policy presented at grand rounds for three major hospitals in Delaware to increase awareness. The Coordinating Council for Children with disAbilities co-sponsored the event. In addition, a Stakeholders Meeting was held to encourage others to participate. Approximately 40 persons attended.

c. Plan for the Coming Year

Enabling:

The Transition Committee will continue to meet monthly under the leadership of the A.I.duPont Hospital for Children. The committee has endorsed the plan to apply for the next cycle of Champions for Progress grants with a focus on the issue of transition of CSHCN to adult health and social services.

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

a. Last Year's Accomplishments

Direct Services:

All children continued to be screened for immunizations if they visit a DPH Well Child Clinic.

DPH provided additional attention to the Amish community in Kent County. Many Amish children are not immunized despite ongoing efforts to increase rates in the Amish community.

There have been outbreaks of Pertussis during the past years that have been difficult to track because the information is not generally volunteered. Lack of follow-up for those treated is also an issue since the Amish do not have insurance and often stop treatment when they feel better. Fortunately, the incidence of pertussis has not spread; only one non-Amish child was reported as being affected.

Enabling Services:

Southern Health Services continues to contract with Delmarva Rural Ministries for the mobile treatment health van, or MATCH van.

Population Based Services:

School nurses continue to help assure immunization compliance of all children entering school for the first time.

Infrastructure:

Delaware's Immunization Program made significant progress over the course of the past year at developing infrastructure, implementing more responsive monitoring, and evaluative processes, and establishing a far-reaching marketing program.

The only significant change in the number of vaccines offered under the program has been the introduction of Pediatrics (a combination vaccine containing IPOL, HepB and DTaP). This vaccine significantly reduced the number of injections required to complete a series of childhood immunizations.

The program has instituted greater scrutiny of vaccine distribution and usage to insure that program providers appropriately use supplies. This scrutiny was evident in a number of activities including greater oversight of VFC vaccine distribution, more intense analysis of the State Immunization Registry to verify the proper use and reporting of vaccines and increased number of AFIX/VFC site audits.

The program has completed a marketing survey of the State's immunization providers, the purpose of which was to gather information on the providers' perception of the immunization program and how the program can further impact immunization coverage in Delaware.

Partnerships with the Delaware Department of Education, the Delaware Office of Child Care Licensing, the Delaware WIC program, the Delaware adult Flu Coalition and the Delaware Valley Immunization Coalition continued. In each of these instances, to better monitor and improve immunization rates among populations, we enhanced cooperative activities. Delaware's policy for supplying vaccine purchased with 317 funds remained unchanged. These funds were used to pay for vaccines to immunize the underinsured and for certain childhood and adult vaccines.

b. Current Activities

Direct Services:

Northern and Southern Health Services continues to provide immunizations in their well-child clinics, primarily for uninsured children. DPH continues to monitor and provide services to the Amish population.

Population Based:

School nurses continue to track immunizations for children entering school for the first time.

Infrastructure Building:

The Immunization Program is tracking the introduction of Pediatrics to determine impact if any

on the rate of immunizations.

One goal that has not been met is to fully populate the State Immunization Registry with all of Delawarean children's vaccinations. To this end, the Immunization Program has been planning a link to the new born screening registry, which will ensure that all children born in Delaware are automatically enrolled in the registry.

The program is currently in the process of exploring the possibility of having a web enabled data entry process. If this turns out to be feasible, it will be much simpler and quicker for information to be provided to the registry.

Plans are underway to use the results of the marketing survey to drive the focus of future social marketing initiatives.

c. Plan for the Coming Year

Direct Services:

Northern and Southern Health Services will continue to provide immunizations in their well-child clinics, primarily for uninsured children. DPH will continue to monitor and provide services to the Amish population.

Population Based:

School nurses will continue to track immunizations for children entering school for the first time while using the Delaware Immunization Registry via the World Wide Web.

Immunization staff will perform a "Lot Quality" Assurance Assessment at all six (6) birthing hospitals in Delaware. This assessment will include gathering information on the percentage of infants who received the hepatitis B birth dose before leaving the hospital.

Infrastructure Building:

The Immunization program will continue to contract with an outside agency to AFIX audit private physician practices in New Castle, Kent, and Sussex counties to determine the immunization status of their pediatric clients.

AFIX is an immunization audit tool. The process will provide a realistic assessment of coverage, identify barriers, allow for the exchange of ideas and support in developing solutions, and provide incentives.

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

a. Last Year's Accomplishments

Direct Services

State funding continued to provide additional social work hours for intensive one-on-one counseling to identify "at-risk" teens based on the "Tran theoretical Behavior Change Model" (TTM) at six School-Based Health Centers (SBHCs).

The state continued contracts with the Liberty Court Boys and Girls Clubs in Kent County and a contract for teen pregnancy prevention services at the Claymont Community Center. The Bridges Carrerra Model project continued with new staff.

Abstinence education was provided at four sites of the Boys and Girls Club of Delaware using the "A.C. Green's Game Plan Abstinence Program". The Family Advocacy and Research

Council provided abstinence programming for teen girls using the "Moral Resonation Therapy" model.

DPH and private agencies provided reproductive health services, some of which were specifically aimed at teens during teen specific periods. 30% of all clients were teenagers.

Population Based

Delaware placed population-based efforts in the hands of the "Alliance for Adolescent Pregnancy Prevention" (AAPP) which is coordinated statewide adolescent pregnancy prevention initiatives, identified needs, targeted high-risk areas and populations, conducted a media campaign, offered educational workshops and technical support.

Local DPH Population Based activities: The following activities were examples of the many activities that took place around this performance measure.

? Information was presented to female teens at local community centers.

? Field nurses worked with ASK-PAT (Adults Supporting Kids -- Purity Among Teens) at their spring conference, which was aimed at teens.

? Abstinence education was provided at the middle and high school assemblies by Jeffrey Dean.

? Trainer/Educators worked with a variety of teen related agencies upon request.

Infrastructure Building-statewide activities

The Joint Work Group is no longer an active body. However, the ideas and goals identified from that technical assistance has continued

The Wilmington Teen Pregnancy Prevention Roundtable was rejuvenated. The Steering Committee held a Males Speak out event to educate the community on young men's perspectives on teen pregnancy prevention and to celebrate National Teen Pregnancy Prevention month in May of 2003.

The Prenatal Care Task Force, whose primary role was to address access to care in Kent County, also addressed teen pregnancy. This group participated in Teen Pregnancy Prevention Month. Activities included: 1) the compilation of a Teen Pregnancy Myth/Fact sheet and poster to be produced and disseminated to schools and community youth organizations; and 2) the securing teen pregnancy prevention Public Service Announcement for TV and radio stations.

b. Current Activities

Direct Service:

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/Direct Services;

(see attachment)

As already described, DPH contracts including Children and Families First to implement the Carrerra Model at Bridges (a comprehensive, holistic approach to teen pregnancy prevention), the Boys and Girls Clubs of Delaware for "Smart Moves" and "Game Plan", School-Based Health Centers for "Wise Guys" and "Teen Hope" programming.

Enabling Services:

Public Health family planning services, 30% of which are teenagers 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 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.

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 funds for the intensive Teen Pregnancy Program initiative, (Teen Hope) and provide the Wise Guy program.

DPH continues to support the Alliance for Adolescent Pregnancy Prevention.

c. Plan for the Coming Year

Direct Services:

Delaware's strategy for reaching all Delawareans will continue 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.

DPH contracts will continue including Children and Families First to implement the Carrerra Model at Bridges (a comprehensive, holistic approach to teen pregnancy prevention), the Boys and Girls Clubs of Delaware for "Smart Moves" and "Game Plan", School-Based Health Centers for "Wise Guys" and "Teen Hope" programming.

Enabling Services

Public Health family planning services will continue to provide services specifically aimed at teens. No teen will be 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. Follow-up calls or visits may be provided based on the teen's interest.

School-Based Health Centers (SBHCs) supported by state and Title V funding will continue to operate in 27 of 29 public high schools and offer health care services, mental health services, and nutrition services to enrolled students. In addition, six of the centers will have funds for the intensive Teen Pregnancy Program initiative, (Teen Hope) and provide the Wise Guy program.

DPH will continue to support the Alliance for Adolescent Pregnancy Prevention.

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

a. Last Year's Accomplishments

Infrastructure Building:

Title V did not have direct responsibility for this measure although Title V dollars supported a dental assistant position providing services in the Southern two counties. However, the Division of Public Health took a lead role in planning the improvement of services to the Medicaid population. As described in the 2000 Needs Assessment, dentists remain in short supply.

The Division of Public Health used SSDI funds to complete a comprehensive intraoral

screening of 3rd grade students. It also included a survey on determinants and behavioral characteristics. In addition to the survey, all identified children, in need of urgent care, received that care.

The dental loan repayment program attracted another dentist to Kent County, and an award was offered to attract another dentist to Sussex County.

b. Current Activities

Infrastructure Building:

Plans continued for implementation of a school screening and sealant program. Significant barriers being addressed are the licensure issues of dental hygiene supervision for these programs, as well as funding resources.

The Division coordinated a second dental screening program for Special Olympics. Plans are being made to develop a training program to prepare dentists in treating persons with special needs. The Division sponsored professional education program on Tobacco Cessation in Dental Offices in June.

Delmarva Rural Ministries applied for HRSA funding and staff to support the opening of a dental clinic in Dover.

The DPH dental clinics continue to provide comprehensive dental care for approximately 9000 children each year. The clinics provide school-linked services to 75 schools overcoming many of the logistical barriers. The number of Medicaid-eligible children was sixty-two thousand (62,000) in 2003 with sixteen thousand seven hundred forty(16,740) children receiving care. Private dentists provided care for approximately 10,000 children while DPH clinics saw the remainder.

An example of the success came with the implementation of the first of its kind, Delaware Seal-a-Smile program. The program was geared toward providing an oral exam, oral health education, application of sealants and referral, for those in need of urgent dental care. The program visited four schools, evaluated 86 third grade students, and applied 205 sealants.

c. Plan for the Coming Year

Infrastructure Building

Plans continue to be made for implementation of a school screening and sealant program. Significant barriers being addressed are the licensure issues of dental hygiene supervision for these programs, as well as funding resources.

The Division will coordinate a third dental screening program for Special Olympics. A training program will prepare dentists to treat persons with special needs.

Delmarva Rural Ministries obtained additional HRSA funding to support a new dental clinic in Dover, with the assistance of two dentists.

The DPH dental clinics will continue to provide comprehensive dental care for approximately 9000 children each year. The clinics provide school-linked services to 75 schools that overcome many of the logistical barriers.

The Oral Health program initiated a school sealant program in May 2004, under a HRSA Oral Health Collaborative Systems grant. The Program targets high-risk schools to provide dental screenings and the placement of sealants for second and third grade children. Dentists and dental hygienists from the community volunteer to provide the screenings and place the

sealants. The program will expand to include 15 schools during the next school year.

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

a. Last Year's Accomplishments

Enabling:

The DPH clinic staffs in Northern and Southern Health Services supplied car safety seats to their clients through a program coordinated with the Division of State Service Centers. Home visiting and clinic staffs advised and provided education to families regarding use of car seats and seatbelts. Child Development Watch included information about car seats and air bag dangers in all intake packets.

Child Development Watch collaborated with the Office of Emergency Services for Children to obtain new car seats for the transport of children for medical appointments.

A Public Health nurse was appointed to the Delaware Coalition for Injury Prevention providing opportunities for field staff to educate clients on pertinent safety issues.

Population Based:

Delaware continued to have a Safety Seat Loaner program at the fourteen State Service Centers. The State Service Centers provided health related services targeting low income families in the state. The Delaware Emergency Medical Services for Children (EMSC) MCHB/HRSA grant funded the purchase of safety seats for the Centers in 1998. EMSC replenished the program with 179 seats in the summer of 2002. Through another National Highway Traffic Safety Administration grant, the Office of Highway Safety provided 50 booster seats for the program. Center personnel were trained to provide instruction to families regarding the seats.

EMS for Children (EMSC) served as the lead agency for Risk Watch injury prevention, which was present in 359 classrooms reaching over 8,000 students statewide. A.I.duPont Hospital for Children paid for a full time coordinator of the Risk Watch program.

b. Current Activities

Direct Services:

DPH nurses and other staff continue to supply car safety seats and to instruct clients on how to use them.

Population-Based Services:

The "Safety Seat Loaner" program is still in the state service centers for low-income families. In the past year, the Delaware Office of Highway Safety has established permanent fitting station in all three counties. The fitting stations are in central locations where families can go and get education from certified Child Passenger Safety Technicians. Parents are referred to these fitting stations to get technical information about properly securing children in appropriate safety seats.

"Risk Watch" is a comprehensive injury prevention program developed by the Nation Fire Protection Association that addresses the top eight risk areas that kill or injure children in Delaware. The eight age appropriate (there are through eight) injury lessons in "Risk Watch" are: motor vehicle, Bike and Pedestrian, Fire and Burn, fall, Choking and Strangulation, Poisoning, Drowning, and Firearms. Schoolteachers and community experts in each of the injury areas present the program in the classroom. Delaware Risk Watch is now in five hundred

thirty three (533) classrooms being delivered to 11, 991 students statewide. Our plan is to implement the program in two hundred (200) more classrooms each year, so our goal for the 2004-05 school year is to implement the program in seven hundred thirty three classrooms statewide. Delaware uses pre-test, post-test methodology to evaluate the effectiveness of "Risk Watch". The test measures safety knowledge gained comparing before the program to after the program. Average knowledge gain for Delaware school children is approximately ten-fourteen percent (10-14%).

The yearly EMSC Delaware "SAFE KIDS" Coalition Childhood Injury Prevention Conference was held June 16, 2004. Approximately seventy five (75) people attended from across the state. Teachers, emergency medical service personnel, and childcare providers attend this conference each year. The conference included presentations on suicide in children and how to hold a bike safety rodeo. Evaluations were over all -- positive

c. Plan for the Coming Year

The "Safety Seat Loaner" program will remain in place and Public Health and Social Services staff will continue to support the safety seat programs. "Risk Watch" will be implemented in two hundred more classrooms through the recruitment of more schools in Delaware.

A new Injury Prevention Epidemiologist has been hired of the Office of Emergency Medical Services in the Division of Public Health. His role will be leading the state wide Injury Prevention Coalition and developing an injury surveillance system of all populations.

A self-learning CD-ROM based course was developed through the University of Delaware to educate health care providers regarding injury prevention. The course will cover all age groups. In the next year, we will pilot the course.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Direct Services:

Clients continued to receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home.

Population-Based:

The WIC program supported the reinforcement of the WIC National Breastfeeding Campaign, Loving Support Makes Breastfeeding Work through local media, and the distribution of pins, pens, banners, posters, baby blankets, breastfeeding resource texts, and other marketing materials to those agencies, employees, participants and facilities that participated in the project.

? WIC ordered and distributed over 100 copies of professional resource books for OB & pediatric offices as well as the Visiting Nurses Association, the Wilmington Adolescent Pregnancy Center, and maternity hospitals Labor and Delivery and nursery nurses' stations. Breastfeeding informational materials in English and Spanish for a variety of age and reading levels were distributed through: WIC clinics, health fairs, school wellness fairs, A. I. duPont Hospital for Children, Wilmington Hospital's Adolescent Pregnancy Center, and the Resource Mothers program. Other item distributed were; Loving Support promotional items for use in doctors' offices and clinics and included pensmouse pads, water bottles, "post its," coffee mugs, and framed prints of breastfeeding mothers and babies.

? WIC had baby blankets embroidered with the multicolored Loving Support Makes Breastfeeding Work logo for distribution to breastfeeding women in clinics and through state

maternity hospitals. World Breastfeeding Month (August) 2002 was celebrated in WIC clinics by distributing night-lights with the Loving Support logo.

? WIC ran a billboard campaign throughout the state with the Loving Support logo. WIC contracted with three theaters (one in each county) to run the logo as a slide presentation, before the feature films. There was radio advertising on four stations through the state.

? There were five breastfeeding/breast pumping rooms established in the state at various public health locations.

WIC's Breastfeeding Coordinator held several in-services with nursing contact hours at "lunch & learn" sessions in the Dover area. She also completed presentations to nursing and dietetic students at the University of Delaware, Delaware State, and Delaware Technical and Community College.

WIC sponsored a breastfeeding conference in New Castle County for dietitians, nurses, and lactation consultants.

b. Current Activities

Direct Services:

Clients continue to receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home.

Population-Based:

World Breastfeeding Month (August) 2003 celebrated in WIC clinics by distributing rubber duckies with the Loving Support logo.

WIC continues to contract with the three theaters to run the logo as a slide before feature films. In addition to the radio advertising in July-August 2003, there continued a TV spot running for five weeks in the southern part of the state.

Presentations by the Breastfeeding Coordinator continue.

More breast feeding/pumping stations will be established in the state service centers.

c. Plan for the Coming Year

Direct Services

Clients will continue to receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home. The program will provide supplemental food as well as nutrition screening and education to at-risk, low-income, pregnant, postpartum, and breastfeeding women, infants, and children less than five (5) years of age. In addition, it will also provide health assessments and counseling, breastfeeding support, and referrals to other programs.

Population Based

World Breastfeeding Month will be celebrated annually in WIC clinics.

WIC will continue to contract with the three theaters to run the logo as a slide before the start of feature films. In addition radio advertising will continue.

Presentations by the Breastfeeding Coordinator will continue and more breast feeding/pumping stations will be established in the state service centers. There are currently five (5) stations of operation. Two more are planned; one will be located at the Williams State Service Center, and the other is planned for Hudson State Service Center.

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

a. Last Year's Accomplishments

This is a performance measure, which was the prime responsibility of hospitals; however, Title V staff provided collaborative support in the area of data collection and public awareness. DPH also provided audio-logy services.

Infrastructure Building:

Title V staff in the Family Health Services Branch worked with the Women's and Reproductive Health Branch staff (Newborn Screening) in the development the system for screening newborns for hearing impairments

Two grants were approved to support this effort. The Centers for Disease Control Early Hearing Detection Intervention (EDHI) Grant started last September. This new program set in place the infrastructure to link the hearing results from the hospitals with the current metabolic newborn screening program and provide tracking and follow-up.

The Universal Newborn Hearing Screening and Intervention grant funded through the MCH Bureau assisted in purchasing necessary equipment for the hospitals and program to track and follow-up abnormal hearing screenings and provided educational materials for parents and providers in English and Spanish.

Both the CDC and the MCH renewed grants to Delaware Public Health/ Section of Community Health Care Access to fund the DE Newborn Hearing Screening Program. As planned, a Coordinator of this Program and an Application Support Specialist were hired.

Regulations were signed for the Birth Defects Surveillance and Registry Program requiring the reporting of all birth defects including hearing impairments. Hearing screening equipment and the ability to report the results of the screening to the NHS Program, were identified for the six birthing hospitals, the Birth Center, A.I.duPont Hospital, and the Amish midwife. Equipment and software were provided to the birth sites that were unable to find funding. A training session was conducted for all hospitals and others who used the OZ tracking system for reporting. All of these facilities continued to screen newborns completing approximately 96% of the Delaware babies.

Educational materials were developed provided for parents and providers, which described the importance hearing screening of newborns. This information was provided in both English and Spanish. A provider's manual with inclusive information as to the recommended guidelines for screening, testing, follow-up, referral, and treatment and a parent manual for diagnosed hearing impaired infants was developed.

b. Current Activities

Infrastructure Building:

With the Delaware Newborn Hearing Screening Program in place, all Delaware babies who are referred for diagnostic evaluation because of their hearing screening will be followed through the Program Office. The Central Reader's Station at the program office records all pertinent information and the Newborn Hearing Coordinator makes contact the with parents, providers, and the Medical Home. Birthing facilities receive Quality Assurance Reports from the Program and scheduled visits. The coordinator maintains records of statistics aiming to achieve a goal of 100% diagnosis for all babies referred and 100% amplification for all babies diagnosed with deafness or hearing loss. Both the MCH grant and the CDC grant for Newborn Hearing Screening were renewed for 2003, thus enabling Delaware Public Health/Community Health Care Access Section to continue the Newborn Screening Program.

A central office for the program was established and the coordinator of the program began receiving hearing information from all the hospitals and other birthing sites of the state A

network of couriers, already carrying metabolic screening information began to bring hearing screening results from the individual sites to the Public Health Hearing Office. The program director added this information to the central database and followed up on any babies who did not pass their initial screens, requiring further testing. Parents, providers, and the medical homes were contacted to ensure immediate and complete care. Ninety-eight percent (98%) of the babies born in Delaware were screened for Newborn Hearing.

The Hearing Aid Loaner Program was established and one hearing aid was loaned to a baby diagnosed with deafness. Quality Assurance Reports for each birthing site were generated in the central office and distributed to those sites.

Educational brochures in both English and Spanish continued to be widely circulated to providers, new mothers, and mothers-to-be. In addition, both a Providers' Manual and a Parents' Manual were completed.

c. Plan for the Coming Year

Infrastructure Building:

The providers' Manuals and Parents' Manuals will be printed and distributed to all pediatricians, Ear, Nose, and Throat (ENTs) physicians and audiologists. In addition, the Parents' Manual will be distributed to the parents of all babies diagnosed with deafness or hearing loss.

Quality Assurance visits will be conducted throughout the state. The main goal continues to be the diagnosis and amplification of 100% of the babies who do not pass the screening.

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

a. Last Year's Accomplishments

Enabling Services

Well child clinics provided for uninsured children in several public health clinics. Services included EPSDT screens and immunizations. Referral for ongoing primary care services were encouraged, usually to the federally qualified health centers.

School-Based Health Centers are located in 27 of 29 districts in the state. Although these centers did not provide primary care, they referred uninsured adolescents to primary care physicians. Frequently to Medicaid and the Delaware Healthy Children program eligibility.

Infrastructure Building:

The Medical Society of Delaware received a Robert Wood Johnson grant Covering Kids and Families. Public Health staffs worked closely with them throughout the grant process. This proposal sought to further strengthen the Delaware safety net by strengthening the capacity of the medical community to continue accepting patients both insured and uninsured, by assisting individuals to becoming better users of the health system, thereby, improving their health status while reducing costs borne of inappropriate utilization of the system.

Local projects utilized lessons learned from the "Covering Kids Program" and fully engaged two communities: the medical community and the childcare community. In each local project, staff resources were dedicated to assisting children and adults through the application and enrollment process and dedicated staff at the Delaware Division of Social Services served as direct liaisons to ensure ongoing quality checks and more timely application processing. In each local project, centralized resources were developed and marketed to the broad constituency being served.

The health consultation system was established through the Healthy Child Care America grant. Another lead agency, the Family and Workplace Connection, was the contractor for this portion of the project.

Another federal grant, the Primary Care grant, was utilized to retain the grant-funded staff that coordinated the Covering Kids pilot initiatives.

Coordination with childcare providers improved because of the Healthy Child Care America 2000 grant. The newsletter, distributed 3 times a year to all childcare provider staff, continued to include information regarding insurance.

b. Current Activities

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

Enabling:

Referrals continue to be made to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, referrals to Medicaid and the Delaware Healthy Children Program are made by all DPH programs (CDW, Kids Kare, immunizations etc.) when it is determined that children under their care do not have a source of insurance. DPH staff also refers and help with applications to private insurance where applicable.

School-Based Health Centers provide referrals to primary care physicians for adolescents who do not have a physician.

Infrastructure Building:

The Nursing Director for the Division was assigned to serve as the DPH representative for the Covering Kids and Families initiative and continues to play an active role. Title V staff work with Families and Workplace Connection to enhance the health consultation systems childcare providers.

c. Plan for the Coming Year

Enabling:

Referrals will continue to be made to the A.I. 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 Delaware Healthy Children 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.

School-based Health Centers will continue to provide referrals to primary care physicians for adolescents who do not have a physician.

Infrastructure Building:

The nursing director for the Division was assigned to serve as the DPH representative for the "Covering Kids and Families" initiative and will continue to play an active role. Title V Staff will work with Families and Workplace Connection to enhance the health consultation systems childcare providers.

Coordination with childcare providers is improving as a result of the States Early Childhood

Comprehensive Systems grant. The newsletter that is distributed three times each year to all childcare providers and staff will continue to include information regarding insurance.

The Interagency Coordinating Council (ICC) has created a subcommittee to address this performance measure of uninsured and under-insured children in Delaware. The subcommittee will be convening meetings with Medicaid late summer, 2004. Dennis Rubino, Director of CSHCN, is a member of ICC and will be an active member of the subcommittee.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

Enabling

What was said regarding insurance coverage for special needs children and non-Medicaid coverage applies for this measure. In addition, the Division of Public Health continued to provide liaisons with the duPont pediatric clinics across Delaware.

Kids Count gathered and analyzed data related to insurance and Medicaid enrollment

b. Current Activities

Enabling:

The liaison activity of the Division of Public Health continues with the duPont pediatric clinics.

The Kids Count reports are reviewed annually related to insurance and Medicaid enrollment. Encounter data is gathered, reviewed, and analyzed by Medicaid and their managed care organizations

c. Plan for the Coming Year

Enabling:

Title V supported clinic and field staff will refer to Medicaid when they determine that a child may be eligible. DPH will continue to provide liaisons with A.I. duPont Pediatric Clinics that refer children through Child Development Watch and the Women Infants and Children (WIC) program.

Kids Count will continue to gather and analyze data related to insurance and Medicaid enrollment. The Kids Count reports will be reviewed annually, as related to insurance and Medicaid enrollment. Encounter data will be gathered, reviewed, and analyzed by Medicaid and their managed care organizations.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Infrastructure Building:

As a result of our high infant mortality rates, DPH established the Infant Mortality Internal Workgroup. The Work Group's Data Committee concentrated on the excess or increase in deaths and on further examination of the data for all of the deaths. In conjunction with the Perinatal Board's Scientific Committee, the following was determined regarding the excess or the increase in the mortality rate:

? Primarily, increase was due to an increase in the mortality rate among very low birth weight

(VLBW) infants

? Secondly, it was due to a small increase in the proportion of VLBW babies among all live births.

DPH worked with the CDC and the Perinatal Board to determine the causes. Since the possible causes were in the early states of investigation, no information was released. It is clear, however, that infants are being born smaller and in poor health. The excess infant VLBW deaths are to older married women who enter care during the first trimester and are educated and insured. Overall, our data showed that the large majority of infant deaths are to women who are poor, lack a high school education, are uninsured, and have other risk factors such as tobacco use.

b. Current Activities

Population-Based:

The Perinatal Board works with the March of Dimes (MOD) on their Pre-maturity Campaign. The Pre-maturity Campaign includes a speaker's bureau, meetings with legislators, and news events. The Board is particularly addressing emotional health issues and how they affect pregnancy outcomes. As a result, the Board is joining forces with the Mental Health Association, Christiana Care Health Services, the Perinatal Association, and the March of Dimes to implement a conference addressing emotional health and to ensure that Resource Mothers are trained in screening for these issues.

Infrastructure Building:

DPH continues to work with the Perinatal Board, Christiana Care Health Services, and the CDC to determine the root causes of deaths to VLBW babies. Christiana Care Health Services received a Community Centers for Excellence in Women's Health in the fall of 2002. This is a five-year grant through the Department of Health and Human Services to coordinate services to provide integrated, culturally competent services to 3,000 high risk, low income, and underserved women in New castle County. Plans include health professional training to work with the underserved communities, increased leadership, and advocacy skills for the women, and involving the community by increasing their health knowledge base. Also planned are a needs assessment and a program evaluation. The needs assessment will help to plan educational opportunities that they will offer and if possible address barriers to care. Planners hope that one result of this effort will be healthy women with improved birth outcomes. DPH is an active participant on the Community Centers for Excellence in Women's Health steering committee.

On June 2, 2004 the honorable, Ruth Minner, Governor of the State of Delaware, established the "Infant Mortality Task Force" by executive order. The Infant Mortality Task Force is mandated to develop broad-based recommendations for the reduction of infant mortality in the state of Delaware. These recommendations will be based upon scientific evidence, defined partnerships, expected contributions, timelines, review, and evaluation. These recommendations encompass but are not limited to charges to business, community, education, communities of faith, providers, insurers, and the government.

c. Plan for the Coming Year

Population-Based:

The Delaware Perinatal Board will continue to work with the March of Dimes (MOD) on their Pre-maturity Campaign. The Board will work with the Mental Health Association Services, Children and Families First, and the March of Dimes to implement a conference addressing emotional health and to ensure that Resource Mothers are trained in screening for these issues.

Infrastructure Building

DPH will continue to work with the Delaware Perinatal Board, Christiana Care Health Services, and the CDC to determine the root causes of Deaths to Very Low Birth Weight (VLBW) babies.

The Infant Mortality Task Force will be implemented with the following goals to include, Christiana Care Health

- * Defining the infant mortality status of Delaware as compared to the nation and the region.
- * Defining the disparities among races related to infant mortality and determining the reasons for the increasing disparity gaps.
- * Identifying risk factors and underlying etiologies when possible.
- * Reviewing scientific literature with the purpose of determining risk factors for infant mortality and best practices for prevention and intervention.
- * Determining and assessing the impact of relevant risk factors.
- * Increasing awareness of the scope of the problem among government officials, medical professionals, and the public.
- * Improving coordination between and among public and private sector agencies.
- * Recommending critical changes to the profile of, operations of, and support of the Delaware Perinatal Board.
- * Identifying areas requiring additional research and education.

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

a. Last Year's Accomplishments

Direct Services:

Public Health clinic services continued to provide depression screening during any contact with youth regardless of the service. Families who experienced a death of a teenager related to suicide were provided support from Public Health field staff. Grief counseling and referral to appropriate agencies was provided as needed.

Adolescents enrolled in the SBWC were eligible for mental health counseling. Students have a brief review of behavioral risk factors with sports physicals, and other preventive care visits. Parents, teachers, friends, the school nurse or guidance counselors referred students for a mental health assessment. Students identified as at-risk for suicide were referred to the appropriate providers or for hospitalization.

SBHCs served as an important resource for teens with emotional concerns. In FY 2002, there were 18,161 visits where emotional concerns were the primary diagnosis. This increased from last year's visit number of 15,798. These visits were 36% of all primary diagnosis visits. Other diagnoses were tracked when a student came in for one concern but another concern was also identified. In these cases, there were 29,190 diagnosis made for emotional concerns. Out of this number, suicide ideation was diagnosed a total of 233 times or about 0.8 % of all diagnoses based on emotional concerns.

The Division of Public Health does not provide staffing support for the Child Death Review Commission. This function was assumed by the Department of Services for Children, Youth, and their Families. The Department Secretary served on the Commission and several public health field staff served on the regional review committees. within schools, communities and family organizations to decrease victimization and its impact on mental health.

b. Current Activities

Direct and enabling

DPH clinic staff and SBHCs continue to assess adolescents and refer when needed.

Infrastructure Building

DPH continues its involvement with the Just for Youth initiative.

DPH and the Division of Child Mental Health work collaboratively to examine how services are coordinated for SBHCs.

c. Plan for the Coming Year

Direct Services

Public Health Clinic services will continue to provide depression screening during any contact with youth regardless of the service. Families who have experienced a death of a teenager, related to suicide, will be provided support from Public Health field staff. Grief counseling will be provided as well, with referral to appropriate agencies as needed.

Adolescents enrolled in the School-Based Health Centers will continue to be eligible for mental health counseling. Students have a brief review of behavioral risk factors with sports physicals and other preventive care visits. Parents, teachers, friends, the school nurse, and the guidance counselors can refer students for a mental health assessment. Students identified as at-risk for suicide will be referred to the appropriate providers, or for hospitalization.

The Division of Public Health will continue its participation on the "JUST for Youth" coalition to support Gay, Lesbian, and Bisexual youth who are prone to suicide ideation. A comprehensive strategic plan is still being developed.

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

a. Last Year's Accomplishments

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

Infrastructure Building

Handling of at-risk deliveries at other than, level III hospitals were reviewed by the Perinatal Board Standards of Care Committee. Transportation by ambulance or helicopter was reviewed for timeliness and appropriateness

b. Current Activities

Infrastructure Building

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

c. Plan for the Coming Year

Infrastructure Building

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

DPH Title V will also support the efforts of the Infant Mortality Task Force to be implemented as per the Governor's Executive Order #56. Discussion will be held on the extent and type of support needed for the efforts to be successful. Types of support may include; secretarial services, in-kind services and staffing of the task force, and its committees.

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

a. Last Year's Accomplishments

Enabling

Smart Start continues to be provided to at-risk mothers.

Infrastructure Building: Addressing Kent and Sussex Entry into Care Issues

Prenatal care in Southern Delaware is still of concern:

? Physicians are continuing to give up their obstetrical practices. National events have also had an impact with the loss of an OB to the Reserves and Iraq.

? One OB/GYN practice will not accept presumptive Medicaid.

? Nanticoke Maternity Center did close on June 30, 2003. They stopped seeing new patients in mid-June the two hundred existing patients were transferred to the private OBs in Western Sussex. While all of the current obstetrical practices have agreed to accept Medicaid during this transition, whether they will continue to accept Medicaid or place a cap on the number of Medicaid clients they accept remains to be seen. La Red has entered into an agreement to have OB services available at La Red and Maternity Center clients from Georgetown will be transferred there.

The Kent County Prenatal Care Committee continues to meet. The committee has been involved in teen pregnancy prevention efforts (see section on the National Performance Measure # 8). In addition, the group was made aware that a specific provider told Medicaid patients that they are unable to accept additional Medicaid clients until they deliver current patients. Patients were directed to call back the following week. The chair has contacted all of the provider groups in Kent County to request their attendance at the meeting and to re-educate OB/GYN care providers on referral resources available to Medicaid patients when the provider is unable to serve them. The OB/GYN offices have attended the meetings in the past but have not recently.

The Division of Public Health continues to support the voucher program in Sussex County but is considering the option of contracting with a private provider to provide the services. During the current year, MCHBG funds have paid for a portion of the dollars needed.

b. Current Activities

Enabling:

Smart Start services continue an evaluation of the program currently underway with a final report due within six months.

DPH is currently reviewing the voucher program and is considering contracting with one agency to provide the needed services rather than the vouchers.

Infrastructure Building:
Public Health continues its participation on the Prenatal Care Committee.

c. Plan for the Coming Year

Enabling:
The Smart Start services will continue during the next year, the evaluation of the program will be completed, reviewed, and analyzed.

Infrastructure Building:
Public Health will continue its participation on the Prenatal Care Committee.

DPH Title V will continue to support the efforts of the Delaware Perinatal Board and will support the efforts of the Infant Mortality Task Force, to be implemented per the Governor's Executive Order #56 of June 2, 2004.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Expanded newborn screening now implemented for Urea cycle disorders, Fatty acid oxidation, Methylmalonic academia, Propionic academia, Isovaleric academia, Glutaric aciduria1, organic acidurias & G6PD deficiency.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. DPH county field staff provide follow-up in the home when screenings have not occurred in the hospital (i.e., home births) or a repeat screen is needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Home visiting program for First Time Parents/SHS follow ups for Newborn Screening for second blood draws.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. HVP and SHS work collaboratively with Newborn Screening to ensure follow up on medical testing for children with genetic disorders.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. State of Delaware Guideline for the Management of Sickle-Cell Disease is in place	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Child Development Watch includes the family in standards development, monitoring plans and IFSPs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partners in Policy Making includes advocacy training in the family?s training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The Delawareans with Special Health Care Needs Managed Care Panel meets monthly and responds to fami	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The Interagency Coordinating Council and The Coordinating Council for Children with disAbilities inc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Developed family support partners for families to support each other. Family survey is conducted annually. Families are encouraged to participate in focus groups as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. All families eligible for Part C services receive a Child Development Watch newsletter informing them of activities that are taking place including information about the family forum meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Child Development Watch includes the child?s primary care physician as a member of the multidiscipli	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Children in the Kids Care program are connected to a medical home and primary care physician.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The Medical Home Planning Committee meets monthly to implement the medical home concept and to estab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The Special Needs Alert Program will establish medical homes for children 0-18.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Child's primary care physician (PCP), is part of the decision making team in developing a care plan.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Case Managers support families in finding/keeping a medical home. Determination of medical home completed at intake and follow up ongoing.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Division of Family Services, Division of Public Health, Memorandum of Understanding (MOU) is now updated to include the new SFS High-Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Infant Referral Protocol.				
8. Staff in child health, dental and field services work with clients to inform them of the service, assist them with the application process or refer them to Medicaid	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Completed out reach visits pediatricians and family doctors who do not regularly refer HVP and/or CDW programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. High-Risk Infant Referral Protocol is in effect and the first discharge planning	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Child Development Watch staff has been instrumental in helping children enroll in Medicaid, and Dela	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Kids Count is gathering data and tracking the percentage of children with insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Referrals are made to A.I.duPont pediatric clinics when a child does not have insurance.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Division of Public Health continues to offer specialty clinics to children in need.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pediatric Neurology, Pediatric Cardiology, and Pediatric Ophthalmology provided for Medicaid, under insured and uninsured clients, in partnership with the Division of the Visually Impaired (DVI).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Kent/Sussex Counties contract doctors provide services for under and uninsured to age 21	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Amish clients who are unwilling to apply for medical insurance are assisted by PH nursing staff and social workers to find resources for special care need	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Free nutritional evaluation is provided to special needs children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. CDW may pay premium for CHIP to avoid loss of coverage. CDW pays co-pay/deductible to support care & provide routine med-care through insurance, & medical coordination so providers understand development delay/ need for early intervention.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. The Medical Home Planning Committee is in the process of conducting a family satisfaction survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. A Family Survey Report under Early Intervention is finalized and will be reviewing the data on family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Four major statewide councils address the organization of service systems that include CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. CompCare of Health Systems Research is conducting an assessment of the services for CSHCN and it inc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. The Transition Committee meets monthly to assess transition needs and to develop a transition plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Coordinating Council for Children with disAbilities is addressing the transition issue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The Institute for Child Health Policy is assisting Delaware in raising the awareness of transition i	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. A survey of children who have ?graduated? from the A.I.duPont Hospital for Children is being planned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Medical Social Work consultant provides case management for children born with cleft palate and neurological disorders and transitioning to adulthood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Intense analysis of the State Immunization Registry to verify t	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Partnerships with the Delaware Department of Education, the Delaware Office of Child Care Licensing,	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Northern and Southern Health Services provide immunizations in their well-child clinics, primarily f	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Immunization Program is working on a link to the new born screening registry.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. The Immunization Program is planning marketing initiatives as a result	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

of the marketing survey.				
6. All children active with CDW have a review of their immunization records and are supported in completing their immunizations in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. A new contract has been initiated with West Side Health Services to provide outreach for children 0-2 delinquent in immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Nursing staff provides physical assessments and immunizations to clients eligible for services under the Division of Public Health.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Immunization action team audits all private physicians in Kent and Sussex counties to determine the immunization status of their clientele in this age group. Day care Centers are also audited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. 1. Teen Hope Additional social work hours providing intense one-to-one counseling to identify ?at-r	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. DPH Contracts with a Boys and Girls Clubs and Community Centers to provide structured after school	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The Bridges Carrerra Model project is an official Dr. Michael Carrera/Children's Aid Society replica	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. DPH and private agencies provide family planning services, some of which are specifically aimed at t	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The Alliance for Adolescent Pregnancy Prevention (AAPP) of Christiana Health Services coordinates st	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Wise Guys is an adolescent male responsibility program that uses an established Wise Guys curriculum	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. The Delaware Partnership for Positive Youth Development and the Kent and Sussex Community Health Out	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. The Delaware Theatre Company conducted a six-week team building and communication workshop through the arts, to help students develop and improve skits and scenarios to share and critique	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Home Visiting Program for First Time Families has implemented a pilot project in Sussex Co. The goal is to provide quality home visiting services to all first time families & address the need to delay a subsequent pregnancy to teen parents.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Field staff work with pregnant women, often teens, to reduce and/or delay the onset of additional pregnancies through counseling, information, and referral to a GYN provider	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Data is being reviewed and analyzed from the needs assessment completed on third grade school childr	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

2. The Division of Public Health continues to coordinate dental screening for the Special Olympics prog	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The Division of Public Health clinics offer comprehensive dental care for those in need.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The dental loan repayment program will continue in an effort to attract more dentists to needy areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Share info on bottle mouth in English and Spanish, at multidisciplinary assessment developmental physician checks mouth/teeth and review brushing with family. Speech pathologist discusses reducing bottle and/or pacifier use as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Our Health Educator has added dental hygiene presentations to her list of community youth trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. The DPH clinic staff in Northern and Southern Health Services supply car safety seats to their clien	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Delaware continues to have a Safety Seat Loaner program at the fourteen State Service Centers. The S	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. EMS for Children (EMSC) is the lead agency for Risk Watch injury prevention, which is in 359 classro	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Community Health Services/NHS has appointed a RN III to represent NHS on the Delaware Coalition of Injury Prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. An assessment of child safety is performed with each visit to the Child Health Clinic and Home Visit under the Smart Start/Kids Care Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. An assessment of child safety is performed with each visit to the immunization clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Trainer Educator provided a presentation on Child safety to students attending the Delaware Prevention Network after school program at the New Hope Recreation Center in Ellendale, Delaware	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. The Child Death Review Committee reviews the deaths of all children in the state of Delaware to determine the preventability of their death. Recommendations from the committee for system changes are presented to the Governor.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				

1. The WIC program supports the reinforcement of the WIC National Breastfeeding Campaign, Loving Support	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Clients receive encouragement, information, and education from WIC, Family Planning, and Smart Start	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. WIC contracts with the three theatres to run the Loving Support Makes Breastfeeding Work logo as a s	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Presentations by the Breastfeeding Coordinator are ongoing.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. HVP/SHS identify moms for referral to lactation consultant or PHN and facilitate. Facilitate obtaining breast pumps, special formulas as needed for special needs infants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Patients who are HIV positive at the DPH Service Center Clinics are educated regarding risk factors that include transmission routes and potential impact on inborn fetuses, breastfeeding, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Field nursing staff has provided breastfeeding information to all clients enrolled in the Smart Start Program. They estimate that 40 percent of their clients? breast feed.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Prenatal clients are encouraged to choose to breastfeed their infants. Clients receive encouragement, information, and education from WIC, Family Planning, & Smart Start visits with PHN in the home	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. The Delaware Infant Hearing Assessment and Intervention Program Committee continues to meet quarterl	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. A parent?s guide for hearing services is being finalized.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. A professional guideline and standards for hearing services is being finalized.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The Newborn Hearing Screening Program is collecting data through a Central Reader?s Station at the p	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. OAE screener is used to screen for hearing problems and refer to PCP for follow up. Facilitate/coordinate follow up on results such as BAER.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Child Health Practitioner completes full physical on all DPH eligible participants. Hearing screenings are completed at first visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Field nursing ensures that families follow up with specialist when infants fail their hearing tests while in the hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Well child clinics are provided for uninsured children in several public				

health clinics. Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. School Based Health Centers are in 27 of 29 districts in the state. Although these centers do not pr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The Medical Society of Delaware has received a Robert Woods Johnson grant Covering Kids and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Children are seen on a walk-in basis initially and are provided with a Medicaid package or referred to Children Health Insurance Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Children without insurance coverage who are seen by DPH staff are referred to Medicaid or CHIPS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. The Division of Public Health continues to provide liaisons with duPont pediatric clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Encounter data is being collected by Medicaid and their managed care organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Kids Count is gathering and analyzing data related to Medicaid enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Case managers assist with application and provide information and support for family in appeal situation. They also assist PCP and providers in understanding the Medicaid benefit.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Children without insurance coverage who are seen by DPH staff are referred to Medicaid or CHIPS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. DPH established the Infant Mortality Internal Workgroup. The Work Group?s Data Committee has concent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Perinatal Board will work with the March of Dimes (MOD) on their Prematurity Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Christiana Care Health Services helps to coordinate services to provide				

integrated, culturally competent services to 3,000 high risks, low income, and underserved women in New Castle County	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Services under the Smart Start Program include; assessment, education/teaching, and monitoring of pregnancy to reduce the number of infants with low and or very low birth weight as a goal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The prevention of teen pregnancy is a current priority for clinic and field staff. Teens often deliver low/very low birth weight infants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Family Planning clinics offer pregnancy testing by appointment daily in hope to offer counseling, education, and referral to OBGYN and Smart Start services to increase early entry into care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Clients with positive pregnancy tests are given prenatal vitamins and referred for WIC services. Clients are assisted to access prenatal care as soon as possible	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Public Health clinic services provide depression screening during any contact with youth regardless	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Adolescents enrolled in the SBHC are eligible for mental health counseling. Students identified as	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The Division of Public Health participates on the JUST for Youth coalition to support Gay, Lesbian,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Observes family members for possible MH issues and refers as needed for follow up to DFS, CMH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Staff routinely observe clients for symptoms of depression during any contact with youth, regardless of the service	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Handling of at-risk deliveries at other than Level III hospitals are reviewed by the Perinatal Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Field staff involved in high-risk cases encourages prenatal cases to take OB's advice to deliver at high-risk facilities in New Castle County	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.					
1. Smart Start is a prevention program designed to address the factors, which may negatively influence		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Kent County Prenatal Care Committee includes representatives from the Division of Public Health,		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The Division of Public Health also supports a voucher program in Sussex County where DPH provides vo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Adolescents identified as pregnant by the School Based Wellness Center are referred to prenatal care		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Medical Social Work Consultant work on an ongoing basis to identify barriers to care at the private OB/GYN offices. Problems are brought to the county administrator for resolution		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. The Nanticoke maternity Center in Seaford, Delaware closed in July. There were over 200 patients impacted. Those with insurance went to three local OB-GYN practices ? the remaining will be going to La Red in Georgetown.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *(Tobacco use by Teens)The percent of youth reporting smoking 2 or more cigarettes per day on the days they smoke.*

a. Last Year's Accomplishments

Enabling

Like all adolescent health measures, while DPH can help to lead this effort, it cannot address these issues alone. Instrumental were 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 Promotion and Disease Prevention, another DPH section.

Work has continued on the following goals for DPH:

? Continuing to provide media, community programs, cessation, and coordination for tobacco use

- ? Prevention programs related to tobacco-related chronic diseases
- ? Preventing tobacco use among young people.
- ? Increasing the proportion of cigarette smokers who attempt to stop smoking.
- ? Reducing routine exposure to environmental tobacco smoke.
- ? Increasing the number of Delawareans who strongly disapprove of cigarette use.

Title V continued the emphasis on eliminating use of tobacco through the development and support of the SBHC program.

Population Based:

- ? The School-Based Health Centers sponsored 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 advised all clients including teenagers to stop smoking.
 - ? Pamphlets regarding the dangers of smoking were placed in all clinics such as dental, STD, and Child Health clinics. Posters and bookmarks are placed at most clinics.
 - ? DPH provided several grants to community agencies including: prevention/peer education grants; cessation, reduction, and health education and stress management. Tobacco settlement dollars funded educational tools for presentations at local elementary and middle schools.
- DPH Health educators and nutritionists provided presentations to schools throughout the school year.

b. Current Activities

Enabling:

Title V continues the current emphasis on eliminating use of tobacco through the development and support of the SBHC program. We will also continue to incorporate this measure in other programs such as Smart Start, Kids Kare, etc.

Population Based:

Comprehensive tobacco control efforts in Delaware continue without significant changes. The state's efforts are coordinated through the Division's Health Promotion and Disease Prevention Section, Tobacco Prevention and Control Program, with funding from the Delaware Health Fund (Master Settlement Agreement funds) and a cooperative agreement from the Centers for Disease Control and Prevention. Additional funds in tobacco prevention go to the Department of Education, the state Attorney General's Office, the state Division of Alcoholic Beverage Control and Tobacco Enforcement, and Tobacco Free Delaware (a Robert Wood Johnson Foundation grant with the American Lung Association of Delaware as the lead agency).

The Delaware Tobacco Prevention and Control Program focuses on several key areas of tobacco control:

- 1) Prevention of tobacco use, primarily among youth and young adults. Youth programs are coordinated through a contract with Tobacco Free Delaware (ALA).
- 2) Community based tobacco prevention efforts
- 3) Smoking cessation, primarily through a smoking cessation toll-free "Quit-line".
- 4) Social marketing and counter-marketing through the media
- 5) Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws.

Delaware youth smoking rates continued to decline dramatically, especially among middle school students, according to the Division of Public Health's 2002 Delaware Youth Tobacco Survey. The survey shows decreasing smoking rates and strong awareness of the hazards of tobacco use among students ages 11-18. The findings indicate that DPH initiatives targeted at educating youth are reaping large rewards.

The Delaware Youth Tobacco Survey was administered to 5,296 students in grades 6-12 in the spring of 2002. The survey, first conducted in 2000, is administered every other year. The report, "Incidence and Prevalence of Youth Tobacco Use in Delaware", contains the following highlights.

* A 63% decrease in middle school students who reported smoking a whole cigarette before age 11, from the 27% in 2000 to 10% in 2002.

* A 23% decrease in the number of middle school youth who have ever tried a cigarette, 44% in 2000 to 34% in 2002. There was a 3% decrease among high school students, from 66% in 2000 to 63% in 2002.

* A 27% decrease in smoking during the past 30 days among middle school students, from 15% in 2000 to 11% in 2002. Current tobacco use for high school students decreased slightly from 27% in 2000 to 26% in 2002.

c. Plan for the Coming Year

Enabling

Title V will continue the current emphasis on eliminating use of tobacco through the development and support of the School-based Health program. We will also continue to incorporate this measure in other programs such as Smart Start, Kids Kare, etc.

Population Based

Comprehensive tobacco control efforts in Delaware will continue without significant changes in the coming year. The state's efforts are coordinated through the Division's Disease Prevention and Control Section, Tobacco Prevention and Control Program, with funding from the Delaware Health Fund (Master Settlement Agreement Funds) and a cooperative agreement from the Centers for Disease Control and Prevention. Total budget is approximately five million dollars per year. Additional funds for tobacco prevention go to the Department of Education, the Delaware Attorney General's office, the Division of Alcoholic Beverage Control and Tobacco Enforcement, and to Tobacco Free Delaware (a Robert Wood Johnson Foundation grant with the American Lung Association of Delaware; as the lead agency).

State Performance Measure 2: *(Alcohol Use by Teens)* *The percent of youth reporting any use of alcohol in the last thirty days.*

a. Last Year's Accomplishments

Direct Services:

School-Based Health Centers provided individual counseling for alcohol and for children of alcoholics. They also worked with parents so that parents can speak to their children about this topic. School-based health centers also referred to the Division of Child Mental Health Services and other agencies for services they could not provide, e.g., beyond their capacity, summer time needs, more intensive inpatient services.

DPH staff, both at clinic visits and during home visits, assessed alcohol use during each client contact. Resources for cessation were suggested. The DPH Trainer/Educator provided educational opportunities regarding alcohol use to the community as requested.

Population Based Services:

DPH no longer has the funding to award mini-grants for the SLAM and Start Smart programs. SBHCs provided "Lunch and Learn" series and other activities for the schools related to decreasing alcohol consumption

b. Current Activities

Direct:

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

Clinics continue to provide information regarding dangers of alcohol consumption in a variety of settings.

Population Based:

School-Based Health Centers continue to include activities such as a play on substance abuse, "Prom Promise", and discussions with teens regarding substance free lifestyles.

In FY 2003, two-thousand, one-hundred sixty (2160) referrals were made by school-based health centers, to a wide variety of organizations providing crisis intervention, drug/alcohol counseling, and to inpatient and outpatient mental health counseling. Direct services are also provided at the center via social workers and drug/alcohol counselors.

Infrastructure Building:

The 2003 youth risk behavior survey was completed as well as the annual "Alcohol, Tobacco, and Other Drug Use Among Delaware Students" study.

c. Plan for the Coming Year

Direct:

School-Based Health Centers will continue to provide individual counseling for alcohol abuse and children of alcoholics. They will also work with parents to provide support regarding speaking to their children about this topic.

Clinics will continue to provide information regarding dangers of alcohol consumption in a variety of settings.

Population Based:

School-Based Health Centers will continue to include activities such as a play on substance abuse, "Prom Promise", and discussions with teens regarding substance free lifestyles.

Infrastructure Building:

The results of the Youth Risk Behavior Study (YRBS) and the annual "Alcohol, Tobacco, and Drug Use Among Delaware Students" study will be reviewed and analyzed. Key results of each respective study include:

* Alcohol use among high school students stayed about the same. The 2003 Youth Risk Behavior Study reported that forty-five percent (45%) of Delaware high school students drank alcohol during the past month.

* The annual "Alcohol, Tobacco, and Drug Use Among Delaware Students" study for 2003 reported that forty-three percent (43%) of eleventh (11th) grade students used alcohol in the past month. The study also showed that twenty-three percent (23%) of middle school students said they drank alcohol in the past month

State Performance Measure 3: *(Youth feeling so sad or hopeless)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.*

a. Last Year's Accomplishments

Direct and Enabling:

In FY 2002, there were 18,161 visits where emotional concerns were the primary diagnosis in SBHC. This is an increase from last year's visit number of 15,798. These visits were 36% of all primary diagnosis visits. Other diagnoses were tracked when a student comes in for one concern but another concern is also identified. In these cases, there were 29,190 diagnosis made for emotional concerns. In FY 2002, 856 referrals were made to a wide variety of organizations providing crisis intervention, drug/alcohol counseling, and inpatient and outpatient mental health counseling.

There are 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 includes 1 charter school, 55 schools and 13 districts but still cannot reach all the schools and students in need. This program is funded through the Department of Education but is provided by the Department of Services for Children, Youth, and their Families. Another 10 schools have been identified which qualify under criteria regarding the percent eligible for free and reduced school lunch program. However, there is no funding for these.

The DOE provides annual grants to districts to improve student school climate. There are other school climate initiatives, which identify at-risk students and those in need of interpersonal skills development, suicide intervention and prevention, etc. The Division of Child Mental Health is mandated to provide or ensure services to Medicaid eligible (through the Diamond State Health Plan) or uninsured children.

The DCMH also has a variety of programs and initiatives underway to address those children who are already facing crises. The major emphasis in all of DCMHS planning is to increase the availability and accessibility of community-based mental health and substance abuse services as opposed to hospital or residential services. Over the last year, the state has reduced utilization of hospital/residential placements.

Finally, DPH, the Department of Education, and others are also seriously looking at the problems faced by gay and lesbian youth as already described.

b. Current Activities

Enabling Services:

The SBHCs continue to provide mental health interventions and referrals for students who use the centers. In FY 2003, two-thousand, one-hundred sixty (2160) referrals were made by SBHCs to a wide variety of organizations providing crisis intervention, drug/alcohol counseling, and inpatient/outpatient mental health counseling. Direct services are also provided at the center via social workers and drug/alcohol counselors. Overall, between FY02 and FY03, the primary reason students came to the centers increased slightly (by 3%) for mental health diagnoses. There was a seven percent (7%) increase in the area of mental health visits under all diagnoses.

Infrastructure Building:

Title V is not the sole agency responsible for ensuring progress for this measure. 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 the data. Although we gathered numerous pieces of information from a variety of sources, there may be resources of which we are not aware. Title V continues to work with other agencies to put these concerns on the table.

c. Plan for the Coming Year

Enabling Services:

The SBHCs will continue to provide mental health interventions and referrals for students who use the centers.

DPH and the Division of Child Mental Health will look closely at how services are coordinated for SBHCs. This work continues as part of an ongoing working collaboration group between DCMHS, DOE, DPH, provider agencies, and schools building on Delaware's System of Care.

DCMHS and the Department of Services for Children Youth and Their Families have undertaken a large scale initiative with other state agencies, private agencies, and families to develop and promote the System of Care philosophy and framework, as well as operationalize the System of Care guiding principles in the daily work we all so serving the citizens of Delaware. There is currently a State System of Care Team representing the above to help guide policy and support initiatives.

The Health Care Commission has a Mental Health Committee with representatives across state agencies and departments, private organizations, and partners which recently put out a report identifying barriers to care in Delaware and recommended strategies to overcome those barriers. Title I is represented on the Mental Health Committee.

State Performance Measure 4: (Increase numbers of Medicaid eligible children under 3 receiving lead screens) The percent of Medicaid eligible children under 3 years that received an initial blood lead screen.

a. Last Year's Accomplishments

Enabling:

Title V pays for a .5 FTE Health Program Coordinator located in Northern Health Services. This position participated on the disease prevention team which tracked non-compliant and delinquent elevated tests, provided case management protocol for elevated lead; and inspected homes for lead. Finally, all DPH programs were expected to determine if there is a need to screen such as WIC staff that ask about lead screening at the 12-month recertification.

Population Based:

On October 28, 2000 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 is using the grant for lead-based paint intervention services as part of an overall rehabilitation strategy. The interventions included intensive preventive cleaning to remove lead dust, window replacement, and abatement. DPH partnered with the Latin American Community Center on these initiatives.

Public health staff targeted an educational campaign toward physicians in areas with low percentages of children tested for lead poisoning. In addition, Title V staff continued to work closely with the Offices of Lead Poisoning Prevention and Office of Child Care Licensing to get the word out about lead screening to parents and the child care community.

Following federal guidance from the Centers for Disease Control and Prevention's Childhood Lead Poisoning Prevention Program, the Division of Public Health issued Case Management Standards for Childhood Lead Poisoning Prevention. These were printed and distributed to

primary care providers statewide. The purpose for developing the Standards was to describe in detail the essential elements required to provide comprehensive services to families who have children with elevated blood lead levels. The standards apply to a single case manager or a team of health professionals and paraprofessional. One individual was assigned as the case manager and was responsible for assuring that all standards are addressed by themselves or with other team members.

b. Current Activities

Enabling:

Delaware developed a monitoring form and plan for appropriate case management that meets all the criteria in the case management standards. The work plan includes developing a tool that measures time frames for the following components of case management: initiating and completing case management services, existence of a written care plan, the reduction of blood lead level rates and rates of case closure (medical or administrative). It also establishes performance baselines for each component.

Population Based:

There is a plan to increase outreach and education efforts through community based organizations like the Girls and Boys Clubs to raise awareness of childhood lead poisoning prevention and lead screening requirements. Efforts include the use of a promotional mascot "sponge bob" and children art contests that focus on lead poisoning prevention themes.

c. Plan for the Coming Year

Enabling:

Delaware will continue use of the monitoring form and plan for appropriate case management that meets all the criteria in the case management standards. The work plan includes developing a tool that measures time frames for the following components of case management: initiating and completing case management services, existence of a written care plan, the reduction of blood lead level rates and rates of case closure (medical or administrative). It will also establish performance baselines for each component.

Population Based:

Plans will continue to increase outreach and education efforts through community-based organizations like the Girls and Boys Clubs to raise awareness of childhood lead poisoning prevention and lead screening requirements. Efforts include the use of a promotional mascot "Sponge Bob" and children art contests that focus on lead poisoning prevention themes.

State Performance Measure 5: (Percent of pregnant women using tobacco)The percent of pregnant women delivering live-born infants reporting any cigarette smoking during pregnancy.

a. Last Year's Accomplishments

Enabling:

Counseling regarding smoking continued to be provided during all Family Planning and Pregnancy test visits. Based on need, a client was counseled through Smart Start. All Public Health staff, including Child Development Watch service coordinators, offered health teaching to families they serve and caution against smoking.

Population- Based Services:

Public Health clients were referred to Delaware's smoking cessation program called the

Delaware Quit-line. The Delaware Quit-Line is a 24-hour, toll-free number staffed by trained tobacco counselors. Callers accessed a smoking cessation program that combines national expertise with local knowledge and service. Those who enrolled received free referrals to specially trained pharmacists and community groups. Vouchers help income-eligible residents access effective pharmaceutical cessation aids.

b. Current Activities

Population Based:

Referrals continue to be made to the Delaware Quit-Line

Direct Services:

Counseling regarding smoking continues to be 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 public health staff continues to offer health teaching to families who are receiving services.

Population-Based:

The Delaware Tobacco Prevention and Control Program will focus on several key areas of tobacco control:

- 1) Community based tobacco prevention efforts
- 2) Smoking cessation, primarily through a smoking cessation toll-free Quit-Line
- 3) Social marketing and counter-marketing through the media
- 4) Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws.

c. Plan for the Coming Year

Population Based

Referrals will continue to be made to the Delaware Quit-Line.

Direct Services

Counseling regarding smoking will continue to be 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 smoking. Other public health staff will continue to offer health teaching to families who are receiving services.

Population Based

The Delaware Tobacco Prevention and Control Program will continue to focus on several key areas of tobacco control:

- * Community based tobacco prevention efforts.
- * Smoking cessation, primarily through a smoking cessation toll-free quit-line.
- * Social marketing and counter-marketing through the media.
- * Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws

State Performance Measure 6: *(Adequate prenatal care for black women)*The rate of infants born to pregnant black women receiving adequate prenatal care.

a. Last Year's Accomplishments

Enabling Services:

DPH worked to ensure that Smart Start services were provided to all women needing them

and to ensure cultural competency. Smart Start is currently under review and being compared to Californian "Black Infant Mortality Project" to determine any needed changes.

Infrastructure Building:

Delaware was chosen to participate in the American Public Health Association (APHA) MCH Community Leadership Initiative in October 2001. The Institute is one of APHA's efforts to address one of its key priority areas - eliminating racial and ethnic disparities. After training in Atlanta team members representing DPH, Christiana Care Health Services, Perinatal Association, and Hill Top Lutheran Neighborhood Center, Inc. developed a method to communicate the issue of disparity in infant mortality. The initial target area was the City of Wilmington. The presentation was developed for use by outreach workers and others from within the community. The main objective was to communicate with and educate other Delawareans on the issue of the disparity in infant mortality in an effort to build collaborative relationships and buy-in on finding solutions that will make a difference in the future health of Delawareans. During the past year, a presentation was developed and then piloted that is at a level for non-professional lay persons to present and share with their neighbors, churches and other groups in their neighborhoods. This presentation will be available for others to use to continue to educate and encourage further discussion within the community. Funding for presentation packages is being paid for by the March of Dimes.

As already described, the Perinatal Board has the lead to address infant mortality and has been paying close attention to addressing the disparity issue. The Board has identified reducing the disparity a top priority and is addressing this issue through the work of its' committees. Particularly important, is the work that several members are doing to keep the Healthy Start Consortium going and downstate members who are taking the Perinatal Board disparity conference video to the Kent and Sussex communities.

b. Current Activities

Enabling Services:

DPH is evaluating Smart Start and in doing so will review cultural competency issues.

Population-Based:

The APHA supported presentation package, called Preparing for a Healthy Baby: a Presentation Guide will be presented to community groups such as the Healthy Start Consortium provider meeting, among others. Members will be able to take the package and present to their constituents. The package includes order and evaluation forms which will be utilized in assessing the interest level of the community and the affect of the presentations.

Infrastructure Building:

DPH continues to work hand-in-hand with the Perinatal Board on disparity issues and particularly to support the work of the Healthy Start Consortium.

The Family Health Services branch and the Office of Minority Health are working with the Center for Cultural Competency (funded through the Maternal Child Health Bureau's Office of Children with Special Health Care Needs) to determine cultural competency throughout the agency.

c. Plan for the Coming Year

Enabling Services:

DPH will complete the Smart Start evaluation and in doing so will review cultural competency issues.

Infrastructure Building:

DPH will continue to work hand in hand with the Delaware Perinatal Board on disparity issues and particularly to support the work of the Health Start Consortium.

State Performance Measure 7: *(Increase birth interval to more than 18 months)*The rate of live births to women who have had another birth at less than 18 months.

a. Last Year's Accomplishments

Direct Services:

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

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

Population-Based:

As already discussed, DPH remained a participant in a project to communicate the disparity to the community. As part of the Preparing for a Healthy Baby: a Presentation Guide, birth spacing was presented. (See State Performance Measure on pregnant black women who receive adequate care for more detail.)

Infrastructure Building:

The Home Visiting Advisory Committee applied for and received funding from the Delaware Children's Trust Fund in 2002 to develop a demonstration project for Sussex County. It focused on coordinating quality home visiting services to first time families. This project was a consortium of services for first time parents, and not a new program. Goals were to ensure consistent, quality services across all agencies by establishing standards and increasing the capacity of existing programs in the county through training, coordination of services, and filling gaps in services. Birth spacing was included in this service delivery system for first time parents.

b. Current Activities

Direct Services:

Support for family planning, Smart Start and Home Visiting program activities continue to ensure that the role of birth interval and infant mortality will be communicated.

Population-Based Services:

DPH continues work with its partners to disseminate the Preparing for a Healthy Baby: a Presentation Guide to the community leaders in Wilmington. The plan is to utilize the skills of community members and the packaged presentation to spread the message.

c. Plan for the Coming Year

Direct Services:

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.

Population Based:

DPH will work with its partners to disseminate the "Preparing for a Healthy Baby: A Presentation Guide" to the community leaders in Wilmington, Delaware. The plan is to utilize the skills of community members and the packaged presentation to spread the message.

Infrastructure Building:

On June 2, 2004 the honorable Ruth Minner, Governor of the State of Delaware, established the "Infant Mortality Task Force" by executive order number fifty-six (#56). The Infant Mortality Task Force is mandated to develop broad-based recommendations for the reduction infant mortality in the State of Delaware. These recommendations will be based upon scientific evidence, defined partnerships, expected contributions, timelines, review, and evaluation. These recommendations encompass but are not limited to charges to business, community, education, communities of faith, providers, insurers, and the government.

DPH Title V will support the efforts of the Infant Mortality Task Force to be implemented as per Executive Order number fifty-six (#56).

State Performance Measure 8: (Decrease percent of extremely low birth weight black infants)The percent of extremely low birth weight black infants among all live births to black women.

a. Last Year's Accomplishments

Enabling:

The Black Infant Health Committee continued to collaborate. However, because most staff had to work on the small pox and bio-terrorism issues, the committee has not met as often as planned. The committee continued to work on improving field services through development of referral guidelines for Smart Start. Brochures have been developed for stress and tummy time. Discussion by the committee has recently centered on whether the committee should have a larger focus and work to improve field services for all clients.

Infrastructure:

The Office of Minority Health has developed a campaign to address black infant health. Brochures have been developed called Every Child Deserves a First Birthday. These brochures relate the facts that black infants die at a greater rate than white infants do and it is crucial for young women to be conscious of their health. It also provided a list of health style behaviors that would support a healthy pregnancy

b. Current Activities

Enabling Services:

The Black Infant Health Committee is discussing with management their recommendation that the Committee be renamed the Field Services Committee which would be assigned to: improve services to clients of all races, keep field service manual current, clarify additions, provide training on changes for current staff and orientation for new staff, and address racial disparities and infant mortality rates and low birth weights on a broader scale by enhancing Smart Start and Kids Kare with measurable guidelines, e.g. measuring outcomes for Smart Start clients, measuring how many women are educated about preterm labor signs and symptoms.

Population Based Services:

The presentation package developed because of the American Public Health Association Maternal Child Health Community Leadership Institute (APHA) is nearly ready for dissemination. Updates need to be made in some of the data provided and it will need to go through a final Division approval process. After that, it will be shared with a variety of community groups and members, who will be asked to do presentations in their communities (i.e., churches, associations). In addition to disseminating the brochure, the Office of Minority Health's campaign will include a presentation package particularly aimed at black women from

a high or middle socio-economic background. Billboards throughout the state will stress the theme that Every Child Deserves a First Birthday. The billboards will include the Helpline (MCH hotline number). Information will be provided to hotline operators regarding healthy lifestyles and telephone numbers. The Office of Health Statistics provided an analysis of the increase in infant mortality. The population showing the increase was determined to be a population that Title V does not traditionally serve. The increase was caused by black mothers who were 30 or older, insured, married, have at least a high school education, and receiving care in the first trimester. This analysis, however, does not change the primary risk groups nor does it signify that we need to change our target groups. The Division of Public Health and the Perinatal Board are continuing to analyze the issue. The Division of Public Health has formed an internal work group to study both the increase in infant mortality and any ongoing changes to the population currently serviced. The group is further examining the data with the purpose of specifying target populations and reviewing the programs currently addressing infant health. Another area being examined closely is the disparity between black and white infant mortality during all periods of death, perinatal, neonatal, and post-neonatal. Although it is clear from our studies that improving maternal health is the key in addressing the racial disparity, more research is needed that better describes the socio-cultural, psychological, and behavioral influences on maternal health. Also, more model programs need to be developed

c. Plan for the Coming Year

Enabling Services:

The Black Infant Health Committee will be continuing discussion on: improvement of services for clients of all races, keep field service manual current, clarify additions, provide training on changes for current staff, orientation of new staff, and address racial disparities, infant mortality rates, and low birth weights on a broader scale by enhancing Smart Start and Kids Kare with measurable guidelines, (e.g. measuring outcomes for Smart Start clients) and measuring how many women are educated about preterm labor signs and symptoms.

Population Based Services:

The presentation package developed because of the American Public Health Association Maternal Child Health Community Leadership Institute (APHA) will be disseminated.

In addition to dissemination of the brochure, the Office of Minority Health's campaign will include a presentation package particularly aimed at black women from a high of middle socio-economic background. Information will be provided to hot-line operators regarding health lifestyles and telephone numbers.

The Division of Public Health and the Delaware Perinatal Board will continue to analyze the issue. An internal working group will continue to study both the increase in infant mortality and any ongoing changes to the population currently serviced. The group will further examine the data to specifying target populations and reviewing the programs currently addressing infant health.

On June 2, 2004 the honorable, Ruth Minner, Governor of the State of Delaware, established the "Infant Mortality Task Force" by executive order number fifty-six (56). The Infant Mortality Task Force is mandated to develop broad-based recommendations for the reduction of infant mortality in the state of Delaware. These recommendations will be based upon scientific evidence, defined partnerships, expected contributions, timelines, review, and evaluation. These recommendations encompass but are not limited to charges to business, community, education, communities of faith, providers, insurers, and the government.

DPH Title V will continue to support the efforts of the Infant Mortality Task Force to be implemented as per the Governor's Executive Order number fifty-six (56).

State Performance Measure 9: *(Decrease numbers of deaths from SIDS)The percent of children under age 1 who die as a result of Sudden Infant Death Syndrome.*

a. Last Year's Accomplishments

Direct and Enabling Services:

"Back to Sleep" continued to be emphasized in prenatal and postnatal teaching. DPH staff linked with the Medical Examiner's Office to receive all referrals statewide with pending SIDS diagnosis. Specially trained Title V (MCH) field staff provided home visits to these families to offer support, counseling and follow-up referrals as needed.

Population-Based:

Child Care Regulations were being revised that stated infants be placed on their backs to sleep. Side sleeping is no longer recommended because the infant can roll onto their stomachs. A meeting was scheduled with the CPR and First Aid trainers for child care providers to discuss how SIDS risk reduction will be incorporated into required training for licensure.

Infrastructure Building:

PRAMS 2000 data showed that a large number of infants were still being put to sleep on their stomachs. Only 37% of black mothers, 42% of teen mothers, and 47% of Medicaid eligible mothers were putting their babies on their backs. This information will allow us to better target the message.

b. Current Activities

Direct Services

DPH continues to focus on this objective through its clinic and field social workers and nurses who train all new mothers to avoid placing infants on their stomach to sleep.

Infrastructure Building

The Healthy Child Care newsletter will inform all childcare providers of the need to put babies on their backs and about the new license requirements.

Delaware has agreed to participate in a national survey with the Children's National Medical Center (CNMC) and the Association of SIDS and Infant Mortality Programs (ASIP). The purpose is to provide a database that will:

? Centralize state, regional, and national data so that trends can be detected and tracked.

? Ascertain the effects of the "Back to Sleep" campaign on particular populations at risk (including infants in child care, regional at-risk groups, etc.).

The software was provided but still needs to be installed, which has been delayed due to lack of staff and bio-terrorism priorities.

DPH will review two years worth of PRAMS data and begin to develop a plan for better targeting the Back to Sleep message.

Title V and other DPH staff continue to support the Perinatal Board in its efforts to decrease SIDS deaths.

c. Plan for the Coming Year

Direct Services:

DPH will continue to focus on this objective through its clinics, field social workers, and nurses who train all new mothers to avoid placing infants on their stomachs to sleep.

Infrastructure Building:

The "Healthy Child Care" newsletter will inform all childcare providers of the need to put babies on their backs and about the new licensing requirements.

Delaware has agreed to participate in a national survey with the Children's National Medical Center (CNMC) and the Association of SIDS and Infant Mortality Programs (ASIP). The purpose is to provide a database that will:

- * Centralize state, regional, and national data so that trends can be detected and tracked.
- * Ascertain the effects of the "Back to Sleep" campaign on particular populations at risk (including infants in childcare, regional at-risk groups, etc.).

The software was provided but still needs to be installed, which has been delayed due to lack of staff and bio-terrorism priorities.

DPH will review two years worth of PRAMS data and begin to develop a plan for better targeting the "Back to Sleep" message.

Title V and other DPH staff will continue to support the Delaware Perinatal Board in its efforts to decrease SIDS deaths.

State Performance Measure 10: *(Hospital discharge of asthma patients) Hospital discharge rate per 10, 000 children (5 years through 17 years of age) for Asthma (ambulatory care sensitive diagnosis).*

a. Last Year's Accomplishments

Title V staff had a leadership role to play in this area through 1) education regarding second hand smoke and asthma; 2) support for Kids Kare; 3) collaboration with duPont Pediatric Clinics and the American Lung Association on their efforts; 4) continual support for medical homes; and 5) the provision of information and training to child care providers.

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).

Infrastructure Building:

During the past year, DPH contracted with the Office of Child Care Licensing to provide additional information on asthma to child care providers. Several of the evaluations from those classes recommended a full class on asthma specifically information on managing asthma and the treatments (i.e. nebulizers, etc.) As a result, a new module, based solely on asthma management that will be offered starting August 2002.

The Department of Education conducted a Chronic Illness Survey during this past year. The report covered 82,245 students in Delaware primary and secondary schools in October 2001. The majority (64%) of these students went to schools in New Castle County; 21% and 15% went to Kent and Sussex County schools, respectively. The schools reported large numbers of students with specific chronic conditions. Among the most commonly reported was asthma. The statewide reported prevalence of asthma in school students was 8%. Prevalence did not differ significantly among the counties, but rates were higher among pre kindergarten (11.5%) and elementary (8.3%) than in intermediate and high school students. There was wide variation in prevalence among schools but a much smaller variation among school districts.

The median reported rate among schools was 8.0%. The Centers for Disease Control estimated the national asthma prevalence rate for persons 5-14 years old in 1994 to be 7.4%, with a significant increasing trend since 1980, and substantial regional variation. Reported rates in Delaware schools are consistent with this national estimate. Although this survey did not obtain detailed demographic information for each school, it is likely that the male: female ratio among students statewide is near 1. In that case, there appears to be a substantial excess of reported male students with asthma over the female rate, consistent with published studies.

b. Current Activities

Infrastructure:

The Department of Education Chronic Disease Survey results will need to be reviewed and analyzed as the report was just published and distributed. The Coordinating Council for Children with DisAbilities will review the results of the survey during the fall of 2003.

The Division of Public Health does not currently have an asthma program. State funding is anticipated in FY 2004 to work jointly with the state's Department of Natural Resources and Environmental Control to produce a Burden of Asthma in Delaware report. In addition, an application is being prepared for funding two Delaware communities through the Steps to a Healthier US grant program, which includes enhancement of asthma education and prevention. The position of Chronic Disease Director, which would normally oversee asthma efforts, is currently vacant and subject to a state hiring freeze.

Delaware's Behavioral Risk Factor Survey has been collecting data on asthma for the past two years, in preparation for the Burden of Asthma report and development of an asthma program when funding becomes available. In the 2002 BRFSS, 14% of Delaware adults reported a doctor or health professional that they have asthma had told them. The BRFSS in 2002 also included modules on adult asthma history and childhood asthma, which will be analyzed in depth for the upcoming report.

c. Plan for the Coming Year

Infrastructure:

The "Department of Education Chronic Disease Survey" results will need to be reviewed and analyzed as the report was recently published and distributed. The Delaware Coordinating Council of Children will review the results of the survey with disAbilities during the fall.

The Division of Public Health does not currently have an asthma program. State funding is anticipated in FY 2005 to work jointly with the Delaware Department of Natural Resources and Environmental Control to produce a "Burden of Asthma in Delaware" report. In addition, an application is being prepared for funding two (2) Delaware communities through the "Steps to a Healthier US" grant program, which includes enhancement of asthma education and prevention. The position Director for Chronic Disease, which would normally oversee asthma efforts, is currently vacant and subject to a state hiring freeze.

Delaware's "Behavioral Risk Factor Survey" has been collecting data on asthma for two years, in preparation for the "Burden of Asthma" report and development of an asthma program when funding becomes available.

In 2003, approximately twelve percent (12%) of Delaware adults reported having been told by a doctor, or health professional, that they had asthma. About seven and one half percent (7.5%) of the adult population reported currently having asthma. Approximately eighty-two percent (82%) of respondents with children under the age of eighteen (18) living in their household reported that at least one of the children had been diagnosed with asthma. That

means, at least forty-four thousand, nine hundred forty (44,940) households in Delaware have at least one (1) child with diagnosed asthma. The "Burden of Asthma in Delaware" report is currently being prepared for publication in the fall of 2004.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) (Tobacco use by Teens)The percent of youth reporting smoking 2 or more cigarettes per day on the days they smoke.				
1. Provide media, community programs, cessation, and coordination for tobacco use through the Tobacco P	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Eliminate the use of tobacco through the development and support of the school based health centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The Smart Start (reproductive) program will continue to advise clients, especially teenagers, on smo	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The Division will promote and enforce the state?s strict Clean Indoor Air Act.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Tobacco use/abuse is assessed at each client contact and resources for smoking cessation are suggested	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Trainer/educator provides smoking cessation classes to community as requested.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) (Alcohol Use by Teens)The percent of youth reporting any use of alcohol in the last thirty days.				
1. School based Health Centers provide individual counseling for alcohol and for children of alcoholics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. DPH staff, both at clinic visits and during home visits, assess alcohol use at each client contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The DPH Trainer/Educator provides educational sessions regarding alcohol use to the community as req	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Since the YRBS is only completed every two years, another survey will be undertaken next year.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The nurse practitioner distributed information on ?alcoholopops? to the local libraries	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) (Youth feeling so sad or hopeless)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.				
1. School Based Health Centers provide mental health services and referrals for identified adolescents.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The Division of Child Mental Health has a variety of programs and initiatives underway to address th	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The Department of Education provides annual grants to districts to improve student school climate. T	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Delaware Ecumenical Council on Children and Families continue work on conference planning committee to reach citizens, clergy, congregational health ministry volunteers, staff, and health professionals on issues related to violence and abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Depression screening is provided as indicated to ?at risk? clients. All individuals exhibiting symptoms are referred for immediate intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) (Increase numbers of Medicaid eligible children under 3 receiving lead screens)The percent of Medicaid eligible children under 3 years that received an initial blood lead screen.				
1. Complete a monitoring plan and form for appropriate case management for the reduction of blood level	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Conduct outreach and education efforts through community based organizations emphasizing lead poison	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Targeted education campaign toward physicians in areas with low percentage of children receiving blo	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Lead blood levels (LBL) are reported to the Disease; Prevention Team and entered into a surveillance database according to Case Management and Environmental Inspection Protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Lead screening is provided within immunization clinics according to age & risk factor. Testing kits are provided via federal funds to private providers serving high-risk populations. The Public Health Laboratory is performing all lead testing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Supported by the EPA grant, 4 articles focusing on lead & restoration of old bldgs were in Building History Newsltr, going to 500 Delaware	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Realtors/ individuals interested in restoration, and included info for the Office of Lead Poison Prevention				
7. Plans are being laid for the Delaware Association of Realtors to add to its website, the URL for the Office of Lead Poison Prevention and HUD.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) (Percent of pregnant women using tobacco)The percent of pregnant women delivering live-born infants reporting any cigarette smoking during pregnancy.				
1. Public Health clients are referred to Delaware?s smoking cessation program called the Delaware Quit!	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Counseling regarding smoking is provided during all Family Planning and Pregnancy test visits. Based	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. All Public Health staff, including Child Development Watch service coordinators, offer health teachi	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) (Adequate prenatal care for black women)The rate of infants born to pregnant black women receiving adequate prenatal care.				
1. DPH is working to ensure that Smart Start services are provided to all women needing them and to ens	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Preparing for a Healthy Baby: A Presentation Guide will be presented to community groups so that the	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. DPH provides ongoing support for the Wilmington Healthy Start consortium.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Efforts to decrease disparities in health care access within minority communities are a priority	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The disparity between races is a priority item is SHS. According to ? Families Count in Delaware?, the percent of African American females who receive appropriate pre-natal care is 72.9.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
7) (Increase birth interval to more than 18 months)The rate of live births to women who have had another birth at less than 18 months.					
1. Support for family planning, Smart Start and Home Visiting program activities ensure that the role o		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. DPH participates with the Sussex First Time Families Pilot Project was developed to establish unifor		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. DPH will work with its partners to disseminate the Preparing for a Healthy Baby: A Presentation Guid		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. A short interval between births is a risk factor for Smart Start services. Nurses provide education regarding the risk factors of onset of rapid pregnancies to prenatal and infant.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
8) (Decrease percent of extremely low birth weight black infants) The percent of extremely low birth weight black infants among all live births to black women.					
1. The Office of Minority Health developed a campaign to address black infant health. Brochures have be		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The Black Infant Health Committee works on improving field services. Brochures have been developed f		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Pregnant black teens are a service priority.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Black Infant Health Project members have proposed broadening the project to include additional populations.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB

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. As of October 1, 2003 Medicaid took over management of one of the managed care plans. 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.

//2005/ The WIC program has been organizationally moved to the Health Promotion and Disease Prevention Section. Communication and coordination between Title V and the WIC program will continue as in the past. //2005//

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

//2004/ 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, the development of the Early Childhood Comprehensive System plan. //2004//

//2004/ A representative from the Division of Vocational Rehabilitation (DVR), Department of Labor was requested to serve on the Coordinating Council for Children with disabilities (CCCD) but has not attended any meetings as yet. By including this perspective, we had hoped to be able to plan for adolescent transition issues. However a DVR representative has been attending the Brain Injury Committee of the State Council for Persons with Disabilities. Efforts are also being extended to include representatives from the Social Security Administration and the State Disabilities Determination Services unit on the CCCD.//2004//

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 about 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.

F. TECHNICAL ASSISTANCE

//2004/ The state is asking for continued technical assistance at this time. During this past year, CompCare of Health Systems Research has worked with the Coordinating Council for Children with disabilities on a major needs assessment project. The project is not yet complete. It includes both a

survey of every agency servicing CSHCN 0-21 and focus groups for families with CSHCN of adolescent age. //2004//

//2005/ On June 2, 2004 the honorable Ruth Minner, Governor of the State of Delaware, established the "Infant Mortality Task Force" by signing Executive Order 56. The request to technical assistance is to acquire a consultant with extensive maternal and child health experience to assist the Division of Public Health and the Community and Family Health section (where MCH sets) with the process of implementing the IM Task Force. Specific tasks required of consultant are:

**** Review and compile past documents reflecting efforts related to Infant Mortality in Delaware.***

**** Conduct interviews with key public and private stakeholders.***

**** Assist with the coordination of the Infant Mortality Task Force meetings.***

**** Facilitate the Infant Mortality Task Force in successfully reaching its goals as defined in Executive Order 56.***

**** Provide professional analysis and consultation to the Delaware Division of Public Health and to the Community and Family Health section on the above. //2005//***

V. BUDGET NARRATIVE

A. EXPENDITURES

The State maintains budget documentation for Block Grant funding/expenditures for reporting consistent with requirements.

B. BUDGET

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. The total match is \$8,795,104. It is made up of school based health center contract funds and salary/benefit dollars for positions providing Kids Kare, Child Development Watch, Smart Start and MCH administration. The match (including maintenance of efforts funds) is funded through state general funds. "Other" dollars are from the Newborn Screening Program. The federal support complements the state efforts for the already existing MCH programs listed above.

The increased funding for the application year is necessary given the increase in costs for health care insurance and other fringe benefits. This is the first increase in years for the block grant. In the past years, as state funded workers received a raise so did federally funded workers. As most of the grant is allotted for positions the past years of pay raises have taken its toll on the restricted budget.

The application's budget includes: \$2,113,130 for salaries and fringe benefits; \$57,141 for contractual services; \$227,620 for indirect costs and \$6,000 for travel, supplies duplication costs, telephones, etc.; and \$4,176 for audit fees. The budget forms provide more detailed explanation. The total federal budget is for \$2,408,067. \$725,420 is provided for preventive and primary care for children. \$722,420 is provided for children with special health care needs. Match is based on salary/benefits dollars allotted to personnel providing services to those populations and on a proportion of dollars allotted to support those positions.

VI. REPORTING FORMS-GENERAL INFORMATION

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

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

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

VIII. GLOSSARY

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

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

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

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

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

D. ANNUAL REPORT DATA

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