



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

**State Narrative for  
Delaware**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

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

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **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 Alisa Olshefsky, M.P.H, Director of Maternal and Child Health or Leah Jones, MCH Deputy Director. The State MCH Program Office is located at 417 Federal Street, Jesse Cooper Building, Dover, DE 19901 (The State Public Health Administration Building).

### **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 March 2009; expires March 31, 2012.

### **E. Public Input**

The MCH Bureau initiated a series of intimate in-person "listening sessions" or "coffee klatches" all across Delaware in early April 2010 targeting families of CYSHCN. Sessions lasting 1.5 hours were set for seven sites across all three Delaware counties at well known and easily accessible State Service Centers. A Spanish language interpreter was available. Sign language interpretation was available on request. Both English and Spanish language flyers were disseminated across various partner and contractor email lists and listservs and websites. Turnout was not as high as hoped. However this was the first year of the strategy, the MCH program is confident that this strategy should be institutionalized and become a part of regular outreach to families of CYSHCN.

In April 2010, the Family Support Initiative (FSI), in partnership with MCH, held a partner meeting with CYSHCN-serving organizations and parent-led groups. During the meeting, the Title V needs assessment was discussed and participants were asked to share an executive summary and brief survey with all the parents and families they represent or connect with on a daily basis. Families could select to provide survey feedback via email, web survey, or hard copy through a self-address stamped envelope. Families were asked to respond to three core questions in addition to free form comments:

- If you could give advice to service providers about how they can improve family/individual involvement in decision-making, what would you say?
- Do you feel that our performance measures are on track as it relates to those who support families with special health care needs?
- Is there anything else you would like to tell us that would help us understand how families of children with special health care needs can be served better in Delaware?

Family feedback was incorporated into the final version of the state priorities around CYSHCN. The support of community organizations involved in FSI was essential to wide spread dissemination of the survey. They endorsed the process and shared the information with families they serve.

In May 2010, the MCH program presented to the Delaware Healthy Mother & Infant Consortium regarding the needs assessment. Similar to the CYSHCN forum, DHMIC members were provided an executive summary and asked to complete three questions about the proposed state priorities. The DHMIC was an ideal forum for feedback since the coalition is composed of over eighty organizations serving women, families, infants and youth. Feedback was provided via email and web-based survey.

In the web-based survey, parents were asked what advice they would give to providers and whether the performance measures for CSHCN were "on track." Parents (n=5) responded that providers should make more information available to families, ask families directly for their feedback, respect the input of families and eliminate bureaucratic barriers in the referral process. Parents thought that generally, the performance measures were on track in measuring their concerns, however there was some sentiment that the performance measures were vague in terms of measuring effectiveness.

//2012/ In 2011, the MCH Title V Director and Deputy Director have made a concerted effort to introduce and incorporate the ten MCH priorities into stakeholder meeting discussions and strategic activities, identified through Delaware's five year needs assessment. Delaware provided the following opportunities for public input:

- Public Health Web Posting
- Outreach to stakeholders (Delaware Healthy Mother Infant Consortium, Family SHADE, Family to Family Health Information Center, councils and consortia)

Planning is under way for 2012 to develop new "Meet and Greet" forums (i.e. listening sessions, coffee klatches), similar to what was initiated in April 2010, whereby the MCH Deputy Director will develop a brief road show power point presentation and share all of the current project initiatives that address the top ten MCH Priorities, identified in the Needs Assessment, with stakeholders and families. The Meet and Greet forums will also serve as an opportunity to share knowledge and expertise, build collaborative partnerships, and encourages an open and ongoing dialogue to address MCH priorities. //2012//

***//2013/ As planned, MCH developed and delivered a series of comprehensive presentations highlighting the ten MCH priorities, the life course perspective, and embarked on an effort to embed and align federal initiatives under a comprehensive and coordinated early childhood framework called Help Me Grow. This outreach strategy was intended to share Public Health's overall goal to improve maternal and child health in DE, and communicated to our partners that we are not only trying to close the gaps in access, quality, and prevention in our MCH system, but in order to do this, we must also carve out a role for MCH in other sectors to ensure that all moms are healthy and children can grow to their full potential. A series of tailored presentations were made to key state and federal partners, some of which included a webinar prepared for the National Help Me Grow Technical Assistance Center, a federal webinar through the Maternal Infant and Early Childhood Home Visiting Program (sponsored by HRSA and Zero to Three), Family SHADE (CYSHCN partners) network, the Governor's Early Childhood Advisory Council, the Home Visiting Community Advisory Board, the Lieutenant Governor's Help Me Grow Summit, and Delaware's 7th Annual MCH Summit. The fruits of our labor paid off, as the MCH Director, Deputy Director and the DPH team demonstrated to the community that MCH is a collaborative partner, with strategic vision and leadership, and is a convener across sectors.***

**A three to five page "Title V Briefing Paper" that serves as an executive summary was updated and prepared describing Delaware's Title V MCH priorities, performance measures, and types of programs funded. As part of the section on its web site dedicated to Title V**

**<http://www.dhss.delaware.gov/dhss/dph/chca/dphmchhome.html>**

**Delaware also has additional pages and links about Title V, including a link to the application narrative and forms, and a dedicated email address to send comments at any time.**

**Working with the DPH Office of Health Risk and Communications, a public relations strategy for the Title V MCH Block Grant was developed to include:**

- Web posting**
- Poster**
- Posting on DHSS Facebook (<http://www.facebook.com/DelawareDHSS>) and twitter ([http://twitter.com/Delaware\\_DHSS](http://twitter.com/Delaware_DHSS))**
- Circulation of the Executive Summaries describing MCH Priorities and performance measures to advisory boards, councils, and consortium via e-mail listservs**
- Four Mall Kiosk Ads -- two each at Christiana Mall and Dover Mall**
- A series of three Focus groups were held statewide (one in each county) targeting Title V MCH Block grant target population (18-44), women who are planning to get pregnant in the near future, expecting parents, fathers, parents with children and parents with children with special health care needs. Focus groups were facilitated with a discussion guide developed in collaboration with Title V staff. The full report is attached.**

**Among the findings from the focus group concerning barriers and access are:**

- Women lack affordable health care, financial ability and education were barriers**
- Expectant mothers, education is a barrier**
- Barriers for mothers are babysitting challenges, ability to take time off from work for appointments, affordability issues and putting themselves last**
- Transportation and fear of results from medical testing are major barriers for women of child bearing ages**
- Parents are often challenged with time management and this presents barriers in terms of taking children to appointments**
- Barriers for women receiving health care are: health insurance limitations, personal time management and priorities, personal responsibility, emotional issues and lack of information**

**For families with children with special health care needs:**

- They receive health treatment for themselves and their children from family doctors, pediatricians, specialists and clinics.**
- Private insurance has limitations in meeting their child's needs**
- More help is needed from the school district before the child reaches school age.**
- Respondents with public health insurance did not experience limitations.**
- Respondents had out of pocket costs relating to their children's health care including: prescriptions, medications, gas and co--pays. //2013//**

**An attachment is included in this section. IE - Public Input**



## II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

Delaware continues to focus on the life course approach. Adopting this approach required building strategic partnerships early in both public health, education and the medical arena to identify multiple points for intervention at different and important stages during people's lives: school, community, clinical and work settings; before, during and after pregnancy; at the time of childbirth, during childhood and so on. Delaware MCH recognizes that health of individuals and populations is a consequence of multiple social determinants (behavioral, biological, environmental, psychological, and social factors) and that collective efforts lead to collective impact.

One of Delaware's most pressing and exciting challenges over the last year was the recent success in leveraging several large federal grants, including the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant and Competitive MIECHV grant, the Race to the Top K-12 and Early Learning Challenge grants. All grants require cross-sector collaboration with our stakeholders and compressed implementation timelines. Work over the last year focused on embedding federal initiatives (i.e. Home Visiting, Race to the Top K-12 and Early Learning Challenge, CYSHCN D70 State Implementation grant, etc.) under a universal and holistic framework. It was truly an eye opener and helped Delaware identify successful components: maximize efficiencies through shared resources, leverage and partner with new and existing organizations working across sectors, identify a visible Leader and Champion (Lieutenant Governor Matt Denn), build capacity through technical assistance and training, "look in the mirror" and be flexible, talk about real solutions, and measure and evaluate results that matter. Finally, the use of social marketing and "framing" or using the same language is absolutely essential to move the "meter" and encourage the public into action.

Through the collaborative Delaware Healthy Mother Infant Consortium, strategies continue focused on the women's health, her family, her health care provider and her community. Aligned with the State of Delaware 2010 MCH Needs Assessment [Maternal and Child Health Title V Five Year Needs Assessment], the Consortium focused on:

- Social determinants of health and the social context in which people live, learn, work and play and how that affects their health.
- Preconception Peer Education for the next generation
- Health Equity and how differential access to health-enhancing resources and/or exposure to health compromising factors result in health disparities; understanding the Black-White Disparity in infant mortality rates.
- Safe Infant Sleeping practices and social factors in the home, and how sleeping arrangements can endanger the lives of infants; develop recommendations for preventing infant sleep related deaths
- Breastfeeding and strategies for encouraging providers and families to support breastfeeding
- Financial and social implications of fatherhood and the role of the male partner in pregnancy outcomes and the importance of improving male partner responsibility in birth control and family planning.

While Delaware continues to see some results in prematurity, low birth weight and infant mortality over time as a result of the important work of the Delaware Healthy Mother Infant Consortium, there is still a lot more work to do. The infant mortality rate in Delaware dropped 10% from its peak of 9.3/1,000 births (2000--2004) to 8.3/1,000 births (2005--2009). According to the March of Dimes, Delaware's preterm birth rate is 12.6% of all births, which is an 8% reduction since 2005.

During the 2005-2009 time period, the DE infant mortality rate for African Americans (15.6/1,000births) was almost triple the rate for non-Hispanic whites (5.7/1,000 births). The teen birth rate is at an all time low in the U.S, however, Delaware is still above the U.S. rate and is highest in Sussex County. The birth rate to single mom's are also on the rise in Delaware (48%).

The Healthy Women, Healthy Babies framework continues to improve women's health, mental health and nutrition before, during and after pregnancy. In 2011, the program offered 16 types of services

New and exciting prenatal and preconception strategies include:

Male Preconception Health Campaign ("Man Up, Plan Up") - A website was developed, targeting males between 19 and 28 years of age, which uses a scrolling technique and allows items on the page to flow quickly and is easy to see on a Smart Phone. The site offers educational tools and links to resources and services with eye catching captions: Think About It, Way to Man Up, and Myth Busters. The site also offers facts about men's health including but not limited to Sexually Transmitted Diseases, offering resources and information on testicular cancer and other men's health issues, links or information on; domestic violence, Fetal Alcohol Spectrum Disorder (FASD) and the effect on a child born with FASD, and respect for your mate/mother. Delaware's site is targeted specifically at males by communicating as males would communicate with each other. The campaign concepts have been tested in the community during small forums for men between ages 15-26 at the Neighborhood House and Kingswood Community Center, to get feedback on the campaign. Over the next year, efforts will be made to identify champions in the community to increase awareness (i.e. College marketing majors, male nursing students, fraternity brothers, young leaders and advocates in the community, etc.)

Pregnant/Postpartum Website - The goal of the Pregnant/Postpartum Website is to link women with resources and services. The site is divided into two major areas; Expectant Mothers and New Mothers (i.e. your physical health, emotional health, and baby's health). Visitors to the site are directed by which topic they chose to click on and will be linked to services, resources, and information regarding that topic. This site is a work in progress and the language is still be tweaked with valuable feedback from the DHMIC's Education and Prevention Committee. The Committee commented on the initial appeal of the site, which focuses on the top issues most important to Delaware's female population but will offer links to national websites, immunization information, and the WIC site.

Teen Life Plan Video Contest - In an effort to increase traffic to the Teen Life Plan available by visiting [facebook.com/MyLifeMyPlan](http://facebook.com/MyLifeMyPlan), planning is underway to develop a contest in the Fall 2012, "Plan it, Vid it, and Win it!" Teens between the ages of 15-18 will be targeted at local high schools, youth programs, Boys and Girls Clubs, etc. about the video contest, and will promote the use of social media as a means to identify their goals in life and write down specific steps for developing healthy relationships and healthy lifestyles. The teens will post the video of their life plan on facebook, and the more "LIKES" they get, along with a review panel convened through the Delaware Healthy Mother Infant Consortium's Education and Prevention Committee, increases their chances of winning.

Safe Sleeping Workgroup -- Established in 2012, the work group is focused on ways to promote Safe Sleeping Practices through a two prong campaign approach (consumer and providers) and will be rolling out both at the same time. The group has been meeting since February 2012 and plans to launch the full campaign in Fall 2012. The Work Group is working on creating messages with positive tones impressing safety, and will look at communicating best practice standards, role modeling, patient education, postpartum phone calls by birthing hospitals, tool kits for providers, training for providers through the National Institute of Child Health and Human Development (NICHD) via a state online portal, and quality assurance.

Delaware's state priority #7 continues to be an important focus. Family SHADE is truly one of our

star initiatives and plays a critical role through-out the five year life cycle of the MCH Needs Assessment process. Family SHADE (Support and Health Care Alliance Delaware), an umbrella organization and network of 40+ partners, is member driven with the mission to provide strategic guidance, family involvement, and coordination of services for children and youth with special health care needs and their families.

The University of Delaware, Center for Disabilities Studies, continues to provide lead staff support to firmly guide the overarching goals of Family SHADE. The Project Director and a Project Coordinator guide the development of a member-driven "umbrella" initiative. Over the last year, the Advisory Board maintained its commitment to the development of an organization that could coordinate information and resources for CYSHCN and their families. The Advisory Board worked over the last year to develop a mission and vision statement for the organization, as well as a new name (Family Support and Healthcare Alliance DElaware or Family SHADE) and a logo that represents the family-friendly nature of the organization that they were shaping. The dedicated Family SHADE Advisory Board then continued to develop a strategic plan for the organization and adopted Bylaws that carefully laid out the criteria for voting and collaborative membership, a governance structure for Family SHADE consisting of a three-year rotation of Advisory Board members, and officers consisting of a Chair, Vice Chair and Secretary.

In addition to the development of an infrastructure for the organization, over the past year Family SHADE has offered technical assistance workshops to its members and other interested organizations that serve CYSHCN.

NOTE: The remainder of this discussion is included in the next section, Overview.

### **III. State Overview**

#### **A. Overview**

Continued from Needs Assessment Update for 2013

In addition to the development of an infrastructure for the organization, over the past year Family SHADE has offered technical assistance workshops to its members and other interested organizations that serve CYSHCN. These workshops have addressed topics such as strategic plan development and effective proposal writing, both of which were funded through technical assistance provided by Title V. Family SHADE staff also conducted a networking "mixer" where organizations had an opportunity to describe the work that they do and share resources and information about upcoming activities.

CDS staff also presented information about Family SHADE at numerous health fairs, Board meetings, and conferences including the LIFE conference (the largest disability-related conference in Delaware) and at the 2012 AMCHP conference.

Family SHADE's broad network of organizations enables the rapid dissemination of information to CYSHCN and their families throughout Delaware. A new Family SHADE project, Families Know Best, will provide a mechanism whereby families can offer regular feedback about the services they receive and quickly bring new concerns to the attention of service providers and policymakers. Families Know Best will conduct periodic online surveys of participating families and their suggestions will be shared with Family SHADE partnering organizations as well as with policymakers when appropriate. This will enable service providers to rapidly tailor their services in response to the needs that families express.

In addition to working to improve the quality of life for CYSHCN and their families, Family SHADE strengthens and supports its partner organizations by providing technical assistance in areas such as grant writing, strategic planning, and fundraising, and by coordinating existing expertise among Family SHADE partners. Family SHADE also provides information regarding funding opportunities to its member organizations and encourages collaborative initiatives that leverage funding among its members to develop new services, or to improve or increase the capacity of existing services. Member organizations have been awarded funding through Family SHADE grants for outreach to Hispanic families of CYSHCN in Sussex County, to identify gaps in services and supports to children and youth with chronic health care needs in Delaware, and to recommend strategies that will lead to improved services and supports to these families.

#### **Title V Agency Overview**

The Delaware Department of Health and Social Services (DHSS) consists of 12 distinct divisions and the Delaware Health Care Commission with an overarching mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. The Delaware Division of Public Health (DPH), the largest division within DHSS, is the Title V agency responsible for planning, program development, administration and evaluation of maternal and child health (MCH) programs statewide. DPH is led by Karyl Rattay, MD, MS, FAAP, FACPM who serves as the Division Director. Within DPH, the Family Health and Systems Management (FHSM) section has direct oversight of Title V, as well as a number of other MCH programs including the Children with Special Health Care Needs (CSHCN), the Early Childhood Comprehensive Systems (ECCS) Program, the Newborn Metabolic Screening Program, the Newborn Hearing Screening Program, the Birth Defects Registry, the Autism Registry, the State Systems Development Initiative, the Adolescent Health Program, the Infant Mortality Elimination Program, the Center for Family Health Research and Epidemiology, the Title X Family Planning Program and the Health Systems Management Bureau (including program management of rural health, Federally Qualified Health Centers [FQHCs], and the Conrad State 30/J-1 Visa Program -a recruitment program for physicians).

FHSM is managed by a Section Chief, Alisa Olshefsky, MPH, who also serves as the state's Maternal and Child Health Director. FHSM is structured into four Bureaus: The Maternal & Child Health Bureau (which directly administers Title V), the Adolescent & Reproductive Health Bureau, the Center for Family Health Research and Epidemiology and the Bureau of Health Resources Management.

***/2013/ Family Health Systems (FHS) Section, recently renamed, is managed by the Section Chief, Alisa Jones, MPH, who also serves as the state's Maternal and Child Health Director. FHS is now structured into three Bureaus: The Maternal & Child Health Bureau (which directly administers Title V), the Adolescent & Reproductive Health Bureau, the Center for Family Health Research and Epidemiology. The Bureau of Health Resources Management was renamed as the Office of Health Reform and was also structurally moved under the Office of the DPH Director. Furthermore, as a result of a new CDC grant, Violence Injury Prevention Program grant, injury prevention activities and initiatives were moved under the Family Health Systems Section. //2013//***

/2012/In addition to programmatic efforts under FHSM, the Title V MCH Block Grant Program funds staff positions in community public health clinics for three key programs. These programs are Smart Start, Child Development Watch (CDW), and the State's Oral Health Program. Field staff is under the direction of the State's Medical Director, Herman Ellis, M.D. Smart Start is a prenatal program addressing women at-risk for poor birth outcomes and focuses on child health for children through 3 years of age. Over the last year, Public Health's home visiting program, Smart Start, went through a rigorous planning process to transition to a comprehensive "evidence-based" home visiting program under the Healthy Families America model. As part of a comparative analysis led by the Delaware Maternal & Child Health Bureau during 2010, an assessment was completed of DPH home visiting services. The MCH program provided leadership on a project to assess the applicability of evidence-based home visitation. In collaboration with other community-based MCH organizations, the state is integrating a comprehensive home visiting program where families are referred to different programs through a centralized intake (e.g. Nurse-Home Visiting, Healthy Families America and Parents as Teachers) depending on needs and eligibility. CDW is a program dedicated to screening, case management and referral for CSHCN from birth through 3 years of age and their families. The Oral Health Program provides preventive dental services to children. In addition to Title V funds, state general funds and appropriated special funds (fees, revenue, for example) also support staff in these programs. //2012//

***/2013/ DPH recently developed a centralized intake system (a free telephone access point) for home visiting through Help Me Grow 2-1-1. This universal approach provides pregnant women and families with children (birth to 8) one access point to connect with existing community support and services. Help Me Grow is a multi-sector collaborative initiative to develop, implement and promote a comprehensive and coordinated early childhood system. This is accomplished first, by creating a centralized telephone access point for children and their families, in partnership with the 211/United Way of Delaware. Physicians and other health care agencies can refer pregnant women and families with children to a centralized call center, Delaware 2-1-1, which is part of United Way of Delaware. Delaware 2-1-1 already provides referrals for a full range of health and human service needs and now with a Help Me Grow focus, 211 specialists with an early childhood background can provide parent education and support and existing resources statewide. //2013//***

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

- developing, coordinating and evaluating programs and initiatives to improve the health of women, infants, children, adolescents and those with special health care needs;

- monitoring health status through newborn screening (metabolic disorders and hearing), birth defects and autism registries;
- eliminating disparities in maternal and child health outcomes, including infant mortality;
- ensuring access to adolescent health care services through School-Based Health Centers (SBHCs) and implementing programs to reduce teen pregnancy;
- applying epidemiology and research to improve delivery of quality health care to women, children and families;
- enhancing reproductive health and ensuring access to family planning services;
- translating evidence into practice to improve early childhood comprehensive systems of care; and
- ensuring health systems across the state have the ability to meet Delawareans' health care needs by focusing on primary care, rural health, identifying and addressing health care provider shortages, and helping to improve access to data and health information. FHSM's programs address the following areas.
  - The Children with Special Health Care Needs program works closely with Child Development Watch, the state's birth to three program, and other organizations throughout the State to coordinate services and address key issues including transition to adult services, family involvement and capacity building. In the past year, a major addition to the CSHCN program has been the implementation of a Family Support Initiative, through the University of Delaware's Center for Disabilities Studies, to provide coordination and other support among the state's assorted organizations and groups that serve families with Children with Special Health Care Needs.
  - The ECCS Program partners with organizations throughout the state to plan, to develop and to implement partnerships to support child development and ensure that all Delaware's children are healthy and are ready to learn at school entry. ECCS is instrumental to the planning and development of the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program.
  - The Newborn Metabolic Screening Program and Newborn Hearing Screening Program screen newborns for metabolic conditions and hearing deficiencies, as well as maintain the state's Birth Defects and Autism registries.
  - The State Systems Development Initiative works with Title V in building capacity for data analysis and the linking of MCH datasets. SSDI also is a key participant in the development of an early childhood data system under the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program, as well as the MCH needs assessment process. SSDI also works closely with the Center for Family Health Research and Epidemiology on pilot studies.
  - The Infant Mortality Elimination Program funds contractual programs for at-risk pregnant women and preconception programs for women (Healthy Women, Healthy Babies. The Infant Mortality Elimination Program's initiatives also include a research component (including the Pregnancy Risk Assessment Monitoring Surveillance survey) carried out through the Center for Family Health Research and Epidemiology and the State's Fetal Infant Mortality Review (FIMR) Program (through the Administrative Office of the Courts).
  - Title X, the federal Family Planning Program, works closely with Title V on a wide range of issues including teen pregnancy prevention, preconception care and women's health issues.

- School-Based Wellness Centers are located in high schools statewide and provide preventive services to students.
- Teen Pregnancy Prevention programs (Wise Guys and Making Proud Choices) are offered throughout the state to reduce the risks of STDs and the incidence of teen pregnancy.

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

### Population Characteristics

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

According to the latest population estimates, in 2010 the State of Delaware had about 896,880 residents, of which 75% were Caucasian and 21% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 539,590 residents or about 60% of the state's total population. New Castle County also has a large population of African-American residents (about 24%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 55 percent of the city's population). New Castle County also has the largest proportion of Hispanics. Kent County and Sussex County, located in the southern two-thirds of the state, are more rural than New Castle County. In 2010, the estimated population of Kent County was about 159,980 residents (75% Caucasian and 23% African-American). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2010 population was about 197,310 (85% Caucasian). Since 2000, the State's population has increased by about 14.0 percent.

In 2010, statewide, it is estimated that there are about 172,250 women of childbearing age (15-44 years of age) and 253,000 infants, children and adolescents aged 0-21 years of age. Annually in the state, about 13,000 infants are born.

### Economic Indicators

In Delaware, from 2008-2010, it is estimated that 15.2% of children, aged 0-17, were living in poverty, with the highest rates among those children aged 0-5 (17%). Children in Kent and Sussex County are slightly more likely to live in poverty than children in New Castle County (17.8% vs. 13.8%). During the same time period, 19.6% of Delaware's children lived in a household with underemployed parents (where no parent worked full-time, year round). Over one-quarter (28.3%) of children from single parent households in Delaware lived in poverty compared to 6.8% of children living in two parent households. The median income of two parent households in Delaware from 2008-2010 was \$85,393 compared to \$28,599 for single parent

households and \$26,202 for female-headed households. Of Delaware's children, 35.6% lived in a one-parent household in the 2008-2010 time period. Almost half (45.4%) of births occurring in the five year period 2004-2008 were to single mothers with 71.5% of African American births occurring among single mothers compared to 37.7% of Caucasian births occurring among single mothers (Kids Count in Delaware, 2011). It is estimated that 13.5% of Delawareans below the age of 65 are without health insurance. As of August 2010, 68,738 adults and 60,849 children received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP) and 2,632 adults and 9,271 children received cash assistance through the Temporary Assistance to Needy Families Program (TANF) (KIDS Count in Delaware, 2011).

As with much of the nation, the current overall economy in Delaware is the worst since the mid-1970's. As of April 2011, Delaware's seasonally adjusted unemployment rate was 8.2% (compared to 9% nationally) (Delaware Department of Labor, May, 2011). This is the lowest in Delaware since August 2009, when the unemployment rate was on the rise to a peak of more than 10 percent. Over recent years, the greatest job losses have occurred in federal government, wholesale trade, transportation, and utilities (Delaware Department of Labor, May, 2011). Currently, Delaware's largest employment sector is Trade, Transportation and Utilities (18% of the non-farm workforce), followed closely by education and health (16%), and government (15%) (Delaware Department of Labor, May, 2011).

#### Geographic Health Disparities

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

Delaware, like other states, faces a shortage of health professionals. Specifically, Kent County, Sussex County, and parts of the City of Wilmington have been federally designated as health professional shortage areas. There are particular shortages among primary care physicians, dentists, nurses and mental health professionals. Ultimately, these shortages threaten the ability of health care entities in Delaware to provide timely access to quality care.

//2012/ At the request of the State Office of Primary Care and Rural Health, the federal government designated the Middletown and Odessa area and the Claymont and Edgemoor area as Governor's Medically Underserved Population (MUP) areas. The designation qualifies existing or new healthcare entities within those areas to qualify for state and federal resources, including federal funding through the Federally Qualified Health Center program. Westside Family Health is interested in expanding services to underserved areas.

Mental Health Professionals in Delaware 2009 report, published by the Division of Public Health in collaboration with the University of Delaware's Center for Research and Applied Demography, assesses the supply and distribution of mental health professionals, including psychiatrists and mental health specialists. It will be used to assess if federally-designated mental health shortage areas meet minimum requirements and if new areas qualify. Within four years, Delaware lost 43 full-time equivalent (FTE) mental health professionals due to payment and insurance challenges. In 2005, there were 534 mental health professionals (stateside ratio of each FTE mental health specialist was 1:2,000 persons and each FTE psychiatrist was 1:7,075 persons). However, by 2009, there were 491 FTE mental health professionals (stateside ratio of each FTE mental health specialist was 1:2,209 persons and each FTE psychiatrist was 1:9,582 persons). //2012//

Statewide, the percentage of women accessing prenatal care in the first trimester was higher than the national average for the five year period 20012002-2005 2006 (87.482% for Delaware vs. 72.766.7% for the United States). In the most recent available two five year periods (20022003-2006 2007 and 20032004-20072008) however, the statewide percent of women accessing prenatal care in the first trimester has been declining (8278% and 7873.9%, respectively). This decline has been reported in each of the state's three counties, as well as the city of Wilmington. In the 20032004-2007 2008 reporting period, Sussex County was lowest in terms of pregnant

women accessing prenatal care in early pregnancy (6359.3.4% vs. 71.568.9% for Kent County, 84.580.2% for New Castle County and 77.973.4% for the City of Wilmington). It is important to note that these data were reported prior to full scale operation of the State's current Infant Mortality indicatives (Healthy Women, Health Babies).

/2012/ According to the National Vital Statistics System (2009), the rate of preterm births in Delaware has been consistently higher than of the nationwide rate and in 2007, Delaware ranked 8th in the nation for babies born low birth weight. Prematurity and low birthweight were the leading sources of infant mortality in Delaware, causing 24 percent of infant deaths in Delaware in the 2004-2008 period. Given these figures, the need to reduce preterm births is of the utmost importance to the state. Reducing preterm births is a priority need established by Delaware's 2010 MCH Needs Assessment. //2012//

***/2013/ Delaware's infant mortality rate has decreased for the fourth consecutive reporting period, dropping by 10 percent. When the Consortium began its work, our infant mortality rate stood at 9.3 deaths for every 1,000 live births. That rate is down to 8.3 deaths according to the last reporting period of 2005 to 2009. In 2005-2009 the five leading causes of infant death were:***

***- Disorders related to short gestation and fetal malnutrition (prematurity and low birth weight), which***

***accounted for 24.8 percent of infant deaths,***

***- Congenital anomalies (birth defects), which accounted for 12.7 percent of infant deaths,***

***- Newborn affected by maternal complications of pregnancy, which accounted for 9.8 percent of infant***

***deaths. Of the 48 deaths attributed to this cause, 46 were due to the newborn being affected by***

***incompetent cervix and premature rupture of membranes,***

***- Sudden infant death syndrome (SIDS) accounted for 8 percent, and***

***- Newborn affected by complications of placenta, cord, and membranes (4.5 percent).//2013//***

From 2004-2008, in terms of birth outcomes, Wilmington is the geographic area with the highest percentages of low birth weights (13.4% compared to 9.1% statewide) and very low birth weights (2.8% compared to 1.9% statewide).

From 2004-2008, New Castle County had a higher infant mortality rate than the state as a whole (9 infant deaths per 1,000 live births compared to 8.4 infant deaths per 1,000 statewide). However, the driving force in New Castle County infant mortality is within the City of Wilmington (13 infant deaths per 1,000 compared to 9 infant deaths per 1,000 in the balance of the county).

The City of Wilmington and Sussex County have the highest teen birth rates (86.0 and 60.3 births per 1,000 females aged 15-19) over the five year period 2004-2008. Statewide, the teen birth rate during this period was 43.1 (compared to 41.6 births per 1,000 females nationally). In the state in general, the teen birth rate among black teens exceeds the teen birth rate among white teens (66.4 vs. 35.2 births per 1,000 females aged 15-19). In the City of Wilmington, however, the teen birth rates are comparable among both black and white teens (91.1 vs. 92.5 live births per 1,000 females aged 15-19, respectively).

Among 11th grade students, Sussex County has the highest rates of youth tobacco (18% compared to 14% statewide). Kent County has the highest rates of alcohol (39% compared to 37% statewide). New Castle County has the highest rates of substance use (25% compared to 24% statewide).

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

According to the 2000 U.S. Census, Kent County is the county with the highest risk of poverty ratio (2.5, comparing female headed households to male householder families). However, both Kent and Sussex Counties exceed the statewide percent of female headed household families living in poverty (30.2% and 31.1%, respectively, compared to 26.3% statewide).

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

#### Racial/Ethnic Disparities

In 2008, the Office of Minority Health released the Delaware Racial and Ethnic Disparities Health Status Report Card. This report highlighted many problematic indicators of health disparities between African-Americans, Hispanics and Caucasians (the reference group) using a "disparity ratio" as the indicator. The African-American Infant Mortality rate from 2001-2005 was found to be 2.5 times that of Caucasians (17.1 vs. 6.8 per 1,000 live births). For the same time period, the percent of Hispanics with late or no prenatal care was 2.7 times that of Caucasians (9.1 vs. 3.4). The rate of diabetes among African Americans in Delaware from 2001-2005 was 2.2 times that of Caucasians (49.2 vs. 22.5 per 100,000 population). For the same time period the adjusted HIV mortality rate among African Americans was 14.5 times that of Caucasians. The report also noted that among Hispanics, the birth rate to teenage mothers was 3.8 times higher than Caucasians from 2001-2005 (131.4 vs. 34.4 per 1,000 females, age 15-19).

#### Children and Youth with Special Health Care Needs (CYSHCN)

//2012//Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills. In 2007, 19% of children nationwide under age 18 years were classified as having special health care needs (i.e., children with an increased risk of chronic physical, developmental, behavioral, or emotional conditions and who also required health and related services of a type or amount beyond that required by children generally). In 2007, 24% of children under age 18 years in Delaware were classified in this manner; this places Delaware (along with Alabama, Arkansas, Kentucky, and Louisiana) as the states with the highest percentage of children with special health care needs. This is an increase from 15% in 2001 and 17% in 2005-2006.5 //2012//

***//2013// With the recent release of the 2009/2010 National Children and Youth with Special Health Care Needs Survey, 17.5% of children in Delaware had special health care needs, bringing Delaware's rank down to 13th nationwide. In the 2005/2006 survey, Delaware had the same percentage of CSHCN, however, DE ranked 5th nationwide at that time. Based on this information, DE ranking has improved overall when compared to other states.***

***In the 2009/2010 survey, DE has shown improvement on several indicators and/or fairs well when compared nationwide:***

***Indicator 1/Child Health: In the 2005/2006 survey, 20.4% of Delaware's children with special health care needs had "conditions that affected their activities usually, always, or a great deal." In the 2009/2010 survey this percentage remained unchanged at 20%. This compares to 27.1% of children with special health care needs nationwide.***

***Indicator 5/Health Insurance Coverage: In the 2005/2006 survey, 32.2% of Delaware's currently insured children with special health care needs had inadequate insurance for their needs. In the 2009/2010 survey, however, this percentage dropped to 25.5%. This compares to 34.3% nationwide.***

**Indicator 8/Access to Care:** In the 2005/2006 survey, 24.3% of Delaware's children with special health care needs needing a referral had difficulty getting it. In the 2009/2010 survey, however, this percentage had decreased to 19.1%. This compares to 23.4% nationwide.

**MCHB Core Outcome #1:** In the 2009/2010 survey, 72% of Delaware's families with children with special health care needs were partners in shared decision --making for their child's optimal health. This compares to 70.3% nationwide.

**MCHB Core Outcome #3:** In the 2005/2006 survey, 63.2% of Delaware's children with special health care needs were in families that had adequate private and/or public insurance to pay for the services they need. In the 2009/2010 survey, this percentage had increased to 69.9%. This compares to 60.6% nationwide.

**MCHB Core Outcome #4:** In the 2009/2010 survey, 84.6% of Delaware's children with special health care needs were screened early and continuously for special health care needs. This compares to 78.6% nationwide.

**MCHB Core Outcome #5:** In the 2009/2010 survey, 69% of Delaware's children with special health care needs could easily access community based services. This compares to 65.1% nationwide.

**Although DE did well on several indicators, a couple of areas seemed to need further attention:**

**MCHB Core Outcome #2:** In the 2009/2010 survey, 41.4% of Delaware's children with special health care needs received coordinated, ongoing, comprehensive care within a medical home. This compares to 43% nationwide.

**MCHB Core Outcome #6:** In the 2005/2006 survey, 42.4% of Delaware's youth with special health care needs received services necessary to make appropriate transitions to adult health care, work and independence (CSHCN age 12-17 only). In the 2009/2010 survey, however, this percentage dropped to 38.4%. This compares to 40% nationwide. //2013//

In 2010, 870 children ages 0-3 years received early intervention services in accordance with Part C in Delaware. Of these children, 49.31% were White non-Hispanic, 25% were Black non-Hispanic, 9.8% were Hispanic, 2.6% were Asian or Pacific Islander, and 0.34% were American Indian or Alaska Native. Children ages 2-3 years accounted for 59.66% of the children receiving services while 28% were ages 1-2 years and 12.3% were birth to 1 year of age. Finally, 61.6% of the children receiving services were male and 38% were female.

Based on rates from the 2005-2006 National Survey of Children with Special Health Care Needs, of families of children to age 18, it is estimated that about 34,500 Delaware children (17.5%) younger than age 18 years may have a special health care need. Around 7,000 (20.4%) of Delaware's CSHCN have health conditions that consistently and often greatly affect their daily activities. Rates were somewhat higher for Black children (22.5%) compared to 17.9% for Caucasian children. Rates were also far higher for families with incomes less than 100% of the federal poverty level (FPL) (32%) and for those between 100% and 200%, (30.5%) compared to 12%-18% for other income groups. As seen in the table below, Delaware had higher prevalence of CSHCN, a greater percentage of households that have at least one child with special healthcare needs; and a higher rate of CSHCN in every age and racial category and gender, than the national average.

Table 1: Select Delaware Data from the National Survey of Children with Special Health Care Needs, 2005/2006  
Prevalence Statistics

% State % Nation

Percentage of Children & Youth with Special Health Care Needs, 0 - 17 yrs old	17.5	13.9
Prevalence by Age:		
Children 0-5 years of age	10.4	8.8
Children 6-11 years of age	21.8	16.0
Children 12-17 years of age	20.5	16.8
Prevalence by Sex:		
Female		13.3
11.6		
Male	21.5	16.1
Prevalence by Poverty Level:		
0% - 99% FPL	17.6	14.0
100% - 199% FPL		16.5
14.0		
200% - 399% FPL		17.6
13.5		
400% FPL or greater	17.9	14.0
Prevalence by Race/Ethnicity:		
Hispanic		9.2
8.3		
White (non-Hispanic)	19.6	15.5
Black (non-Hispanic)	16.0	15.0
Multi-racial (non-Hispanic)		17.0
17.9		
Asian (non-Hispanic)	....	6.3
Native American/Alaskan Native (non-Hispanic)	....	14.5
Native Hawaiian/Pacific Islander (non-Hispanic)	....	11.5

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

The Survey data also indicate that 29.7% of all Delaware CSHCN are without family-centered care. More than 50% of Hispanic (53.8%) and 47.5% Black CSHCN are without family centered care, compared to 27.1% for Caucasian. About half of CSHCN living in families below 200% did not have family-centered care, compared to fewer than 30% at higher income levels. Family centered-care is a philosophy that incorporates the family as an integral component of the health care system. These data on unmet needs, lack of family-centered care, and lack of a medical home indicates the disparate needs of Black and Hispanic families and low-income families.

According to the 2005-2006 National Survey of Children with Special Health Care Needs, 57.6% of families with CSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. duPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To which types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they

receive in the community?

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

The findings of this study supports the NSCSHCN data that adult transitions are problematic for many youth. The process of transition was reported as difficult by about 50% of study participants. They also reported child health services much easier to navigate than adult health services. In addition, participants reported many services available in the child system were not available in the adult system (e.g., daily care support).

#### /2012/ Disparities Among Families of CYSCHN in Delaware

Based on findings from the 2007 National Survey of Children's Health (NSCH), a number of key disparities have been identified for CYSCHN when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators. According to the 2007 NSCH:

##### Disparities in Child Health Indicators

**General Health.** Among those aged 0-17 years in Delaware, 71.0% of CYSCHN were reported to be in overall excellent or very good health. This compared to 88.7% of non-CYSCHN.<sup>8</sup>

**Oral Health.** Among those aged 1-17 years in Delaware, 64.1% of CYSCHN were reported to have teeth that were in excellent or very good condition. This compared to 75.2% of non-CYSCHN. In this same age range, although not statistically significant, 15.2% of CYSCHN were reported to have two or more oral health problems in the past six months. This compared to 8.1% of non-CYSCHN.<sup>8</sup>

##### Disparities in Emotional and Mental Health

**Parental Concern.** Among those aged 4 months to 5 years in Delaware, 58.0% of parents of CYSCHN reported concern over their child's physical, behavioral or social development. This compared to 36.4% of parents of non-CYSCHN.<sup>8</sup>

**At-Risk Children.** Among those aged 4 months to 5 years in Delaware, 28.5% of CYSCHN were reported to be at high risk for developmental, behavioral, or social delay. This compared to 7.2% of non-CYSCHN.<sup>8</sup>

**Social Behaviors.** Among those aged 6-17 years in Delaware, 81.1% of CYSCHN were reported to consistently exhibit positive social behaviors. This compared to 94.6% of non-CYSCHN. Furthermore, among this same age cohort, 24.8% of CYSCHN were reported to often exhibit problematic social behaviors. This compared to 4.5% of non-CYSCHN.<sup>8</sup>

##### Disparities in Health Care Access and Quality

**Continuous and Coordinated Health Care.** Among those aged 0-17 in Delaware, 48.4% of CYSCHN were reported to have a medical home that provided continuous, coordinated, comprehensive, family-centered and compassionate health care services. This compared to 63.6% of non-CYSCHN.<sup>8</sup>

**Effective Care Coordination.** Among children needing care coordination in the past year, 52.1%

of CYSHCN were reported to receive effective care coordination. This compared to 79.3% of non-CYSHCN.

Specialist Care. Among children that needed specialist care in the past year, 14.2% of CYSHCN were reported to have had problems getting specialist care. This compared to 3.9% of non-CYSHCN.

#### Disparities in Family Health

Mother's Health. Among children in Delaware that lived with their mother, 53.9% of mothers of CYSHCN were reported to be in very good or excellent general health. This compared to 66.6% of mothers of non-CYSHCN.

Mother's Mental/Emotional Health. Among children in Delaware that lived with their mother, 63.2% of mothers of CYSHCN were reported to have very good or excellent mental or emotional health. This compared to 75.4% of mothers of non-CYSHCN.

Fathers Mental/Emotional Health. Among children in Delaware that lived with their father, 71.4% of fathers of CYSHCN were reported to have very good or excellent mental or emotional health. This compared to 82.2% of fathers of non-CYSHCN. //2012//

#### Current Priorities and Initiatives

The Family Health and Systems Management (FHSM) is currently working on a number of initiatives focused on improving Maternal and Child Health. The MCH Bureau is working with the University of Delaware to implement a statewide survey of families with children and youth with special health needs. The survey will be based on items from the National Survey of Children with Special Health Care Needs. The survey's results will provide evaluative data of our current efforts in enhancing supports for families with CYSHCN through the family support initiative. The Newborn Metabolic Screening and Newborn Hearing Screening Programs are working to create a data system and processes for follow-up. This follow-up will include the capacity to follow-up on interventions for birth defects, late onset hearing loss and possibly some metabolic disorders. Related to this system enhancement is an effort to increase reporting to the state's Autism registry. Reporting of autism and autism spectrum disorders is required by Delaware statute; however the system is currently underutilized. As the Healthy Women, Healthy Babies program completes its first full year, FHSM, through the Infant Mortality Elimination Program and the Center for Family Health Research and Epidemiology will measure and evaluate the behavior change that results from the array of interventions offered through this program, as well as health outcomes that may be captured. The Infant Mortality Elimination program is also launching a statewide preconception care social marketing campaign that includes promotion of a reproductive life plan.

A new initiative closely related to one of Delaware's State Performance Measures (decreasing the proportion of children at risk of developmental delays in early childhood) resides within the Early Childhood Comprehensive Systems (ECCS) program. In the proposed program, a child care health consultant (CCHC) will be a licensed or certified health professional (e.g. nurse, nurse practitioner, physician, health educator, oral health professional, and nutritionist) specifically trained to work with child care providers. Families depend upon child care businesses to meet their children's needs, anticipate problems and concerns, and to direct or refer families to needed resources. Other best practice state models use nurses, solely, to fill the role of the CCHC (e.g. Iowa and Illinois). As such, Delaware is proposing the Child Care Nurse Consultant (CCNC) program to provide the missing link and credibility for needed health, safety, and positive development in early care and education programs.

//2012/ In an effort to support the development of a comprehensive early childhood system that spans the prenatal-through-age-eight continuum, Delaware diverted resources from the proposed CCNC program to the development of a Help Me Grow system. In December 2010, Delaware applied for and was successfully awarded a Help Me Grow systems building grant through the

W.K. Kellogg Foundation. In collaboration with several community based maternal and child health organizations, the DE-HMG will align with the federal and state's new priority to develop a comprehensive and integrated statewide system that acknowledges that children and their families are touched by sectors across health, education and social services. It is in the best interest of the children and families that we serve to find efficiencies that emphasize collaboration and adopt new approaches to program integration.//2012//

***/2013/ Help Me Grow embeds several federal initiatives under one umbrella framework including the Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting program, the Children and Youth with Special Health Care Needs activities, Race to the Top Early Learning Challenge grant activities (awarded in December 2011), and other early childhood (ECCS) related activities to improve young children's health and development to ensure healthy development and success in school and throughout the lifespan.***

***In 2012-13, Delaware continues to work on the planning and implementation of a Help Me Grow (HMG) system. Help Me Grow, serves as a comprehensive, integrated and universal system designed to address all families with children (and expecting parents) and the need for early identification and linkage to developmental and behavioral services and supports for the birth through age eight populations. The ECCS Administrator plays an essential role in the infrastructure planning and implementation of Help Me Grow.***

***In February 2012, Delaware held the Lieutenant Governor's HMG SUMMIT, which included a structured discussion during break out workgroups on the four components of Help Me Grow. The Summit focused on two broad themes --Systems Building and Cross-sector Collaboration. In addition, the objectives of the summit were to develop strategies for a HMG implementation plan, allow partners to network together to have a dialogue, and it was designed to share MCH priorities with a broader audience. The turnout of stakeholders/partners was incredible, with almost 250 people in attendance representing public libraries, Department of Education, Department of Children, Youth and Their Families (i.e. child welfare agency, child mental health), DHSS (i.e. DPH, WIC, Social Services), Lieutenant Governor's Office, DE Chapter of the American Academy of Pediatrics, Head Start, home visitors (i.e. Nurse Family Partnership, Parents as Teachers, Smart Start/Healthy Families America), Part C early intervention program (i.e. Child Development Watch), Nemours Health and Prevention Services, Office of Child Care Licensing, United Way of Delaware, early childhood professionals, parents, health care providers (i.e. nurses, family doctors, pediatricians), oral health professionals, University of Delaware, Prevent Child Abuse DE, Federally Qualified Health Centers, federal partners (i.e. HRSA MIECHV project officer.) There was energy, commitment, and a vision of endless possibilities for a comprehensive and coordinated early childhood system; the contagious Buzz that was present in the room continues to last. MCHB is spearheading the momentum, through an established Help Me Grow Advisory Committee.***

***Championed by the Lieutenant Governor Matt Denn, a state-wide Help Me Grow Advisory Committee was established in 2012 to effectively accomplish building the infrastructure for Delaware's HMG system. Collaboration and coordination of efforts with several stakeholders include the development of four key components: 1) centralized telephone access point; 2) community outreach to promote use of DE-HMG; 3) physician outreach to support early screening and intervention; and 4) data collection (surveillance, case management, referrals, follow-up) to identify gaps and barriers impeding the current system. Help Me Grow serves as an early childhood system framework and integrates with the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting program, Race to the Top Early Learning Challenge grant (awarded to Delaware in December 2011) the Children and Youth with Special Health Care Needs activities, and other early childhood related activities to improve young children's health and development to ensure success in school and throughout the lifespan.***

**211/Delaware Helpline, a subsidiary of the United Way of Delaware has a contractual relationship with the Division of Public Health to operate the Help Me Grow (HMG) centralized telephone access point. Delaware Helpline, a subsidiary of the United Way of Delaware has provided telephone based information and referral for the Division of Public Health's Help Me Grow initiative designed to assist families of young children with access to services, information, and assistance with health and social services. 2-1-1 serves as the primary information and referral service (DEL. Code Title 16 Chap 102).**

**The Help Me Grow Delaware 2-1-1 monitors and continues to enhance an existing Delaware 2-1-1 database, iCarol, for client tracking and identifying community resources. With a staff of 1.25 FTE, consisting of Wanda Lopez, Child Development Director (hired 12/20/11) and Jennifer Fromme, a 211 Information & Referral Call Specialist, additional work is underway to accommodate the needs of the program. As a result of the Race to the Top (RTTT) Early Learning Challenge grant, funds are helping cover two additional contractual 2-1-1 Help Me Grow positions. The following are a list of accomplishments, since the 2-1-1 Help Me Grow Call Center went live:**

- Developed an intake form to capture the HMG incoming calls and track them separately from the general 2-1-1 calls.**
- Attended all HMG Advisory Committee Meetings from January through April 2012, including the official launch held on February 10, 2012.**
- Met with key partners of the HMG Advisory Committee: Child Development Watch, Child Find, Children & Families First, Family SHADE, WIC, Smart Start, and Nemours Health & Prevention Services.**
- Attended HMG National Webinars and implemented a summer internship program based on Utah's HMG model.**
- HMG Child Development Director serves as Chair of the HMG/211 I&R Call Center Work Team; developed goals and supporting monthly meetings to meet Year 1 goals.**
- Lopez & Fromme attended the Help Me Grow National Forum May 2-4, 2012 in Hartford, CT.**

**Since the implementation of the HMG intake form (call report), the team has received 50 calls as of April 30, 2012. Of the 50 calls: 5 were Spanish dominant; 14 heard about HMG through word of mouth; leading Problem/Needs were 7 developmental issues, 7 screening requests and 6 educational issues. The majority of callers had multiple needs.**

**Additional database upgrades have been implemented to allow for more granularities in data collection process like adding multiple fields to segregate information on each child in the household. Our goal is to have multiple ways to "Check-In" and follow-up with families to confirm a connection to services, via phone, cell, mail, email and text. Other data captured and features are available and will be implemented once the 2-1-1 taxonomy project is complete. Each record must be assigned taxonomy terms that will replace the current key word searches. Taxonomy terms were developed by the Alliance of Information & Referral Services (AIRS) to standardize the categorization of data and create efficiencies in coding. Delaware 2-1-1 will apply for AIRS accreditation for the organization by year-end and the HMG staff will work towards AIRS certification after their one year anniversary.//2013//**

As a result of the 2010 Needs Assessment, and as described in greater detail in the 2010 Needs Assessment report, Delaware has identified 10 priorities specifically related to the Title V MCH Block Grant Program. These priorities are:

Reduce Infant Mortality. Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistency higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the Delaware Healthy Mother and Infant Consortium (DHMIC). The Consortium united with the

DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached about 15% of all Delaware pregnancies in 2009. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007. The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

/2012/ New data shows that Delaware's state initiatives are proving successful in reducing Delaware's infant mortality rate. The state's infant mortality rate decreased for the third consecutive reporting period, dropping by 10 percent to 8.4 deaths for every 1,000 live births in 2004-2008 (compared to 6.8 deaths per 1,000 live births nationally). In the 2000-2004 reporting period, the state's infant mortality rate was 9.3 deaths for every 1,000 live births. Delaware's black infant mortality rate remains 2.6 times higher than the rate for whites and remains a prime focus of reduction efforts. The mortality rate for black infants for the period 2004-2008 is 15.1, compared to 5.9 for whites and 7.7 for Hispanics.

Healthy Women Healthy Babies, which was established in July 2009, addresses infant mortality head on by focusing on the lifestyle and environmental risk factors that may put women at greater risk of preterm labor and birth. Healthy Mothers Healthy Babies provides women at 17 sites statewide with the tools to maintain a healthy weight, eat a nutritious diet, include adequate amounts of folic acid, manage chronic disease, understand and mitigate environmental risk factors and work toward a tobacco- and substance-free lifestyle in addition to prenatal care. In 2010, the Healthy Mothers Healthy Babies program served more than 7,400 African-American women, women with health risk factors or whose most recent pregnancy resulted in a poor birth outcome. The program was recognized by the national Association of Maternal & Child Health Programs for providing evidence-based preventive services beyond the scope of routine prenatal care. More information on the program is featured at [healthywomende.com](http://healthywomende.com)

Another promising approach to help women in Delaware achieve healthier pregnancies and avoid preterm births and infant mortality is the development of Reproductive Life Plans for teens and adults, which are being distributed throughout the state. The Delaware Healthy Mother and Infant Consortium created the Reproductive Life Plan, per CDC's recommendations, into booklets in 2009 to serve as a tool. The plans contain information about avoiding pregnancy if desired, planning the spacing of pregnancies, preventing STDs, preparing for a healthy pregnancy, identifying unhealthy relationships, assessing and developing personal health goals, and communicating with health care providers.//2012//

***/2013/ The Healthy Women/Healthy Babies (HWHB) has completed its second full year of operation. The program provides health care, mental health and nutrition services for women before, during and after pregnancy. Services are offered through 7 different health clinic providers in over 20 different locations throughout the state including 3 specifically located in Sussex County. The HWHB program is one of several infant mortality programs implementing the Life Course Model. This Life Course Perspective looks at the health of the mother from the day of her birth to the birth of her child. Programs are created around this model to implement multi-level initiatives for the woman herself, her family, her health care provider and her community.***

***In calendar year 2011, there were 36,415 visits for 12,146 unique patients. There was an average of 3 visits per patient. Initial HWHB data on process evaluation is now available,***

**with outcome evaluation data expected next year. One of the outcome measures specifically examines the impact of preconception care on entry into prenatal care.**

**In addition to continued work through HWHB to promote early prenatal care, the revamped Smart Start home visiting program will also help reach high-risk women early in pregnancy to connect them with a medical home. Smart Start has implemented the evidence-based model, Healthy Families America, as of May 2012, and under this new model pregnant women residing in high-risk communities, or zones, will be targeted for enhanced home visiting services. Health ambassadors, or lay health advocates, will also be identified in each high-risk zone. These health ambassadors are charged to use their existing social networks and innate leadership skills to galvanize communities toward health promotion. This will include early access to prenatal care and the importance of women's health before, during and after pregnancy. Delaware's approach includes direct care through HWHB, home-based supports through Smart Start home visiting, and community mobilization through health ambassadors.//2013//**

Reduce the Incidences of Low Birth Weight Births and Preterm Births. Infant low birth weight is a major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation. The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Delaware had the 11th highest preterm birth rate in the nation in the 2004-2008 period. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health. Interpregnancy intervals (IPIs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPIs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

Reduce the Prevalence of Child/Teen Obesity and Overweight. A child's weight status is determined based on an age-and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:

- Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
- Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

Due to character limitations, the remainder of this narrative continues in the next section, Agency Capacity.

## **B. Agency Capacity**

Due to Character Limitations, the following is the remainder of the Section IIIA. Overview Section Narrative.

According to 2007 NSCH data, Delaware ranks 36 in overall prevalence with 33.2% of children considered either overweight or obese. Delaware's prevalence rank has changed since 2003, falling from a rank of 45. The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age). The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide. For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007. According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.

Reduce the Prevalence of Obesity Among Women of Childbearing Age. Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was \$117 billion, \$61 billion in direct cost, and \$56 billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

Reduce the Incidences of Unintentional Injury and Mortality among Children and Youth. The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years. Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

Reduce the Prevalence of Teen Smoking. Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days. These results parallel nationwide rates (50.3% of students nationwide

tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data). Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days. In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years. Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.

## Agency Capacity

### Determining the Importance, Magnitude, Value, and Priority of Competing Factors

As a Title V Maternal and Child Health Block Grant funded agency, the Delaware Department of Health and Social Services (DHSS), Division Public Health is required to conduct a comprehensive needs assessment every five years. Delaware's 2010 Needs Assessment serves as a road map to guide program activities, resource allocation and impact evaluation for programs and services that target MCH populations.

The goal of the needs assessment is to assess the health status of women, infants, children, adolescents, and CYSHCN through the lens of the most up-to-date epidemiologic data, evidence-based practice, and population self-reported needs. It also provides a framework for program activities by outlining state health priorities, indicators, objectives, and activities. The State of Delaware envisions the 2010 Needs Assessment as a living document for guiding and measuring programs and services over the next five years. As such, the Delaware 2010 Needs Assessment represents the first step in a cycle of continuous improvement of maternal, child, and adolescent health. Between 2010 and 2015, actions and strategies will be implemented, results will be monitored and evaluated under the State Performance Measures included in this application, and necessary adjustments will be made in an effort to enhance the health of women, children, and adolescents in Delaware.

The MCH Director (Ms. Alisa Olshefsky, MPH) led the Delaware 2010 Needs Assessment process. Ms. Olshefsky serves as the Chief of Family Health and Systems Management within the Delaware Division of Public Health. She began outlining the process and timeline for the needs assessment in March 2008. This included conducting a thorough environmental scan of all MCH programs and services DPH provided, either directly or indirectly. The scan also organized programs by the MCH service delivery pyramid (i.e. direct, enabling, infrastructure, or population-based service) and included information on the target populations, outputs, funding sources, evidence base for the program, and whether a formal evaluation had been conducted. The Center for Family Health Research and Epidemiology (Center) within the Family Health and Systems Management Section conducted thorough reviews of the literature and provided epidemiologic analyses. The Center contracted with APS Healthcare to conduct epidemiologic research and evaluation that was beyond the capacity of Center staff.

Family leaders and advisors to the MCH Children and Youth with Special Health Care Needs Program were key in ensuring the MCH Needs Assessment Workgroup and process was inclusive of family input and insight. Over the course of six months, the workgroup maintained at least 25% representation of families at all meetings. This accomplishment was due to the outstanding work of Family to Family, a CYSHCN family-led organization through the University of Delaware, Center for Disabilities Studies.

In addition to family members, the composition of the workgroup (n=35) included executive leadership from DPH, program managers from Child Health, Early Childhood, State Systems Development Initiative, Newborn Metabolic Screening, Newborn Hearing, WIC, Immunizations, Adolescent and Reproductive Health, Primary and Rural Health Care, Health Statistics and staff from Community Health Services including Northern Health Services Clinics, Southern Health Services Clinics and the Oral Health Program. Representation from the Division of Child Mental

Health Services, Children and Families First and the March of Dimes also participated on the workgroup.

A range of quantitative and qualitative resources were used to assess the strengths and needs of each of the MCH populations (infants, children ages 1-22, children and youth with special health care needs and pregnant women). Quantitative data collection included meticulous searches through vital statistics, population-based surveillance, and program evaluation data. Qualitative data collection included structured interviews, surveys, and client observation.

Although all of the health priorities identified by stakeholders through the six-month assessment process are important, the MCH program and DPH do not have the capacity to address them all. In order to systematically analyze the Division's capacity, the workgroup chose to use the HRSA CAST-5 system. CAST-5 is a methodology for assessing an organization's capacity to carry out core MCH functions. The internal MCH Needs Assessment Workgroup was trained on the CAST-5 system then completed an assessment on each of the essential services process indicators. In groups of two or three members, the teams scored the level of adequacy and capacity needs. Rich comments were provided on each process indicator through a SWON (strengths, weaknesses, opportunities and needs) analysis. This process was conducted over three meetings for a total of 12 hours.

The state priorities identified in this application for the 2011-2015 cycle were derived from a consideration of existing capacity and a Q-sort procedure applied to a total of 33 health conditions or health problems. These procedures are described in detail in the 2010 Needs Assessment Report included with this application. Given the diversity in background of the workgroup members, it was important they all had a baseline understanding of the epidemiology, severity, causes and strategies for each of the 33 health problems. Thus, informational fact sheets were created and distributed for workgroup review. These were modeled on fact sheets created by similar Title V programs (such as the program in Minnesota). Members were divided into six teams and each team was given five to seven health conditions on which to focus. Each individual did a ranking worksheet on all 33 health conditions. Then, as a group, they developed one consensus ranking worksheet on the five to seven assigned health conditions. This dual approach of individual and group review allowed for all members to be engaged on each health condition while still focusing on those that most impacted/interested them. //2012//

/2012/ Maternal, Infant and Early Childhood Home Visiting Program. In July 2010, the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program awarded Delaware with a \$1,280,893 federal grant. Funds provide evidence-based home visitation services to improve outcomes for children and families residing in communities at high risk of public health problems such as infant mortality, premature birth, domestic violence, child maltreatment, poverty, crime and substance abuse. Delaware recently submitted its Updated State Plan outlining activities and strategies to demonstrate the program's effectiveness, and produce and measure positive impacts for children, their families and communities. Based on a thorough analysis, Healthy Families America, an initiative of Prevent Child Abuse America (PCA America), is the evidence-based home visiting model selected by Delaware for implementation. About \$673,000 of the ACA grant is allocated for Delaware Children and Families First, a non-profit organization that was an original Evidenced Based Home Visiting grantee through the Administration on Children and Families. DPH and several external partners are developing a continuum of home visiting services and a cross-organization approach to identifying and referring families for such services.

Public Health has long been a provider of home visits to pregnant women needing enhanced support and education to encourage successful pregnancy outcome, as well as prevent low birth weight and infant mortality. DPH has selected the nationally recognized Healthy Families America program to meld with the existing Delaware Smart Start program to target pregnant women living in specific areas of the state with high infant mortality rates. Healthy Families America (HFA) is an intense program of frequent visits during pregnancy and during the first six months postpartum, with extended support for parents to address their children's needs. Public Health staff are currently engaged in intense planning and are receiving training throughout the summer from the

national HFA program to learn about the model, the outcomes expected, roles and responsibilities. While our current Smart Start services are continuing at this time, transition to the new model is expected in early 2012. //2012//

***/2013/ Smart Start fully transitioned to the Healthy Families America evidence based home visiting model on May 1, 2012.***

***Delaware was one of thirteen states that applied for and was successfully awarded the Competitive Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant in the amount of \$2.9M. Funding will help build capacity of Parents as Teachers, Nurse Family Partnership and DPH's Smart Start program, which will support Delaware's continuum of home visiting services framework. Additional funding will help strengthen the reach to pregnant women residing in high-risk communities, or zones identified through our 2010 MIECHV Needs Assessment, targeted for enhanced home visiting services. Also under this grant, Health ambassadors, or lay health advocates, will also be identified in each high-risk zone. Health Ambassadors will work within the community to accomplish the following:***

- 1. Build social capital, social cohesion, within communities to identify respected members and elders who are influential. These respected members will help identify social networks that can be leveraged to promote health and prevent disease.***
- 2. Increase access to medical/ social services, early learning and development programs and enhance self sufficiency.***
- 3. Build community support and acceptability to home visiting services to retain home visiting clients through the duration of the program.***
- 4. Use innovative, creative and culturally sensitive strategies to engage community member and promote individual, family and community wellness.***

***A social media component will be built into the Health Ambassador's activities, to address social cohesion by acting as a connector to current online resources. Social media will be used as a promotion tool for community events, and will help facilitate the development of online health conversations that will help to influence conversations and strengthen the Health Ambassador's ability to reach the community. In addition, traditional approaches will be used to educate the community on key perinatal health messages and inform the community about available health care services, early childhood learning and development programs, home visiting programs, basic needs services (i.e. WIC, food stamps, etc.) and how to access them through 2-1-1 Help Me Grow. //2013//***

Enhance Family Support of Children and Youth with Special Health Care Needs. Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approach to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered --it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

*/2012/*The Advisory Council members chose a new name for the Family Support Initiative at the April Advisory Council Meeting. The Family Support Initiative will now be known as Family SHADE, for Family Support and Healthcare Alliance DElaware. The next task is to develop a logo. Funds are available to post this task on [www.crowdspring.com](http://www.crowdspring.com) where artists would submit graphic designs and the Advisory Council would then select the winning entry. The Advisory Council agreed that Crowdspring worked well for the development of potential names and that it would worthwhile to try this route again.//2012//

***//2013/ Family SHADE enhanced and developed new features and frequently posts updated resources on their website, [www.FamilyShade.org](http://www.FamilyShade.org). The website provides partners with a place to access the latest updates, includes the quarterly newsletter, a list of Advisory Board member representatives, recent mini-grant awards and awardees under the D70 State Implementation grant to improve children and youth with special care needs, the Advisory Board governance structure and bylaws, and more.***

***A more robust Family SHADE website is currently under development and should be online this summer. In addition, a comprehensive database that includes information and resources of importance to CYSHCN is under development under a contract with Children and Families First. The database will be family-friendly and searchable and can be accessed via a portal on Family SHADE's website as well as portals of Family SHADE member websites. Also of importance, the database will be an expansion of an existing database that addresses resources for adults with disabilities as well as a database of child care providers in Delaware. . The Family SHADE database will also include the Delaware Central Directory of Services for Young Children with Special Needs that was formerly published by the Department of Health and Social Services' Birth to Three Early Intervention System. The resources available to families through this expanded database will address not only CYSHCN, but it will include resources that cover the lifespan of individuals with disabilities and special healthcare needs. //2013//***

Ensure the Early Detection of Developmental Delay. Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

Decrease Disparities among Families of Children and Youth with Special Health Care Needs. Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators;

Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

Improve the Availability of Dental Services (Preventive and Treatment) for Children. Delaware is taking steps to reduce the shortage of oral health access. The DPH's Oral Health Program, the Delaware Dental Society, the Delaware Oral Health Coalition, and the Delaware Dental Hygienists Society all collaborate to provide support to increase access to dental prevention and treatment.

#### State Program Collaboration and Coordination

The Title V Maternal and Child Health Program partners with numerous other state and community-based agencies to advance its mission to improve the health and wellness of preconception and pregnant women, children and children with special health care needs and their families. This collaboration takes place at a number of levels within the Family Health and Systems Management Section, as well as at the Division (Public Health) and Departmental (Health and Social Services) Levels.

At the highest level, health policy is driven by the Health Care Commission. The Delaware Health Care Commission embodies the public/private efforts which have traditionally spelled success for problem solving in Delaware. Four government officials -the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner -are joined by six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors. By

creating the Commission as a policy-setting body the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. The Commission is expressly authorized by statute to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. To achieve its goals, the Commission strives to balance various viewpoints and perspectives.

The Commission generally has followed a strategy built on the notion that initial efforts should target areas most in need and gradually build toward a more comprehensive plan. Since 1995, the Commission has used a committee system as a means of reaching out to the community and involving those impacted by its decisions in the consensus building process.

The leadership of the Division of Public Health is also served by a number of advisory committees/councils that provide input on a variety of health topics. Specific to Maternal and Child Health are two committees --the Delaware Healthy Mothers and Infants Consortium, a governor appointed body charged with the reduction of infant mortality and the Teen Pregnancy Prevention Advisory Committee, a body appointed by the Director of the Division of Public Health. Staff from Family Health and Systems Management, including the Maternal and Child Health Bureau provide staff and logistical support to both of these committees.

Under Family Health and Systems Management leadership there are committees that are specifically charged with issues affecting Children with Special Health Care Needs (Coordinating Council for Children with Disabilities; Family Support Network), early childhood (Early Childhood Comprehensive Systems Advisory Committee); newborn bloodspot screening (Newborn Screening Advisory Committee), newborn hearing screening (Delaware Hearing Assessment and Intervention Program Advisory Board), and the birth defects and autism registries (Birth Defects and Autism Registry Advisory Board).

Each of these committees consist of representatives from community-based agencies, other state agencies and family members of affected populations and provide critical input into MCH-related programs and activities.

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

Currently, preventive and primary care services for pregnant women, mothers and infants are supported through Title V Maternal and Child Health Block Grant and state general funds in statewide programs for pregnant women, women of reproductive age, infants, children and adolescents. Historically, these programs have included the home visiting programs Smart Start and Kids Kare. Smart Start is a prenatal program for at-risk pregnant women and Kids Kare provides support for families with children who are at risk for delayed development. These programs are currently being merged into a new evidence-based program model under the Healthy Families America framework, Smart Start which will serve at-risk pregnant women and children. Over the past, the Family Practice Team Model and the Preconception Care Program have been merged into Healthy Women, Healthy Babies, a program that serves women at the preconception, prenatal and interconception periods. In this program, women are screened for risk factors in four domains: nutrition, social, mental health and medical. Once enrolled, pregnant women are seen at least monthly throughout their pregnancy and depending on their risk factors, provided information and education on topics including domestic violence, reproductive health, labor and delivery, alcohol, substance and tobacco use, and post partum issues. Other programmatic efforts that offer preventive and primary care services for women and infants include WIC, Family Planning, and services offered on-site at Public Health clinics throughout the state.

As part of the research completed in the design and implementation of both the Family Practice Team Model and Preconception Care programs, the State of Delaware created a Registry for Improved Birth Outcomes. The registry, compiled from all births in Delaware occurring over during the past two decades, has helped to identify key risk factors associated with poor birth

outcome (prematurity, low-birth weight and infant mortality). These factors include smoking, maternal weight (either too low or too high), chronic disease and short intervals between pregnancies.

The Newborn Metabolic Screening Program offers initial and confirmatory (second) screening for 37 conditions for every infant born in Delaware. The Newborn Metabolic Screening program also offers follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services.

In the Spring of 2010, DHHS Secretary Sebelius released recommendations to screen for 30 core conditions. Currently, Delaware screens for 29 of these conditions. The one condition that is not currently included in Delaware's 37 conditions is Severe Combined Immunodeficiency Disease (SCID). In June of 2010, the state's Newborn Screening Advisory Council recommended that Delaware should investigate SCID screening, costs, equipment and staffing requirements. A final decision on this matter is expected later this year.

/2012/ SCID is a group of disorders characterized by a deficiency of the immune system, affecting approximately one in 100,000 newborns. Infants affected by SCID develop recurrent infections leading to death in early childhood. Treatment in the first months after birth can prolong life and prevent infections. The newborn screening test that suggests the presence of SCID can also detect a number of other congenital disorders of the immune system. Recently the U.S. Secretary of Health and Human Services' advisory committee on Heritable Disorders in Newborns and Children (SACHDNC) recommended that states add SCID testing to their newborn screening panel. The Delaware Newborn Screening Program Advisory Committee endorsed this recommendation with the support of national organizations, parents of children with SCID, and pediatricians. The DPH Director agreed to the recommendations on February 22, 2011. SCID testing will begin in the DPH laboratory pending staff training, equipment delivery and the implementation of supporting data systems. In a joint effort between the Public Health Lab and Maternal and Child Health, a Press Release was written and released in April 2011 sharing information on the addition of SCID testing to the Newborn Screening Program. Quotes were obtained from the Director of DPH, a parent of two children with SCID and the Governor. //2012//

***/2013/ In May 2010, Kathleen Sebelius, Secretary of the US Department of Health and Human Services, made the recommendation for states to adopt the national uniform screening panel as recommended by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) and add SCID to their newborn screening panels. In February 2011, Dr. Karyl Rattay, Director of Public Health, approved DPH's Advisory Council's recommendation that SCID be added to the testing for the Delaware newborn screening panel. Since then DPH staff (laboratory and follow-up personnel) have been sent for training sponsored by the regional genetics network NYMAC, have travelled to CDC to prepare the standards which are not yet available commercially, bid out the equipment, rearranged molecular laboratory space, and set up TREC testing in the DPH Laboratory. They are now in the pilot phase of testing.***

***The SCID pilot phase began the end of September 2011, all initial specimens are being tested for SCID. TREC and RNaseP tests are now in the production environment. The Standard Operation Procedure, SOP has been completed and approved, as of June 15, 2012. The results reference range information is being updated in the data system and will be displayed on the Secure Remote Viewer (SRV) in addition to the results mailer. The Secure Remote Viewer is the web access method of viewing the newborn screening results mailers. Currently physicians are not notified electronically when results are available, they are required to look up results for their patients by entering the baby's date of birth and at least one other identifier. Physicians must complete access paperwork and receive an ID and password to login to SRV. Delaware is in the final phase of adding SCID to the Natus data system to display the test results on the newborn screening results mailer, anticipated to be complete by December 2012.***

***In 2011, a family affected by SCID attended the Newborn Screening Program Advisory Board meeting and visited the Delaware Public Health Laboratory to see the testing process for TREC, the analyte responsible for identifying Severe Combined Immunodeficiency (SCID), which is sometimes referred to as the 'bubble boy disease'. SCID, thought to affect 1/150,000 newborns is characterized by the absence of T-cell lymphocytes and the inability to fight off even the most common infections or colds. The family was uniquely interested in this disorder because they have two teen age children with the disease. Their first born daughter was not diagnosed until 9 months of age. She celebrated her first birthday in a hospital bed, on life support. The family then had a son, who was tested at birth and spent his first birthday enjoying birthday cake. Treatment for SCID involves a bone marrow transplantation from an identical sibling or parental donor to avoid the graft vs. host disease. For best results, the transplant should be done before 3.5 months of life. According to statistics provided by Dr. Rebecca H. Buckley and Duke University Medical Center, of babies transplanted before 3.5 months of life, 45/48 survive up to 28 years (94%). Overall survival rates are 76% or 126 of 166. Most causes of death after transplant are due to viral infections, such as Cytomegalovirus, Adenovirus, Epstein-Barr virus, Parainfluenza 3, Varicella, Herpes simplex, etc. Without treatment, life expectancy is less than two years. A considerable amount of work and commitment went into adding SCID testing to Delaware's Newborn Screening (Metabolic) Program testing panel, which will certainly help Delaware's children and families.//2013//***

The Newborn Hearing Screening Program offers universal screening. Currently, the program screens over 93% of infants born in the state. The program also manages a hearing aid loaner program for children until a source is identified to obtain their own hearing aid.

#### Services for CSHCN

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

CDW is evaluated on an ongoing basis. One of the evaluative tools is the annual Family Survey which is conducted via telephone with a stratified random sample of families based on geographic region, ethnicity and length of time in the program. The 2007 survey found: -97% of families indicated that they had overall satisfaction with the services they received; -94% of families perceived the program as accessible and receptive; -93% of families perceived change in themselves and their family; -93% of families perceived change in their child; -93% of families reported a positive perception of family decision-making opportunities; -92% of families reported a positive family-program relationship with CDW staff; and, -92% of families reported a positive perception of their quality of life.

The Child Development Watch (CDW) Program provides developmental assessments to children birth to 3 years of age and service coordination for developmental services and therapies. According to an annual University of Delaware survey, 95.9% of families perceived the CDW program as accessible and receptive, while more than 92.5% perceived change in their child's abilities. As of the end of FY09, CDW has case managed 3,094 children statewide; 1,875 are served by the NHS' CDW office. An additional 124 children will be re-evaluated. CDW strives for compliance with federal timelines despite high caseload numbers. This year,

CDW North achieved 90% for providing services within 30 days. In a study sample of 236 children, 78% of CDW children with skills below age expectations made gains by their discharge date. Forty-seven percent of these children are functioning at age level upon discharge.

CHILD DEVELOPMENT WATCH (CDW) RECOGNITION --Southern Health Services' Child Development Watch (CDW) staff surpassed their federal 45-day timeline standard from date of referral to delivery of individual family service plans (IFSP) by reducing the interval to 39 days by year's end. While 55% of the Family Service Coordinators were compliant at the beginning of 2009, 83% attained this standard by December. Success is correlated with the systematic implementation of individual and group data feedback provided by the management analyst and supervisors.

CDW PROGRAM AWARENESS --Dr. Carol Owens, Developmental Pediatrician, and Jennifer Donahue, Trainer/Educator, formed a professional outreach committee to encourage physician referrals to the CDW Program. They provided Kent and Sussex County physicians with resources, information and opportunities for collaboration. A practice can elect to receive one or all of the following: a CDW Program manual; one-on-one or group training; one-time contact or monthly contact to discuss referrals. To date, response is lower than expected. New approaches are being considered.

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

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

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

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

Due to character limitations, the remainder of this narrative is continued in the next section, Organizational Structure.

## **C. Organizational Structure**

Continued, from previous section - Agency Overview

In addition to the relative strengths of DPH in striving for cultural competence, the report identified areas for improvement. These areas include: -Services tend to operate independently of each other and, as a result, there was little opportunity to engage across them or to learn from their experiences or initiatives. -Insufficient resources to provide important cultural competence services, including restrictions and requirements regarding dollar allocations, limit scope and reach and make it difficult to prioritize cultural diversity given other pressing needs. -From staff in administration and direct service there was very little to no information gathered related to a formal process for collecting and monitoring client based race and ethnic data. Direct service staff do not have a formal mechanism for capturing client language needs in electronic databases. Although individual programs have added this information to their intake questionnaires, these data are not captured for administration to observe trends in demographic shift of clients. -Although, there were many connections to the community, most of the work to incorporate community was project specific and oriented toward direct service personnel. To address these challenges, the DPH Office of Minority Health and the Office of Workforce Development have developed an ongoing training half day training, "DPH: Journey to Cultural Competence." The training is filled with rich discussion and interactive activities to help DPH employees increase cultural awareness to better serve our customers, clients, patients and co-workers. In 2009, approximately 163 professionals attended the training and gave overwhelmingly positive evaluations.

In 2008, the Office of Minority Health released a Health Disparities Report Card that was designed to show the health disparity gaps among Delaware's racial and ethnic minorities, and to help monitor the community's and state's progress in eliminating those gaps.

Leading health and related indicators for broad racial and ethnic populations were included, along with supporting data and a letter grade to rank the health status of those groups.

This report card's aims are to:

- Inform the public and professionals, helping to guide them as they develop strategies, plans and programs to eliminate health disparities;
- Provide data to guide services and outreach provided by community-based organizations, faith-based organizations, state agencies and organizations, legislators, businesses, health care providers and hospitals; and
- Inform key decision makers on eliminating health disparities through policy reform and systems change.

### Recent Legislation (2009-2010)

In the current legislative session ending 6/30/2010 several notable bills were signed into law. House Bill #44. This bill authorized the State Fire Prevention Commission to incorporate a non-profit, non-stock corporation known as the Delaware Burn Camp Corporation for the purpose of establishing, administering and operating an overnight camp devoted to helping burned children cope with the emotional and physical issues from their injuries.

House Bill # 328. This bill requires courts, administrative tribunals, school districts, and schools to use the definition of "free and appropriate education" with respect to disabled children that has been enumerated for this region of the country by the United States Third Circuit Court of Appeals in *Ridgewood Board of Education v. N.E.*, 172 F.3d 238 (3d. Cir. 1999).

Free appropriate public education' means special education that is specially designed instruction including classroom instruction, instruction in physical education, home instruction and instruction in hospitals and institutions, and related services as defined by Department of Education rules and regulations approved by the State Board of Education and as may be required to assist a handicapped person to benefit from an education that:

- a. Is provided at public expense, under public supervision and direction and without charge in the public school system;
- b. Meets the standards of the Department of Education as set forth in this title or in the rules and regulations of the Department as approved by the State Board;
- c. Includes elementary, secondary or vocational education in the State;
- d. Is individualized to meet the unique needs of the handicapped person;
- e. Provides significant learning to the handicapped person; and
- f. Confers meaningful benefit on the handicapped person that is gauged to the handicapped person's potential.

Delaware's Children's Health Insurance Program (CHIP) was extended to include reduced-cost health insurance coverage for children of families with personal incomes above 200% of the Federal Poverty Level. A law requiring the developmental screening of infants and toddlers has been signed. This law requires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings have historically been covered for children in the state's Medicaid program. The estimated cost to policyholders of covering these screenings is three cents per member per month.

A law to expand access to dental care for children with disabilities was signed. Parents of children with severe disabilities experience difficulty in identifying practitioners willing and able to provide effective dental care. Strict application of "in-network" insurance restrictions exacerbates the parents dilemma since there may be no nearby in-network dentist willing and able to treat their child. When parents with secondary child Medicaid insurance are unable to effectively access private dental insurance, the result is an increase in Medicaid claims. This bill only applies to insurers which include dental services in their benefits package. It allows parents with such private dental insurance to secure dental care for a child with a severe disability irrespective of "in-network" restrictions. Finally, it promotes the availability of in-network practitioners willing and able to treat such children.

On June 30, 2010, House Bill 283 was sent to the Governor and is awaiting signature at the time of submission of this application. HB 283 creates a "Hearing Bill of Rights" for school-aged children who are deaf or hard of hearing. Specifically, the bill allows deaf and hard of hearing children to receive instruction in more than one communication mode or language.

//2012// In the current legislative session ending 6/30/2011 several notable bills were signed or are expected to be signed into law.

SIGNED -HB 3 w/ HA 1 Bans Trans Fats in Schools. To combat childhood obesity, this Bill prohibits public schools, including charter schools, and school districts from making available or serving food with more than 0.5 gram of artificial trans fatty acids to students in grades K through 12. The Amendment clarifies that not only is a school prohibited from serving food to students containing industrially produced trans fat, a school is also prohibited from using food containing industrially produced trans fat in the preparation of a food item for such students.

To Governor for Signature -HB 91 People First Language (PFL) PFL legislation is part of a national movement to promote dignity and inclusion for people with disabilities. PFL specifies that the order of terms used to describe any individual places the person first, and the description of the person second. For example, when using PFL, outdated terms such as "the disabled" would be phrased as "people with disabilities."

To Governor for Signature -HB 141 DSCPD Brain Injury Council The Delaware State Council for Persons with Disabilities (DSCPD) has informally maintained a 24-member brain injury committee

since 2003. This bill would amend the Council's enabling statute to confirm its status as the State's primary brain injury council, clarify the role and membership of its brain injury committee, and enhance prospects for acquiring competitive grant funds. The bill also maintains a standing brain injury committee to facilitate prevention and centralized interdisciplinary planning, assessment and an improved service delivery system for individuals with brain injury comprised of the following members, or designees of such members: Director of the Division of Public Health. //2012//

***/2013/ As of this writing, in the current legislative session ending 6/30/2012 several notable bills were proposed, and/or passed both houses, which impact Maternal and Child Health.***

***HB 384 w/ HA 1 (Passed both House and Senate; On to Governor for Signature) Universal Newborn and Infant Hearing Screening Act***

***This Bill updates the Universal Newborn and Infant Hearing Screening Act to require tracking and intervention protocol. In addition, families are to be provided with information on early intervention and treatment. The Bill also creates the Early Hearing Detection and Intervention Advisory Board.***

***HA 1 corrects the reference to the appropriate agency to reflect the Department of Health and Social Services. It also retains language presently in the Code regarding the hospital's duty to ensure that the physician or other person attending to child is made aware of community resources. Furthermore, it removes the audiologist's reporting as a condition of licensure. It then clarifies that agencies in addition to DHSS will utilize the tracking system and removes the statutory minimums for the tracking system. It makes a technical correction that DHSS refers all children with a degree of diagnosed hearing loss to determine if they are eligible under Part C of IDEA; DHSS does not "define" them. Lastly, it adds the Secretary of DHSS or a designee to the EHD Advisory Board.***

***HB 303 (Signed by Governor 6-26-12) School Based Health Centers & Insurance***  
***School Based Health Centers exist in 28 Delaware high schools and provide convenient and effective health services to students. The federal government is requiring that Delaware change the manner in which it bills for SBHC services, by requiring that private insurers be billed before Medicaid is billed. This legislation establishes the framework for doing such billing.***

***SCR 34 w/ HA 1 Emerging Adults w/ Disabilities Task Force (Passed both Houses; 06.27.12 Governor signature not required). This Resolution creates a State Transition Task Force for Emerging Adults with Disabilities and Special Health Care Needs (the "Task Force") within the Governor's Advisory Council for Exceptional Citizens (GACEC) with research support from the University of Delaware Center for Disabilities Studies (CDS) and the Catalyst Center. The Task Force shall study the transitional needs of children and youth with disabilities and special health care needs and develop strategies to ensure successful transition from children and adolescent services into adult services. The Task Force shall present a final report of its findings and recommendations to the Governor and the General Assembly within one year of the passage of this Resolution. The Task Force shall consist of the following members: ... The Director of the Division of Public Health or a designee thereof (Bhavana Viswanathan, CYSHCN Director, will serve in this capacity). HA 1 adds the executive director for the Governor's Advisory Council for Exceptional Citizens to the State Transition Task Force for Emerging Adults with Disabilities and Special Health Care Needs as a co-chairperson. Additionally, this bill adds the Insurance Commissioner or a designee thereof to the Task Force. This amendment also creates an education and housing/transportation subcommittee working group. Lastly, the amendment makes technical corrections.***

***HB 365 (passed by both House and Senate; onto Governor for signature)***  
***This Act allows parents and guardians who successfully challenge the denial of services***

***to their children with special needs to recover the costs of expert witnesses that they needed to hire to advocate for their children. Prior to 2006, many courts held parents were entitled to recover such costs under the IDEA, but a divided U.S. Supreme Court reversed the holdings. Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy, 548 U.S. 291 (2006). Since that time, many families have been unable to pursue appeals for their children due to the prohibitive cost of retaining expert witnesses, resulting in many children receiving special education services that their parents and treating medical professionals believe to be inadequate. Only parents and guardians who prevailed in their appeals of service denials would be entitled to recover the costs of their experts.//2013//***

Due to character limitations, this narrative continues in the next section, Other MCH Capacity.

***An attachment is included in this section. IIIC - Organizational Structure***

#### **D. Other MCH Capacity**

Continued from previous section.

***/2013/House Substitute 1 for House Bill 371: (Passed both Houses and is on to Governor for signature). This bill is incredibly important as it establishes within our child welfare system (in the Children's Department) a tracking function that will monitor the progress of all cases of abuse and neglect, and where the case involves serious physical injury, death or alleged sexual abuse, the tracking coordinator will report on the status of the case every thirty days to the Children's Dept., DFS, DOJ and the Office of Child Advocate. The bill will establish a system of monitoring, accountability and cooperation that will directly address fundamental structural issues that were identified by Dean Ammons (Dean and Provost, Widener Law School) in her report examining the high profile Bradley (pediatrician convicted of child abuse) case.***

***Senate Bill 234 w/ SA2: (Passed both Houses and is on to Governor for signature). This bill establishes the new crime of "Child Abuse." The bill is intended to address particularly difficult cases, where (for example) the inability to prove "state of mind" or active involvement have precluded prosecutions where children have suffered abuse due to reckless neglect by caregivers. There are a number of additional provisions, and consideration of the bill was not without controversy. //2013//***

#### Organizational Structure

Governor Jack Markell heads the executive branch of Delaware's state government. The Delaware Department of Health and Social Services (DHSS) is among the cabinet-level agencies in the executive branch. DHSS is led by Secretary Rita Landgraf.

The Delaware Department of Health and Social Services is the largest state agency, employing almost 5,000 individuals in a wide range of public service jobs. The department includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long term care, visual impairment, aging and adults with physical disabilities, and Medicaid and medical assistance. The Department includes four long term care facilities and the state's only psychiatric hospital, the Delaware Psychiatric Center.

The Division of Public Health is the largest division within DHSS and is under the direction of

Karyl T. Rattay, MD. In Delaware, there are no county/local health departments. DPH administers both state and local public health programs. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. The Title V Maternal and Child Health (MCH) Block Grant program and the Children with Special Health Care Needs (CSHCN) program are part of the Family Health and Systems Management Section (FHSM), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH. Alisa Olshefsky, M.P.H. is the section chief for FHSM, as well as the state MCH Director. Within FHSM, the Bureau of Maternal & Child Health is led by the MCH Deputy Director, Leah Jones, MPA. The Bureau includes the Title V Block Grant, the Newborn Screening program, the Newborn Hearing program, the Genetics program, Early Childhood Comprehensive Systems, and the State Systems Development Initiative, and Children with Special Health Care Needs. The Bureau of Adolescent and Reproductive Health, under Gloria James, Ph.D. includes the Adolescent Health Program (which includes School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Bureau of Health Planning & Resources Management, led by Judith Chaconas includes the Offices of Primary Care & Rural Health and the J-1 Visa program. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program. (See attached Organization Chart).

Due to character limitations, Organizational Structure Narrative continues in the next Section, Other MCH Capacity.

***//2013/ There were a couple of name changes that occurred over the last year, staff turnover of key positions, as well as restructured staff roles and responsibilities in the Family Health Systems section to align with MCH priorities. DPH is also happy to report that over the last year, we have also filled long-standing vacancies and recruited new personnel to address Delaware's MCH priorities. Alisa Jones, M.P.H. is the section chief of the Family Health Systems Section (FHS). The MCH Deputy Director is Leah Woodall, M.P.A. Paulina Gyan, M.P.H. was hired in October 2011 as the Early Childhood Comprehensive Systems Administrator. Bhavana Viswanathan, M.B.A., M.P.H., was hired as the Children and Youth with Special Health Care Needs Director, which was vacant for almost four years. Kathryn Tullis, PhD, was hired in November 2011 as the Newborn Screening/Genetics Administrator. John (Kevin) Massey was hired to serve as the Violence and Injury Prevention Administrator, which now oversees a Violence and Injury Prevention Program as a result of a CDC grant, and now sits in the Family Health Systems section of DPH. Finally, to align with priorities, the MCH Bureau went through a restructuring which prompted some welcomed changes in staff roles and responsibilities. Walt Mateja, PhD, is a Family Health Special Projects Manager, and Crystal Sherman (formerly the State Systems Development Initiative Administrator) is the Home Visiting Program Administrator as a result of the Maternal, Infant and Early Childhood Home Visiting Program grants. //2013//***

Nurses, social workers and nutritionists within the Smart Start, Kids Kare, and Child Development Watch Programs are directed by Herman Ellis, MD and Kristin Bennett, RN., MSN. Beyond the FHSM section, several other critical programs are part of the MCH array of services and programs. These include Oral and Dental Health Services; Northern Health Service Clinics, led by Anita Muir, M.S.; and Southern Health Clinics, led by Sherry Eshbach. Northern and Southern Health Services Clinic sites are the providers of three primary programs funded by Title V funds: Smart Start, Kids Kare (currently being integrated into Smart Start) and Child Development Watch. The state Public Health Nursing Director is Kristin Bennett, PhD., RN. DPH also includes a number of other programmatic areas which work closely with the MCH array of programs and activities. These programs are located throughout the strands of DPH and include Immunizations, Sexually Transmitted Diseases, Emergency Medical Services for Children, and the WIC program.

The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes \$1,814,303 for 29.4 FTEs (2.0 FTES

are projected to remain vacant during FY 2010). State general funds and appropriated special funds from Oral Health revenue will pay for 72.0 FTEs (a total of \$4,989,395) and contractual funds under the Infant Mortality Elimination program (a total of \$4,600,000).

/2012/ The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes \$1,557,202 for 24.4 FTEs (2.0 FTEs are projected to remain vacant during FY 2012). State general funds and appropriated special funds from Oral Health revenue will pay for 63.5 FTEs (a total of \$4,430,585) and contractual funds under the Infant Mortality Elimination program (a total of \$4,600,000).  
//2012//

***/2013/The total MCH Partnership budget in this application includes Title V funds, state general funds and appropriated special funds. The Title V allotment is estimated at \$1,966,509 for FY 13 with an additional \$400,000 available from FY 12 funds. State funds include \$9,281,008 in State General Funds and Appropriated Special Funds. 24.4 FTEs are funded under the federal portion of these funds and 62.5 FTEs from the state portion. Additionally, federal funds cover contractual services, travel, supplies, indirect costs and other miscellaneous expenses as detailed in the budget section of this grant. State funds also include the Infant Mortality initiatives in Delaware.//2013//***

#### Other MCH Capacity

Alisa Olshefsky, MPH. Alisa serves as the state Maternal and Child Health Director and is the Section Chief for Family Health and Systems Management. Alisa is in her third year serving in these capacities. Prior to assuming section chief responsibilities at the Division of Public Health, Alisa served as a Bureau Chief for Chronic Disease from 2006-2008 where she built and sustained the Delaware Cancer Consortium, a public/private collaborative. Alisa also has past experience as an Evaluation Manager at the University of California (San Diego), Division of Community Pediatrics.

Leah A. Jones, M.P.A. is the Maternal and Child Health Bureau Chief and MCH Deputy Director. Leah is responsible for direct oversight of the Title V Maternal and Child Health Block Grant Program, the State Systems Development Initiative, the Children with Special Health Care Needs Program, Early Childhood and Comprehensive Systems, the Autism Registry and the Birth Defects Registry and the Newborn Screening Programs (Metabolic and Hearing). Leah joined the Division of Public Health this year in the Spring. Leah's prior experience includes serving as the Director of Planning & Policy for the Delaware Health Care Commission. In the past administration, Leah worked as the Executive Assistant to Cabinet Secretary of Delaware Health and Social Services. Leah also served as the Caregiving Program Administrator for the Division of Services for Aging and Adults with Physical Disabilities.

/2012/ Delaware recognizes the importance of achieving a family-centered system of services for children and youth with special health care needs and their families, and is very pleased to report that in June 2011, DPH was approved to recruit candidates for the Children with Special Health Care Needs Director position within the Maternal and Child Health Bureau. The incumbent in this position will oversee the Children and Youth with Special Health Care Needs program (CYSHCN). Duties include: creating a system that allows families to partner in decision making and improving the services they receive, enhancing medical provider capacity regarding access to a medical home, ensuring adequate health insurance is available to pay for needed services, improving early identification of CYSHCN through enhanced developmental screening and awareness, and improving access for families to reliable information, resources and quality services. //2012//

***/2013/Alisa Jones, M.P.H. is the section chief of the Family Health Systems Section (FHS). The MCH Deputy Director is Leah Woodall, M.P.A. In October 2011, Bhavana Viswanathan,***

***M.B.A., M.P.H., was hired as the Children and Youth with Special Health Care Needs Director. Additional MCH personnel (i.e. Newborn Screening/Genetics Administrator, ECCS Administrator, Violence and Injury Prevention Program Administrator) have been hired to meet MCH capacity and address MCH priorities and are listed in the FY13 application under Organizational Structure. //2013//***

Parents of Children with Special Needs. Beth MacDonald, a CSHCN parent, is the Special Needs Alert Program (SNAP) program coordinator. Additionally, the MCH Program works closely with Family 2 Family, Delaware Family Voices, Delaware Hands and Voices and each of the organizations involved with the Family Support Initiative to ensure parent / family involvement in planning and evaluation of initiatives focused on Children with Special Health Care Needs.

/2012/ Investing in our best and brightest, including new and seasoned personnel as well as our key partners is critically important. Over the last year, we have focused on building leadership skills and competencies in Maternal and Child Health. Alisa Olshefsky, MCH Director, participated in the MCH-Public Health Leadership Institute, which is designed to significantly expand self-awareness, build practical skills for effectively leading, managing people, and building partnerships, to advocate for and create MCH systems improvements. Ann Phillips, Director of the Family Voices' Family to Family Health Information Center, and a key Title V MCH partner and family leader, was also recently accepted into the MCH-Public Health Leadership Institute. //2012//

***//2013/ Ann Phillips also serves as the Delaware Title V MCH Family Delegate.//2013//***

/2012/In December 2010, Leah Jones Woodall, MCH Deputy Director, was accepted into the AMCHP New Director Mentorship Program. Ms. Woodall was matched with Valerie Ricker, Director of the Family Health Division in the State Maine. The program is a great opportunity that matches experienced Title V Directors with new MCH Directors to help develop his or her goals and skills over 12 months through one on one conversations, learning activities and interactive online learning modules.

Walt Mateja, PhD, the Child Health Branch Director, competitively applied to the 2011 Training Course in Maternal and Child Health Epidemiology and was accepted. Dr. Mateja attended the training course in May 2011. The course provided states with an opportunity to build capacity for Maternal and Child Health Epidemiology. The training covered an in-depth description of the needs assessment-program evaluation cycle. The course also covered several approaches to identifying appropriate numeric targets for performance measures. Along with other State personnel, Dr. Mateja was afforded the opportunity to apply key concepts to practical case studies throughout the course. Knowledge and skills gained from this training will be applied within the Delaware Division of Public Health's Title V programs (Newborn Screening, Early Childhood, Children with Special Health Care Needs and Maternal and Child Health).

In the Spring 2011, Delaware applied for Technical Assistance through the HRSA MCHB to provide two workshops, one that covered strategic planning and a second on grant proposal writing. The Family Support Initiative conducted an environmental scan in August 2010 of 44 community based organizations and agencies who serve CYSHCN. As part of this scan, organizations were asked what technical assistance would be beneficial to their organizations, which 68% of the organizations indicated that technical assistance in the area of grant writing would benefit their organization. This TA opportunity provided Maternal and Child Health staff and key partners of the Family Support Initiative participating to focus on sustainability and capacity building. In addition, the TA served as a tool to plan programs and services as well as assess and plan for short and long-term financial stability to provide services. //2012//

***//2013/ In 2012, Delaware continues to see the value of professional and leadership development as well as developing our staff's core competencies in Maternal and Child Health. Bhavana Viswanathan, the CYSHCN Director, was accepted into the AMCHP New***

**Director Mentorship Program. Ms. Viswanathan was matched with Ana Novais, the Executive Director of Health, Division of Community, Family Health and Equity (MCH/Title V Director) in RI. Rhode Island has truly been a pioneer in the use of Parent Consultants in developing programs, policies, and quality improvement for RI families and especially children and youth with special health care needs. RI can serve as a valuable resource on best practices and offer a lot of expertise, as Delaware further enhances Family SHADE, a network for CYSHCN and their families, and develops a medical home pilot for CYSHCN. The program is a great orientation opportunity that matches experienced Title V Directors with new MCH Directors to help develop his or her goals and skills over 12 months through one on one conversations, learning activities and interactive online learning modules.**

**While there are currently travel restrictions for the Department of Health and Social Services employees, travel requests and strong justifications were made for training and professional development opportunities for key MCH personnel (two of which were hired in the Fall 2011) to attend the annual 2012 AMCHP conference. Travel was approved for the Title MCH Director, Deputy Director, the CYSHCN Director and the ECCS Administrator. In addition, the Title V MCH Director, Alisa Jones, was appointed as an AMCHP Board member for Region III, which has truly been a resource and elevates the great work that we are doing in Delaware. //2013//**

Staff Dedicated to the Maternal and Child Health Block Grant Staffing for the Title V programs includes 29.9 FTEs supported with Federal Title V funds and 72 FTEs supported by State General Funds (65 FTEs) and Appropriated Special Funds (7.0 FTEs).

## **E. State Agency Coordination**

Continued from previous section, Other MCH Capacity

Positions included as part of the Federal-State MCH Partnership are distributed as follows:

-10 Administrative Specialists -10.5 Advanced Practice Nurses -1 Section Chief (MCH Director) - 1 Clinic Aide -4 Clinic Managers -1 Community Relations Officer -9 Dental Assistants -6 Dentists - 1 Genetics Coordinator -.5 Health Program Coordinator -1 Management Analyst -3 Medical Records Technicians -1 Medical Social Worker Consultant -7 Nursing Supervisors -1 Nutritionist - 3.0 Public Health Program Administrators -.4 Public Health Physician -17.5 Registered Nurses -2 Senior Child Development Specialist -5.0 Senior Medical/Social Work Consultants -1 Social Worker -4 Social Service Specialists -8 Social Service Technicians -1 Teacher -1 Teacher's Aide -2 Trainers

These positions are located throughout the state's 9 Public Health Clinic Locations and work primarily in Smart Start, KIDS Kare, Child Development Watch and the Oral Health Program. Several positions (Program Administrators, Management Analyst, Section Chief) are centrally located in the DPH Administration Building in Dover, DE.

/2012/ Staffing for the Title V programs includes 24.4 FTEs supported with Federal Title V funds and 63.5 FTEs supported by State General Funds (56.5 FTEs) and Appropriated Special Funds (7.0 FTEs).

Positions included as part of the Federal-State MCH Partnership are distributed as follows:  
-11 Administrative Specialists -9.5 Advanced Practice Nurses -1 Section Chief (MCH Director) -1 Clinic Aide -4 Clinic Managers -.5 Community Relations Officer -8 Dental Assistants -5 Dentists -

.5 Health Program Coordinator -1 Management Analyst -3 Medical Records Technicians -1 Medical Social Worker Consultant -4 Nursing Supervisors -1 Nutritionist -2.5 Public Health Program Administrators -1.4 Public Health Physician -11.5 Registered Nurses -2 Senior Child Development Specialist -5 Senior Medical/Social Work Consultants -1 Social Worker -3 Social Service Specialists -6 Social Service Technicians -1 Teacher -1 Teacher's Aide -2 Trainers -1 Operation Support Specialist

***//2013/The staff component remains unchanged from 2012.//2013//***

#### State Agency Coordination

Delaware prides itself in building and maintaining partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core services within public health and specific health priorities. The aim is to have DPH working at the "bottom of pyramid" on population-based and infrastructure-building services. The four Division priorities include:

- Healthy lifestyles
- Health reform
- Disparities elimination
- Organizational development

These priorities are addressed in part through the following relevant relationships between the Division of Public Health/Title V MCH Program and external partners.

Delaware Healthy Mother and Infant Consortium. The targeted effort of providers, DPH, and the Delaware Healthy Mother and Infant Consortium (DHMIC) and its subcommittees to reach pregnant women and mothers is very successful. In 2008, the prenatal programs reached almost 20% of all pregnancies in Delaware.

Child Death, Near Death and Stillbirth Commission (CDNDSC). Delaware's child death review process was established by legislation passed on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The statute was amended in 2002, and again in 2004, changing the name from the Delaware Child Death Review Commission to the Child Death, Near Death and Stillbirth Commission (CDNDSC). The mission of the commission is to safeguard the health and safety of all Delaware children as set forth in 31 Del. C. c. 3. The key objectives are:

- Review in a confidential manner, the deaths of children under the age of 18, near-deaths of abused and/or neglected children and stillbirths occurring after at least 20 weeks of gestation.
- Provide the Governor, General Assembly and Child Protection Accountability Commission with recommendations to alleviate those practices or conditions that impact the mortality of children.
- Assist in facilitating appropriate action in response to recommendations.

The CDNDSC has the authority to create up to three regional child death review panels and three regional Fetal Infant Mortality Review (FIMR) teams to conduct retrospective reviews of all child deaths, near deaths due to abuse/neglect and stillbirths (after 20 weeks gestation) that occur in the state. The Commission provides meaningful system-wide recommendations to prevent the deaths and/or near deaths of children and improve services to children. The process brings professionals and experts from a variety of disciplines together to conduct retrospective case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

CDNDSC/Fetal and Infant Mortality Review. Reviews every fetal and infant death in Delaware using the Fetal and Infant Mortality Review (FIMR) process, which includes reviewing medical records, death certificates and other health information, and interviewing mothers. FIMR helps to

inform why there is a high number of fetal and infant deaths in Delaware. The information received from interviews with mothers helps make recommendations for changes in public health programs and interventions.

The top four issues identified in 2008-2009 were:

- preexisting medical conditions;
- medial and social services and community resources that were available and not used;
- obesity and poor nutrition;
- preterm labor.

More specifically, 71 percent of women interviewed had a preexisting medical condition, 40 percent had inadequate or delayed referrals for home-based services; 26 percent were obese and 24 percent had inadequate nutrition or anemia in the first trimester; and 32 percent went into preterm labor.

The DHMIC is the community action arm or implementation teams for FIMR findings.

In 2010 CDNDSC is collaborating with the Division of Public Health and Nemours to implement the National "Cribs for Kids Program" in Delaware. This program provides cribs and educational materials related to safe sleeping practices to mothers in need.

FIMR Infant Safe Sleeping Practice. In 2009: FIMR distributed Infant Safe Sleeping Posters to all licensed daycare centers in the state and continued community education on Safe Sleeping Practices as community events/trainings.

Delaware Birth Defects Registry. A statewide program that collects and analyzes information on children with birth defects. By collecting information for a statewide registry, Public Health officials hope to identify health, environmental and genetic risk factors which could lead to pinpointing the causes and prevalence of birth defects. The Delaware Birth Defects Registry is designed to collect information on children diagnosed under the age of five with a birth defect. The children are residents of Delaware or their parents are Delaware residents. Confidentiality is a key component of the program. All information is kept in utmost confidence using strict security measures.

March of Dimes. The March of Dimes-Delaware Chapter (MOD) works to improve the health of babies by preventing birth defects, prematurity and infant mortality. The mission is accomplished through research, community services, education and advocacy and collaborations with many organizations to save babies' lives. Delaware's MOD also is one of 15 chapters to support the NICU Family Support Program which provides direct service and support to families with infants in the NICU of Christiana Care. Through partnership, families are directly linked to community programs to assist with transition from hospital to home for the most vulnerable babies prior to discharge. DPH will continue to collaborate with the March of Dimes in a joint effort to increase access to quality prenatal care, reduce the number of premature births and birth defects and improve health outcomes of all children. The MOD staff serve on DHMIC committees.

Department of Education (DOE). The Delaware Health and Social Services and the Department of Education work collaboratively to develop programs promoting the health of all children in Delaware. Examples include the delivery of EPSDT services in the school setting and in providing support for School-Based Health Centers. Currently there are commissions on Health Education, Health Services, and Physical Education, Nutrition Services, School Climate, Staff Wellness, and Counseling Services. 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 DOE has also collaborated with DPH 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. The

Office of Health Services, DOE, in partnership with the DPH provides training to school nurses on teen pregnancy prevention, lead poisoning, tuberculosis, immunizations, bio-terrorism and emergency preparedness and public health resources. Delaware has a comprehensive system of school nurses, with one in each school and most private schools. There are over 320 full and part time school nurses in Delaware that serve students in public and private schools.

Head Start and Early Childhood Assistance Program. Head Start is administered by DOE through community-based organizations throughout the state. There are three locations in Kent County, four in Sussex County, and twelve in New Castle County. Early Childhood Assistance Programs are state-funded, comprehensive child development programs for low-income families with children age four and eligible for kindergarten the following year. These programs follow the Head Start Performance Standards. Approximately 1,795 children between ages three and five are served by the traditional Head Start program. All programs followed the federal Head Start Performance Standards. The Division of Public Health participates on the Head Start State 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, social and emotional wellness, disabilities, educational opportunities, volunteerism, literacy, and homelessness. The Head Start State Collaboration Office director serves on the ECCS steering and executive committees and Healthy Child Care America-Delaware (HCCA-DE) advisory committee. HCCA-DE and the Head Start State Collaboration Office partnered to provide funding and resources for the piloting of Partners In Excellence: Promoting Social & Emotional Competencies in Young Children (PIE) in 15 Head Starts, ECAPS and Child Care Centers statewide. An additional partner is the Devereux Foundation and one of the evaluation measures will utilize the Devereux Early Child Assessment (DECA) tool. This pilot worked with classroom teachers and parents to infuse PIE and DECA strategies into classroom curriculum to identify and minimize challenging behaviors. The pilot utilized child care health consultants as technical advisors in the classroom setting and will impact over 1500 children, between the ages of 3 to 5. In addition, Child Development Watch staff work with local Head Starts and other providers on the Sequence in Transition to Education in Public Schools (STEPS) Committee, which concentrates on transition issues for 3 year olds.

Early Success. 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. Initiated in 1998, Early Success was developed as the state's coordinated plan to address the early childhood issues of children, birth to eight, who received out of home care. The governor established an interagency resource management committee made of the cabinet secretaries from the Department of Health and Social Services, Department of Services to Children, Youth and their Families, Department of Education, Office of Budget, and the Controller General's Office. Additionally, the governor established the Delaware Early Care and Education Council, comprised of private citizens, and the Office of Early Care and Education (OECE) to ensure that Early Success goals and objectives were met. In an effort to provide a comprehensive approach of early childhood services to all families, the ECCS and the OECE, with full support from the Delaware Early Care and Education Council, have partnered to unify Delaware's early childhood initiatives and broaden the initial Early Success plan to include child health, social-emotional development, and expand family engagement domains. This will provide a statewide strategic plan that is comprehensive, coordinated and accessible to all children from birth to age five, and their families. It will also enable the DPH to provide statewide leadership on child health and development issues through multiple public/private collaborations.

Early Childhood Work Groups. The Early Childhood Education workgroup provides leadership to ensure that Delaware delivers an equitable and effective system of education for young children in full compliance with federal and state law. The group ensures that the interests of young children are represented in all aspects of Delaware's education reform. The group operates, oversees and monitors programs made possible by both federal and state funds.

The School Support Services workgroup includes programs and support services necessary to

assure a supportive and healthy environment that nurtures academic growth and development. The group is responsible for the development of programs and services in the areas of:

- Nutrition Programs;
- School Climate and Discipline;
- School Health Services;
- Student Services and Special Populations.

Delaware Oral Health Coalition. Promotes good oral health through its Awareness and Prevention Committee and its Integrated Delivery Systems Committee. The Coalition was instrumental in developing the Oral Health Awareness Campaign. Members developed a curriculum for all health classes and presented it to the Delaware Department of Education for review. It also reviewed topics such as Medicaid enrollment for dentists, improving access to care in underserved areas, and expanding the dental residency program downstate.

DHSS Division of Management Services (DMS). Provides human resources, budget development, and evaluation services to other DHSS divisions. DMS also houses the Birth to Three Office, which provides administration for Part C. Birth to Three is a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. DMS staff provides overall management for the system and ensures compliance with the federal requirements of the Individuals with Disabilities Education Improvement Act of 2004, which provides funding to help support the system.

Children and their families receive early intervention supports and services by Child Development Watch within the Division of Public Health, with staff drawn from DPH and DDDS. Major external partners, through interagency agreements and contracts, are Department of Education; Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Alfred I. duPont Hospital for Children; and community providers.

DHSS Division for the Visually Impaired (DVI). The DPH Child Development Watch works with DVI to provide service coordination for children with visual impairments or who blind.

DHSS Office of Emergency Medical Services. Delaware first received EMSC grant funding in 1997 and the program officially began with the hiring of a program coordinator in 1998. Some examples of cutting-edge work underway with support from the EMSC program are projects to: provide specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for child care agencies; and ensure that all state trauma/disaster plans address pediatric needs. More detailed information on Emergency Services for Children is outlined in Section VI.

Department of Services for Children, Youth, and Their Families (DSCYF). Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the DPH. Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and after care. The KidsDepartment employs approximately 1,200 staff at 31 locations, who serve over 8,000 children on any given day. Among the workforce are 52 Family Crisis Therapists (FCTs), who work in elementary schools throughout the state. Additionally, the Department provides licenses to nearly 2,200 daycare operations, which provide services for more than 49,000 children in Delaware.

Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with

the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training and support to many day care providers throughout the state, and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

Division of Youth Rehabilitative Services (DYRS). Provides services to youth who have been adjudicated delinquent and ordered by the court system to receive rehabilitative services. DYRS works closely with the community and DPH through the Community Advisory Board, DYRS serves approximately 5,000 youth per year, ranging from probation to secure care incarceration. In Delaware, there are five secure care facilities that provide secure detention for youth and 24-hour custodial care and treatment for incarcerated, adjudicated youth. Secure care also provides appropriate education, treatment, counseling, recreation, vocational training, medical care, and family focused case management for youth in secure residential facilities. Furthermore, the DYRS Community Services unit provides probation and aftercare services to approximately 3,000 youth per year, in addition to overseeing 47 contracts with providers offering residential and nonresidential programs and services. Community Services operate to ensure that the risks to the public is minimized, youth are served in the least restrictive environment appropriate for their needs, and the families of the youth are strengthened through Community Services intervention.

American Academy of Pediatrics (AAP). The DPH has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Section have participated on the vaccine committee, EPSDT implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality.

The Delaware Coordinating Council for Children with Disabilities (DCCCD or CCCD) has been active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide.

The Autism Surveillance and Registration, or an Autism Registry. Enables the DHSS and DPH to collect basic descriptive information on the individuals with autism, to track changes in prevalence over time, to inform the planning of service delivery to children with autism and their families, and to facilitate autism research. The purpose of the Autism Registry is to provide an accurate and continuing source of data concerning autism to provide information to Public Health officials. The Autism Registry will gather data to assist with: prevalence estimation, cluster investigation, risk factor identification, and outcome assessment.

Section 619/Special Education for Ages 3-5 Coordinators: This program provides free appropriate public education (FAPE) for children, ages 3 through 5 years, with disabilities in Delaware.

State Interagency Coordinating Council (ICC). The ICC advises appropriate agencies on the unmet needs in early childhood special education and early intervention programs for children with disabilities, assists in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

CYSHCN Survey. To better understand the CYSHCN population and the needs and challenges they face, the CDC conducted a telephonic survey in 2005--2006 titled the National Survey of Children with Special Health Care Needs. The results did provide valuable information for Delaware but due to a small sample size and lack of a diverse sample, the results were not representative of CYSHCN in Delaware. The DPH is conducting an additional mixed method survey in 2010 to try to capture a broader and more representative sample. The CDC is aware of

the survey and offered assistance if needed.

Transition of Care for CYSHCN. A major challenge to CYSHCN and their families is the transition into adult care. Collaborations exist between family members, physicians, therapists, educators, and service providers who belong to DCCCD, the Office of Children with Special Health Care Needs, DPH, and the Alfred I. duPont Hospital for Children Transition Committee to understand the struggles to navigate and transition to adult care for young adults with chronic conditions and disabilities. The Delaware Transition Initiative at the Alfred I. duPont Hospital for Children established the Transition Survey Project to further explore young adults and families issues when they transition from specialized pediatric health care systems into community-based adult health care systems. The major takeaways from the survey demonstrated the significant lack of specialized providers for young adults, the lack of assistance and education families and the youth receive about the process, and the lack of communication between current and future providers. The CYSHCN survey the DPH is conducting in 2010 is also addressing the transition issue and hopes to make positive changes in the near future.

Family Support Initiative (FSI): The FSI, or umbrella organization concept, was developed by the MCH Director in 2008 after a site visit with the Rhode Island MCH program. Rhode Island had a successful model for CYSHCN and family support services where an umbrella organization (Rhode Island Parent Information Network) helped convene and strengthen resources and services through a network of CYSHCN organizations. In Delaware, the goal is that the umbrella organization convenes partner organizations (either formal organizations or parent groups) whose work focuses on meeting the needs of CYSHCN. Partner organizations provide input and strategic guidance as part of an Advisory Council to the umbrella organization. CYSHCN are strongly represented as part of the organization's governance structure. The umbrella organization has the "bird's eye view" and works with partner organizations to decrease duplication in services, increase access to services and address unmet needs to ensure the system of CYSHCN family support is meeting the needs of families.

***/2013/ FSI is now known as Family Support Health Care DE Alliance (Family SHADE).***

***Sussex County Health Promotion Coalition is a relatively new partner that MCHB is building a collaborative partnership with to strengthen a family-focused effort to improve the health of children and youth in Sussex County. Delaware is eager to work with this group to address an area long identified as an area of critical child mental health service shortage. In response to this need, Title V MCHB is working with the Department of Children Youth and Their Families' Division of Prevention and Behavioral Health Services (i.e. Child mental health agency) as well as the Help Me Grow Advisory Committee to identify ways to partner on early childhood, health and wellness, family outreach and community engagement activities.***

***A Help Me Grow Advisory Committee was established in February 2012 and is staffed by DPH MCHB, following a state-wide Summit, to assist with the infrastructure development and implementation of Delaware's Help Me Grow system. Members of the Committee were designated by the Lieutenant Governor Matt Denn, and representatives include Office of the Lieutenant Governor, Part C Coordinator (i.e. Birth to Three Program), Part B Coordinator (IDEA Section 619 Coordinator, Department of Education), Nemours Health and Prevention Services, United Way of Delaware, DE Chapter of the American Academy of Pediatrics, parents/family members, Medical Director of the Birth to Three Program, Executive Director and CEO of Children and Families First (non-profit agency that also supports and facilitates Delaware's Home Visiting Community Advisory Board), Executive Director, Family to Family Health Information Center, Family SHADE Coordinator, network of Children and Youth with Special Health Care Needs, Executive Director of Prevent Child Abuse Delaware, Director, Head Start State Collaboration Office (Department of Education), Director of the Division of Family Services, Dept. of Services to Children, Youth and Families, DPH's MCH Title V Director and Deputy Director, and the Early***

## **F. Health Systems Capacity Indicators**

### Priority Health System Capacity Indicators

Among the most critical Health System Capacity Indicators for the Delaware Maternal and Child Health Program are:

- HSCI #4: The percent of women (15 to 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; and
- HSCI #5 - Medicaid / NonMedicaid Comparison
  - a. Low Birth Weight
  - b. Infant deaths
  - c. Percent born to women receiving care starting in first trimester
  - d. Percent born to women receiving adequate care

Under Delaware's Home Visiting efforts, HSCI #2, "The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen" and HSCI 7A, "The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program" are also a critical measures that will be of particular interest in future years as we track the penetration and effects of the program.

Children are not eligible for SCHIP in Delaware until one year of age (infants are served by Medicaid), therefore HSCI #3 is not applicable and although we work closely with a number of other agencies on asthma issues, Delaware's Division of Public Health currently does not have a dedicated asthma program.

### Data and Trends

Health Systems Capacity Indicator #1: The rate of hospitalization for asthma per 10,000 children less than five years of age.

The latest available data are from 2009 Hospital Discharge records and indicate 82.2 per 10,000 children less than five year of age were hospitalized with an indication of asthma. This appears to an increase over 2007 and 2008.

Health Systems Capacity Indicator #2: The Percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial period screen.

In 2010, 92.9 % of Medicaid enrollees whose age was less than one received an initial period screen. This appears to be trending upward since 2007 when 86.4% of Medicaid enrollees less than one were reported to receive at least one screen. This data is reported annually on the EPSDT Participation report, Form CMS 416. The latest available data are from 2010, as reported to CMS in February 2012.

Health Systems Capacity Indicator #3: The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen. As mentioned above, this indicator is not applicable in Delaware.

Health Systems Capacity Indicator #4: 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.

In 2009, 75.6% of women aged 15 through 44 with a live birth record had scores of 80 percent or

greater on the Kotelchuck index as recorded in Delaware's birth records. This appears to be a slight uptick from 2008 and an increase over the 69.4% reported in 2007.

Health Systems Capacity Indicator #5A: Percent of low birth weight.

In 2009, 9.4% of women on Medicaid at the time of birth gave birth to low birth weight infants compared to 7.7% of non-Medicaid women who gave birth. This is a slight decrease since 2008 when 9.7% of mothers on Medicaid gave birth to low birth weight infants.

Health Systems Capacity Indicator #5B: Infant deaths per 1,000 live births

In 2009, the infant mortality rate among women giving birth on Medicaid was 10.1 per 1,000 live births. Among non-Medicaid women the infant mortality rate was 6.3 per 1,000. This appears to be a slight decrease since 2008 when the infant mortality rate was 10.3 per 1,000 among Medicaid women.

Health Systems Capacity Indicator #5C: Percent of pregnant women entering care in the first trimester.

In 2009, 63.9% of women who gave birth on Medicaid entered prenatal care in the first semester compared to 85.5% of their non-Medicaid counterparts. This is a slight improvement over 2008 when 61.2% of women who gave birth on Medicaid entered prenatal care in the first trimester.

Health Systems Capacity Indicator #5D: Percent of pregnant women with adequate prenatal care.

In 2009, 66.9% of women who gave birth on Medicaid received adequate prenatal care as measured on the Kotelchuck index compared to 84.5% of non-Medicaid women who gave birth. This is a slight increase since 2008 when 65.2% of women who gave birth on Medicaid received adequate prenatal care.

Health Systems Capacity Indicator #6: Medicaid Eligibility Levels

As shown on Form 18, infants are at or below 200% of Federal Poverty level are eligible for Medicaid. Children from 1 to 5 years of age are eligible for Medicaid at or below 133% of FPL and children 6 to 19 are eligible for Medicaid at or below 100% of FPL. Pregnant women at or below 200% of FPL are eligible for Medicaid.

Health Systems Capacity Indicator #6: SCHIP Eligibility Level

Infants are not eligible for SCHIP, however infants up to 200% of Federal Poverty Level are eligible for Medicaid. Children from ages 1 to 19 are eligible for SCHIP at 200% of FPL.

Health Systems Capacity Indicator #7A

Percent of potentially Medicaid eligible children who have received a service by the Medicaid program.

In 2011, 89.8% of Medicaid eligible children received a service paid by the Medicaid program. This year we revisited the parameters for determining the numerator and denominator for this variable, as there have been some questions about how this indicator was calculated in the past, so comparisons to prior years' data are not valid. We have increased the scope of "potentially eligible" thus increasing the denominator for this indicator and have included any aid category code and thus might include those covered by Expanded Populations, Medicaid for Workers with Disabilities, Delaware Cancer Treatment Program, Family Planning and all the waiver categories - in addition to the regular Medicaid aid categories.

Health Systems Capacity Indicator #7B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

In 2010 58.4% of EPSDT eligible children (ages 6 to 9) received a dental service during the year. This appears to be an increase over previous years beginning in 2007 when 33.4% of EPSDT eligible children (ages 6 to 9) received a dental service during the year. This data is reported on the Annual EPSDT Participation Report, Form CMS-416.

Health Systems Capacity Indicator #8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

In Delaware the CSHCN program provides infrastructure building services and capacity statewide. Therefore, in our view, all children and families in Delaware "receive" services from the CSHCN program. In 2011, 3,139 children less than 16 were reported as SSI Beneficiaries as reported by the Supplemental Security Record.

As mentioned above, the Health System Capacity Indicators directly related to the health of pregnant women and birth outcomes are priorities in Delaware that we continue to monitor. In terms of measures of birth outcomes such as infant mortality and low birth weight, Delaware remains well below the national average, but we have noted improvements over the past few years. In 2009, the year that of the most recent data for these indicators, initiatives of the Delaware Infant Mortality Elimination program were only partially implemented.

As the Home Visiting Program becomes fully implemented, the indicators concerning Medicaid utilization and EPSDT are becoming more central to our efforts in terms of understanding program impact and penetration.

Though we have not set "evaluation" targets for these indicators, we will continue to gauge these measures compared to national data and other states, as well as the region.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

In the 2010 MCH Block Grant application, Delaware revisited its State Performance Measures based on the early stages of the Five Year Needs Assessment process. With this application, which incorporates the seven original performance measures reported in July 2010, three new state performance measures have been added. Two of these performance measures were included in revisions to the 2010 MCH Application submitted in September 2009 as result of recommendations from the Federal-State Partnership Review. One of the measures is related to developmental disabilities and the second tracks benchmarks completed for the implementation of the statewide Family Support Initiative for Children with Special Health Care Needs.

Since September, the State has recognized the need for a broad measure to gauge progress on issues related to Children with Special Health Care Needs. It was decided to track disparities among Children with Special Needs along a number of domains. Based on findings from the 2007 National Survey on Children's Health (NSCH), a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

According to the 2007 NSCH:

#### Disparities in Child Health Indicators

- **General Health.** Among those aged 0-17 years in Delaware, 71% (CI 65.1-76.9) of Children with Special Health Care Needs (CSHCN) were reported to be in overall excellent or very good health. This compared to 88.7% (CI 86.4-91.0) of non-CSHCN.
- **Oral Health.** Among those aged 1-17 years in Delaware, 64.1% (CI 57.8-70.4) of CSHCN were reported to have teeth that were in excellent or very good condition. This compared to 75.2% (CI 72.0-78.4) of non-CSHCN. In this same age range, although not statistically significant, 15.2% of CSHCN were reported to have two or more oral health problems in the past six months. This compared to 8.1% of non-CSHCN.

#### Disparities in Emotional and Mental Health

- **Parental Concern.** Among those aged 4 months to 5 years in Delaware, 58% (CI 42.3-73.7) of parents of CSHCN reported concern over their child's physical, behavioral or social development. This compared to 36.4% (CI 30.9-41.9) of parents of non-CSHCN.
- **At-Risk Children.** Among those aged 4 months to 5 years in Delaware, 28.5% (CI 11.9-45.1) of CSHCN were reported to be at high risk for developmental, behavioral, or social delay. This compared to 7.2% (CI 4.2-10.3) of non-CSHCN.
- **Social Behaviors.** Among those aged 6 -- 17 years in Delaware, 81.1% (CI 74.6-87.7) of CSHCN were reported to consistently exhibit positive social behaviors. This compared to 94.6% (CI 92.4-96.8) of non-CSHCN. Furthermore, among this same age cohort, 24.8% (CI 17.8-31.8) of CSHCN were reported to often exhibit problematic social behaviors. This compared to 4.5% (CI 2.8-6.3) of non-CSHCN.

#### Disparities in Health Care Access and Quality

- **Continuous and Coordinated Health Care.** Among those aged 0-17 in Delaware, 48.4% (CI 42.0-54.8) of CSHCN were reported to have a medical home that provided continuous,

coordinated, comprehensive, family-centered and compassionate health care services. This compared to 63.6% (CI 60.3-67.0) of non-CSHCN.

- **Effective Care Coordination.** Among children needing care coordination in the past year, 52.1% (CI 44.6-59.7) of CSHCN were reported to receive effective care coordination. This compared to 79.3 (CI 74.9-83.7) of non-CSHCN.

- **Specialist Care.** Among children who needed specialist care in the past year, 14.2% (8.9-19.5) of CSHCN were reported to have had problems getting specialist care. This compared to 3.9% (CI 2.5-5.2) of non-CSHCN.

#### Disparities in Family Health

- **Mother's Health.** Among children in Delaware that lived with their mother, 53.9% (CI 47.3-60.4) of mothers of CSHCN were reported to be in very good or excellent general health. This compared to 66.6% (CI 63.2-70) of mothers of non-CSHCN.

- **Mother's Mental/Emotional Health.** Among children in Delaware that lived with their mother, 63.2% (CI 56.6 -- 69.8) of mothers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 75.4% (CI 72.3-78.5) of mothers of non-CSHCN.

- **Fathers Mental/Emotional Health.** Among children in Delaware that lived with their father, 71.4% (CI 64.7-78.2) of fathers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 82.2 (CI 79.2-85.1) of fathers of non-CSHCN.

## **B. State Priorities**

The States Priorities are as follows:

### Infant Mortality

Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistency higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the DHMIC. The Consortium united with the DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached 20% of all Delaware pregnancies in 2008. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007.<sup>1</sup> The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

During the 2003-2007 period, the primary cause of infant death in Delaware was low birth weight and prematurity.<sup>1</sup> The second leading cause of death, however, varied by racial group. For Black non-Hispanic women, sudden infant death syndrome (SIDS) was the second leading cause of death while birth defects were the second leading cause of death among White non-Hispanic women.

### Low Birth Weight Infants/Preterm Birth

Infant low birth weight is a major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation.<sup>7</sup> The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.<sup>1</sup>

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health.<sup>12</sup> Interpregnancy intervals (IPs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

#### Child/Teen Obesity and Overweight

A child's weight status is determined based on an age- and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:

- Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
- Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age).<sup>52</sup> The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide.<sup>52</sup> For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007.<sup>52</sup> According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.<sup>52</sup>

The link between early childhood and the onset of childhood obesity has been identified as a growing concern in Delaware. In collaboration with the Health Promotion and Disease Prevention Section, the Title V MCH Program provided start-up funds for the development of a childhood obesity curriculum, "Healthy Habits - Healthy Start." The goal of "Healthy Habits, Healthy Start" is to train childcare providers in Delaware in how to use tools to increase physical activity and healthy eating of the children in their care while keeping in mind current childcare regulations. The tools in this training are the Sesame Street Healthy Habits for Life Resource Kit and Nemours Best Practices for Healthy Eating: A Guide to Help Children Grow Up Healthy. Under this project, the University of Delaware's Cooperative Extension, with input from Nemours Health and Prevention Services developed a curriculum consisting of 2 three hour sessions. Trainings commenced in January 2010 and have been offered on a monthly basis.

#### Obesity Among Women of Childbearing Age

Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over

age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was \$117 billion, \$61 billion in direct cost, and \$56 billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

#### Unintentional Injury and Mortality among Children and Youth

The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years.<sup>1</sup> Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

#### Teen Smoking

Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days.<sup>53</sup> These results parallel nationwide rates (50.3% of students nationwide tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data).<sup>55</sup> Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days.<sup>53</sup> In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years.<sup>53</sup> Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.<sup>53</sup>

#### Family Support of Children and Youth with Special Health Care Needs

Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approach to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered -- it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support

needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

**Developmental Delay**

Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

**Disparities among Families of Children and Youth with Special Health Care Needs**

Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

**C. National Performance Measures**

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

**Tracking Performance Measures**

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	35	33	48	60	61
Denominator	35	33	48	60	61
Data Source		Newborn Screening Data	Newborn Screening Data	Newborn Screening	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2011**

2011 Newborn Screening Data

**a. Last Year's Accomplishments**

A main focus of the Newborn Metabolic Screening during 2011 was planning for the addition of Severe Combined Immunodeficiency Disease (SCID) to the core panel of conditions screened for through Delaware's Newborn Metabolic Screening Program.

The program also continued to work on remote data entry in concert with the Newborn Hearing Screening Program.

Surveillance System for Active Birth Defects. After establishing a working group on the Birth Defects Registry, the Newborn Screening (Metabolic) Program, Newborn Hearing and Birth Defects Registry transitioned from a passive to an active surveillance system. The registry inputted 2007 data over the last year and is currently working on 2008 and 2009 data.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening Program	X	X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2012, the program continued work to implement SCID screening and investigate the feasibility of screening for congenital cardiac defects, as warranted.

The program also initiated DNA testing for Cystic Fibrosis.

SRV (Secure Remote Viewer) is completely implemented and as soon as providers are completely trained, the program will eliminate mailing test results to providers thus realizing a cost savings and improving turn-around time.

**c. Plan for the Coming Year**

In the coming year, the Newborn Metabolic Screening Program hopes fully implement SCID screening and reporting.

In 2012, Delaware's largest birth facility began screening Pulse Oximetry on all infants. Building on this effort, the program will provide technical assistance to other hospitals throughout the state to meet the current AAP recommendations, as the recommendations from the Secretary's Advisory Committee on Heritable Disorders and Newborn Screening.

The Program will explore sharing screening results electronically with the Delaware Health Information Network -- an exchange for Electronic Medical Records.

The program will complete a cost recovery initiative in the coming year that will result in significant cost savings and more efficient use of resources.

The program is working a Request for Proposals (RFP) to contract with a medical geneticist to provide consultation and oversight to the program. Our long time genetics expert, Dr. Louis Bartoshesky, will be transitioning some of his duties.

### Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	11627					
<b>Reporting Year:</b>	2011					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11668	100.4	4	2	2	100.0
Congenital Hypothyroidism (Classical)	11668	100.4	9	6	6	100.0
Galactosemia (Classical)	11668	100.4	2	0	0	
Sickle Cell Disease	11668	100.4	12	9	9	100.0
Cystic Fibrosis	11668	100.4	8	5	5	100.0

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

#### Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	65	65	65	65	65
Annual Indicator	61.1	61.1	61.1	61.1	72
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2009-2010
Check this box if you cannot					

report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	72.7	73.4	74.2	74.9	75.6

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

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

**Notes - 2009**

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

**a. Last Year's Accomplishments**

The Family SHADE (formerly known as Family Support Initiative) held a statewide Summit Meeting in October, 2010. Over 50 community organizations, agencies and family members came together to begin a dialog on how to improve service and reduce fragmentation for families of CYSHCN. Several brainstorming activities resulted in strategies that could be accomplished by using the umbrella organization framework. One element that was repeated over and over by Summit attendees was the need for parents to have a consistent voice that could help to guide the service that they receive. One of strategies suggested was the formation of a Parent Advisory Group using an online methodology. The FSI Advisory Board then took this strategy and recommended Families Know Best (FKB). The tenants that guide FBK and its integration into the community are: Parents have the most complete understanding of their child's physical, developmental and social needs; Parents understand their child's needs in the context of the family's situation, culture and community; Parents are the only adults who have been and will continue to be deeply involved throughout the child's life. FKB will allow Family SHADE

participating organizations to gain input from families on a routine basis.

**Current Year:**

The Bureau continues to press forward with the "umbrella" organization, in partnership with the University of Delaware, Center for Disabilities Studies. In order to strengthen community groups serving CYSHCN, DPH led a year-long initiative to develop an "umbrella organization" for family support. The Delaware Division of Public Health partnered with the University of Delaware, Center for Disabilities Studies to administer and coordinate an "umbrella" organization, the Family Support and Healthcare Alliance Delaware or Family SHADE.. Family SHADE is a member-driven, collaborative alliance of family partners and organizations committed to improving the quality of life for CYSHCN by connecting families and providers to information, resources and services. The Family SHADE also provides technical assistance to member organizations in a variety of topics identified by members such as developing a strategic plan and developing grant proposals. In addition, Family SHADE plays a critical role through-out the five year life cycle of the MCH Needs Assessment process.

Family SHADE has developed a new online parent advisory board that will provide a mechanism whereby families can offer regular feedback about the services they receive and quickly bring new concerns to the attention of service providers and policymakers. Family SHADE staff developed a standard web-based and print survey format using Survey Monkey to create an online and print survey consisting of no more than 10 questions every other month. This survey, which helps drive family input, is coined Families Know Best (FKB). Each month, one question will ask about access to or availability of insurance. Other questions will be submitted by Family SHADE members in order to gauge the current and long term service needs of families. Questions from other Delaware board or councils can be incorporated with the approval of the Family SHADE Advisory Board, thus, making FKB a statewide resource for all agencies serving CYSHCN throughout the state. All individual responses will remain anonymous. It is critical to the success of the project that families provide input on a regular basis. This helps with continuity of information and reducing the need for continual recruitment. FKB families receive modest incentives (\$10 gift cards for six surveys completed) for their continuing participation. Family SHADE staff analyze and disseminate data received through surveys to organizations and policy makers across the state. Staff provide follow-up with the FKB families who request it, and inform them of: a) how the information is being used to improve services for CYSHCN; b) how they can stay involved to shape the services and policies that affect their family.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening Program	X	X	X	
2. Children Development Watch	X	X	X	
3. Oral Health Program	X	X		
4. Autism Registry				X
5. State Interagency Council				X
6. Delaware Developmental Disabilities Council				X
7. CSHCN Survey				X
8. Family SHADE				X
9.				
10.				

**b. Current Activities**

(Continued - Due to Character Limitations, discussion of current activities begins under "Last Year's Accomplishments for this Performance Measure).

The third prong is to replicate portions of the CDC CYSHCN survey in Delaware using a mixed-methods approach in the intervals between the telephone survey so as to acquire more timely feedback on system performance and family perceptions of services. This survey is expected to be launched in 2012, and will be championed by the Children and Youth with Special Health Care Needs Director (hired effective October 2011); CDC's lead for the survey has expressed intellectual support for this survey and is available for technical assistance, but has no funds available to invest in the process. This survey will be one of the components of The Bureau's evaluation strategy.

**c. Plan for the Coming Year**

Thirty three families currently participate in Families Know Best and these families represent a wide range of disability and health concerns. During the next year, Family SHADE staff and member organizations will continue to promote the participation of families in FKB at conferences, meetings, health fairs, etc., with the intent of increasing the numbers of families providing input to the survey, particularly in Kent and Sussex Counties.. FKB brochures and surveys have been translated into Spanish and the Parent Information Center, on behalf of Family SHADE, will continue to solicit input via FKB from the Hispanic population in Sussex and Kent Counties

Planning for the CYSHCN Survey Replication Project has begun and will continue in the coming year with implementation of the project scheduled for Spring -- Fall of 2013.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	60	50	50	50	50
Annual Indicator	48.1	48.1	48.1	48.1	41.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2009-2010
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	41.8	42.2	42.6	43.1	43.5

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

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

**Notes - 2009**

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

**a. Last Year's Accomplishments**

During 2011, the Family SHADE's goals directly relate to the achievement of this performance measure. The Family SHADE contract began on March 1, 2010. In Delaware, the goal is that the umbrella organization convenes partner organizations (either formal organizations or parent groups) whose work focuses on meeting the needs of CYSHCN. Partner organizations provide input and strategic guidance as part of an Advisory Council.

The contractor facilitating this effort, University of Delaware, Center for Disability Studies (UDS-CDS) formulated a work plan that had these essential elements:

- A group meeting of probable collaborators to launch effort and solicit public input into Needs Assessment
- Conduct a comprehensive environmental scan
- Facilitate a Collaborator's Summit
- Web and print (large print, Braille and audio) information resources
- Communication of emerging issues, opportunities

Current Activities:

Family SHADE goals continue to directly relate to the achievement of this performance measure. CYSHCN are strongly represented as part of the organization's governance structure. The

umbrella organization has the "bird's eye view" and works with partner organizations to decrease duplication in services, increase general knowledge about medical homes in primary care pediatric practices through partnerships (DE AAP, Medical Society of Delaware, etc.), increase access to services and address unmet needs to ensure the system of CYSHCN family support is meeting the needs of families.

In response to a new HRSA funding opportunity (D70), Delaware was awarded the State Implementation grant to Improve Services to Children and Youth with Special Health Care Needs in July 2011. Informant interviews were completed for pre-planning purposes with representatives from the Delaware Chapter of the American Academy of Pediatrics, the Medical Society of Delaware, the Division of Public Health, Nemours Health and Prevention, private health service providers, and the Family to Family Information Center to measure interest and commitment to planning and participation in a Medical Home pilot. These early key stakeholders possess over two decades of direct or related experience to the medical home model. In several cases, early CYSHCN medical home efforts in Delaware have been funded/supported through external funding sources such as the National American Academy of Pediatrics, the CATCH grant program, and private philanthropy.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. Early Childhood Comprehensive Systems				X
3. Autism Registry				X
4. State Interagency Council				X
5. Delaware Developmental Disabilities Council				X
6. Family SHADE				X
7.				
8.				
9.				
10.				

**b. Current Activities**

(Continued - Due to Character Limitations, discussion of current activities begins under "Last Year's Accomplishments for this Performance Measure).

In February 2012, Title V MCH identified and engaged over 250 stakeholders including but not limited to public and private sectors, advocacy organizations, health providers, education, hospitals and other child service providers, in active dialogue at the Lieutenant Governor's Help Me Grow Summit to discuss collaborative partnerships and system building efforts to develop a comprehensive and coordinated early childhood system including children with special needs. 2012 targeted activities include:

- Convene Help Me Grow summit to engage key stakeholders to exchange information and strategies about increasing physician capacity and enhancing access to medical homes.
- Assemble a team that will be trained in the Learning Collaborative model and use the training to implement the medical home in four medical practices in June 2013.
- Define the role and responsibility of the Learning Collaborative Stakeholder Team relative to medical homes and systems improvement planning and activities. Supported through the HRSA State Implementation Grant, a contract has been established with a local consulting company, Wheeler and Associates Management Services, Inc., to manage the CYSHCN Medical Home Pilot Project in conjunction with the newly hired CYSHCN director.

**c. Plan for the Coming Year**

Family SHADE staff and member organizations will be participating on the Help Me Grow Advisory Board and its Committees to ensure coordination of information and services to CYSHCN and their families. Family SHADE will also work closely with Help Me Grow to disseminate information throughout the Family SHADE network about medical home initiatives in Delaware

Efforts to launch the Medical Home Pilot Project will take place in the coming year. Activities include:

- Establishing a stakeholder team that will provide critical input to project design, and implementation planning.
- Preparing a "medical home for CYSHCN" pilot project design including goals, implementation plan and evaluation plan.
- Planning and conducting a Round Table event for stakeholders who comprise the team, other target guests, and potential participants.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	65	65	65	65
Annual Indicator	63.2	63.2	63.2	63.2	69.9
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2009-2010
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	70.6	71.3	72	72.7	73.4

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

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

**Notes - 2009**

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

**a. Last Year's Accomplishments**

Last year activities as reported in last year's Block Grant narrative was to establish the umbrella organization, Family SHADE.

**Current Activities:**

In 2012, the Bureau intends to develop a survey protocol for families of children with special health care needs by web and pencil-and-paper that replicates sections of the CDC telephone survey. This will be a lead project of the new Children and Youth with Special Health Care Needs Director, as the Director was recently recruited and hired in October 2011. This mixed-methods survey will provide valuable data in between CDC-released findings. Questions on insurance status to the CYSHCN survey will be included; there is also the ability to ask families to report instances of not being able to acquire care due to lack of insurance --separate and distinct from question of being unable to acquire care due to lack of providers. The Bureau also plans to reach out to Department of Insurance and/or Gov. Council on Exceptional Citizens to see how they are tracking/handling complaints from CYSHCN families as a second and possibly third source of data. The Family Support Initiative and its collaborating partners will also be tapped to develop methods of quantifying access to care, to assist with addressing this performance measure

Supported through HRSA MCHB and Title V, Family to Family (F2F) is a family-led parent empowerment and education program that helps families of CYSHCN navigate the health care system, access resources and services, and make informed decisions about health care issues. F2F helps families find solutions to issues of health care access, including those created by inadequate private and public insurance. To address these issues, F2F developed the Delawareans with Special Health Care Needs Medicaid Managed Care Panel. The Panel, consisting of representatives of Medicaid and Managed Care Organizations, is convened quarterly to provide an opportunity for families to raise issues of concern regarding insurance coverage directly with those who manage these services. F2F facilitates the dialogue between Medicaid and MCO representatives and parents in an effort to find solutions to issues raised during the call. The CYSHCN Director participates on these scheduled calls.

Families Know Best, a new project of Family SHADE, provides a mechanism whereby families can offer regular feedback about the adequacy of their insurance coverage and quickly bring new concerns to the attention of the Special Health Care Needs Medicaid Managed Care Panel.

Families Know Best includes specific questions about the adequacy of families' health insurance coverage on regular FKB surveys, and families' responses are shared with F2F and with the Panel. The Panel's agenda is responsive to the specific concerns expressed by families participating in the survey and the Panel has the ability to quickly identify and address new issues as they arise in the community. In addition, families receive feedback about the concerns they express on the survey and F2F and Family SHADE are available to provide additional health care-related assistance as needed. In addition, the Parent Information Center of Delaware (PIC), a Family SHADE partner, has been canvassing Hispanic families of CYSHCN in Sussex and Kent Counties about the adequacy of their insurance coverage and about barriers (such as language, transportation, etc.) that may prevent them from successfully accessing medical services and insurance. This information is also shared with Family SHADE member organizations and policy makers as indicated.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. State Interagency Council				X
3. Delaware Developmental Disabilities Council				X
4. Family SHADE				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Planned Activities for Next Year:

Planning for the CYSHCN Survey Replication Project has begun and will continue in the coming year with implementation of the project scheduled for Spring -- Fall of 2013.

Supported through the HRSA State Implementation Grant, planning is underway for the development of a new Special Health Care Needs Medicaid Managed Care Panel focusing on mental/behavioral health facilitated by DE Family Voices (FV). DE FV will work with Division of Prevention and Behavioral Health Services (DPBHS) and the Parent Information Center (PIC) to plan and develop a replication of the Medicaid Managed Care Organization Panel (MCO) that will address the needs of the many families with children who have behavioral or emotional issues. MCO panel calls were established by families of children with special health care needs (CSHCN) to address issues and policies related to managed care companies and Medicaid. Families frequently call to find out why a service is denied or dropped. Participants include representatives from Managed Care Organizations, Delaware Medical & Medicaid Assistance (DMMA), the Disability Law Program and other agencies that choose to participate. The result is that families either see their issue resolved or have a better understanding of policy and why it was denied or dropped. As a result of the calls, families, providers are educated on policy and frequently inform MCO and Medicaid of clients that are negatively affected. (continued)

**c. Plan for the Coming Year**

(Continued - Due to character limitations, discussion of Planned Activities continues from previous section "Current Activities").

The interaction between the families, providers, MCO and Medicaid is extremely valuable to all groups from an education perspective. As a result of the teleconference discussions, MCO and Medicaid have reversed policy when families have been able to demonstrate adverse impact.

**Plan for the Coming Year**

Families Know Best will continue to include a question on each bimonthly survey about the adequacy of families' health insurance coverage, and feedback from families will be shared with Family SHADE member organizations and policymakers as appropriate. PIC will also continue to ask Hispanic families for input regarding access/barriers to health insurance and healthcare services.

Planning is also underway for the development of a new Special Health Care Needs Medicaid Managed Care Panel focusing on mental/behavioral health facilitated by DE Family Voices (FV). DE FV will work with Division of Prevention and Behavioral Health Services (DPBHS) and the Parent Information Center (PIC) to plan and develop a replication of the Medicaid Managed Care Organization Panel (MCO) that will address the needs of the many families with children who have behavioral or emotional issues. MCO panel calls were established by families of children with special health care needs (CSHCN) to address issues and policies related to managed care companies and Medicaid. Families frequently call to find out why a service is denied or dropped. Participants include representatives from Managed Care Organizations, Delaware Medical & Medicaid Assistance (DMMA), the Disability Law Program and other agencies that choose to participate. The result is that families either see their issue resolved or have a better understanding of policy and why it was denied or dropped. As a result of the calls, families, providers are educated on policy and frequently inform MCO and Medicaid of clients that are negatively affected. The interaction between the families, providers, MCO and Medicaid is extremely valuable to all groups from an education perspective. As a result of the teleconference discussions, MCO and Medicaid have reversed policy when families have been able to demonstrate adverse impact.

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

**Tracking Performance Measures**

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	80	90	90	90	92
Annual Indicator	88.1	88.1	88.1	88.1	69
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2009-2010
Check this box if you cannot report the numerator because 1. There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	69.7	70.4	71.1	71.8	72.5

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

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

**Notes - 2009**

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

**a. Last Year's Accomplishments**

Family SHADE focuses directly on this performance measure. A comprehensive environmental scan was completed, followed up by a Collaborator's Summit in the Fall of 2010. Following these interactive table discussions, the group provided input regarding the major themes that emerged in the course of their discussions. Feedback included: comments about the need for a more collaborative culture in Delaware; the need to communicate better about programs and the possibility of devising a shared state-wide calendar; the importance of holding trainings together instead of fighting over families; the value of training on best practices concerning the use of social networking; the possibility of having a statewide online family advisory listserv (council) that could be surveyed periodically and provide feedback to the entire Family SHADE membership; funding barriers to collaboration; and, perhaps most importantly, the need to develop trust. The Summit participants presented a wide variety of ideas and models, but eventually voted to accept as Advisory Council members those Summit participants who volunteered to serve and could make a commitment to working on development of the infrastructure of the organization over the next year. This work included developing mission and vision statements, a strategic plan, bylaws and a draft Memorandum of Understanding for its member organizations.

**Current Activities:**

Families of CYSHCN acquire information about health care services in fragments from various service providers and conveyors of information. The Family SHADE environmental scan identified that the majority of organizations and providers have difficulty reaching groups that do not have access to computers and email. Over 85% of organizations surveyed send their newsletters and information exclusively via email. This is primarily due to budgetary constraints, but leaves families without internet access with very limited information about programs and services. Additionally, there is no opportunity for families to acquire information from multiple service providers in one location. Through Family SHADE stakeholders, plans are underway to invite service providers to participate and showcase their services and how these services can be accessed by families in an annual health and resource event in Delaware's three counties. This event will be broadly marketed to low income and minority populations through the Family SHADE network of organizations, WIC offices, FQHCs, schools and other agencies.

Family SHADE has a new, temporary website at [www.familyshade.org](http://www.familyshade.org) where current activities of member organizations are listed as well as links to various community service providers. The development of a more comprehensive and sophisticated website is underway and should be online in July or August. Family SHADE is also working with Children and Families First, a non-profit organization, to expand their extensive, existing database of services in Delaware to include parameters that specifically address the health care needs of CYSHCN and their families. The database, which is currently under development, will also be directly available to families via family friendly online portals located on the website home pages of Family SHADE and its member organizations.. The database will include information about community organizations, non-profit and private for-profit organizations as well as government agencies. The Family SHADE database will also include the Delaware Central Directory of Services for Young Children with Special Needs that was formerly published by the Department of Health and Social Services' Birth to Three Early Intervention System. A list of dentists that work with children with disabilities throughout the State was also recently included in the database. For example, families will be able to look up information about physicians or therapists in their area and whether they have accessible offices, take Medicaid, serve children with disabilities, etc. The Family SHADE database will be available as an adjunct source of information to Help Me Grow information and referral specialists. The database should be available to families by August, 2012.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family SHADE				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

(Continued)

In 2006, a print document called Connecting the Dots was developed by the Family to Family Health Information Center staff in collaboration with the University of Delaware's Center for Disabilities Studies. Connecting the Dots serves as a resource tool and provides families with a central location for agency information. An updated version of this document was produced, printed and distributed in 2012. As service agencies change locations and contact information, continuous updates are necessary. Through Family SHADE, an electronic and printed "roadmap" (flowchart) that clarifies the relationships between various services, providers, funding streams and eligibility criteria will be developed. The roadmap will also show families the "route" they can take to obtain services when they access the system from various entry points. Plans are underway to develop a linkage between services and the Family SHADE database to create a resource guide for parents that is dynamic and frequently updated. The roadmap is one strategy developed as result of the D70 State Implementation grant funding leveraged to Delaware to improve the system of services for Children and Youth with Special Health Care Needs and their families, which DPH feels is a direct result of and is attributed to the great work and infrastructure for Family SHADE developed under the Title V MCH Block grant.

**c. Plan for the Coming Year**  
(Current Activities, Continued)

Family SHADE staff also shared information about Family SHADE and its member organizations as well as the Families Know Best online survey at numerous conferences and health fairs including Delaware's largest disability-related conference (the LIFE conference). A Family SHADE mixer was also held in July 2011 where Family SHADE organizations shared information about their services with other organizations that serve CYSHCN. The organizations can then share their knowledge with the families of CYSHCN that they serve. A Family SHADE Summit was held on June 13, 2012 and two speakers described how nonprofits can effectively use social media to reach families with information about their organization's services and activities.

Families Know Best will continue to collect and share family input about unmet needs and services regarding CYSHCN so that service providers can refine their existing services and develop new services to meet current gaps in services.

Finally, discussions continue between DPH and Family SHADE to identify a one-stop I&R phone number, using Help Me Grow 2-1-1 (in partnership with the United Way of Delaware) as the first tiered level of a centralized telephone access point, to assist parents with children with special health care needs in finding existing community resources and service providers with expertise.

**Planned Activities**

Family SHADE will expand their website to include more services and activities available to CYSHCN and their families and to serve as a portal to access the new Family SHADE database. Representatives of Family SHADE member organizations will be also be trained in information and referral best practices and they will have access to a "professional portal" to the website. Resources will be continually added to the database and service providers will have an option to update their own project description and records. In addition, the website developer will be developing apps for the Droid and iPhone that will enable families to access and search the Family SHADE database with a smart phone, anytime, wherever they are.

The electronic Roadmap to Services will be developed through a mini-grant process administered by Family SHADE and funded through HRSA (D70 grant). Through a separate mini-grant, PIC will also expand its outreach to the Hispanic population in Kent and Sussex counties and will obtain information about gaps in services and/or barriers to accessing existing services. F2F was also awarded a mini-grant to conduct focus groups and a needs assessment to ascertain the

services are needed to support families of children with a chronic healthcare condition, and then they will reach out to these families through trainings on various topics.

Family SHADE will also offer technical assistance to organizations serving CYSHCN in areas that will enable them to expand their capacity, understand existing best practices, etc.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	25	45	45	45	45
Annual Indicator	42.4	42.4	42.4	42.4	38.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2009-2010
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	38.8	39.2	39.6	39.9	40.3

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**a. Last Year's Accomplishments**

The Bureau assembled questions needed to establish performance on this measure as a part of its mixed-methods replication of portions of the CDC CYSHCN process it will be establishing, which will be led by the CYSHCN Director, hired in October 2011. This assessment activity will help inform the work of the Family Support Initiative, now known as Family SHADE.

Delaware has launched various health care transition activities through different entities over the last few years. The Center for Disabilities Studies (CDS) at the University of Delaware established a transition information website in 2005 in partnership with KenCrest. This online resource for CYSHCN and their families is now located at [www.gohdwd.org/health-care/transition-for-young-adults/](http://www.gohdwd.org/health-care/transition-for-young-adults/). In addition, since 2010, CDS has been offering "Healthy Transitions" workshops for youth and young adults with special health care needs and their families to prepare them for their transition from pediatric health care to the adult health care system. "Healthy Transitions" workshops are conducted in partnership with Title V Maternal and Child Health, Delaware's Family to Family Health Information Center and Nemours/Alfred I. duPont Hospital for Children. A statewide, comprehensive transition plan is also under development that involves all major State and community partners serving youth with special health care needs (YSHCN).

**Current Activities**

In 2012, through Family SHADE (Family Support and Healthcare Alliance of Delaware), which was initiated and is funded through Delaware's Division of Public Health Maternal Child Health Bureau, a database is under development that will provide information on health care providers in the community who are interested and have expertise in working with patients with complex needs and disabilities. In addition, this database will be a comprehensive resource of supports, services and providers that work with children and youth with special health care needs.

In 2012, Title V, through the Delaware Maternal Child Health Bureau, continued to provide funding to the Center for Disabilities Studies to conduct its Healthy Transitions workshop series (brochure attached). Healthy Transitions is a 4-part workshop for youth and young adults with disabilities and special health care needs and their family members and/or educators about health care transition preparation. Workshops are offered in schools and to community groups and contain a social component (e.g. dinner; discussion, etc.) and presentation. The four sessions address 1) general transition issues (e.g. starting to identify an adult PCP and specialist(s), making appointments for doctor visits, taking care of one's medication, etc.), 2) insurance issues (e.g. what changes in coverage when you become an adult, how long can you

be on your parents' insurance, Medicaid/Medicare, dental care coverage changes, carrying your own ID card and insurance card, etc.), 3) healthy lifestyles (e.g. healthy nutrition, physical activity and exercise, good oral hygiene, mental health well-being), and 4) healthy relationships (e.g. what does a healthy relationship look like, being assertive, saying "no", feeling good about yourself, etc.). Presentations are conducted by experts on the various topics (e.g. the first session is presented by the Social Worker from Alfred I. duPont Hospital for Children's Division of Transition of Care, the component on healthy nutrition is presented by a certified dietician, etc.). The Healthy Transitions series this year has been focused on providing information to transitioning students and families via a school (Charleton and Woodbridge High Schools) or University of Delaware's (Career and Life Studies Certificate (CLSC) program, a comprehensive, inclusive and customized postsecondary education programs for students with developmental and intellectual disabilities. Information on transitions was also distributed at numerous health fairs, disability awareness days and conferences. Healthy Transitions is organized and run by the Center for Disabilities Studies but happens in collaboration with many community partners.

Continued in Next Section.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family SHADE				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Continued from Previous Section

CDS staff have also been instrumental in researching State Transition Plans and organizing a team in Delaware to develop such a plan. The Team has been actively meeting to develop a State Transition Plan for Delaware and several workgroups have been formed to work on various aspects of transition. Each work group has also been assigned the task of developing a document that addresses their specific transition-related topic. These documents will then be assembled into a comprehensive transition booklet for distribution to youth and families throughout Delaware. The State Transition Team will develop legislation regarding the adoption of a State Transition Plan. CDS staff will also be presenting an overview of the process to the Delaware Healthcare Commission.

Family SHADE recognizes the importance of having direct input from youth and has reserved a place on the Advisory Board for a youth representative.

Although the environmental scan revealed that various Family SHADE partners have experience working with youth on self-advocacy skills, little is currently offered in a formalized way to help youth develop advocacy and leadership skills. Through Family SHADE partners, the development of a training curriculum for youth was issued through a mini-grant, specifically addressing the skills and knowledge needed to effectively participate on boards and councils in Delaware that address services for CYSHCN.

Continued in Next Section

**An attachment is included in this section. IVC\_NPM06\_Current Activities**

**c. Plan for the Coming Year**

Continued from Previous Section - Current

Through Family SHADE, partners, boards and councils will be educated about the importance of including youth and Family SHADE partners will work collaboratively with boards and councils to increase youth presence and involvement. The RFP for this mini-grant on youth leadership as described in this paragraph was issued but was not awarded due to lack of response. The RFP could be re-issued if an interest was expressed by a Family SHADE member organization.

Planned

This Federal Performance Measure has to do specifically with the experiences reported by youth during transition regarding their ability to receive the "...services necessary to make transitions..."

CDS staff will continue to offer the Healthy Transitions series to transitioning students and their families via school venues and the CLASC program mentioned above. They are coordinating their efforts with a new transition program at Al DuPont Hospital. In addition, CDS staff will continue to participate on the State Transition Team and in the development of a State Plan for Transition.

Family SHADE is currently considering to re-issue an RFP to address leadership training for youth with special health care needs. The training will equip them with the knowledge and confidence to participate on Boards and Councils that directly impact their lives. A youth representative will be sought to participate as a member of Family SHADE's Advisory Board.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	80	82	74	70
Annual Indicator	78.9	80.3	71.8	65.3	72.2
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	72.9	73.6	74.4	75.1	75.8

**Notes - 2011**

Estimated Vaccination Coverage with 4:3:1:3:3:1 Among Children 19-35 Months of Age by Race/Ethnicity, U.S. National Immunization survey, July 2010 - June 2011. Confidence Intervals +/- 6.4%.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2009 National Immunization Data, Q1-Q4 (4:3:1:3:3:1). Confidence Interval +/- 7.1 %. There is not statistically significant difference between rates reported for 2009 and 2010.

**Notes - 2009**

National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2008. Confidence interval for the estimate is +/- 6.8. Note that the CIs for the 2007-2008 Surveys overlap. There is not statistically significant difference for the 2008-2009 estimates.

**a. Last Year's Accomplishments**

According to the most current NIS Survey (Jan-Dec 2010), Delaware achieved a 72.9% vaccination rate for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B, which is only 2 percent lower than the national average of 74.9%.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware Immunizations Program				X
2. Delaware Division of Public Health Nursing and Field Staff	X	X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

DPH has worked tirelessly to roll-out the new Immunization Registry, DelVAX. The new immunization registry, DelVAX was implemented in a read-only basis on 12/31/2011. The new

registry will greatly enhance the provider ability to reduce missed vaccination opportunities through reminder, recall, enable providers to determine their immunization rates, track a patient's immunization records, and increase the percentage of children who are up-to-date for their immunizations.

**c. Plan for the Coming Year**

The Immunization Program will target children ages 19-35 months, adolescents, adults at increased risk of hepatitis B infection and minorities and other traditionally under-immunized populations. The program ensures VFC (Vaccines for Children) providers have access to all Advisory Committee on Immunization Practices recommended vaccines, keeps providers abreast of relevant developments in the vaccine field and maintains their awareness of the epidemiology of vaccine preventable disease in Delaware and nationwide. By conducting regular provider site visits, the program ensures providers administer only viable vaccine and also encourages providers to improve their vaccine immunization rates through:

- Implementation of provider reminder or recall systems.
- Education targeting parents and providers.
- Measures to reduce out-of-pocket costs for vaccines.
- Expanding access to immunizations through increased clinic hours and other measures.
- Giving feedback to providers on their performance indicators.

Collaboration with the Dept. of Education and the Office of Child Care Licensing allows the Immunization Program to ensure high immunization rates for enrolled children.

Through the DPH Smart Start home visiting program, which adheres to the Healthy Families America evidenced-based framework, DPH will practice and apply a model standard which assures that at a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g. timely immunizations, well-child visits, etc.). This critical element is currently practiced, whereby DPH Smart Start home visitors work with clients prenatally/post-partum infant care and ensure that clients are linked with a medical home. Furthermore, home visitors continuously monitor and assess all target children to determine whether or not they have an up to date schedule of age appropriate immunizations, recommended by the CDC.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	26	20	20	20	20
Annual Indicator	22.0	21.2	17.8	17.8	17.8
Numerator	387	369	308	308	308
Denominator	17600	17439	17346	17346	17346
Data Source		Delaware Vital Statistics, 2007	Delaware Vital Statistics, 2007	Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	17.6	17.4	17.3	17.1	16.9

**Notes - 2011**

2010 data are not available. Estimate is based on 2009.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2008 Vital Statistics Data.

**Notes - 2009**

2008 Delaware Vital Stats Data.

Target Setting Method: 5 Percent Improvement by 2016.

**a. Last Year's Accomplishments**

During the period, 14 of the 28 School-Based Health Centers, (SBHC) have been approved as Title X, family planning providers. The Division of Public Health provided training to orient staff on reproductive health policy and procedure as it relates to providing oral contraceptives and condoms to adolescents within the centers as well as on standard policy and procedure and submitting reports.

DPH was also successful in getting the new SBHC Title X providers with 340B pricing which will increase the amount of oral contraceptives and condoms given to adolescents at those sites. The Division provides funding for the statewide Alliance for Adolescent Pregnancy Prevention Program (AAPP) that in turn, provided evidence-based programs to reduce teenage pregnancy prevention and STIs. There were a total of 44 Wise Guy programs, 16 Be Proud! Be Responsible! and 22 Making Proud Choices programs effecting 600+ youth. AAPP also sponsored an annual Team Summit where there were adolescent and parent workshops. Topics included were: the cost and negative impact of teenage pregnancy, dating violence, how to talk about sex and sexuality and how the media glamorizes sex.

Through grant money and Planned Parenthood of Delaware, DPH was successful in establishing a Sexual Education Training Institute which provides evidence-based curriculum training and technical support for middle and high schools on reducing teen pregnancy and STIs.

Current:

The Division of Public Health is working collaboratively with the Division of Medicaid and Medical Assistance (DMMA) to develop a policy and procedure, operational manual which will provide useful information for the medical vendors on how to enroll as a provider, how to check for student eligibility and how to submit data for the upper limit, cost recovery report. In addition, DPH is working with the Title X program in order to develop sexual and reproductive health policy

and procedures guidelines that will address how to become a new provider, how to report data and how to order oral contraceptives from the state pharmacy. With the additional resources and training, approved Title X sites will be able to increase their efforts on reducing teen births.

The Division of Public Health continues to work with Planned Parenthood of Delaware, the subgrantee for the Personal Responsibility Education Program, to provide Making Proud Choices and Be Proud! Be Responsible! programs. During the period, the subgrantee has been working with school districts and various communities that have high risk adolescent populations. The programs will target county census divisions with high teen birth and STI rates and minority populations.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title X Family Planning	X	X		
2. School-Based Wellness Centers	X	X		
3. Reproductive Life Plan			X	
4. Teen Pregnancy Advisory Board				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

DPH is working on implementing a new SBHC database. The design and implementation of this database/evaluation system was the result of multi-collaborative efforts and will provide will provide DPH and other agencies with valid, reliable data and robust and timely information on teen pregnancy/STI preventive health screenings and follow up and referral on the positive results.

**c. Plan for the Coming Year**

For the coming year, DPH plans to work with SBHC medical vendors to increase the number of Title X provider sites. DPH also intends to increase the number of trained male instructors to implement Making Proud Choices and Be Proud! Be Responsible! as well as increase the number of adolescents served. The AAPP will offer a Wise Guys (male responsibility program) training session in Sussex County, Delaware so that more instructors can be certified in the program so that they can implement and target adolescent males in high schools and community settings.

DPH will also be working to get approval for 340B pricing structures in the remaining 14 SBHC so that they can receive reduced pricing for medications including those for the prevention of STIs. DPH will provide training on the new SBHC database which includes an evaluation module which captures information from a 50-question survey that the student has to fill out and the provider assess for information, treatment and referral based on the identified risks. Of the 50 questions,

7 specifically deal with pregnancy and STI risks.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	40	35	35	35	35
Annual Indicator	34	34	34	34	34
Numerator					
Denominator					
Data Source		Delaware Dental Survey	Delaware Dental Survey	Delaware Dental Survey	Delaware Dental Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	34.7	35.4	36	36.7	37.4

**Notes - 2011**

The 2011 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Method of Target Setting: 20% improvement over next 10 years.

**Notes - 2010**

The 2010 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

**Notes - 2009**

The 2009 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

2010 Sealant Stats for the Oral Health Program:

# of Children Screened (2nd grade): 30

# of Children w/ Caries Presence (Decay): 18

# of Total Sealants Placed: 68

#Regular Referral: 15

#Urgent Referral: 5 (urgent is classified when pain or infection present within diagnosis of decay/extraction)

**a. Last Year's Accomplishments**

Delaware did not conduct a survey of third grade children during this last school year, so it is not possible to provide a statistically valid percentage of third grade children who have dental sealants on molar teeth. However, Delaware has been very active in providing sealants in both the private sector and through its dental public health program for at-risk children. The Bureau of Oral Health and Dental Services (BOHDS) uses two paths to provide sealants: a) The school-linked dental clinics and b) the Seal-A-Smile program. Both programs target schools that have a high percentage of children who are eligible for the free/reduced school lunch program. The dental clinics provide general dental services in addition to sealants, while the Seal-A-Smile program provides a dental screening, sealants, and referrals for follow-up care for children who do not have a dental home. This combination provides an opportunity for children in 75% of the state's 59 elementary schools to obtain dental sealants.

During the 2011-2012 school year, the Bureau of Oral Health and Dental Services (BOHDS) Seal-A-Smile Program visited 35 schools and screened 556 second grade students, of which 387 received a total of 1278 dental sealants. The number of students diagnosed with untreated dental caries is 238 (43%). In addition, 47 students received an urgent care referral due to presence of infection and/or the child experiencing pain associated with the tooth.

Current:

The BOHDS is preparing to launch its First Smile Initiative that will address the prevalence of dental disease in young children by promoting regular home care and a dental home. The initiative includes an Oral Health Literacy campaign, promotion of age-one dental visits, oral health assessments with fluoride varnish application by physicians, the Tooth Troop, and the Seal-A-Smile program.

The Delaware Oral Health Coalition (DOHC) recently hired a fulltime Executive Director who will be responsible for overseeing the development and planning of the Tooth Troop Program and the Case Management and Dental Referral Network. The DOHC is focused on reducing the high level of dental disease among the state's children and early prevention and maintenance. Through local and national partnerships, the Coalition develops an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health.

The Tooth Troop is a Train the Trainer program where dental professionals train child care agency leaders to provide oral health information to parents. The program capitalizes on a motivational interview to promote changes in oral hygiene home care and dental visits. The Tooth Troop program is one of the initiatives being implemented by the DOHC to community organizations to provide direct outreach to underserved families. The Bureau plans to continue these activities with added emphasis on preventing Early Childhood Caries (ECC) by encouraging age-one dental visits to prevent the onset of ECC. BOHDS has been emphasizing dental visits for children under age four through outreach with WIC and child care agencies such as Head Start. These visits emphasize prevention guidance for parents with the application of fluoride to prevent Early Childhood Caries. Since January 2012, the number of visits for children under age four has increased from 15 in January to 78 in March, an increase of 520%. This will also serve as a model for private dentists to see children under age four.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Program	X	X	X	
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

BOHDS has developed new patient education materials to help providers educate their patients about the importance of practicing good oral health habits at home. The materials are designed based on a similar peer reviewed campaign with four years of research that demonstrates their effectiveness in inspiring positive behavior changes. These materials are easy to read with simple language and easy to remember tips for new and expecting parents. Roughly 720 stakeholders were part of the initial direct mail card offer. In addition, a strategic communications plan has been developed to increase awareness of the importance of oral health for Delawareans that will include persons with disabilities and underserved families. This plan will serve as a basis for launching the Oral Health Literacy Campaign.

Oral health promotional materials were prepared and distributed in a number of venues, particularly with the Tooth Troop program. Discussions continued with the Dental Society to increase to develop a network of dentists who will accept referrals for children who are identified as having difficulty with accessing dental care. The BOHDS has increased its emphasis on age one visits and will continue to expand these efforts. Over 7,000 patient educational cards will be distributed throughout the state.

**c. Plan for the Coming Year**

Based on recommendations received for the 2012 Maternal and Child Health Block Grant at the annual review of the application, the Maternal and Child Health Bureau is seeking to strengthen its existing collaborative efforts with the Delaware Oral Health Program. An area of identified need, in terms of overall resources, is support to complete the Delaware 3rd Grade Survey scheduled for the Fall of 2012. The survey will collect information on the prevalence of tooth decay, the percentage of third grade children who have sealants, the accessibility of oral health care services and the impact of race, ethnicity and socio-economic status on each of these issues. The study will provide a baseline for evaluating changes in the oral health status of Delaware's children. Survey results will be used to focus prevention and treatment programs and services where they are needed most.

The assessment will consist of two separate data collection methods -- a parent questionnaire and an oral health screening completed by a dentist. Data will be stratified by county, race and ethnicity, and eligibility in the free and reduced price school meal program as a measure of socio-economic status. All data presented in this report will be weighted for non-response. The report will also take a comparative look at where Delaware's children rate with regard to the national Healthy People 2020 oral health objectives.

Supported by the Title V MCH Block grant, the Delaware Oral Health Program will order supplies, equipment and brochures that will support the 2012 Delaware 3rd Grade Dental Survey. The budget includes the costs: for dental supplies such as caviwipes, disposable lab jackets, gloves, cone earloop mask, patient bibs, disposable mouth mirrors, tooth brush, toothpaste and dental floss; Brochures will be produced in both English and Spanish to promote oral health awareness; and dental telescopes. Additionally, a consultant epidemiologist from ASTDD provided preliminary support for development of the survey methodology. This request was approved as part of a separate process. The consultant will also provide analytical support upon completion of

data collection, but this will not take place until late Fall, 2012.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	2.5	1.7	1.7	1.7	3.4
Annual Indicator	1.8	3.6	3.2	3.2	3.2
Numerator	9	6	16	16	16
Denominator	500732	168041	506490	506490	506490
Data Source		Hospital Discharge Data, 2005	Delaware Vital Stats Data	Delaware Vital Stas Data.	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	3.1	3.1	3.1	3.1	3

**Notes - 2011**

2011 data are not available. This indicator is provisional.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2010 data are not available. This indicator is provisional.

**Notes - 2009**

2007-2009 Delaware Vital Statistics Data.  
This is a three year rate.

Single year rates are as follows:

2007: 1.2 / 100,000 (C.I. +/- 1.6)  
2008: 3.6 / 100,000 (C.I. +/- 2.9)  
2009: 4.7 / 100,000 (C.I. +/- 3.3)

The national rate for 2010 is 2.3 / 100,000.  
The expected number of deaths based on the national rate is 3.9.

The three year average for 2007-2009 is lower than than national rate for 2010 (National Vital Statistics Report, 60(4), January 11, 2012).

Method of target setting: 5% improvement by 2016.

**a. Last Year's Accomplishments**

The Bureau renewed its participation in the Delaware Injury Prevention Coalition at the March 2010 meeting. MCH representation on the Coalition help continue efforts to identify strategies to address injury prevention. In the absence of a formal injury prevention staff person solely devoted to this issue, an MCH Bureau staff member interfaced with the Office of Highway Safety, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance.

In 2011, MCH collaborated with Safe Kids and the Office of Highway Safety to purchase car seats for a low-cost Child Safety Seat Program for the State of Delaware. The Bureau also assisted with the planning of Delaware's 2011 Safe Kids/Emergency Medical Services for Children Childhood Injury Prevention Conference.

Current:

The Bureau continued its commitment and participation in the Delaware Injury Prevention Coalition in 2012. The Division of Maternal and Child Health Bureau (MCH) recognizes the impact and importance of injury prevention. In support, MCH designated a staff member to the Delaware Coalition for Injury Prevention and as a member of the Safe Kids Delaware Coalition and this representation continued in 2012. This enabled MCH the opportunity to focus on data driven priorities shared with sister agencies, develop community partnerships to address childhood injuries and help establish initiatives to protect the youth of Delaware.

The Delaware Division of Public Health (DPH) supports a widespread network of violence and injury prevention partners, including the Coalition for Injury Prevention (i.e. Delaware's Injury Community Planning Group (ICPG)), which is a coalition made up of more than 50 representatives of 35 agencies. Membership includes state and local government, not-for-profit and private entities. The Delaware Coalition for Injury Prevention, at one time was facilitated by the Office of Emergency Medical Services, a unit within the Division of Public Health, and was an unfunded group until recently. In July 2011, Delaware was pleased to learn from CDC that our successful application was federally funded to develop a Violence and Injury Prevention Program (VIPP) under the Base Integration Component.

In 2012, as a result of the new grant award, the VIPP was aligned closely with the Family Health Systems section of DPH, which also houses the Maternal Infant and Early Childhood Home Visiting Program and Maternal and Child Health/Title V Programs. The existing family health infrastructure ensures cohesion and is consistent with our strategic plans to emphasize linking and integrating public health programs in order to maximize protective factors and minimize risks across the lifespan.

The new CDC VIPP grant funding supports building program infrastructure, an update of the state injury prevention plan, engagement of a statewide coalition to bring about systems-level changes, and a concerted effort to strengthen injury surveillance and reporting within the state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Emergency Medical Services for Children				X

2. Injury Prevention Coalition				X
3. Home Visiting Programs		X		
4. Child Development Watch		X		
5. Office of Injury Prevention				X
6. State Service Centers Child Safety Seat Loaner Program		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

In 2012, MCH continued to collaborate with Safe Kids and the Office of Highway Safety to purchase car seats for a low-cost Child Safety Seat Program for the State of Delaware. The Bureau also played an integral part of the planning and contributed financially to the Delaware's 2012 Safe Kids/Emergency Medical Services for Children Childhood Injury Prevention Conference.

Below, is a summary of current injury prevention activities and accomplishments since February 2012:

1. Developed and approved a Terms of Reference document that will provide governance structure for the Injury Community Planning Group
2. Secured dedicated Violence and Injury Prevention Administrator, housed in the Division of Public Health's Family Health Systems section.
3. Restructured Injury Community Planning Group

**c. Plan for the Coming Year**

Future injury prevention activities over the next 12 Months include:

1. Establish Memorandum of Understanding with existing community based organizations that focus on Core VIPP Grant areas
2. Secure dedicated Violence and Injury Prevention and Program Management Analyst that will collect and analyze data to support program interventions
3. Strengthen partnership with Injury Control Research Center designate, Johns Hopkins Violence and Injury Prevention Institute. This partnership will consist of: Participating in monthly meetings, lead planning groups, community outreach, shared research and technical assistance and provide grant development support.
4. Develop a State VIPP Strategic Plan which will include: Problem Statement, Data to support burden of injury in Delaware, Program and Policy Intervention Recommendations, Program Evaluation Criteria, Measures of Success and Operational Plan
5. Produce the required reporting as outlined by the CDC Violence and Injury Prevention Program (VIPP) grant.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	36	36	32	34	44

Annual Indicator	30.6	30.6	32.8	43.2	48.9
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	Delaware PRAMS Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	49.4	49.9	50.4	50.9	51.3

**Notes - 2011**

2008 Delaware PRAMS Data. Percent of women who are still breastfeeding at time of interview.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2007 National Immunization Survey. Breastfeeding at 6 Months (n=268). Confidence Interval +/- 6.7%.

**Notes - 2009**

2006 National Immunization Survey (32.5% +/- 6.6%) - Any breastfeeding at 6 months of age.

**a. Last Year's Accomplishments**

MCH funds an expanded pilot project within the Smart Start home visiting program, encouraging women to maintain breastfeeding through the first six months of an infant's life, by providing intense case management, breastfeeding education and a lactation consultant for additional support, which continues to be supported. Breast pumps, educational materials and other supplies are available to breastfeeding women. The second component of this project is the annual Breast is Best conference which approximately 130 professionals attended in June 2010 and in 2011, its popularity increased to 198 professionals in attendance (i.e. MDs, RNs, RDs).

The Breastfeeding Coalition of Delaware, although established years ago, is finally growing its partnership base and is gaining strength, due to the leadership and support of Nemours Health and Prevention Services, the health prevention arm of Delaware's children's hospital, A I DuPont Hospital. In June 2011, BCD launched a web site (<http://www.delawarebreastfeeding.org/>) that serves as a resource and support for the breastfeeding mothers in our First state. The Mission of the Coalition is to improve maternal and infant health by increasing the initiation and duration of breastfeeding, the gold standard for infant feeding. As a result of the coalition's recent efforts and a growing interest in improving breast feeding rates, two hospitals have recently signed Baby Friendly "Letters of Intent". Beebe Medical Center was the first to sign and shortly thereafter, Bayhealth Medical Center. Last year, Bayhealth solicited the support of several DPH employees

to sit in on their "Baby Friendly" planning meetings. DPH nurses also participate as members of the Breastfeeding Coalition of Delaware, and continue to stay engaged. To achieve its mission, the Breast Feeding Coalition's goals are to:

- Increase public awareness of the benefits of breastfeeding for babies, mothers, families and communities.
- Educate professionals so they can better support the breastfeeding family.
- Promote communication and collaboration among individuals and organizations working to support breastfeeding.
- Promote development of the profession of International Board Certified Lactation Consultants.

Current:

BCD hopes to continue to grow and strengthen, and is planning on holding a conference specifically targeting physicians as a fundraiser in the fall 2012.

#### Baby Friendly Hospital Initiative

Bayhealth Medical Center and Beebe Medical Center have progressed through the 4-D Pathway to "Baby Friendly" designation. Both medical centers are in the 3rd phase, the Dissemination Phase, and have begun implementing their plans to adopt the Ten Steps to Successful Breastfeeding. For more info on 4-D pathway: <http://www.babyfriendlyusa.org/eng/04.html>  
 In May 2012, Christiana Care Health System (CCHS) applied to the Best Fed Beginnings learning collaborative with the intention of pursuing "Baby Friendly" Hospital Designation. The National Initiative for Children's Healthcare Quality (NICHQ), with support from the Centers for Disease Control and Prevention (CDC), is leading this nationwide effort in close partnership with Baby-Friendly USA to help hospitals improve maternity care and increase the number of Baby-Friendly hospitals in the United States. CCHS will get notification of NICHQ selection decisions anticipated in early June 2012.

#### Discharge Bags

CCHS will no longer distribute formula samples in hospital discharge bags and has begun distributing breastfeeding-friendly discharge bags.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breast is Best Initiative		X		X
2. WIC		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Current Continued:

### BCD Conference 2011

Together, the Breastfeeding Coalition of Delaware, Nemours, the Delaware Academy of Medicine and Christiana Health Care Services (CCHS) sponsored the first annual Delaware Breastfeeding Symposium in October, 2011.

Over 110 professionals, primarily from Delaware, attended the 2011 Delaware Breastfeeding Symposium. The majority (75%) worked in a hospital or primary care setting. Over half (53.8%) were nurses and another third (31.9%) were lactation consultants. A significant majority reported providing verbal (96.7%) and/or written (88.9%) breastfeeding support to new and/or expectant mothers. Professionals in attendance support many of the estimated 12,000 births in Delaware each year.

The 2011 conference agenda included topics such as medications and breastfeeding mothers, and breastfeeding support in the primary care office. Speakers at the conference included national experts Suzanne Hayes, Ph.D., Thomas W. Hale, Ph.D, and Ruth Lawrence, M.D. A free community lecture was also sponsored as part of the Symposium. Both CME and CERP professional development credits were offered.

The 7th MCH Annual Summit included a breakout session on the public health perspective on breastfeeding and suggested best practice strategies for encouraging providers and families to support breastfeeding.

### **c. Plan for the Coming Year**

Current Continued:

DPH initiated a coordinated breastfeeding demonstration project at the Milford Health Unit, which has expanded statewide over the last year. The voluntary program provides intensive case management, breastfeeding education and lactation consultant support to the Smart Start home visiting program and WIC clients. MCH funds expanded the pilot project within the Smart Start program, encouraging women to maintain breastfeeding through the first six months of an infant's life, and will continue to be supported in 2012. Breast pumps, educational materials and other supplies are available to breastfeeding women. The second component of this project is the annual Breast is Best conference that 130 professionals attended in June 2010 and in 2011, its popularity is increasing with 198 professionals in attendance (i.e. MDs, RNs, RDs). Conference evaluations for the Breast is Best Conferences are overwhelmingly positive, and planning activities will occur over the next year for a fourth annual conference.

Planned:

BCD has begun planning for a 2012 conference. The Delaware Breastfeeding Symposium will be held September 11, 2012 at the John H. Ammon Medical Education Center, Christiana Hospital, Newark, Delaware. The goal of the Symposium is to provide scientifically based and up-to-date education and training on breastfeeding support to healthcare professionals who provide services to new and expectant mothers in Delaware. The conference objectives are to:

- Increase awareness of the benefits of breastfeeding for babies, mothers, families, and communities.
- Educate professionals so they can better support the breastfeeding family.
- Increase implementation of best practice in breastfeeding promotion and support.
- Promote communication and collaboration among individuals and organizations working to support breastfeeding.

Conference Sponsors: Together, the Breastfeeding Coalition of Delaware, Nemours, the Delaware Academy of Medicine and Christiana Care will collaborate again to host the Symposium in 2012.

Target Population: Healthcare providers with access to new and expectant mothers in the state of Delaware are the target population for the conference. Over 100 attendees are expected based on the 2011 conference. The target population will provide support to expectant mothers of all races, ethnicities, and ages from both rural and urban settings across the state.

Conference Agenda: The 2012 conference agenda will be finalized by the planning committee. Topics under discussion include the Baby Friendly Hospital Initiative, the Business Case for Breastfeeding, Breastfeeding is a health issue/not a lifestyle choice, the American Academy of Pediatrics' updated breastfeeding policy, healthcare professionals as breastfeeding advocates. A free community lecture will also be offered as part of the conference.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	93.7	98.7	99.4	98.7	99.7
Numerator	11864	12468	12079	11545	11587
Denominator	12666	12627	12153	11694	11627
Data Source		Delaware Newborn Hearing Screening Program	Delaware Newborn Screening Program	Delaware Newborn Screening Program	Delaware Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**a. Last Year's Accomplishments**

In 2010 98.7% of babies born in Delaware received a hearing screen before 1 month of age. The Newborn Hearing Screening program continued to work closely with the Delaware Chapter of Hands and Voices to implement the Guide by Your Side Program. Four guides were trained by the national organization to provide unbiased information to families of children newly diagnosed with hearing loss. The Guide By Your Side program serves as Delaware's single point of entry to services for children with hearing loss. Guides also provide peer support for families. The Newborn Hearing Screening Program worked closely with the Delaware Chapter of Hands

and Voices to implement and develop the program infrastructure of the Guide by Your Side Program. Guide by Your Side assists families with navigation of services and provides family peer support on the early intervention system.

The Delaware Infant Hearing Assessment and Intervention Program (DIHAIP) Advisory Board has shifted its focus from merely increasing screening utilization to a more in depth planning and develop to ensure entry into early intervention services. Guide by Your Side will play a crucial role in this process.

The Newborn Hearing Screening Program has developed a pilot protocol for tracking late on-set hearing loss among children through age 18.

Current:

In 2011 99.5% of Babies born in Delaware received a hearing screen before 1 month of age.

The Newborn Hearing Screening Program recently held the fifth annual "Delaware's Still Listening Conference" in March 2012. Evaluations received from this event were very positive. The agenda included sessions for professionals and sessions for families of children with hearing loss.

The Delaware Infant Hearing Assessment and Intervention Program Advisory Board has shifted its focus from merely increasing screening utilization to meet the 1,3, 6 month Early Hearing Detection and Intervention (EHDI) guidelines in the last few years, and in order to refocus its efforts on clear priorities, the Board will go through an in depth strategic planning process. In addition, in collaboration with DPH staff, they also seek to develop and ensure entry into early intervention services, by coordinating with the Part C Birth to Three Program and the Department of Education Part B.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware Early Hearing Detection and Intervention Program			X	X
2. Hands and Voices / Guide by Your Side		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

Activities for the Newborn Hearing Screening Program for 2012 include the following:

- Implement a web-based reporting system for the newborn hearing screening program that will allow data input from our outpatient audiology partners and access to diagnostic information for our primary care practices.
- Analyze data for the EHDI program and other related child health programs; and
- Prepare comprehensive analytical and statistical reports.
- Develop interagency data agreements with birth sites, hospitals and diagnostic centers
- Generate monthly reports on progress toward EHDI goals and objectives.

- Conduct technical assistance at birth sites, diagnostic centers and hospitals based on identified issues from data analyses.
- Develop guidelines for the reporting of data from diagnostic centers and medical homes..
- Develop and implement a process for tracking referral to- and entry into- early intervention.
- Systematically collect, input and analyze data elements from the Late On-Set Hearing Loss pilot project and explore options to implement this initiative statewide.

**c. Plan for the Coming Year**

All activities listed above as 2012 activities will continue throughout 2013. Next year, the program also plans to develop research designs and determine the information needed, including data sources, data reliability and appropriate methods for analyzing and evaluating data.

In addition, the program will increase training and education for audiologists and medical providers around newborn hearing screening including the process/system of reporting information to the Newborn Hearing Screening Program.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	8	12	10	9.2	8
Annual Indicator	12.3	10.5	9.4	8.5	8
Numerator	24992				
Denominator	203188				
Data Source		Kids Count Fact Book, 2009	2010 Kids Count Fact Book, 2009	2011 Kids Count Fact Book	2012 Kids Count
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	7.9	7.8	7.8	7.7	7.6

**Notes - 2011**

2009-2011 three year average as reported in 2012 KIDS COUNT.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2007-2009).

**Notes - 2009**

This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2007-2009).

**a. Last Year's Accomplishments**

The Delaware Health Care Commission was responsible for managing the Uninsured Action Plan. This plan explored strategies to preserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care. The Commission annually completes a report, Delawareans without Health Insurance: A Demographic Overview, to better understand the nature of the uninsured population. The Delaware Health Care Commission has been monitoring its size and structure for a number of years, which is updated annually, however, there have been delays in producing a current report.

We will continue to direct uninsured families and children to appropriate resources in the community for access to Federal Qualified Health Centers located throughout the state.

In 2010, Delaware Health and Social Services' Cabinet Secretary Rita Landgraf formed a Health Reform Workgroup, which is staffed by DPH, to provide strategic oversight on implementation and policy development, which continues to meet. Many partners are included in this workgroup to address many opportunities such as health workforce development, health insurance exchanges, public health evidenced-based home visiting programs, Medicaid, and insurance coverage to Delawareans as a result of the Health Reform law.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Community Health Access Program (CHAP) helps to provide access to primary care doctors, specialists, and other health care services.	X	X		
2. MCH Programs provide SCHIP and Medicaid eligibility determination and referral.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Lieutenant Governor Matt Denn (at the time, Delaware Insurance Commissioner) proposed using schools' information about participation in the National School Lunch Program to bolster enrollment in health insurance programs. This became a reality in 2008, whereby several members of the Delaware State General Assembly introduced a bipartisan bill in January 2008 that would use information from schools to identify children who are eligible for SCHIP (House Bill 286). This bill was signed into law by the previous administration, Governor Minner on June 18, 2008 and began collecting information in November 2008. Under this current law, school districts provide DHSS on an annual basis with the child's eligibility information for the free or reduced lunch or free milk program, and DHSS then sends information about SCHIP and Medicaid to the

children's parents.

**c. Plan for the Coming Year**

Delaware Medicaid and Medical Assistance conducts a school district data match in collaboration with the Department of Education to identify children on the free and reduced lunch programs who were not already enrolled in either Medicaid or the Children's Health Insurance Program (S-CHIP). The results of this data match performed in 2010 and 2011 were shared with the Division of Public Health for the MCH Block Grant to show progress in meeting this performance measure.

In 2010, Medicaid ended up enrolling 1,859 children in Medicaid (1,520) and CHIP (339), as a result of the data match with the school Districts to identify children on the free and reduced lunch programs who were not already enrolled in either program.

In 2011, Medicaid enrolled 511 children in Medicaid (401) and CHIP (110), after conducting the data match.

The 2012 results should be coming soon and will be shared in future Title V MCH Block grant applications.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	33	20	20	15	20.4
Annual Indicator	28.4	20.2	16.0	20.6	21.5
Numerator	2814	2075	2075	2669	2704
Denominator	9920	10264	12962	12937	12593
Data Source		Delaware WIC Program	Delaware WIC Program	Delaware WIC Program	Delaware WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	21.1	20.6	20.2	19.8	19.4

**Notes - 2011**

2011 Delaware WIC Program

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

Delaware WIC Program Data for Calendar Year 2010

**a. Last Year's Accomplishments**

Based on data provided by WIC, the percentage of children, ages 2 to 5 years of age, receiving WIC services with a BMI at or above the 85th percentile slightly rose from 20.6% in 2010 to 21.47% in 2011. In response, WIC has provided staff with more training and professional development opportunities, particularly around speaking with families about childhood obesity and prevention.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health partners with Nemours Health and Prevention Services on child health issues including obesity prevention.				X
2. Maternal and Child Health partners with the DPH Health Promotion and Prevention Section's Physical Activity, Nutrition and Obesity (PANO) program to address obesity prevention through promotion and programming.				X
3. Nutritionists are part of the Healthy Women, Healthy Babies programs' staff, as well as the part of Home Visiting programs' staff.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCH program is currently considering additional initiatives around this issue. This includes public relations/social marketing on healthy nutrition and physical activity and heightening awareness regarding the promotion of breastfeeding. In addition, healthy prevention and promotion activities such as healthy BMI, physical activity, nutrition, and breastfeeding will be through our DPH Smart Start home visiting program, which adheres to the Healthy Families America evidence based model.

WIC also offers WIC families monthly cooking demonstrations including healthy recipes using WIC foods.

**c. Plan for the Coming Year**

Both WIC staff and MCHB staff participates in the State's Obesity Prevention Taskforce, DE Healthy Eating and Active Living (DE HEAL) Communities and Families workgroup.

Effective strategies that will continue in the coming year, include the cooking demonstrations

offered to our WIC families, nutrition education quarterly modules on physical activity and healthy eating, and the promotion and support of the State's Baby Friendly initiative, which is championed by several key partners.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	10.9	6.5	6.6	9.4	9.4
Annual Indicator	6.8	9.6	10.3	10.3	10.3
Numerator	814	1157	1172	1172	1172
Denominator	11898	12016	11369	11369	11369
Data Source		Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Stats
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	10.2	10.1	10	9.9	9.8

**Notes - 2011**

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2008 Delaware Vital Statistics Data.

**Notes - 2009**

2008 Delaware Vital Statistics Data.

**a. Last Year's Accomplishments**

Smoking has decreased among pregnant women in Delaware to 9.76% overall, and 12.83% among white women and 8.5% among black women. Although the prevalence of smoking during pregnancy has slightly decreased over time, white women consistently smoke more than average in Delaware.

Smoking cessation among pregnant women continues to be a focus of Smart Start, nurse home visiting program for high risk pregnant women, and the Infant Mortality Initiative Program that provides enhanced prenatal care. Women are referred to the well-established and widely recognized DPH Tobacco Prevention and Control services of Quitline and Quitnet. Through the Quitline women can access 24-hour counseling and advice from local experts. Free nicotine

replacement therapy is available for those who qualify. Quitnet provides cessation information and assistance via the web.

Smoking cessation is also promoted through WIC, which serves more than half of all pregnant women in the state.

The 2008 Delaware PRAMS data indicated that 60.03% of respondents (946 of 1,576) stated that a health care worker informed them during at least one prenatal visit of how smoking during pregnancy would affect their baby.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking continues to be a main risk factor reduction priority in Maternal and Child Health programs. Women are provided counseling and educational materials to assist in smoking cessation.	X	X		
2. The MCH programs refer women to the Delaware Quitline, a statewide resource that offers support, counseling and vouchers for pharmaceutical products.	X	X		
3. The Delaware Healthy Mother and Infant Consortium partners with community-based agencies to address the reduction of tobacco use among pregnant women and women of childbearing age.		X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The comprehensive smoking cessation programs and services are having an impact on Delaware women. In 2012, Delaware will continue to fund multiple interventions to reduce maternal smoking during pregnancy including:

- Healthy Women/Healthy Babies program aimed at recruiting women when they find out they are pregnant and providing services through the postpartum period;
- Preconception Care program aimed at recruiting non-pregnant women of childbearing age for care;
- Delaware Quitline focused on smoking cessation;
- DelaWELL program initiated to offer referrals to Delawareans who want to engage in healthier lifestyles;

The Delaware Tobacco Program created a specific social marketing campaign for OB/GYNs and primary care physicians who treat pregnant women, which will continue in 2012. In addition to posters and educational materials, women are given a "quit kit" that includes stress relieving items and information about tobacco cessation support services.

**c. Plan for the Coming Year**

The 2009 Delaware PRAMS data indicated that 69.9% of women who had a live birth had a health care worker inform them during at least one prenatal visit of how smoking during

pregnancy would affect their baby. Also according to PRAMS data, 70.9% did not smoke in the 3 months before pregnancy and 82.8% did not smoke in the last three months of pregnancy, showing that some women stopped smoking sometime during pregnancy.

In response to the following question, "In the 3 months before you got pregnant, did you smoke at least 11 cigarettes on average each day?" 16.1% of white women indicated yes, while 7.3% of Black women indicated yes. This shows that White women still consistently smoke more than Black women.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.4	5.4	13	8	3.2
Annual Indicator	8.3	3.4	5.6	5.6	5.6
Numerator	5	2	10	10	10
Denominator	59899	59701	179765	179765	179765
Data Source		Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics Data	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	5.5	5.5	5.4	5.4	5.3

**Notes - 2011**

2007-2009 Delaware Vital Statistics Data. Provisional data.

Due to low numbers, indicator is reported as a three year moving average.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2007-2009. Delaware Vital Statistics Data. Due to low numbers, indicator is reported as a three year moving average.

**Notes - 2009**

2007-2009 Delaware Vital Statistics Data. Due to low numbers, indicator is reported as a three year moving average.

**a. Last Year's Accomplishments**

In 2011, the Division of Public Health, (DPH) continued to work in collaboration with the Delaware Division of Medicaid and Medical Assistance (DMMA) to develop a policy and procedures manual outlining provider enrollment, SBHC student eligibility for services, reporting requirements and establishing reimbursement rates for such services. DPH and DMMA were successful in establishing a competitive SBHC reimbursement rate and where at least two visits per day could be charged. The inclusion of reimbursement for two visits per day per eligible students places mental health services on par with medical ones, thus, allowing medical vendors to provide additional mental health visits/services.

During the period, DPH also worked with the medical vendors and the Forward Consultant Group, a research, evaluation and epidemiology vendor, to establish an at-risk tool for student evaluation. This 50-item questionnaire includes 13 questions that specifically identify mental health risks in students with one question solely focusing on suicide ideation risk. Other mental health items include screening for depression, anxiety and trauma.

**Table 4a, National Performance Measures Summary Sheet**

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

**b. Current Activities**

DPH is working with DMMA to establish a separate SBHC Medicaid unit cost reimbursement rate that is more reflective of the overall costs that medical vendors incur as the result of operating SBHCs. This new rate will allow medical vendors to bill for more mental health services at the SBHC sites.

DPH is also working with the Department of Insurance and the state legislators in order to establish SBHCs in the Delaware Code. This will provide a consistent mechanism for medical vendors to negotiate reimbursement costs associated with providing services in wellness centers which will positively impact providing mental health services. DPH is also working with the Attorney General's Office to develop a generic consent form so that students will have increased access to the full gamut of services provided at the wellness centers.

After three suicides at a local high school this year, DPH worked with the medical vendor

responsible for administering services at that site, to establish guidelines of working with high school personnel and district staff on its role in serving on the school's crisis intervention team.

**c. Plan for the Coming Year**

DPH will provide training on the SBHC Periodic Questionnaire and will establish reporting requirements of centers so that mental health risk can be consistently identified, treated and or referred. This will increase the continuity of care for students presenting with mental health issues and increase coordination and follow up for those students identified with suicide ideation.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	80	80	92	78
Annual Indicator	90.5	77.5	78.7	78.7	78.7
Numerator	182	172	166	166	166
Denominator	201	222	211	211	211
Data Source		2007 Delaware Vital Statistics	2007 Delaware Vital Statistics	2008 Delaware Vital Statistics Data	Delaware Vital Statistics Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	79.5	80.3	80.1	81.8	82.6

**Notes - 2011**

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2008 Delaware Vital Statistics Data

**Notes - 2009**

2008 Delaware Vital Statistics Data

**a. Last Year's Accomplishments**

Ensuring deliveries at appropriate facilities based on level of care and monitoring the maternal transport system is overseen by the Delaware Perinatal Cooperative in collaboration with the Standards of Care Committee of the Delaware Healthy Mother & Infant Consortium.

In February 2011, the Delaware Perinatal Cooperative was formally established as a functional unit of the Delaware Healthy Mother & Infant Consortium. The Cooperative was modeled after other effective statewide consortia established in states such as Ohio, North Carolina and California. Each hospital and birth center Chief Executive Officer was asked to delegate a representative to the Perinatal Cooperative. Dr. Garrett Colmorgen, a well-respected perinatologist and Mid-Atlantic appointee to the March of Dimes, was elected to serve a 3-year term as the Medical Director of the Perinatal Cooperative.

**Current:**

In the first full year of operation the Perinatal Cooperative has accomplished significant goals. These including: 1) hiring a part-time Perinatal Cooperative Nurse Educator, 2) assessing the use of the fetal movement tracking media campaign "Kicks Count", and 3) implementing quarterly reporting of steroids data. The Perinatal Cooperative Nurse Educator is an experienced maternal-fetal medicine practitioner with over twenty years of experience. She functions using an academic detailing model, similar to that used by pharmaceutical companies, to engage practices around standards of care and inform them of tools and resources available for their clients. More than 14,200 kits have been distributed statewide. The Kicks Count campaign was evaluated in fall 2011. Of seventy-two providers surveyed, fifty-four (75%) were using the materials and found them helpful. The easy "10 kicks in 2 hours" message resonated with patients and encouraged them to see immediate medical attention if they experienced decreased fetal movement. Tracking of administration of steroid data to prevent preterm birth was the third accomplishment of the Perinatal Cooperative. The data shows that consistently hospitals are meeting and exceeding the threshold of 90% of women experiencing signs/symptoms of preterm labor receiving steroids.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware Healthy Mother and Infant Consortium, Standards of Care Committee monitors neonatal transportation to the Level III facility.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

The Perinatal Cooperative also updated the maternal transport form, a tool to ensure appropriate communication among birth hospitals when a mother is transferred to the level III hospital. The maternal transport form, an order set for preterm admission and management guidelines for patients at risk for preterm delivery was all made available on the Division of Public Health website (<http://www.dhss.delaware.gov/dhss/dph/chca/imdhmichome.html>) and the Perinatal

Cooperative website (<http://dhmic.healthywomende.com/PerinatalCooperative>).

**c. Plan for the Coming Year**

In the coming year the Perinatal Cooperative will continue monitoring births at each hospital to ensure appropriate transport when medically indicated. The Perinatal Cooperative will work to accomplish two goals. 1) Implementation of a provider and patient education campaign to promote safe sleeping environments, in alignment with the new AAP guidelines. 2) Promoting hospital standards that prohibit early term/late pre-term elective deliveries. The Cooperative will continue quality improvement assessments of steroid use and impact of the Kicks Count media campaign.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	75	75	68	73
Annual Indicator	66.9	72.7	74.9	74.9	74.9
Numerator	8092	8739	8519	8519	8519
Denominator	12097	12016	11369	11369	11369
Data Source		Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	79.5	80.3	81.1	81.8	82.6

**Notes - 2011**

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2008 Delaware Vital Statistics Data

**Notes - 2009**

2008 Delaware Vital Statistics Data

**a. Last Year's Accomplishments**

The Healthy Women/Healthy Babies (HWHB) program of the Delaware Healthy Mother & Infant Consortium provides preconception care, prenatal care, interconception care, mental health and nutrition services. Given the disproportionate number of Hispanic women who enter care late, the HWHB vendor in Sussex County, the county with a high percentage of Hispanic residents, is a key partner in program work to increase early access. La Red Health Center employs promotoras, or lay health workers, to increase early access to care.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting Program		X		
2. Transportation to prenatal programs		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Healthy Women/Healthy Babies (HWHB) has completed its second full year of operation. The program provides health care, mental health and nutrition services for women before, during and after pregnancy. Services are offered through 7 different health clinic providers in over 20 different locations throughout the state including 3 specifically located in Sussex County. The HWHB program is one of several infant mortality programs implementing the Life Course Model. This Life Course Perspective looks at the health of the mother from the day of her birth to the birth of her child. Programs are created around this model to implement multi-level initiatives for the woman herself, her family, her health care provider and her community.

In calendar year 2011, there were 36,415 visits for 12,146 unique patients. There was an average of 3 visits per patient. Initial HWHB data on process evaluation is now available, with outcome evaluation data expected next year. One of the outcome measures specifically examines the impact of preconception care on entry into prenatal care.

**c. Plan for the Coming Year**

In addition to continued work through HWHB to promote early prenatal care, the revamped Smart Start home visiting program will also help reach high-risk women early in pregnancy to connect them with a medical home. Smart Start has implemented the evidence-based model, Healthy Families America, as of May 2012, and under this new model pregnant women residing in high-risk communities, or zones, will be targeted for enhanced home visiting services. Health ambassadors, or lay health advocates, will also be identified in each high-risk zone. These health ambassadors are charged to use their existing social networks and innate leadership skills to galvanize communities toward health promotion. This will include early access to prenatal care and the importance of women's health before, during and after pregnancy. Delaware's approach includes direct care through HWHB, home-based supports through Smart Start home visiting, and community mobilization through health ambassadors.

## D. State Performance Measures

### State Performance Measure 1: *The rate of infant deaths between birth and 1 year of life.*

#### Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			8	8	7.8
Annual Indicator	8.3	8.4	8.0	8.0	8.0
Numerator	99	101	91	91	91
Denominator	11898	12016	11369	11369	11369
Data Source		Delaware Vital Statistics	Delaware Vital Stats	Delaware Vital Stats	Delaware Vital Stats
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	7.9	7.8	7.8	7.7	7.6

#### Notes - 2011

2011 data are not available. The data reported for 2011 are provisional.

Method of Target Setting: 10% improvement over next 10 years.

#### Notes - 2010

2008 Delaware Vital Statistics Data

#### Notes - 2009

2009 Delaware Vital Statistics Data

#### a. Last Year's Accomplishments

Delaware's infant mortality rate has decreased for the fourth consecutive reporting period, dropping by 10 percent. When the Consortium began its work, our infant mortality rate stood at 9.3 deaths for every 1,000 live births. That rate is down to 8.3 deaths according to the last reporting period of 2005 to 2009.

In 2005-2009 the five leading causes of infant death were:

? Disorders related to short gestation and fetal malnutrition (prematurity and low birth weight), which

accounted for 24.8 percent of infant deaths,

? Congenital anomalies (birth defects), which accounted for 12.7 percent of infant deaths,

? Newborn affected by maternal complications of pregnancy, which accounted for 9.8 percent of infant

deaths. Of the 48 deaths attributed to this cause, 46 were due to the newborn being affected by incompetent cervix and premature rupture of membranes,

? Sudden infant death syndrome (SIDS) accounted for 8 percent, and

? Newborn affected by complications of placenta, cord, and membranes (4.5 percent).

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>
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	DHC	ES	PBS	IB
1. Lifespan approach to reproductive health through the Delaware Healthy Mother and Infant Consortium.	X	X	X	X
2. Healthy Women, Healthy Babies	X	X	X	
3. Cribs for Kids	X	X		
4. Family Planning, STD Prevention	X	X		X
5. Newborn Screening	X	X	X	
6. PRAMS				X
7. Fetal & Infant Mortality Review				X
8. Child Death, Near Death and Still Birth Commission				X
9. Birth Defects Registry				X
10.				

**b. Current Activities**

Delaware's strategy to reducing infant mortality includes addressing the major contributors to infant death. These include prematurity/low birth weight, congenital anomalies and Sudden Unexplained Infant Deaths (SUID). To address these health outcomes a multi-faceted approach is necessary. This approach includes the Healthy Women/Healthy Babies (HWHB) program that offers preconception, prenatal, interconception, mental health and nutrition services to address chronic health conditions and other factors leading to prematurity. In addition to direct care, health promotion including free access to folic acid and screening for exposures to toxins aim to reduce congenital anomalies. Delaware is currently analyzing the second year of active surveillance of birth defects. Increased access to data on birth defects will help hone interventions to address those anomalies with the highest incidence. To reduce SUID, two strategies have been implemented: promotion of safe sleep environments and maternal tobacco cessation.

In calendar year 2011, there were 36,415 HWHB visits for 12,146 unique patients. Over 3,125 smoking cessation toolkits have been distributed statewide.

**c. Plan for the Coming Year**

During the upcoming year, outcome evaluation data for HWHB will be analyzed to assess the impact of program services on prematurity and infant mortality. With three years worth of data, there will be sufficient numbers to determine if enhanced preconception, prenatal, interconception, nutrition and mental health services are related to improvements in maternal and infant health outcomes. Indicators include: low birth weight, gestational age, congenital anomalies, and inter-birth intervals. Access to this level of data analysis will allow the program to make modifications as needed to enhance services.

**State Performance Measure 2:** *The rate of live births at 32 to 36 weeks of gestation (preterm birth).*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			110	108	106
Annual Indicator	112.4	102.5	102.3	102.3	102.3
Numerator	1337	1232	1163	1163	1163

Denominator	11898	12016	11369	11369	11369
Data Source		Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Stats
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	101.3	100.3	99.2	98.2	97.2

**Notes - 2011**

2011 data are not available. Data reported for 2011 are provisional.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2010 data are not available. Data reported for 2010 are provisional.

**Notes - 2009**

2009 Delaware Vital Statistics Data

**a. Last Year's Accomplishments**

The Perinatal Cooperative has worked to establish standards of care for the treatment of preterm labor with the goal of preventing prematurity. This includes the appropriate use of steroids for women who present with signs of preterm labor. Additionally, the Prematurity Prevention Program continues promoting awareness among 100% of all OB/GYN providers about progesterone and offering it free to patients without insurance or means to pay for the drug.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Women, Healthy Babies	X	X	X	
2. Family Planning	X	X		X
3. PRAMS				X
4. Center for Family Health Research and Epidemiology				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Delaware Division of Public Health has signed on as a partner to the March of Dimes Healthy Babies are Worth the Wait campaign and ASTHO Presidential Challenge of reducing prematurity. To further this agenda, the Delaware Healthy Mother and Infant Consortium has finalized a website on the HealthyWomenDE.com site specifically for pregnant and postpartum women. This website provides interactive links to show the impact that an additional few weeks of pregnancy can have on fetal brain and vital organ maturation. The website also promotes Text4Baby and additional resources available to support full-term pregnancies.

**c. Plan for the Coming Year**

The Perinatal Cooperative will promote hospital standards that prohibit early term/late pre-term elective deliveries. The recommended standards will include options such as a hard and soft stop, where nursing staff have the authority to stop a non-medically indicated early term/late pre-term delivery. Policies that include medical review and authorization by the department chair will also be promoted to discourage unnecessary early deliveries.

**State Performance Measure 3: *The rate of low birth weight and very low birth weight deliveries.***

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			92	90	84
Annual Indicator	92.4	84.9	104.6	104.6	104.6
Numerator	1118	1020	1189	1189	1189
Denominator	12097	12016	11369	11369	11369
Data Source		Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Stats
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	103.6	102.5	101.5	100.4	99.4

**Notes - 2011**

2011 data are not available. Data reported for 2011 are provisional.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2010 data not available. Data reported for 2010 are provisional.

**Notes - 2009**

2009 Delaware Vital Statistics Data

**a. Last Year's Accomplishments**

The Healthy Women/Healthy Babies (HWHB) program is a direct service to reduce low birth weight and very low birth weight deliveries. Through patient-centered, culturally competent care, women receive a gamete of services that aim to increase healthy pregnancies. Additionally, the prematurity prevention program provides free access to progesterone to women statewide. As of the last quarter of 2011, over eighty four percent of women served delivered after 34 weeks gestation.

The Division of Public Health continues the Statewide Education Campaign, which develops and distributes resources for educating teens and adult women on subjects relating to infant mortality. This includes the distribution of the Reproductive Life Plan toolkits to help teen and adult women set and follow personal goals that will help them achieve healthy pregnancies, when and if desired. In addition, efforts of the Tobacco Prevention and Control Program continue to ensure all pregnant women have access to tobacco cessation counseling and services.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Women, Healthy Babies	X	X	X	
2. Family Planning	X	X		X
3. PRAMS				X
4. Center for Family Health Research and Epidemiology				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Delaware Division of Public Health has signed on as a partner to the March of Dimes Healthy Babies are Worth the Wait campaign and ASTHO Presidential Challenge of reducing prematurity. To further this agenda, the Delaware Healthy Mother and Infant Consortium has finalized a website on the HealthyWomenDE.com site specifically for pregnant and postpartum women. This website provides interactive links to show the impact that an addition few weeks of pregnancy can have on fetal brain and vital organ maturation. The website also promotes Text4Baby and additional resources available to support full-term pregnancies.

Given that maternal tobacco use is a known contributing factor to low birth weight, the program continues actively promoting tobacco cessation through promotion of maternal smoking cessation toolkits. As of May 2012, over 3,125 smoking cessation toolkits have been distributed statewide.

**c. Plan for the Coming Year**

Activities for the upcoming year will focus on understanding more about the impact of mental health, nutrition and medical care services on maternal and infant health outcomes. By assessing individual level Healthy Women/Healthy Babies program data, the program can determine associations between services, or amount of specific services (i.e. nutrition counseling) and infant outcomes such as birth weight.

**State Performance Measure 4:** *The percent of children and adolescents who are overweight or obese.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			33	33	33
Annual Indicator		33.2	33.2	33.5	29.1
Numerator					
Denominator					
Data Source		2011 KIDS	2011 KIDS	2011 KIDS	2011 Delaware

		Count Fact Book	Count Fact Book	Count Fact Book	High School YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	28.5	27.9	27.4	26.8	26.2

**Notes - 2011**

2011 Delaware High School YRBS. Overweight 16.9% CI (14.9-19.0); Obese 12.2% CI (10.8-13.8).

Method of Target Setting: 20% improvement over next 10 years.

**Notes - 2010**

Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative

**Notes - 2009**

Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative

**a. Last Year's Accomplishments**

The Physical Activity, Nutrition and Obesity (PANO) program within the DPH Health Promotion and Disease Prevention Section continues to move forward with limited state funding (annual funding from the Delaware Health Fund, Tobacco Master Settlement Agreement dollars) to develop and implement a statewide plan and last year, hired a new PANO Director to provide oversight of the program and activities. The program's vision is that all Delawareans should live, work, learn and play in healthier communities, live healthier lives and achieve and maintain healthier weights. By building capacity to implement evidence-based policy, programmatic, environmental and infrastructure changes, the PANO Director has been able to implement several evidence-based strategies throughout diverse statewide communities that focus on the following:

- Healthy and Safe Community Environments
- Clinical and Community Preventive Services
- Empowered People
- Health Equity

The program's mission is to provide goals and strategies for government, media, communities, health care providers, schools and worksites to decrease childhood, youth, and adult overweight and obesity in Delaware. PANO's work supports the National Prevention Council's National Prevention Strategy: America's Plan for Better Health and Wellness in the areas of:

- Infrastructure and Capacity Building;
- Community Prevention and Outreach; and
- Surveillance and Evaluation.

PANO formed the Delaware Coalition for Healthy Eating and Active Living (DE HEAL) to assess and implement programs in DE. The DE HEAL (Delaware Coalition to promote Healthy Eating and Active Living) continued efforts to achieve their goals and objectives. The goals are to:

- Increase physical activity
- Increase the consumption of fruits and vegetables
- Decrease the consumption of sugar-sweetened beverages

- Increase breastfeeding initiation and duration
- Reduce the consumption of high-energy-dense foods
- Decrease television viewing The statewide coalition has established seven committees/workgroups.

These include:

- Community-based programs
- School/Youth
- Environment
- Industry/Employee Health
- Policy and Legislation
- Health Care Delivery
- Research and Evaluation

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC	X	X	X	
2. School-Based Wellness Centers	X	X	X	
3. Early Childhood Comprehensive Systems				X
4. Breastfeeding Promotion			X	
5. Home Visiting	X	X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The PANO program was awarded ARRA (American Reinvestment and Recovery Act ) Communities Putting Prevention to Work (CPPW) funds to do the following:

- To develop and implement procedures for healthy food choices for Delaware State Parks that provides healthy eating choices and limits the availability of unhealthy foods for all parks and park facilities through procurement practices and competitive prices in the vending machines, campground shops, and concession stands. The kickoff was held at Killens Pond State Park on June 11th.
- To work with the Delaware Department of Transportation to improve signage for bicycle routes and bicycle facilities.

PANO established a very successful Farmers' Market to promote locally grown fruits and vegetables and began it's second year on June 16th.

**c. Plan for the Coming Year**

There is a considerable amount of work going on in Delaware to meet this performance measure through joint efforts of state and local government agencies, nonprofit organizations, business leaders, health care providers and insurers, and education organizations to support policy, systems, and environmental change strategies associated with overweight, obesity and related chronic diseases.

First, DPH provides staff support to the Coalition for Healthy Eating and Active Living-(DE HEAL)

to carry out health promotion and prevention activities statewide. The DE HEAL is a network of over 70 organizations and 200 individuals that provide statewide leadership to promote the vision of transforming the culture of Delaware to make healthy eating and active living a priority. DE HEAL serves as a catalyst for policy, environmental, and systems changes that aim to prevent obesity through healthy eating and increasing physical activity throughout Delaware.

The Delaware Coalition for Healthy Eating and Active Living-(DE HEAL) released the first DE HEAL Annual Report, Physical Activity, Nutrition, and Obesity Prevention Plan 2010-2014, published in March 2012. This report is a look at the efforts and progress of Delaware HEAL and its' partners to reduce the prevalence of obesity and related chronic health conditions. To see the DE HEAL's Annual Report on Progress please visit <http://www.deheal.org/wp-content/uploads/2011/09/DEHEALAnnualReport2011Final.pdf> .

In Fall 2011, DE HEAL launched the newly revised website, [www.deheal.org](http://www.deheal.org) to further awareness and partnerships as well as enhance communication efforts about the importance of obesity prevention, healthy eating and active living.

DE HEAL, in collaboration with University of Delaware's Institute for Public Administration, developed, tested, and launched two global assessment toolkits that identify healthy community resources:

A Walkability Assessment Tool to evaluate safe and accessible walking areas in our towns. <http://www.ipa.udel.edu/healthyDEtoolkit/tools/walkability/>

A Comprehensive Plan Assessment Tool to guide cities and towns in Delaware to write more health-focused comprehensive plans or plan updates: <http://www.ipa.udel.edu/healthyDEtoolkit/tools/complan/>.

In March 2012, DE HEAL hosted their 4th Annual Summit titled, "Impacting Obesity through Environmental and Policy Changes," to reflect on the current climate in Delaware of creating strong, healthy communities through equitable development and collaboration.

**State Performance Measure 5:** *The percent of women of childbearing age (15-44) who are obese (BMI 30 or higher).*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			26	26	25
Annual Indicator	27	27	27	14.7	14.7
Numerator					
Denominator					
Data Source		Delaware BRFSS	Delaware BRFSS	2010 Delaware BRFSS	2010 Delaware BRFSS
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	14.4	14.1	13.8	13.5	13.2

**Notes - 2011**

2010 Delaware BRFSS, Obese Women, ages 18-64.

Method of Target Setting: 20% improvement over next 10 years.

**Notes - 2010**

2010 Delaware BRFSS, Obese Women, ages 18-64.

**Notes - 2009**

Percent of women 25-34 (Obese and Overweight), 2007 Delaware BRFSS

**a. Last Year's Accomplishments**

The Infant Mortality Elimination program and DHMIC have developed a preconception social marketing campaign. A significant message of the campaign is the need to achieve a healthy weight before pregnancy. Novel messaging and distribution via new media (e.g. text messaging, blogs) promotes widespread dissemination of this message to women of childbearing age.

In addition, the Healthy Women, Healthy Babies program provides nutritional counseling to all overweight and obese women. The women are eligible to meet with a Registered Dietician within their current care setting to develop individual healthy eating and healthy weight goals. Impact evaluation on an individual-level will take place during the upcoming year.

**Current Activities:**

The Healthy Women/Healthy Babies Program, aimed at serving women for preconception care, prenatal care and interconception care will be continued over the next year. All women in the program have access to free services from a Registered Dietician. They give women the tools to learn to maintain a healthy weight, eat a nutritious diet, including adequate amounts of folic acid daily, managing chronic disease, as well as being tobacco and substance free.

Smart Start/Healthy Families America: Public Health nurses, nutritionists and social workers provide enhanced prenatal care via home visits. In addition, clients are offered nutritional counseling for women who need additional services beyond what the nurse is able to provide.

Women, Infant, and Children (WIC) Program: Promotes healthier eating habits. WIC is a federally funded program that safeguards the health of low-income pregnant, breastfeeding and postpartum women, and infants and children five years of age. The program provides nutritious foods, information on healthy eating, breastfeeding support, and referrals to other healthcare, welfare and social services.

The PANO program, in collaboration with the DE HEAL Families in Communities committee, is completing the first phase of the Municipal Wellness Leadership Program with three municipalities in the state, and will continue expanding over the next year. The purpose of the MWL is to conduct a community needs assessment and an environmental scan. The municipalities received training by the PANO Program on the CDC evidence-based CHANGE Tool model for use in identifying gaps in programs and policy, systems and environmental strategies for chronic disease prevention.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting Program	X	X		
2. Healthy Women, Healthy Babies	X	X		
3. Family Planning	X	X	X	

4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current (continued from previous section).

The Sussex County Health Promotion Coalition (SCHPC) is a group of active partners working in the largely underserved and low-income areas of western Sussex County, and will continue to stay actively engaged. The SCHPC was recently awarded an ACHIEVE (Action Communities and Innovation for Environmental Change) grant. The DPH PANO Program Administrator is also the ACHIEVE State Health Department Expert Advisor and provides state-level technical support to the coalition.

DE HEAL Coalition Annual Meeting- On May 12, 2011, the DE HEAL Coalition's held its Annual Meeting. Setting Chairs/Co-Chairs of the Leadership Team presented their annual accomplishment reports at the meeting. This meeting was concluded with the changing of leadership for the coalition. With the installation of the New Leadership Team for 2011-2012, new goals and activities will be established.

**c. Plan for the Coming Year**

The Healthy Women/Healthy Babies Program, aimed at serving women for preconception care, prenatal care and interconception care will be continued over the next year. All women in the program have access to free services from a Registered Dietician. They give women the tools to learn to maintain a healthy weight, eat a nutritious diet, including adequate amounts of folic acid daily, managing chronic disease, as well as being tobacco and substance free.

Smart Start/Healthy Families America: Public Health nurses, nutritionists and social workers will continue to provide enhanced prenatal care via home visits. In addition, clients will be offered nutritional counseling for women who need additional services beyond what the nurse is able to provide.

**State Performance Measure 6: *The mortality rate among children and youth (0-21 years) due to unintentional injuries.***

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			10.5	10.5	12.6
Annual Indicator	16.1	12.8	15.4	15.4	15.4
Numerator		32	39	39	39
Denominator		250636	253638	253638	253638
Data Source		Delaware Health Statistics	Delaware Health Statistics	Delaware Health Statistics	Delaware Health Statistics

Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15.2	15.1	14.9	14.8	14.6

**Notes - 2011**

2011 data are not available. Data reported for 2011 are provisional.

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2010 data are not available. Data reported for 2010 are provisional.

**Notes - 2009**

2009 Delaware Vital Statistics

**a. Last Year's Accomplishments**

The OHS, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) continue to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance. See also State Performance Measure # 20 which relates to reduction of injuries for youth aged 15-18. In addition to participation in DIPC, the Bureau is an active collaborator of the Safe Kids Coalition. Safe Kids Delaware is a non-profit organization established in 1989 comprised of volunteers dedicated to reducing unintentional childhood injury in children from birth to age 14. Throughout the year SK held multiple safety awareness events, educational activities and injury prevention health fairs and conferences.

Current:

The Bureau will continue to focus on passenger safety within the realm of unintentional injury/mortality prevention in the coming year. As a result of the new Violence and Injury Prevention Program grant, the MCH Deputy Director and staff will get more involved and shape the specific emphases and interventions within these performance measures overall. The Bureau will continue to actively participate in the DIPC and collaborate in all possible ways. Additionally, the Bureau will continue its role and partnership with the Safe Kids Coalition. The Delaware MCH Bureau is involved in the Motor Vehicle workgroup as a part of its needs assessment to analyze severity of motor vehicle crash-related injury data for children and youth who are treated at a hospital. The coalition is divided into several risk areas that report information each quarter on actions, and upcoming plans. The risk areas are listed below with example 2011-12 activities:

- Drowning/Submersion -- Researching C-Spine surf injuries. Produced short pool safety video
- Fires/Burns -- 15,000.00 received by each county to purchase smoke alarms they will distributed as a part of Fire Prevention Month. Children from the state of Delaware ages 6 - 18 that have sustained serious burn injury are invited to attend Delaware Burn Camp. The mission of the Delaware Burn Camp is to assist young burn victims from the State of Delaware in their adjustment to injury through the provision of a safe, supportive environment and providing companionship through physical and social activities in a camp setting.
- Motor Vehicles -- Offering car seat safety checks in all 3 counties Presentations on the Graduated Drivers License program. Offering Mock-tail parties around the state throughout the holiday season.
- Poisonings
- Suicide/Suicide Attempts-- Depression screening offered throughout state. Delaware Suicide Gatekeeper Training "Project Life (living is for everyone) classes held in all 3 counties.
- Traumatic Brain Injuries/Spinal Cord Injuries -- 200 bike helmets and T-shirts were given out as part of a stay safe campaign. Every child caught wearing a helmet received a "Rita's Ice: during the "Caught You being Safe" program.

- Violent Injury: Assault, Firearm, Homicide -- 13 boys signed up for the Kindergarten through 10th grade Fire Arm Safety course. Approximately 20 students attended the anti-bullying safety-program in Sussex County where they have partnered with the First State Community Action committee who has plans to conduct more programs for that community. Additional neighborhoods were identified as areas where people are concerned with the same topics. Community safety surveys were completed to assist with identification of areas on concentration and subject matters such as gang drive-by shootings.
- Data Review Committee -- Reviewed data from Delaware Trauma System Registry for the years 1998-2009 and presented to group. The information was able to show that resources for pediatric pedestrian trauma management and prevention should be directed in target zip codes of 19801, 19802, 19805, and 19720 where there were 319 pediatric pedestrian deaths.
- Community safety surveys were completed to assist with identification of areas on concentration and subject matters such as gang-related drive-by shootings.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Injury Prevention Coalition				X
2. Emergency Medical Services for Children				X
3. Office of Injury Prevention				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

Over the next year, MCH will work with the Delaware Coalition for Injury Prevention on implementing strategies identified in the updated state plan.

Home Visiting Services: Home visiting by nurses to families at high risk of injury is used in Delaware for a wide range of purposes, including improving the home environment, family development and addressing child behavior. This will be key element of DPH's evidenced-based home visiting program.

**c. Plan for the Coming Year**

The Bureau of Maternal Child Health will continue to collaborate with Safe Kids and the Office of Highway Safety to purchase car seats for a low cost Child Safety Seat program for the state of Delaware.

The Low Cost Car Seat Program provides an opportunity for low income families, identified by hospitals and state social workers, to purchase a new car seat at an Office of Highway Safety Child Restraint Fitting Station at a minimal cost. The Child Restraint Fitting Station is a location that is open year-round, where parents can go to have their child safety seats inspected. The stations are staffed by trained Fitting Station Technicians according to the curriculum standards by the National Highway Traffic Safety Administration. The technicians have knowledge and expertise on the correct use and installation of child restraints and safety belts to help parents do a better job protecting their children and is intended to reduce unintentional injuries caused by

motor vehicle crashes, which involve children as passengers. In Delaware (2003-2007), 27% of children aged 0-14 years involved in a motor vehicle fatality were occupants.

"Preventing Injury in the 21st Century" is the theme for the upcoming Safe Kids/Emergency Medical Services for Children Childhood Injury prevention Conference. The goal/objectives of the conference is sharing knowledge, information and resources regarding injury prevention for children with Delawareans whose livelihoods put them in a position of preventing injury to the children. The agenda includes the following presentations:

- Bullying & Violence: Julie Hubbard, PhD, University of Delaware
- 5- 2 -1 -Almost None, Strategies for Healthy Eating and Physical Activity: Milton Delgado, EdD, MBA -- Nemours Health and Prevention
- Injury Prevention in the 21st Century: Deena Brecher, MSN, RN, APRN - Emergency Nurses Association Board of Directors, Nemours Health and Prevention
- Playing it Safe Outside -- Jean Shappet, Co-Founder and Trainer, Boundless Playgrounds
- Aquatic Safety -- Jennifer Whaley, RN, CCRN -- Beebe Hospital

**State Performance Measure 7:** *The percent of Delaware public high school students who currently smoke.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			10	10	18.8
Annual Indicator	18.2	19.1	19.1	19.1	18.3
Numerator					
Denominator					
Data Source		Delaware YRBS	Delaware YRBS	Delaware YRBS	2011 Delaware High School YRBS
Is the Data Provisional or Final?				Provisional	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	18.1	17.9	17.8	17.6	17.4

**Notes - 2011**

2011 Delaware High School YRBS, Smoked cigarettes on at least 1 day in the last 30 days. 18.3%, CI (16.2-20.5).

Method of Target Setting: 10% improvement over next 10 years.

**Notes - 2010**

2009 YRBS

**Notes - 2009**

2009 YRBS

**a. Last Year's Accomplishments**

Teens Against Tobacco Use (TATU) is a curriculum that trains adult facilitators and high school aged teens on tobacco prevention. The trained teens then take the program to middle schools and other community settings to work with younger children; Delaware Kick Butts Generation

(KBG) is a program that empowers youth to develop and maintain groups in schools and communities to work on tobacco issues that are relevant to their environment. Not-On-Tobacco (N-O-T) is a smoking cessation program designed for youth that is gender specific to help them quit smoking.

Schools reached 14,500 youth in the TATU program, 51 in NOT and 27,500 in the KBG program. Another 27,700 adults and youth saw billboards or read a newsletter produced through the youth prevention program.

In June 2009, a new bill (HB211) was introduced to increase the tobacco excise tax by 45 cents. Increases in excise tax have been shown to reduce youth smoking.

**Current Activities:**

The high school smoking rate continues to drop and as of the 2010 YTS the rate is 14.9. More than 3,500 adult Delawareans enrolled in cessation counseling services; 3,315 chose Quitline (telephone); 386 chose face-to-face counseling (FY11 numbers for Delaware Quitline). There were 32 mini-grants awarded to community organizations statewide. The majority of the mini grant awards (26) focused on youth prevention activities. Through the contract with American Lung Association, several youth prevention activities have taken place such as Teens Against Tobacco Use (TATU) and the youth empowerment group, entitled Delaware Kick Butts. Generation has over 40 interns working for the cause with over 8,000 active members.

Five towns adopted smoke-free ordinances and four towns created no-smoke zones within their jurisdictions. Areas that ordinances and smoke free zones addressed included parks, boardwalks, historic downtown areas, playgrounds and specific distances from public buildings. Towns used CPPW funds for educating citizens about the new policies and enforcement of the policies.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Teens Against Tobacco Use			X	
2. Delaware Kick Butts Generation		X		
3. Youth Tobacco Cessation Program		X		
4. Quitline and Quitnet Tobacco Cessation Program		X		
5. Reproductive Life Plans			X	
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current (continued from previous section)

A bill for increasing the tax on other tobacco products to that equal to cigarettes was introduced in June 2011. However the bill was tabled until this current legislative session which ends this June 30.

Over 250 community leaders and policy makers received education on the dangers of other tobacco products (cigars/cigarillos, chew, snus etc) and the science behind certain pricing strategies (prevalence rates decrease as prices increase) using CPPW resources.

CPPW funds were also used to develop a comprehensive social marketing campaign on the dangers of other tobacco products including cigars, cigarillos and smokeless tobacco. Six focus groups were conducted throughout the project period to gain input on campaign development and provide feedback on campaigns and more insight to behaviors and attitudes towards other tobacco products. Campaign materials covered cigars/cigarillos, chew, snus, orbs, strips etc. Media outlets included local cable television, radio, newspaper, local magazines, internet banner ads, gasoline pump toppers, interior bus boards, pamphlets distributed during community outreach and education. A website was also developed called the Dirtytruth.com.

**c. Plan for the Coming Year**

The Delaware Impact Coalition drafted a new five year Strategic Plan. The goals of the plan are:

- Goal 1: Prevent the initiation of tobacco use among Delawareans.
- Goal 2: Increase quitting and quit attempts among Delawareans who use tobacco products.
- Goal 3: Reduce exposure to secondhand smoke.
- Goal 4: Decrease the social acceptability of tobacco use.
- Goal 5: Enhance Delaware's position of leadership in comprehensive tobacco prevention and control.

The Division of Public Health's Health Promotion and Disease Prevention Program will continue supporting these goals.

**State Performance Measure 8:** *The percent of benchmark measures completed for implementation of a formal umbrella structure for organizations serving families with children with special health care needs in Delaware.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			60	80	100
Annual Indicator		20.0	60.0	80.0	80.0
Numerator		1	3	4	4
Denominator		5	5	5	5
Data Source		State Title V Program Data	State Title V Program	State Title V Program	State Title V Program
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2010**

See Form 16, SPM 8 "Detail Sheet" for how this measure is determined.

**Notes - 2009**

See Form 16, SPM 8 "Detail Sheet" for how this measure is determined.

**a. Last Year's Accomplishments**

As was relayed in Federal Performance Measures 2,3 4, 5, and 6, the principal strategy for achieving systems-oriented goals is through the creation of an umbrella organization, Family SHADE, a mechanism for bringing the many valuable, yet disparate, informal groups and formal

organizations in order to reduce fragmentation, improve information and referral, strengthen organizational capacity, and advocate for CYSHCN. Themes that Family SHADE aim to address, include:

1) Increase efficiency of the systems serving children, youth and young adults with special health care needs by:

- a. Reducing fragmentation and duplication
- b. Enhancing collaboration
- c. Identifying and addressing gaps in services

2) Care coordination/Case management

3) Capacity-building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella should include, at a minimum, the following:

- a. Governance
- b. Sustainability
- c. Strategic Planning
- d. Family partnership in decision-making
- e. Evaluation - It is expected that the CBO work with partner organizations to

complete an organizational assessment and develop a strategic plan.

4) Provide information and referral services that reflect the complex information needs of families.

The University of Delaware, Center for Disabilities Studies, continues to provide lead staff support to firmly guide the overarching goals of Family SHADE. The Project Director and a Project Coordinator guide the development of a member-driven "umbrella" initiative. Over the last year, the Advisory Board maintained its commitment to the development of an organization that could coordinate information and resources for CYSHCN and their families. The Advisory Board worked over the last year to develop a mission and vision statement for the organization, as well as a new name (Family Support and Healthcare Alliance DElaware or Family SHADE) and a logo that represents the family-friendly nature of the organization that they were shaping. The dedicated Family SHADE Advisory Board then continued to develop a strategic plan for the organization and adopted Bylaws that carefully laid out the criteria for voting and collaborative membership, a governance structure for Family SHADE consisting of a three-year rotation of Advisory Board members, and officers consisting of a Chair, Vice Chair and Secretary.

#### Current Activities:

Standing committees were also designated in the Family SHADE bylaws. A membership application based on the bylaws was also developed and presented to interested organizations at a Summit in November 2011. Since that time, membership applications have continued to be submitted to the Board for approval at each Advisory Board meeting. A slate of Advisory Board members and officers will be submitted to the membership at a Summit on June 13, 2012.

In addition to the development of an infrastructure for the organization, over the past year Family SHADE has offered technical assistance workshops to its members and other interested organizations that serve CYSHCN. These workshops have addressed topics such as strategic plan development and effective proposal writing, both of which were funded through technical assistance provided by Title V. Family SHADE staff also conducted a networking "mixer" where organizations had an opportunity to describe the work that they do and share resources and information about upcoming activities.

CDS staff also presented information about Family SHADE at numerous health fairs, Board meetings, and conferences including the LIFE conference (the largest disability-related conference in Delaware) and at the 2012 AMCHP conference.

Family SHADE also developed a new, temporary website ([www.familyshade.org](http://www.familyshade.org)) where families and other organizations can learn about Family SHADE, its members, ongoing activities and

upcoming opportunities. A more robust website is currently under development and should be online this summer. In addition, a comprehensive database that includes information and resources of importance to CYSHCN is under development under a contract with Children and Families First. The database will be family-friendly and searchable and can be accessed via a portal on Family SHADE's website as well portals of Family SHADE member websites.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family SHADE				X
2.				
3.				
4.				
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**b. Current Activities**

Current (continued from previous section).

Also of importance, the database will be an expansion of an existing database that addresses resources for adults with disabilities as well as a database of child care providers in Delaware. . The Family SHADE database will also include the Delaware Central Directory of Services for Young Children with Special Needs that was formerly published by the Department of Health and Social Services' Birth to Three Early Intervention System. The resources available to families through this expanded database will address not only CYSHCN, but it will include resources that cover the lifespan of individuals with disabilities and special healthcare needs.

Family SHADE's broad network of organizations enables the rapid dissemination of information to CYSHCN and their families throughout Delaware. A new Family SHADE project, Families Know Best, will provide a mechanism whereby families can offer regular feedback about the services they receive and quickly bring new concerns to the attention of service providers and policymakers. Families Know Best will conduct periodic online surveys of participating families and their suggestions will be shared with Family SHADE partnering organizations as well as with policymakers when appropriate. This will enable service providers to rapidly tailor their services in response to the needs that families express.

**c. Plan for the Coming Year**

Current (continued from previous section).

In addition to working to improve the quality of life for CYSHCN and their families, Family SHADE strengthens and supports its partner organizations by providing technical assistance in areas such as grant writing, strategic planning, and fundraising, and by coordinating existing expertise among Family SHADE partners. Family SHADE also provides information regarding funding opportunities to its member organizations and encourages collaborative initiatives that leverage funding among its members to develop new services, or to improve or increase the capacity of existing services. Member organizations have been awarded funding through Family SHADE

grants for outreach to Hispanic families of CYSHCN in Sussex County, to identify gaps in services and supports to children and youth with chronic health care needs in Delaware, and to recommend strategies that will lead to improved services and supports to these families.

Plan for Coming Year.

The Family SHADE activities planned for current year will likely extend into next federal FY. The next series of deliverables will include a second environmental scan to assess organizational capacity (e.g.

governance), support in promotion of the state mixed-methods CYSHCN survey, continued family input into Bureau plans, and the planning and implementation of several activities proposed in the State Implementation Grant to Improve Services to Children and Youth with Special Health Care Needs.

Family SHADE will continue to broaden its membership base and will focus on expanding its membership to include more organizations in Kent and Sussex Counties. In addition, a networking meeting for organizations that serve CYSHCN will be hosted either bi-monthly or quarterly in New Castle County.

Technical assistance to Family SHADE organizations will be provided via workshops that address specific topics as indicated by the membership. These topics may enable organizations to increase capacity, effectiveness, and outreach to families. Family SHADE will also continue to share funding opportunities with the membership and will administer funding opportunities that are made available to members via Family SHADE (such as mini-grants that address MCHB objectives/performance measures and that are funded by HRSA ).

Family SHADE will also continue to develop venues whereby families can easily access consistent, reliable information about needed services by expanding the website and database and by training representatives of member organizations in best practices related to information and referral so they can more effectively assist families in their quest for services. Family SHADE will also have a mobile app available whereby families can access and search the database from their mobile phones, wherever they may be.

**State Performance Measure 9:** *The percentage of children aged 4 months to 5 years with no or low risk for developmental, behavioral or social delays.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective			76	76	78
Annual Indicator		74	74	74	74
Numerator					
Denominator					
Data Source		NSCH, 2007	NSCH, 2007	NSCH, 2007	NSCH 2007
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	74.7	75.5	76.2	77	77.7

**Notes - 2011**

2007 National Survey on Children's Health

Method of Target Setting: 10% improvement over next ten years.

**Notes - 2010**

2007 National Survey on Children's Health

**Notes - 2009**

2007 National Survey on Children's Health

**a. Last Year's Accomplishments**

Standardized developmental screening among pediatric and primary care practices resulted from a collaboration between DPH's Early Childhood Comprehensive Systems, Delaware's Chapter of the American Academy of Pediatrics, and Nemours Health and Prevention Services.

The Lieutenant Governor also led an effort to secure state funds for the Division of Public Health to launch the Parents Evaluation Developmental Status (PEDs) tool online.

An education campaign supported H.B. 99. This bill was subsequently signed into law and requires reimbursement for developmental screening. In April 2011, the Commonwealth Fund State Scorecard on Child Health System Performance ranked Delaware 50th (lowest) for the percent of young children (ages 10 months-5 years) who received standardized developmental screening during visit. The data is based on the 2007 National Survey of Children's Health (NSCH) where Delaware's percent of children screened was 10.9% compared to the national percentage of 19.5%. While there is no indication that the data is inaccurate, it is important to note that the National Survey of Children's Health is a phone-based survey. The findings caught the attention of the Lieutenant Governor Matt Denn as a concern and he immediately identified timely developmental screening and surveillance of children as a priority issue.

Current:

The Early Childhood Comprehensive Systems administrator is continuing to work with the Delaware Chapter of the American Academy of Pediatrics and other state partners to expand developmental comprehensive screening among both pediatric and primary care practice sites, as part of the Help Me Grow system initiative. In addition, several evidence based home visiting programs (i.e. nurses, social workers, parent educators) such as Nurse Family Partnership, Parents as Teachers, and Smart Start nurses and social workers ( under the Healthy Families America model) have been trained in the use of the validated developmental screening tool, Ages in Stages:3 and Social Emotional Questionnaires.

DPH established a partnership with the Department of Children, Youth and Their Families' Office of Child Care Licensing to co-lead a Comprehensive Screening project, as a result of the Race to the Top Early Learning Challenge grant awarded to Delaware. The project will be implemented over the next year and aims to train Delaware Stars (Early Success is a Quality Rating and Improvement System) early learning and development program professionals (i.e. early learning educators, curriculum specialists, and administrators) in the use of a validated developmental screening tool (i.e. Ages in Stages:3 and Ages in Stages: Social/Emotional Questionnaires) to increase the early identification of at-risk children with developmental delays or social emotional concerns and get them connected with early intervention services and treatment.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early Childhood Comprehensive Systems				X
2.				
3.				
4.				
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**b. Current Activities**

Planned for Next Year:

The Early Childhood Comprehensive Systems (ECCS) initiative will continue to work with the Delaware Chapter of the American Academy of Pediatrics, the Home Visiting Community Advisory Board, the Help Me Grow Advisory Council, the Governor's Early Childhood Advisory Council and other partners toward the implementation of comprehensive developmental screening and surveillance initiative, using validated screening tools.

The Lieutenant Governor Matt Denn is very passionate about a new effort to increase the use of validated development screening tools and surveillance, which was successfully funded in the FY12 State budget process. Over the next year, DPH will bolster efforts to promote the PEDS tool to health care providers (i.e. pediatricians and family doctors) available online to enroll as a participating provider so that families can complete the assessment. PEDS Online is a web-based tool that allows parents to complete an assessment which is then securely transmitted to the provider. This assessment can be done before the office visit, saving valuable time and resources. Additionally, providers can score the tool, print parent education, send automated referral letters, and store the results in an electronic medical record. Nemours Health & Prevention services and the DE-Chapter of Academy of Pediatrics will provide on-site training and technical assistance to provider practices implementing standardized screening.

**c. Plan for the Coming Year**

Planned Continued:

Information and resources are also made available through the Delaware Chapter of the American Academy of Pediatrics. Promotional strategies to increase provider participation in PEDs includes a series of Grand Rounds, the first of which is scheduled in June 2012 with Al DuPont Hospital pediatricians and a second scheduled in August 2012 for Christiana Health Care Services' pediatricians and family doctors. The Lieutenant Governor Matt Denn, Dr. Rattay, the Director of the Division of Public Health, and DPH staff will present at the Grand Round sessions on the importance of developmental screening and surveillance, the PEDs project, and provide an overview of Help Me Grow 2-1-1 (in partnership with United Way of Delaware), a centralized telephone access point to refer families with young children to find information on resources and get connected to existing community services.

In 2012-13, Delaware will continue to work on the planning and implementation of a Help Me Grow system. Help Me Grow, serves as a comprehensive, integrated and universal system designed to address all families with children (and expecting parents) and the need for early identification and linkage to developmental and behavioral services and supports for the birth through age eight populations. Championed by the Lieutenant Governor Matt Denn, a state-wide Help Me Grow Advisory Committee was established in 2012 to effectively accomplish establishing the infrastructure for Delaware's HMG system. Collaboration and coordination of efforts with several stakeholders include the development of four key components: 1) centralized telephone access point; 2) community outreach to promote use of DE-HMG; 3) physician outreach to support early screening and intervention; and 4) data collection (surveillance, case management, referrals, follow-up) to identify gaps and barriers impeding the current system. Help Me Grow serves as an early childhood system framework and integrates with the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting program, Race to the Top Early Learning Challenge grant (awarded to Delaware in December 2011) the Children and Youth with

Special Health Care Needs activities, and other early childhood related activities to improve young children's health and development to ensure success in school and throughout the lifespan

**State Performance Measure 10:** *The percent of health indicators that improve across four domains (child health, mental health, health care access and quality, and family health) for children with special health care needs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				0	20
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	20	30	30	30	30

**Notes - 2011**

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

See Form 16, SPM 10 "Detail Sheet" for how this measure will be determined.

Method of target setting: 50% improvement over next five years.

**Notes - 2010**

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

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**Notes - 2009**

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

**a. Last Year's Accomplishments**

As was relayed in Federal Performance Measures 2,3 4, 5, and 6, the principal strategy for achieving systems-oriented goals is through the creation of an umbrella organization, Family SHADE, a mechanism for bringing the many valuable, yet disparate, informal groups and formal organizations in order to reduce fragmentation, improve information and referral, strengthen

organizational capacity, and advocate for CYSHCN. Themes that Family SHADE aim to address, include:

1) Increase efficiency of the systems serving children, youth and young adults with special health care needs by:

- a. Reducing fragmentation and duplication
- b. Enhancing collaboration
- c. Identifying and addressing gaps in services

2) Care coordination/Case management

3) Capacity-building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella should include, at a minimum, the following:

- a. Governance
- b. Sustainability
- c. Strategic Planning
- d. Family partnership in decision-making
- e. Evaluation - It is expected that the CBO work with partner organizations to

complete an organizational assessment and develop a strategic plan.

4) Provide information and referral services that reflect the complex information needs of families.

The University of Delaware, Center for Disabilities Studies, continues to provide lead staff support to firmly guide the overarching goals of Family SHADE. The Project Director and a Project Coordinator guide the development of a member-driven "umbrella" initiative. Over the last year, the Advisory Board maintained its commitment to the development of an organization that could coordinate information and resources for CYSHCN and their families. The Advisory Board worked over the last year to develop a mission and vision statement for the organization, as well as a new name (Family Support and Healthcare Alliance DElaware or Family SHADE) and a logo that represents the family-friendly nature of the organization that they were shaping. The dedicated Family SHADE Advisory Board then continued to develop a strategic plan for the organization and adopted Bylaws that carefully laid out the criteria for voting and collaborative membership, a governance structure for Family SHADE consisting of a three-year rotation of Advisory Board members, and officers consisting of a Chair, Vice Chair and Secretary.

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CDS staff also presented information about Family SHADE at numerous health fairs, Board meetings, and conferences including the LIFE conference (the largest disability-related conference in Delaware) and at the 2012 AMCHP conference.

Family SHADE also developed a new, temporary website ([www.familyshade.org](http://www.familyshade.org)) where families and other organizations can learn about Family SHADE, its members, ongoing activities and upcoming opportunities. A more robust website is currently under development and should be online this summer. In addition, a comprehensive database that includes information and

resources of importance to CYSHCN is under development under a contract with Children and Families First. The database will be family-friendly and searchable and can be accessed via a portal on Family SHADE's website as well portals of Family SHADE member websites.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family SHADE				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Current Continued:

Also of importance, the database will be an expansion of an existing database that addresses resources for adults with disabilities as well as a database of child care providers in Delaware. . The Family SHADE database will also include the Delaware Central Directory of Services for Young Children with Special Needs that was formerly published by the Department of Health and Social Services' Birth to Three Early Intervention System. The resources available to families through this expanded database will address not only CYSHCN, but it will include resources that cover the lifespan of individuals with disabilities and special healthcare needs.

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**c. Plan for the Coming Year**

Current Continued:

In addition to working to improve the quality of life for CYSHCN and their families, Family SHADE strengthens and supports its partner organizations by providing technical assistance in areas such as grant writing, strategic planning, and fundraising, and by coordinating existing expertise among Family SHADE partners. Family SHADE also provides information regarding funding opportunities to its member organizations and encourages collaborative initiatives that leverage funding among its members to develop new services, or to improve or increase the capacity of existing services. Member organizations have been awarded funding through Family SHADE grants for outreach to Hispanic families of CYSHCN in Sussex County, to identify gaps in services and supports to children and youth with chronic health care needs in Delaware, and to recommend strategies that will lead to improved services and supports to these families.

Planned for Comming Year:

The Family SHADE activities planned for current year will likely extend into next federal FY. The next series of deliverables will include a second environmental scan to assess organizational capacity (e.g. governance), support in promotion of the state mixed-methods CYSHCN survey, continued family input into Bureau plans, and the planning and implementation of several activities proposed in the State Implementation Grant to Improve Services to Children and Youth with Special Health Care Needs.

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## **E. Health Status Indicators**

In Delaware, as mentioned elsewhere in this application, two major Maternal and Child Health Initiatives are the Infant Mortality Elimination Program, including the Delaware Healthy Woman and Infant Consortium, and the newly formed Office of Injury Prevention. As such, Delaware's priority health status indicators include the indicators related to birth outcomes and injury prevention:

- HSI #1A: The percent of live births weighing less than 2,500 grams
- HSI #1B: The percent of live singleton births weighing less than 2,500 grams
- HSI #2A: The percent of live births weighing less than 1,500 grams
- HSI #2B: The percent of live singleton births weighing less than 1,500 grams
- HSI #3A: The death rate per 100,000 due to unintentional injuries among children 14 years and younger
- HSI #3B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle.
- HSI #3C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth 15 through 24.
- HSI #4A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
- HSI #4B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
- HSI #4C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

## Data and Trends

HSI #1A: The percent of live births weighing less than 2,500 grams

In 2009, 8.6% of live births were at birth weights below 2,500 grams. This indicator remains about the same at the 8.5% reported in 2008 and represents a decrease since 2007 when 9.2% of live births were low birth weight infants.

HSI #1B: The percent of live singleton births weighing less than 2,500 grams

In 2009, 7.1% of live singleton births were at birth weights below 2,500 grams. This indicator was a slight uptick from the 6.8% reported in 2008 and represents a decrease since 2007 when 7.6% of live singleton births were low birth weight infants.

HSI #2A: The percent of live births weighing less than 1,500 grams

In 2009, 1.9% of live births were at birth weights below 1,500 grams. This indicator is a slight increase since 2007 when 1.7% of live births were very low birth weight infants.

HSI #2B: The percent of live singleton births weighing less than 1,500 grams

In 2009, 1.6% of live singleton births were at birth weights below 1,500 grams. This indicator is an increase since 2007 when 1.3% of live singleton births were very low birth weight infants.

HSI #3A: The death rate per 100,000 due to unintentional injuries among children 14 years and younger

In 2009, the death rate per 100,000 due to unintentional injuries among children 14 years and younger was 8.2. This is an increase since 2007 when the death rate was 3.6 per 100,000. This increase is not statistically significant due to small numbers.

HSI #3B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle.

In 2009, the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 4.7. This is an increase since 2007 when the death rate was 1.2 per 100,000. This increase is not statistically significant due to small numbers.

HSI #3C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth 15 through 24.

In 2009, the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years was 15.2. This is a decrease since 2007 when the death rate was 28.3 per 100,000. This decrease may not be significant due to small numbers.

HSI #4A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

In 2009, the rate per 100,000 of all nonfatal injuries among children aged 14 years and younger was 343. This is a decrease from 2008 when the rate was 387 per 100,000. The data reported for 2007 is incorrect and cannot be changed. We will request an update for this indicator after the August 2013 MCH Block Grant Review.

HSI #4B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

In 2009, the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger was 30.6. This is slight decrease since 2008 when the reported rate was 32.1. The data reported for 2007 is incorrect and cannot be changed. We will request an update for this indicator after the August 2013 MCH Block Grant Review.

HSI #4C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

In 2009, the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among you aged 14 through 24 years was 133.8. This is a decrease since 2007 when the rate was 176.0 per 100.000.

The chlamydia rates for women aged 15 through 19 and women aged 20 through 44 has increased since 2007. Reduction of STDs/STIs is an important objective of the Healthy Women, Healthy Babies Program, Title X Family Planning, the Delaware Adolescent Program and DPH's HIV/STD Program.

As discussed throughout the application, indicators related to healthy birth outcomes remains a priority in Delaware and initiatives supporting these efforts have been discussed at length throughout the narrative.

During the coming year, the newly formed Office of Injury Prevention will continue to develop a strategic plan for injury prevention initiatives throughout the state.

Though we have not set "evaluation" targets for these indicators, we will continue to gauge these measures compared to national data and other states, as well as the region.

## **F. Other Program Activities**

The Office of Women's Health works to improve the health of all women in Delaware. Recent activities / accomplishments include:

SUSSEX HEART TRUTH CAMPAIGN -- The Delaware Office of Women's Health (OWH) successfully organized and presented the Sussex Heart Truth Campaign with its partners: La Red Health Center, the Delaware Division of Public Health's Diabetes Prevention and Control Program and DPH's Southern Health Services Section.

Between April 20 and June 8, 13 lectures highlighted by Powerpoint slides were held in Sussex County churches and community centers. Speaker presentations (in English and Spanish) covered the definition of heart disease, risk factors, methods to prevent heart disease, symptoms of stroke and myocardial infarction, and the frequent results of heart disease.

Most attendees were women aged 18-60 years. Participants represented the following ethnicities: 65% African American, 25% Hispanic, 7% Caucasian, 0.5% Asian American, and 1% 'Other' (does not sum to 100% due to rounding error). Of the 130 consenting individuals screened, 84% were overweight or obese; 64% were hypertensive or pre-hypertensive; and 57% were diabetics or pre-diabetics.

A few rare attendees with excessively high blood pressures or blood glucose levels were referred to private physicians and La Red Health Center. Although not required by the grant, public health nurses followed some participants to assist them in altering health behaviors.

DIMINUTION OF HEALTH DISPARITIES --The OWH extended its support of evidence-based programs and efforts to diminish health disparities through speaking engagements, such as at the Visions of Justice X conference in November. It also reviewed projects, such as the Kaiser Family Foundation's "Putting Women's Healthcare Disparities on the Map" for a local African American

women's charitable group, Alpha Kappa Alpha.

**DOMESTIC VIOLENCE PREVENTION** -- The OWH became increasingly involved in preventing domestic violence:

- The Office supported the active Campaign/Walk of the Whitney's Lights Violence Against Women Group. Over 500 persons celebrated the life of Dr. Whitney Lucas and to affirm their commitment to end domestic violence.
- The OWH is a member and consultant to the Delaware Task Force on Teen Dating Violence.
- The OWH continues to participate in the Delta Project of the Delaware Coalition Against Domestic Violence, which formulated a state plan to prevent domestic violence.

The Office of Minority Health works to improve cultural competence and reduce disparities in Delaware. Recent activities / accomplishments include:

**HEALTH DISPARITIES** -- OMH and the Metropolitan Wilmington Urban League produced Blueprint for Action. The report summarizes the recommendations generated from the Stronger Together II Minority Health Summit held on March 12, 2009. Another collaboration with the League created the Delaware Health Equity Consortium.

**FUNDING** -- OMH received the fourth of the five-year, federally funded State and Territorial Disparities Elimination Partnership Grant. Although funding was reduced, OMH was able to continue the contractual partnership with Delaware State University for the Health Professions Academy and provide resources to develop DPH's cultural competency training series. The grant also funds the interpreter training for 2009 and supports OMH's one FTE.

**HEALTH PROFESSIONS ACADEMY** -- Through this initiative, DPH seeks to increase students' likelihood of pursuing health careers by introducing fourth, fifth and sixth graders to health professions. Students also strengthen their math and science skills. Twenty-eight students enrolled and completed the 2009 class; 38 are enrolled in the 2009-2010 program. Partners are DPH's Rural Health Program, Delaware State University, and the Delaware Chapter of the National Medical Association.

**CULTURAL COMPETENCY** -- OMH partnered with the Office of Workforce Development to develop DPH: Journey to Cultural Competence," offered year-round. Thirteen DPH staff members were trained as facilitators. Secondly, OMH engaged Social Solutions, a training and consulting firm, to coordinate a series of workshops to build a culturally competent health care system in Delaware. Approximately 163 professionals attended the five trainings and gave overwhelmingly positive evaluations.

**MEDICAL INTERPRETER TRAINING** -- In April 2009, OMH coordinated and hosted its seventh "Bridging the Gap" Medical Interpreter Training. Of the 24 registrants, 21 (87.5%) successfully completed the training. Of the 93 certificate holders, 79 are registered members of Delaware's medical interpreter corps. OMH responded to several community requests to locate interpreters. In May 2009, interpreters staffed DPH's H1N1 Influenza Call Center. In the fall, about 20 interpreters worked at six mass vaccination clinics arranged in response to the epidemic.

**OMH WEBSITE** -- OMH's new website offers information on Delaware disparities, statistics, and upcoming trainings. Books, reports and links are included. Visit it at <http://www.dhss.delaware.gov/dhss/dph/mh/minority.html>.

The Special Needs Alert Program (SNAP) recognizes children with special medical needs child when the family calls 911. Since 2004, parents/guardians have enrolled over 181 children in SNAP statewide. Part of enrollment is completing a set of forms which includes a consent form giving permission to share medical information with local EMTs and paramedics so they can access it on the way to, or prior to an emergency call. Once paperwork is completed, the information is entered in a secure SNAP electronic data base located in the Office of EMS. The

child's medical information is given to the 911 dispatch center, the county based paramedic service and the local fire company upon enrollment and is made accessible to responding units.

## **G. Technical Assistance**

### 1. Develop Cultural and Linguistic Competence of Delaware Title V MCH personnel

Delaware Maternal and Child Health is requesting assistance with building capacity of its MCH personnel through a workshop to (1) value diversity, (2) conduct an organizational self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities we serve.

### 2. Centralized Intake System development for Children and Youth with Special Health Care Needs and their Families and consensus building

Partner organizations and families of CYSHCN provide input and strategic guidance to Family SHADE's work via their participation on its Advisory Council. With support by Title V, the Center for Disabilities staff that are devoted to Family SHADE, shepherded the launch of the umbrella activities very carefully to ensure that our collaborators felt a genuine sense of ownership and self-determination in governance, direction, and implementation.

Technical assistance is requested to further refine and develop the Family SHADE organization, and assist the group with coming to a consensus on a centralized intake system (information and referral) in order to achieve its goals and priorities.

Below is a list of the issues that were expressed by the Family SHADE -- network of CYSHCN partners Board and advocates which we are trying to work through:

Create a separate 800 direct line for special needs families, based on the Wisconsin First Steps model, in addition to HMG 2-1-1.

Family SHADE I&R- consider the creation of a position for coordinated care specialists, Level 2 referrals, for complex issues. This position would provide a 2 hour consultation to support families with special needs, develop a plan to address their specific needs and provide follow-up. Possibly consider Level 3 support, which includes developing care planning and long-term follow-up. The Board feels that it is important that I&R for this population is provided by a parent of a child with special needs.

Age range Birth to 8 -- what happens with those families out of the age range, currently targeted for Help Me Grow 2-1-1. (It is a long-term goal to provide I&R support to HMG families with children 9+. However, first, the current infrastructure and resources needs to be established and long-term sustainability planning is critical.)

Database limitations- Delaware 2-1-1 database does not list private providers unless they serve low-income families, offer sliding scale fees, accept Medicaid or provide a unique service. (This policy will be reviewed. It is assumed that this is due to liability.)

Complexity of Issues -- Family SHADE members believe the I&R should be a parent of a special needs child.

This request addresses NPM#2, NPM#5, and SPM#18.

### 3. Children and Youth with Special Health Care Needs Medical Home Pilot

Delaware Maternal and Child Health Bureau is requesting technical assistance to develop and improve medical homes for children and youth with special health care needs and their families. Professional development on resources such as Bright Futures, health care transitions, and other AAP provider tools is necessary to build local capacity to support medical homes. This request addresses NPM #3, NPM#6, NPM#13, and SPM#18.

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	1966509	1966509	1966509		1966509	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	400000	400000	400000		400000	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	9589395	9589395	8625223		9281008	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	0	0	0		0	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	0	0	0		0	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	784800	784800	1024800		1440000	
<b>7. Subtotal</b>	12740704	12740704	12016532		13087517	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	1539610	1539610	2456300		7591940	
<b>9. Total</b> <i>(Line11, Form 2)</i>	14280314	14280314	14472832		20679457	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	3353814	3353814	3061344		3437898	
<b>b. Infants &lt; 1 year old</b>	3348298	3348298	3058237		3568668	
<b>c. Children 1 to 22 years old</b>	2261837	2261837	2207929		2226687	
<b>d. Children with</b>	1543437	1543437	1506651		1519451	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	2137609	2137609	2086662		2239104	
<b>f. Administration</b>	95709	95709	95709		95709	
<b>g. SUBTOTAL</b>	12740704	12740704	12016532		13087517	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	100000		97260		71636	
<b>c. CISS</b>	0		0		0	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	0		0		0	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	0		0		0	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		4664355	
<b>k. Other</b>						
<b>1st Time Motherhood</b>	0		320000		320630	
<b>D70</b>	0		0		300000	
<b>ECCS</b>	132000		140000		346187	
<b>EDHI</b>	0		0		122047	
<b>Hearing</b>	0		0		250000	
<b>PRAMS</b>	85000		135000		120542	
<b>Title X</b>	0		0		1146543	
<b>VIPP</b>	0		0		250000	
<b>Home Visiting</b>	0		595091		0	
<b>TITLE X</b>	0		1168949		0	
<b>Title X</b>	1222610		0		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	4058584	4058584	3751597		4188276	
<b>II. Enabling Services</b>	5915444	5915444	5564199		6080246	
<b>III. Population-Based Services</b>	1172088	1172088	1144153		1194253	
<b>IV. Infrastructure Building Services</b>	1594588	1594588	1556583		1624742	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	12740704	12740704	12016532		13087517	

**A. Expenditures**

BUDGET October 1, 2012 -- September 30, 2013

A. Expenditures

Title V Maternal and Child Health Block Grant Funding has historically funded staff positions within the Division of Public Health's clinic-based MCH programs, including the Smart Start/Healthy Families America home visiting program, Child Development Watch, and the Oral Health program. As a result, most of the federal allocation of each year's MCH Block Grant award is budgeted for staff salaries, other employment costs (OEC), and indirect costs. Staffing vacancies and state hiring freezes over recent years has resulted in an on-going moving bubble of unexpended funds from current year funds.

In addition to staff salaries and associated employment costs, the Title V funds supported a number of strategic initiatives over the past year:

Contractual \$329,348

1) Family SHADE \$147,425

The Family Support Initiative, adopted a new name in 2011, entitled Family Support and Healthcare Alliance Delaware. Family SHADE supports several organizations and parent groups that focus on issues related to Children with Special Health Care Needs and their families. As described throughout this application, the contract is with the University of Delaware's Center for Disabilities Studies to manage collaborative activities and provide staff support.

2) Smart Start "Best Start, Breast is Best" -- Breast Feeding Initiative \$27,600

MCH Funds were utilized to continue the Smart Start "Best Start, Breast is Best" project statewide within the Smart Start home visiting program. The program initiative supports women statewide to initiate and maintain breast feeding through the first six months of an infant's life. Breast pumps, educational materials and other supplies are made available to women who breast feed their infants. These services are women who are not WIC eligible or as an enhancement for services/supplies that WIC does not cover. A second part of this initiative is an annual conference, "Breast is Best". In 2012, the 4th conference attracted 187 professionals (compared to 130 professionals in 2010) throughout the state.

3) Special Needs Alert Program (SNAP) \$30,000

The DE-MCHB continues to support the SNAP program, which recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in SNAP, EMS providers are alerted of the child's medical history. Providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, the emergency medical service team, together with the family will determine the child's most important needs.

4) Unintentional Injuries -- Childhood Injury Prevention Activities \$15,500

a) DE MCHB, as a part of its needs assessment, analyzed severity of motor vehicle crash-related injury data for children and youth who were treated at a hospital. The two efforts that the program initiated this past year related to the unintentional injury performance measure selected by DE MCHB included:

- In Sussex County, DE MCHB, in partnership with OHS and others, conducted one child safety seat inspection/installation event in a community (not at an OHS-established station) setting, targeting Hispanic residents.
- In Sussex County, DE MCHB, in partnership with OHS and others, conducted one evening parent education session of teen drivers. OHS provided the speaker and DE MCHB mobilized partners and coordinated promotion of event.
- DE MCHB established networks for future dissemination of prevention, risk-reduction and protective factor enhancement messages, resources and behavior change programs.

b) In 2012, MCH continued to collaborate with Safe Kids and the Office of Highway Safety to purchase car seats for a low-cost Child Safety Seat Program for the State of Delaware.

\$10,000

c) The Bureau also played an integral part of the planning and contributed financially to the Delaware's 2012 Safe Kids/Emergency Medical Services for Children Childhood Injury Prevention Conference. \$5,500

5) Operations of the Autism Registry \$59,606  
DE MCHB, through a contractual relationship with Christiana Health Services, Inc. (CCHS) will move from passive to active Autism surveillance, in collaboration with individuals from the Nemours Alfred I. DuPont Hospital for Children, to create an Autism registry for the state of Delaware. CCHS will work closely with Nemours AI DuPont Hospital for Children and the Division of Public Health in this effort. Clinicians and researchers at the two institutions represent much of the statewide leadership in maternal child health, both institutions have strong informatics infrastructure, and have experience working with registries in other disease categories. CCHS is responsible for completing the following:  
(1) Develop an approach to an autism registry based on procedures used to create the birth defects registry, already determined to be successful, including case definition, case-finding and ascertainment strategy, and case abstraction method;  
(2) Amend the DBDR Manual of Operations to include Autism Spectrum Disorders;  
(3) Begin case finding and ascertainment, medical record abstraction, and case review and validation to populate the registry.

6) Supplies \$20,000  
The MCH Bureau ordered new computers for MCH personnel (Home Visiting Program Administrator, Family Health Special Projects Manager, and an Administrative Specialist II), which were aging (5 yrs+) and no longer under warranty. The computers were approximately \$2,000 each. In addition, due to an increase in MCH staff, and limited office space, office cubicles were purchased to accommodate space planning needs.

7) Oral Health Study \$29,217.58  
Based on recommendations received for the 2012 Maternal and Child Health Block Grant at the annual review of the application, the Maternal and Child Health Bureau is seeking to strengthen its existing collaborative efforts with the Delaware Oral Health Program. An area of identified need, in terms of overall resources, is support to complete the Delaware 3rd Grade Survey scheduled for the Fall of 2012. The survey will collect information on the prevalence of tooth decay, the percentage of third grade children who have sealants, the accessibility of oral health care services and the impact of race, ethnicity and socio-economic status on each of these issues. The study will provide a baseline for evaluating changes in the oral health status of Delaware's children. Survey results will be used to focus prevention and treatment programs and services where they are needed most.

Supported by the Title V MCH Block grant, the Delaware Oral Health Program will order supplies, equipment and brochures that will support the 2012 Delaware 3rd Grade Dental Survey. The budget includes the costs: for dental supplies such as caviwipes, disposable lab jackets, gloves, cone earloop mask, patient bibs, disposable mouth mirrors, tooth brush, toothpaste and dental floss; Brochures will be produced in both English and Spanish to promote oral health awareness; and dental telescopes. Additionally, a consultant epidemiologist from ASTDD provided preliminary support for development of the survey methodology.

## **B. Budget**

B. Activities for FY13

Contractual \$352,744

1) Oral Health Training \$20,000

The DE MCHB is collaborating with the Developmental Disabilities Council and will provide up to \$20,000 (combined with other funding sources) for a contractor to develop and implement a program to educate at least 300 Oral Health Providers so they become comfortable accepting patients (women and children) with developmental disabilities and on the need for accessibility within healthcare facilities.

2) Maternal and Child Health Social Marketing \$25,000

o Develop a plan and budget for early childhood and strengthening families, home visiting, folic acid education initiative (i.e. social marketing campaign targeted to population using varied media outlets)

DPH is proposing the development of a Maternal and Child Health Campaign and airing of televised public service announcements to increase maternal and child health awareness and education (i.e. nutritional and health benefits of folic acid across the lifespan, and its role in preventing birth defects of the brain and spine). The campaign will target low-income women of childbearing age in Delaware. Other media activities include mailings to food stamp recipients, local cable shows and advertising. Professional educational materials will be distributed to internal and external partners including DPH health clinics, Family Planning providers, WIC and Federally Qualified Health Centers.

- 1,427 televised public service announcement spots (30 seconds) on Comcast Spotlight \$20,000.00

- Educational materials \$5,000.00

3) Smart Start "Best Start, Breast is Best"- Breast Feeding Initiative \$30,656

a) Breast feeding educational supplies and materials 10,362

Purchase breastfeeding supplies and incentives to enhance the Breast is Best project at all Public Health field units statewide. (See attached for detailed budget for this item).

b) 5th Annual Breast is Best Conference \$13,960

a. Improve maternity care practices as a strategy to improve breastfeeding

b. At the end of the 5th annual conference, participants will be able to:

i. Describe ways to improve common hospital practices that can interfere with breastfeeding.

ii. Describe adverse effects that common caretaking practices have on the newborn.

iii. Identify successful breastfeeding interventions with the late preterm newborn.

iv. Discuss breastfeeding advocacy projects and programs.

v. Discuss the current breastfeeding recommendations from the A. A. P.

(See attached for detailed budget for this item).

c) Breast Feeding Coalition \$6,335.00

The Breastfeeding Coalition of Delaware is growing its partnership base and is gaining strength, due to the leadership and support of Nemours Health and Prevention Services, the health prevention arm of Delaware's children's hospital, A I DuPont Hospital. The Mission of the Coalition is to improve maternal and infant health by increasing the initiation and duration of breastfeeding, the gold standard for infant feeding. As a result of the coalition's recent efforts and a growing interest in improving breast feeding rates, two hospitals have recently signed Baby

Friendly "Letters of Intent". Beebe Medical Center was the first to sign and shortly thereafter, Bayhealth Medical Center. DPH is interested in working more closely with the Coalition, and is budgeting funds to support their work in the community to improve breast feeding rates in Delaware.

4) Unintentional Injuries -- Childhood Injury Prevention Activities \$15,000.00

In 2012, as a result of the new CDC grant award, the Violence and Injury Prevention Program was aligned closely with the Family Health Systems section of DPH, which also houses the Maternal Infant and Early Childhood Home Visiting Program and Maternal and Child Health/Title V Programs. The existing family health infrastructure ensures cohesion and is consistent with our strategic plans to emphasize linking and integrating public health programs in order to maximize protective factors and minimize risks across the lifespan.

The Title V MCH grant funding will be used to help build program infrastructure and will help update the state injury prevention plan, engage a statewide coalition to bring about systems-level changes, and strengthen the injury surveillance and reporting within the state. Title V MCH funding will also support activities identified through the development of an injury prevention strategic plan.

5) Operations of the Autism Registry \$50,000

DE MCHB, through a contractual relationship with Christiana Health Services, Inc. (CCHS) will continue working on developing an Autism registry for the state of Delaware. CCHS will work closely with Nemours Al DuPont Hospital for Children and the Division of Public Health in this effort. Clinicians and researchers at the two institutions represent much of the statewide leadership in maternal child health, both institutions have strong informatics infrastructure, and have experience working with registries in other disease categories.

6) Family SHADE \$147,416

The Family SHADE (aka Family Support Initiative) supports 40+ organizations, agencies, and parent groups throughout Delaware that focus on issues related to Children and Youth with Special Health Care Needs and their families. The MCHB will continue its relationship with the University of Delaware's Center for Disabilities Studies (CDS) who directs the umbrella organization for family support services for children and youth with special health care needs (CYSHCN). CDS will address performance through the following systems level and targeted organizational level actions:

- Increase efficiency of the systems servicing children, youth and young adults with special health care needs by reducing fragmentation and duplication and enhancing collaboration
- Care Coordination
- Capacity building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella includes, at a minimum, the following: Governance, Sustainability, Strategic Planning and Evaluation.
- Develop an information and referral service process that integrates with the Delaware Help Me Grow 2-1-1 system replication

7) Special Needs Alert Program (SNAP) \$25,000

Since 2004 the Office of Emergency Medical Services (OEMS) has developed the Special Needs Alert Program (SNAP). The program recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in SNAP, EMS providers are alerted of the child's medical history. Providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, the emergency medical service team, together with the family will determine the child's most important needs.

In partnership with the OEMS, the Maternal and Child Health Bureau supports the cost of a skilled individual in the coordination of the Delaware Special Needs Alert Program (SNAP) for 20 hours per week and a Special Needs Alert Program Assistant for 24 hours per week to maintain

SNAP database and facilitate the SNAP enrollment process. The SNAP Coordinator will work with the EMSC Program Manager and the Director of Children with Special Healthcare Needs. The SNAP Coordinator shall report to the Director of EMS to develop and implement a program to identify children with special healthcare needs for Emergency Medical Services personnel.

8) School Based Wellness Center Evaluation and Third Party Billing Database \$39,672  
 Title V MCH Block grant dollars will cover \$39,672 in FY13 to support the licensing costs for the School Based Wellness Center evaluation and third-party billing database, which will help DPH effectively evaluate the SBHC program.

Supplies	\$2,500
Other	\$1,065.73
Audit Fee (.003 of budget)	
The audit fee is .003 of the budget and covers DPH costs associated with auditing.	

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FY 13 TOTAL BUDGET	\$365,309.73
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***An attachment is included in this section. VB - Budget***

## **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.