Delaware Rural Health Plan

June 2000

Planning today to improve the lives of tomorrow

State of Delaware
Department of Health and Social Services (Division of Public Health)
and
Delmarva Health Initiative

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Executive Summary

In recognition of the unique and predominantly rural nature of Sussex County, the State of Delaware Department of Social Services - Division of Public Health (DPH) applied for Federal Office of Rural Health Policy grant funding to develop a Rural Health Plan (RHP). The Plan was designed to present an organized and strategic approach to improving the health of Sussex County residents.

The RHP takes a community sensitive approach to addressing health status and access to services within Sussex County. The principal approaches employed in the RHP include:

1. *Recognizing and building upon the prior and anticipated future collective efforts of multiple stakeholders to improve health status and access to health care services in Sussex County;*
2. *Balancing Sussex County health needs with existing and potential resources; and*
3. *Developing recommendations for policies and implementable targeted initiatives, which rely upon collaboration between government and community stakeholders.*

The authors of the Plan believe that in order to be relevant, and to play an instrumental role in improving the health of Sussex County residents, recommendations must **deliver value** to citizens. The RHP therefore applies business concepts of value creation to the greatest degree possible in the context of recommendations for health care improvement. The RHP's "customers" are the residents of Sussex County whose health status it addresses.

The process of RHP development deeply involved committed and knowledgeable stakeholders. The Delmarva Health Initiative (DHI) served as Steering Committee for plan development. The Steering Committee itself met monthly with the consultants to review and critique interim findings and recommendations. Written documentation was supplemented by additional primary and secondary qualitative research, including more than 50 individual interviews with a diverse range of Sussex County stakeholders, stakeholder focus groups involving key constituencies, and finally, a working stakeholder retreat held at Dewey Beach, Delaware on May 22, 2000. Final recommendations were drafted only after the stakeholder retreat input focused on action planning was available.

In **Section II** of the Plan, needs and resources are organized by lifecycle (Infant and Perinatal; Child and Adolescent; Adult; and Geriatric), by clinical service type (Primary Care; Dental Care; Behavioral and Mental Health; and Home Care) and additionally by certain special needs areas (Cultural, Minority, Racial and Ethnic Issues; Access to Resources; Leadership and Planning; and Infrastructure).

Each of the ten *recommended policies* and ten *suggested initiatives* in **Section III** were matched to identified needs and resource gaps. These are summarized in **Table III-1** (page 43). Both policies and initiatives are a focused and feasible set of recommendations that could lead to measurable implementation goals. The RHP focuses on the highest priority issues. In developing these recommendations, an active attempt was made to build on existing activities and infrastructure wherever possible. An effort was also made to avoid emphasis on those areas that are already being actively addressed in an organized and effective way.

Prioritization and operational implementation planning will be the next task of the stakeholders. Leadership and staffing will therefore be key to successful implementation of RHP recommendations. Leadership issues are directly addressed in **Section IV**. The concept of "accountable entities" (stakeholders committed to "leading change") is introduced in this section and should be viewed as applicable to suggestions for initial collaborators, which are provided with each recommendation.

Section V addresses funding. The Plan stresses that while direct service resources require funding in order to focus on eliminating gaps, financial resources should also be directed toward training leaders, providing staff to develop and facilitate coalitions of stakeholders and accountable entities, and to supporting systems that can deliver county specific, statistical and other data essential to making sound decisions. The RHP has documented the significant need to leverage available resources through concerted shared responsibility.

The RHP is not itself a grant application or a direct funding mechanism. Rather it is a potential guide to local or state agencies for setting funding priorities based on delivering value to Sussex County. Discrete initiative recommendations from the RHP can be extracted and enhanced for presentation as funding requests whereas policy recommendations may create the vehicle for a range of fundable opportunities.

Risks and uncertainties detailed in **Section VI** denote potential barriers to successful implementation of the RHP. By recognizing these, proactive strategies may be undertaken to minimize risks of achieving less than full value through the RHP. While it is not possible to predict all the potential barriers to success for each initiative and policy recommendation in the RHP, it is worthwhile to focus some attention on major anticipated areas of risk and uncertainty for the RHP as a whole.

Section VII contains a "strategic synthesis." This is an opportunity to overview the RHP as a whole and ask 10 important questions which ensure that the rural health business plan considers and applies key strategic principles appropriately. These same questions can, and should, be re-applied to specific strategies and initiatives developed in the course of implementing the RHP.

The RHP is presented jointly to the Governor and Sussex County Administration. It is submitted as a contribution to health planning for Sussex County. The Plan honors past accomplishments with both pride and respect. It offers sober and candid analysis regarding those challenges that remain. It embodies optimism regarding the real potential for positive change which can be realized by building on the collaborative spirit and energy which has characterized prior successes.

Acknowledgements

As principal collaborators in the development of the Delaware (Sussex County) Rural Health Plan, both the Delmarva Health Initiative and the Department of Social Services – Division of Public Health wish to recognize the Sussex County hospitals as well as numerous other agencies, organizations, institutions, and individuals who have contributed to improving the health of Sussex County residents in advance of this plan. Although it has been impossible to individually note each of these past contributions in the Rural Health Plan, the current effort to organize and coordinate efforts going forward would not have been possible without the important groundwork accomplished more informally in the past. Only through the continuation of such important and dedicated grassroots efforts will progress on the ambitious goals of the Rural Health Plan be successful.

Steering Committee Members

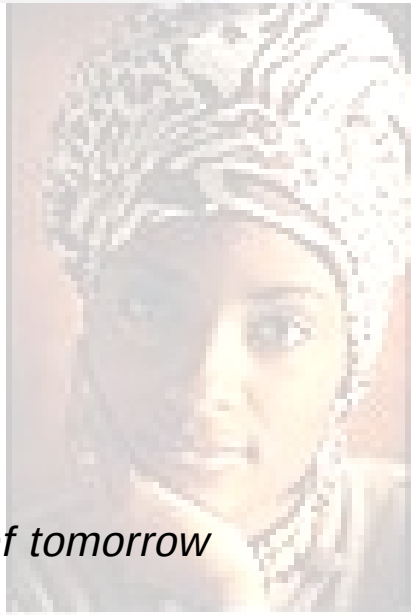
Prue E. Albright	Division of Public Health
Norene Broadhurst	Beebe Medical Center
Don Clark	Nanticoke Health Services
Barbara DeBastiani	Division of Public Health
Stephany Foster	Electronic Data Systems Liaison to DE Healthy Children
William Gallery, DVM	
Edward Goate	Central Delaware Community Health Partnership, Inc.
Reverend John Hird	Beebe Medical Center Trustee
Wallace Hudson	Beebe Medical Center
Paul Lakeman	Bayhealth Medical Center
Joe Liefbroer	Johnson Wax
Colonel Mike Martin	Dover Air Force Base
Bill Neaton	Bayhealth Medical Center
Gina Bianco Perez	Division of Public Health
Beverly Smith	Division of Public Health
Lois Studte	Southern Delaware Community Health Partnership, Inc.

Acronyms

Abbreviation/ Acronym	***Full Text***
AARP	American Association of Retired Persons
AHCRQ	Agency for Health Care Research & Quality
ALS	Advanced Life Support
AAPP	Alliance for Adolescent Pregnancy Prevention
BBA	Balanced Budget Act
BLS	Basic Life Support
CAH	Critical Access Hospital
CD/SA	Chemical Dependency and Substance Abuse
CDC	Center for Disease Control
CON	Certificate of Need
CTT	Certified Therapeutic Technician
DAAPD	Division of Aging Adults with Physician Disabilities
DADAMH	Division of Alcohol, Drug Abuse and Mental Health
DDAIC	Delaware Dental Access Improvement Committee
DHCC	Delaware Health Care Commission
DHI	Delmarva Health Initiative
DHSS	Department of Health and Social Services
DIDER	Delaware Institute for Dental Education and Research
DIMER	Delaware Institute for Medical Education and Research
DPH	Division of Public Health
DSCYF	Department of Services for Children, Youth, and their Families
DSS	Division of Social Services
EMS	Emergency Medical Service
FTE	Full Time Equivalent
HCFA	Health Care Financing Administration
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
LBW	Low Birth Weight
MCO	Managed Care Organization
MRHFP	Medicare Rural Hospital Flexibility Program
MVA	Motor Vehicle Accident
NASW	National Association of Social Workers
NHG	Northland Health Group
ORHA	Federal Office of Rural Health Policy
PCP	Primary Care Physician
RHP	Rural Health Plan
RWJ	The Robert Wood Johnson Foundation
SBHC	School Based Health Care
SCI	Strong Communities Initiatives
SEER	Surveillance, Epidemiology, and End Results Program
STD	Sexually Transmitted Disease

Delaware Rural Health Plan

Section I
Introduction to the Rural Health Plan



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I. Introduction to the Rural Health Plan

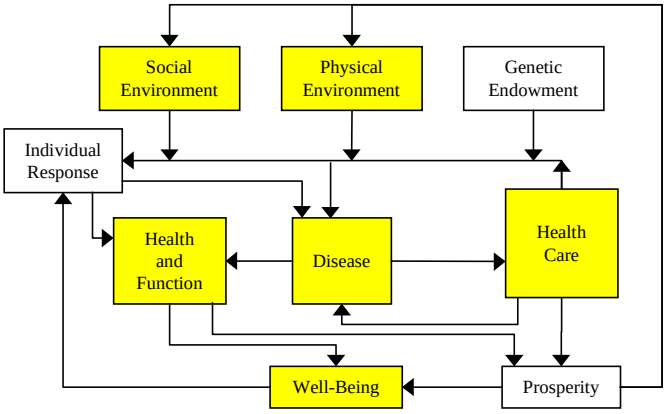
Plan Overview

In recognition of the unique rural nature of Sussex County, Delaware, the Division of Public Health (DPH) applied for Federal Office of Rural Health Policy grant funding to enable development of an innovative Delaware (Sussex County) Rural Health Plan (RHP). The RHP takes a community sensitive approach to addressing the following aspects of health status and access to services in Sussex County (illustrated in Figure I-1):

- Health care resources;
- Physical environment;
- Social environment;
- Disease prevalence;
- Health and function; and
- Well-being.[1]

While addressing each of these issues at some level, the RHP focuses primarily on the issues of *primary* (characteristics of the population and health care delivery system) and *secondary* (environmental) determinants of health.

Figure I-1: IOM Model - Health Care Operating Environment



Evans and Stoddard, 1990, "Producing Health, Consuming Health Care"

The RHP is intended to create awareness for those who are relatively unfamiliar with the county (e.g., new residents and policy makers from other parts of the state), as well as deepen the understanding and perspective of established stakeholders within Sussex County.

General Characterization of Sussex County

Sussex County is unique among both its peer counties within Delaware (Kent and New Castle) and the bordering counties in Maryland to the south and east. Given its area of 950 square miles, Sussex is one of the largest counties east of the Mississippi River and accounts for nearly half of the state's total area. The total population of approximately 141,000 is aggregated primarily around the county's four cities: Georgetown, Lewes, Milford, and Seaford. Not unexpectedly, health care resources are also concentrated in these areas.

Rural Health Plan - Strategies

The principal strategies employed in the RHP include:

1. *Recognizing and* ***building upon the prior and future collective efforts of multiple stakeholders*** to improve health status and access to health care services in Sussex County;

[1] Institute of Medicine. Improving Health in the Community. National Academy Press: 1997.

2. ***Balancing Sussex County health needs with area resources***, as reflected by a qualitative and quantitative understanding of existing assets and circumstances. This includes the input from government agencies, community groups, and individuals, representing health care providers, regulatory agencies, policy makers, social services, advocacy, and/or referral agencies; and
3. ***Developing policy and strategy recommendations and implementing targeted initiatives,*** which rely upon identified lead agencies and organizations that can achieve success through collaboration with relevant and interested community stakeholders.

Although the distinctive geographic and demographic characteristics of Sussex County may not easily permit comparisons to rural areas in other eastern states, many of those states have completed RHPs focused on improving the quality of, and access to, health care in rural areas. These strategies have generally focused on facilitating the designation of Critical Access Hospitals (CAH), small facilities (with up to 15 acute care beds) which agree to certain size and activity limitations in exchange for generally favorable Medicare reimbursement. While this option has been explored in Delaware, it does not currently apply to any of the three existing Sussex County hospitals. The state's approach to considering possible CAH development is set forth in Appendix A. The Delaware (Sussex County) Rural Health Plan therefore focuses on community-based health improvement rather than hospital-specific strategies.

Through the Delaware State Office of Rural Health, DPH has shared responsibility for developing the RHP with the Delmarva Health Initiative (DHI), a county-wide collaborative of health care providers and advocates largely derived from past Sussex County Health Summits. DHI identified the need for technical assistance to facilitate RHP development and selected the Maine based Northland Health Group[2] (NHG) to research and author the Plan.

Rural Health Plan - Process

DHI met monthly as the Steering Committee for this effort. DHI reviewed and critiqued interim findings and recommendations based on a review of existing need assessments and resource descriptions. This analysis was supplemented by additional primary and secondary qualitative research, including more than 50 interviews with a diverse range of Sussex County stakeholders. Complete listings of interviewees and documentation reviewed are provided in Appendices D and E. NHG also visited certain key community sites, government and community agencies, and provider facilities. Interviewees provided meaningful contributions to the understanding of key opportunities, challenges, and barriers addressed by the Plan.

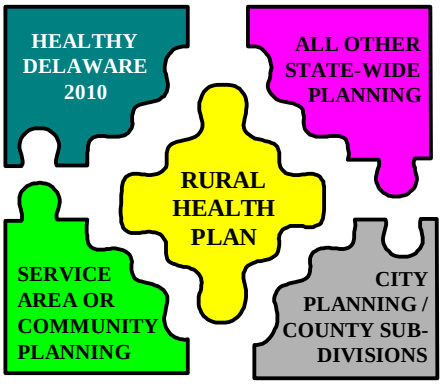
Rural Health Plan - Context within Existing State and Local Planning Efforts

Lessons learned from historical public health planning efforts reveal an important balance for the RHPs users to appreciate. From one perspective, the Plan could be expected to be "all-encompassing" so that the interests of all stakeholders are meaningfully represented (e.g., "wide representation and participation"). From another point of view, the Plan must be focused on high priority and high impact issues, and must contain clear and specific guidance for policy and

[2] For NHG qualifications and firm background please see Appendix B

action (e.g., "less is more") with value derived from focusing attention on a limited number of issues.

Figure I-2: Context for Rural Health Plan



In either circumstance, successful development of the RHP must create a contextual "fit" between existing state and community-level planning processes and activities (illustrated in Figure 2). The RHP does not replace, but rather complements, initiatives targeted to individual community needs or "at-risk" populations in particular areas. It provides a strategic and advocacy focus, at all levels of policy and implementation, for issues relevant to Sussex County. It can inform collaborative action across communities and can guide both policy makers and funders on pressing county-wide issues. At the broadest level, the RHP can serve to create relevant connections among state planning initiatives such as Health Delaware 2010, the Delaware Institute for Medical Education and Research (DIMER), and the Delaware Health Care Commission (DHCC) as well as multiple new and ongoing agency specific initiatives.

The Rural Health Plan and Value Delivery

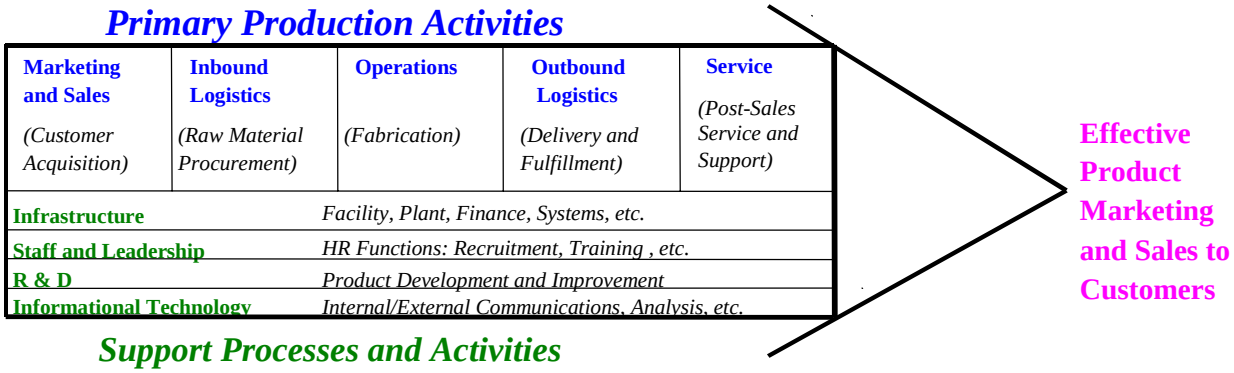
In order to be relevant and to play an instrumental role in improving the health of Sussex County residents, projects and initiatives must **deliver value** to citizens. The model for understanding value delivery is found in commercial businesses, which regularly focus on the importance of value for attracting and retaining customers. This focus supports the ability of any business to operate efficiently, responsively, and profitably and thus be durable in its marketplace.

The RHP applies the business concept of value creation to the greatest degree possible in the context of health care improvement. The RHPs "customers" are the residents of Sussex County whose health status it addresses. Additionally, however, customers could include the hospitals and other direct service providers, community based social service agencies, businesses, the state of Delaware itself, and perhaps many others who will use the RHP and benefit from its vision of policy and project opportunities.

Components of the "Value Chain" for Rural Health

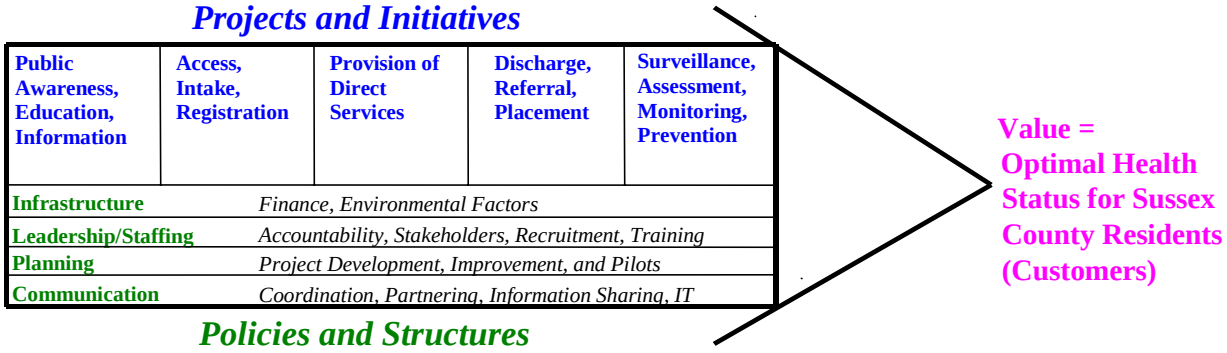
The top value chain model seen below (Figure I-3) is presented to illustrate the components of value production for a manufacturing firm that produces goods from raw materials. ***Primary production activities*** are those that are easily recognizable as components of selling, constructing, or delivering a manufactured product. ***Support Activities and Processes*** are the "back room" functions that are necessary to support the primary activities but which are sometimes overlooked when measuring value. Both primary production and support activities are necessary. Each category expresses functionalities that are provided by the firm or delivered collaboratively with partnering organizations (e.g., subcontracted activities, joint ventures, etc.).

Figure I-3: Classical Manufacturing Value Chain Model



The value chain expresses the way in which different components of a business system complement each other to create value for "end users" or "customers." A value chain adapted to rural health care is represented below (Figure 4). For each element of rural health care (i.e., dental health, primary care, and home health care), analogous ***Primary Activities*** (Projects and Initiatives) contribute in a linear fashion to program execution or delivery of services. This can be compared to an assembly line in a manufacturing production process for making "widgets." Similarly, ***Support Activities*** (Policies and Structures) are essential enablers of the primary activities and the system, but do not directly play a role in production or delivery of services.

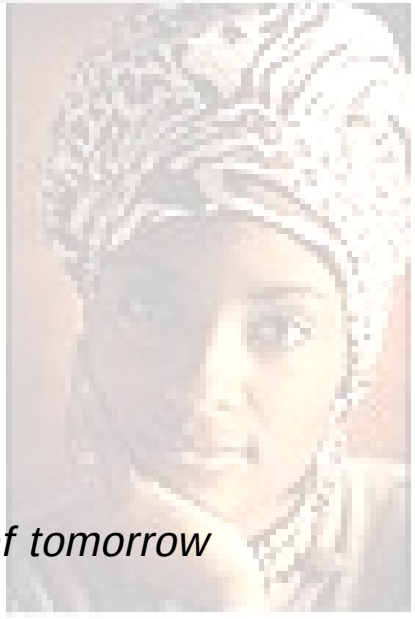
Figure I-4: Rural Health Plan Value Chain Model



The concept of RHP "value delivery" therefore encompasses all of the components required for successful accomplishment of recommended projects and initiatives. The model is used throughout this document to analyze needs and resources as well as to target policies and initiatives to yield the most effective impact on community health status.

Delaware Rural Health Plan

Section II
Environmental Analysis - Needs, Resources, and Gaps



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II. Environmental Analysis – Needs, Resources, and Gaps

Needs Considered in the Rural Health Plan

After reviewing existing needs studies, NHG generally focused on those studies that were no more than three years old and contained specific, quantitative information regarding Sussex County issues. The focus on county-level studies limited the amount of available information. While there was no shortage of analytic studies and monographs for review, many contained data and observations that were aggregated and reported at the state level. Using these studies to plan at the county level would have required an assumption that Sussex County residents have the same needs and characteristics as Kent and New Castle Delawareans. However, this is not the case. For example, a review of data that is available for Sussex County (e.g., vital statistics) reveals that patterns of health, disease, and behavior differ dramatically in Sussex County when compared to the state as a whole or to Kent and New Castle Counties.

Types of Resources Considered in the Rural Health Plan

Multiple resources contribute to the Sussex County health care delivery system. In the Plan, resources are categorized into three types:

- **Direct Health Care Providers** (providers of direct clinical health care services)
- **Human Service Providers** (community or state agencies providing social services)
- **Service Integrators/Advocates** (organizations providing referrals and/or problem solving assistance to clients across a broad range of needs)

Each resource type contributes uniquely to the health status of rural Delawareans through delivery of components such as: *health care services, health education, basic needs assistance, advocacy, and/or financial support*.

Observations on Resource Sufficiency and Quality

Different methods for determining resource quality and utility are required to consider the three categories of resources addressed by the Plan. Direct Health Care Providers represent the only area for which accepted planning benchmarks exist, and for which estimates for the number of professionals required to serve a population are even moderately available. Even in this relatively limited context, the use of quantitative measures is controversial and problematic due to problems such as geographic distribution and lack of access. Therefore, assessment of resource adequacy, and the potential for resources to meet community needs, must be both a quantitative and qualitative exercise. In this plan, alignment between resources and needs has thus been determined by structured, qualitative assessments provided by individuals experienced with an "on the ground" perspective. To the extent possible, additional objective data (e.g., surveys, quantification, studies on access, etc.) have been used to further inform this process.

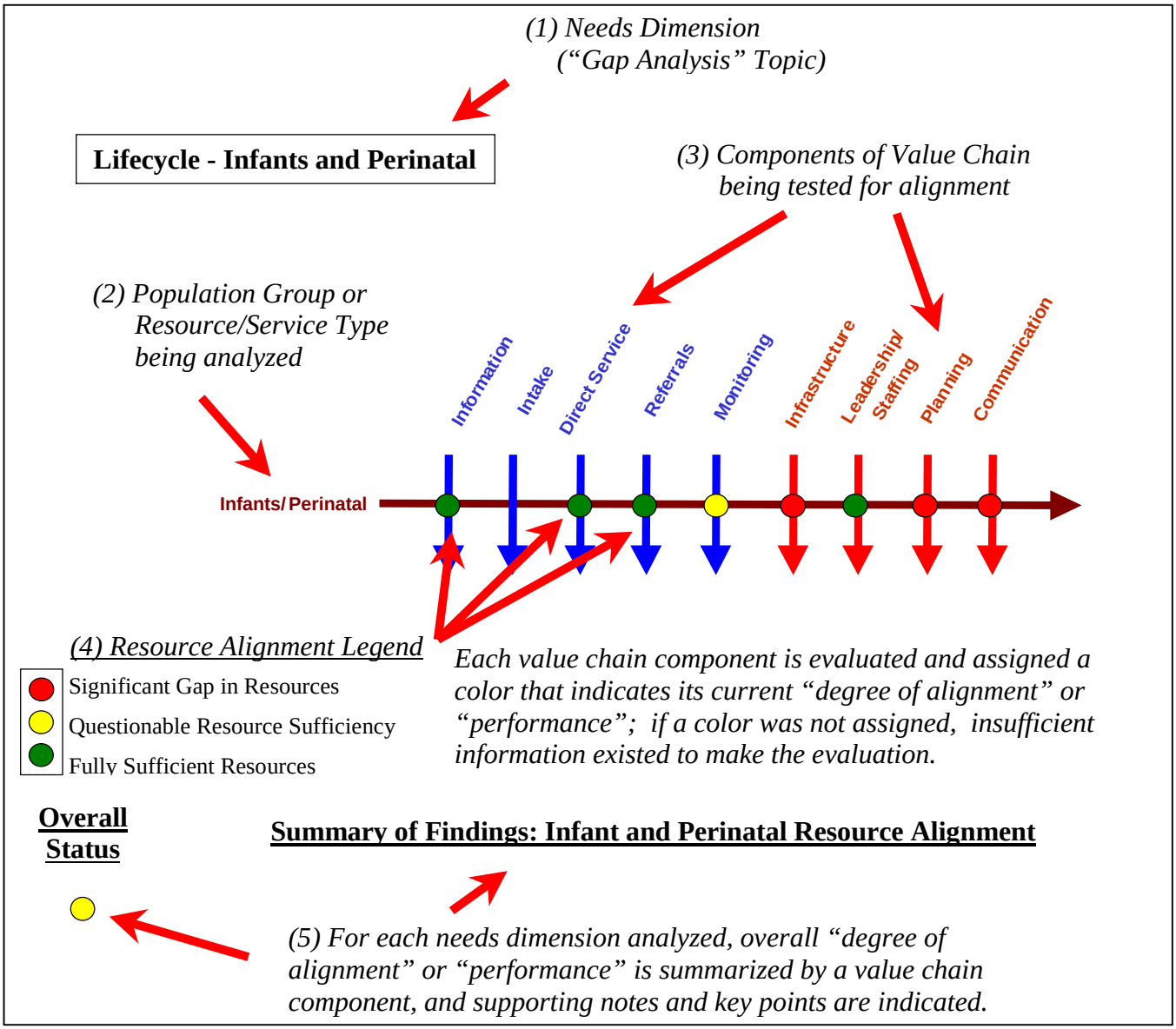
Aligning Resources with Needs - "Where are the Gaps?"

The sections that follow provide both narrative descriptions and schematic representations of

resource adequacy considered in three dimensions. A life cycle perspective (perinatal, child/adolescent, adult, and geriatric) and a provider or clinical service perspective (primary care, dental, behavioral health, home health) are both included as is a "special considerations" section. Each resource is examined in the context of its perceived performance in meeting existing needs and in delivering value. The graphics are used to represent alignment that does (or does not) exist among Sussex County's resources.

The RHP uses a "traffic light" scoring approach to depict resource adequacy at points along the value chain. Red indicates that gaps between needs and available resources are so significant that the system is "stopped;" yellow is a "warning" of incomplete functionality; and green means that the system operates smoothly, hence a "go." Thus, a green marker denotes points where resources fully meet needs, yellow indicates questionable or sub-optimal resources, and red denotes a significant and potentially problematic gap between needs and resources. From a planning perspective, the most critical areas to address are the red markers or "gaps."

Figure II-1: Gap Analysis Example



Lifecycle #1- Needs of the Infants and Perinatal Population

Source for all data below is Delaware Vital Statistics Annual Report (1998)

- Key outcome indicators of infant and perinatal health care effectiveness are the neonatal/infant mortality and low birth weight (LBW) rates. In Sussex County, neonatal and infant mortality have risen for the past two 5-year cycles as compared to state. The LBW fraction has risen from a favorable level (pre-1995) to approach the higher state rate:

Figure II-2

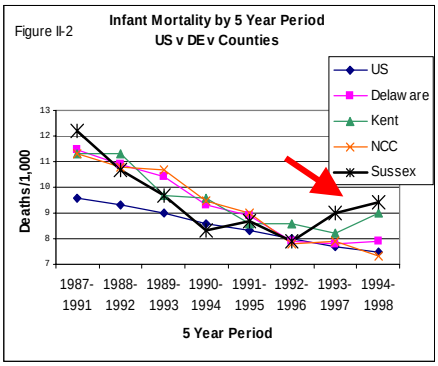


Figure II-3

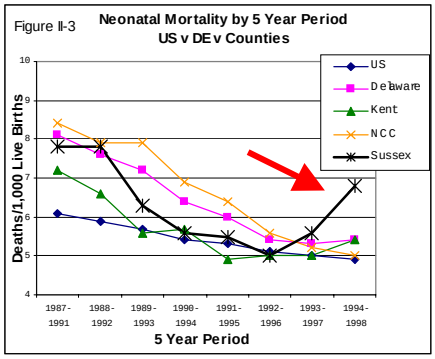
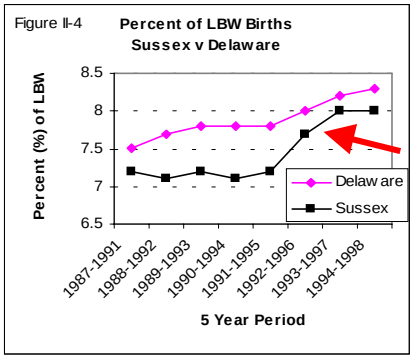


Figure II-4



- Sussex County and Delaware are now higher than US in neonatal mortality (see Figs. II- 2 and II-3). The rise in Sussex County infant mortality over the past two 5-year periods is unexplained and is of concern. Statewide LBW rates are generally driven more by births to teens and African American females; however, in Sussex County, teens and white births are the drivers. Among the white population in Sussex County, the percentage of LBW infants exceeds both the US and the state.

- Sussex County has more births to single mothers (43.7) compared to the state (35.79%) and other Delaware counties (Figure II-5).

Figure II-5
Births to Single Mothers by County (1994-1998)

County	% Births to Single Mothers
Delaware - All	35.7%
New Castle	33.4%
Kent	36.0%
Sussex	**43.7%**

- Prenatal care adequacy in Sussex County is lower than the state in the aggregate and in each racial/ethnic subgroup measured. While Sussex is not alone in this regard, the comparison between non-urban New Castle County and Sussex County is striking.

Figure II-6
Births to Mothers Receiving Adequate Prenatal Care by Race

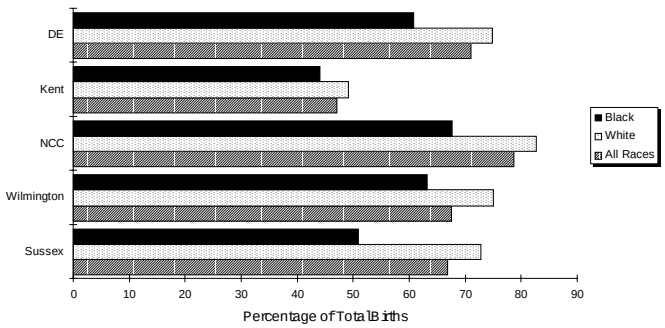
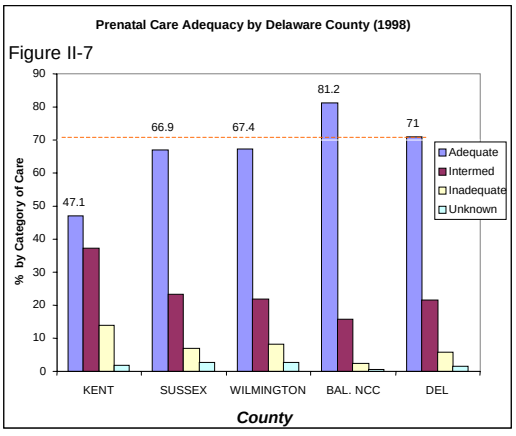
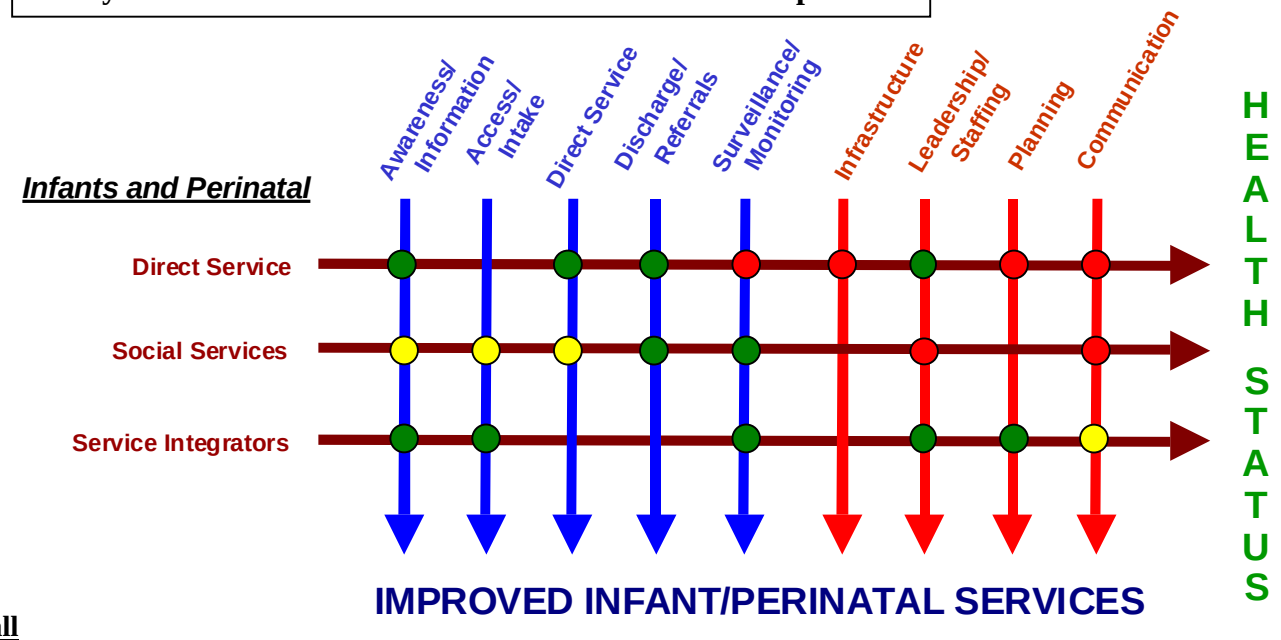


Figure II-7



Lifecycle #1- Resources for the Infants and Perinatal Population



Overall Status

Summary of Findings: Infant and Perinatal Gap Analysis

- Awareness (of Resources): Good for some populations (white, insured), poor for others (Hispanic, Black, disadvantaged); More hospital-based education is needed; State Service Centers provides clearinghouse function.
- Access to Care: Delmarva Rural Ministries has a mobile van and is expanding beyond migrant population; Geographic access/transportation problematic for fixed site resources; Generally more bilingual capacity needed; Social Service availability to disadvantaged and racial and ethnic minority populations needs improvement; new health center to open in Georgetown.
- Direct Service: Physicians up-state support down-state providers with specialty care; Each hospital provides labor and delivery services with comparable service levels; Linkage of social services with direct clinical services needs improvement.
- Referral: More lay support (resource fathers/mothers) needed; Child Development Watch is an important resource re: coordination of care and case management; Home visiting for first time parents provides opportunity to follow the family and observe in their own environment.
- Monitoring: United Way and Child Development Watch are monitoring outcomes; Perinatal mortality is rising - reasons are not well understood; No systematic appreciation of health status on a county level.

- Infrastructure: There are three duPont Pediatric Clinics (Milford, Georgetown and Seaford) that serve infants, and children and adolescents (up to 19 years) with family income up to 200% of poverty on a sliding fee scale basis. Transportation is a significant limitation to receiving infant and perinatal services for those who live a distance from these sites.
- Leadership: The Perinatal Board has been very effective in providing system level leadership, however the social service sector does not have focused leadership in addressing this population.
- Planning: Services for children with special health care needs, appear to be a strong potential resource but are currently under-funded; Perinatal Board is an important planning resource, helped raise Delaware's ranking infant mortality from worst to 25th in country.
- Communication: Provider-provider communication is spotty; 53 separate agencies on teen pregnancy; The symposium "Cradle of Hope" was effective.

Lifecycle #2 - Needs of the Child and Adolescent Population

- While meaningful Sussex County specific data is lacking on younger childhood needs, extrapolation of state level data suggests that injury prevention, asthma, and special needs support services areas all may require attention.
- As articulated in Delaware's Maternal and Child Health Grant application, the following needs are apparent in Sussex County for special needs children:
  - Insufficient services for OT, PT, and speech therapy needs;
  - Child care needs for the population may be insufficient and currently under study;
  - Care coordination is insufficient for children > age 3 with special needs;
  - Culturally compatible specialty care access is insufficient.
- Sussex County teen live birth rates are well above the US and state rates for both younger and older teens. For white teen mothers, the rate is rising whereas the US rate is falling for this group. African-American teen birth rates are falling at a rate similar to US and are decreasing faster than the state rate. Teen live birth rates in several census tracts (Bridgeville, Selbyville, and Laurel) stand out as extraordinarily high.

Figure II-8

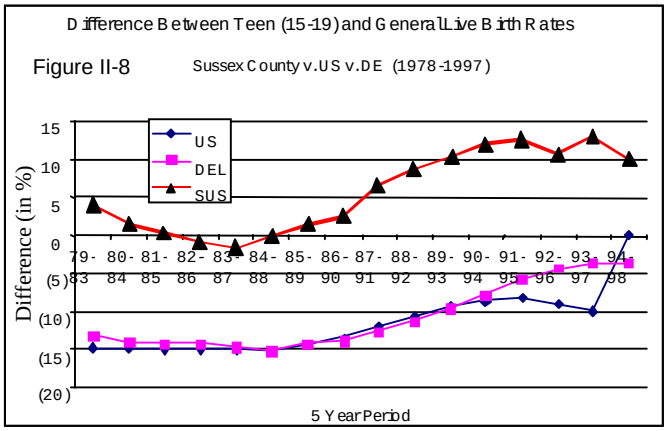
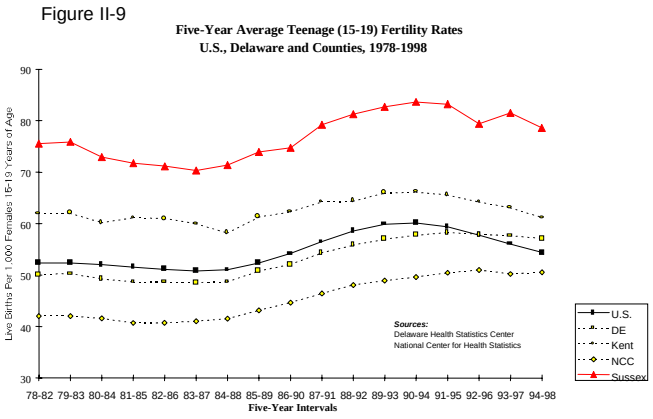


Figure II-9



Source for above data is Delaware Vital Statistics Annual Report (1998)

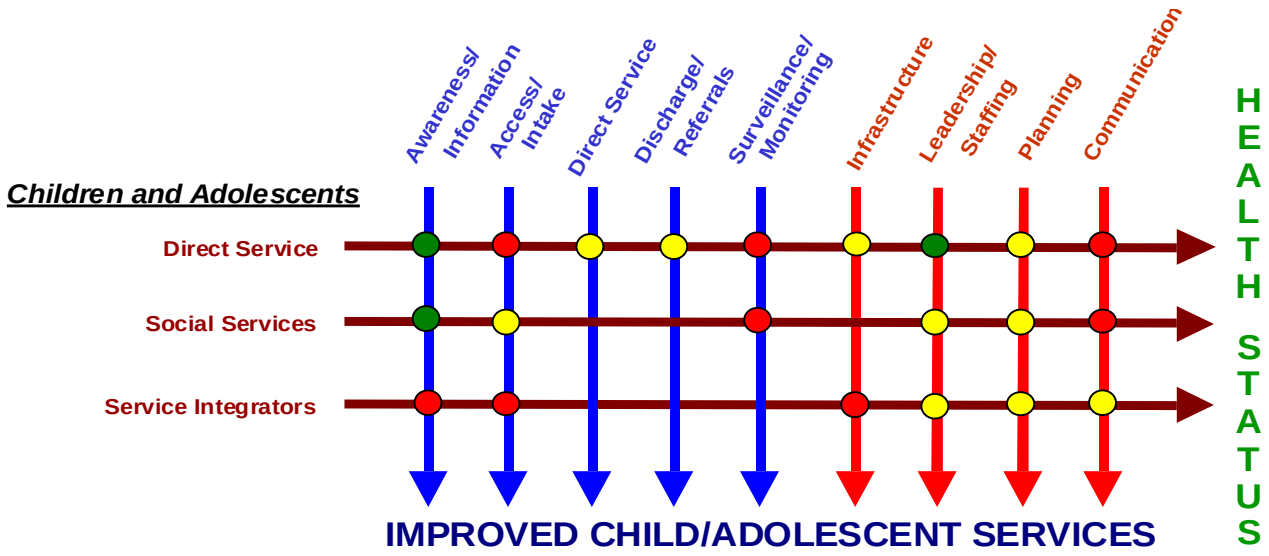
- School Based Health Centers (SBHC) are in all Sussex County high schools; based on interviews and SBHC data, teen primary health care needs are characterized as "largely unmet." Teen mental/behavioral health needs are also not adequately being met due, in part, to a lack of providers serving this population. In addition, for both primary care and mental health needs, transportation is inadequate and conflicts with access and confidentiality needs. Approximately 35% of SBHC visits are for mental health concerns.

- Self reported substance use in older Sussex County adolescents exceeds state rates. The need for improvement is particularly apparent from the increase in use reported between grades 8 and 12, which greatly exceeds the state as a whole.

8th v 11th Grade Self Reported Substance

Use	***Grade 8***	***Grade 11***	***Change***
Sussex	%	%	%
Cigarettes	22	39	**17**
Alcohol	25	53	**28**
Marijuana	15	25	**10**
Delaware	%	%	%
Cigarettes	24	33	9
Alcohol	29	47	18
Marijuana	19	25	6

Lifecycle #2 - Resources for the Child and Adolescent Population



Overall Status

Summary of Findings: Children and Adolescents Gap Analysis

- Awareness: State Service Centers are primary resources for reproductive health including education and services for family planning and sexually transmitted diseases (STD); YMCA resource centers and Boys and Girls Club disseminate information; SBHCs provide treatment for STD but do not provide broader family planning services in most districts; Resource guide is published for resources serving children with special needs
- Access: Poor access to behavioral health, mental health, primary care, and family planning; Few transportation options; the Delaware Healthy Children Program (children's health insurance) is an important resource; Access van is expanding awareness/access; Limited services for special needs children remains a problem; Adolescents access into family planning services remains problematic (e.g., confidentiality, lack of SBHC services, transportation and clinic hours were cited as barriers).
- Direct service: Quality can be very good when services are available, with possible exception of teen OB/GYN services; Language and socio-cultural barriers impact patient-provider communication; Patient-physician communication problems make direct service quality less than ideal.
- Referral: Little county level data is available to determine resource or care adequacy.
- Monitoring: School nurses, especially at elementary and middle school levels, and SBHC are important resources, especially in the area of prevention, but little evaluative data is available; Outcomes measurement under development at United Way but not active.

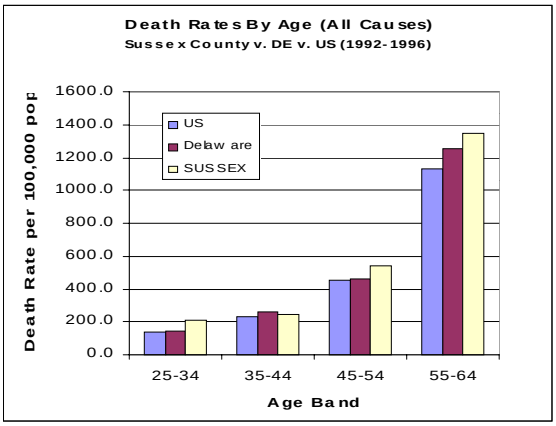
- Infrastructure: duPont Pediatric Clinics provide direct services; Resource infrastructure is not sufficient to meet behavioral health needs for this population; Direct state contracting has may have unintentionally reduced providers and decreased access; Head Start is an important resource; Feedback from mothers concerned about access/adequacy of special needs services for children.
- Leadership: Leadership: Despite a proliferation of services, coordination of efforts to meet needs may be lacking; Community health partnerships have been initially successful, but more work is to be done.
- Planning: Not clear if resources are equally available to Hispanics; Additional planning is needed, re: the stage of intervention for children, especially in areas of behavioral risk factors (e.g., prevention of substance use between 8th and 11th grade).
- Communication: When children graduate, there is insufficient communication between SBHC and private health care systems to assure that primary care is in place; Although the role of SBHC is not provision of primary care, their role in assuring a medical home "drops off" precipitously upon graduation; Insufficient communication among providers; Agency collaboration is rising.

Lifecycle # 3 - Needs of the Adult Population

- Delaware cancer mortality rates are the second highest in the US (1992-1996 SEER data). Mortality from prostate, colorectal, cervical, and lung cancers are extremely high in state. County rates are indistinguishable from state in vital statistics data for individual cancers due to small populations numbers. African-American men (lung, prostate, colorectal) and African-American women (cervical) predominate in excess mortality. Hospitals have been instrumental in developing integrated cancer care and support programs.

- Sussex County exceeds Delaware and US mortality rates for all adult age groups except ages 35-44. Mortality is apparent across all age groups particularly for cancer, heart disease, and motor vehicle accidents (MVA).

Figure II-10

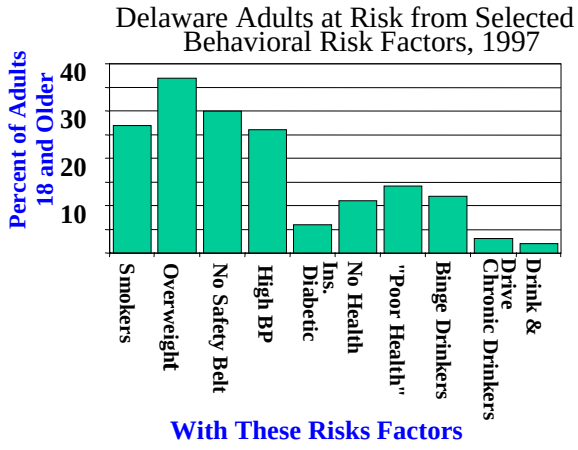


Source for above data is Delaware Vital Statistics Annual Report (1998)

- Sussex County death rates from congestive heart disease exceed state rates. Cardiac disease is also the most frequent cause for hospitalization in Sussex County. Lifestyle and controllable risk factor issues predominate as predisposing factors:
  - Smoking
  - Overweight
  - Hypertension
  - Motor vehicle accidents
  - No seat belt use
  - Operating under the influence of alcohol

- County specific Behavioral Risk Factor Survey data are not currently available. State level data is shown in Fig. II-11.

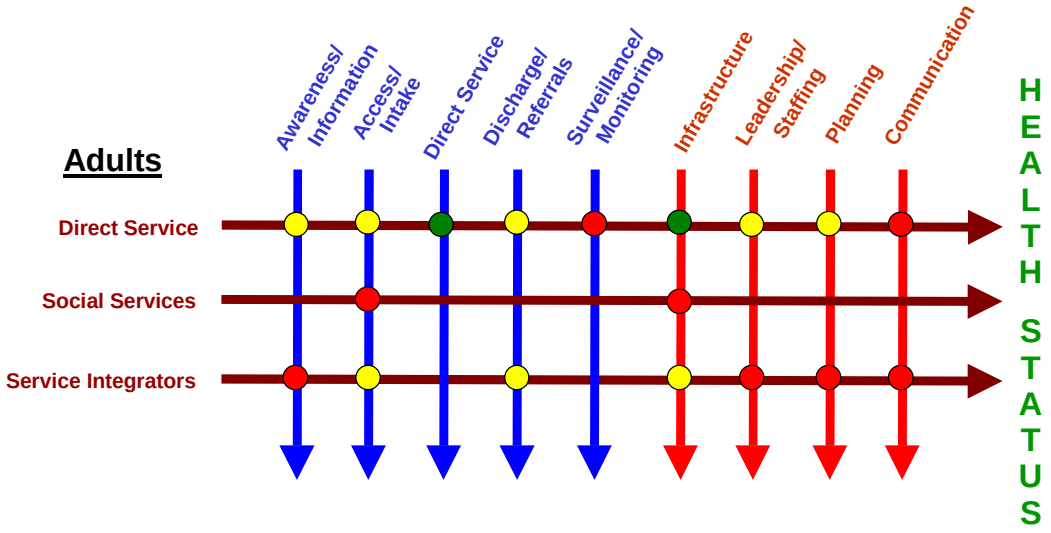
Figure II-11



- All racial and ethnic groups in Sussex County exceed US mortality rates in diabetes. African-American females in Sussex County have a strikingly high mortality (greater than 50 per 100,000) which exceeds both the state (40 per 100K) and US (28 per 100K).

- Sussex County rates for STDs such as syphilis, gonorrhea, and chlamydia exceed state rates which themselves are high compared to US rates.

Lifecycle # 3 - Resources for the Adult Population



Overall Status

Summary of Findings: Adult Gap Analysis

- Awareness: Good for those highly familiar with the system, but relatively poor for all others; Delaware Help Line serves primary referral function providing general state level information; Database is extensive, but the use by (and focus on) Sussex County population is unclear; Mixed to poor impressions by other providers; Awareness of multiple other resource directories is low.
- Access: Primary care provider numbers appear adequate for population when federal shortage area criteria are applied BUT this may not result in operational access if practices are closed to new patients, certain payer types or do not have accessible hours or geographic sites for special populations; Dental access is limited, even for populations able to pay, joint planning is trying to address this; Lack of transportation infrastructure is a long standing problem; Managed care networks limit access to some physicians.
- Direct service: Direct medical and dental care service quality is acceptable for adults by report, however, the availability of such services may be significantly limited for many residents who encounter access barriers (see above).
- Referral: Most problematic for mental health; Hospitals provide referrals to physicians; Most frequent call is for family practice physicians accepting Medicaid; Awareness for referral opportunities may limit otherwise functional systems.
- Monitoring: Little county level data is available to determine resource or care adequacy.

- Infrastructure: Many services focused on adult population; State funding mechanism lowers incentive to collaborate and may lead to inter-agency competition; Mental health access or infrastructure (too few providers) is a problem; Transportation remains problematic, particularly for residents of more rural and less densely populated portions of the county.
- Leadership: Leadership and joint planning among direct providers are of mixed quality - some good examples, but many more opportunities for improvement; Division of Volunteerism not functioning well or meeting potential as an integrator.
- Planning: Community/state supports multiple referral services and resource directories which could be coordinated better - it is not clear if funding is adequate to support all; Good coordination of resources in rehab (DE Association of Rehabilitation Facilities); Less joint planning/coordination in other areas; Should look at cost and efficiency issues for long range.
- Communication: Hospitals serve catchment areas well however there is minimal *operational* collaboration across hospital services and staffs; Increased coordination of services and resource inventories represents an opportunity to improve their advocacy/service integration role.

Lifecycle # 4 - Needs of the Geriatric Population

- As a result of both the aging of the population and an increasing retiree population, the Sussex County elderly population is anticipated to grow rapidly through 2010. The greatest growth rate will be in the over 85 age group.

Figure II-12

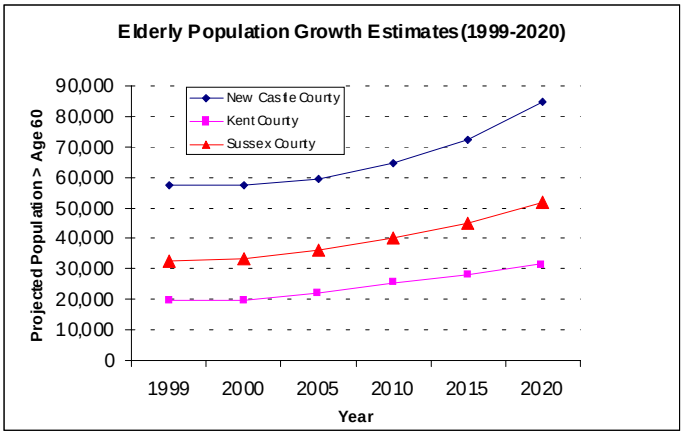
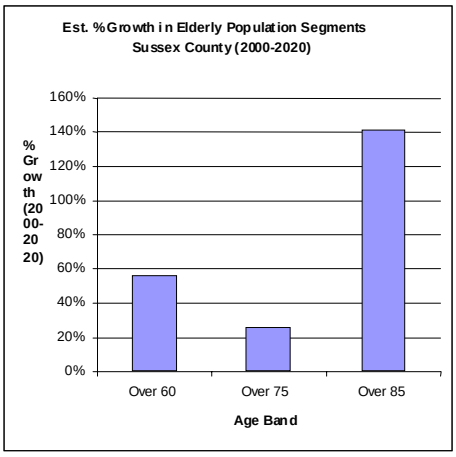


Figure II-13



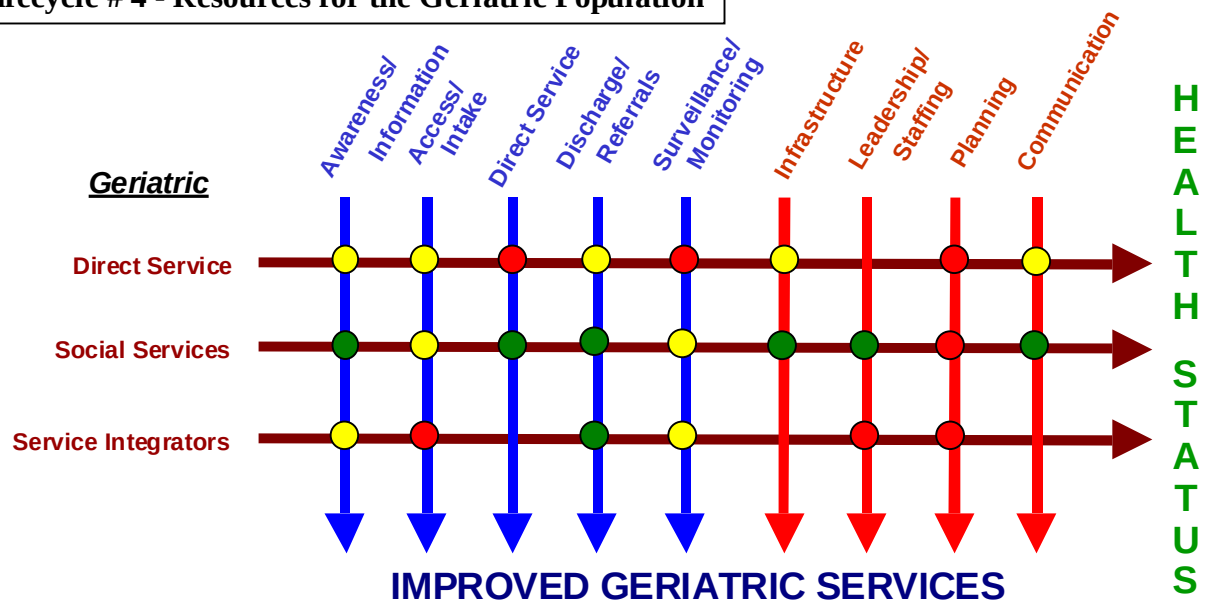
- Mortality rates for elderly population in Sussex County exceed state and US in the greater than 65 age groups in the aggregate:

All causes	65-74	75-84	85+
US	2578.7	5851.5	15280.2
Delaware	2731.5	6209.4	17297.2
Sussex Co.	**2597.8**	**6362.8**	**17126.3**

and, significantly, for the following specific conditions:
  - Pneumonia and influenza
  - Motor vehicle accidents

- Other than basic mortality data, despite an anticipated explosive geriatric population growth, there is a striking lack of data to support the identification of needs for this population. This data is required for a thorough understanding of needs and for resource development. Anecdotal and qualitative data suggests needs in the following areas:
  - Primary care
  - Geriatric medical specialists
  - Home care
  - Transportation
  - Social activities
- Coordinated and long range planning for this population appears to be lacking at the county level.

Lifecycle # 4 - Resources for the Geriatric Population



Overall Status

Summary of Findings: Geriatric Gap Analysis

- Awareness: Population is bypassing integrators and working directly with providers.
- Access: Access to prescription medication is a problem; "Pill Bill" may increase access to prescription drugs for low income; Not clear if adult day care is meeting need or is appropriately located; CHEER and senior centers are key resources; Vans believed to have significantly alleviated transportation problems for the geriatric population, but individuals requiring multiple services or living in low population density areas continue to experience transpiration related limitations.
- Direct service: Difficult population to serve due to cultural and access issues; Home Health is an important support and is in short supply; Geriatric medical specialists are not readily available in Sussex County.
- Referral: Discharge planning is working well, but limited by a resource availability or knowledge; Adequacy of discharge largely depends on the area - many services in the Beebe area; Out-referral hampered by lack of Sussex County geriatricians (see above).
- Monitoring: Division of Aging and Adults with Physical Disabilities (DAAPD) does not have current health status or needs/resource assessment for geriatric population; Unclear if CHEER adequately meets all need or if it is serving a large enough percentage of the population; Senior Summit indicated that resources are not meeting needs.

- Infrastructure: State directory of geriatric services indicates many resources are present but sufficiency is unknown; CHEER and Senior Centers are important resources (e.g., providing immunizations, focus for day activity, housing, recreation); Assisted living increasing, but not clear if demand supports increase in housing units; Information on the advocate/service integrator area is limited; Transportation options inadequate.
- Leadership: Centralized funding may be a threat to these organizations; Seniors benefit from some advocacy through AARP; Leadership shown by DHSS/DAAPD limited by lack of planning data.
- Planning: With no data, planning is insufficient; Each agency is perceived as doing its own thing, no joint planning; Some believe direct services are not prepared for rapid growth of this population (migration to Sussex) or the aging of the population; Additional work in the planning of services is needed; Social service agencies should work with direct service providers to plan for improved geriatric services.
- Communication: Better communication with direct service providers can improve services.

Service Area #1: Primary Care Needs

- Substantial data and analysis from Division of Public Health University of Delaware Survey (1998) and DIMER report (10/99) are available to support an understanding of primary care needs.

- The estimated need for additional primary care providers differs when taking a "by the numbers" view versus documenting the experience reported by individuals related to “limited practical access or availability” of numerically adequate providers. Sussex County is currently designated a medically underserved area. Northern Sussex County is designated as a primary care shortage area. Designation is based in part on the overall number of full time equivalent (FTE) physicians. However, contradictory information exists regarding true operational capacity (consumer perceptions and experience of practitioner availability) for the following reasons:

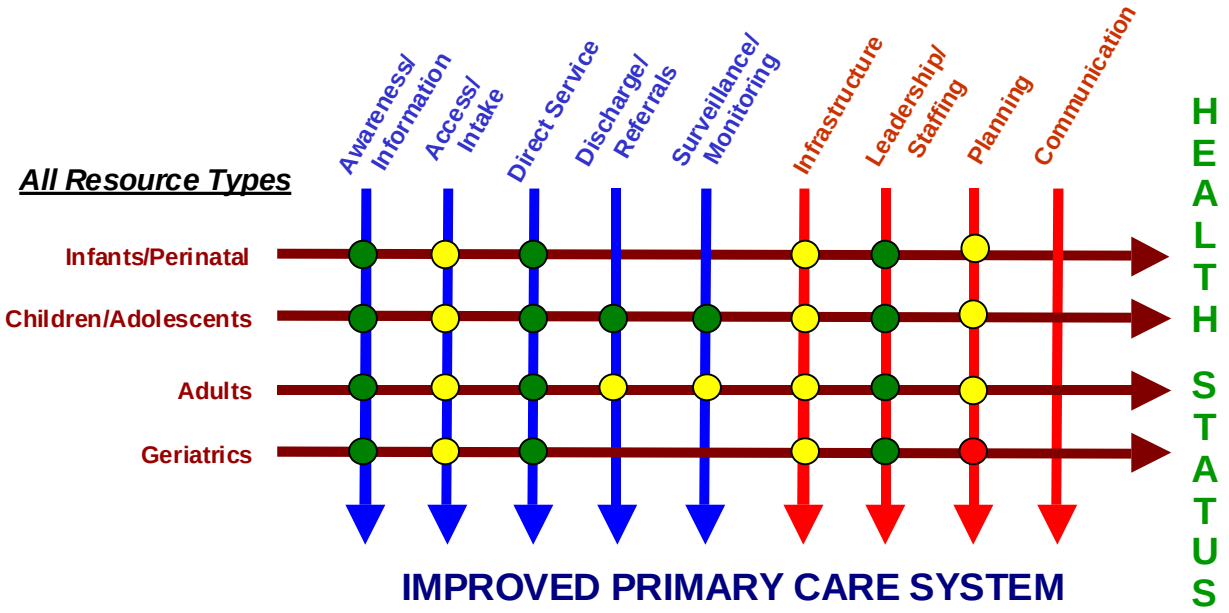
  - Practices may be closed to new patients;
  - Practices may accept limited insurance or network participation;
  - While the federal criteria for FTE (hours of practice per week) are met, productivity is not considered (i.e., low productivity would effectively reduce capacity);
  - Typical hours of operation (no evenings or weekends) may effectively limit access for certain populations;
  - Lack of knowledge or skill in the care of special populations (e.g., disabled, child/adolescent, AIDS, and geriatrics) may limit the effective availability of providers;
  - Sussex County has the lowest use of non-physician clinicians (e.g., physician assistants, nurse practitioners and certified nurse midwives) in the state, thus limiting the “extendibility” of practices;
  - The primary care capacity is clustered around hospitals, especially for OB/GYN services, thus making access geographically difficult for some citizens - particularly those lacking private transportation. This geographic problem is institutionalized, to some degree, by hospital credentialling rules requiring physicians to live within 30 miles of the hospital; and
  - Cultural accessibility (Hispanic population) and multi-lingual capacity are limited.

- The general orientation of primary care in Sussex County is toward acute/sick care rather than “wellness” or preventative care. This may affect the impact of lifestyle-related conditions as well as early diagnosis of serious disorders (such as cancer) which may result in higher mortality. Contributing factors include:

  - **Availability**: In situations of limited practitioner availability, both providers and consumers reserve their use to the most acute needs rather than preventive services; and
  - **Cultural Attitudes**: The generally conservative Sussex County population holds a “take care of yourself” ethic that supports receiving care only when ill.

- As public health clinics have transitioned away from direct primary care services, private providers have become the only resource for care such as maternal and child health services. This may have resulted in an unintended negative impact on primary care availability.

Service Area #1: Primary Care Resources



Overall Status

Summary of Findings: Primary Care Gap Analysis

- Awareness: Hospitals make medical staff directories available and provide information through the hospital on available primary care practices; Telephone directories contain listings only; Little systematic information on a county-wide basis that provides practice details.
- Access: Improvements have been made to access/intake; Sussex County has numerically adequate capacity; but problematic geographic distribution; fewer than 37% of PCP sites have Spanish bilingual capacity; 25% of Sussex County PCPs do not participate in a managed care network; Primary care access for special populations is problematic; Few providers are open to Medicaid; Recruitment of healthy individuals to receive primary "well care" remains problematic.
- Direct service: As public health clinics have transitioned away from direct services, private providers are the only source of primary care; Quality of care from primary providers is perceived as acceptable.
- Referral: Linkages with behavioral health, geriatric specialists, and dental services remain questionable.
- Monitoring: School nurses and SBHC support surveillance of children and adolescents by monitoring vaccinations and "medical homes"; Minimal County level measurement or monitoring of the quality or accessibility of primary care; DIMER has a statewide role.

- Infrastructure: Hospital bylaws require physicians reside within 30 miles of hospital; Sussex County has lowest use of mid-level providers in state.
- Leadership: Hospitals, DIMER, and Physician Organizations are providing leadership.
- Planning: DIMER has taken a coordinating role in planning and recruitment; DHCC has reported planning related data.
- Communication: Insufficient data to determine resource adequacy.

Service Area #2: Dental Care Needs

- Delaware Institute for Dental Education and Research (DIDER) data and interviews confirm Sussex County meets Dental Health Professional Shortage Area (HPSA) criteria for dental care (1998 Dentists in Delaware Report).

- There is a substantial capacity deficit in Sussex County dental services for treating both insured and non-insured populations. Shortages are particularly acute in western Sussex County, from Bridgeville to Laurel. There is also a shortage of culturally compatible dentists for certain populations (Hispanic, African-American). Many dental practices are closed to new patients. Further, the capacity of dentists is likely to deteriorate due to planned retirements. One in five dentists was uncertain if s/he would be in practice in five years in Sussex County.

- Sussex County dentists reportedly have heavier workloads than industry standards. Improved access may require a change in office hours, but this is difficult to reconcile with their current workload. Those patients that are seen in Sussex County primarily receive urgent care. Preventative dentistry is not emphasized like in other parts of the state.

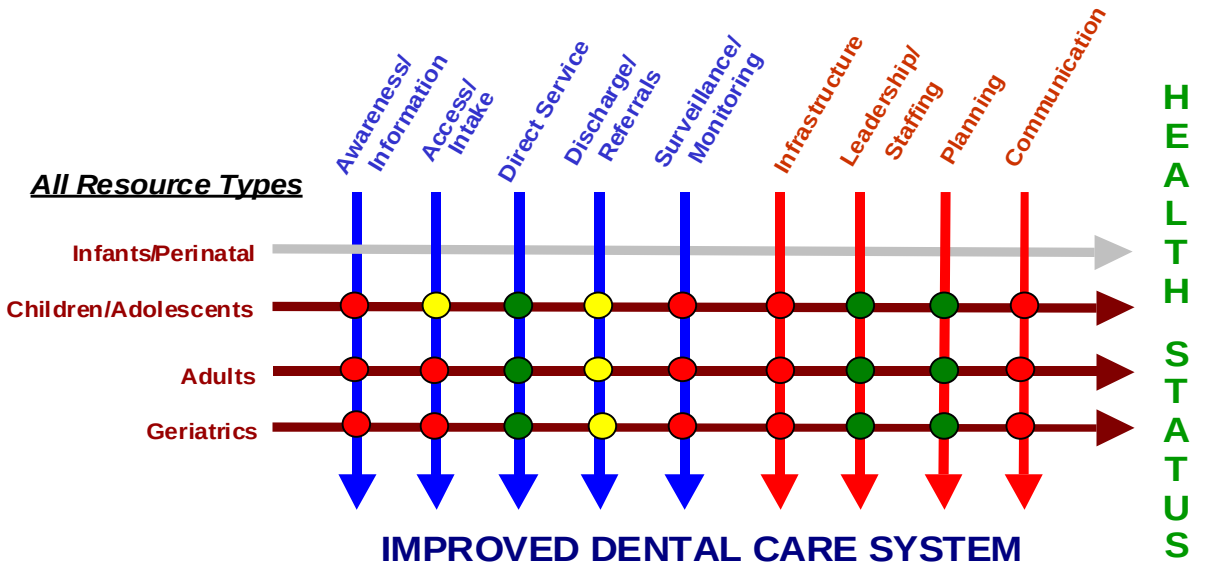
- Employers report an increased cost of dental coverage resulting from the need to allow network access outside of the local (Sussex County) area. It is not uncommon for insured patients to travel to Kent or Wilmington counties for a dentist. Most uninsured travel to Wilmington County for care at one of the dental clinics.

- There are a number of ongoing initiatives focused on attracting dental resources to Sussex County. These have been associated with some success to date. The response to the dental crisis indicates a capacity for effective crisis planning. The Delaware Dental Access Improvement Committee (DDAIC) report (Spring, 2000) articulated a coordinated approach to improvement. As proposed, activity intended to attract dentists to Sussex County has begun and includes a recruitment campaign, indicating that proactive planning to address the dentist shortage has begun. Current efforts are focused on addressing infrastructural issues (including licensing regulations) that constitute barriers to additional recruitment:

  - Training and licensure requirements are restrictive;
  - Delaware has its own testing program and does not grant license reciprocity to other states;
  - Dental hygienists are not permitted to practice preventative dentistry other than under the direct supervision of a dentist; and
  - There is no dental school in Delaware. The General Practice Dental Residency Program and dental hygiene education programs are both located in New Castle County.

- Although there has been substantial effort to focus on and improve the dental issue, those involved say it is too early to tell what the final outcomes will be, but progress has been made and they continue to be optimistic.

Service Area #2: Dental Care Resources



Overall Status

Summary of Findings: Dental Care Gap Analysis

- Awareness: There is no organized way for the population to know if there is a new provider or resource; Little or no prevention related education to general population.
- Access: Of the few practices available, many are closed to new patients; Strategies to improve access by expanding office hours are difficult to reconcile with current workload; Medicaid children have limited access through public health clinics, with less than one-third of eligible children receiving services each year. Children above the Medicaid threshold have problematic access, with affordability being a primary barrier.
- Direct service: Sussex County dentists have heavier workloads than industry standards - despite this, wait times (in office) are low; Quality of dental providers is perceived as adequate.
- Referral: There is a lack of dental sub-specialists located in Sussex County.
- Monitoring: Preventative care is not a high priority, many practices do not send reminders for regular care and checkups; Dental health status to date has not been measured on a population basis - plans are underway for Fall 2000.

- Infrastructure: Sussex County is under-served; shortages particularly acute in western Sussex County; One in five dentists was uncertain if s/he would be in practice in five years in Sussex County; Efforts are underway to attract dental resources to Sussex(e.g., recruitment campaign, training programs); State licensing regulations are a barrier in increasing the number of dentists (e.g training requirements are restrictive Delaware has its own testing program, no reciprocity with other states, etc.).
- Leadership: Effort to get water fluoridated in under-served communities was successful; Western Sussex Health Coalition has been active; DDAIC report (Spring, 2000) articulated coordinated approach to improvement.
- Planning: The response to the dental crisis indicates orientation toward crisis-focused planning, and the beginning of proactive planning; Planning has resulted in effective policy advocacy (e.g., allowing hygienists limited practice outside of dentist's office); DIDER/DDAIC are focal. Recruitment campaign is underway.
- Communication: Little communication between dentists and other health care providers; Few newspaper articles describing needs or calling attention to problem.

Service Area #3: Mental/Behavioral Health Needs

- Behavioral health needs were characterized and documented in the 1999 DIMER report as inadequate. DIMER documented a "severe shortage" of mental health practitioners in Sussex County. However, Sussex County lost its federal Mental HPSA designation in 1998. Data analysis is underway at DPH to determine if HPSA designation can be reinstated.

- Based on interviews and a review of limited Sussex County data available from the Division of Alcohol, Drug Abuse and Mental Health (DADAMH):

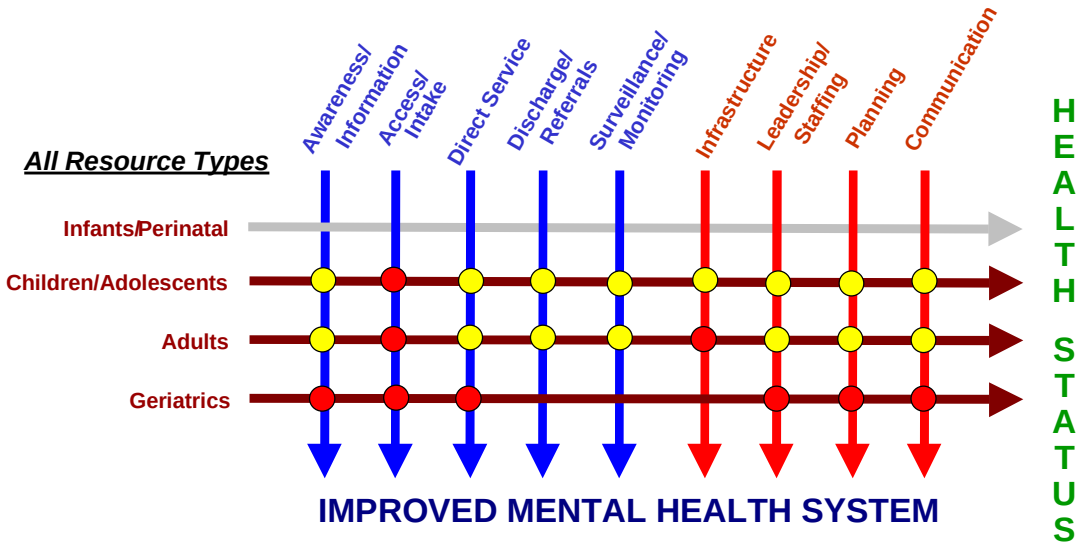
  - Ambulatory chemical dependency and substance abuse services (CD/SA) appear to be insufficient;
  - Child and adolescent services are insufficient;
  - Specialty geriatric mental health services are virtually non-existent;
  - SBHC staff report significant access problems to mental health services for children and adolescents:
    - No formal process is available for adolescent behavioral health referrals or for linkages between primary care and behavioral health resources;
    - There is 0.5 FTE child psychiatrists in the county, located on the coast; There are no pediatric or adolescent behavioral health inpatient units nor hospital services in Sussex County;
    - Knowledge of, and linkages between, resources (communication) in the child and adolescent population are lacking;
    - Transportation/data from schools confirm that access for adolescents is a real problem; and
    - Needs data reveal high suicide rates (although small absolute numbers) among teens.

- Hospital personnel report a significant proportion of emergency room use is directly related to behavioral health needs and that providers do not feel they can provide optimal care for these problems in the emergency room setting. Sussex County has no involuntary admission capacity, patients are taken to the state hospital in New Castle County, often utilizing sub-optimal transportation arrangements (most often transported in police cars by on-duty officers).

  - Managed care organizations as well as other payers are emphasizing outpatient treatment, BUT
  - Credentialling limitations limit use of non-physician providers.

- For many Sussex County individuals, there are cultural issues driving a hesitancy to use mental health and substance abuse services. For example, the adult and geriatric population associates a stigma with the use of mental health treatment. Some faith communities may also discourage or minimize the potentially beneficial role of mental health professionals. Leadership, planning, and communication for those populations which can be reached needs to be improved, especially addressing dual diagnosis, isolation and depression, and stigma associated with seeking mental health care.

Service Area #3: Mental/Behavioral Health Resources



Overall Status

Summary of Findings: Mental/Behavioral Health

- Awareness: Easter Seals produced a study on information for adult awareness/information; Geriatric population barriers are cultural and related to the stigma associated with mental health treatment; Differences in awareness may be related to geography (closer to hospitals = higher awareness); Western Health Council is actively investigating issues of awareness and access.
- Access: "By the numbers," Sussex is not classified as a HPSA for mental health care; One part-time child psychiatrist in Lewes is the only one in the county and is involved mostly in crisis work; Significant access to specialized child, adolescent and geriatric providers was consistently reported; Transportation/data from schools complicate access for adolescents creates a real problem.
- Direct service: A significant portion of emergency room use is directly related to behavioral health needs; Direct providers are perceived as doing an "average" job under these circumstances; Reimbursement levels for providers are well below average and may impact quality; Providers perceived as not knowledgeable about special needs for geriatric population.
- Referral: No formal process for adolescent referral or linkages between resources; Adult population may know what is needed, but may take multiple calls to arrange for services.
- Monitoring: Needs data reveal high suicide rates (although small overall numbers) in several age groups; External outcomes measurement is beginning (United Way, Managed Care, DHSS/DADAMH); Burden of "non institutionalized" mental health is not well understood at the county level; Mental Health Parity Law passed in 1999, regulations under development.

- Infrastructure: No involuntary admission capacity within Sussex County; Transportation of involuntary patients is inadequate; Licensing and health plan credentialling regulations problematic for non-physician providers; Inadequate CD/SA services.
- Leadership: Sussex County could benefit from more support from state; agencies doing "best they can;" Seaford area initiative (Western Health Council) has recently begun to assess mental health needs regionally.
- Planning: Need more focus on outpatient care; Looking more at parity in mental health benefits for adult population; More focus on geriatric population, especially in the areas of dual diagnosis, isolation, mental health stigma.
- Communication: Linkages among providers serving adolescent population are lacking; Interagency Council is helping increase communication.

Service Area #4: Home Health Needs

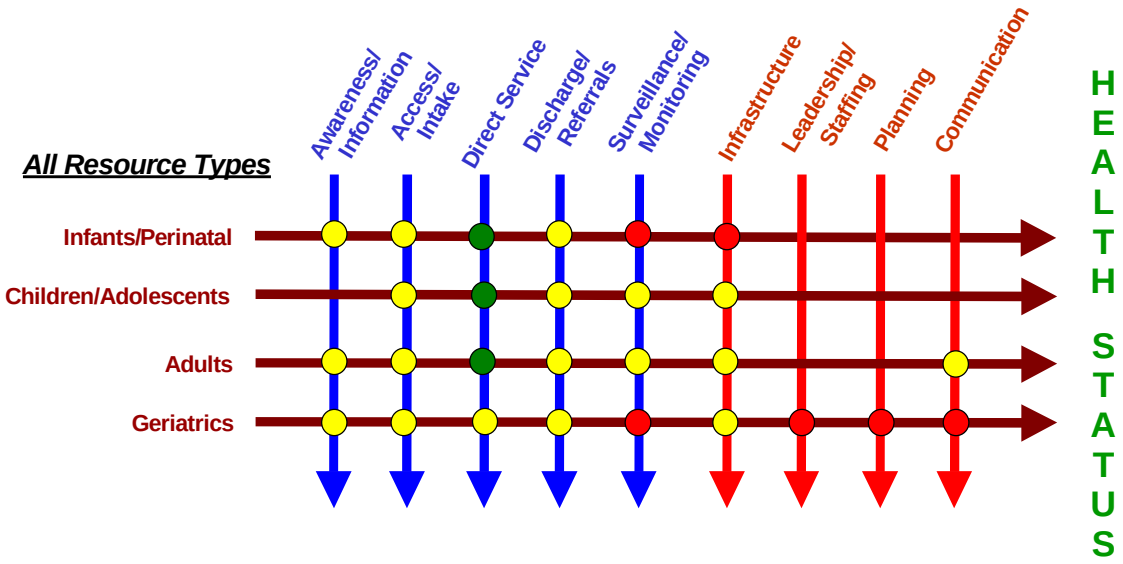
- Home health services are an increasingly important part of the health care system as delivery is transitioned away from hospital inpatient care. Based on a population over age 65, (approx. 26,250) it is projected that there will be 2,339 annual users of home health care services in Sussex County. Special population groups (perinatal/infants, special needs children, convalescing and chronically debilitated individuals, and older adults) may be disproportionate users of home health services and further stress capacity. Anecdotally, there is a general belief that currently, people who need services most urgently are receiving them. However, others with less acute or urgent needs, but who could benefit from home health services for preventive or disease management benefits are unlikely to receive services. It is unclear whether or not home health resources can keep pace with the population growth. At this time, there is no quantitative data on Sussex County's present or future home care capacity or requirements. The following interim conclusions appear warranted:

  - Home health resources are not positioned to accommodate growing population:
    - Ancillaries, supportive services, and chronic disease management resources are minimal and have not been studied as to adequacy of focus and distribution;
  - The limited labor pool creates both staffing and quality of care issues. Home health agencies are facing staffing needs and shortages. With low unemployment and competitive employers able to pay more competitive wages, agencies are having a difficult time retaining staff and paying competitive wages. Some believe this may threaten the quality of services.

- Home health service access and infrastructure focused on treating the Medicare population are at risk due to severe decreases in funding from the federal government. Across the country, this makes the future and long term viability of home health agencies uncertain. Specific to Sussex County, there is a concern that resources are progressively less able to meet needs and that the situation is getting worse. General categories of need were identified as:

  - Skilled nursing;
  - Homemaker services;
  - Personal care services;
  - Child aide services for special need children;
  - CTT services in behavioral health;
  - Services for special needs populations; and
  - Coordination and communication of services for geriatric population.

Service Area #4: Home Health Resources



Overall Status

Summary of Findings: Home Health Gap Analysis

- Awareness: Population understanding of home health services is variable by ethnic status; Much information is distributed via the hospitals as part of the discharge planning process.
- Access: Threatened by changes in Medicare reimbursement; General belief that people who need services most urgently are served; Care can be accessed for most urgent needs, but sometimes it takes a "long time;" Services for chronic disease management, special needs and subacute needs may be more difficult to access.
- Direct service: Service is considered of acceptable quality, except in geriatrics where there is room for improvement in considering this population's special needs.
- Referral: Chronic disease patients may return to the hospital more frequently due to lack of access to a primary care provider linked with good home health supports.
- Monitoring: No monitoring systems or performance data were known; No quantification of population need for home health services; Lack of outcome monitoring is a problem, particularly for infant/perinatal and geriatric populations.

- Infrastructure: Viability of home health providers is threatened by decreasing Medicare reimbursement; Long term viability is uncertain; Labor pool shortages aggravate the situation; Anticipated worsening of situation as rapid retail growth continues.
- Leadership: Labor shortage is making it difficult for agencies; Recruiting home health staff is getting harder and more expensive; No clear leadership on this issue.
- Planning: No clear consensus that resources can keep pace with growing need; resources are perceived as having a more difficult time meeting needs and the situation is getting worse, not better.
- Communication: Coordination and communication of services for geriatric population is a real need.

Special Considerations: Hispanic Population Needs

Hispanic Population

The identifiable and rapidly growing Hispanic population in Sussex County prompted a specific focus on needs in that community. In the first large scale attempt to characterize Hispanic population needs, DPH in conjunction with La Esperanza/La Red, conducted a survey in 1999. While there have been multiple initiatives and efforts to provide health services for the Hispanic community in the past several years, concern remains regarding the level of health care services accessible to Hispanics in Sussex County. Key findings are summarized below:

- Qualitative information from some providers, employers, and community agencies suggesting there are generally adequate levels of health care services, but the Hispanic population itself perceives that services are not available.
- Most of the Hispanic population is resident rather than migrant. According to the survey, about one-third of Sussex Hispanics consider themselves migrant. Most respondents have been in the area for less than five years but more than one year. The majority of the Sussex County Hispanic population lives in Georgetown, followed by Seaford and Milford.
- Nearly 88% of the population surveyed speak Spanish only. Improved access to care, therefore, requires substantial bilingual capabilities at provider sites. In addition, transportation and reduced financial barriers were prioritized as needs by respondents.
- Most of the population is single, but live in a group environment with annual household incomes of less than $20,000. Most of the employed Hispanic population works in a high risk environment for occupational injuries, such as farming and poultry industries.
- In order to enroll in financial and medical assistance programs, individuals must present evidence that they are "legal." The need to verify "legal" status adds a layer of complexity to accessing many services. This does not apply to Medicaid eligibility for children.
- More migrants reported receiving "no care" than reported using a "clinic" site for care. Longer term residents appear to be more likely to receive care in private practice or hospital settings.
- There is an indication that services for Hispanic children are more adequate than for adults due to existing resources and Medicaid eligibility (for children who are US citizens and whose parental income qualified them for Medical Assistance). Too often, however, undocumented parents do not apply for Medicaid for their otherwise eligible children due to fears of deportation.
- There is much less evidence that services for adults are accessible. Nearly one half of respondents reported being denied medical care, or avoiding seeking that care, during the past 12 months; approximately one quarter specifically cited denial of medical care due to inability to pay or avoidance of seeking services for financial reasons. Few survey respondents reported seeking preventive medical care. All interviewees indicated that access to dental care was a significant problem.

Special Considerations: EMS and County Infrastructure

EMS

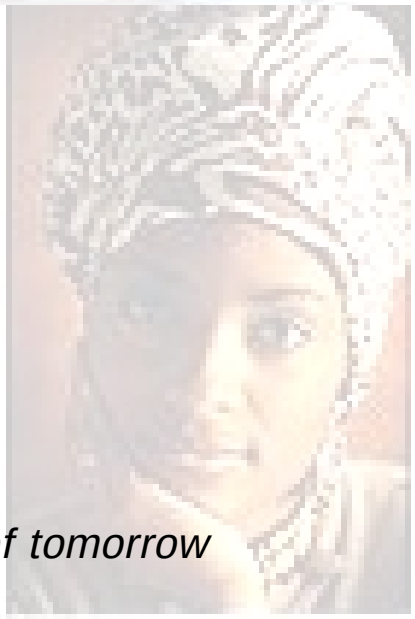
- Including Emergency Medical Services (EMS) in the RHP recognizes the special role pre-hospital care plays in Sussex County health delivery.
  - Early intervention (improved outcomes);
  - Safe, appropriate, and timely transport (stabilization/reduce pain and anxiety);
  - Maximized effectiveness within available resources (cost and staffing).
- EMS issues for Sussex County identified in interviews include:
  - Sussex County is large and sparse;
  - The 911 system is, in some senses, a victim of its own success in achieving broad public awareness - "misuse of 911;"
  - EMS dispatchers regularly make social service referrals to 911 callers - there is an important message here that is not necessarily the same as misuse;
  - EMS representatives are aware of, and concerned about, adequacy of response times;
  - Historically separate systems between the county (ALS) and the local services (BLS); and
  - Measuring the quality of pre-hospital care remains a challenge despite positive steps taken within the system.
- The Fitch Report and Delaware Emergency Medical Services Improvement Committee Report studied EMS needs and specified state-level policy recommendations, e.g.:
  - Illustrated need for development of better data and tracking systems.
  - Led to creation of a new board to oversee EMS operations and improvements.

Infrastructure Needs

- Sussex County demographic characteristics: High poverty rate, high percentage of citizens who have not completed high school (50-55% of African American adults have not completed high school); Better estimates for the status and needs re: Hispanic populations are needed.
- Eight Sussex County communities were identified in the Strong Communities Initiative (SCI) as high risk for health and safety due to significant infrastructural deficiencies.
- The purpose of the SCI was to assist the eight unincorporated, rural Sussex County communities to become self sufficient and to create a working partnership between the communities, state, county, local governments and businesses:
  - Many of the Strong Communities (neighborhoods) had experienced deterioration; single-parent families lived amidst the highest rates of violence, drug trafficking, teen pregnancy and substandard housing;
  - Critical issues included crime, water quality, septic/sewer, trash and dumping, etc. continue to impact quality of life and, possibly, health in these communities and others.
- Only 77% of respondents in the Strong Communities Survey reported that they had health insurance.
- A total of over 30 additional and similar communities exist in Sussex County for which environmental/infrastructural issues predominate as health concerns.
- Significant leadership, planning and monitoring needs remain:
  - County-wide and local data regarding nature and adequacy of infrastructure;
  - A county-wide representative body to lead and evaluate initiatives; and
  - Initiatives that will engage the public more broadly to solve infrastructural problems.

Delaware Rural Health Plan

Section III
Strategic and Operational Improvements



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III. Strategic and Operational Improvements (Broad Policy and Targeted Initiative Recommendations)

Introduction

The value chain presented in Sections I and II demonstrated that for the RHP, ***broad policies*** and ***targeted initiatives*** represent the direct value generating activities. Each of the ten recommended policies and ten suggested initiatives detailed below were matched to identified needs and resources (from Section II) through an iterative process consisting of documentation review, site interviews, DHI Steering Committee workgroups, stakeholder focus groups, and finally, a working stakeholder retreat held at Dewey Beach, Delaware on May 22, 2000. This conference had a broad invitational list and was attended by over 70 stakeholders. For ease of reference, the key components of each recommendation are summarized in Table III-1 at the end of this section. The DHI Steering Committee determined that the Plan should have a focused and feasible list of implementation recommendations. While recognizing that enough input would be obtained to create an exhaustive array of possible projects and studies, the Committee wisely recognized that this could be paralytic and that later accomplishments could be more easily built on a platform of early and significant successes. The RHP honors this approach by providing a sufficiently broad, but quantitatively and scope limited, initial menu of policy and implementation recommendations for each area of analysis from Section II. A more detailed compendium encompassing the broader input and learning obtained is recorded and reported in Appendix F.

In developing recommendations, an active attempt was made to build on existing activities and infrastructure wherever possible. Simultaneous efforts were made to avoid emphasis on those areas which are already being actively addressed in an organized and effective way.

Recommendations are organized according to key needs and resource areas defined in the preceding section.

Lifecycle Needs Recommendations

Infants and Perinatal

Needs Addressed: Infant mortality and low birth rate trends

Policy Recommendation 1: Support and enhance existing initiatives focused on improving infant and perinatal outcomes.

- The RHP endorses current activities being performed under the auspices of the Perinatal Board and the Alliance for Adolescent Pregnancy Prevention (AAPP);
- These activities should be enhanced and publicized widely in Sussex County in order to increase enrollment and participation; and
- Encourage expansion and support for "resource mothers" and "resource fathers" programs.

Policy Recommendation 1
Suggested Policy Collaborators Should Include:

- **Agencies/Advocacy Groups**
- **Department of Health and Human Services (DHSS)/Department of Health (DPH)**
- **Hospitals**
- **School Districts**

Policy Recommendation 2: Implement Medicaid reimbursement and procedural reforms that eliminate barriers to the provision of prenatal care in the first trimester for eligible and presumptively eligible pregnant females.

- Reimbursement rules for obstetric practitioners that do not penalize providers of care to pregnant women who may experience first and second trimester fetal losses;
- Procedures for presumptive eligibility voucher use which are well understood by practitioners and clients and which result in a favorable pattern of use and care delivery;
- Enforce existing rules and mandates requiring presumptive eligibility to be honored by practitioners and facilities; and
- Expand voucher availability and acceptability for individuals who are not presumptively eligible but require first trimester pregnancy care.

Policy Recommendation 2
Suggested Policy Collaborators Should Include:

- **DHSS/DSS (Division of Social Services) and DPH**
- **Sussex County medical providers**

Children and Adolescents

Needs Addressed: Children and adolescents at risk for abuse and neglect, chemical or substance abuse, teen pregnancy, and behavioral problems.

Policy Recommendation 3: Actively plan, implement, and promote family and community focused initiatives to support family unity and child and adolescent healthy lifestyles.

As a matter of public policy, stress and prioritize funding for community and family oriented projects in such areas as:

- Family communication;
- After school recreational and social activities;
- Day care;
- Behavioral health information and education;
- Parenting classes and parent-parent mentoring initiatives;
- Adult-child mentoring initiatives;
- Diversity training and education;
- After school activities and recreational opportunities; and
- Job initiatives for teens.

Policy Recommendation 3
Suggested Policy Collaborators Should Include:

- **DHSS/ Department of Services for Children, Youth, and their Families (DSCYF)**
- **Faith Communities**
- **School Boards and Parent Teacher Associations (PTA)**
- **State Police**

Initiative Recommendation 1: Implement and market a peer support and advisory system for Sussex County teens.

- Teen Advisory Panel to serve as a problem solving resource and forum for policy discussion and feedback;
- Teen Crisis Line to respond to confidential inquiries and concerns of teens;
- Teen Peer Counseling Program to enable peer-peer problem solving, support, and relationship building;
- Extend services to younger teens (middle school level);
- Enhance emphasis on social, family support, and behavioral health services;
- Actively collect and analyze encounter level data and use it to measure outcomes and plan services;
- Address rise in substance abuse between grades 8 and 11; and

- Seek, to the maximal degree possible, to leverage SBHC services to diminish teen pregnancy.

Initiative Recommendation 1
Suggested Initiative Collaborators Should Include:

- **Boys' and Girls Clubs**
- **Chambers/Employers**
- **County Administration**
- **DHSS/DPH**
- **Faith Communities**
- **School Districts**
- **YMCA**

Initiative Recommendation 2: Support the expansion, depth, and optimal utilization of SBHC services.

- Extend services to younger teens (middle school level);
- Enhance emphasis on social, family support, and behavioral health services;
- Actively collect and analyze encounter level data and use it to measure outcomes and plan services;
- Address rise in substance abuse between grades 8 and 11; and
- Seek, to the maximal degree possible, to leverage SBHC services to diminish teen pregnancy.

Initiative Recommendation 2
Suggested Initiative Collaborators Should Include:

- **DHSS/DPH**
- **Faith Communities**
- **Hospitals**
- **Legislature**
- **School Districts**

Adults

Needs Addressed: Unintentional injury prevention and diabetes mortality.

Initiative Recommendation 3: Undertake intensive and coordinated injury prevention education efforts targeting motor vehicle crashes, workplace injuries, and substance use related injuries.

- Leverage existing Trauma Center designations to provide enhanced analysis and trending of injuries, follow up education, community and workplace based education and prevention programs; and
- Identify best practices and develop interventions through a multi-disciplinary task force of hospitals, EMS, ER physicians, nurses, etc.

Initiative Recommendation 3
Suggested Initiative Collaborators Should Include:

- **Community Colleges**
- **DHSS/DPH (Healthy Delaware 2010)**
- **Emergency Medical Services (EMS)**
- **Hospitals**
- **High Risk (for injury) Employers**
- **State Police**

Initiative Recommendation 4: Undertake intensive *diabetes mellitus* health improvement initiative.

- Components to include screening, education, self care and monitoring components as well as enhancing access to specialty care; and
- White males and black females should be targeted.

Initiative Recommendation 4
Suggested Initiative Collaborators Should Include:

- **American Diabetes Association**
- **DHSS/DPH**
- **Faith Communities**
- **Hospitals**
- **Managed Care Organizations (MCOs)**

Geriatric

Needs Addressed: Planning and geriatric specialty clinical resources.

Initiative Recommendation 5: Undertake a formal data collection and planning initiative, with a specific Sussex County and local community focus, to better understand the health and social service needs of elderly adults currently and for the next decade of anticipated high geriatric population growth.

- Data obtained should provide information about:
  - Demography and epidemiology;
  - Burden of illness/morbidity;
  - Service use patterns;
  - System capacity;
  - Quality of life;
  - Functional status; and
  - Other health status measures.
  - Analysis and planning based on this data should be ongoing; broad review and goal setting should be accomplished at an annual Sussex County Geriatric Summit.

Initiative Recommendation 5
Suggested Initiative Collaborators Should Include:

- **AARP**
- **CHEER**
- **DHSS/Division of Aging and Adults with Physical Disabilities (DAAPD)**
- **Hospitals**

Initiative Recommendation 6: Use the output obtained from the above to inform and execute a recruitment strategy for geriatric specialists, physician extenders, and primary care physicians with an interest in caring for the elderly, to Sussex County.

Ensure that current and future analytic and planning activities through the DAAPD are structured to provide specific information and recommendations for Sussex County:

- Ensure that there is coordination between accountable and advocacy groups representing the elderly.

Initiative Recommendation 6
Suggested Initiative Collaborators Should Include:

- **CHEER**
- **DHSS/DAAPD**
- **Hospitals**
- **Sussex County medical providers**

Service Area Needs Recommendations

Primary Care

Needs Addressed: Quantity and distribution of primary care practitioners in Sussex County.

The RHP strongly recognizes the critical importance of improving primary care access in Sussex County. Needs in this area are currently being addressed through DIMER and DHCC analyses and recommendations that are both adopted and endorsed by the RHP. Area hospitals play a significant role in improving access to physician resources.

Dental Care

Needs Addressed: Quantity and distribution of dental practitioners in Sussex County.

The RHP strongly recognizes the critical importance of improving dental care access in Sussex County. Needs in this area have been addressed through Dental Care Access Improvement Committee analyses and recommendations which are both adopted and endorsed by the RHP.

Mental/Behavioral Health

Needs Addressed: Quantity and distribution of mental and behavioral health practitioners in Sussex County.

Initiative Recommendation 7: Develop a behavioral health provider staffing plan, as well as an active recruitment and retention strategy, for mental and behavioral health practitioners for Sussex County, which ensures adequate provider staffing and access for county residents.

- Target recruitment to ensure addressing needs by age, geographic location, service requirements, racial, cultural, and ethnic compatibility;
- Given the scarcity of behavioral health resources, provider recruitment should ensure the maximum potential to share these resources across hospital service areas;
- Use the models of dental and primary care manpower assessment and recruitment to guide development of a customized approach to behavioral health recruitment; and

- Seek to integrate recruitment and retention activities with payment reform and payer, as well as employer network reform, to ensure sufficient and balanced incentives to achieve goals.

Initiative Recommendation 7
Suggested Initiative Collaborators Should Include:

- **Agencies**
- **DHSS/ DSCYF**
- **Hospitals**
- **MCOs**

Policy Recommendation 4: Review practitioner licensure regulations and MCO network credentialling requirements with the goal of permitting, and enabling reimbursement for, the supervised practice of behavioral health counseling and therapies by qualified pre-licensees during their periods of practical professional training.

Enable the practice and reimbursement of otherwise license eligible, fully educated, Masters' level counselors and therapists while they are under professional licensed supervision in the process of obtaining required practical experience.

Policy Recommendation 4:
Suggested Policy Collaborators Should Include:

- **DHSS/DPH**
- **Employers**
- **Legislature**
- **MCOs**
- **National Association of Social Workers (NASW)**
- **State Board of Social Work Examiners**

Home Health

The RHP notes, with concern, potential limitations in resource availability and current reimbursement structure in this area. There was insufficient planning data and topical expertise among the stakeholders to support specific recommendations at this time. This area should be revisited in light of the activities recommended in the geriatric section above.

Special Considerations Needs Recommendations

Cultural, Minority, Racial and Ethnic Issues

Needs Addressed: Issues of cultural barriers to care for racial, ethnic, and other minority residents of Sussex County.

<u>Policy Recommendation 5:</u> Establish dialogue and a mutually receptive environment between key employers of ethnic and racial minority residents and their workers in health planning activities; Solicit multilateral long term participation in strategy development.

- Emphasize the intersection and shared benefit from improved health status of ethnic and minority residents of Sussex County;
- Ensure bilingual and culturally compatible access to such meetings, as appropriate; and
- Use meetings as a means for bilateral education and consciousness raising.

<u>Policy Recommendation 5</u>
<u>Suggested Policy Collaborators Should Include:</u>

- **Advocacy Groups/Agencies**
- **Chambers/Employers**
- **Community Colleges**
- **County Administration**
- **DHSS/DPH**
- **Faith Communities**
- **Hospitals**

<u>Initiative Recommendation 8:</u> For minority and ethnic populations, develop regular community forums for communications between consumers and accountable entities.

- Use this input for gaining knowledge about needed resources and services;
- Use input as a basis for innovative development of new services;
- Develop approaches for meeting non-traditional family units; and
- Forums should be bilingual, as appropriate to constituencies.

Initiative Recommendation 8
Suggested Initiative Collaborators Should Include:

- **Agencies/Advocacy Groups**
- **Community Colleges**
- **County Administration**
- **DHSS/DPH**
- **Faith Communities**
- **Hospitals**

The following recommendation is applicable to both the **minority** and **access** needs areas:

Initiative Recommendation 9: Actively support, pursue, and create opportunities for non-traditional access to health care services attractive to racial and ethnic minority as well as non-minority residents of Sussex County.

- Non-traditional siting of service facilities (i.e., employment sites, shopping malls, mobile units, community centers);
- Culturally compatible physical space, staffing, and language; and
- Create access which encourages service use by all members of non traditional family and living units.

Initiative Recommendation 9
Suggested Initiative Collaborators Should Include:

- **Agencies/Advocacy Groups**
- **Chambers/Employers**
- **County Administration**
- **DHSS/DPH**
- **Faith Communities**
- **Hospitals**

Access to Resources

Needs Addressed: Linking consumers and referring professionals and agencies with resources.

Policy Recommendation 6: As a matter of public policy, encourage the statewide consolidation and reorganization of existing resource compendia and directories into a master directory of services.

- Standardize content to reflect key information required for timely and appropriate referrals for services;
- Organize and index in a geographically and service friendly fashion to enable easy identification of local and appropriate resources;
- Commit to publication in, and access from, a variety of media, including electronic and web based, to extend availability to the public more broadly;
- Update on a frequent basis;
- Provide "real time" access to the directory by key referral resources (such as EMS dispatch, hospitals, key agencies, Delaware Help Line); and
- Consider the creation of centralized toll free referral "hot line(s)" with compendium access to respond to telephonic requests for local and appropriate resources and referrals.

Policy Initiative 6
Suggested Policy Collaborators Should Include:

- **DHSS**
- **Legislature**
- **State Service Center Office**

Leadership and Planning

Needs Addressed: The lack of available data to support leadership in health planning and implementation of change in Sussex County.

Policy Recommendation 7: As a matter of public policy, mandate the collection and distribution of all statewide health (including vital statistics) demographic, epidemiologic, and sociologic data on at least a county level and preferably on a ZIP code level.

- Given the significant disparities in population and demography between northern and southern Delaware, regional and local data is essential to understanding the population of Sussex County and using that understanding to plan for resources and services;

- A model exists for the differential collection and reporting of New Castle County and Wilmington area data for this reason.
- Although data integrity may be compromised by relatively small numbers of observations in Sussex County, knowledge of this potential pitfall can result in appropriate corrections and offsets when necessary and should not prevent the collection of county specific data.

Policy Recommendation 7
Suggested Policy Collaborators Should Include:

- **County Administration**
- **DHSS**
- **Legislature**

Policy Recommendation 8: As a matter of public policy, support and encourage leadership development within ethnic and non-ethnic communities of Sussex County.

- Seek opportunities to engage community constituencies in planning and problem solving forums;
- Develop opportunities to engage residents across age, racial, and ethnic groups;
- Sponsor leadership development experiences (i.e., seminars, retreats, school curriculum, committee and initiative participation) which include both identified and potential new leaders from the community; and
- Ensure that language and cultural diversity is not a barrier to engaging Sussex County residents in leadership experiences.

Policy Recommendation 8
Suggested Policy Collaborators Should Include:

- **Community Colleges**
- **County Administration**
- **DHSS**
- **Faith Communities**
- **First State Community Action**
- **Legislature**
- **School Districts**

Policy Recommendation 9: As a matter of public policy, commit to ongoing collaborative planning and strategy for health improvement in Sussex County.

- Build and expand upon the positive experience of DHI by encompassing a larger representative constituency including County Administration, DIMER, MCOs, employers/business; School Districts, faith communities, and consumers.

Policy Recommendation 9
Suggested Policy Collaborators Should Include:

- **Chambers/Employers**
- **County Administration**
- **DHI**
- **DHSS**
- **Faith Communities**
- **Hospitals**
- **School Districts**

Initiative Recommendation 10: Set, and monitor progress towards, specific improvement goals for health status, access, planning, and implementation for Sussex County related to key recommendations in the RHP.

- Using the value chain model, create and monitor specific metrics of effectiveness and implementation to inform stakeholders and enable assessment of progress; and
- Regularly measure against these to provide feedback to planners and funders regarding the effectiveness of goals.

Initiative Recommendation 10
Suggested Initiative Collaborators Should Include:

- **All stakeholders, coordinated by DHI and DPH**

Infrastructure

Needs Addressed: The ongoing need for upgrading and maintaining roads, sanitation, public safety, telecommunications, and transportation in Sussex County.

Policy Recommendation 10: As a matter of public policy, continue support of community infrastructure improvement initiatives, including ongoing planning and upgrading based on a sound understanding of the growth and use characteristics of the region.

- Continue to support, and expand as needed, community improvement and decay prevention programs such as the SCI; and
- Develop a mechanism to assess and report on the "state of infrastructure" of Sussex County on a regular basis with the goal of ensuring that evolving infrastructure matches developing needs based on growth, innovation, and natural obsolescence of infrastructure.

Policy Recommendation 10
Suggested Policy Collaborators Should Include:

- **Chambers/Employers**
- **County Administration**
- **DHSS**
- **Department of Transportation**
- **EMS**
- **First State Community Action**
- **State Planning Authorities**
- **State Police**

Table III-1: Summary of RHP Recommendations

Category	***Initiative #***	***Policy #***	***Page #***	***Brief Description***
Infants/Perinatal		1	30	Support and enhance existing initiatives focused on improving infant and perinatal outcomes.
Infants/Perinatal		2	30	Implement Medicaid reimbursement and procedural reforms that eliminate barriers to the provision of prenatal care in the first trimester for eligible and presumptively eligible pregnant females.
Child/Adolescent		3	31	Actively plan, implement, and promote family and community focused initiatives to support family unity and child and adolescent healthy lifestyles.
Child/Adolescent	1		31	Implement and market a peer support and advisory system for Sussex County teens.
Child/Adolescent	2		32	Support the expansion, depth, and optimal utilization of SBHC services.
Adults	3		33	Undertake intensive and coordinated injury prevention education efforts targeting motor vehicle crashes, workplace injuries, and substance use related injuries.
Adults	4		33	Undertake intensive *diabetes mellitus* health improvement initiative.
Geriatric	5		34	Undertake a formal data collection and planning initiative, with a specific Sussex County and local community focus, to better understand the health and social service needs of elderly adults currently and for the next decade of anticipated high geriatric population growth.
Geriatric	6		34	Use the output obtained from the above to inform and execute a recruitment strategy for geriatric specialists, physician extenders, and primary care physicians with an interest in caring for the elderly, to Sussex County.
Mental/Behavioral	7		35	Develop a behavioral health provider staffing plan, as well as an active recruitment and retention strategy, for mental and behavioral health practitioners for Sussex County, which ensures adequate provider staffing and access for county residents.
Mental/Behavioral		4	36	Review practitioner licensure regulations and MCO network credentialling requirements with the goal of permitting, and enabling reimbursement for, the supervised practice of behavioral health counseling and therapies by qualified pre-licensees during their periods of practical professional training.
Cultural/Minority		5	37	Establish dialogue and a mutually receptive environment between key employers of ethnic and racial minority residents and their workers in health planning activities; Solicit multilateral long term participation in strategy development.

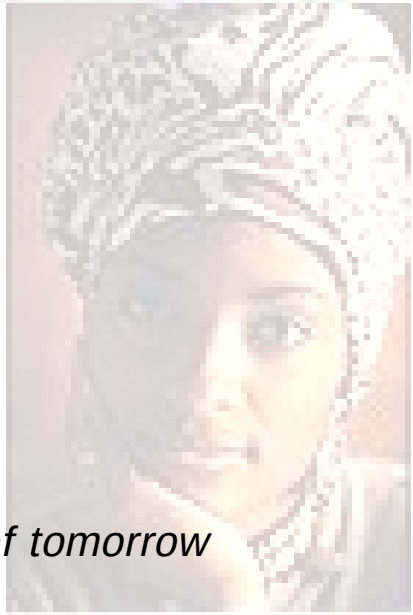
Cultural/Minority and Access	9		38	Actively support, pursue, and create opportunities for non-traditional access to health care services attractive to racial and ethnic minority as well as non-minority residents of Sussex County.
Access		6	39	As a matter of public policy, encourage the statewide consolidation and reorganization of existing resource compendia and directories into a master directory of services.
Leadership and Planning		7	39	As a matter of public policy, mandate the collection and distribution of all statewide health (including vital statistics) demographic, epidemiologic, and sociologic data on at least a county level and preferably on a ZIP code level.
Leadership and Planning		8	40	As a matter of public policy, support and encourage leadership development within ethnic and non-ethnic communities of Sussex County.
Leadership and Planning		9	41	As a matter of public policy, commit to ongoing collaborative planning and strategy for health improvement in Sussex County.
Leadership and Planning	10		41	Set, and monitor progress towards, specific improvement goals for health status, access, planning, and implementation for Sussex County related to key recommendations in the RHP.
Leadership and Planning		10	42	As a matter of public policy, continue support of community infrastructure improvement initiatives, including ongoing planning and upgrading based on a sound understanding of the growth and use characteristics of the region.

Table III-2: Master Table of Suggested Collaboration

	Agencies/Advocacy Groups	*CDC*	*CHEER*	*Chambers/Employers*	*County Administration*	*DHI*	*DHS/DAAPD*	*DHSS/(all other)*	*DHSS/DPH*	*EMS*	*Faith Communities*	*Hospitals*	*Legislature*	*MCOs*	*School Districts*	*State Police*	*Other*
Initiatives																	
1				x	x	x			x		x				x		
2						x			x		x	x	x		x		
3				x		x			x	x		x				x	x
4						x			x		x	x		x			
5			x			x	x					x					x
6			x			x	x					x					x
7	x					x		x				x		x			
8	x				x	x			x			x					x
9	x			x	x	x			x		x	x					
10	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Policies																	
1	x					x			x			x			x		
2						x		x									x
3						x		x			x				x	x	
4				x		x			x				x	x			x
5	x			x	x	x			x		x	x					x
6						x		x					x				x
7					x	x		x					x				
8					x	x		x			x		x		x		x
9				x	x	x		x			x	x			x		
10				x	x	x		x		x						x	x

Delaware Rural Health Plan

Section IV
Leadership and Staffing



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IV. Leadership and Staffing

Introduction

Leadership and staffing are key to successful implementation of policies and targeted initiatives developed as a result of the RHP. Leadership must provide overall vision, direction, and guidance for initiatives, while project staff attends to day-to-day operational issues. Without capable leadership, projects will either fail to "get off the ground" or will be limited in their effectiveness. Issues of leadership simultaneously constitute the key to success, as well as the greatest potential vulnerability for the RHP.

Staffing community-based initiatives may take various forms. For large-scale projects, a dedicated program staff may be necessary. For shorter term or smaller initiatives, volunteers or contributed staff time from supporting organizations may be sufficient.

Developing leadership for community-based programs is challenging. Collaboration and joint action, while advantageous in bringing organizations together, may also lead to unintended consequences such as diffusion of responsibility, or alternatively stated, a lack of clear accountability.

Stakeholders Defined

For the purpose of the RHP, "stakeholders" may be defined as organizations and individuals that have an interest in the health of a community's population and share responsibility for monitoring, assessing, and improving community health. As a group, stakeholders may include consumers, providers, businesses, government, and other relevant sectors of the community. Entities comprising stakeholders may expand or contract in number, and membership may change, to reflect shifts in health issues and strategies that present themselves.

Accountable Entities and Shared Responsibility

Accountable entities are stakeholders or groups of stakeholders that are clearly identified as "leading change" and which are expected to achieve specific results as part of the community's strategy for addressing health issues. Realizing the true benefits of collaborative efforts requires a paradigm of shared responsibility supported by all stakeholders. Shared responsibility in the context of health care planning begins as individuals and organizations explicitly take ownership for improving health status, show commitment to collaboration focused on measurable goals, and assume mutual accountability for creating change.

The process of creating responsibility for actions in the form of specific accountable entities will differ from problem to problem, from strategy to strategy, from time to time, and from place to place. The basis for designating a stakeholder as an accountable entity may include regulatory requirements, legislative mandates, social pressures, market forces, lobbying, voluntary initiatives, enlightened self-interest or, most likely, a combination of these and/or other factors.

Accountability in Sussex County

Section III (Strategic Approaches to Improvement – Policies and Initiatives) identifies "suggested initial collaborators." These represent those accountable entities which must be "at the table" to begin to discuss and advance the RHPs recommended policies and/or initiatives. They are not, in themselves, responsible for staffing or funding recommendations but without their commitment and support, it is unlikely that forward motion can be attained. The following accountable entities are anticipated to play key roles in multiple policies and initiatives and deserve special mention in this discussion:

- **Delmarva Health Initiative:** DHI emerged from the Health Summit of 1998. Its very existence is a reflection of the county-wide appreciation of the value of accountable and collaborative leadership. The membership of DHI is currently composed primarily of hospital affiliated representatives – equally balanced between Bayhealth Medical Center, Beebe Medical Center, and Nanticoke Health Services representatives, including both administrative staff and board members. In addition, a number of state and independent agencies are represented, including the United Way. DHI's primary role may be characterized as the overall convener of county-wide planning, and thus the "keeper of the RHP." Going forward DHI will need to take central accountability for advancing RHP recommendations.

- **Regional/Community Health Coalitions:** Other coalitions, such as the regional Health Councils as well as various hospital-affiliated community health boards, provide additional leadership. Ideally, these organizations would maintain active participation with DHI.

- **Hospitals:** The three Sussex County hospitals play a pivotal role both in the communities they serve as well as throughout the county through shared accountability for most urgent care and substantial non-urgent care. Each hospital provides a full range of acute care services and leadership support to projects impacting their distinct service areas. The hospitals are also committed to improving overall health in Sussex County and fully recognize that impacting community health is dependent on many more factors than the delivery of direct hospital sponsored services. Participation in DHI by the hospitals underscores the ability of otherwise competitive entities to collaborate on a larger vision of health improvement.

- **Other health care providers:** Development of leadership among physicians, other medical and dental care providers, behavioral health providers, and other providers is an important strategy for promulgating policies and initiatives that directly impact their practices or agencies. Minimally, these categories of stakeholders need to play a role in project development, from designing the initiative to recruiting participation from consumers who are their clients, and finally to monitoring and interpreting outcomes.

- **State Agencies**: In the course of developing the RHP, interviewees representing both community organizations and state government indicated that Sussex County is often "overlooked," "ignored," and/or "not considered," in state level planning or by state agencies. This occurs even though DPH hosts both the state's Office of Rural Health and

Southern Health Services which have provided valuable support to Sussex County development.

- **Sussex County Administration:** Local government has a major stake in improving health care, social services, and both employment and commerce within the county. It has supported DHI from its inception and is expected to be an important influence on any county-wide initiatives going forward.

- **Faith Community Leaders:** Faith leaders can play important roles in supporting both individual healthy behaviors and enhanced community activism. Indeed, they have demonstrated positive influence on health and infrastructure issues, particularly in the African-American and Hispanic communities. Clergy and clergy-led community efforts can also be influential at the policy level, as exemplified by the Strong Communities' success in drawing attention to inadequate infrastructure.

Allocating Resources for Leadership Development and Staff Support

Resources allocated toward strategies identified in the Plan should be balanced between direct services and supporting structures (e.g., leadership development, communication, infrastructure, etc.). Indeed, the need for leadership development was highlighted in Section III of the RHP. While direct service resources are focused on eliminating gaps, funding should also be channeled to training leaders, providing staff to develop and facilitate coalitions of stakeholders and accountable entities, and to supporting systems that can deliver county specific, statistical and other data essential to making sound decisions. The RHP has documented the significant need to leverage available resources through concerted shared responsibility. RHP objectives will be best met if leadership is multi-disciplinary, cross-organizational, and inclusive of ethnic, racial, and minority populations.

Delaware Rural Health Plan

Section V
Funding

Planning today to improve the lives of tomorrow

V. Funding

Introduction

Consistent with the themes for the RHP, applying business concepts is a useful mechanism to help consider, as well as enable, funding strategies. The RHP is not itself a grant application or a direct funding mechanism. Rather it is a potential guide to local or state agencies for setting funding priorities based on delivering value to Sussex County. Discrete initiative recommendations from the RHP can be extracted and enhanced for presentation as funding requests whereas policy recommendations may create the vehicle for a range of fundable opportunities.

The funding necessary to support new initiatives stemming from the RHP can be considered as similar to "startup capital" in the business world where firms seeking to implement new ideas (or "dot.com" strategies) compete for initial funding from external investors ("venture capitalists"). In business, sustained funding is derived from returns on ongoing operations. Sustained funding for rural health initiatives must be justified on the basis of a return on funding which takes the form of improved health outcomes and diminished public spending on illness, accident, or addiction services. The parameters of funding competition thus remain: value, capacity to execute, and potential for "return on investment."

Using the RHP to Finance Health Improvement

Firms seeking capital develop business plans and then seek the support of venture capital investors who perceive a potential for a favorable return. Similarly, projects and initiatives identified in the RHP also require "venture/startup capital." Sources of such funding include private foundation grants as well as both state and federal government grants and allocations. The RHP supports project development by contributing to the justification and/or demonstration of the effectiveness of a program. Funders increasingly require ongoing program evaluation to ensure that programs meet initial expectations. The outcomes can be expressed as improved health status and translated into "dollars saved" in unnecessary health care costs, reduced employer benefit costs and enhanced profitability for business, decreased loss of work capacity, increased worker productivity, and enhanced attractiveness of Sussex County to new residents, businesses, and professionals. Dovetailing initiatives with Healthy Delaware 2010 objectives, for instance, can represent a credible and "pre-qualified" return opportunity.

The "grants as venture capital" analogy thus creates a useful framework. The community program or initiative becomes a "business" and external funding sources become "investors." This approach is particularly relevant in addressing the issue of long-term sustainability. Few external funders are interested in contributing resources indefinitely to sustain projects that are appropriately funded as "pilots." This reality often leads grantees to focus significantly on the time frame of the grant, whereas the "business planning" frames a longer-term perspective that identifies stakeholders and benefits and seeks internal sources of funding or enhance sustained fundability from external sources.

General Funding Strategy Process

Steps towards a general funding strategy process are as follows:

1. Identify a community need based on observation, data, and an understanding of resource gaps along the value delivery continuum;
2. Understand and communicate the impact of that need in the context of what target customers value and the potential return on investment as described above;
3. Develop a project, service, or intervention that is targeted to address a specific problem (e.g., relieve a "bottleneck" in the value delivery chain) and which "fits" or complements the other initiatives;
4. Define and clearly state the project's goals, objectives, deliverables, etc. and determine an appropriate budget and return;
5. Identify potential funding sources (e.g., foundation grant, local stakeholders, and federal or state grants or allocations) for whom value delivery is a priority and, therefore, whose goals are complementary to the project goals; pursue multiple funding vehicles if possible and permitted; consider seed funding with "follow-on" sustained funding based on demonstrated return;
6. Receive funding, implement the program and develop a sustainability plan; and
7. Monitor and report performance against goals using metrics that are directly relevant to measurement of return and value delivery and, thus, to enhancing and assuring sustainability.

Stakeholders should plan to use the understanding of Sussex County needs, value creation, and gaps in resources, presented in the RHP, to support funding requests. Focusing on these elements will support responsive project development and will increase the likelihood of receiving funding from competitive sources seeking optimal value for invested funding.

The process of defining the projects and initiatives is well underway. Section III of the RHP (Strategic and Operational Improvements [Broad Policy and Targeted Initiative Recommendations]) provides broad policy and specific implementation recommendations as they were identified in the development of the RHP. Additional focused planning may be required to create specific business plans for these and to bring them to the implementation phase.

Sources of Funding

Since value delivery is largely measured in terms of achieving population and health system goals, governmental (federal, state, or local) funding sources should be sought for sustained direct support, in anticipation of population-wide returns or benefits. In addition, private foundations often support the development of effective, efficient, and exportable models for health improvement. The unique "value orientation" of the Delaware RHP, and of projects spawned by it, can provide competitive advantage in obtaining such funding. Consistency with Healthy Delaware 2010, CDC initiatives, and other consensus improvement efforts can support the appropriateness of funding requests.

Pursuing grant dollars may be expensive in terms of the "person hours" required between developing the grant and securing the funding decision. Not every grant application is successful – few grant writers achieve "hit rates" over 50 percent. Local alternatives to grant funding are appropriate and desirable to seek including, but not limited to, private contributors, grassroots fundraising, and cost sharing from collaborating agencies.

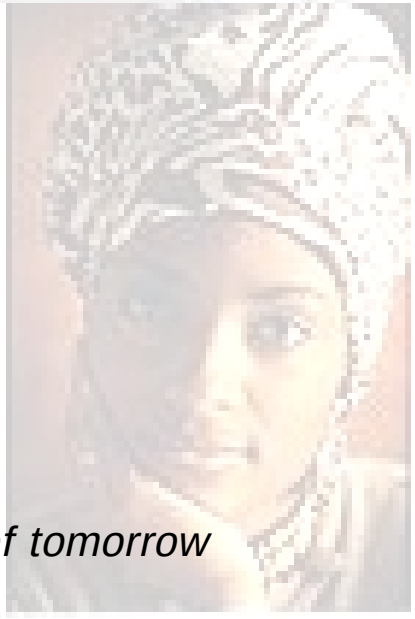
- **Federal Programs:** A wide array of federal programs focused on health already exists. Three major sources of funding are the Health Resources and Services Administration (HRSA)[1], the Federal Office of Rural Health Policy (ORHP)[2], and the Agency for Health Care Research and Quality (AHCRQ)[3]. Staff to Delaware's US Representative and/or Senators may also be able to assist in identifying and facilitating opportunities at the federal level.
- **State and Local Government:** Significant state funding is directed at Sussex County through direct service programs and insurance (e.g., Medicaid, Children's Health Insurance, etc.). The state has also created the Delaware Health Fund, which provides significant resources to support community health initiatives. Local government may also be positioned to provide financial support to efforts that will result in improved health for local citizens. Healthy Delaware 2010 is funded by DPH and federal sources. The Behavioral Risk Factor Survey is funded through grants.
- **Private, State or Local Foundations**: The duPont/Nemours philanthropies distribute funds for child health in Delaware, operate clinics, and may have an interest in providing additional support to Sussex County. The Robert Wood Johnson (RWJ) Foundation[4] is the largest private foundation making grants exclusively in health care and has historically funded demonstration programs. Current areas of interest include access, care of chronic conditions, and harm reduction strategies – all of which link directly to Sussex County needs as identified in this RHP. Information on other foundations can be found though the Foundation Center[5].
- **Local Industry and Business:** Depending on the issue, local businesses may be willing to contribute to initiatives. For example, the employer may underwrite a work site wellness program by emphasizing benefits such as reduced absenteeism or lower health care costs. Similarly, promoting access to state health insurance programs for dependents of low income, part time, or non-benefited employees may be advantageous to businesses. Hospitals, under their charitable giving programs, may be willing to contribute to seeding direct service or infrastructural initiatives which directly or indirectly enhance their community mission, benefit residents of their catchment areas, and/or indirectly enhance their attractiveness to a referral base.
- **Individuals:** Support from individuals may take one of two forms: large gifts from wealthy contributors or smaller gifts from broader community fundraising. Expenses associated with fundraising from a broader base of individuals may be significant in terms of "person hours," mailing, phone calls, etc. Raising money from individuals also may put one in "competition" with agencies that use fundraising as their main source of income and support (e.g., United

[1] Internet address: www.hrsa.gov
[2] Internet address: www.nal.usda.gov/orhp/
[3] Internet address: www.ahcpr.gov/
[4] Internet address: www.rjwf.org
[5] Internet address: www.fdncntr.org

Way) and which also address health care or social service missions. This speaks for careful consideration of collaborative initiatives rather than stand-alone competitive grassroots fundraising.

Delaware Rural Health Plan

Section VI
Risks and Uncertainties



Planning today to improve the lives of tomorrow

VI. Risks and Uncertainties

Introduction

Risks and uncertainties denote potential barriers to successful implementation of the RHP. By recognizing these, proactive strategies and planning may be undertaken to minimize risks of achieving less than full value through the RHP. While it is not possible to predict all the potential barriers to success for each initiative and policy recommendation in the RHP, it is nonetheless worthwhile to focus some attention on major anticipated areas of risk and uncertainty for the RHP as a whole. As specific projects are planned in more depth, stakeholders should determine which of the following concerns apply, or if other risks and uncertainties will present themselves and should be understood.

Potential Risks and Uncertainties

Market Risks

- Demographic/Epidemiological: The population characteristics of Sussex County are dynamic. Continuing change can be anticipated in age, socioeconomic status, race, and ethnicity mixes. Each sub-population has unique health needs and access considerations. While ongoing monitoring and planning efforts will help ensure accurate forecasts of these changes, the risk exists that services developed for today's population will not serve the changing population's health needs. Implementation of the RHP as currently outlined might then be irrelevant.

Strategic/Planning Risks

- Data Integrity and Availability: The relatively small population of Sussex County may create difficulties in analysis of health indicators and data at an optimal level of statistical significance. The RHP was significantly limited in its assessment of needs due to the unavailability of statistically valid information finer than state-level data. For this reason, some vital statistics data is regularly aggregated over multiple years in an effort to enhance its significance. When collecting data at the county or sub-population level (e.g., age bands, socioeconomic status, racial/ethnic sub-populations, etc.), stakeholders should therefore exercise caution in both data collection and interpretation. While failure to consider local data represents a profoundly flawed approach to planning, the limitations of that data can also be problematic. In the limited instances where reliable vital statistics data by county is available, important differences between counties and sub-county (urban) regions have been seen.

- Maintaining Focus: As indicated in Section I of the RHP, health status has a wide variety of determinants. A focus of improvement efforts on the provision of identifiable and direct health related services (e.g., access to care, more clinics, etc.) may result in overlooking infrastructure issues (e.g., clean air, clear water, sewer, fluoridated water, etc.) which are critically important to maintaining a healthy population. Failure to maintain focus in

multiple areas simultaneously risks uneven implementation or omission of important policies or initiatives.

Competitive Risks

- Service Area Competition: Providers, hospitals, and agencies naturally operate in competition with one another for many services. There are examples (among the hospitals, for instance) suggesting that this approach has resulted in improvements to health care in each service area despite a relative lack of coordinated planning at the county level. On the other hand, as the "bar is raised" to include more county-level policies and initiatives under the strategic influence of the RHP, there is potential that local competitive issues may interfere with coordinated action. RHP success will be driven by the relative ability of the three hospitals, as important leading health organizations, to maintain a commitment to working together on important county-wide health issues. If such collaboration is not achievable, the resulting gap in the commitment by the hospitals could be paralytic. Similarly, agencies and other providers that are unable to manage the delicate balance between local competition and county-wide collaboration may pose implementation risk to the RHP.

- Funding Competition: There will always exist some amount of competition among agencies for limited funding sources. In addition to a finite "pie" of dollars, structural elements of available funding mechanisms may contribute to competition. For example, human service agency directors' experiences indicated that while collaboration is encouraged by state funding sources from a strategic perspective, it may be discouraged operationally through funding rules and application requirements that make collaboration disadvantageous. To the extent that such "disconnects" or misalignments are present, there is risk that agencies will not collaborate at the level required for successful RHP implementation leading to health improvement interventions. The policies and initiatives recommended in the RHP represent more that any single agency can implement; funding that divides rather than amalgamates stakeholders poses implementation risk to the RHP.

Leadership and Staffing Risks

- Human Resources: Much of the work that needs to be done to implement the RHP will be performed by volunteers. This includes both individuals using "personal time" or organizations contributing staff and/or administrators to certain projects. There are a relatively small number of Sussex County residents who work on community health projects; many are already stretched thin. In any human resource intensive program, there always exists a risk that individuals will tire, become distracted or impatient, lose interest, or that sponsoring organization priorities may change. Staffing and leadership personnel can thus be lost.

- Collaboration: Launching successful policies and initiatives requires high levels of collaboration between and among community agencies and with governmental or non-governmental funders. Such coalitions are often difficult to convene, and even harder to functionally sustain. Program success may be limited when coalitions dissipate while

waiting for grant funding, or other support, to materialize. The potential for distraction and attrition of stakeholders is high since people (especially entrepreneurial people) typically want to ***do something***. If the ability to work on one initiative is slow or stalled, it is not uncommon for constituencies to seek other opportunities for fulfillment. "Re-recruitment" may be difficult due to lack of individual time or resources.

- Stewardship of the RHP*:* To date, DHI has provided the leadership necessary to complete and launch the RHP, meeting monthly as a Steering Committee. DHI membership is heavily represented by the hospitals' senior management, administrative staff, and board members. In addition, DPH, other state agencies, and community agencies (such as the United Way) are participants.

  The best DHI membership mix going forward is uncertain. This is not a negative comment regarding the skills and capabilities of the current DHI participants. Rather, the question reflects a deeper set of legitimate concerns regarding the fate of the RHP going forward: (1) "Do current members have the interest and skill sets required for RHP implementation?" (2) "Do the sponsoring organizations each share a commitment to provide staffing and leadership support for implementation?" (3) "What other stakeholders are available, or required, who could contribute meaningfully and are potentially interested in participating in DHI?" and (4) "If changes to membership are made, can the size, level of commitment and resource, and operability of DHI, be workable and successful?" These uncertainties, if not positively resolved, can become risks to RHP success.

- Broadening the Collaboration – Health Professionals: It may be advisable, for instance, to define a direct role for health care professionals (e.g., physicians, nurses, mental health providers, etc.) as RHP implementation supporters. Indeed, providers who may credibly "champion" specific issues may be valuable experts for individual projects. There is a profound need for participation of health care professionals who can influence their peers in the support of programs impacting county health. While essential to the process, such provider involvement is rendered difficult by economic realities as well as multiple conflicting demands for professional and personal time. Success on initiatives requiring professional time may be at risk if expansion of participation to include these providers cannot be accomplished.

- Broadening the Collaboration – Clergy: When behavior change is required, clergy can often provide the positive influence necessary to enable people to make changes and may also provide the important support system for personally making healthy lifestyle changes. Most significantly, the clergy are critical components of the overall "health" system as they are essential linkages between physical and spiritual health. The faith communities do not speak as one, however, and represent a spectrum of doctrine, philosophy, and tolerance of racial and ethnic diversity. Some faith leaders expressed disappointment regarding their inability to recruit their peers into greater involvement with health and social welfare issues. Others have indicated that some peer clergy can be the source of unintended counterproductive influences on behaviors in situations where rigid adherence to doctrine precludes positive engagement with "at risk" populations. While the availability of faith communities

represents an opportunity for leadership and support, the uncertainty about their positive engagement around the RHP represents a risk.

Operational Risk

- Sustainability of Effort: Given the comprehensive nature of the RHP, there is a risk that policy and implementation efforts will be started, but not sustained over the long term. This risk is also present for any projects that may be grant funded and led by a professional staff.

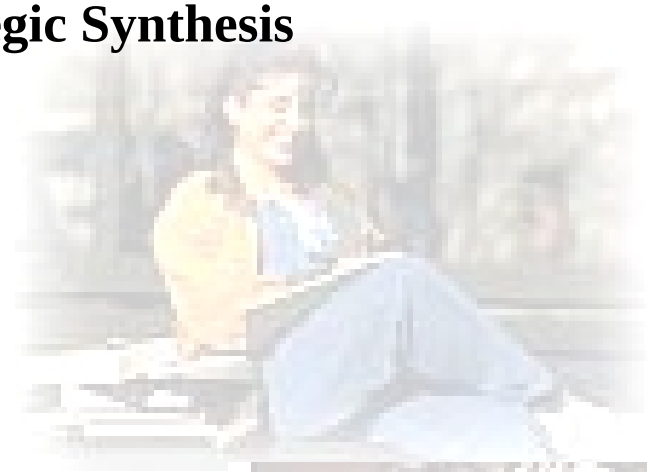
- Sustainability of Stakeholder Participation: Beyond leadership and staffing, ongoing stakeholder participation is essential to RHP success. Stakeholders provide important knowledge about needs and resources, as well as key expertise in effectively intervening for improvement. The Health Summit may be used to sustain stakeholder interest and energy, celebrate periodic progress, and assist in recruitment and retention of committed stakeholders. However, attendance at the Health Summits has diminished and it is uncertain if there is sufficient interest for future summits to be held. If stakeholder participation cannot be sustained, the RHP will be at great risk of failure.

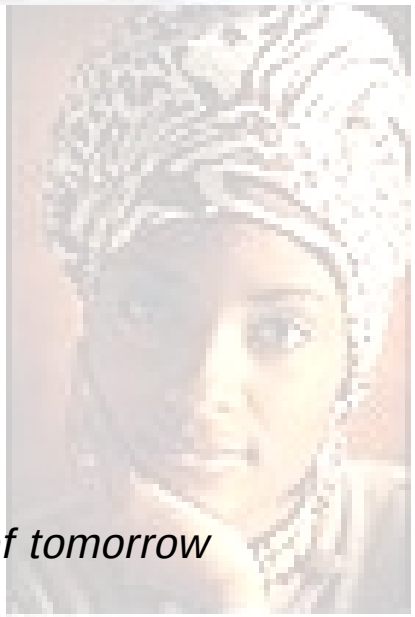
Financial Risk

- Policy and Initiative Funding: Obtaining and sustaining revenues to undertake policy development and fulfillment as well as initiative execution are the most tangible critical elements required for success. Whether it is obtained by public funding, grant funding, "in kind" contribution or investment by key participants (such as hospitals), successful maintenance of funding streams will be required to execute the RHP. While numerous funding strategies were considered in Section V, all are uncertain. As described in that section, sound financial planning, demonstrable public health "returns" on "invested funding," a continuing high level of knowledge and acumen in identifying and advantaging available funding sources, and maintaining sound performance metrics to demonstrate value are all required to hedge against funding crises.

Delaware Rural Health Plan

Section VII
Strategic Synthesis





Planning today to improve the lives of tomorrow

VII. Strategic Synthesis

Introduction

A strategic synthesis serves as a "double check" to ensure that a business plan considers and applies key strategic principles appropriately. The synthesis has been approached as a series of questions applied to "test" the integrity of the RHP. These same questions can, and should, be re-applied to specific strategies and initiatives developed in the course of implementing the RHP.

Principles/Tests of the RHP Strategy

1. Is the RHP strategy consistent with the environment?

Yes. Policies and initiatives recommended in the RHP were based in, and respond to, a thorough analysis of the unique nature and health care needs of Sussex County

2. Does the RHP strategy have consistent (internal) intent (e.g., "strategic fit")?

Yes. Strategies were developed for the RHP using a value chain context that assured an appropriate and consistent framework for policies and initiatives for increasing value in the form of health status improvement.

3. Does the RHP strategy focus existing or available resources?

Yes. The strategy focuses significantly on both understanding and leveraging existing and available resources. The gap analysis technique utilized indicates points of alignment, where existing resources meet needs, as well as areas of misalignment where additional resources (enhanced or new) should be focused.

4. Does the RHP strategy focus strength against weakness?

Yes. The strategy actively focuses the strengths of committed stakeholders and accountable entities, through county-wide collaboration addressing some of Sussex County's current deficiencies.

5. Does the RHP strategy address garnering resources effectively?

Yes. The RHP positively addresses resource development in its recommendations. The outcome of implementation will remain in doubt until practical tests are applied. The risks of implementation are addressed in Section VII.

6. Does the RHP strategy appropriately limit and evaluate risk?

Yes. Section VII anticipates and evaluates the major risk and uncertainty areas associated with implementation of policy changes and initiatives in the RHP. Development of collaborative

leadership and maintenance of stakeholder constituency participation has been identified as risk limiting strategies.

7. Is the RHP strategy controlled, and in control?

Yes. The RHP strategy for policies and initiatives reflects an approach that is feasible and manageable. It was constructed to provide realistic goals and to stress measurement and accountability as key controls. Despite this, it is clear that effective community health improvement requires a high degree of trust among stakeholders as well as substantial collaboration. While these factors are inherently difficult to control, the RHP has addressed those key controls that are most likely to contribute to stability.

8. Does the RHP strategy build on previous success and become stronger?

Yes. A central theme in the RHP is honoring and building upon the past successes of joint planning and action targeting improved health status. In addition, implementation of recommended policies and initiatives will solidify the core strengths of the health maintenance and delivery apparatus in Sussex County, thereby amplifying prior accomplishments. The synergistic contributions of many resources are recognized in Section II of the Plan.

9. Is there awareness and support for the RHP from community leaders?

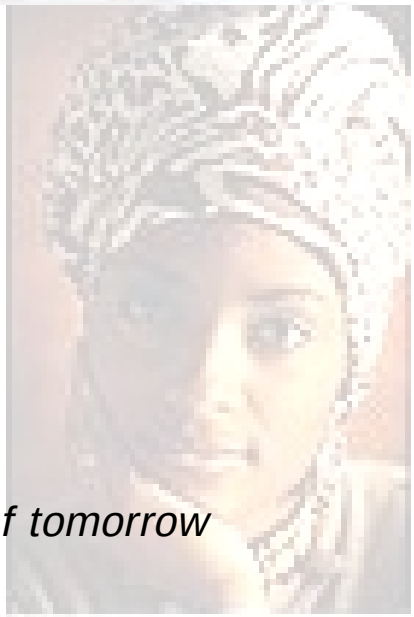
Yes. The RHP was nurtured and supported, in its development, by a multilateral constituency that included representation and participation from public health authorities, key provider entities, representative agencies, as well as a broad spectrum of stakeholders. Throughout the process of RHP development, care was taken to be inclusive, notably through use of multiple personal interviews, stakeholder and Steering Committee focus groups, and a widely publicized stakeholder retreat (Health Summit). However, broad dissemination of the RHP will only occur after it is published. The challenge to obtain broad based and ongoing community leadership support will begin at that time.

10. Does the RHP strategy build advantage for Sussex County?

Yes. The RHP clearly documents existing needs, resources, and service gaps and is designed to improve deficiencies and position Sussex County for a healthier, more productive, and higher quality future for its residents. It provides a guiding framework for making improvements with specific recommendations for how these can be instituted. This level of planning at a county level is unique. It may be the “raw material” for funding/grant support, which provides an opportunity for stakeholders to make drastic improvements in the population’s health status.

Delaware Rural Health Plan

Appendices



Planning today to improve the lives of tomorrow

Appendix A. Medicare Rural Hospital Flexibility Program (MRHFP)

Relevance to Delaware (Sussex County) Rural Health Plan

The Balanced Budget Act (BBA) of 1997 created the Critical Access Hospital (CAH) program. CAH constitutes a new and distinct designation category available for smaller rural inpatient facilities. Under the BBA Medicare Rural Hospital Flexibility Program (MRHFP), rural hospitals designated as CAH qualify for cost-based Medicare reimbursement under customized Medicare Conditions of Participation, in return for restructuring their clinical programs to conform to statutory limits on both inpatient lengths of stay and total bed count. Implementation of a CAH program at the state level requires the development of a Rural Health Plan approved by the Health Care Financing Administration (HCFA). The BBA designated State Offices of Rural Health as lead agencies and conduits for Federal funding in support of the CAH program.

Federal regulations governing the MRHFP provide states considerable latitude in some areas of the program, while constricting their authority in others. The CAH designation is available to existing hospitals, certain qualifying rural health clinics that wish to undergo conversion to inpatient facilities, and to recently closed/downsized (within 10 years) hospitals that wish to reopen as CAH. Hospitals may be of any ownership type (public, private, or not-for-profit), but must be located in a designated rural area, including those rural census tracts that lie within Metropolitan Statistical Areas (MSAs). Federal regulations specify a requirement for a minimal 35-mile distance from a CAH to the next nearest full service facility; however, states may bypass this test through the use of separate criteria for designating "necessary providers."

Applicability of MRHFP to Existing Facilities in Delaware

Each of the three Delaware counties encompasses rural areas. New Castle and Kent Counties, while part of the Wilmington MSA, have rural census tracts. Sussex County is outside of the MSA and is considered rural in its entirety.

None of the Delaware hospitals currently meet Federal guidelines for the CAH program, nor do they appear to be a good match for the program. CAHs must agree to limit their total bed count to 25, with no more than 15 acute patients at any one time and up to 10 "swing beds" available for patients receiving a skilled nursing level of care in the inpatient setting. In addition, the CAH length of stay must not exceed a limit of 96 hours determined on an average annual basis. With respect to bed complement, usage, and length of stay experience, the three Sussex County hospitals greatly exceed CAH requirements. According to the State of Delaware, Health Resources Management Plan (updated July 26, 1999), these rural Delaware hospitals are:

- **Bayhealth Medical Center**, with locations in Dover and Milford, operates as a not-for-profit community hospital. The Milford site, in Sussex County, is approved for 122 medical/surgical beds and 9 obstetrical beds.
- **Beebe Medical Center**, located in Lewes, operates as a not-for-profit community hospital. It is approved for 111 medical/surgical beds and 8 obstetrical beds.

- **Nanticoke Memorial Hospital**, located in Seaford, operates as a not-for-profit community hospital approved for 90 medical/surgical beds and 8 obstetrical beds.

None of the facilities is greater than 35 miles from the next nearest hospital. Due to this geographic factor as well as operating scope, none of the facilities is considered a viable candidate for CAH under either the MRHFP or this RHP.

Potential for New Facilities under MRHFP

In the future, there may be interest in developing new facilities as CAHs in Sussex County. Because the federal regulations do not permit facilities to open as CAHs, interested parties who may wish to build or convert a facility in an eligible location would first need to be licensed as a general acute hospital. For example, an area of Sussex County with a rising elderly population may be targeted for a CAH emphasizing outpatient services, but with a few acute care beds.

The requirement that a hospital must first be designated as a general acute facility permits the State of Delaware to evaluate specific proposals under its Certificate of Need (CON) process. As of the July 26, 1999 updating of the Health Resources Management Plan, no additional bed capacity is needed in rural Delaware.

Should additional bed capacity be considered through the CAH designation, application of the "necessary provider" provision will mirror the review criteria for general hospital CON, including:

- The relationship of the proposal to the Health Resources Management Plan;
- The needs of the population for the proposed project;
- The availability of less costly and/or more effective alternatives to the proposal including alternatives involving the use of resources located outside the State of Delaware;
- The relationship of the proposal to the existing health care delivery system;
- The immediate and long-term viability of the proposal in terms of the Applicant's access to financial, management, and other necessary resources;
- The anticipated effect of the proposal on the costs of, and charges for, health care; and
- The anticipated effects of the proposal on the quality of health care.

Should a proposed new facility receive CON approval, it will automatically be considered a "necessary provider" by the State and thus become eligible for CAH designation under the MRHFP independent of other geographic considerations. Its review and licensure will follow all applicable state and federal law.

Appendix B. Northland Health Group (NHG)

Brief Overview of the Firm

NHG is a healthcare consulting firm with offices in South Portland and Bangor, Maine. Founded in 1985, the firm's professionals have developed expertise in the areas of healthcare strategic planning and implementation, rural healthcare, integrated delivery/financing system development, provider network development, medical practice management, and physician-hospital relations. For work on the RHP, NHG subcontracted with Westport Group, another Maine-based rural health care consulting practice, which provided support for some sections of this Plan.

Rural healthcare is a principal focus for NHG. The firm's clients have included State Offices of Rural Health; rural hospitals, health centers, physicians, and other providers; and larger institutions serving as referral centers and/or seeking affiliations with rural providers. Additional descriptive information regarding NHG, including staff, publications, and resources on rural health, can be found at the firm's Internet site: www.nhgmaine.com or by contacting the firm directly at:

7 Ocean Street
South Portland, ME 04106
Tel: 207-767-7500
FAX: 207-767-7504
E- mail: srb@nhgmaine.com

Project Staffing

Stephen Blattner, MD, MBA (Senior Consultant): Dr. Blattner served as project manager. He was principal liaison to the Steering Committee and participated in conducting on-site interviews, facilitating the stakeholder focus groups and retreat, and was a principal author of the Rural Health Plan. His interests and experience include: strategic and hospital program planning, rural health planning, organizational and patient care program development, quality improvement programs, medical staff affairs (organization, relationships, leadership, and credentialing), regulatory and accreditation compliance.

Brian Haapala, MHSA (Consultant): Mr. Haapala provided data analysis support, participated in conducting on-site interviews, facilitating the stakeholder focus groups and retreat, and was a principal author of the Rural Health Plan. His experience includes: small rural hospital planning, operations development, business planning, applying quantitative data to decision-making processes, and health policy analysis.

Jonathan Sprague, MS (Partner): Mr. Sprague served as a senior advisor to the Rural Health Plan. He works with health care organizations, communities, and physicians in strategic planning with engagements ranging from large hospitals to small physician practices and health

businesses. He has in-depth experience with health systems development and hospital-physician relations and has worked on engagements in southern Delaware for many years.

Karen Travers (Westport Group): Ms. Travers assisted the NHG effort by investigating and reporting on the needs of special populations for the Rural Health Plan. She specializes in the development of multi-provider rural health networks, and in the regulatory and reimbursement strategies available to support this development. She provides services in the areas of grant writing, practice management, health care plan design and development, Board training, quality assurance programs, and cost reimbursement options.

Appendix C. Value Chain Detail

The value chain for rural health care was introduced and defined in Section I. This model served as the basis for framing the needs and resources analyses and for developing recommendations and funding strategies for the RHP. The schematics which follow present explanatory details of the individual components of the model. The examples shown are not exhaustive, but provide the reader enough detail to understand key aspects of the value chain model.

Note that expressed linearly along the top of the value chain are the ***direct services, projects, and initiatives*** that directly result in the "production" of health care delivery. They include:

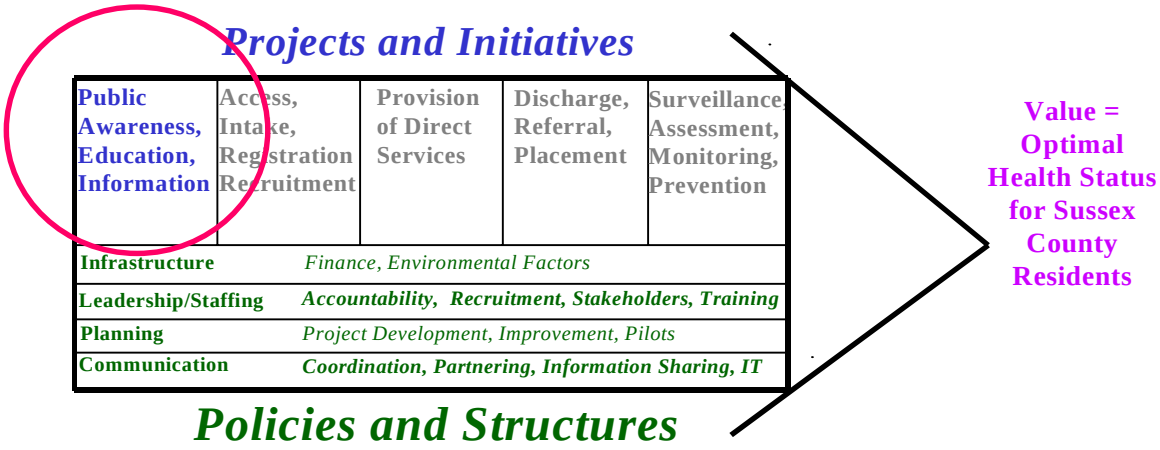
- Public awareness, education, and information;
- Access, intake, registration, and recruitment;
- Provision of direct services;
- Discharge, referral, and placement; and
- Surveillance, assessment, monitoring, and prevention.

Expressed vertically under the direct activities (and literally "supporting them") are the key ***supporting structures or policies*** which enable direct value production in each primary area. These include:

- Infrastructure;
- Leadership and staffing;
- Planning; and
- Communication.

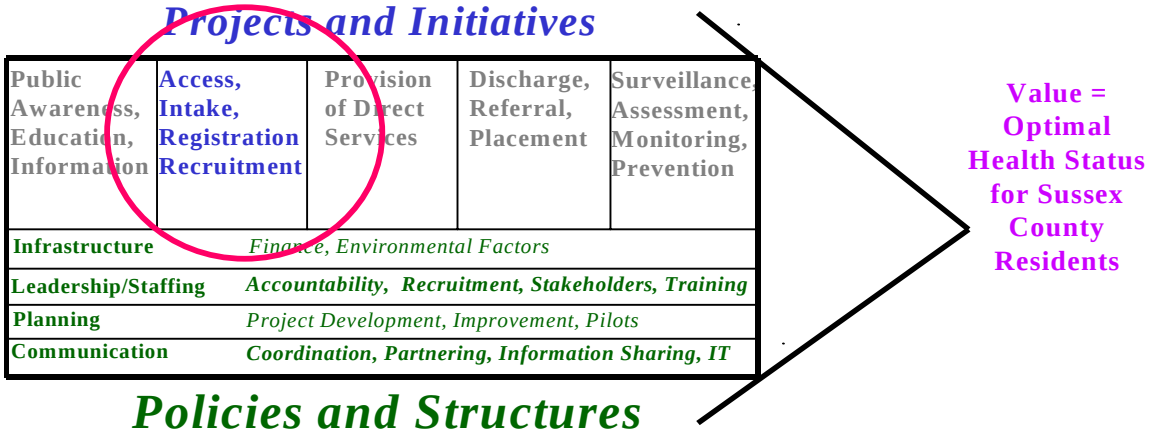
Public Awareness, Education, Information

- **There is broad public awareness of services, including location, availability, cost, etc.**
- **Consumers can learn more about services from readily available materials.**
- **Advocates are knowledgeable about where to obtain informational materials**
- **Information about services is accessible to consumers of different cultures**
- **Providers and services have knowledge about complementary services and programs**



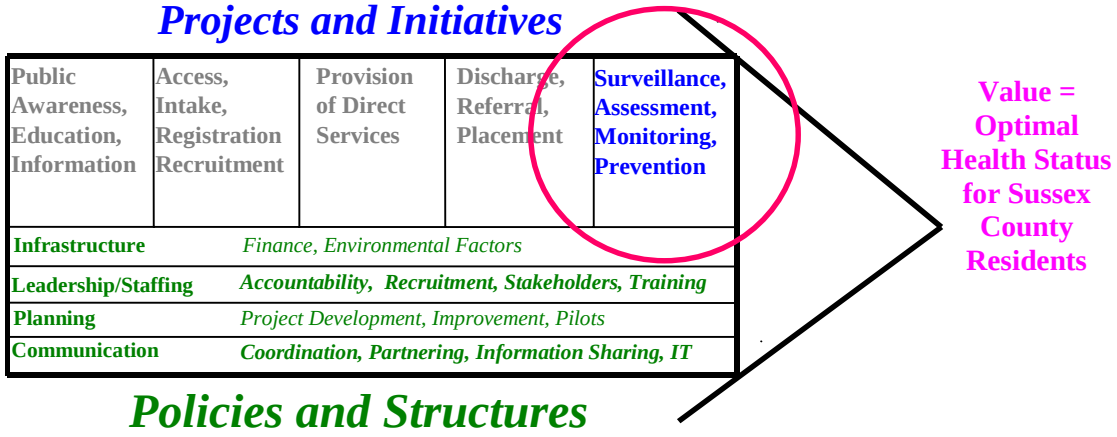
Access, Intake, Registration, Recruitment

- **Service/program is geographically and physically accessible**
- **Intake procedures function efficiently**
- **Intake and access function well for consumers of different cultures**
- **Collateral providers and services are aware of the intake requirements and provide consumers with the necessary prerequisites for intake**
- **Consumers are actively encouraged to participate in the program or service**



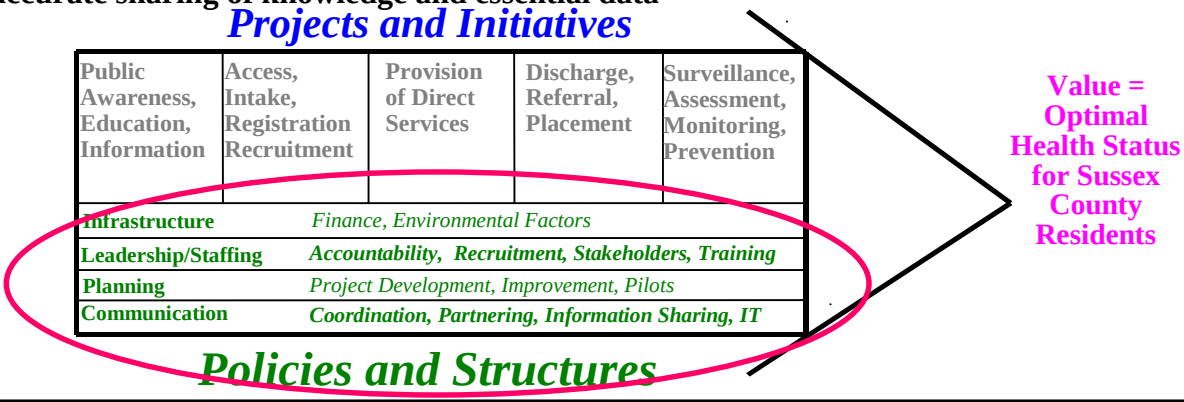
Surveillance, Assessment, Monitoring, Prevention

- **Systems are in place to provide information to planners, providers, and consumers about the overall functionality of the program or system of care**
- **An ongoing process exists for comparing outcomes to "standard" or "benchmark" performance**
- **There are mechanisms to promote performance improvement**
- **Anticipatory care and programs are in place to prevent and avoid further health complications**



Infrastructure, Leadership, Staffing, Communication

- **Infrastructure: Sufficiency of resources in terms of system capacity, human resources, finances, etc.**
- **Leadership and Staffing: Leaders have vision, are capable, competent, and are held accountable for health system development; Training, credentialling, and ongoing education programs are present for staff.**
- **Planning: Leaders translate and execute their visions into specific projects and initiatives and can execute strategies**
- **Communication: Communication within the organization and/or between system components is prioritized and functional; Information systems support the efficient and accurate sharing of knowledge and essential data**



Appendix D. Stakeholders Contributing to the Rural Health Plan

Prue Albright	Division of Public Health
Cathy Anderson	Easter Seals
Jo Ann Baker	Division of Public Health
Chris Bauer	Nanticoke Health Services
Don Berry	Division of Management Services, Health Statistics Center
Michael Berry	Delaware State Police
Sgt. Sheri Benson	Delaware State Police
Steven Blessing	DPH/Office of Emergency Medical Services
Gene Bookhammer	Beebe Medical Center Trustee
Letia Boseman	Division of Public Health
Joan Boyce	Greater Millsboro Chamber of Commerce
Mary Bradley	Sussex Central Wellness Center/Bayhealth Medical Center
John Bryant	Division of Social Services
Norene Broadhurst	Beebe Medical Center
Judith Ann Chaconas	Delaware Health Care Commission
Germaine Chapis	Division of Public Health
Richard Cherrin	Visiting Nurses Association
Linda Chick	Southern Delaware Community Health Partnership, Inc.
Don Clark	Nanticoke Health Services/Retired
Elsburgh Clarke, M.D.	Bayhealth Medical Center
Alice Davis	Perinatal Association
Dee Davis	Children and Families First
Barbara Debastiani	Division of Public Health
Nancy Diehl	United Way of Delaware
Elizabeth Dubravcic	Division of Alcoholism, Drug Abuse, and Mental Health
Florence Fickes	Division of Public Health
John Forest, M.D.	Delaware Institute for Medical Education and Research
Stephany Foster	Electronic Data Systems liaison to DE Healthy Children
William Gallery, DVM	
Edward Goate	Central Delaware Community Health Partnership, Inc.
Kent Gory	CHEER Home Services
Anne Green	Dental Hygienist
Vonda Green	Helping Hands Wellness Center Physician
Leatha Gregory-Foreman	Division of Social Services
Pat Gunnin	Boys and Girls Club
Susan Gumbs	Division of Alcoholism, Drug Abuse, and Mental Health
Eileen Gureke	Division of Public Health

Appendix D. Stakeholders Contributing to the Rural Health Plan

Barbara Hanson	Division of Social Services
A. Leroy Hathcock	Division of Public Health
Renata Henry	Division of Alcoholism, Drug Abuse, and Mental Health
Catrina Hinds	Division of Youth Rehab Services
Rev. John Hird	Beebe Medical Center Trustee
Wallace Hudson	Beebe Medical Center
Bishop Major Foster	Philadelphia Pentecostal Church
Gloria James	Division of Public Health
Rev. Leslie James	First State Community Action Agency
Theodore Jarrell	Bureau of Health Planning & Resource Management
Bob Jewitt	First State Community Action Agency
Kae Johnson	Division of Public Health
Rev. Kurt Johnston	First Presbyterian Church, Milford
Debbie Jones	Sussex County Emergency Medical Services
Finley Jones	Sussex County Council
Eleanor Kane	Division of Aging and Physical Disabilities
Traci Kasten	
John Kennedy	Division of Public Health
Gregory Kenyon	Perinatal Association of Delaware
Michael Kersteter	People's Place
Margot Kia	VISTA/DTCC/Owens
Judy Knutstad	Bayhealth Medical Center
Paul Lakeman	Bayhealth Medical Center
Maureen Leary	AIDS Association - Rehoboth
Ann Lee	Delaware State Police
James Lewis	La Esperanza
Joe Liefbroer	Johnson Wax
Arlene Littleton	Sussex County Senior Services
Cindy Madden	Delmar Wellness Center/Nanticoke Health Services
Lisa Marcum	Division of Public Health
Dianna Maredo	Coventry Health Care
Colonel Mike Martin	Dover Air Force Base
Gonzalez Martinez	La Esperanza
Walter Mateja	Division of Alcoholism, Drug Abuse, and Mental Health
Gregory B. McClure	Division of Public Health
Bill McGowan	Cooperative Extension, UD
Ross Megargel, DO	Office of Emergency Services
Anthony Mellone	Perdue Farms
E. James Monihan	Beebe Medical Center

Appendix D. Stakeholders Contributing to the Rural Health Plan

Renee Morris	Nanticoke Health Services
Charles Moses	Southern Delaware Community Health Partnership, Inc.
Renie Mullaney	Nemours Children's Clinic
Loretta Newsom	Division of Public Health
Gina Perez	Division of Public Health
Barbara Peterson	Bayhealth Medical Center
Deborah Pfaffenhauser	Bayhealth Medical Center
Maria Picazo	La Esperanza
Anthony Policastro, M.D.	Nanticoke Health Services
Joan Powell	Division of Public Health
Mariann Powell	Perinatal Association
Polly Pusey	Seaford Wellness Center
Betsy Reamer	Lewes Chamber of Commerce
Allen Reese	AIDS Delaware
Carol Reid Hall	The ARC of Delaware
Francisco Rodriguez	Nanticoke Surgical Association
Paula Roy	Delaware Health Care Commission
Michael Schnyder	Office of Emergency Services
Donna Shaffer	Cape Henlopen Wellness Center/Beebe Medical Center
Gail Short	Woodbridge High School
Paul Silverman	Division of Public Health
Val Siktar	Sussex Family YMCA
Debra Singletary	Delmarva Rural Ministries, Inc.
Melinda Sletter	
Beverly Smith	Division of Public Health
Carol Smith	
Bill Stevenson	DPH/Office of Emergency Medical Services
Lois Studte	Southern Delaware Community Health Partnership, Inc.
Suzanne Tait	Coventry Health Care
Richard Tator	Division of Public Health
Terry Tipton	
George Torbert	Sussex County Emergency Medical Services
Harold Truxton	Ellendale Civic Association
Sally Van Schaik	Easter Seals-Georgetown
Mary Lee Verdi	Beebe Medical Center
Alma Villalobos	Nemours Children's Clinic
Penny Vlach	Delaware Healthcare Association
Sandi Voss	Bayhealth Medical Center

Appendix D. Stakeholders Contributing to the Rural Health Plan

Gary Webb	Division of Public Health
Joan Weinman	Delaware Helpline
Beth Wetherbee	Division of Public Health
Betsy Wheeler	Management Concepts, Inc.
Linda Wolfe	Department of Education
Terrance Zimmerman	Division of Public Health

Appendix E. Table of Authorities

Introductory Note:

The RHP analysis and recommendations rely heavily on a substantial body of prior analysis and research regarding the health status and needs of Sussex County residents. The authors reviewed an exhaustive library of such resources. While many were of great value, the utility of others was more modest due to a variety of methodologic, technical, or "age of findings" limitations. The sources listed below represent those which were most relevant and applicable to development of the RHP.

Community Mental Health Services Block Grant FY 1999 State Plan: Implementation Report; Delaware Health and Social Services, Division for Alcoholism, Drug Abuse and Mental Health; November 29, 1999.

Community Prioritization in Delaware; by Don Berry & Ted Jarrell; July 28, 1998.

Delaware Emergency Medical Services: Report to the governor and General Assembly; Improvement Committee; May 26, 1999.

Delaware Health Care Commission: Delaware Institute of Medical Education & Research; Report from the DIMER Committee on Rural Health to the DIMER Board of Directors October 1999.

Delaware Population Consortium, Annual Population Projections; Delaware Population Consortium; July 1, 1999.

Delaware Vital Statistics Annual Report 1998; Delaware Health Statistics Center; Dec. 1999

Delawareans Without Health Insurance 1998; by Edward C. Ratledge; May 1999.

Dental Care: Access Improvement Project; Draft Summary of Presentations and Staff Research.

Dentist in Delaware 1998; by Edward C. Ratledge.

EMS System Review; Prepared for Office of the Governor (State of Delaware); Dec. 1998

Final Report: Focus Groups of School Based Health (Wellness) Centers; Research Dept., Family Planning Council; June 1999.

Health Needs Assessment; Western Sussex County; Richard Tator, DPH Clinic Manager & Jan Crouch, Prevention Team Leader.

Health Resources Management Plan; Delaware Health Resources Board; 1995.

Appendix E. Table of Authorities

Health Status Assessment; Kent and Sussex Counties: Southern Delaware Partnership

Healthy Delaware 2000; Delaware Health and Social Services, Division of Public Health; January 1994.

Healthy Delaware 2010: Summary of Stakeholder Interviews and Focus Groups; Prepared by the Public Health Foundation.

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Hospital Discharge Summary Report; Delaware Health and Social Services; 1992-1998.

Kids/Families Count in Delaware; Family Services Cabinet Council Fact Book; 1999.

Needs Assessment; Georgetown and Southeastern Sussex.

Primary Care Physicians in Delaware; by Edward C. Tatledge; 1998.

Report on the Strategic Assesment of: Care & Services for Adults with Disabilities in Delaware; Sponsored by Longwood Foundation under the Leadership of Easter Seals of Delaware and Maryland's Eastern Shore.

Southern Delaware Health Survey; Beebe Medical Center; February 10, 1997.

Appendix F. Summary of Notes for Policy and Initiative Development

Introductory Note:

The table in this Appendix contains an "unprocessed" cumulation of all stakeholder commentary and relevant source findings which served as background for RHP recommendations. It served as the earliest draft or outline for Section III of the plan. The material is generally organized along the same dimensions of analysis as the RHP however no attempt has been made to formally structure or edit it. Inputs for this table included:

- Stakeholder Interviews
- Steering Committee Focus Groups
- Notes from Source Materials
- Stakeholder Focus Groups
- Stakeholder Retreat Work Group Output

This material is provided in order to document and preserve those inputs which informed the RHP but did were not directly retained in the form of policy or initiative recommendations. This was generally either due to lack of consensus, duplication, lack of feasibility, or the fact that they were already being addressed by other projects or initiatives. As DHI and accountable entities explore specific recommendations, it may be useful to examine these inputs for opportunities and/or guidance regarding the breadth of scope of their activities

Appendix F. Summary of Notes for Policy and Initiative Development

- **Table 1: Summary of Notes for Policy and Initiative Recommendations - By Life Cycle**

Key Identified Needs Areas	*Policy Notes – REC'S TO BE DEVELOPED*	*Initiative Notes – REC'S TO BE DEVELOPED*

1. Infants-Perinatal (age <1)
• Rising infant mortality for past two 5-year cycles (1993-1997 and 1994-1998) as compared to State – most striking in white population
• LBW paralleled by State rates which are driven by births to teen and African-American females
  • BUT in Sussex County, LBW to white mothers exceeds that of State or US
• High births to single mothers compared to State and other counties
	Infants-Perinatal (age <1)
	1. Support for PRAMS/AAPP/Prenatal Board initiatives and activities – expand monitoring activities in Sussex County
	2. Prenatal Care Access and Outreach policies
	3. Low Birth Weight (Related to prenatal care, access, and teen pregnancy) policy initiatives
	4. Must study the results of fragmentation that occurred when managed care decentralized the maternal child health care system (i.e. the one stop system) *
	5. Change reimbursement to Ob/Gyn physicians as they relate to first trimester services and "presumptive eligibility" - correct disincentives to provision of first trimester care to indigent mothers. Current policies requiring physicians to honor presumptive eligibility should be enforced.
	6. Advocate for policies to implement wellness centers in Middle Schools and to provide a comprehensive human sexuality curriculum, age appropriate for all grades.
	7. Advocate for improved transportation services.
	8. Develop a study to measure other health indicators as contributors to low birth weight and infant mortality and develop prevention services accordingly.
	9. Develop and expand leadership to existing committees. These include:
	  • Western Sussex Coalition
	  • Perinatal Board (which maintains a Kent/Sussex Outreach Committee)
	  • Alliance for Adolescents (prevention)
	  • Title X agencies (family planning)
	  • Others
		Infants-Perinatal (age <1)
		A. Prenatal Care initiatives
		B. Insurability initiatives
		C. Teen pregnancy initiatives (see Adolescent Lifecycle Needs)
		D. Projects which address reduction in births to single women OR support systems for non-traditional families (?Hispanic Pop)
		E. Genetic Counseling initiatives
		F. Resource mother/father programs – expansion and creation
		G. Insure bi-lingual services and geographic access at clinic services.
		H. Use non-traditional methods to get health related information in the hands of teens. (For example, computer screen savers and LCD Banners in the school cafeterias.)
		I. Look at marketing materials and information in non-traditional ways to improve access. These include evenings, and Saturdays and locations like the mall. And maximizing "One stop" service availability
		J. Planning and leadership could be improved/expanded by staffing existing health committees that have solely relied on volunteers and state public health employees.
		K. Expansion of the voucher system would improve access to care when presumptive eligibility is not accepted.
		L. Improve and/or coordinate pregnancy prevention outreach/education after the first pregnancy.
		M. Leverage SBHCs and extend availability of sexuality services
		N. Use curricular vehicles to disseminate data and trends to school aged children

Appendix F. Summary of Notes for Policy and Initiative Development

Key Identified Needs Areas	***Policy Notes – REC'S TO BE DEVELOPED***	***Initiative Notes – REC'S TO BE DEVELOPED***

2. **Children (ages 1-12+)**
• MCH Grant documents needs and approaches very well – should be supported in RHP
• Special Health Care Needs population
  • Inadequate services for OT, PT, Speech therapy needs
  • Child care needs for population believed to be inadequate and currently under study
  • Care coordination and management deficiencies in children > age 3 with special needs
• Culturally and racially compatible specialty care access inadequate
• Child development problems as a potential indicator/marker of family substance abuse should be explored
Adolescents (age 13-19)
• Teen live birth rates well above US, State, and County rates for both younger and older teens
  • White teen rates rising whereas US is falling.
  • African-American teen rates falling at a rate similar to US and greater than State
  • Rates in several census tracts (Bridgeville, Selbyville, and Laurel) stand out as extraordinarily high
• Many teen Primary Health Care needs not met as determined through interviews and school based health clinic (SBHC) data
• High School dropout rates exceed State and other Counties for all ethnic and racial groups except Hispanic
• Self reported substance use in older adolescents exceeds State and rise from grade 8 to grade 11 exceeds State increase
	Children (ages 1-12+)
	• Support MCH grant initiatives
	• Seek balance in resources currently disproportionately focused on NCC
	• ? Potential for expansion of duPont/Nemours role
	Adolescents (age 13-19)
	• As a matter of policy, stress community and family focus for priority funding and development. Project development should be supported in such in improving areas such as:
	  • Family communication
	  • Mental behavioral health services
	  • Parenting classes and educational initiatives
	  • After school activities and recreational opportunities
	  • Job initiatives for teens
	• Support School Based Health Services
	  • Extend services to middle and elementary school level
	  • Enhance mental health services
	• Support sex education initiatives
		Children (ages 1-12+)
		• Any task force addressing child and adolescent needs should include this age group.
		Adolescents (age 13-19)
		• Downstate presence for AAPP should be increased
		• Teen Advisory Panel for public policy input from youth
		• PCP education initiatives re: adolescent health
		• Scholarships for "at risk" youth
		• Develop mentoring programs linking youth with peers, business community, adults
		  • Support and extend SEED (Student Education and Economic Development)
		• Teen Crisis line / peer counseling programs?
		• Support extended DPH clinic services in "adolescent friendly" ways
		  • Extended hours (incl summer)
		  • Enhance confidentiality preserving approaches and services
		  • Dispense contraception and STD treatment at point of service

Appendix F. Summary of Notes for Policy and Initiative Development

Key Identified Needs Areas	***Policy Notes – REC'S TO BE DEVELOPED***	***Initiative Notes – REC'S TO BE DEVELOPED***

Adolescents (age 13-19) (cont)
• Teen mental health needs not adequately met based on interview findings. Thirty six percent (36%) of SBHC visits are for mental health
  • No eating disorder services
• SBHC limitations
  • SBHC need to be started at elementary or middle school level
  • Handoff post graduation to PCP inadequate
• Children with special health care needs
• Homeless adolescents an increasing problem in Sussex
	Adolescents (age 13-19) (cont)
	• Continue to support recruitment of adolescent trained providers in key areas
	  • Mental health
	  • Primary care
	  • OB/GYN
	• Integrate data on adolescent substance use, STDs, and pregnancy into academic curriculum to increase awareness
	• Increase public service programming re: key adolescent issues
	• Engage churches/faith leaders proactively and in an organized fashion based on Strong Communities model
	• Alignment of school response to truancy with appropriate incentives to remain in school
	• Support continuation/extension of community policing models
	• Task Force, including MCO Medical Directors to address needs broadly
	  • Suggested initial collaborators:
	  • DPH and DHI
	  • MCOs
	  • Faith communities
	  • Hospitals
	  • DADAMH
		Adolescents (age 13-19) (cont)
		• Achieve consensus and commitment to on capture and report County and ZIP level data to assist planning of services for youth – create performance instrument panel to assess efficacy of interventions
		  • SBHC intake and contact statistics
		  • SBHC focus group findings
		  • Alliance for Adolescent Pregnancy
		  • Information from Youth Development Model (Wilmington DPH pilot)
		  • DCMHS
		  • Nontraditional hours for SBHC (weekends, evenings, summer)
		  • Easier links to complementary services from SBHC
		  • Enhanced MH services at SBHC

Appendix F. Summary of Notes for Policy and Initiative Development

Key Identified Needs Areas	***Policy Notes – REC'S TO BE DEVELOPED***	***Initiative Notes – REC'S TO BE DEVELOPED***

3. Adults (age 20-64):
• Overall Mortality
  • Sussex County exceeds State and US mortality rates for all adult age bands except 35-44.
  • Sussex County mortality rates exceed State and US across all age groups for cancer, heart disease, motor vehicle accidents (MVA).
• Cancer
  • Mortality for all invasive cancers combined is high for Delaware compared to US (SEER). DE ranks 2nd in US for SEER cancer mortality/100,000 (194 v 170)
  • DE cancer mortality rates are 2nd highest in US (1992-1996 SEER data)
  • Mortality from lung prostate, colorectal, cervical, and lung cancers extremely high in State
  • County level incidence largely mirrors the State (Vital Statistics data)
  • African-American cancer mortality rates significantly exceed African-American US rates for all cancers combined and specifically for lung, colorectal, prostate and cervical cancers
  • African-American men (lung, prostate, colorectal) and African-American women (cervical) predominate in excess mortality
• Heart Disease
  • Sussex County death rates from CHD exceed State rates. Cardiac disease is most frequent cause for hospitalization
	Adults (age 20-64):
	• Target healthy lifestyle promotion and awareness programs and public education to county level BRFSS data – address:
	  • Smoking cessation emphasis
	  • Diabetogenic diets and lifestyles
	  • Screening of high risk populations
	  • Recruitment of high risk individuals into programs
	  • Physical exercise promotion
	  • Foot care, retinal care, self management support for diabetics
	  • Injury prevention (target MVA)
	• Safety education beginning in schools aimed at accident prevention in adulthood
	  • Child safety initiatives
	  • Driver education curriculum strengthening for MVA prevention
	• Trauma Center (each Sussex County hospital) based prevention and education initiatives aimed at reducing MVA fatalities
	  • Population wide awareness and education
	  • PCP
	  • Population
	• Cervical cancer screening and education for African-American females
	• Education, awareness, screening for African-American males
	• Engage industry (business) in a constructive dialogue regarding workplace safety, primary care provision, and strategic spending of their health care dollars
		Adults (age 20-64):
		• Ongoing commitment to obtain and report BRFSS county level data
		• Use tobacco settlement funds for patch "give away" program

Appendix F. Summary of Notes for Policy and Initiative Development

Key Identified Needs Areas	***Policy Notes – REC'S TO BE DEVELOPED***	***Initiative Notes – REC'S TO BE DEVELOPED***

Adults (age 20-64) (cont):
• Lifestyle and controllable risk factor issues predominate (BRFSS) as predisposing factors
  • Smoking
  • Overweight
  • Hypertension
• MVA/MVC
  • No seat belt use
  • OUI/DWI
• Diabetes
  • All ethnic groups in Sussex County exceed US mortality rates
  • African-American females in Sussex County have a strikingly high mortality (> 50/100,000) which exceeds State (40) and US (28) rates
• STD rates
  • State rates for AIDS deaths, syphilis, chlamydia, and gonorrhea exceed US rates
  • Sussex County rates for syphilis, gonorrhea, and chlamydia exceed State rates
• Increase focus on occupational health is needed both in terms of injury prevention as well as primary care encouragement
• There is concern about female unintentional injury rates and the degree to which they are both unrecognized and may indicate a more serious and dangerous underlying pattern of abuse		

Appendix F. Summary of Notes for Policy and Initiative Development

Key Identified Needs Areas	***Policy Notes – REC'S TO BE DEVELOPED***	***Initiative Notes – REC'S TO BE DEVELOPED***

4. Geriatric (age 65+):
• Rapidly growing elderly population anticipated to continue through 2010
  • Greatest growth rate will be in the > 85 age band
• Mortality rates for elderly population in Sussex County exceed State and US in all > 65 age bands
  • Rates significantly higher than State and US for pneumonia and influenza and MVA
• Striking lack of data to support understanding of needs or resources
• Understanding or resource development
• Anecdotal (interview) data suggests needs in:
  • Primary Care
  • Geriatric Specialties
  • Home Care
  • Transportation
  • Social activities
  • Behavioral Health Services for elderly and their families; including coping issues
• Need for geriatric specialists and primary care physicians interested in the elderly
• Access and intake considerations
• Planning needs for elderly and populations growth
	Geriatric (age 65+):
	• Planning and study needs are significant at State and County level – data needs to be generated to characterize geriatric needs
	  • DASAPD/Univ. Of Delaware study needs Sussex focus and data
	• Coordinate/pool transportation for elderly
	• More geriatricians should be recruited as specifically that specialty - not lumped in with "Primary care".
	  • Accountability for this should initially include DHSS/DAAPD/DPH and Rural Primary Care recruiters
	• Utilize geriatric nurse practitioners as physician extenders and to lessen some of the cultural barriers older females may have.
	  • Accountability for this should initially include the Medical Society and Hospitals.
	• Use older volunteers from AARP or CHEER to accompany elderly patients to physician visits to ensure communications between elderly and their physican so that diagnosis and treatment are comprehended correctly.
	  • Accountability for this should initially include "neighbor to Neighbor" (MMH), AARP, Cheer.
	• Home health providers are adequate, the number of visits the MCO's will pay for is not, esp. for homemakers. AARP could lobby for this change, and engage MCO Medical Directors as well as DHSS/DAAPD
	• DHSS/DAAPD should be charged with data collection on elderly health needs by county.
		Geriatric (age 65+):
		• Count geriatricians when measuring primary care needs
		Suggested Accountability:
		• DPH and Hospitals
		• Medical Ombudsman to accompany elderly patients to medical visits
		• Establish communications vehicle between care systems for the elderly
		Suggested Accountability:
		• DPH and Hospitals
		• CHEER,AARP
		• Faith communities
		• Needs data focused on elderly must be collected and monitored for Sussex County
		Suggested Accountability:
		• DPH and Hospitals
		• CHEER, AARP
		• The problems are LOCAL and cry for customized local planning. DHS/DPH/DAAPD should dialogue to solve the issues collaboratively. We suggest an annual Geriatric Summit.
		• Any resource directory effort should include a specific geriatric section

Appendix F. Summary of Notes for Policy and Initiative Development

Table 2 : Summary of Notes for Policy and Initiative Recommendations - By Service/Provider Category

Need/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***

1. Primary Care
• Data and analysis from DPH/Univ Del Survey (1998) and DIMER report (10/99)
• Sussex County currently qualifies under as a Federal MUA. Additionally, northern Sussex qualifies as a primary care shortage area. These are based on population and FTE available
• BUT: Confusing and contradictory information exists re: access to practitioners and practices:
  • Open v. closed
  • Insurance acceptance and participation
  • FTE v. productivity v. capacity
  • Absolute v. relative access
  • Timing/hours of operation
  • Physical access
  • Cultural accessibility (Hispanic population)
  • Additional resources are required by elderly populations
• Lowest use of mid-level practitioners in State
• Mal-distribution issues – are there some areas of over-saturation??
• Disparity between study data and consumer perception
• Planning Improvement Needed
• Communications Enhancement
• Access and Intake Deficiencies
	Primary Care
	• Improved data capture and maintenance re: PCP practice and capacity characteristics
	• Support 1999 DIMER report policy initiatives
	  • Monitor supply of PCP and tailor DIMER recruitment initiatives to need as it evolves
	  • Improve use and acceptance of mid-level practitioners
	  • Encourage minority candidates for professional education
	  • Study and utilize alternative access strategies to address transportation and other socio-economic barriers to access
	  • Consider creation of centralized recruitment clearing house
	  • Explore loan repayment programs as recruitment strategy
	  • Study and consider use of hospitalists
	  • Monitor and support the Downstate Residency Rotation Pilot
	  • Better coordination of existing planning efforts - DIMER, Healthy Delaware 2010, DPH, Hospitals, etc.
		Primary Care
		• DEDO (Delaware Economic Development Office) "relocation packet" should include *Finding a Doctor* section informed by improved practice characterization
		• Create "PCP finding" advocacy services as a collaborative hospital initiative in each catchment area
		• Renewed attempts to create functional annual or biennial PCP surveys as part of licensure renewal
		• Further leverage J-1 Visa Program
		• Form Steering Committee for broad ongoing planning to address:
		
		Eligibility and Intake Level:
		  • Simplify access DHCP-enrollment
		  • Increase Case Management Services and Provider Communication
		
		Provider Level Access:
		  • Surveillance & Monitoring-Consistent measurement of access and outcomes across all access points for a reasonable length of time (longer than one month).
		  • Linking office staff with information regarding access to available services.
		  • Surveillance & Monitoring-Identify reasons for access barriers
		  • Extend office hours through the promotion of non-physician clinicians (NPs & PAs)

Appendix F. Summary of Notes for Policy and Initiative Development

Need/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
		Primary Care (cont.) • Coordination of education, intake, and discharge referral that results in timely and adequate access Transportation Level Access: • Engage DOT • Bring services to the community • Increase use of mobile, community based, services **Suggested Accountability:** • Jointly DHCC/DHSS-DPH • Include DIMER, Hospitals, etc.
2. Dental • DHC report confirms Sussex County meets MUA criteria • There is a shortage of culturally compatible dentists for special populations (Hispanic, African-American) • The situation for dental care is likely to deteriorate due to planned retirements	**Dental** • Enable/encourage community recruitment efforts • Support Dental Care Access Improvement Committee (DCAIC) report (3/2000) policy recommendations • Changes to DIDER • Training and recruitment policies • Dental and hygienist licensure reform strategies	**Dental** • Translate DCAIC report recommendations into targeted initiatives for recruitment, training, and access improvement
3. Behavioral Health • DIMER report documents "severe shortage" of mental health practitioners in Sussex County • Ambulatory Chemical Dependency and Substance Abuse Services (CD/SA) appear to be insufficient (DADMA interviews) in Sussex County • Deficiency in CTT services	**Behavioral Health** • Mental health resource study in Sussex County is needed • Licensure and MCO network reform for MSW level providers • SBHC MH services (see adolescent Lifecycle Section) • DIMER report recommendations • CD/SA program enhancement	**Behavioral Health** • Nanticoke/Western Sussex Health Council survey as tool for development of prototype compendium and referral guide • Work with DCMHS to develop county specific mental and behavioral health needs data • Systematically identify individuals using 911 for primary behavioral health needs and proactively deliver services in more appropriate settings

Appendix F. Summary of Notes for Policy and Initiative Development

Need/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
Behavioral Health (cont.) Problem Areas Identified as: • ACCESS • INFRASTRUCTURE: • DIRECT SERVICE:	**Behavioral Health (cont.)** • Greater community awareness re: programs which DO exist • Access enhancement for existing programs • Provider recruitment • Licensure Credentialing of non-licensed providers working under professionals • Diminish stigma of mental health care requirement – mental health parity • Educational System / Working to break stigma • Environmental/Move Services to more decentralized location • More Providers/ No available referral options currently • No Involuntary Admissions • General Psychiatry beds not broadly available	**Behavioral Health (cont.)** **Suggested Accountability:** • NASW (Association of Social Workers) Educational System • Legislature • MCOs

4. Home Health
• No quantitative data at this time
• Categories of need defined as:
  • Skilled nursing
  • Homemaker services
  • Personal care services
  • VNA
  • Child aide/attendant services
• Consider impact of PPS on agencies and referrals
• Consider impact of labor pool on staffing
	Home Health
	• Advocacy at federal MCARE policy level in light of BBA pressures
		Home Health
		Information gathering remains a priority to better understand needs. Additional sources include:
		✔ Association of Home and Community Care Providers
		✔ Hospital Discharge Planners
		✔ Del Tech Business and Economic Development Workgroup

Appendix F. Summary of Notes for Policy and Initiative Development

Table 3 Summary of Notes for Policy and Initiative Recommendations - Special Considerations

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***

1. Infrastructure and Environment
• "At Risk" Communities
  • Major water, sewer, housing deficiencies in over 30 communities in Sussex County (DPH; First State Community Action Agency)
  • Strong Communities to be considered as subset of "at risk" communities
• Lack of public transportation is a major physical barrier to access for health care
  • Vulnerable populations particularly impacted
  • Adolescents
  • Elderly
  • Poor
• Rapid population growth impacts availability of services, labor, and providers
	Infrastructure and Environment
	• Continue to support infrastructure planning and improvement throughout Sussex County
	• Support community policing initiatives
	• Alternative health care delivery addressing transportation deficiencies
	• Public and/or private-public partnering transportation initiatives and alternatives
	  • Use of inactive agency vehicles
	  • Enhancements to current public transportation
		Infrastructure and Environment
		• Focused studies of linkages between infrastructure deficiencies (water, sewer, housing) and health indicators

2. Poverty / Insurability
• Sussex County uninsured fraction (16.3%) exceeds State (12.9%) despite the presence of state sponsored insurance programs for which many are eligible
• Unemployed and self-employed predominate in this population
• Limited availability/scope of insurance coverage, and benefits in retail, service, and poultry industries
  • NB: High injury rates in poultry industry
• Leadership Development at all levels
• Awareness of available programs to be enhanced
• "Culture of poverty" must be reversed
	Poverty / Insurability
	• Target service/trade industries due to ↓ insured rates and ↑ injury rates
	  • Occupational education – injury prevention
	  • Job based health services
	  • Employer forums on "best practices" in expending health care dollars
	• Encourage Development of "Universal Access Product"
	• Health Fund as funding vehicle for extending primary coverages through business incentives
	
	Potential Accountabilities:
	Business owners/Insurance purchasers
		Poverty / Insurability
		• Collect and analyze OSHA data re: occupational injuries
		  • Collect and analyze data re: poultry industry injuries
		• Targeted initiatives to enroll eligibles in state sponsored health insurance programs
		• Develop compendium or database of charity care programs/parameters listing:
		  • Attributes by program/Barriers to obtaining assistance/Sliding fee scales
		• Mentoring

Appendix F. Summary of Notes for Policy and Initiative Development

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
		Poverty / Insurability (cont.) **Suggested Accountabilities:** • School Based Health Clinics • Marketing awareness of available care programs • Non traditional access

3. Cultural Barriers to Care (including White, Ethnic, and Non-White Populations)
• Hispanic (from 1999 DPH survey)
  • Lack of health insurance
  • Insufficient primary care services
  • Plant clinics provide limited services and access
  • Cumbersome access during work hours
  • Limited availability of culturally compatible physicians
  • Lack of services for family members of employees
  • Poor preventive service utilization
  • Dental care difficult to obtain
  • Poverty as access limiter
  • Denial of care
  • Non-seeking of care
  • Lack of culturally compatible services
• African-American (integrated into lifecycle sections)
• Lack of understanding re: cultural competency of existing and/or programs (e.g CHIP)
• Racism exists! While white middle and upper class may believe this is no longer a problem, there is still an atmosphere of mistrust and even paranoia running as an undercurrent.
	Cultural Barriers to Care (including White, Ethnic, and Non-White Populations)
	1. ***Improved communication***
	1.1 Develop venues for engaging consumers
	1.2 Use this input for innovative development of new services
	1.3 Approaches for meeting non-traditional family units
	1.4 Family based care
	1.5 Free clinic
	1.6 Rx programs
	1.7 Continuous improvement of existing programs
	2. ***Lowering barriers to care***
	2.1 Diminish legal status as a factor for accessing care
	2.2 Confidential and non-traditional "off-site" services
	2.3 When necessary to access the "system," lower barriers and seek to provide:
	2.4 A bilingual medical environment that feels safe
	2.5 Open during non-traditional work times
	2.6 Close to the population
		Cultural Barriers to Care (including White, Ethnic, and Non-White Populations)
		1. Use clergy/churches, service groups such as sororities, civic organizations, education or other groups that clients might trust to get client feedback and "sell" programs.
		2. Get information from community leaders on the best method to inform their communities of various programs. Consider literacy levels, which "buttons" to push.
		• Employers, churches, educational institutions all have a role in providing the training on an ongoing basis but must be supported from top leadership. Individuals need to carefully explore their personal value systems and be acutely aware of their personal reactions to people of color.
		Potential Accountabilities:
		• First State Community Action providing "Public Allies" program to build grass roots leadership. DHI leadership and CBOs need to support this effort.
		• Del. State Police Community policing can play an active role in safety/support.
		• Governmental agencies, community based organizations, hospitals, and basically all potential employers
		• Legislative mandates and requirements

Appendix F. Summary of Notes for Policy and Initiative Development

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
Cultural Barriers to Care (cont.) • Lack of identified leadership in ethnic and minority populations • Lack of staffing for programs to address cultural compatibility issues	**Cultural Barriers to Care (cont.)** 3. ***Getting employers to the table*** 3.1 Engage employers and solicit their long term participation in strategy development 3.2 Emphasize the intersection of shared benefit from improved health status 3.3 Support outreach initiatives at or near the workplace 3.4 Focusing on caring and prevention for the types of injuries and illnesses common to the poultry industry risks 4. ***Striving for continuity of care*** 4.1 Opportunities for providing continuity of care for those with established residence exist 4.2 Requires access, availability, and affordability of: 4.3 Medical services, 4.4 Prevention, and 4.5 Dental care • Obtain information and feedback from clients on their perceptions of various programs and possible trust factors involved (ie: how is personal information I am giving going to be used?, will it affect other benefits that I might use?) • Enable provider training on population based social/cultural competency. • Build leadership capabilities within minority/ethnic communities and identify and address barriers/threats to potential leaders (for example, threats from the drug culture). Provide active support to enable leaders to carry out their roles • Adequately staff and resource the programs developed to address the needs that are targeted	

Appendix F. Summary of Notes for Policy and Initiative Development

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
	Cultural Barriers to Care (cont.) (don't try to do all things to all people all at once) Providers need to identify specific priorities and then place adequate staff/resources in place to actually make a difference. • Staff/resources need to reflect the population served. Need to hire more racially, ethnically, culturally, and developmentally different • Delaware Health Fund needs to ensure that the special linguistic and cultural needs of racial, ethnic, cultural, and special needs populations are identified and reflected in any contracts or other funds disbursement.	

4. EMS
• Fitch Report (12/98) and Improvement Committee Report (5/99) detailed design and operational deficiencies of EMS system
	EMS
	• Support findings and recommendations of Fitch Report and Improvement Committee Report
	• In addition, concentrate Sussex County efforts in those areas within County sphere of influence:
	• **Human resources and training**
	  • Develop and implement strategies to recruit and retain qualified EMS volunteers and professionals at all levels of service
	  • Implement joint Continuing Education, training (ACLS, ATLS, CPR), and skills verification programs with hospital personnel to share resources and improve relationships
	  • Identify strategies to increase the cultural sensitivity of EMS providers
	• **Communication**
	  • Broaden the definition of the communication component (e.g., radios, telemetry, etc.) to include coordination of services with other components of the health system
	• Work with social service resources on the
		EMS
		• Establish non-emergency call line (i.e. "211") for resource advice and referral based on well maintained compendium

Appendix F. Summary of Notes for Policy and Initiative Development

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***

	EMS (cont.)
	efficient referral (e.g., State Services Center resources directory at dispatch center) and "hand off" of 911 callers with non-emergent needs
	• **Public information and education**
	  • Establish a prevention effort with trauma centers -- individually or as a group -- to reduce the number of preventable deaths due to motor vehicle accidents and other unintentional injuries
	  • Increase resources for educational efforts re: appropriate use of EMS and hospital emergency room services
	• **Medical direction**
	  • Ensure state-level recommendations re: quality assurance and medical oversight are fully implemented in Sussex County
	  • Lack of protocols,
	  • Little coordination among system components at county level,
	  • Limited physician involvement, and
	  • Unsatisfactory retrospective medical control
	  • Document "best practices" components of Sussex County system is strong and leverage this information for system improvements (e.g., physician involvement, collection of data)	

Appendix F. Summary of Notes for Policy and Initiative Development

Needs/Data Issues/Gaps	***Policy Notes – REC'S TO BE DEVELOPED Following Retreat***	***Initiative Notes – REC'S TO BE DEVELOPED Following Retreat***
5. Lack of Coordinated Resources Inventory; Lack of County Level Planning and Monitoring Data • Consultants observed, and validated in interviews, that minimal and inconsistent County level data is available to document needs and monitor delivery system functionality in Sussex County • Resources exist which are not well known of documented and for which duplicative but poorly focused public information efforts exists • Multiple resource compendia with overlapping / incomplete data and poor distribution	**Lack of Coordinated Resources Inventory; Lack of County Level Planning and Monitoring Data** • State level commitment to production of County level data on health indicators, health status, behavioral risks, demographics and epidemeology, etc.	**Lack of Coordinated Resources Inventory; Lack of County Level Planning and Monitoring Data** • Develop consolidated resources compendium (under State Service Center Office??) which is regularly updated, widely disseminated, available electronically, and which provides relevant access information