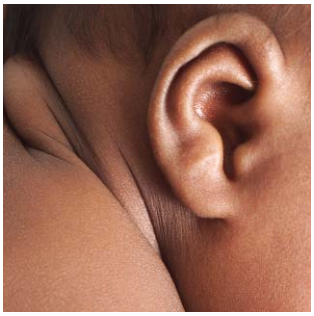
THE BIRTH OF CHANGE | HEALTHY MOTHERS. HEALTHY INFANTS.



Delaware Healthy Mother and Infant Consortium

Reducing Infant Mortality in Delaware

ANNUAL PROGRESS REPORT | FEBRUARY 2008

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

In 2004, Governor Minner convened a task force to learn why there was such a high rate of infant mortality in the state of Delaware. Through her leadership, $4.5 million was committed to implement change. Since that time, we have made significant progress. This is the second annual report that is the result of the work of the Delaware Healthy Mother and Infant Consortium (DHMIC). The DHMIC oversees all infant mortality projects. It is the job of the DHMIC to monitor the recommendations set forth by the 2005 Infant Mortality Task Force, and report progress to Governor Minner. The Consortium uses the most recent data such as demographic shifts in state population or changes in infant mortality trends to guide all it does. In the past year alone we have seen direct results of the research we've undertaken and new programs we've offered.

Ruth Ann Minner, *Governor of Delaware*

OUR PROGRESS HAS MADE AN IMPACT:

- **WE LISTENED TO MOTHERS** who had experienced an infant death and—using a national model called the Fetal and Infant Mortality Review (FIMR)—we learned where more interventions were needed;

- **WE FORMED A CONSORTIUM** of concerned individuals from the medical, health care and social service fields—by working together they have spearheaded efforts to lower infant mortality in Delaware;

- **WE EXAMINED DATA** about births in Delaware to learn all we can about the women who are at risk to deliver low birth weight infants—including their lifestyles, the condition of their health, whether they seek or don't seek care before, during or after pregnancy, and how long they wait between pregnancies;

- **WE ENROLLED NEARLY FIVE THOUSAND WOMEN** in preconception programs who are uninsured or underinsured, who are part of an ethnic minority, who live in geographic locations with the highest number of infant deaths, who have had previous problems delivering healthy newborns or who suffer from chronic diseases;

- **WE CREATED A PROGRAM TO PROVIDE OUTREACH** into the home—using the Family Practice Team Model—along with social and mental health support, so that women understand the things they can do to improve their health before and after they give birth;

- **WE EDUCATED THOSE WHO WORK IN HEALTH CARE** about at-risk women and how their intervention can make a dramatic difference in birth outcomes;

- **WE CONSISTENTLY MONITORED** the experiences of pregnant women in Delaware using a Pregnancy Risk Assessment Monitoring System (PRAMS)—the information we gathered helped us target the women most at risk.

All progress reported in this document is for Fiscal Year (FY) 2007.

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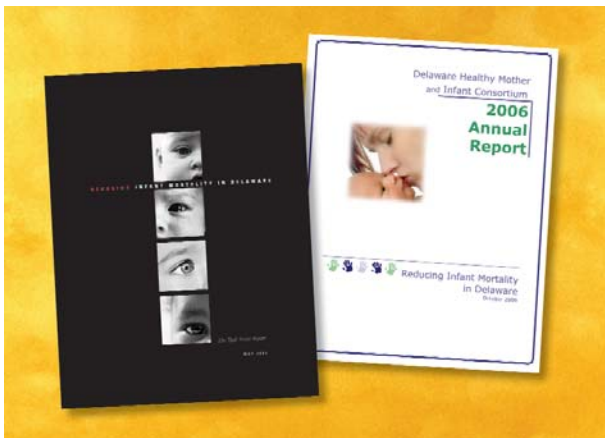
No matter what part you play in the process, it's impossible for any citizen of Delaware to overlook the feelings associated with infant mortality. For a parent, along with intense grief, there's a sense of helplessness. For a health care provider, there's a need to search for a reason why. For a community, there are questions about how, surrounded by so many resources, infant deaths can occur with such regularity in certain populations.

Thankfully, in Delaware, the individuals who play every part in the process have come together to make a difference. And with a well-developed plan, we are finding ways to change the Infant Mortality Rate in our state.

Thanks to Governor Minner's leadership and the $4.5 million investment secured from the General Assembly, we're offering programs and new points of access that address the needs of those among us who are most at risk. We have brought in experts to guide us. We are talking with women about their experiences to help us understand where we should be going next. We are acquiring and sharing more knowledge, using vital records data from our newly created Center for Excellence in Maternal and Child Health and Epidemiology. We continue to help thousands of prospective mothers get the preconception and prenatal care they need.

We've begun to make a difference in reducing infant mortality in Delaware. But we can't let our guard down. There are so many more ways we can make a positive impact. I look forward to our future achievements!



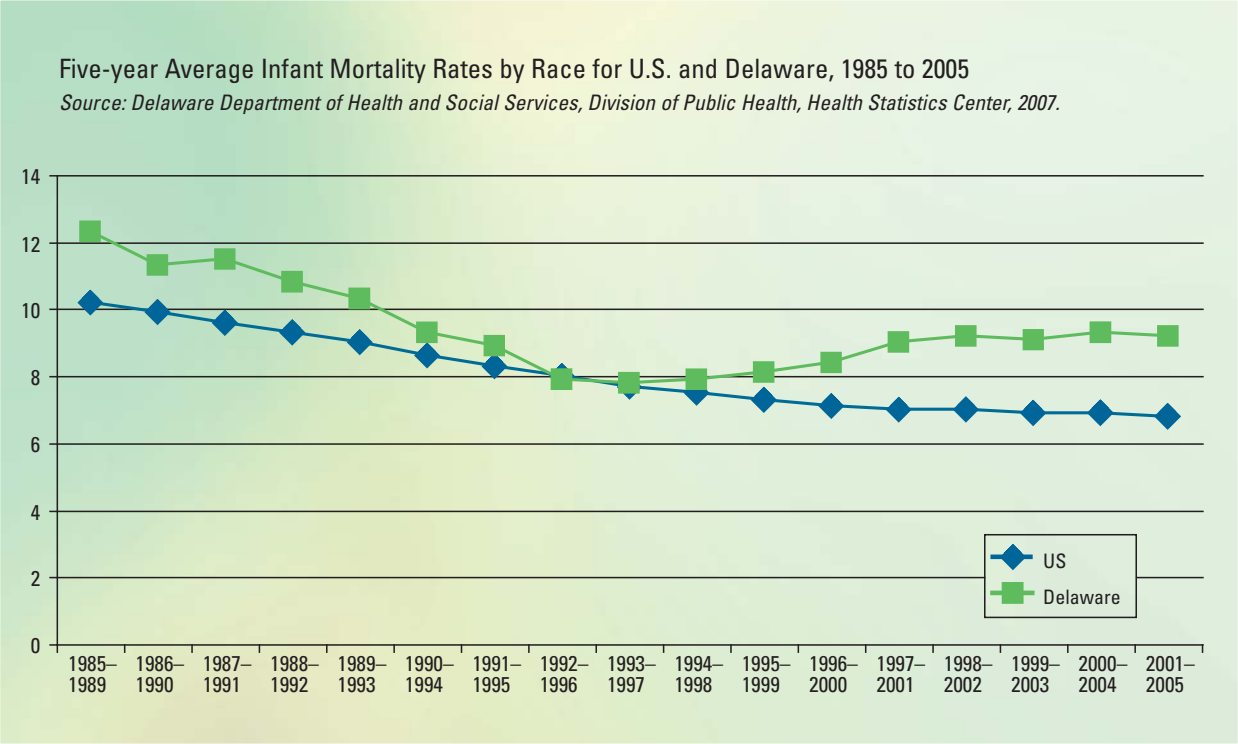
(Left) Infant Mortality Task Force Report and *(right)* the First Annual Report to the Governor.

David Paul, MD
Co-Chair
Delaware Healthy Mother and Infant Consortium

INFANT MORTALITY BACKGROUND

DELAWARE'S INFANT MORTALITY RATE STARTED TO CLIMB IN THE MID-1990'S AND HAS CONTINUED TO INCREASE WHILE THE U.S. RATE HAS DECREASED. Infant Mortality—the record of the number of babies who die from the first day of birth up to 12 months of life—is an indicator of the health of the prior generation. In Delaware, mothers who aren't getting prenatal care, have a chronic illness or don't wait long enough between pregnancies are having babies who are sick when they're born.

WHAT DOES THE INFANT MORTALITY RATE LOOK LIKE IN DELAWARE?



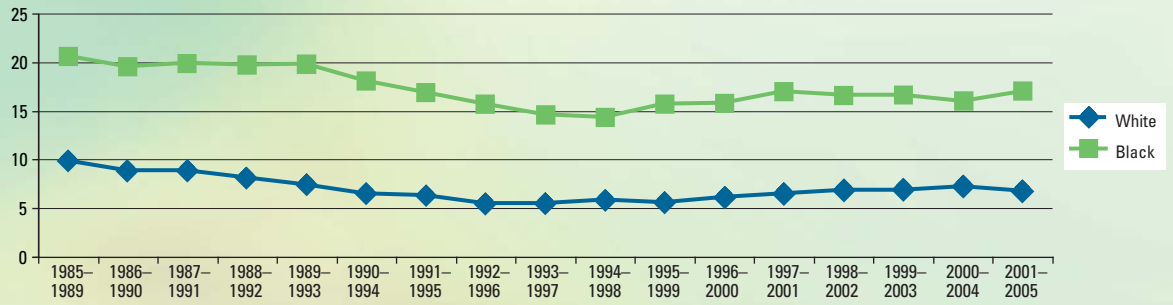
Delaware's Infant Mortality Rate (IMR)*, 2001–2005, is 9.2 deaths per 1,000 live births.

**The Infant Mortality Rate is the number of infant deaths per 1,000 live births.*

In Delaware, there is a significantly higher Infant Mortality Rate among black infants—as much as two to nearly three times that of white infants.

Five-year Average Black and White Infant Mortality Rates for Delaware, 1985 to 2005

Source: Delaware Department of Health and Social Services, Division of Public Health, Health Statistics Center, 2007.

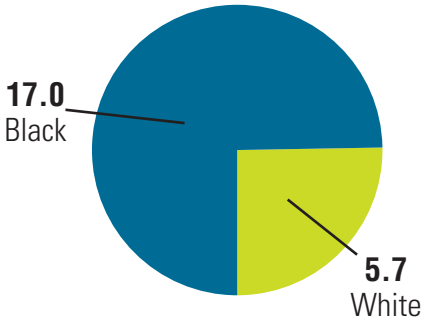


The Infant Mortality Rate for blacks is consistently higher than for whites in all three counties and in Wilmington.

Source: Delaware Department of Health and Social Services, Division of Public Health, Health Statistics Center, 2007.

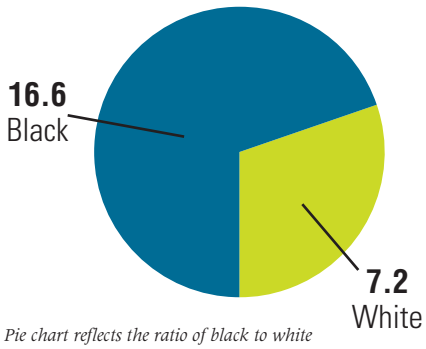
Infant Mortality Rates by Race, 2001 to 2005

CITY OF WILMINGTON—12.4 DEATHS PER 1,000 LIVE BIRTHS



Pie chart reflects the ratio of black to white

REMAINDER OF NEW CASTLE COUNTY—8.7 DEATHS PER 1,000 LIVE BIRTHS



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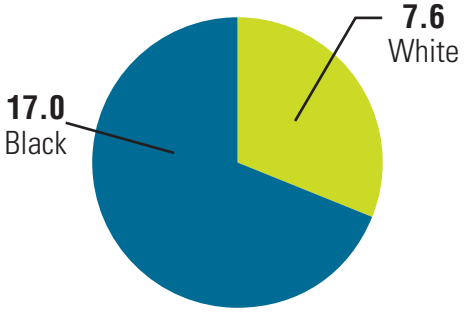
KENT COUNTY—10.0 DEATHS PER 1,000 LIVE BIRTHS



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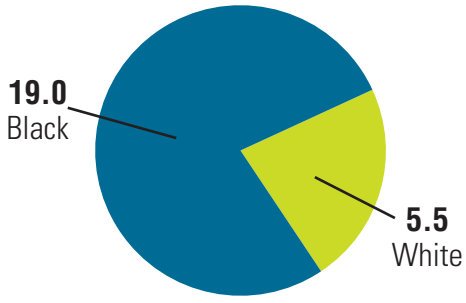
SUSSEX COUNTY—8.2 DEATHS PER 1,000 LIVE BIRTHS



Pie chart reflects the ratio of black to white

Key facts about Infant Mortality in Delaware:

- The two most important risk factors for infant deaths in Delaware are infants born too small or infants born too early. These two factors have also proven to be risks nationally.
- In 2005, there were 11,603 Delaware births—and 104 infant deaths.
- Most of Delaware's infant deaths occur within the first 28 days of life.
- In 2005, 14.2 percent of all infants born in Delaware were delivered prematurely.
- In 2005, 9.5 percent of all infants born in Delaware were considered low birth weight at delivery.
- In 2005, 21.2 percent of all infant deaths occurred in infants who were born too early and too small.

What we've learned.

In examining the infant mortality cases in Delaware we have uncovered certain risk factors that exist and raised awareness about positive changes that can be made, including:

- Recognizing signs of premature labor.
- Understanding the need for spacing pregnancies.
- Understanding the role of certain chronic illnesses during pregnancy.
- Understanding the role nutritional advice or support plays during pregnancy.
- Understanding how smoking can affect a baby during pregnancy.
- Making sure women have access to services they need such as community outreach, transportation and medical and social services.
- Understanding how stress affects premature birth.

WE'RE MOVING FORWARD AND MAKING PROGRESS

In this report you will see evidence of progress that has been made to reduce infant mortality since the original task force report. Our goal, as it has always been, is to give every infant born in Delaware a healthy beginning, regardless of race, socioeconomic status or geography. Our belief, that every child deserves a chance to thrive from birth, drives all that we do.

RECOMMENDATION

Implement a comprehensive and holistic Family Practice Team Model so that pregnant women can learn from other mothers, outreach workers, nurses, social workers and nutritionists how to better care for themselves and their infants up to two years after giving birth.

THE FAMILY PRACTICE TEAM MODEL PROGRAM PROVIDES OUTREACH into the home and social support to women before and after they give birth. Programs throughout the state that provide these services include Christiana Care Healthy Beginnings, Delmarva Rural Ministries, Henrietta Johnson Medical Center, La Red Health Center, St. Francis Tiny Steps, and Westside Health in Newark and Wilmington.

Program Resource Cards

When we reviewed data about pregnant women in Delaware we discovered a direct connection between infants who were born prematurely with low birth weight and women who didn't have access to certain services while they were pregnant. Through statewide programs we are able to provide wrap-around services to women before, during and after pregnancy, including services for their infants up to two years after delivery. More than medical services, this holistic way of helping women has already resulted in great success in targeted populations.

IMPACT

Out of 1,292 pregnancies only three infant deaths occurred—67 percent lower than expected in the high-risk group.

In women who participated in the program, only 10 percent had premature births and only 5 percent had low birth weight infants. All others were normal birth weight.

"I am learning how to take care of myself better. I had three kids very close together. I got on birth control and I get transportation to my doctor appointments. I'm learning about how important eating and sleeping habits are to both myself and my children. They really have helped me out."

BLOOMA WEST | Program Participant from Magnolia, Delaware

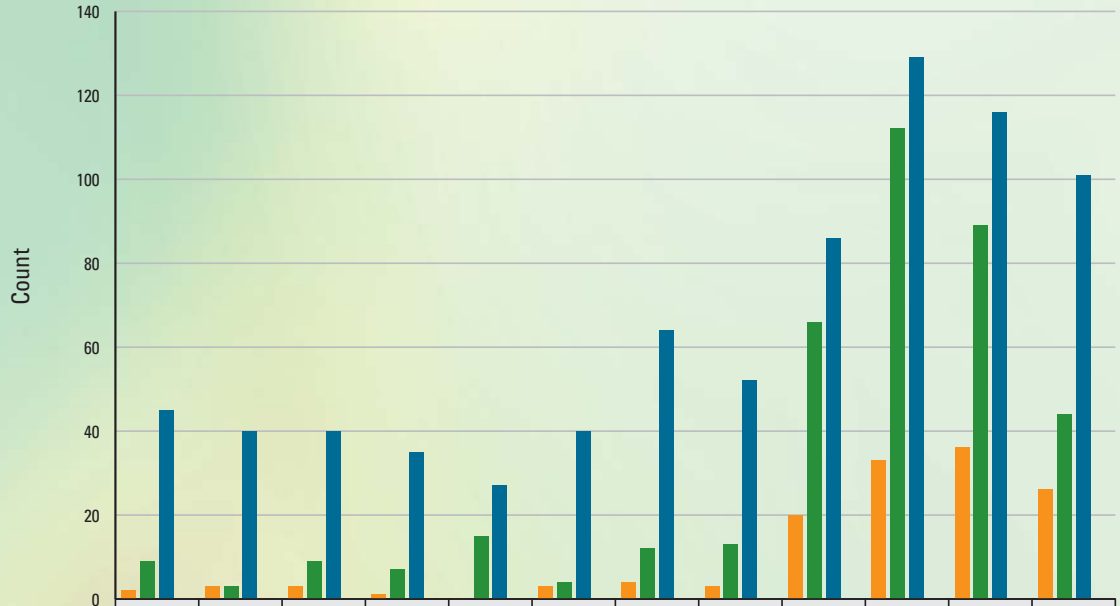
The Family Practice Team Model targets women who:

- are uninsured or underinsured
- are part of an ethnic or minority population
- live in geographic locations with the highest numbers of infant deaths
- have previous poor birth outcomes such as premature birth, low birth weight deliveries or infant death
- are diagnosed with chronic diseases.

WHO DO WE SERVE?

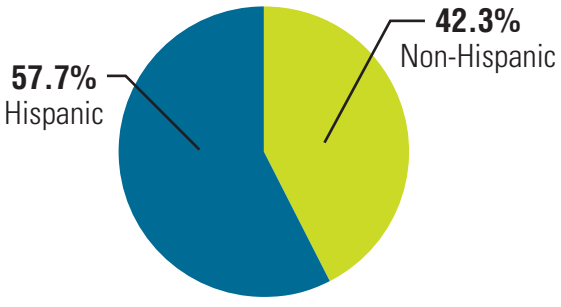
Total Number of Prenatal Participants by Racial/Ethnic Distribution for Fiscal Year 2007

Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
White	2	3	3	1	0	3	4	3	20	33	36	26
Black	9	3	9	7	15	4	12	13	66	112	89	44
Other	45	40	40	35	27	40	64	52	86	129	116	101

In 2007, the program targeted black women and continued to maintain a large percentage of services to Hispanics.



FY 2007 GOALS

- Establish a baseline for all new programs.
- Challenge current program sites to increase the number of participants by 20 percent from that baseline.
- Monitor the implementation of programs at all sites.

FY 2007 ACCOMPLISHMENTS

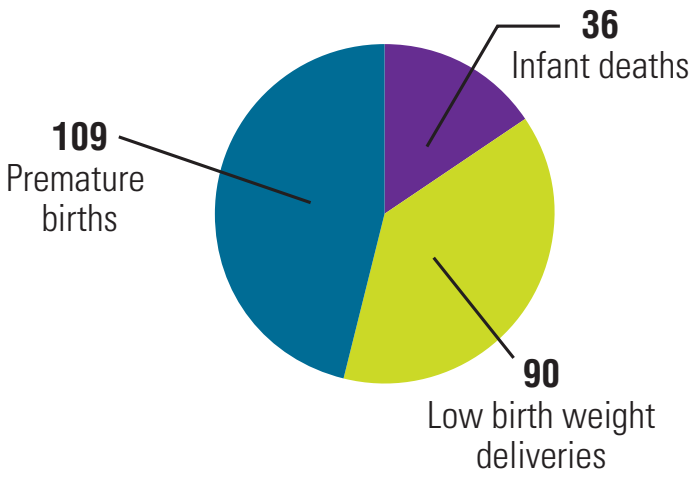
- Established baseline participation rates for programs and new clinic sites.
- Westside Health served 12 percent more women than their baseline rate.
- Delmarva Rural Ministries served 41 percent more women than their baseline rate.
- Continued to offer programs at all sites.

Unique features

- Special nutritional counseling.
- Mental health services.
- Community outreach.
- Social services in a case-managed approach.
- Increased postpartum care to women six weeks to two years after delivery.

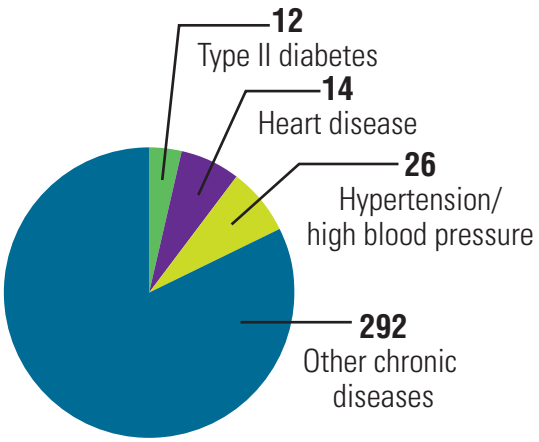
Among the 1,292 participants, 18 percent had previous delivery complications.

Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology, 2007.



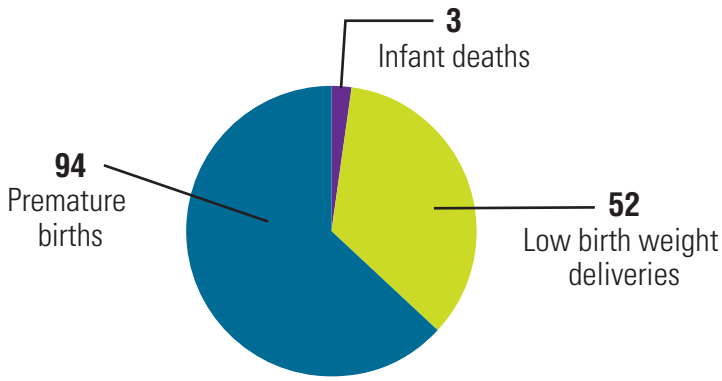
Among the 1,292 participants, 27 percent were coping with chronic disease.

Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology, 2007.



Among the 966 participant deliveries, 10 percent of infants were premature, 5 percent were low birth weight and three infant deaths occurred.

Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology, 2007.



Next steps for FY 2008

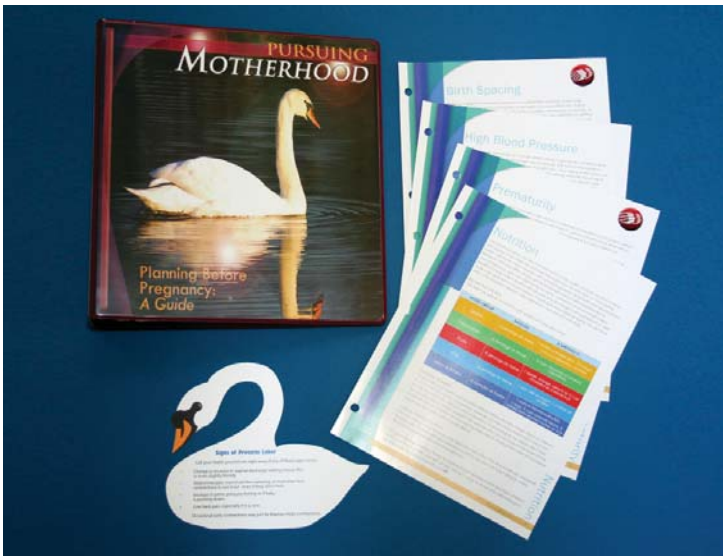
- Establish community partnerships to conduct outreach and promote both participation in the program and its benefits. Women who participate will also learn where they can access additional support services for themselves and their families.

- Evaluate the effectiveness of all programs.

RECOMMENDATION

Provide access to preconception care to all women of childbearing age with a history of poor birth outcomes.

PRECONCEPTION CARE HELPS A WOMAN PLAN HER REPRODUCTIVE LIFE COURSE including learning about a healthy diet, exercise, and how to reduce daily stress, manage chronic diseases and limit risky behaviors such as smoking or drug use. Programs that provide these services include Christiana Care Healthy Beginnings and Planned Parenthood of Delaware. A part of preconception care planning is understanding the role a previous pregnancy plays in a woman's health. To do this, a registry composed of women who have had a premature birth, a low birth weight infant or an infant death was developed by the Division of Public Health. By looking at these women, we can begin to understand the impact of these behaviors on infant health.



The Swan Shower Hanger won third place in the Print & Graphic Specialty Projects category at the National Public Health Information Coalition's 2007 Annual Conference.

This recommendation has two parts. The first is to collect and continue to monitor information to help us learn what risk factors characterize the women most likely to experience poor birth outcomes. The second is to use the information to provide education and other services to women with those risk factors to help them learn what they can do to improve their health and better prepare for pregnancy.

IMPACT—PROGRAMS

- Women enrolled in our program waited longer to have their next child (87 percent increased the period between pregnancies to more than 18 months).

IMPACT—REGISTRY

- We learned that in the high-risk group certain behaviors, such as smoking, weight gain and inadequate spacing between pregnancies, may play a key role in infant health.
- Consistent monitoring of the causes and conditions that can lead to infant mortality will help prevent it.

PARTICIPANTS HAVE POSITIVE EXPERIENCES

"During my first four months of pregnancy I was lonely, lost and basically a couch potato. I got into the Healthy Beginnings program and starting with my first appointment, they gave me the tools I needed to start getting my life together."

20-YEAR-OLD WOMAN FROM WILMINGTON

"I learned a lot about myself."

25-YEAR-OLD WOMAN FROM HARRINGTON

"I had three children very close together. I realize now how important it is to get healthy first before I have another baby."

23-YEAR-OLD WOMAN FROM DOVER

"My life has definitely changed for the better."

18-YEAR-OLD WOMAN FROM NEW CASTLE

The Preconception Program targets women who:

- Are uninsured or underinsured
- Are part of an ethnic population
- Live in geographic locations with the highest number of infant deaths
- Have previous birth outcomes such as premature birth, low birth weight deliveries or infant death
- Are diagnosed with chronic diseases

FY 2007 GOALS—PROGRAMS

- Establish baseline rates for all new programs by June 2007.
- Monitor the implementation of programs at all sites by January 1, 2008.

FY 2007 ACCOMPLISHMENTS—PROGRAMS

- Established baseline rates for programs with Planned Parenthood servicing 4,522 women for the year and Christiana Care Health Systems' Healthy Beginnings servicing 246 women.
- Implemented programs between January 1 and 20, 2007.

Over 4,768 women participated in the Preconception Care programs.

FY 2007 GOALS—REGISTRY

- Establish the Registry for Improved Birth Outcomes with inclusion criteria, internal agreements and methodology.
- Identify and define an education-based intervention for women included in the Registry for Improved Birth Outcomes.

FY 2007 ACCOMPLISHMENTS—REGISTRY

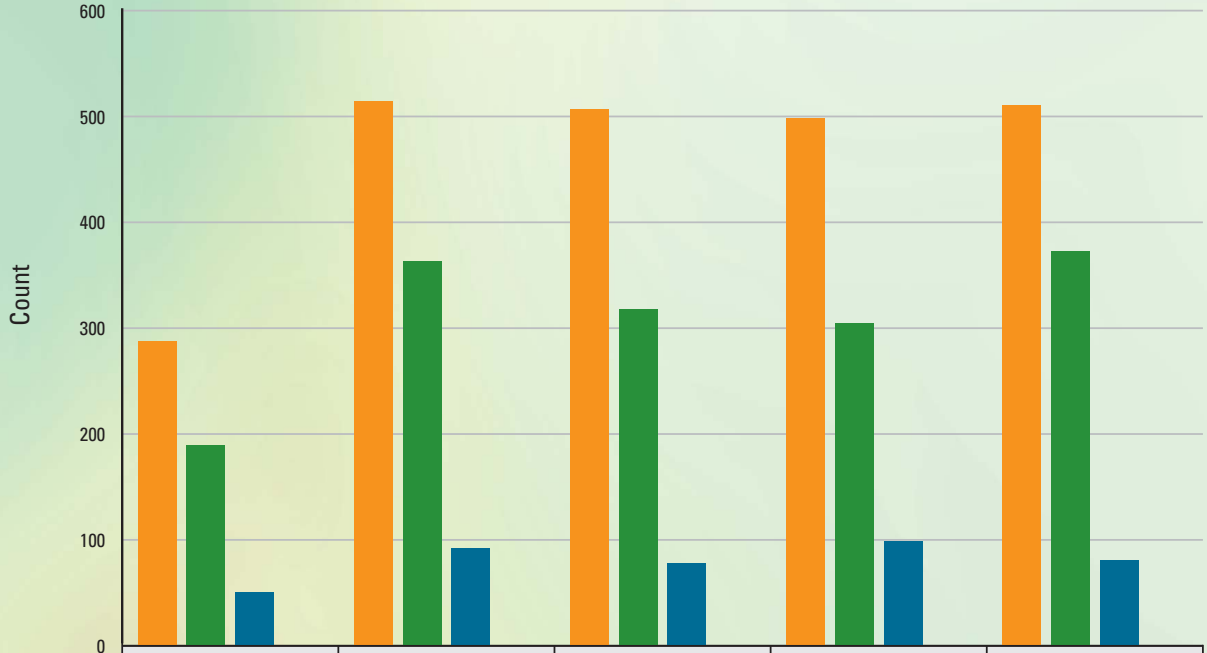
- Formally established the Registry for Improved Birth Outcomes with the Delaware Health Statistics Center.
- A conference in Wilmington was held that highlighted findings from the Registry. We published a planning guide for pregnancy; an educational resource for all women considering pregnancy using Registry data results. All conference participants received a copy.

The Registry also helped identify those risks that most needed to be addressed—for example, 20% of the women smoked.

WHO DO THE PROGRAMS SERVE?

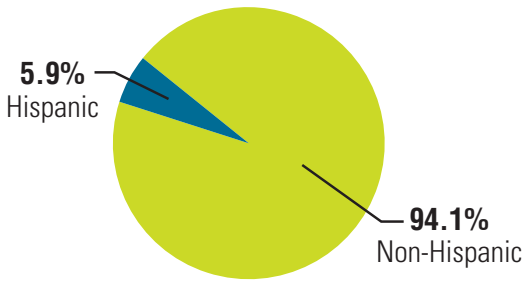
Total Number of Preconception Participant Racial/Ethnic Distribution for Fiscal Year 2007

Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology, 2007.



	February	March	April	May	June
White	288	514	507	498	511
Black	189	363	318	305	373
Other	51	92	78	99	81

The programs target high-risk women thoughout the state.

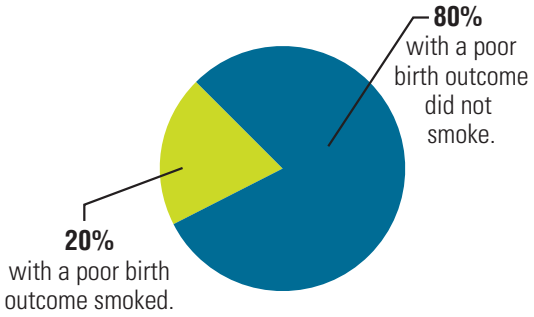


WHAT DID WE LEARN FROM THE REGISTRY?

Between 1989 and 2003, more than 19,000 women delivered infants with complications in Delaware. Of those, 20 percent experienced complications with a second pregnancy.

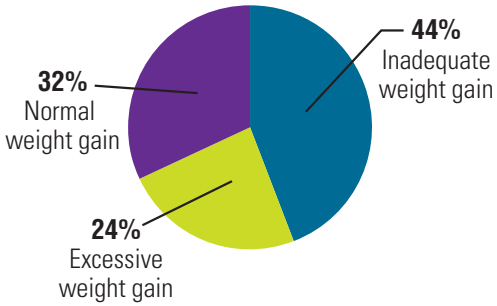
Source: Delaware Department of Health and Social Services, Division of Public Health, Center for Excellence in Maternal and Child Health and Epidemiology, 2007.

SMOKING DURING PREGNANCY



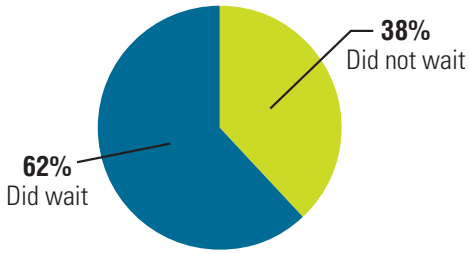
We found that one out of every five women with a poor birth outcome smoked during pregnancy.

WEIGHT GAIN



We found that 68% of the women in the high-risk group gained too little or too much weight during pregnancy.

LESS THAN 2-YEAR WAIT BETWEEN PRGNANCIES



We found that 38% of women in the high-risk group didn't wait long enough between pregnancies.

Unique features—Programs

- Programs are prevention-based.
- Programs work with women to educate them about what they can do to maintain their health and the health of their children by waiting longer between pregnancies.

Next steps for FY 2008—Programs

- Continue to identify women who had a previous poor birth outcome, live in specific high-risk zip codes, are members of a minority group, have chronic diseases, are Medicaid-eligible, medically underinsured or uninsured to receive services.
- Maintain and award new contracts.
- Establish an evaluation process.

Unique features—Registry

- Instead of examining information about outcomes only, we looked at women's behaviors during their pregnancies.
- Risk factors for women during pregnancy and at delivery are examined.

Next steps for FY 2008—Registry

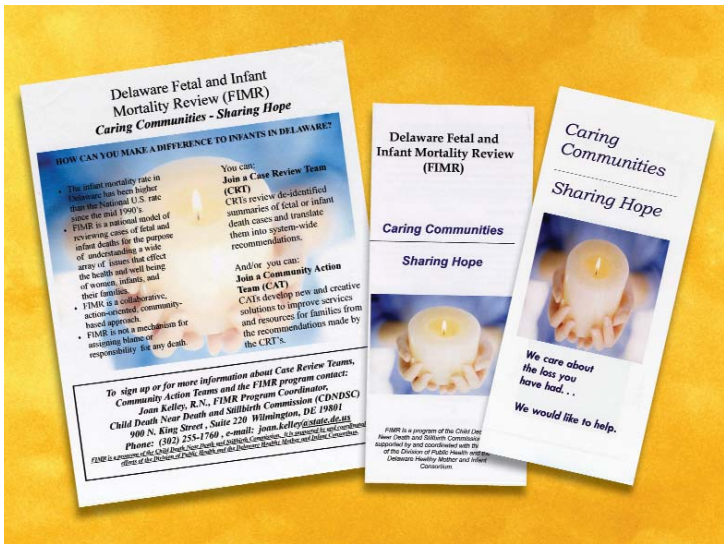
- Update annually as information becomes available.
- Continue to study risk factors for poor birth outcomes.

RECOMMENDATION

Conduct a comprehensive review of every fetal and infant death in Delaware using the Fetal and Infant Mortality Review (FIMR) process.

THE FETAL AND INFANT MORTALITY REVIEW (FIMR) COMBINES EXPERIENCES voiced by mothers with medical review, community partnerships and field expertise to reduce future fetal and infant death.

Every Child Deserves A Tomorrow
Child Death, Near Death and Stillbirth Commission



FIMR flyer and brochures

This evidence-based national model will help us learn why there is a high rate of infant mortality in the state and how we can reduce it. By listening to mothers who dealt with their own tragedies, conducting full medical reviews and creating opportunities for dialogue with community advocates and health professionals, we will learn what changes should be made.

Infant mortality does not exist in a vacuum. The FIMR program helps us understand the things that need changing, both in life and in the health care system.

IMPACT

- Increases monitoring of high-risk women and infants
- Identifies where more focused interventions are needed for women of childbearing age to reduce infant mortality

"We call our FIMR program 'Caring Communities—Sharing Hope.' My role is to conduct maternal interviews with women who experienced a fetal or infant loss. I have a great deal of respect for the women I have interviewed. The women who agree to do the interview truly care about their communities and are sharing the hope that future women will not have to go through the pain and loss experienced by others."

KRISTIN JOYCE | Senior Medical Social Worker

FY 2007 GOALS

- Establish a baseline rate of fetal and infant deaths.
- Hire and train staff.
- Initiate development of the FIMR database.
- Create case review teams and community action teams statewide.
- Develop formal relationships with key stakeholders in Delaware and the nation.

FY 2007 ACCOMPLISHMENTS

- Identified a total of 110 infant and fetal deaths.
- Conducted five maternal interviews; 20 women declined participation.
- Fully staffed FIMR.
- Identified and secured a database program, BASINET, to track FIMR data.
- Recruited volunteers for two case review teams.

Unique features

- Assessment of medical records, birth certificates and death certificates.
- Interviews with mothers and their families.

Next steps for FY 2008

- Monitor full implemention of FIMR through the Child Death, Near Death and Stillbirth Commission (CDNDSC).
- Identify core issues and themes learned by the case review teams.
- Act on the issues identified.

RECOMMENDATION

Create a monitoring system to increase understanding of the risks faced by pregnant women in Delaware.

THE PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS) USES THE VOICE of the pregnant woman to gain a better understanding of her health care needs and experiences.

PRAMS brochures and resource cards

The Pregnancy Risk Assessment Monitoring System, or PRAMS, is a program that uses a questionnaire to examine maternal behaviors, beliefs, practices and experiences before, during and after pregnancy. PRAMS also provides a way to monitor our progress toward achieving the Healthy People 2010 goal of reducing infant morbidity and mortality. PRAMS gives us information that will help us target the highest-risk populations, including minorities and women who deliver low birth weight infants.

IMPACT

- Consistent monitoring of the factors and emerging lifestyle trends or behaviors that lead to infant mortality
- The development of new and better health programs to lower the rate of infant mortality

"As the PRAMS Spanish-speaking interviewer, I find it both challenging and rewarding when I am able to help new mothers complete the surveys by phone. I feel an overwhelming sense of gratification that I have taken part in the input of a sample of Delaware mothers for our project."

SONIA JACKSON | PRAMS Data Entry Specialist

FY 2007 GOALS

- Develop PRAMS protocol using CDC guidance.
- Select the target population.
- Sample approximately 1,250 women between two and four months postpartum who gave birth in Delaware in 2007.

FY 2007 ACCOMPLISHMENTS

- Established protocols for collecting data including sample selection from infant birth certificates, structure of mailing packet and telephone interview.
- Proposed a focus on women who delivered a low birth weight infant.
- Established a final sample size of 1,534 women.

Unique features

- Information collected in the population-based survey helps us understand the health of women delivering babies in Delaware.
- Because the survey is anonymous, women freely respond to sensitive questions.
- The survey is a way women can talk about the care they received during their pregnancy and delivery.

Next steps for FY 2008

- Begin statewide PRAMS that will follow a calendar year timeframe.
- Use PRAMS results to modify existing state programs and better target women who are likely to deliver low birth weight infants, since low birth weight is a risk factor for infant death.

RECOMMENDATION

Create the Center for Excellence in Maternal and Child Health and Epidemiology (CEMCHE) within the Division of Public Health.

THE CENTER FOR EXCELLENCE IN MATERNAL AND CHILD HEALTH AND EPIDEMIOLOGY provides research and support to the Division of Public Health by looking at national, state and local data to consistently monitor the trends that affect infant mortality in Delaware.

The Center collects data, analyzes it and then generates reports to give us a snapshot of the local, state and national picture of maternal and child health. In collaboration with the Division of Public Health and the Delaware Healthy Mother and Infant Consortium (DHMIC), the Center's dedicated staff provides expertise in applying for federal and other funding opportunities to help evaluate our programs. The Center also helps us monitor, evaluate and document our progress to reduce infant mortality and eliminate disparities in birth outcomes.

IMPACT

- In-depth analysis of Delaware's infant mortality data and its translation into programs
- Better and more complete understanding of women's and children's health issues so that they may be addressed effectively

By surveying samples of women who were pregnant and assessing their health and well-being during preconception, pregnancy and post-pregnancy, we can learn about the factors that influence premature births and low birth weight infants. The Center for Excellence in Maternal and Child Health and Epidemiology is taking vital records data and turning it into knowledge that guides evidence-based interventions to reduce infant mortality.

CENTER STAFF

Back row *(left to right)*: Mawuna Gardesey (Chief), Stephanie Busch, Sonia Jackson, Dr. Charlan Kroelinger (Director) and Hashini Seneviratne.
Front row *(left to right)*: Victoria Runyon and George Yocher

FY 2007 GOALS

- Provide scientific expertise for implementation of the 20 recommendations in the Infant Mortality Task Force Review.
- Develop a strategic plan to carry out responsibilities.
- Establish a student internship training program.

FY 2007 ACCOMPLISHMENTS

- Provided monitoring for the Fetal and Infant Mortality Review (FIMR), the Pregnancy Risk Assessment Monitoring System (PRAMS), the Preconception Care program, the Family Practice Team Model program and the annual report.
- Began approval process for the strategic plan at the close of the second year.
- Established a student internship program with the University of Delaware.

Unique features

- Created for the sole purpose of conducting research.
- Dedicated epidemiologists focus on the issues surrounding maternal and child health.
- Dedicated staff for analysis of data.
- Maternal health trends that affect infant mortality closely monitored.

Next steps for FY 2008

- Continue to monitor progress toward reducing infant mortality and eliminating racial and ethnic disparities in birth outcomes.
- Collaborate on research-based projects with the CDC.
- Explore future research collaboration with the University of Delaware, Delaware State University, Johns Hopkins University and Drexel University.
- Continue Student Internship Program.

POLICY RECOMMENDATIONS

The following three recommendations, reflecting policy changes, are important to the overall success of our efforts to reduce infant mortality in Delaware: ensuring high standards of care; improving the way we transport at-risk newborns; and reporting capacity issues to the Governor. The DHMIC continues to work toward making policy changes.

IMPACT

- Assurance that the ways in which we offer care to women meets the guidelines established by medical benchmarking organizations
- As care guidelines change, we will change our standards of care

"Examining our standards of care was an important step in the process of understanding how to reduce infant mortality. It's important to realize that this is an ongoing effort. As guidelines change, we will alter the way we provide services to match them."

DAVID PAUL, MD | Co-Chair, Delaware Healthy Mother and Infant Consortium

REVIEW CURRENT STANDARDS OF CARE for preconception, prenatal and interconception care.

The Infant Mortality Task Force report recommended that all insurers within the state cover services included in federal standards of care for preconception, prenatal and interconception care. The first step in ensuring such coverage is to establish standards of care for preconception health in collaboration with providers, the Medical Society of Delaware, and the American College of Obstetricians and Gynecologists (ACOG). In 2007, the DHMIC Standards of Care Committee convened to lay the groundwork by providing expertise in review of state standards.

FY 2007 GOALS

- Review existing standards of care.
- Convene the Standards of Care Committee and key stakeholders.
- Develop implementation plan.

FY 2007 ACCOMPLISHMENTS

- A Standards of Care Committee was formed consisting of representatives from Medicaid, Woman to Woman Health Care, Nanticoke Hospital, Christiana Care Hospital, Beebe Medical Center, Bayhealth Medical Center and the Division of Public Health.
- A full review of current standards of care was conducted, which included American College of Obstetricians and Gynecologists state and national recommendations.
- The committe determined that the standards were adequate.

Unique features

- Dialogue between key stakeholders in the process.
- Evaluation of current practices that can become a catalyst for change.
- Promote optimum care standards for all women of childbearing age.

Next steps for FY 2008

- Focus on preconception health among women of childbearing age.
- Review standards of preconception care.

CONTINUE TO IMPROVE THE STATEWIDE NEONATAL TRANSPORT PROGRAM.

Every child born deserves a chance to survive. In some cases that may mean transporting the infant to a facility where he or she can receive the highest level of care. Evaluation of the existing neonatal transport program enables both the state agencies and tertiary care providers to identify gaps in regional services and provides a forum for modification of current protocols.

The DHMIC Standards of Care Committee began reviewing the existing neonatal transport program and identifying key stakeholders to discuss the existing system.

FY 2007 GOALS	FY 2007 ACCOMPLISHMENT
• Review existing neonatal transport program. • Develop recommendations for improvements.	• The existing neonatal transport system was reviewed and we concluded that the program adequately functioned in its current structure.

Next steps for FY 2008

- Continue to review recommendations for improvements in the transport system.

PROVIDE AN ANNUAL REPORT to the Governor on current and future risk factors impacting the availability of obstetrical practitioners.

In the initial recommendations, the Division of Public Health determined that the annual report to the Governor must include a summary of progress to date on all 20 priority recommendations and a commentary on biennial health care capacity studies completed within the state. The Center for Excellence in Maternal and Child Health and Epidemiology is coordinating with the Health Systems Bureau to review capacity studies and any studies that are scheduled to be implemented in the next two fiscal years.

FY 2007 GOAL	FY 2007 ACCOMPLISHMENT
• Review the most recent Health Capacity Studies (within the past four years) and any applicable methodology and data.	• The First Annual Report to the Governor was completed and was submitted to the Governor's office.

Next steps for FY 2008

- The Center for Excellence in Maternal and Child Health and Epidemiology will coordinate with the Health Systems Bureau to review Capacity Studies that have been completed and any studies to be implemented in the next two fiscal years.

MOVING FORWARD

We've identified two new important goals from the data we've gathered and our understanding of that data. One is to increase women's access to prenatal care. And the second is to educate women statewide, through a media campaign about what they can do to reduce their risk of experiencing an infant death. These new goals will be part of the Infant Mortality focus in the next year. Prioritizing recommendations that can make the most impact gives us a greater chance to be heard and understood. Everything we do has one goal—to give all newborns a chance at a healthy start in life.

"In a little less than two years we have made remarkable progress. We've enrolled more than 4,768 women in our preconception care program and helped women who are pregnant learn what they can do to deliver full-term, healthy infants. We're targeting more women in areas with the highest risk. We're educating them, improving access to care and collecting data to constantly monitor what we do. As we move forward, we'll reach out farther to create partnerships in the community and spread the word through a media campaign while removing barriers to care for at-risk populations. We will give every woman the information she needs to give birth to a healthy infant."

JAIME RIVERA, MD | Director, Delaware Division of Public Health

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

IMPROVE ACCESS TO CARE for populations disproportionately impacted by infant mortality.

Limited access to care increases a woman's risk for poor birth outcomes. We want to reduce barriers in accessing care among all women in Delaware. Our goal is to increase enrollment in Medicaid and provide additional access to care for women who are only eligible for emergency services. Projects under this recommendation include enhancement of translation services for medical visits and providing prenatal vitamins to women who can't afford to buy them.

Next steps for FY 2008

- Enhance services to women who are most susceptible to poor birth outcomes.
- Make prenatal vitamins available.
- Enhance translator services.

CONDUCT A STATEWIDE EDUCATION CAMPAIGN on infant mortality targeted at high-risk populations.

It will take an entire community to reduce infant mortality. It is important to have an educational health campaign focusing on improving birth outcomes aimed at all women in Delaware. We will focus this campaign on women at highest risk for poor birth outcomes.

Next steps for FY 2008

- Conduct a coordinated campaign with other educational efforts aimed at high-risk populations such as HIV Prevention of lateral transmission and the Child Death, Near Death Stillbirth Commission's Safe-Sleeping Campaign.

LIST OF MEMBERS

DHMIC Appointed Members
Jaki Gorum
David Paul, MD
The Honorable Liane Sorenson, State Senator
The Honorable Patricia Blevins, State Senator
Tiffany Chalk
Garrett Colmorgen, MD
Cari DeSantis
Katherine Esterly, MD
Rev. John Holden
Catherine Kanefsky
Lolita Lopez
The Honorable Pam Maier, State Rep.
MaryKate McLaughlin, Governor
Susan Noyes
Anthony Policastro, MD
Rose Rivera Prado
Agnes Richardson, PhD
Laura L. Rossi
The Honorable Teresa L. Schooley, State Rep.
Alvin Snyder
Judy Walrath, PhD
Jaime Gus Rivera, MD

Data & Science
David Paul, MD
Michael Antunes, MD
Aparna Bagdi, PhD
Louis Bartoshesky, MD
Deborah Ehrenthal, MD
Mo Gavin
Joan Kelley
Rob Locke, MD
Karen McDonald
The Honorable Diana McWilliams, State Rep.
Meena Ramakrishnan, MD
The Honorable Teresa L. Schooley, State Rep.
Kevin Sullivan
Charlan Kroelinger, PhD
Victoria Runyon
George Yocher

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Stephanie Busch
Jacqueline Christman, MD
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Maddy Anderson
Kathleen Absalom
Jennifer Barr
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Janet Brown
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Marta Castro
Tiffany Chalk
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Helene Diskau
Catherine Dukes, PhD
Barbara Gale
Valene Harris
Diana Hartley
Sheila Hobson
Mary Beth Hoffecker
Amy Johnson
Kristin Joyce
Joan Kelley
Moonyeen Klopfenstein
Leslie Kosek
Nancy Mahoney
The Honorable Pam Maier, State Rep.
Kathleen McCarthy
Nickia Naylor
Pat Nelson
Megan O'Hara
Liz O'Neill
Edward Okonowicz
Janet Ray
Michele Savin
Sue Samuels
Marilyn J. Sherman
Ellen Simpson
Cynthia Smith
Wendy Sturtz, MD
Sandy Voss
Gail Wade
Laura Wedel
Mela Wilburn
Walter Mateja

Health Disparities
Agnes Richardson, PhD
Rose Rivera Prado
Tamica Barbour
The Honorable Patricia Blevins, State Senator
Dorothy Griffith
Andrea Hinson
Rev. John Holden
Joan Kelley
Joan Powell
Mariann Powell
Warren Rhodes, PhD
Cynthia Smith
Yvonne Stringfield
Glyne Williams
Kimberly Henry
Michelle Mathew
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Linda Daniel
Sandy Elliott
Dot Fowler
Richard Henderson, MD
Joan Kelley
Katherine Kolb
Pat Lynch
Meta McGhee
Susan Oswalt
Nancy Oyerly
Sharon Painter
Anthony Policastro, MD
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John Stefano, MD
Wendy Sturtz, MD
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Willa Langdon
Lolita Lopez
Janice Mascelli
Virginia Phillips
Julia Pillsbury, MD
Carol Post
Jennifer Pulcinnella
Prue Sadowski
Barbara Akenhead
Jan Crouch
Diane Dillinger
Terry Dombrowski
Norma Everett
Barbara Mengers
Crystal Sherman

*Names in bold are Chairs and Co-Chairs

**Names in italic are DPH Employees

INFANT MORTALITY TASK FORCE ORIGINAL RECOMMENDATIONS

1. Conduct a comprehensive review of every fetal and infant death in Delaware . . . . . *page 18*
2. Create a monitoring system to increase understanding of the risks faced by pregnant women in Delaware . . . . . *page 22*
3. Create the Center for Excellence in Maternal and Child Health and Epidemiology (CEMCHE) within the Division of Public Health . . . . *page 26*
4. Improve access to care for populations disproportionately impacted by infant mortality . . *page 39*
5. Provide access to preconception care for all women of childbearing age with a history of poor birth outcomes . . . . . *page 12*
6. Require that insurers cover services included in standards of care for preconception, prenatal and interconception care . . . . . *page 33*
7. Implement a comprehensive and holistic Family Practice Team Model to provide continuous comprehensive care and comprehensive case management services to pregnant women and their infants up to two years post partum. Services will include comprehensive case management, trained resource mothers, outreach workers, nurses, social workers and nutritionists . . . *page 6*
8. Implement Federal Standards for Culturally and Linguistically Appropriate Services (CLAS).
9. Create a cultural competence curriculum for providers.
10. Improve comprehensive reproductive health services for all uninsured and underinsured Delawareans up to 650 percent of poverty.
11. Fund an in-depth analysis of programs in Delaware that mitigate infant mortality and create and implement an ongoing process for continuous quality improvement for services and programs developed to eliminate infant mortality.
12. Create an epidemiological surveillance system to evaluate and investigate trends and factors underlying infant mortality and disparity.
13. Create a linked database system to meet data analysis and program assessment goals and improve health care and services provided to the public.
14. Conduct a statewide education campaign on infant mortality targeted at high-risk populations . . . . . *page 39*
15. Expand the birth defect registry surveillance and make it proactive by broadening monitoring, early intervention and prevention programs.
16. Continue to improve the statewide neonatal transport program . . . . . *page 34*
17. Evaluate environmental risk factors for poor birth outcomes.
18. Promote oral health care, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal programs.
19. Provide an annual report to the Governor on current and future risk factors impacting the availability of obstetrical practitioners. Include recommendations to remedy systems capacity issues . . . . . *page 35*