



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

**State Narrative for
Alabama**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

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

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

B. Face Sheet

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

C. Assurances and Certifications

Documentation of assurances and certifications is maintained by the Alabama Department of Public Health's (ADPH's, or Department's) General Counsel. Like other information, information about assurances and certifications can be requested from the Department's web site.

Specifically, ADPH's web site (<http://www.adph.org/>) provides an option for emailing the Department; and emails received are referred to the appropriate person, who then replies to the person requesting information.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The Alabama Title V Program is administered by ADPH, through its Bureau of Family Health Services (FHS, or Bureau). FHS does not directly administer aspects focusing on children and youth with special health care needs (CYSHCN) but contracts with Children's Rehabilitation Service (CRS), a major division of the Alabama Department of Rehabilitation Services (ADRS), which administers services to this population. Discussion of how FHS and CRS invite public input follows. (A list of acronyms and shortened terms used in this document is attached to Section III.A.)

PUBLIC INPUT: FHS

As part of the fiscal years (FYs) 2009-10 maternal and child health (MCH) needs assessment, FHS sought public input via the following initiatives: 3 web-based surveys (1 of primary care providers serving Title V populations, 1 of non-medical organizations serving Title V populations, and 1 of families), 10 focus groups, several key informant interviews, and an advisory group convened for the MCH needs assessment. Methods for these initiatives are detailed in Section 1 of the full needs assessment report, entitled "Statewide 5-Year Maternal and Child Health Needs Assessment, Alabama, Fiscal Years 2009-10." The State of Alabama's (State's) FYs 2009-10 MCH needs assessment is subsequently referred to as the "2009-10 Needs Assessment" or the "Needs Assessment." The full report of the Needs Assessment is referred to as the "Needs Assessment Report" or the "2009-10 MCH Needs Assessment Report."

As well, FHS seeks input by convening several State advisory groups that have consumer representation for persons affected by particular health issues. These groups respectively advise FHS on the following programs: Newborn Screening, Early Childhood Comprehensive Systems Planning Grant, Child Death Review, and Family Planning. The Newborn Screening advisory group advises the Bureau on both screening for hematological and biochemical disorders and on screening for hearing impairment. Members of the State Child Death Review Team are offered

travel reimbursement for quarterly meetings occurring outside of their base city if such is not available from other sources.

/2013/ The Child Death Review Program is now located in the Bureau of Health Promotion and Chronic Disease (HPCD). //2013//

FHS's advisory groups serve as channels for public input on resource and policy development for their respective programs. For example, the Newborn Screening advisory group recommended criteria for the provision and distribution of metabolic foods and formula to infants and adults with phenylketonuria (PKU) in FY 2008, as well as a standardized protocol for newborn-screening blood collection from infants in the neonatal intensive care nursery in FY 2009. Both recommendations were implemented.

Further, 2 key ways that FHS seeks input on MCH issues are through collaboration with the State Perinatal Advisory Council (SPAC) and the Regional Perinatal Advisory Councils (RPACs). The SPAC and the RPACs are discussed in multiple places in this document (for example, [e.g.], under Health Status Indicator 2B in Section IV.E).

/2013/ The Alabama Title X Family Planning Program has an Advisory Committee that meets annually or more often. Committee members broadly represent their various communities across the State and are knowledgeable of the family planning service needs in their area. A consumer of the program is also a member. The purpose of the committee is to provide feedback regarding the development, implementation, and evaluation of the family planning program, as well as to review and approve any educational or informational material used in the program. This committee ensures that the family planning needs of the various communities are being met and that all educational and informational materials are suitable for the population and community for which they are intended.

FHS's Cancer Prevention and Control Division obtains public input through 2 roundtable groups. The Breast Cancer Roundtable meets annually to assist in program decisions. Representatives include the Susan G. Komen for The Cure, North Central Alabama, which represents constituents in northern Alabama; The Joy to Life Foundation, which represents constituents in southern Alabama; the American Cancer Society; the Deep South Network, which represents disparate populations in the Black Belt; REACH US, which represents disparate populations across 3 southeastern states; several hospitals across the State; cancer centers in the State; the Poarch Band of Creek Indians; other community organizations; and survivors of cancer.

The Colorectal Cancer Roundtable meets annually to assist in program decisions. Representatives include the American Cancer Society, Blue Cross and Blue Shield of Alabama (BCBS), several hospitals across the State, cancer centers in the State, the Deep South Network, drug manufacturing representatives, and others. //2013//

As well, the Bureau maintains a State Title V MCH web site (<http://www.adph.org/mch/>, which is part of ADPH's main web site) that informs viewers about the Federal-State Title V partnership. One of the pages on this site provides a mechanism for the public to email comments directly to the State Title V program. Further, the 3 web-based surveys that were conducted during the Needs Assessment were posted on the site. With respect to usage of the State Title V MCH web site, 5,902 page views of the site occurred in FY 2009.

/2012/ The MCH Epidemiology Branch (MCH Epi Branch) has updated the State Title V MCH web site to include the 10 MCH priorities selected during the 2009-10 Needs Assessment; the 18 National Performance Measures (NPMs); the 7 State Performance Measures (SPMs) from the 2006-2010 Needs Assessment cycle; for each of the performance measures, Tables 4a and 4b from the Alabama MCH Block Grant FY 2009 Annual Report/FY 2011 Application (MCH 2009

Report/2011 Application); and all attachments from the MCH 2009 Report/2011 Application, including the full report of the Needs Assessment. //2012//

/2013/ The MCH Epi Branch has updated the State Title V MCH web site to include the 7 SPMs from the 2011-2015 Needs Assessment cycle. As well, the branch has updated Tables 4a and 4b (which summarize activities for each performance measure) to correspond to those tables in the MCH 2010 Report/2012 Application. Additionally, the branch has replaced the attachments from the MCH 2009 Report/2011 Application with those from the MCH 2010 Report/2012 Application. The full report of the Needs Assessment is no longer included in the posted attachments; but the site includes a link to the federal Title V Information System web site, where each state's report of their latest 5-year MCH needs assessment is posted.

In late FY 2011, the MCH Epi Branch compiled detailed reports of qualitative data from 2 of the web-based surveys conducted during the 2009-10 Needs Assessment. The reports were prepared specifically for the Alabama Medicaid Agency (Alabama Medicaid, or Medicaid), because many of the respondents' comments pertained to Medicaid and that agency is a critical partner in efforts to improve the well-being of Alabama residents. One report focused on the Survey of Alabama Organizations Serving Women of Childbearing Age, Children/Youth, and/or Families. The other focused on the Survey of Alabama Primary Health Care Providers for Women of Childbearing Age, Children, and Youth. Each report was a broad compilation of the respondents' comments and was intended to reflect the various views of respondents to the open-ended questions in the survey. The reports were not limited to comments that directly concerned Medicaid, but the comments that specifically concerned Medicaid were highlighted so they could be easily identified. In early FY 2012, the State Title V Director provided the reports to Alabama Medicaid's Medical Director, after discussing the reports with him. In the view of FHS, Medicaid had already explored and addressed many of the Medicaid-related issues mentioned by respondents, but the reports were nevertheless relevant as a compilation of diverse stakeholders' views.

In early FY 2012, FHS mailed bound copies of the full report of the 2009-10 Needs Assessment to several participants in focus groups held during that assessment. The mailing also included a 2-page brief, listing the 10 MCH priority needs and inviting comments, but no comments have been received. //2013//

PUBLIC INPUT: CRS

CRS, located in ADRS, administers services to CYSHCN and seeks input from this population and their families. The CRS Needs Assessment process included family, youth, and State-level partners focus groups; family, youth, and county-level provider surveys; key informant interviews; and an interagency advisory group.

CRS Local Parent Advisory Committees (LPACs) meet at least 3 times per year to provide input to the program. The State Parent Advisory, Medical Advisory, and Hemophilia Committees meet once each year. The Youth Advisory Committee meets as needed. Local Parent Consultants (LPCs) and the State Parent Consultant (SPC) participate year round. Families and youth are compensated for participation on State advisory committees; and CRS assures cultural and linguistic competence and compliance with the Americans with Disabilities Act at all meetings.

CRS requested input on program activities and Needs Assessment methods and findings at the State Parent Advisory Committee meeting. LPACs conducted pilot testing for the CYSHCN Family Survey that was later conducted as part of the Needs Assessment. LPCs rated the agency on Form 13 characteristics. Draft CRS portions of the MCH 2009 Report/2011 Application were reviewed by the SPC and LPCs and were made available to families in local CRS offices.

/2012/ CRS Local Parent Advisory Committees meet at least 3 times per year to provide input to

the program. The State Parent Advisory, Medical Advisory, and Hemophilia Committees meet once per year. The Youth Advisory Committee meets as needed. LPCs and the SPC participate year round. LPCs rated the agency on Form 13 characteristics. CRS portions of the MCH 2010 Report/2012 Application were shared with the SPC and LPCs and were made available to families in local CRS offices. //2012//

//2013/ CRS Local Parent Advisory Committees continue to meet at least 3 times per year to provide input to the program. The State Parent Advisory, Medical Advisory, and Hemophilia Committees meet once per year. With the recent hiring of a youth consultant, the Youth Advisory Committee will be re-established and regular meetings will be scheduled. The State Implementation Grant for Systems of Services for CYSHCN Project Advisory Committee met 2 times during the first year of the grant. LPCs rated the agency on Form 13 characteristics. CRS continues to share its portion of the MCH 2011 Report/2013 Application with SPC and LPCs and makes it available to families in local CRS offices. //2013//

II. Needs Assessment

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

C. Needs Assessment Summary

The 2009-10 MCH Needs Assessment Report (reference 1) can be retrieved from the federal Title V Information web site, <https://perfddata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx>. (A list of references cited in this report/application is attached to Section IV.G.)

This update begins with a recap of the MCH priority needs selected during the 2009-10 Needs Assessment. Then, per current MCH Block Grant guidance (reference 2), the update addresses the following issues: 1) changes in population strengths and needs, 2) changes in program or system capacity to address priorities selected during the Needs Assessment, 3) activities to operationalize the Needs Assessment, and 4) ongoing activities to gather information and evaluate implementation of the Needs Assessment. Discussion of the 4 topics specified above focuses on intensified concern about drug poisoning deaths and nonmedical use of prescription drugs.

RECAP OF MCH PRIORITY NEEDS

The MCH priority needs that FHS and CRS selected, which are detailed in Section 5 of the Needs Assessment Report and listed on Form 14, follow (sometimes in abbreviated statements). The numbers assigned are identification numbers; they do not rank the priorities. Priorities for the 2011-2015 cycle are to:

- 1) Increase access to culturally competent care coordination services for CYSHCN, including transition planning.
- 2) Promote access to a medical home for children, youth, and women of childbearing age.
- 3) Promote positive youth development to reduce high-risk behaviors in adolescents.
- 4) Reduce the prevalence of obesity among children, youth, and women of childbearing age.
- 5) Reduce the prevalence of violent behavior committed by or against children, youth, and women.
- 6) Reduce infant mortality, especially among African Americans.
- 7) Increase family and youth participation in CYSHCN policy-making.
- 8) Promote access to community-based services for CYSHCN and families.
- 9) Promote access to a dental home.
- 10) Promote access to mental health services for all children, youth, and women of childbearing age.

CHANGES IN POPULATION STRENGTHS AND NEEDS

Concern about drug poisoning deaths and an underlying issue, nonmedical use of prescription drugs, has intensified. This concern cuts across the federally prescribed issues to be discussed in this section, so various aspects of drug poisoning deaths and nonmedical use of prescription drugs are discussed under each of the headings that follow. Here, some national information on

nonmedical use of prescription drugs, including risk markers for such use, is briefly discussed. State-level surveillance and actions are discussed later.

According to the Centers for Disease Control and Prevention (CDC, located in the U.S. Department of Health and Human Services [DHHS]), overdose deaths from prescription painkillers have skyrocketed in the past decade (reference 3). Specifically, overdoses involving prescription painkillers--which include hydrocodone, methadone, oxycodone, and oxymorphone--are a public health epidemic. Among U.S. residents ages 12 and older, 1 in 20 people used prescription painkillers nonmedically (without a prescription or for the feeling they cause) in 2010. According to CDC, risk markers for abuse of or overdose on prescription painkillers include the following: male sex, middle age (with middle-aged adults having the highest prescription painkiller overdose rates), rural residence (with people in rural counties being about 2 times as likely to overdose on prescription painkillers as people in large cities), and race (with Whites and American Indian or Alaska Natives being more likely to overdose on prescription painkillers).

CHANGES IN CAPACITY

Discussion here focuses on the capacity to address nonmedical use of prescription drugs.

This issue cuts across the third (positive youth development) and tenth (access to mental health services) priorities listed at the beginning of this section. Conjecturally, it may contribute to some episodes of violent behavior, which pertains to the fifth MCH priority. As well, this issue cuts across age groups, including the reproductive years.

FHS does not have a funding stream dedicated to reducing the nonmedical use of prescription drugs. However, the Bureau has worked closely with ADPH's State Pharmacy Director, who directs ADPH's Pharmacy Division, located in the Bureau of Professional and Support Services. The Pharmacy Division operates the Department's Prescription Drug Monitoring Program (PDMP), which is the main avenue through which ADPH addresses nonmedical use of prescription drugs. The collaboration between FHS's MCH Epi Branch and the Pharmacy Division is discussed later in this section.

The involvement of the Governor of Alabama (Governor), as co-chair, in the National Governor's Association's new prescription drug academy should enhance the State's capacity to reduce the nonmedical use of prescription drugs (reference 4). The nation's governors plan to develop best practices that can be used by State governments to reduce such use.

OPERATIONALIZING THE NEEDS ASSESSMENT

Discussion here concerns operationalizing the 2009-10 Needs Assessment and ongoing needs assessment.

The 2009-10 Needs Assessment

In FY 2011, the MCH Epi Branch coordinated preparation of a comprehensive action plan to address the 10 MCH priorities selected during the Needs Assessment. The action plan is attached and includes a worksheet for each of the 10 priorities. To develop the plan, the branch convened a meeting of key FHS staff members, the CRS staff member responsible for ongoing needs assessment, and a staff member from ADPH's Nutritional and Physical Activity Program (located in the Bureau of Professional and Support Services). A key program administrator was assigned to take the lead for each priority and submit the plan for addressing that priority to the MCH Epi Branch, who incorporated the 10 plans into a single document. The branch coordinates annual updates to the plan, which are provided by key program staff.

Ongoing Needs Assessment

Recently, FHS's ongoing needs assessment has focused on drug overdose deaths and nonmedical use of prescription drugs. ADPH's efforts to address this issue have included a news release and public health surveillance, which is in its initial stage. The State Pharmacy Director, ADPH's Public Information Manager (located in HPCD), and the MCH Epi Branch Director

collaborated on the news release, which is attached. As well, the MCH Epi Branch Director prepared several PowerPoint slides for potential use by the State Pharmacy Director in his presentation to Blue Cross and Blue Shield of Alabama (BCBS). Some of these slides are attached, and several findings are discussed later in this section. Further, information from the news release was included in ADPH's publication, "Alabama's Health."

As previously stated, ADPH addresses nonmedical use of prescription drugs mainly through PDMP, which has been in place since April 2006. The goals of this program are listed in the attached news release.

ONGOING INFORMATION AND EVALUATION

Discussion here focuses on ongoing needs assessment, which includes information gathering. Concerning evaluation, FHS evaluates implementation of the Needs Assessment during preparation of and annual updates to the previously discussed action plan. As well, each SPM assesses progress on 1 aspect of an MCH priority.

To follow up on certain findings from previous 5-year MCH needs assessments, the MCH Epi Branch studied drug poisoning deaths, using Alabama statistical death files for selected years. Brief discussion of findings from this study follows. Details, including the International Classification of Diseases, 10th Revision codes used, are shown in the last part of the attachment to this section, entitled "Drug Poisoning Deaths, Alabama Residents, Specified Years." All the following findings pertain to drug poisoning deaths among Alabama residents in the specified 3-year periods (combining the 3 years). The slides cited below are on pages 27-29 of the attachment.

In 2008-10, 1,804 deaths were due to drug poisoning. Most (81%) of these deaths were unintentional (Slide 2). Therefore, subsequent discussion focuses on unintentional deaths due to drug poisoning.

Of the 1,463 unintentional drug poisoning deaths in 2008-10, 50% were in 26-44 year-olds, 36% in 45-64 year-olds, and 10% in 18-25 year-olds (Slide 3).

In 2008-10, unintentional drug poisoning deaths were a notable cause of death in 18-25 year-olds and in 26-44 year-olds. Specifically, 7.8% (151/1,927) of all deaths in 18-25 year-olds and 9.5% (726/7,645) of all deaths in 26-44 year-olds were due to unintentional drug poisoning (Slide 4).

Among 18-25 year-olds, the number of deaths due to unintentional drug poisoning was 89 in 2002-04, 149 in 2005-07, and 151 in 2008-10. Thus, the number of these deaths increased by 67% in the middle of the surveillance period and then remained about the same (Slide 5).

Among 26-44 year-olds, the number of unintentional drug poisoning deaths was 249 in 2002-04, 429 in 2005-07, and 726 in 2008-10 (Slide 6). Thus, in this age group, the number of these deaths increased by 72% in the middle of the surveillance period (2005-07 versus 2002-04), then increased again, by 69%, at the end of the surveillance period (2008-10 versus 2005-07). Comparing 2008-10 to 2002-04, the number of these deaths nearly tripled (from 249 to 726, a 2.9-fold increase).

Along with the national concern about these issues, the above findings indicate that drug poisoning deaths and a related issue, nonmedical use of prescription drugs, indeed merit priority as an MCH issue. For this reason, to the degree feasible, the MCH Epi Branch will continue conducting surveillance on this issue and collaborating with ADPH's Pharmacy Division. As well, through appropriate administrative channels, FHS will seek to become aware of the activities and recommendations of the National Governor's Association's new prescription drug academy.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

A list of acronyms or shortened terms is included in the attachment to this section.

Issues important to understanding health needs of the State's population include the health care environment, selected changes in the State's population, the number of State Title V-served individuals, strategic and funding issues, and special challenges in delivery of services to CYSHCN--all of which are discussed in this section. Also key to understanding the health needs of the State's Title V populations are salient findings included in the Needs Assessment Report (reference 1) and priority MCH needs based on these findings.

The process used by the State Title V Director to assess the importance and magnitude of factors impacting the delivery of health services and the priority of addressing these factors, including current and emerging issues, is multifaceted. This process includes collaboration with FHS staff, with other ADPH staff, and with a variety of organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCH needs assessment, consideration of findings from such assessment, and consideration of priority needs identified via such assessment. Further, the process includes consideration of public input and readily available evidence on the cost/benefit ratios of certain potential public health services. Multiple collaborations are discussed in Sections 1 and 2 of the Needs Assessment Report and throughout this MCH Report/Application.

Included in FHS's considerations are racial, ethnic, and geographic disparities in health status or access to care. Special challenges regarding CYSHCN who live in rural areas are described later in Section III.A, as are indicators concerning geographic living area and poverty. Certain socioeconomic disparities in MCH indicators, using source of payment for delivery as a surrogate for socioeconomic status, are detailed in the Needs Assessment Report. Further, poverty, geographic distribution, urbanization, and socioeconomic, racial, and ethnic disparities in MCH indicators are discussed in the Needs Assessment Report.

As previously stated, The Alabama Title V Program is administered by ADPH through FHS, who contracts with CRS, who administers services to CYSHCN. Other programs administered by FHS include the Title X Family Planning Grant; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the State Perinatal Program (SPP); the Healthy Childcare Alabama Program, ADPH's Cancer Prevention and Control Program, and the State Dental Program. The Title V Program, as well as these other programs, serves all of the State's 67 counties.

THE HEALTH CARE ENVIRONMENT

MCH Services Block Grant annual reports for FY 1997 and onward have described changes that have occurred in Alabama's health care environment. These changes caused a shift in the provision of direct medical services from county health departments (CHDs) to private providers. As a corollary, the changes prompted a paradigm shift in the roles of CHDs--toward a greater emphasis on the core public health functions of assessment, policy development, and assurance. This shift has been especially evident with respect to provision of services to pregnant women and to children and youth. Because the shift continues to affect ADPH's role in providing services, salient history concerning the health care environment is summarized here.

Medicaid Managed Care Programs

A discussion of previous and current Medicaid managed care programs, as well as case management or care coordination services provided through these programs, follows.

Medicaid Maternity Care Program

Under Alabama Medicaid's Maternity Waiver Program that was effective from 1988 through May

1999, ADPH had been the primary provider of prenatal care for 23 of the State's 67 counties and subcontractor for care in many other counties. Under this plan, many women eligible for Medicaid-funded services under the Sixth Omnibus Budget Reconciliation Act (SOBRA) received their prenatal clinical health care and care coordination services mainly through CHDs. Home visits were made for high-risk patients: that is (i.e.), if the mother was less than 16 years of age or tested positive for human immunodeficiency virus (HIV); if there were indications of substance abuse or domestic violence; or if the baby was premature, low birth weight, or had special needs.

The Department's role in directly providing prenatal care markedly declined with Medicaid's current State Plan for Maternity Care, which began in June 1999 and was fully implemented by October 1999. This plan, the State Plan for Maternity Care, divides the State into 14 Medicaid maternity districts. With implementation of the plan, ADPH no longer provided maternity services via a direct contract with Medicaid. Instead, ADPH began providing prenatal care and/or care coordination in certain counties, via subcontracts with groups who assumed responsibility for provision of prenatal care under a direct contract with Medicaid. However, ADPH gradually withdrew from providing direct prenatal care and now provides maternity care coordination in only 7 counties.

Specifically, the number of counties in which ADPH provided prenatal care as a subcontractor declined from 14 circa FY 2000, to 10 by FY 2003, to 9 as of July 2004. The latter decline occurred because, in May 2004, prenatal care that had previously been provided by the Jefferson County Department of Health (JCDH) was transferred to the University of Alabama at Birmingham (UAB). By March 2005 it was determined that the private sector had the desire and capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to completely withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant patients. Therefore, by early FY 2006, ADPH was no longer providing direct prenatal care. Further, the number of counties in which ADPH provided maternity care coordination as a subcontractor, which had been 54 counties circa FY 2000, declined to 7 counties by April 2006. These 7 counties, which continue to provide maternity care coordination, are: Cullman, Houston, Dale, Henry, Geneva, Coffee, and Mobile.

/2012/ ADPH now provides maternity care coordination in only 2 counties, Mobile and Cullman. //2012//

Since initiating its current State Plan for Maternity Care, Medicaid has awarded contracts to various Primary Contractors. Under the current contracts, which became effective January 1, 2010, Medicaid contracts with 10 Primary Contractors to provide maternity services in the 14 Medicaid Districts. For pregnant women, the upper parameter for Medicaid eligibility continues to be 133% of the federal poverty level (FPL). Effective October 2008, all Primary Contractors were encouraged by Medicaid to employ or contract with Certified Application Assistants. Effective January 2010, Medicaid began requiring the provision of these Application Assistants, who help with paperwork and conduct patient interviews. (Only Medicaid Eligibility Workers can award Medicaid eligibility.) Medicaid provides formal training to certify or update Application Assistants upon request. Due to a State hiring freeze, the longstanding shortage of Medicaid Eligibility Workers continues. Timely Medicaid eligibility determination continues to be a challenge.

/2012/ Medicaid is setting up Customer Service Centers to promote access to eligibility workers and allow for completion of applications by phone: with Birmingham, Montgomery, and Mobile now having a center. //2012//

/2013/ The Customer Service Centers continue to operate in Birmingham, Montgomery, and Mobile--which are respectively located in north-central Alabama, south-central Alabama, and south Alabama. As well, one has opened in Huntsville (in north Alabama), and one is expected to open in Foley (in south Alabama) in FY 2012. //2013//

Though enrollment in the Medicaid Maternity Care Program is limited to U.S. citizens and others legally residing in the U.S., Medicaid provides limited funding to hospitals and doctors for emergency deliveries of women whose residence in the U.S. is not legally documented.

Patient 1st and Case Management/Care Coordination

The course of the Patient 1st Program, a primary care case management program (PCCM) implemented by Medicaid, affects provision of case management or care coordination by ADPH staff to non-pregnant individuals. Therefore, discussion of the history of Patient 1st and of care coordination/case management of non-pregnant individuals follows. Case management and care coordination, which are provided by licensed public health social workers and nurses, help patients access medical, social, and educational services and other community resources. In this report, the terms "case management" and "care coordination" pertain to the same service--though some programs use one term and some the other.

Medicaid fully implemented Patient 1st by November 1998, when all Alabama counties except Mobile used the Patient 1st model. (Mobile County later began participating in Patient 1st.) The Patient 1st model assigned all Medicaid recipients to a medical home that managed their health care needs, including referrals for specialty care and pre-authorization of specified Medicaid services. Many believed that Patient 1st increased access to primary care for Medicaid recipients. Under Patient 1st, though a few CHDs provided some child health services via memorandums of understanding (MOUs) with private providers, the number of children seen in ADPH clinics for care declined markedly, as discussed later in this section. PCCM and a prior increase in willingness of private providers to see Medicaid-enrolled patients were thought to be major factors in this decline.

As the need and/or opportunities for provision of direct health care services to children and youth in the CHD setting diminished, FHS and some CHDs shifted their focus from direct services provided in the CHD to enabling and community-based services. This shift gave rise to increased emphasis on provision of care coordination. Care coordinators worked in several clinical programs, including ADPH's Family Planning, Child Health, and HIV/Acquired Immunodeficiency Syndrome (AIDS) Programs. While Patient 1st as originally implemented was in force (November 1998 through February 2004), ADPH provided case management to certain children through the Medically at Risk (MAR) Case Management Program. As of early calendar year (CY) 2001, most MAR referrals were for immunizations, dental care, appointments missed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), social systems issues, specialty referral coordination, and problems with a medical regimen. As of early FY 2004, about 45 nursing or social worker fulltime equivalents (FTEs) were working as MAR care coordinators under the Patient 1st Program.

In early FY 2004, the Governor appointed a new Medicaid Commissioner. Medicaid then discontinued Patient 1st, effective March 1, 2004, because of financial constraints and waiver expiration. When Patient 1st ended, Medicaid-enrolled patients were no longer assigned to a primary care provider and could receive services from any physician who provided services under the Medicaid Program, but Medicaid no longer reimbursed for provision of care coordination for adults.

Many rural medical providers had depended heavily on the Patient 1st case management fees paid by Medicaid. For this and other reasons, primary medical providers in the State petitioned Medicaid to restart the managed care program. A task force, which included persons from CRS and ADPH, was established to create a new waiver for a revised managed care program for Medicaid enrollees. The Patient 1st Program was redesigned and reinstated in increments, beginning December 1, 2004. Counties were slowly added back to the program, with all counties being a part of Patient 1st by February 1, 2005. The reinstated Patient 1st Program, which remains in effect, has a similar structure to that of the previous program and provides financial incentives for physicians to provide a true medical home and perform EPSDT screenings. Medicaid pays the provider graduated case management fees, determined by the components of

care (e.g., providers' availability after office hours) that the provider agrees to incorporate. The reinstated program includes increased quality assurance efforts, performance-based goals, and a greater focus on affecting behavior through providers being more active in patient education.

One change in the redesigned Patient 1st Program was that Medicaid no longer required a referral from the patient's primary medical provider to provide care coordination for children and adults. The removal of this barrier allowed ADPH care coordinators to receive referrals from a variety of sources, including schools, hospitals, and self-referrals by patients and families. Further, under the redesigned program, ADPH Central-Office staff could refer children with elevated lead levels, infants who had failed their newborn hearing screenings, and infants who had been identified with certain conditions at birth through the newborn hematologic screening program for care coordination by trained CHD staff. Moreover, with the redesigned program, CHD care coordinators could provide information and counseling on birth control methods and sexually transmitted diseases (STDs), including HIV infection, to Medicaid-enrolled teens who presented for family planning services.

Because the redesigned Patient 1st Program did not require referral from the patient's primary medical provider for ADPH staff to provide care coordination, the Department's provision of care coordination under Patient 1st increased notably in FYs 2005 and 2006. As of January 2006, 68 staff FTEs were working in ADPH's Patient 1st Care Coordination Program (up from about 45 FTEs working in MAR care coordination in early FY 2004). Of the 68 FTEs, 57 were providing care coordination for children. Further, Patient 1st care coordination grew rapidly in FY 2007, when 103 ADPH care coordinators provided this service. FHS implemented an electronic Care Coordination Referral System (CCRS) in May 2007. This ongoing system is used for referrals received from the Children's Health Division for children with elevated lead levels and for newborns who need care coordination services with respect to hearing screening or metabolic or hematologic screening. As well, the system is used for infants referred by Medicaid for care coordination. The growth in provision of care coordination services continued in FY 2008, when ADPH began providing chronic disease case management to asthma patients (in February 2008) and to diabetes patients (in March 2008) under Medicaid's Together for Quality (TFQ) federal grant. In FY 2008, there were 30 nursing or social worker FTEs working in the TFQ 8-county pilot (Montgomery, Bullock, Pike, Tuscaloosa, Lamar, Pickens, Calhoun, and Talladega Counties). Referrals for asthma and diabetes were sent electronically to ADPH from Medicaid and then distributed to the appropriate public health areas (PHAs, or Areas) using the CCRS system. Since implementation of CCRS, several thousand referrals have gone through the statewide system to the PHAs or counties.

The Patient 1st Care Coordination Program continued to grow, with 133 FTEs (76 of them dedicated to children) providing care coordination by the end of FY 2008. By this time, however, growth in the program had created financial concerns for ADPH in regard to the Medicaid match (which was 33%). In September 2008 Medicaid agreed to pay half of the federal match on any Medicaid-related expansion of the program relative to FY 2007, after ADPH paid a \$2.1 million match in Medicaid-related expansion of the program. Further, ADPH worked to run a more efficient program.

Despite the cost sharing and cost containment, in FY 2009 ADPH determined that it could not maintain the program as then funded and began negotiating with Medicaid for further help with the federal match. Since further cost sharing could not be achieved in FY 2009, ADPH's provision of care coordination under Medicaid's Patient 1st Program decreased. Specifically, by the end of FY 2009, 101 FTEs (70 of them serving children) were devoted to care coordination under the Patient 1st Program, versus 133 FTEs in FY 2008. In FY 2010, the Medicaid match dropped from 33% to 23.46%, but the Governor required that ADPH turn over any savings to the State for distribution to other agencies.

/2012/ The number of ADPH FTEs providing care coordination in the Patient 1st Program was 116 in early FY 2010, but declined to 93 by March 2011. The cost sharing arrangement with

Medicaid is being modified, effective June 30, 2011. As of that date, ADPH will pay 10% of the allowed fee for care coordination services. The fee for these services will be adjusted to actual documented cost at least annually. ADPH will also pay Medicaid 1% of program benefit expenditures, to offset cost incurred by Medicaid in administering this program. This new arrangement should allow ADPH to continue providing care coordination services under Medicaid's Patient 1st Program, though the frequency and extent of these services remain to be determined. //2012//

/2013/ Later in FY 2011, 81 FTEs were providing care coordination in the Patient 1st Program. This number is expected to increase in FY 2012. //2013//

Until the TFQ care coordination pilot ended in March 2010, ADPH continued to provide chronic disease management to asthma and diabetes patients in pilot counties under Medicaid's TFQ federal grant. UAB's evaluation of the pilot will continue through December 2010.

/2012/ In FY 2010, Medicaid and ADPH received positive evaluations of the asthma and diabetes pilots from the UAB School of Public Health and the Agency for Health Research and Quality.

Medicaid is conducting pilot studies of the medical home concept. These studies are discussed under SPM 5 in Section IV.D. //2012//

Collaboration Between CRS and Medicaid

The Medicaid Commissioner has emphasized children's issues as an agency priority, and CRS has specific Medicaid staff members assigned to work with CRS's programs. Meetings between Medicaid and CRS are conducted quarterly, leading to greater coordination. CRS is providing input to Medicaid on issues likely to impact CYSHCN and their families.

This strong partnership has facilitated collaboration such that CRS has established procedures to bill for therapy services provided by vendors. CRS credentials its staff and vendor physical, occupational, and speech therapists, as well as licensed physical therapist (PT) assistants and certified occupational therapist assistants according to the Medicaid Administrative Code to provide services to CRS clients.

A list of approved multidisciplinary clinics within the Children's Specialty Clinic Program, with required minimum staff, has been negotiated with Medicaid to ensure consistent quality, statewide standards of care, and access to community-based clinical services. CRS works with Medicaid to add new clinics or modify existing clinics as needed.

CRS has become a direct provider with Medicaid for audiological services, hearing aids, and related supplies, thereby providing better coordination of these services for Medicaid-eligible CRS clients. CRS has also negotiated with Medicaid to provide specialty eye clinics staffed by optometrists, thereby increasing access to basic eye care and to specialists as needed.

CRS has an ongoing collaboration with Medicaid to meet Health Insurance Portability and Accountability Act (HIPAA) standards for privacy and billing. Also, a data-sharing agreement has been re-established to match CRS and Medicaid data to confirm coverage and determine receipt of Supplemental Security Income (SSI).

CRS staff, including the SPC, participate on advisory committees and work groups associated with various Medicaid initiatives, including the TFQ grant. TFQ, which is an effort to build a statewide health information system, is further discussed under NPM 5.

CRS reviews all statewide requests to Medicaid for augmentative communication devices. CRS had previously reviewed all power wheelchair requests, but these are now contracted to a private company.

/2013/ CRS was awarded the State Implementation Grant for Systems of Services for CYSHCN. The project is focusing on medical homes, transition of youth with special health care needs to adult services, and provision of ongoing statewide support through coordination and collaboration. CRS has new capacity for partnership with the State's Medicaid Patient Care Networks as it carries out the goals and objectives of the State Implementation grant.

CRS recently negotiated with Medicaid for coverage for Oticon Medical Ponto external sound processor coupled to softband to be used by clients diagnosed with congenital malformations such as bilateral atresia or bilateral microtia. Children who are too young to have a bone anchored hearing aid (BAHA) surgical implant or who are not suited for implantation may be amplified using a BAHA external sound processor coupled to a softband or headband. //2013//

Medicaid Family Planning Waiver and Related Issues

The 1115(a) Family Planning Waiver Proposal, submitted by ADPH and Medicaid to the Health Care Financing Administration (HCFA) in FY 1999, was implemented in October 2000. (HCFA, located in DHHS, became the Centers for Medicare and Medicaid Services [CMS]). This waiver, called "Plan First," expanded Medicaid eligibility for family planning services for women aged 19-44 years to 133% of FPL. (The previous cut-off had been about 16% of FPL.) Family planning services for adolescents less than 19 years old were already covered by Alabama's State Children's Health Insurance Program (CHIP, discussed later in this section), which then provided Medicaid coverage for those at or below 100% of FPL and private insurance coverage for those between 100% and 200% of FPL. Care coordination and outreach were key components of the Family Planning Waiver Proposal.

Plan First is in its second 3-year extension, which will expire September 30, 2011. Effective January 1, 2010, women seeing private Plan First Providers are now allowed to take contraceptive prescriptions to the pharmacy. Women receiving services through a CHD continue to obtain their contraceptives on site at the time of their visit, often receiving a 12-month supply. Also effective January 1, 2010, women applying for Plan First no longer have to provide a birth certificate for proof of citizenship. Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, states may now use a data match with the Social Security Administration (SSA) to verify citizenship.

/2012/ ADPH is working with Medicaid to seek a 3-year renewal of the 1115(a) Family Planning Waiver. //2012//

/2013/ CMS has extended the Plan First family planning waiver through December 2013. //2013//

The State Children's Health Insurance Program

CHIP was added to the Social Security Act by the Balanced Budget Act of 1997. The purpose of this program is to provide health insurance to the country's uninsured children who are 18 years of age or younger. Alabama was the first state in the nation to have a federally approved CHIP plan. Alabama's CHIP is administered through ADPH's Bureau of Children's Health Insurance and partners with Alabama Medicaid and the Alabama Child Caring Foundation (ACCF). Discussion of the foundation follows, and is followed by the history of Alabama's CHIP.

ACCF is a non-profit, publicly supported organization that is the funding mechanism for the Alabama Child Caring Program (ACCP). BCBS provides all the administrative support for the foundation, so all money contributed to the foundation goes directly to providing healthcare coverage for children. BCBS also matches every contribution. The mission of ACCF is to provide immediate medical care and ongoing medical coverage for needy uninsured children who are not eligible for the State's governmental programs. Since the first child was enrolled in the program in March 1988, more than 65,000 children have received assistance from ACCP.

/2012/ As stated later, in October 2009 the State Legislature increased the upper income limit for ALL Kids, Alabama's CHIP, from 200% to 300% of FPL. This expansion exceeded ACCP's upper income limit of 235% of FPL and notably expanded the number of children who were eligible for ALL Kids. Due to this expansion and recently enacted federal healthcare reform laws, ACCP was no longer needed for health insurance coverage. Accordingly, the donations received by ACCF on or after May 1, 2010 were returned to the donors. Through December 31, 2010, BCBS covered the cost of claims for children enrolled in ACCP, though these claims exceeded ACCP's revenue for that period. ACCP staff referred then-enrolled children to Alabama Medicaid and to ALL Kids for future health care coverage and worked with the families to ensure a smooth transition. ACCF closed on January 1, 2011. By that time, over 71,000 children had received medical coverage through ACCP, since ACCF's creation in 1987 (per a BCBS web site, reference 5). //2012//

In 1997 the State Legislature appropriated funds for Alabama's CHIP. The State Legislature also created the Children's Health Insurance Program Commission to oversee development of the State's plan for implementing CHIP and designated ADPH to submit the CHIP plan to HCFA and to receive the federal funds. The Children's Health Insurance Program Commission first met in October 1997. This commission endorsed expansion of children's health insurance coverage from 100% of FPL to 200% of FPL, with the expanded coverage to be provided through private insurance.

Even before passage of the State legislation, a work group had been formed and begun development of a CHIP plan for Alabama. The work group included representatives from numerous agencies, professional associations, and interest groups. With ADPH and Alabama Medicaid taking a coordinating role, the work group determined that a 2-phased approach would be the most beneficial for Alabama's children. Phase I of Alabama's CHIP, a limited Medicaid expansion, was begun in February 1998. This expansion covered children who were born before October 1, 1983, were under 19 years of age, and were living in households with incomes under 100% of FPL. Phase II (the ALL Kids Program), a private-like insurance package for children whose household income ranged from 100% (133% for children under 6 years of age) through 200% of FPL, began on October 1, 1998. Effective October 1, 2009, the upper income criterion for enrollment in ALL Kids increased, with 300% of FPL now being the maximum allowable household income.

/2012/ "Current Enrollment by Age" reports for Alabama's CHIP are posted on the ALL Kids web page, for the last day of each month from June 2003 through a recent month. The following is based on review of reports from June 2003 through January 2011 but focuses on September 2009 onward. ALL Kids enrollment increased following the expansion, in October 2009, of the upper income criterion for enrollment to 300% of FPL. Specifically, the number of ALL Kids enrollees increased from 68,440 in September 2009 to 72,587 in January 2010, reached 75,112 in June 2010, and remained above 75,000, peaking at 75,842 in September 2010 (a record high for the surveillance period). ALL Kids enrollees numbered 75,267 in January 2011, close to the median value (75,328) for June 2010 through January 2011. Further, comparing January 2011 to January 2009, when ALL Kids had 70,770 enrollees, 4,497 more persons were enrolled in ALL Kids. A total of 120,045 persons were enrolled in ALL Kids for at least 1 day in CY 2010. //2012//

/2013/ ALL Kids enrollees numbered 83,999 in January 2012: 8,732 more persons than in January 2011, or 11.6% above the corresponding number for January 2011 (when 75,267 persons were enrolled). Concerning annual enrollment, the unduplicated number of children ever enrolled in ALL Kids during the specified year was as follows: 100,530 in FY 2010 and 109,255 in FY 2011 (reference 6). Thus, in FY 2011 versus FY 2010, annual enrollment in ALL Kids increased by 8,725 individuals, or by 8.7%. //2013//

New federal legislation, the Children's Health Insurance Program Reauthorization Act of 2009, reauthorized CHIP and finances the program through FY 2013. This legislation requires that, as

of January 1, 2010, the citizenship of CHIP enrollees be verified. In an arrangement with SSA, the State is using an automated match of certain information from the CHIP application and certain information from Social Security files to meet the verification requirement.

/2012/ Three major activities concerning CHIPRA implementation include: 1) citizenship verification, 2) prospective payments for federally qualified health centers (FQHCs) and rural health centers, and 3) mental health parity. Verification of citizenship relies heavily on coordination with the federal SSA (discussed above), follow up with parents, and internal tracking. Since being established, the verification process has worked well.

Establishing a prospective payment system required substantial programming by BCBS, as well as coordination with FQHCs and rural health centers. BCBS implemented this new claims payment system in August 2010, with the system being retroactive to October 1, 2009.

BCBS researched program benefits and conducted appropriate analysis to assure readiness for compliance with mental health parity requirements, which became effective October 1, 2010.

//2012//

/2013/ Effective October 1, 2010, mental health benefit limits for ALL Kids enrollees were changed in order to be compliant with mental health parity as required by CHIPRA for ALL Kids (reference 6). //2013//

Due to incremental, federally mandated Medicaid coverage of persons from 6-18 years of age with household incomes below 100% of FPL, ALL Kids became the sole component of Alabama's CHIP in FY 2004. (For this reason, in this document "Alabama's CHIP" and "ALL Kids" are used interchangeably to refer to Alabama's State Children's Health Insurance Program.) Persons eligible for Medicaid are not eligible for ALL Kids.

Medicaid and ALL Kids continue collaborating on the application process, however. In fact, since its formation, Alabama's CHIP has sought to streamline and coordinate applications for children's health insurance. Specifically, since the inception of ALL Kids, a joint application form has been used for SOBRA Medicaid and ALL Kids. In 1999 ACCP was added to the application; in 2000 applicant information for Medicaid services for family planning was added; and in 2003 applicant information for the Medicaid for Low Income Families Program was added. The joint application has made applying for these programs much simpler and referrals among the programs more automated and streamlined.

Additional activities designed to inform the public about ALL Kids and to promote enrollment of eligible children in ALL Kids, Medicaid, or ACCP are described under NPM 13.

/2012/ Since ACCP was discontinued, the joint application no longer has an ACCP option.

//2012//

/2013/ Due to the austere fiscal climate projected for FY 2013, ALL Kids is halting all media-related outreach in FY 2012 and will research all possible cost-saving measures to help address the State's projected budget deficit (reference 6). //2013//

Department of Children's Affairs

The Department of Children's Affairs (DCA) was created in 1999 through legislation endorsed by the Governor. Per their web site (www.dca.alabama.gov), DCA's mission is "to provide state leadership that identifies, promotes, and coordinates services for children, their families, and communities." This mission is accomplished via 4 major initiatives administered by DCA: 1) Children First, 2) State and County Children's Policy Councils (CPCs), 3) the Head Start State Collaboration Office, and 4) the Office of School Readiness. DCA advises the Governor and the Legislature on matters pertaining to the coordination of services for children and functions as a liaison between the Governor and state agencies that serve children. Through the State CPC,

DCA prepares and submits for approval and adoption legislation required to meet the unmet needs of children. DCA submits annual reports to the Governor and the State Legislature on activities and expenditures of State and local agencies related to children. The Governor continues his support for DCA and CPCs.

Since its inception DCA has accomplished many activities to benefit Alabama's children. These activities included the following: managing the growth and development of 67 local CPCs across the State; organizing and sponsoring an annual statewide CPC conference; managing and overseeing the budgeting of Children First Fund dollars (discussed in Section III.B); publishing the State CPC's Annual Needs Assessment from 67 counties; maintaining the work of Alabama's Head Start Program; cosponsoring (along with ADPH and others) the Oral Health Summit to identify barriers and strategies to promote oral health in Alabama; cosponsoring the Black Belt Health Summit; organizing a statewide Hispanic Coalition; and cosponsoring Alabama's first statewide fatherhood conference. DCA provided leadership in the development of the Alabama Resource Management System (ARMS), which it now jointly administers with the Alabama Criminal Justice Information Center. ARMS is an interactive, web-based system that uses reports, graphs, and maps to share resource, financial, and statistical information about Alabama's children and families and to allow users to conduct advanced queries and analyses with its data.

DCA's Office of School Readiness provided leadership in the development and expansion of Alabama's nationally recognized pre-kindergarten program, First Class. The program's mission is to provide Alabama's pre-kindergarten children with early childhood experiences that prepare them for school and lifelong learning. This model allowed Alabama to build on its existing preschool infrastructure, while providing affordable access to voluntary, high quality pre-kindergarten for a greater number of Alabama's 4-year-olds. Beginning in 2000-01 with 8 pilot sites, First Class grew to 185 programs in 2008-09. With the long-term goal of achieving universal pre-kindergarten in the State, First Class continues to be a major focus for DCA and the Governor.

The Governor has tasked the DCA Commissioner with convening an Early Childhood Advisory Council on his behalf, as required in the Improving Head Start for School Readiness Act of 2007. This council is to conduct periodic needs assessment of the quality and availability of early childhood education programs within the State; promote collaboration and coordination among agencies responsible for early childhood services; and develop recommendations for increasing participation of children in early childhood programs, establishing unified data collection systems, enhancing professional development of early childhood educators, and improving early learning standards. DCA successfully applied for a grant from the National Governors Association to provide technical assistance to the State during FY 2010.

//2012/ DCA was awarded \$1.96 million by DHHS in FY 2010 to be used for further development of the Early Childhood Advisory Council and implementation of its activities, especially those related to unified data collection systems. Further, DCA was designated by the Governor as the lead agency for the Maternal, Infant, and Early Childhood Home Visitation Program and successfully applied for funding. DCA is now developing its updated state plan for the home visitation program. //2012//

//2013/ The Early Childhood Advisory Council has continued its work. In FY 2011, DCA released 3 requests for proposals to fund new home visitation services in the 13 Alabama counties found to be at highest risk through the Home Visitation Needs Assessment: Barbour, Bullock, Chambers, Conecuh, Dallas, Greene, Lowndes, Macon, Perry, Russell, Sumter, Tuscaloosa, and Wilcox. Nurse Family Partnership, Parents as Teachers, and Home Instruction for Parents of Pre-school Youngsters are the national home visitation models being implemented with the federal funding. //2013//

ADRS, including CRS, the Alabama Early Intervention System (EIS), and Vocational Rehabilitation Service (VRS), is active at the State and local levels with the CPCs as a voice for

children and youth with disabilities. A staff member from ADRS sits on CPCs in all counties. CRS staff and LPCs attend the CPC's statewide and regional conferences and training events.

CRS Services to Certain Medicare Enrollees

In FY 2009, CRS served about 40 clients with Medicare benefits, about a 33% increase over the number served in FY 2005. Most of these clients were adults with bleeding disorders. CRS provides assistance to clients with Medicare coverage to select the health plan option that best addresses their needs and to help them locate Medicare pharmacies for factor treatment of bleeding disorders. With the implementation of Medicare Part D, CRS administrators identified those Medicare recipients that had dual eligibility with Medicaid. CRS care coordinators then helped these recipients research the most appropriate prescription drug benefit plan. Although factor treatment is considered major medical and therefore is not impacted by Medicare Part D prescription drug plans, many clients have co-morbid conditions that require medications. Enrolling in the most appropriate plan initially is preferable to choosing or being assigned to a plan that does not cover all necessary medications.

//2012/ For FY 2010 CRS served 35 clients with Medicare benefits, most of whom were adults with bleeding disorders. CRS has continued to help the above mentioned clients enroll in the most appropriate Medicare Part D prescription plan. //2012//

//2013/ For FY 2011 CRS served 37 clients with Medicare benefits, most of whom were adults with bleeding disorders. CRS has continued to help the above mentioned clients enroll in the most appropriate Medicare Part D prescription plan.

EMERGENCY PREPAREDNESS: ADPH AND CRS

ADPH and CRS continue to be involved in emergency preparedness. All ADPH bureaus, offices, and centers play a role in emergency preparedness. Though not a first responder, ADPH has a key role in promptly responding to potential man-made disasters and potential weather-related disasters. The Department's role during the latter is to provide medical needs shelters close to the devastated area. The Department's role was further detailed in an attachment, which is available upon request, to previous MCH Block Grant Services reports/applications (MCH reports/applications). Current information about emergency preparedness is posted on ADPH's web site at <http://www.adph.org/cep/>. CRS's role in emergency preparedness is summarized in the attachment to this section.

THE STATE'S FISCAL SITUATION

The State, especially the Medicaid Agency, is anticipating an austere fiscal climate in FY 2013. Concerning the Medicaid budget, earlier in CY 2011 the Governor's administration had estimated that Medicaid could save \$111 million in this year's budget, but this amount was overstated by \$80 million, and Medicaid had been unable to make the anticipated cuts. Soon after the extent of Medicaid's fiscal shortfall was recognized, the Governor ordered 10.6% proration in the State's General Fund budget over the last 6.5 months of the current FY. Upon the former Medicaid Commissioner's resignation (submitted on March 26, 2012 with an effective date of March 30, 2012), the Governor asked State Health Officer Donald Williamson, who directs ADPH, to lead a task force to ensure a smooth transition in leadership at the Medicaid Agency. In addition to leading the task force, Dr. Williamson continues to serve as State Health Officer.

The State's fiscal situation is expected to worsen in FY 2013, for which some project a \$366 million deficit in the State's General Fund budget (reference 7). On April 10, 2012, the Alabama House of Representatives (House) passed a General Fund budget that its sponsor described as "dire." Should this budget be implemented, Alabama Medicaid, the largest single element of the General Fund, would have its State funding cut by 30%, which would also cut federal funding for the program. Dr. Williamson said that the total loss for the Medicaid program, including a loss of matching federal funds and 10.6% proration in this year's budget, could be \$720 million under the House-passed budget. He

expressed concern that the budget passed by the House would not only lead to cuts in optional services provided by Medicaid, but to cuts in federally mandated Medicaid programs, including pharmacy for children, and deeper cuts in Medicaid reimbursements for physicians. Under the House-passed budget, most other State agencies would probably see reductions of 20% or more in their General Fund dollars. However, Dr. Williamson noted that the House-passed budget would likely face changes in the State's Senate and possibly in a conference committee (reference 8). Nevertheless, ADPH, along with Alabama Medicaid and other State agencies, must prepare for a severe fiscal climate in FY 2013. //2013//

SELECTED CHANGES IN ALABAMA'S POPULATION

The following information is from several places in the Needs Assessment Report, which provides additional details, including references.

Total Population

The estimated population of the State in 2008 was 4.7 million. Comparing 2008 to 2000, the State's population had increased by 4.8% and the nation's by 8.0%.

0-24 Year-Old Residents

This discussion is based on U.S. Census (Census) population estimates. In 2008 there were 1,572,695 Alabama residents from 0-24 years of age: an increase of 0.6% relative to 2000.

Here, persons classified by the Census Bureau as "Hispanic" or "Not Hispanic" are respectively referred to as "Latino" or "non-Latino." Races other than White or Black are combined into an "Other" category. Information below draws from far more detailed information (under "Infants, Children, and Youth: Race and Ethnicity") in Section 3 of the Needs Assessment Report. The following overlaps with discussion of Health Status Indicators (HSIs) 6A and 6B. Concerning 0-24 year-old Alabama residents in 2008:

- 1) 4.3% were Latino, up from 2.5% in 2000.
- 2) 61.5% were White, non-Latino, down from 63.4% in 2000.
- 3) 31.1% were Black, non-Latino, down from 31.7% in 2000.
- 4) 3.1% were Other, non-Latino, up from 2.4% in 2000.

The recent increase in the unemployment rate (described later) may have slightly affected Alabama's demographic composition in 2009. That is, conjecturally, some Latino residents who were not U.S. citizens may have returned to their country of origin in 2009, due to the presence of fewer job opportunities in Alabama. We do not have population estimates for 2009, so cannot quantitatively assess whether such a change occurred.

Live Births

In this report, unless stated otherwise, counts of births pertain to live births to Alabama residents, and the race and ethnicity of the infant are presumed to be that of the mother. In 2008 there were 64,345 live births to Alabama residents: an increase of 1.9% relative to 2000.

Discussion here also combines races other than White or Black into an "Other" category. Information below is drawn from far more detailed information (under "Live Births According to Race, Ethnicity, and Maternal Age") in Section 3 of the Needs Assessment Report. The following overlaps with discussion of HSIs 7A and 7B. Concerning live births to Alabama residents in 2008:

- 1) 8.2% were Latino, up from 3.1% in 2000.
- 2) 59.2% were White, non-Latino, down from 63.4% in 2000.
- 3) 30.7% were Black, non-Latino, down from 32.3% in 2000. Most of the decline in the number of

Black, non-Latino infants occurred in those whose mother was 19 years of age or younger.

4) 1.8% were Other, non-Latino, up from 1.1% in 2000.

//2013/ Brief updates concerning HSIs 6 and 7 are in Section IV.E. //2013//

ECONOMIC ENVIRONMENT AND POVERTY LEVELS

According to the U.S. Bureau of Labor Statistics, in December 2009 the unemployment rate was higher in Alabama than in the nation: with a rate of 11.0% in Alabama and 10.0% in the nation. (Alabama's rate was preliminary). This was in contrast to preceding years. That is, in the month of December for the years 2001 through 2008, Alabama's unemployment rate was below the nation's rate. For example, in December 2008 the unemployment rate was 6.5% in Alabama and 7.4% in the U.S. In fact, according to the University of Alabama's Center for Business and Economic Research (CBER), Alabama entered the recent recession later than the nation, but the decline has been steeper in Alabama. In Alabama in 2009, manufacturing, construction, and professional and business services experienced the worst job losses. Nevertheless, according to CBER, 2000-2010 as a whole is becoming one of Alabama's best decades. During this time, the State has made notable strides in economic and workforce development, in personal income growth, and in tourism and exports industries. As well, economic diversification has grown high-paying manufacturing and white-collar jobs during this time period. CBER expects that these strides will help Alabama rebound economically and that 2010 will be a year of recovery for the State's economy, though Alabama's rate of improvement may be slower than the nation's. Alabama jobs are expected to continue to decline in most sectors at least through mid-2010. However, CBER expects that, later in 2010, job losses will slow and job gains will occur in services and government, to keep employment about level for the year.

//2013/ From January 2002 through August 2011, Alabama's monthly, seasonally adjusted unemployment rate peaked at 10.6% in September 2009, remained there through December 2009, declined to 9.0% by July 2010 and remained there through September 2010, but then ranged from 9.1%-9.3% from October 2010 through August 2011. The rate then declined each month through April 2012, when it was 7.2%. It rose in May 2012, when the State's preliminary, seasonally adjusted unemployment rate was 7.4%. (The aforesaid information is from material downloaded from the U.S. Bureau of Labor Statistics' web site on 6/22/2012. For reasons detailed on the web site, currently posted rates differ from preceding postings.) //2013//

The prevalence of poverty has been higher in Alabama than in the nation and has been higher among children and youth than among adults. According to the 2006-2008 American Community Survey, the percentages of Alabama residents who were living below FPL, according to age, were as follows: 22.9% of persons 17 years or younger, 14.6% of persons 18-64 years, and 12.2% of persons 65 years or older. Corresponding percentages for the U.S. were: 18.2% of persons 17 years or younger, 11.8% of persons 18-64 years, and 9.8% of persons 65 years or older.

TRENDS IN NUMBERS OF ALABAMA TITLE V-SERVED PERSONS

Numbers in this discussion pertain to numbers of individuals served by the State Title V program, as reported on Form 7 in the current or previous MCH reports/applications, and to FYs.

Pregnant Women--Numbers of pregnant women served under Title V were 28,989 in 1997, 5,914 in 2004, 1,827 in 2008, and 1,780 in 2009. Thus, comparing 2009 to earlier years, the number of Title V-served pregnant women declined by 93.9% over a 12-year period, 69.9% over a 5-year period, and 2.6% over a 1-year period. As previously discussed, ADPH no longer provides direct prenatal care. Presumably, CHDs provided care coordination, rather than direct care, to pregnant women served in 2008 and 2009.

Infants--Numbers of infants served under Title V were 58,668 in 1998, 54,841 in 2004, 60,951 in

2008, and 58,956 in 2009. Thus, comparing 2009 to earlier years, the number of Title V-served infants increased by 0.5% over an 11-year period, increased by 7.5% over a 5-year period, and declined by 3.3% over a 1-year period. Methodological details are in notes to Form 7.

Children and Youth--Numbers of children and youth served under Title V were 76,357 in 1997, 35,614 in 2004, 33,571 in 2008, and 33,800 in 2009. Thus, comparing 2009 to earlier years, the number of Title V-served children and youth declined by 55.7% over a 12-year period, declined by 5.1% over a 5-year period, and increased by 0.7% over a 1-year period.

CYSHCN--This figure represents CRS-enrolled CYSHCN who receive direct and enabling services or families who receive information and referral services from CRS staff. It is difficult to capture those who benefit from population-based or infrastructure-building services but are not enrolled in the program. Numbers of CYSHCN served under Title V were 23,441 in 1997 and 16,296 in 2009; from 1997-2009, the highest number of CYSHCN served in a year was 24,545 in 2000. The number served in 2009 (16,296) is 1.8% below the number served in 2008 (16,591), with the year 2008 number being 1.5% above the number served in 2007 (16,346). The number of CYSHCN served has been fairly stable since 2007, following a notable decline (of 15.6%) in 2005. The decline in 2005 may be attributed to the following factors: the elimination of eligibility for purchased services for certain diagnoses, a change in the CRS case closure policy, increased access to care in the private sector due to physicians more widely accepting Medicaid, and service cuts implemented due to budget constraints. In 2007 CRS began efforts to increase numbers served, including a public awareness campaign and a focus on screenings for scoliosis and hearing loss through partnerships with schools, Head Start centers, and daycares in underserved areas. These efforts may have contributed to the relative stability in numbers served since that time. CRS is operating and serving CYSHCN near its maximum capacity given current funding and staffing levels.

Others--The "others" class consists of males and females served in CHD Family Planning clinics. Numbers of other clients served under Title V were 91,206 in 1997, 96,519 in 2004, 109,238 in 2008, and 111,263 in 2009. Thus, comparing 2009 to earlier years, the number of Title V-served individuals classified as "other" increased by 22.0% over a 12-year period, 15.3% over a 5-year period, and 1.9% over a 1-year period.

As detailed above, the number of pregnant women served at CHDs has markedly declined over the years. As also detailed above, the number of Title V-served children and youth has markedly declined relative to 1997 and moderately declined relative to 2004. As detailed earlier in this section, changes in the health care environment, especially Medicaid's managed care plans, have caused a shift in the provision of direct medical services from CHDs to private providers, which has impacted the numbers of children and youth and pregnant women served at CHDs.

As previously stated, the above numbers served are from Form 7. Except for the "Infants < 1 year old" class, Form 7 counts only persons who received services in a CHD facility or a CRS facility, not persons served beyond the walls of these facilities. Some individuals who were not seen in these facilities have received information via an ADPH or CRS toll-free phone line or via other ADPH- or CRS-sponsored outreach efforts.

//2013/ The above discussion of numbers served has been shortened due to space constraints. Form 7 now shows annual numbers served for a 6-year period. Numbers served in 2011, versus 2009, declined in all but 1 category, children and youth. //2013//

//2012/ In FY 2010, CRS served 15,481 CYSHCN, a 5% decrease over FY 2009. As stated above, this figure represents only CYSHCN and families who receive services directly from CRS. CRS continues its public awareness campaign and provision of onsite screenings for scoliosis and hearing loss as described above. //2012//

//2013/ In FY 2011, CRS served 11,436 CYSHCN, a 26% decrease over FY 2010. This

decrease is due to a change in reporting and CRS efforts to eliminate duplicate records. As before, this figure represents only CYSHCN and families who receive services directly from CRS. CRS continues its public awareness campaign and provision of onsite screenings for scoliosis and hearing loss. //2013//

SPECIAL CHALLENGES IN DELIVERY OF SERVICES TO CYSHCN

Addressing the service delivery needs of Alabama's CYSHCN presents special challenges. The State is largely rural, with greater population concentrations surrounding 3 larger urban areas (Mobile, Birmingham, and Huntsville). In rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN in the general child population, such as higher poverty levels and lower educational levels. Also, comprehensively meeting the needs of CYSHCN in rural areas is more difficult due to transportation barriers and an inadequate supply of providers with specialized experience in treating complicated health issues. Specialists and allied health professionals with pediatric experience are mainly located in the larger urban areas, necessitating travel to access them. In general, the State has poor public transportation systems. Though private programs exist in some areas and reimbursements for transportation are provided through various sources (including Medicaid and CRS), the State lacks the infrastructure to meet needs in all locations. Thus, CRS continues to have an integral direct service role in the State's system of care for CYSHCN via its 15 community-based offices. Via the provision of multidisciplinary medical specialty and evaluation clinics, family support, and care coordination throughout the State, more CYSHCN have access to quality services in their home communities. Public/private partnerships, including agreements with the State's 2 tertiary-level pediatric hospitals, enable CRS to bridge gaps in the system of care, thereby increasing the State's capacity to address the health, social, and educational needs of Alabama's CYSHCN. Through its intradepartmental collaboration with VRS, CRS promotes the transition of youth with special health care needs, including SSI beneficiaries, from school to work and to independence.

//2013/ CRS now has 14 community-based offices. //2013//

Due to fairly consistent reductions and/or level funding from federal MCH Block Grant monies and State appropriations, significant budget shortfalls have faced the State Children with Special Health Care Needs (CSHCN) Program. CRS is also responsible for adults with hemophilia and other bleeding disorders. The increased manufacturing costs for clotting factor products and the increased utilization in response to a shift in standard of care toward prophylactic treatment have caused concerns about the long-term sustainability of the program at current funding levels. For the first time since 1991, CRS was forced to implement significant budget reductions resulting in cuts to services provided to CYSHCN and their families in FYs 2005 and 2006. These cuts included suspension of purchased services for families with annual taxable income above 200% of FPL, suspension of the incontinence supply (diaper) program, elimination of purchased services for certain diagnoses, elimination of the purchase of certain durable medical equipment items (standers, ramps, and patient lifts), reduction of transportation reimbursement to the Medicaid rate, implementation of strict guidelines for the purchase of therapy services, elimination of funding to the medical genetics programs at the UAB and the University of South Alabama (USA), and elimination of the Associated Medical Programs with the Children's Health System and the USA. This latter program had allowed children to see specialists at those institutions without attending a CRS clinic, but CRS found it difficult to coordinate care, track the services received, and pre-authorize expenditures. These difficult decisions were made by a work group consisting of State Office administrators, field supervisors, CRS medical consultants, and family representatives.

In response to the cuts and reductions, CRS directed much effort toward informing families about the changes and helping them access alternative resources. Family Voices of Alabama (FVA) sponsored a statewide letter-writing campaign during 2 legislative sessions. This contact with lawmakers provided families an opportunity to discuss the specialized needs of CYSHCN and to express concerns over the potential impact of budget cuts. The ADRS Commissioner led the agency in educating State legislators about the crucial role of ADRS, including all divisions, in

meeting the needs of the State's CYSHCN. As a result of these educational and public awareness efforts, CRS received a notable increase in State appropriations for FY 2007. This provided stability to CRS's budget to avoid office closures, staff reductions, and further cuts in services. With increased funding in FYs 2007 and 2008, CRS was able to restore purchased services for families with annual taxable incomes up to 300% of FPL.

With difficult economic times, the State again experienced a budget shortfall. This resulted in a budget cut for CRS in FY 2009. Also, the Governor declared a 9% proration in December 2008 and an additional 2% proration in July 2009. CRS has not reduced eligibility for the program or for purchased services, but did have to make more service cuts and policy changes. These included elimination of purchases of secondary seating systems (manual wheelchairs) except for children who use power wheelchairs, suspension of purchases of brand name drugs except in limited special approval situations or when brands are unavailable, reduction of funding support to partners (UAB Sparks Center and UAB Physical Medicine), and a reduction in operational costs (travel, training, supplies, etc.). A hiring freeze has resulted in reduced personnel costs. All State agencies are now filling only critical vacancies, which can be filled only with the approval of the State Finance Director.

Though CRS did not receive any American Recovery and Reinvestment Act (ARRA) funds directly, the increased Federal Medical Assistance Percentages (FMAP) rates provided some savings to the program. However, the FY 2010 State appropriation was set at the prorated FY 2009 level minus most of the FMAP savings. No additional cuts in services have been implemented at this time. CRS staff members have sought to assure that CYSHCN and their families continue to receive high quality services in their local communities and have helped identify resources for additional support. The CRS leadership team has sought innovative partnerships that can maximize the program and is closely monitoring staffing and budgets to assure efficiency. Continued funding challenges will make it difficult for CRS to expand its role in meeting the needs of CYSHCN and families and could potentially hinder its ability to maintain the current service system.

/2012/ The budget shortfall continues due to a 9.5% proration declared by the Governor in FY 2010. CRS continues to fill only essential vacancies. //2012//

/2013/ The budget shortfall continues due to a 3% proration declared by the Governor in FY 2011. CRS merged 2 community-based offices and now provides direct services to CYSHCN via 14 offices. CRS continues to fill only essential vacancies. //2013// An attachment is included in this section. IIIA - Overview

B. Agency Capacity

ADPH PROGRAM CAPACITY

ADPH: Fiscal Issues and Capacity

The Title V Program has substantial capacity to provide services to--and promote and protect the health of--mothers, infants, children and youth, and pregnant women. To maintain capacity, ADPH, including FHS, has periodically adapted to budgetary constraints imposed by factors beyond the Department's control. Such factors, as well as the Department's adaptation to resultant budgetary constraints, have been detailed in previous MCH reports/applications. Because they are critical to maintenance of MCH capacity and illustrate the resilience of the State's Title V Program, these previous adjustments to fiscal constraints are summarized below. The summary is followed by an update on current funding capacity.

Compared to preceding years, ADPH's funding was notably reduced circa FY 1999. These reductions were largely due to changes in the federal Home Health Care Program and an increase in the State costs of insurance coverage for State employees. This reduction in funding resulted in many layoffs (about 1,400) in CHDs in FY 1999 and a reduction in State funding provided by the State Health Officer to other FHS programs. Though not at previous levels,

ADPH funding stabilized by late FY 1999, and further massive layoffs have not occurred. However, several adjustments to fiscal constraints have been necessary since FY 1999. Late in FY 2003, for example, the State Health Officer asked FHS to reduce FY 2004 projected expenditures of MCH Services Block Grant funds (MCH Title V funds) on FHS programs by \$1.6 million, compared to FY 2003. One purpose of these reductions was to increase MCH Title V support of CHDs, who faced inadequate local support and decreased availability of State funds. Such use of MCH Title V dollars supported local infrastructure, so that CHDs could continue serving the State's low-income maternal and child population. In FY 2003, FHS was informed that State dollars previously available to support the SPP and the State Dental Program would no longer be available. Accordingly, FHS's Deputy Director and Division Directors scrutinized projected expenditures for potential savings. Consequently, FHS discontinued certain contracts or programs and abolished certain positions, in order to redirect funds to assure continuance of the SPP and the State Dental Program.

Due to stabilization (albeit temporary) of funding by FY 2005, FHS was able to add several new positions in FY 2005 or FY 2006. The position of Medical Director for Women's Health, now located in the Consultants Adjunct, was added in early FY 2005 and filled in May 2005. Key positions added and filled in FY 2006 included the following. In the Consultants Adjunct, a Senior Environmentalist position was added to the Oral Health Branch (OHB), using funds from the State Oral Health Collaborative Systems Grant awarded by the U.S. Health Resources and Services Administration (HRSA). (An identical position had been abolished in late FY 2003 or early FY 2004.) The purpose of this ongoing grant is to promote oral health among the maternal and child populations in underserved communities. Also in FY 2006, a Public Health Research Analyst II was added to the Family Planning Branch, and a Social Worker III was added to the Social Work Branch. In the Children's Health Division, a Nurse Coordinator was added to the Lead Branch, and a Nurse Supervisor was added to the School and Adolescent Health Branch. Compared to early FY 2005, the addition of these positions increased FHS's capacity with respect to provision of medical consultation to CHDs, promotion of oral health, analysis of and reporting on MCH indicators, tracking provision of care coordination by CHD staff, prevention of lead poisoning in children, and promotion of the health and well-being of adolescents.

/2012/ The School and Adolescent Health Branch is now the Adolescent Health Program (AHP) Branch. //2012//

In December 2008, in response to the weakening economy (discussed in Section III.A), the Governor announced a Deficit Prevention Plan for the remainder of FY 2009. As part of this plan, State government agencies funded through the General Fund, which includes ADPH, were asked to cut their budgets by 10%. State and educational agencies funded through the Education Trust Fund, which includes ADRS, had their State allocation reduced by 9%. To facilitate these cuts, the Governor's plan implemented a State hiring freeze, a freeze on merit pay raises, limitations on equipment purchases and professional service contracts, and reductions in travel by State employees. Consequently, in FY 2009 ADPH's budget was decreased by approximately \$20.8 million, necessitating a reduction of the State-level budget by \$10.8 million and the County-level budget by \$10 million. Fortunately, ADPH was able to use Title V carry-forward funds of \$1.6 million to lessen the impact of these reductions on MCH-related programs.

Currently, Alabama and the national economy are still experiencing the effects of the recent recession. Though the recession may have technically ended, high unemployment will probably remain well into 2011 and may continue in 2012. In response to the weak economy, the Governor's 2010 budget includes a reduction of 12% for State agencies. The Governor's plan continues the freeze on State government hiring and merit pay raises. ADPH's share of the reductions to the General Fund totals \$6 million. As well, there has been a reduction of \$1.1 million in the Educational Trust Fund, which is a source of funding for ADRS. The State has used the remaining funds from the ARRA of 2009 to lessen the impact of the cuts on agencies receiving General Fund dollars. For FY 2010, ADPH has received General Funds at a level close to the 2009 allocation. Title V funding remains level for MCH-related programs, and ADRS

continues to receive 30% of the State's Title V dollars for the administration of services to CYSHCN. ADPH continues to use Title V carry-forward funds to lessen the impact of the reductions on MCH-related Programs.

As discussed in Section I.E, ADPH contracts with ADRS for CRS to administer services to CYSHCN. The funding situation of ADPH has affected the proportion of MCH Title funds that ADPH transfers to ADRS for the purpose of serving CYSHCN. As part of the contract between ADPH and ADRS, prior to FY 2004 ADPH had transferred about 35% of MCH Title V funds to ADRS. Fiscal constraints necessitated that, effective FY 2004, ADPH transfer only about 30% of MCH Title V funds to ADRS. When the funding situation seemed to stabilize by early FY 2005, ADPH began transferring 32% of such funds to ADRS, which was still below the corresponding percentage prior to FY 2004. Then, due to FY 2009 fiscal constraints, the percentage of MCH Title V funds transferred to ADRS was again reduced to 30% in FY 2009.

In order to maintain and enhance MCH capacity and adapt to the changing health care environment, FHS has periodically undergone structural reorganization over the years. The more recent reorganizations, which include changes in staff positions, are discussed in Section III.C.

//2012/ Alabama's MCH Title V funding for FY 2011 was reduced \$128,428 (9.8%). As Congress debates deficit reductions for FY 2012, all federally funded programs including MCH could see deeper cuts. The percent of MCH Title V funds transferred to ADRS remains at 30% in FY 2011. //2012//

//2013/ STRATEGIES TO ADDRESS DISPARITIES: ADPH

The "FY 2012 MCH Block Grant Application Review Summary Statement" said that the State has clearly described racial, ethnic, and geographic disparities. (Such disparities are detailed in the 2009-10 MCH Needs Assessment Report.) However, reviewers suggested that, in this report/application, we describe specific interventions to address disparities. In response to that suggestion, FHS has compiled information about how several ADPH programs, some within and some external to FHS, address disparities. Collectively, these programs address disparities at both strategic and tactical levels. Full presentation of the compiled information is beyond the scope or space constraints of this report/application. Therefore, the compiled information is attached to this section and summarized here in general terms only. See the attachment for specific interventions. The attached discussion and most of what follows on disparities are based on information from several ADPH entities: the Office of Minority Health; 3 FHS programs; the Alabama Strategic Alliance for Health Program, administratively located in HPCD; and the Office of Primary Care and Rural Health, located in ADPH's Bureau of Professional and Support Services.

Activities conducted by ADPH's Office of Minority Health to address disparities include: participation in health planning and public policy formation, promotion of statewide and local partnerships, promotion of increased minority health participation in the health professions, provision of training on chronic disease self management to minority and marginalized communities, provision of professional development education, and implementation of public forums to address health equity.

Several FHS programs provide services that directly focus on health disparities and/or are performed in partnership with organizations that specifically address disparities. For example, SPP promotes regionalization of perinatal care (discussed later in this section and under NPM 17, as well as in the attachment); implements statewide fetal and infant mortality review (FIMR, discussed under SPM 6, as well as in the attachment); implements the GAL (Get a Healthy Life) Campaign (discussed in Sections III.E and IV.F, as well as in the attachment); and helped coordinate the Summer Feed and Fun Program for low-income children in Tuscaloosa County (in west-central Alabama). The Bureau's Breast and Cervical Cancer Early Detection Program offers services statewide to eligible underserved women: that is, to eligible 40-64 year-old women and, as well, younger women who have

certain breast problems. This program partners with the Deep South Network, which receives federal funding to increase cancer screening and reduce disparities in the Black Belt region. (The historical use of the term "Black Belt" is explained later in this discussion.) The Alabama Family Planning Program (Family Planning), administratively located in FHS, seeks to reduce the income-related disparity in the prevalence of unintended pregnancy by making contraceptive services available to low-income women in need of such services.

The Alabama Strategic Alliance for Health Program, administered through the Healthy Communities Branch, located in HPCD, is a cooperative agreement program with CDC that focuses on reducing the prevalence of obesity, diabetes, heart disease, poor nutrition, physical inactivity, and tobacco use and exposure in 15 counties in west Alabama that are part of the Black Belt. These counties are among the most rural and disadvantaged counties in the State.

The term "Black Belt" originally described the prairies and dark soil of central Alabama and northeast Mississippi, but has long been used to describe a broad agricultural region in the American South characterized by a history of plantation agriculture in the 19th century and a relatively high percentage of African Americans in the population. The term is still used in the physiographic sense to describe a crescent-shaped region about 300 miles long and 25 miles wide, extending from southwest Tennessee to east-central Mississippi and then east through Alabama to the border with Georgia. Most of the area continues to be rural, with a diverse agricultural economy [reference 9]).

Approximately 44% of all Alabama residents live in rural areas (including but not limited to the Black Belt). Most of these rural areas are considered health professional shortage areas. The mission of ADPH's Office of Primary Care and Rural Health (PCRH), located in ADPH's Bureau of Professional and Support Services, is to improve access to health care providers for residents in these underserved rural communities. PCRH is responding to the critical shortage of health care providers in rural Alabama by offering a free medical placement service, initiated in 2007: to assist communities in the recruitment of primary care physicians, dentists, physician assistants, and nurse practitioners.

Neither the above summary nor the attached discussion is a comprehensive discussion of how ADPH addresses disparities. For example, as detailed in an attachment to Section III.E, the Poarch Band of Creek Indians and ADPH have partnered for many years to promote health in the Poarch Creek population. As well, via ALL Kids, the State's Children's Health Insurance Program, ADPH seeks to promote access to health insurance for children living in relatively low-income families. (ALL Kids, administratively located in ADPH's Bureau of Children's Health Insurance, is discussed in several places in this report/application.)

BEST PRACTICES: ADPH

During the August 2011 federal review of the MCH 2010 Report/2012 Application, reviewers suggested that the State Title V Program highlight some of its best practices. Full presentation of selected best practices is beyond the scope or space constraints of this report/application. Therefore, the attachment to this section includes discussion of selected best practices that FHS participates in or is seeking to develop. These practices pertain to: 1) collaboration with ADPH's Office of Performance Management to improve the efficiency and effectiveness of Title X family planning services, 2) clinical performance by nurse practitioners (model clinic, consult system, and annual conference), 3) the State's newborn screening program (also discussed under NPMs 1 and 12), and 4) Healthy Childcare Alabama, which pertains to health and safety within child care settings. Another best practice, FIMR, is discussed under SPM 6. //2013//

CULTURALLY COMPETENT CARE: ADPH AND CRS

ADPH seeks to provide culturally competent care that is appropriate for populations receiving the particular service being provided. For example, a component of ADPH's Pediatric Physical Assessment Course covers cultural factors and how these factors influence patient and family responses and the care provided. This training is required by Medicaid for non-baccalaureate nurses who perform EPSDT assessments. The pediatric assessment pocket guide that is given to the nurses at the training has a section on cultural variations in family and health practices (reference 10). Further, ADPH provides a refresher course for baccalaureate-prepared nurses who have not recently performed assessments. Though these nurses do not receive the aforesaid pocket guide, they receive a lecture and didactic information on cultural factors. Moreover, FHS's Newborn Hearing Screening Program's brochure, which is distributed by birthing facilities to all new mothers, has been translated into Spanish. In addition, this summer (in 2010) ADPH is offering a series of satellite programs on cultural sensitivity and diversity awareness for health care providers and social workers who treat patients in community clinics, public health departments, and medical and dental facilities. The training is offered to both private- and public-sector health care providers. The training offered will enable community medical providers to better understand the stereotypes, prejudices, stigmatizations, and personal conclusions that can often present barriers to minority, vulnerable, and underserved populations--as individuals in these populations seek to access health care and fully benefit from the care provided. With respect to public input, the 10 focus groups convened by FHS during the 2009-10 Needs Assessment included 2 groups comprised of Latino individuals and 1 group comprised largely of Native Americans.

Three Bureau staff members are members of the ADPH Health Disparities Advisory Council, which seeks to address health disparities and culturally competent care. The advisory council was formed in CY 2007 and has been charged with tasks including, but not limited to, the following: 1) identify service delivery problems, 2) analyze data and develop solutions to address program planning issues concerning health disparities, and 3) measure patient and staff satisfaction with health care services provided in CHDs. The advisory council's recommendations include, but are not limited to, development of: 1) an interactive methodology to obtain immediate feedback on service delivery at the points of service and at all ADPH sites, and 2) training modules for ADPH staff on communicating effectively with diverse population groups, to include cross-cultural and multicultural care. The council, which meets quarterly, is currently hosting monthly satellite programs concerning the previous tasks and recommendations and is developing a State report card on the aforesaid issues.

As well, new care coordinators for ADPH receive an hour of training, provided by ADPH's Office of Minority Health, on working with Latino individuals. Satellite presentations on cultural competence are broadcast to all CHDs and are available for viewing at the time of presentation or at a later date. Several FHS programs provide Spanish-translated materials. For example, the Healthy Child Care Alabama Program provides Spanish-translated health, safety, developmental, and support services information materials to child care providers and the families of children in child care. As well, ACDRS, the Alabama Child Lead Poisoning Prevention Program, and FHS's Newborn Screening Program provide educational and/or outreach brochures in Spanish.

//2012/ The major focus of the Office of Minority Health has shifted since its creation, from providing health promotion and disease prevention services to improving minority representation and cultural competency in the health care service industry. Although the office is still involved in health promotion activities, the director notes that a culturally sensitive staff is a prerequisite to creating culturally sensitive materials. The Office of Minority Health reviews ADPH's health education materials for cultural and language sensitivity. Acknowledging the diversity and changing demographics of Alabama, the office has designed training videos and health education brochures--with the goal of improving health screening, eliminating language barriers, improving cultural competency, and eliminating health disparities. //2012//

CRS promotes the provision of culturally competent care to all CYSHCN and families. The 2009-10 Needs Assessment activities for CYSHCN included a focus group for Spanish-speaking

families and surveys for families and youth available in Spanish in hard copy and online versions. Public awareness materials, clinic brochures, and the HIPAA Privacy Notice are translated into Spanish. Staff use the AT&T language line and/or interpreters to communicate with linguistically diverse families in clinics and/or for service planning. ADRS's staff conference includes sessions on cultural competence. CRS seeks to provide services that are individualized based on need and are respectful of cultural diversity and family tradition, including but not limited to language, race, ethnicity, spiritual beliefs, and generation.

CRS PROGRAM CAPACITY

CRS has taken an active role in ensuring a statewide system of services that is comprehensive, community-based, coordinated, culturally competent, and family-centered. Through its program capacity as described below and partnerships with families and other State and local agencies, CRS is influential in policy making and service provision for CYSHCN.

Through ongoing State-level collaborative initiatives, CRS addresses systems development for Alabama's CYSHCN and provides leadership in policy making and service provision. Functioning as a voice for CYSHCN, CRS works with DCA, discussed in Section III.A, through the State CPC to review information concerning children's services statewide. CRS also partners to implement an enhanced benefits package for CYSHCN through ALL Kids Plus, provided through SCHIP. CRS is involved in the EIS Governor's Interagency Coordinating Council (ICC), which has developed policies and monitoring standards for service delivery, crafted budget requests, and shared data on infants and toddlers with disabilities. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinics and facilitates service planning via its advisory role regarding the unique needs of CYSHCN and their families.

CRS staff support community systems building and coordination of health and other community services through EIS's District ICCs and in their involvement with county-level CPCs. Special education, social services, and family support services are brought together by the District Coordinating Councils (DCCs). County-level CPCs address coordination of a wide array of children's services, including primary, specialty, home health, and mental health services at the community level. CRS represents CYSHCN and their families on these councils.

CRS also coordinates health services for CYSHCN within community-based systems. These efforts occur at the CRS State Office and in 15 local offices across 8 service districts. CRS offices are co-located with EIS and VRS in most locations, facilitating service coordination and smoother transitions for CYSHCN. CRS district offices function as powerful resource networks in local communities, responding to requests for information on CYSHCN. The agency has provided specialized training to selected care coordinators to develop transition specialists in 6 of its 8 districts. These specialists provide targeted, comprehensive transition services to CRS-enrolled youth. CRS has also purchased specialized Auditory Brainstem Response (ABR) equipment to offer non-sedated testing, an important service for medically fragile children.

CRS works closely with the State's 2 tertiary-level pediatric hospitals to provide community-based care coordination, family support activities, and financial assistance to CRS-eligible children receiving care at these institutions. This ensures that children are referred and receive appropriate services from both providers. Medicaid's Patient 1st Waiver has enhanced the flow of information between primary and specialty care at the community level, through the assignment of all children, including CYSHCN, to a medical home. CRS maintains good communication with these providers to assure that needs are identified and comprehensive services are received.

CRS is 1 of 3 agencies responsible for early intervention services through the sponsorship of 13 EIS programs statewide. These programs provide a more coordinated, team approach to early intervention as opposed to a previous model in which the CRS districts provided case management services directly to eligible infants and toddlers and purchased related services (physical, occupational, and/or speech therapy) via a vendor system. CRS State Office staff participate in annual Provider Appraisal Reviews for these programs to ensure consistent quality

and fiscal responsibility, provide technical assistance, and inform program coordinators of the benefits of referral to CRS for eligible infants and toddlers with special health care needs.

Via these initiatives, CRS has far-reaching influence on the State's service system at both State and community levels. As new challenges and opportunities present, CRS's mission and infrastructure, as detailed below, support a ready response.

The mission of CRS is to enable CYSHCN to achieve their maximum potential within a community-based, family-centered, comprehensive, culturally sensitive, and coordinated system of services. CRS is organized in 3 levels--State, district, and local--to provide a statewide system of care that identifies and utilizes resources while avoiding duplication of services. At the State level, administrative staff provide program direction through policies, staff resource development, program planning and evaluation, data analysis, quality assurance, technical assistance, and fiscal management. The State team also includes a medical consultant, the SPC, and a vacancy for a State Youth Consultant. Four State advisory committees (parent, medical, hemophilia, and youth), as well as LPACs that meet in every district office, ensure consumer and provider input into the program. Collaborative planning with public and private agencies occurs at the State level to develop and enhance systems of services for CYSHCN and their families. Mechanisms for systems development include interagency agreements, training and in-service activities, data sharing, task forces and committees, and State legislation.

The State is divided into 8 service districts for CYSHCN, each led by a supervisor responsible for personnel, service implementation, and office operations. Fifteen local offices around the State provide community-based services to children and families through outpatient specialty medical clinics; care coordination activities; home, school, and community visits; and agency consultations. Specialty medical staff are recruited from the public and private sector and are credentialed by the CRS medical consultant. They may provide services in their home community or travel to CRS clinic sites in rural areas where specialty services are not otherwise available. Care coordinators, typically nurses or social workers, travel within their assigned counties to meet families, arrange services, and maintain working relationships with other service programs and providers. They also work to develop the State's system of care by identifying local providers with expertise related to CYSHCN and working with community groups on planning issues concerning CYSHCN. Care coordinators have access to a team of CRS specialists to deliver community-based care, education, consultation, or therapy. CRS staff members are mobile and not restricted by district boundaries in the delivery of services. Families are similarly unrestricted and may access services in any CRS office.

Any State resident from birth to 21 years of age who has a special health care need is eligible for CRS services. Financial assistance and family participation are determined by the program's sliding fee scale. Families with incomes at or below 300% of FPL and children who are insured through Medicaid, ALL Kids, or ACCF are eligible for full financial assistance. SSI beneficiaries less than 16 years old are eligible for CRS services. Referrals for children evaluated for SSI are received in the State Office from the State Disability Determination Units (DDUs) in Birmingham and Mobile and are directed to the appropriate local office. Families are then contacted to offer CRS services, including care coordination. Flyers with the State toll-free number and a listing of CRS services are distributed through the local offices of the SSA, and a CRS staff member provides an annual outreach effort to each local SSA office.

CRS operates 7 service programs to serve CYSHCN and their families. Services provided in each of these programs are paid for in full or in part by Title V funds. The 7 programs are:

- 1) Information and Referral--provision of information on resources available in the community, in the form of educational materials related to pediatric specialty health care, community resources, etc.
- 2) Specialty Clinical Services/Clinical Medical--clinics directed by physicians and staffed by

multidisciplinary teams for provision of diagnosis, evaluation, treatment, and related services.

3) Specialty Clinical Services/Clinical Evaluation--physician-supervised clinics to provide functional evaluation and planning services by multidisciplinary teams.

4) Client/Family Education--provision of information to clients and their families that is necessary for carrying out prescribed treatment regimens and making informed choices about services that best meet their needs.

5) Care Coordination--arrangement of services to assist clients and families in identifying, accessing, and utilizing health and related resources to effectively meet their needs.

6) Parent Connection--provision of family-to-family support and information through State and LPCs, a parent-to-parent network, family resource centers, sibling support activities, and publication of the Parent Connection Newsletter.

7) Youth Connection--facilitates youth-to-youth connections, supports youth involvement in policy development and decision making, and promotes transition services for youth with special health care needs to all aspects of adult life. The Youth Connection Program consists of the Youth Advisory Committee (YAC), the State Youth Consultant (vacant), Teen Transition clinics, linkages to VRS, and a Youth News insert in the quarterly Parent Connection newsletter.

ADRS maintains a public web site with information about the agency and services offered. CRS pages are designed with a unique look and tag line as adopted by the program. This matches other CRS public awareness materials and serves to increase the visibility of the State CYSHCN Program. A link from the CRS pages provides access to a directory of ancillary care providers for each CRS district.

/2012/ CRS has provided specialized training to selected care coordinators to develop transition specialists in 7 of its 8 districts.

CRS will facilitate activities under the State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs to support transition, build medical provider capacity, and provide ongoing statewide support for CYSHCN.

As previously discussed, the upper income limit for ALL Kids increased in October 2009, and ACCF closed in January 2011. CRS provides or purchases certain services for clients who do not qualify for Alabama's Medicaid program or the ALL Kids program and whose families are unable to purchase private health insurance coverage. //2012//

//2013/ At the end of FY 2011, CRS merged 2 of its community-based offices and now has a total of 14 offices providing direct service to CYSHCN. //2013//

SOME STATUTES RELATED TO THE TITLE V PROGRAM

Salient legislation pertaining to the Title V Program includes the following:

1) CRS Statutory Authority--The State statutory authority for the CRS program is in Code of Alabama 1975 SS 21-3-1 et seq. The administrative responsibility for the program was given to the State Department of Education (SDE) due to its administration of a State program for CSHCN prior to passage of the Social Security Act in 1935. The Alabama Hemophilia Program was created in Code of Alabama 1975 SS 21-8-1 et seq. and placed within CRS administratively. Code of Alabama 1975 SS 21-9-1 et seq. created ADRS by moving the former division, with all its component programs, out of SDE on January 1, 1995. The major impact of these legislative acts is that CRS is administratively under ADRS rather than ADPH and serves, in addition to CSHCN, adults with hemophilia and related bleeding disorders through the Alabama Hemophilia Program.

2) Alabama Perinatal Health Act--The Perinatal Health Act was enacted in 1980 in an effort to confront the State's high infant mortality rate. The statute established SPP and the mechanism for its operation under the direction of the State Board of Health and SPAC, with the latter representing the RPACs. The RPACs make recommendations on perinatal concerns to SPAC. SPAC advises the State Health Officer in the planning, organization, implementation, and evaluation of SPP. SPP is based on the concept of regionalization of health care, a systems approach in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their newborns have access to care at the appropriate level.

3) "Neonatal testing for certain diseases; rules and regulations for treatment thereof..." (Reference: Public Health Laws of Alabama, 1993 Edition, Section 22-20-3)--This legislation created the requirement and established the responsibility for the hospital, physician and/or guardian, who may be attending a newborn infant of 28 days old or less, unless declined by parents, to administer a reliable set of newborn screening tests as designated by the State Board of Health. The law also requires that infants who have positive test results be provided care and treatment, in accordance with established State Board of Health rules and regulations, for a reasonable fee. All 29 core disorders are mandated by Alabama law; however, the Newborn Screening Program (NSP) voluntarily removed Tyrosinemia I from the Alabama test panel because the testing methodology was deemed unacceptable. The NSP is working to complete the addition of Tyrosinemia I to the newborn screening panel with an expected completion date of December 2010.

/2012/ Tyrosinemia has been added to the NSP protocol, for a total of 29 of the 30 disorders recommended by the American College of Medical Genetics (ACMG). //2012//

/2013/ The ACMG currently recommends screening for 31 disorders. //2013//

4) Child Death Review--Legislation creating the Alabama Child Death Review System was enacted in 1997 and has a mandate to review all unexpected/unexplained deaths of children in Alabama from birth through 17 years (HB.26,97-893). Reviews include children who die from a vehicle accident or from drowning, fire, sudden infant death syndrome (SIDS), child abuse, suicide, suffocation, etc. Deaths from prematurity or birth defects, as well as deaths from terminal illnesses, are not reviewed by these teams. The purpose of these reviews is to identify trends in unexpected/unexplained childhood deaths, educate the public about the incidence and causes of these deaths, and engage the public in efforts to reduce the risk of such injuries and deaths. Funding for this program comes from the national settlement with the tobacco industry and is disbursed through the Children First legislation described later in this section.

5) Alabama Act 98-611--This legislation supports development of the Alabama Trauma Registry, which involves collection, storage, and subsequent manipulation of trauma-related data on a statewide level. The Head and Spinal Cord Injury Registry and Traffic Injury Registry, along with additional trauma elements, are incorporated into a centralized database managed by ADPH's Office of Emergency Medical Services and Trauma.

6) School Nurse Law Act of 09-280--This act, passed by the Alabama Legislature in 2009, funds 1 school nurse for every 500 students and allows for licensed practical nurses to be hired as school nurses under registered nurses' supervision, at a ratio not to exceed 5 licensed practical nurses to 1 registered nurse within each school system. It also continues the mandate for a School Nurse Consultant at SDE and requires an annual assessment of all student health needs within each school system.

7) CHIP--See "The Health Care Environment," in Section III.A.

8) Children First--A major legislative event was the passage by the Alabama Legislature of the Children First Bill (in April 1999), which allocated some of the money the State would receive from the national settlement with the tobacco industry to various programs to improve the welfare of

Alabama children. When tobacco settlement dollars come to Alabama they are deposited into the 21st Century Fund, where about 12% are used first for debt service on economic development bonds. Remaining tobacco dollars are then divided among Children First (about 53%), Medicaid (about 35%), and the Senior Services Trust Fund (1%). Money that comes to Children First is divided among 12 State agencies for specific programs as instructed by law (Section 41-15B-2.2). Agencies collectively receiving the bulk (about 79%) of Children First funds are SDE (22%), the Alabama Department of Human Resources (DHR) (20%), the Alabama Department of Youth Services (17%), the Administrative Office of Courts, for use in provision of juvenile probation services (10%), and ADPH (10%). ADPH uses its portion of Children First funds (about \$6.2 million in FY 2003) to help provide health insurance to uninsured children (reference 11).

9) DCA--Legislation created this new State department, discussed in Section III.A, in 1999. In 2000, legislation was passed that expanded the powers and duties of DCA to include creating and maintaining a "repository for information" on children's programs in Alabama, reviewing budget requests, and reporting annually to the Governor and State Legislature on the activities and expenditures of State and local agencies related to children. DCA is to gather information for the purpose of acquiring additional funding for children. ADPH and ADRS, including both CRS and EIS, were specifically included in this legislation.

10) Graduated driver's license law--Alabama's graduated driver's license legislation became effective in October 2002. For licenses issued during or after that month, restrictions apply to 16 and 17 year-old drivers who have been licensed for less than 6 months. Under the October 2002 legislation, restricted drivers cannot have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent/guardian, a licensed adult driver. The circumstances under which the graduated licensees are not required to be accompanied by a parent/guardian/licensed adult designee include driving to or from work, to or from a school or church event, or due to an emergency.

After several failed previous attempts, a bill to enhance the above graduated driver's license law passed and was signed into law in 2010. The changes included defining the 3 tiers of the graduated licensing process, limiting the number of non-family passengers permitted to 1 (the original law allowed 4), adding a hunting/fishing exception to the restricted driving hours, and prohibiting the use of nonessential electronic devices while driving (not addressed at all in the original law). All other restrictions and exceptions of the original graduated driver's license law remain intact.

11) Woman's Right to Know Act--The State Legislature passed the Woman's Right to Know Act in 2002, and the law went into effect in October 2002. Its purpose is "to ensure that every woman considering an abortion receives complete information on the procedure, risks and her alternatives." The act requires that ADPH create a printed informational booklet as well as an informational video tape. Accordingly, ADPH's Bureau of Health Provider Standards drafted a pamphlet for distribution to abortion centers.

12) State's Office of Women's Health--This office was created with passage of State legislation in 2002 to educate the public regarding women's health; to assist the State Health Officer with identification and prioritization of women's health issues and concerns relating to the reproductive, menopausal, and postmenopausal phases of a woman's life; to assist the State Health Officer in coordination of services to address these issues and concerns; to serve as a clearinghouse and resource for information on women's health data, strategies, services, and programs; and to collect, classify, and analyze relevant research information and data concerning women's health. This office is located in ADPH's Bureau of Professional and Support Services.

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

DCA, DHR, the Alabama Department of Mental Health (DMH), and Medicaid are all cabinet-level agencies, and the Governor directly appoints their commissioners. ADPH, SDE, and ADRS are not cabinet-level agencies. As their respective boards appoint the heads of these 3 departments, they have experienced more stability and continuity in leadership, enabling a more consistent program direction. However, compared to agencies having a commissioner appointed by the Governor, ADPH and ADRS have relatively less access to the Governor. Linkage for communication and organizational cooperation exists on 2 levels for ADRS and ADPH. The State Health Officer and the ADRS Commissioner work together on matters of mutual concern, as do the CRS and FHS Directors. Staff members from CRS and FHS meet 3 times a year to discuss programmatic and administrative issues regarding MCH services. ADPH operates under the direction of the State Board of Health and is not under the direct authority of the Governor. FHS is a major unit within ADPH, and CRS is a major division within ADRS. Current organizational charts for ADPH, FHS, ADRS, and CRS are attached to this section.

ADPH'S ORGANIZATIONAL STRUCTURE

FHS has reorganized several times to accommodate staffing changes and enable ADPH and the Bureau to efficiently respond to public health challenges and opportunities. In recent years, the Bureau has had from 4-6 divisions and, most of the time, a Consultants adjunct. The evolution to the Bureau's current organizational structure, which includes 5 divisions and a Consultants adjunct, illustrates the flexibility of the Bureau and its adaptation to new responsibilities. Therefore, a summary of the Bureau's 5 major organizational changes from FY 2005 through FY 2010, with elaboration on the current organizational structure, follows.

In FY 2005, 4 divisions comprised the main units of FHS: Administration, WIC, Professional Support, and Women's and Children's Health. FHS was (and continues to be) administered by the Bureau Director and, under his oversight, the Bureau Deputy Director, with input from the Bureau Management Team (BMT). The BMT consisted of the Bureau Director, Bureau Deputy Director, each Division Director, and each Assistant Division Director.

In October 2005 FHS reorganized. The key change brought about by this reorganization was the splitting of the Women's and Children's Health Division into 2 divisions: Women's Health and Children's Health. The former Professional Support Division was dissolved and replaced with a Consultants adjunct to FHS's Deputy Director. The Consultants adjunct included the Epidemiology/Data Management, Medical, and Oral Health Branches. With this organizational restructuring, the composition of the BMT included FHS's Director, FHS's Deputy Director, the director and assistant director of each of FHS's 4 divisions, and the Medical Director for Women's Health. In March 2006 the BMT expanded to include the OHB Director, the Epidemiology/Data Management Branch Director, and the Administrative Support Assistant (ASA) to the Bureau Deputy Director. Also in April 2006, the name of the Epidemiology/Data Management Branch was changed to the MCH Epi Branch.

At ADPH's request, in October 2006 a review of ADPH's newborn screening laboratory was performed by invited experts, and a report of this review was provided by the National Newborn Screening and Genetics Resource Center, located in Austin, Texas. The State Health Officer, in consultation with other ADPH staff, determined that consolidation of key staff involved in newborn screening into 1 division, under the supervision of 1 director, would enable the Department to better address issues raised in the report. He then advised that the Division of Newborn Screening be created and administratively located in FHS. This Division, created in January 2007, included staff comprising FHS's former Newborn Screening Program, which had been located in the Children's Health Division, certain staff from the Bureau of Clinical Laboratories (BCL), and a director and an ASA who transferred from other FHS positions.

Another organizational issue addressed in FY 2007 concerned nursing practice and quality assurance. To facilitate prompt communication between ADPH nurse practitioners and their collaborative physicians, a HIPAA-compliant electronic medical consultation network was implemented in April 2007. This network operates via the ADPH intranet system (Lotus Notes),

but can also be accessed via the Internet. The network is used by the Medical Branch to allow nurse practitioners (46 in number, as of March 2010) from 65 counties to consult with the Bureau's Director and its Medical Director for Women's Health, both of whom are physicians. (Some of the 46 nurse practitioners cover more than 1 of the 65 counties. Two CHD systems, Mobile and Jefferson, do not participate in the network.) The nurse practitioner enters the patient information and submits it in a pending status. The physician on call for the day receives an email notice of a pending consult and responds with recommendations. Upon completion of the consult, the nurse practitioner accesses a printable view of the consult and copies and prints it for the patient's medical record. This network is used for quality assurance purposes by the Alabama Board of Nursing to ensure compliance with Alabama statutes pertaining to nursing practice. As well, the network facilitates auditing of medical charts by ADPH Central-Office auditors. The current consult template has undergone several enhancements since its conception and will continue to have changes, including a complete revamping planned for 2010. From its conception through March 2010, there were 7,200 consults made through this consult template network.

In May 2008 the Bureau added a sixth Division, the Breast and Cervical Cancer Division. Staff from the Breast and Cervical Cancer Program, which had been located in the Women's Health Division, comprised the new division.

In FY 2010, FHS again underwent an organizational change. Specifically, by February 2009, the Newborn Screening Division ceased being a separate division, and non-laboratory staff from the division returned to the Children's Health Division. As well, the cancer registry and cancer prevention program (along with program staff), which had previously been located in HPCD, was relocated to FHS's Breast and Cervical Cancer Division. Thus, FHS again has 5 divisions and a Consultants adjunct--all under the oversight of the Bureau Deputy Director. As depicted in the organizational chart attached to this section:

- 1) The Consultants adjunct consists of the MCH Epi Branch, the Medical Branch, and the OHB.
- 2) The Administration Division consists of the Financial Management Branch and the Contract Management Branch.
- 3) The Cancer Prevention and Control Division, formerly the Breast and Cervical Cancer Division, has been expanded to include 3 branches. These branches are the Cancer Prevention Branch, which receives specific funding for the prevention of prostate cancer and colorectal cancer; the Cancer Registry Branch, which maintains a statewide cancer registry; and the Breast and Cervical Cancer Branch, which focuses on early detection of breast and cervical cancer.
- 4) The Women's Health Division consists of the Family Planning and Plan First Branch, the Perinatal Branch, and the Social Work Branch.
- 5) The Children's Health Division consists of the Lead Branch, the Healthy Childcare Alabama Branch, the Child Death Review Branch, the Newborn Screening Branch, the Preventive Health Education Branch, and the School/Adolescent Health Branch.
- 6) The WIC Division consists of the Vendor Management, Operations Management, and Nutrition Services Branches. The State Agency Model Project--which is a U.S. Department of Agriculture (USDA) Food and Nutrition Service 5-year initiative to plan, develop, and deploy model information systems in WIC State agencies--is a part of the Operations Branch.

/2012/ FHS continues to have 5 divisions and a Consultants adjunct. However, in April 2010, ACDRS, which had been administratively located in the Children's Health Division, moved to HPCD. Prior to this move, a new division, the Health Behavior Division, had been formed in HPCD. This new division includes 4 branches: Statewide Tobacco Control, Community Tobacco Prevention, Injury Prevention, and Child Death Review. The Director of ACDRS now directs the Injury Prevention Branch and the Child Death Review Branch. The rationale for this organizational change is that the Injury Prevention and Child Death Review programs have many

related goals. //2012//

/2013/ Concerning the organization of ADPH as a whole, the State Health Officer continues to oversee ADPH and remains responsible to the State Committee of Public Health, which is responsible to the State Board of Health. However, as reflected in ADPH's 2 most recent organizational charts (for January 2011 and January 2012), several changes in the flow of authority from the State Health Officer to other major ADPH entities occurred by January 2012, relative to January 2011. This discussion focuses on the flow of authority from the State Health Officer to FHS, which is now as follows: from the State Health Officer, to the Deputy Director for Medical Affairs, to the Assistant State Health Officer for FHS (a new position relative to January 2011), who serves as the Director of FHS. Dr. Thomas Miller, who has directly or indirectly overseen FHS since 1987 and was at one time the State's Title V Director, serves as the Deputy Director for Medical Affairs. As well as overseeing the Assistant State Health Officer for FHS, Dr. Miller oversees the Assistant State Health Officer for Disease Control and Prevention (also a new position relative to the January 2011 organizational chart), who oversees the BCL and the Bureau of Communicable Disease. In addition, Dr. Miller now oversees the Bureau of Home and Community Services. Dr. Miller's broad authority within ADPH and his particular expertise in MCH help assure that pertinent MCH issues are considered in the operation of a wide range of programs. Although Dr. Miller no longer directs HPCD (as he did in January 2011), FHS and HPCD staff consult on MCH issues as needed. (Brief biographical sketches for Dr. Miller and Dr. Grace Thomas, who serves as the Assistant State Officer for FHS, are in Section III.D).

Concerning the organization of FHS in particular, FHS continues to have the same 6 divisions or adjuncts: the Consultants Adjunct, the Administration Division, the Cancer Prevention and Control Division, the Women's Health Division, the Children's Health Division, and the WIC Division. Within the Children's Health Division, 2 changes have occurred relative to May 2011. First, the Preventive Health Education Branch, which had no staff solely assigned to it, has been dissolved. Secondly, the Adolescent Health Branch has been renamed and is now the Teen Pregnancy Prevention Branch. Within the WIC Division, what was previously termed the "State Agency Model Project" is now termed the "Crossroads State Agency Model." However, this project continues to focus on the same task: Alabama's application of the Crossroads State Agency Model (SAM) Project. (The Crossroads SAM Project is a new web-based system that is designed to expedite most aspects of the WIC participant clinic experience. This system is a collaborative effort of a consortium of southeastern states: Alabama, North Carolina, Virginia, and West Virginia. It is anticipated that this system will be implemented in the fall of 2013.) //2013//

ADRS'S ORGANIZATIONAL STRUCTURE

ADPH contracts with CRS, a division of ADRS, for services to CYSHCN. CRS has administrative responsibility for the State Title V CSHCN Program and the Alabama Hemophilia Program. The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS, which consists of 4 major divisions: EIS, CRS, VRS, and the State of Alabama Independent Living (SAIL) Program. The current chairperson of the board is a parent of young adults with special needs.

Melinda Davis, MS, CCC-A, CPHL, has been the ADRS Assistant Commissioner for CRS since November 2006. Supervision of the 8 CRS district supervisors is directly under the CRS Assistant Commissioner. She is also responsible for serving as the CSHCN Director and for supervising several State Office staff members.

David Savage, the State Supervisor for Professional Services, is responsible for training, public awareness, oversight of the non-medical vendor program, and supervision of the Care Coordination Specialist and the program specialists for speech-language pathology and audiology.

Wanda Williams, the Clinical/Policy Specialist, is responsible for overseeing the clinical program, monitoring budgets, updating policy, overseeing the physician vendor program, and supervising the Hemophilia Coordinator and the program specialist for nursing.

Julie Preskitt, the Special Programs Coordinator, is responsible for MCH Block Grant activities and planning, evaluation, and data analysis. She also oversees the State Pediatric Traumatic Brain Injury (TBI) Program, the electronic medical record system, and the physical and occupational therapy programs.

Other administrative staff include the SPC, a Patient Accounts Manager, and the program specialists and coordinators as described above. The HIPAA Privacy Officer, nutrition, and social work program duties are assigned within the State Office administrative team. The CRS State Youth Consultant position remains vacant.

/2012/ Julie Preskitt left the agency in August 2010. Lolita McLean, former District Supervisor, is the new MCH Coordinator. Serving as the Nutrition Program Specialist and overseeing the CRS Quality Improvement Program are also part of Ms. McLean's duties.

The State TBI Program, the electronic medical record system, and the physical and occupational therapy programs are assigned within the State Office administrative team. //2012//

***/2013/ Wanda Williams retired from the agency in December 2011. The clinical program, budget monitoring, policy updates, overseeing the physician vendor program, and supervising the Hemophilia Coordinator and the program specialist for nursing duties are assigned within the State Office administrative team. //2013//
An attachment is included in this section. IIIC - Organizational Structure***

D. Other MCH Capacity

ADPH'S OTHER CAPACITY

Cost-center data provided by ADPH's Bureau of Financial Services were used to estimate the number of ADPH FTEs devoted to serving Title V populations. FTEs reported here are not limited to those paid for by Title V, because funds from other sources also help pay for services to Title V populations.

/2013/ For example, EPSDT is included (with "excluding WIC cost centers") because Alabama Medicaid's EPSDT Program covers care coordination services, as well as direct services. Specifically, Alabama Medicaid administers an EPSDT care coordination service that is available at no cost for EPSDT-enrolled children, whether served by private or public providers. The goal of these services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services. As discussed in Section III.A, under Medicaid's redesigned Patient 1st Program, ADPH care coordinators can receive referrals from a variety of sources. These referrals include but are not limited to children enrolled in Medicaid's EPSDT Program. For instance, physicians providing EPSDT may contact the local CHD to request EPSDT care coordination. //2013//

Excluding WIC cost centers, 267.4 FTEs served Title V populations in FY 2009. These 267.4 FTEs include cost centers for the following: Family Planning, which accounted for 105.7 FTEs; EPSDT, which accounted for 67.6 FTEs; and a variety of other programs pertaining to MCH, which accounted for 94.1 FTEs. The "variety of other programs" included a wide range of programs or activities: for instance, maternity case management, child health assessments and primary care of children, school and adolescent health, dental health, newborn screening (biochemical and hearing) and screening for high lead levels in children, the State Systems Development Initiative (SSDI, which enhances MCH data capacity), child death review, and infant

mortality review. This group does not include the cost center for MCH administration; therefore, the 267.42 FTEs do not count some of the administrative time that FHS devotes to MCH.

The 267.4 FTEs were geographically distributed as follows: 82.1% at the county level, 1.4% at the PHA level, and 16.6% at the State level. The positions accounting for 5.0% or more of the total non-WIC FTEs serving Title V populations were social workers (57.5%); nurses (18.5%); and ASAs (12.6%).

/2012/ Excluding WIC cost centers, 256.7 FTEs served Title V populations in FY 2010: down by 4.0% (or 10.7 FTEs) since FY 2009. According to cost center groupings, the corresponding decline was 1.1 FTEs for Family Planning, 3.1 FTEs for EPSDT, and 6.5 FTEs for MCH. Thus, in FY 2010, Family Planning accounted for 104.6 FTEs, EPSDT for 64.45 FTEs, and MCH for 87.6 FTEs. The geographic distribution of these FTEs remained the same. That is, in FY 2010, the 256.7 total non-WIC FTEs serving Title V populations were distributed as follows: 82.3% at the county level, 1.2% at the PHA level, and 16.5% at the State level. Again, the positions accounting for 5.0% or more of the total non-WIC FTEs serving Title V populations were social workers (58.6%), nurses (18.6%), and ASAs (11.5%). //2012//

/2013/ Excluding WIC cost centers, 258.2 FTEs served Title V populations in FY 2011: about the same as in FY 2010. The geographic distribution of these FTEs did not notably change. Once again, the positions accounting for 5.0% or more of the total non-WIC FTEs serving Title V populations were social workers (60.3%), nurses (18.3%), and ASAs (7.5%). //2013//

In FY 2009, 229.2 FTEs were devoted to WIC, which is an adjunct to health care.

/2012/ In FY 2010, 288.1 FTEs were devoted to WIC: up by 25.7% (or 58.9 FTEs) since FY 2009. SSDI, for which FTEs have not previously been reported here, is funded through HRSA's Maternal and Child Health Bureau (MCHB) and focuses on enhancing MCH data capacity. In FY 2010, 0.9 FTEs were devoted to SSDI. //2012//

/2013/ In FY 2011, 328.4 FTEs were devoted to WIC: up by 14.0% (or 40.3 FTEs) since FY 2010. Also in FY 2011, 0.9 FTEs were devoted to SSDI, the same as in FY 2010. //2013//

Brief biographies of selected key Title V personnel in FHS follow.

Thomas M. Miller, MD, MPH, FACOG, who serves as FHS's Director, has been with ADPH since 1987. His roles as clinician, consultant, and Assistant State Health Officer for PHA 5 particularly qualified him to serve as Director of FHS--a role he assumed in 1993. Other experience includes work as an obstetrics/gynecology clinician in the private sector (before joining ADPH) and occasional labor and delivery coverage for the Montgomery County Maternity Waiver Program and for a private practitioner. He is a member of the Medical Association of the State of Alabama, a fellow of the American College of Obstetricians and Gynecologists (ACOG), and a member of the Alabama Section of ACOG, where he has been a Board member since 1992. Academic credentials include studies in medicine and public health. As well as serving as FHS's Director, since circa October 2005, Dr. Miller has served as Assistant State Health Officer for Personal and Community Health. In this capacity he oversees HPCD, as well as FHS.

/2012/ In early FY 2011, Dr. Miller became responsible for overseeing BCL, in addition to overseeing FHS and HPCD. //2012//

In May 2005 Grace Thomas, MD, FACOG, joined FHS as Medical Director for Women's Health. In this capacity she serves as collaborative physician for CHD nurse practitioners. Before joining FHS, Dr. Thomas worked as a private practitioner for over 10 years in New York City. There she served on the faculty of St. Luke's-Roosevelt Hospital Center, where she was preceptor for Residency Education and Co-Director of the Colposcopy Clinics. She is a member of the

American Society for Colposcopy and Cervical Pathology, Fellow of ACOG, and a member of the Alabama Section of ACOG, for which she is a board member. Other board of directors affiliations include the Gift of Life Foundation (located in central Alabama) and the Alabama Campaign to Prevent Teen Pregnancy.

Chris R. Haag, MPH, the Deputy Director of FHS and the Title V Director, worked in the Madison CHD in Alabama for 2 years, where his duties included direction of health education activities and outreach services. He joined FHS in 1989 to direct an adolescent pregnancy prevention project. After the completion of that project, Mr. Haag held various positions in FHS, including Director of the Administration Division and, later, of the Professional Support Division. Academic credentials include studies in education and public health. Mr. Haag had been Deputy Director of FHS for several years before assuming the position of Title V Director in March 2005.

//2013/ In mid CY 2011, at the request of the State Health Officer, Dr. Miller became ADPH's Deputy Director for Medical Affairs. In that role, he continues to indirectly (through 2 Assistant State Health Officers) oversee BCL and FHS. Additionally, he indirectly oversees the Bureau of Communicable Disease and directly oversees the Bureau of Home and Community Services. Concomitant with the change in Dr. Miller's responsibilities, Dr. Thomas became the Assistant State Health Officer for FHS and, in that role, began serving as Director of FHS. Mr. Haag continues serving as Deputy Director of FHS. Thus, the upper-level leadership of FHS collectively provides a rich perspective on MCH that is remarkable in its scope and depth.

Robert L. Meador, Jr., DMD, MAGD, joined FHS in February 2012 as State Dental Director and Director of OHB. Immediately prior to joining ADPH, Dr. Meador had served for 8 years as Assistant Professor at the UAB School of Dentistry in Birmingham. While there his responsibilities included faculty private practice, several management positions, and clinical instruction and guidance for dental students. Prior to teaching at the School of Dentistry, Dr. Meador had engaged in the private practice of dentistry for 20 years. He is a member of the American Dental Association, Alabama Dental Association, Academy of General Dentistry, and the American College of Dentists. //2013//

Sherry K. George, BS, MPA, Director of the Bureau's Division of Women's Health, has been with the Bureau since 1975. During this time she has become familiar with issues concerning perinatal health, child health, and family planning; visited many CHDs; and developed excellent working relationships with health professionals around the State. Academic credentials include studies in business management and public administration.

Dianne M. Sims, BSN, RN, Director of the Bureau's Division of Children's Health, has been with ADPH since 1981 and joined FHS in 1999. Her experience includes serving as a public health nurse and administrator at the county, Area, and State levels. Previous positions include those of FHS Nurse Coordinator, staff development coordinator, and acting director of Program Integrity. Academic credentials include studies in social work, nursing, child development, and early childhood education.

Dan Milstead, BS, MBA, assumed directorship of the Administration Division in April 2005. Mr. Milstead joined ADPH in January 1989 as Director of the WIC Division's Financial Management Branch. In this position he was responsible for all of WIC's federally required accounting and financial reports. In 1998 Mr. Milstead transferred to the Bureau of Financial Services to be the Director of Third Party Collections; in this capacity he managed the Department's billing operations and distribution of funds. In July 2000 he returned to FHS as Director of the WIC Financial Management Branch. In 2003 his position with the WIC Division was incorporated into the Administration Division, where he was responsible for the WIC and Family Planning Programs.

Carolyn J. Battle, MS, RD, was appointed State WIC Director in December 2007. Ms. Battle has

been with ADPH for 18 years and joined FHS in 2000 as Director of Nutrition Services for the Alabama WIC Program. Her prior experience includes work at the local level as a county WIC nutritionist and at the PHA level as PHA 5 Nutrition Director. She has previous experience as a clinical dietitian in the private sector. Ms. Battle's credentials include an advanced degree in nutrition, registration as a dietitian by the Commission on Dietetic Registration of the American Dietetic Association, and licensing as a dietitian by the Alabama Board of Examiners for Dietetic Practice.

In FY 2009 Nancy Wright, MPH, was appointed to the position of Director of the Breast and Cervical Cancer Division, which is now the Cancer Prevention and Control Division. She has been with ADPH since 2001. Ms. Wright's background includes 12 years of experience with program management in the health care field, 8 of which are with ADPH. Academic credentials include an undergraduate degree in communications and a graduate degree in public health.

Charlena M. Freeman, LCSW, Assistant Director of the Division of Women's Health, brought 20 years of medical social work experience when she joined the Bureau in 1996. Academic credentials include advanced degrees in social work and counseling. Her duties at FHS include development and implementation of protocol and assurance of training for all ADPH clinical care coordination programs.

Dawn Ellis, MPH, RN, was appointed to the position of Assistant Director of the Division of Children's Health in November 2009. Prior to joining the Division of Children's Health, since October 2008, Ms. Ellis had been Assistant Director of the MCH Epi Branch--where she coordinated the MCH reports/applications, public input for the MCH needs assessment, and the SSDI grant. When joining the MCH Epi Branch, Ms. Ellis brought over 15 years of MCH administrative and grants management experience. Academic credentials include an undergraduate degree in nursing and a graduate degree in public health-MCH.

Janice M. Smiley, MSN, RN, who has been with ADPH since 1996, serves as Director of SPP. Ms. Smiley's background includes 25 years of experience in maternal child nursing and worksite wellness. Academic credentials include an undergraduate degree in nursing and a graduate degree in nursing administration.

Anita Cowden, MPH, DrPH, Director of the MCH Epi Branch, has been located at ADPH since 1989 (including 2 years as a CDC assignee). Dr. Cowden joined the Bureau in 1998 and coordinates MCH reports/applications and Bureau MCH needs assessment activities. Her masters-level studies concentrated in MCH; and her doctoral-level studies concentrated in epidemiology first, biostatistics second, and MCH third.

CRS'S OTHER CAPACITY

As of April 2010, there are 217.75 FTEs in the field: 8 district supervisors, 71 ASAs, 48 social workers, 31 nurses, 18 rehabilitation assistants, 8 nutritionists, 8 audiologists, 7.5 parent consultants, 6.75 PTs, 6 speech language pathologists (SLPs), 2 occupational therapists (OTs), 2 medical care benefits specialists, and 1.5 rehabilitation counselors. There are 12.1 budgeted vacancies: 5 social workers, 2.6 ASAs, 1.5 parent consultants, 1 nurse, 1 OT, and 1 audiologist. The State Office had 10.75 administrative and 5 clerical FTEs, respectively. Administrative staff include 2 nurses, 2 SLPs, 2 audiologists, 1 rehabilitation counselor, 1 social worker, 1 patient account manager, 1 OT, and 0.75 parent consultant. There is a vacancy for a .5 FTE youth consultant.

Brief biographical information on selected key CRS staff follows.

Melinda Davis, MS, CPHL, is the Director of CRS and the Assistant Commissioner of ADRS. Her background includes pediatric audiology, speech-language pathology, administration, and service provision to CYSHCN in clinical and school system settings. She served as a District Supervisor in a local CRS office for 7.5 years and briefly as the CRS Assistant Director before assuming her

current position. She is a member of the American Speech-Language and Hearing Association and the Speech and Hearing Association of Alabama. Her academic credentials include an undergraduate degree in communication disorders, a graduate degree in audiology, and a certificate in public health leadership.

David H. Savage, BA, MSC, is the CRS State Supervisor for Professional Services. He was a speech-language pathologist in school and rehabilitation settings prior to assuming his current role. His expertise includes staff training, quality assurance, and augmentative communication technology. He is a member of the American Speech-Language and Hearing Association and the Speech and Hearing Association of Alabama. Academic credentials include undergraduate and graduate degrees in speech-language pathology.

Wanda Williams, RN, MEd, is the Clinical/Policy Specialist. Her extensive experience in pediatric nursing includes public health, early intervention, administration, and service provision to CYSHCN. She is a certified rehabilitation counselor; and her academic credentials include undergraduate and graduate degrees in nursing and rehabilitation counseling, respectively.

//2012/ Lolita A. McLean, RD/LD, MPH, JD, is the MCH Coordinator/Nutrition Program Specialist. Ms. McLean has been with ADRS for 7 years and joined the CRS State office in 2010. Her prior experience with CRS includes work at the district level as a nutritionist and district supervisor. She also has prior experience as a clinical and administrative dietitian in the state and private sectors. Ms. McLean's credentials include an undergraduate degree in dietetics, a graduate degree in public health with a concentration in MCH, and a juris doctorate. //2012//

//2013/ Miracle Woods, a college senior majoring in English Education, is the new CRS State Youth Consultant. She is the 2011 recipient of the Montgomery Area Governor's Committee on Employment of People with Disabilities Student of the Year Award. She has Alabama State University inclusive summer camp experience. //2013//

Through a partnership with United Cerebral Palsy (UCP) of Mobile, CRS employs 10 parents of CYSHCN as LPCs. UCP employs and supervises the LPCs, provides insurance and benefits, and supports State and Local Advisory Committee activities. The SPC is employed through a partnership with Easter Seals of Central Alabama. Based in CRS's State Office, she advises in collaborative interagency efforts, recruits additional parent participation, facilitates the State Parent Advisory Committee, coordinates the parent-to-parent network and the Youth Advisory Committee, and publishes the Parent Connection newsletter.

//2013/ As of May 2012, there are 210 FTEs in the field: 8 district supervisors, 66 ASAs, 50 social workers, 30 nurses, 17 rehabilitation assistants, 7 nutritionists, 8 audiologists, 6.75 parent consultants, 7.75 PTs, 6 SLPs, 2 OTs, 1 medical care benefits specialist, and .5 rehabilitation counselors. There are 14 budgeted vacancies: 1 staff nurse, 1 nutritionist, 1 audiologist, 1 occupational therapist, 2 social workers, 1 social work administrator, 5 ASAs, 1 rehabilitation assistant, and 1 medical care benefits specialist.

The State Office has 11 administrative and 4 clerical FTEs, respectively. Administrative staff include 1 nurse, 2 SLPs, 2 audiologists, 1 rehabilitation counselor, 1 parent consultant, 1 social worker, 2 patient account managers, 1 nutritionist, and 1 youth consultant.

Easter Seals of Central Alabama employs and supervises staff carrying out the activities of the State Implementation Grant for Systems of Services for CYSHCN. //2013//

E. State Agency Coordination

Coordination of the Title V Program with entities mentioned in the Guidance (reference 12) for this section occurs in the context of FHS and CRS seeking to accomplish their respective

missions and identify priority MCH needs, rather than under a particular plan to coordinate with certain programs. Since FHS administers the Title X Family Planning Grant and WIC, coordination with these 2 entities is built into FHS's organizational structure and internal collaborative mechanisms. Similarly, CRS and VRS are major divisions of ADRS, facilitating collaboration between the Title V Program and VRS. Concerning identification of Medicaid-eligible infants and pregnant women, via CHIP (discussed in Section III.A and under NPM 13), ADPH and Medicaid collaborate to identify Medicaid-eligible infants and pregnant women and help with their applications for Medicaid coverage. Concerning SSA, as discussed in Section III.B, SSI beneficiaries less than 16 years old are eligible for CRS services; some ways that CRS coordinates with SSA are also discussed in Section III.B. CRS's collaboration with SSA via the DDU's and CRS's involvement with families are discussed later in this section.

SELECTED COLLABORATIONS INVOLVING BOTH FHS AND CRS

FHS and CRS have collaborated via interagency meetings held 3 times a year and partnership on such tasks as preparing the MCH reports/applications and conducting 5-year MCH needs assessments.

CRS serves as a member of the State Newborn Hearing Screening Advisory Committee, a subcommittee of the Alabama Newborn Screening Advisory Committee convened by FHS. This group meets at least once a year to provide input to ADPH, the lead agency in Alabama for the Universal Newborn Hearing Screening Program. Member agencies meet throughout the year as the State Early Hearing Detection and Intervention Committee to address ongoing State needs. CRS also serves as the voice of CYSHCN and families on the Alabama Newborn Screening Advisory Committee related to implementation of expanded newborn screening, development of surveillance methods, and establishment of follow-up procedures.

FHS and CRS collaborated extensively with one another and many other organizations when conducting the Needs Assessment. These collaborations are detailed in Section 1 and, with respect to selection of priority MCH needs, Section 5 of the Needs Assessment Report. For example, FHS and CRS each convened an MCH advisory group or committee and collaborated with various organizations to hold focus groups around the State.

A full discussion of FHS's or CRS's collaborations, some of which are discussed in various places throughout this report, is beyond the scope of Section III.E. What follows are discussions of selected collaborations in which FHS or CRS engage.

ADPH COLLABORATIONS

Description of certain collaborations involving external groups follows. Unless otherwise stated, the collaborations began prior to FY 2010 and are expected to continue in some form through FY 2010 or later.

FHS's Collaborations with External Entities

Staff from the Division of Women's Health collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with: Alabama Chapter of the March of Dimes (AMOD) on the March of Dimes' campaign to reduce the prevalence of prematurity, Medicaid on an 1115(a) Family Planning Waiver (see Section III.A), SPAC to promote a strong regionalized system of perinatal care (see NPM 17), and regional FIMR teams to review infant deaths (see SPM 6). Other collaborations that Division of Women's Health staff engage in include those with: DMH, whereby Family Planning Program care coordinators outreach to DMH facilities and DMH refers clients to the Family Planning Program; Family Planning Program coordination with hospital facilities and private physicians for the provision of sterilizations, intrauterine device (IUD) insertions, etc; and the Alabama Campaign to Prevent Teen Pregnancy.

As well, since October 2002 SPP has collaborated with AMOD to improve the health of babies by reducing the occurrence of birth defects, premature births, and infant deaths. Additionally,

effective FY 2011, AMOD is helping to support the initiatives of SPP's FIMR Program.

/2013/ SPP spearheaded ADPH's use of the national Text4Baby Program to educate parents about important preventive health care practices for their children. The program is a public-private partnership with mobile phone companies that allows ADPH to send texts on nutrition, immunization, and prevention of birth defects to the cell phones of pregnant women and new mothers who request the free mobile information. //2013//

Since September 2008 FHS's Plan First Manager has participated on the Quality Assurance Board of the Gift of Life, a Medicaid Maternity Care Program that provides services and education to pregnant women in 20 Alabama counties. These counties are located in 3 of the State's 5 Perinatal Regions, with none located in the northern-most region or the west-central region. Women who reside in 1 of the above counties, have a documented positive pregnancy test, and are enrolled in Medicaid or want to apply for Medicaid can enroll in the Gift of Life Maternity Care Program. The program's multidisciplinary board meets quarterly and reviews various programmatic reports, including client grievances, in order to ensure that the program is meeting the expectations of those served as well as Medicaid standards of care.

The Division of Women's Health Family Planning Program continues to contract with DHR for contraceptive supply funding for clients of Family Planning clinics. (DHR began providing these funds in FY 2004.)

Children's Health Division staff collaborate with several entities, such as with: delivery hospitals to assure that newborns receive appropriate biochemical and hearing screening (see NPMs 1 and 12), DHR to implement the Healthy Child Care Alabama (HCCA) Program, and DHR's work group developing a Quality Rating Improvement System for child care programs. Through HCCA, 9 registered nurse consultants work in a variety of community settings in 52 of the State's 67 counties. Their services include provision of information on health and safety for child care providers and families of children in child care, linkage of families and child care providers to community resources and services, and assistance to child care providers with integration of CYSHCN into the child care environment. For example, HCCA collaborates with the Children's Hospital's Regional Poison Control Center to provide poison prevention trainings and information for child care providers, children in child care, and the children's families. The HCCA Nurse Consultants also provide child passenger safety information and technical assistance for child care providers and parents of young children, in collaboration with the Children's Health System's Alabama Safe Kids Campaign. The Children's Health System is headquartered in Birmingham and includes the Children's Hospital.

/2012/ As discussed in Section III.C, ACDRS has administratively relocated to HPCD. //2012//

/2013/ In FY 2012, the Children's Health Division Director began serving on the CRS Hemophilia Advisory Committee. //2013//

In 1999 WIC joined the Alabama Farmer's Market Authority and the Alabama Cooperative Extension System in a pilot project to provide fresh, unprepared, locally grown fruits and vegetables to WIC participants in 3 clinics in Montgomery County. This program allows participants to shop at local farmers' markets, learn how to prepare fresh fruits and vegetables, and consume nutrient-rich fruits and vegetables. The WIC Farmer's Market Nutrition Program expanded to include 16 counties in FY 2005, 22 counties in FY 2006, 24 counties in FY 2007, and 25 counties in FYs 2008 and 2009.

/2012/ Due to lack of funds for the state match, the Farmer's Market Nutrition Program was reduced to 4 counties in FY 2010. //2012//

/2013/ In FY 2011, the Farmer's Market Nutrition Program continued in the 4 counties. Due to a slight increase in funding, 2 additional clinics will be added to the program in FY 2012,

so that the program will be operating in 6 counties.

ADPH has partnered with the Poarch Band of Creek Indians (PCI) on many initiatives over a period of many years. This partnership is unique when compared with other state organizations and Native American tribes across the U.S. The PCI government structure is located in Escambia County, in southern Alabama. PHA 9, which includes Escambia County, and the Escambia County Health Department (ECHD) lead ADPH in partnering with the PCI; and the PCI allows ADPH to use facility space for trainings, meetings, and exercises. Without such partnership, ADPH would not have been able to conduct many large-scale meetings and trainings that have benefited many organizations and individuals within the county, area, State, and tribe. Collaborations have involved several issues, including, respectively, WIC and MCH needs assessment. More information on these collaborations is attached. //2013//

FHS's Collaborations with Other ADPH Entities

Many collaborations occur within FHS and among FHS staff and other ADPH staff. For example, Family Planning staff collaborate with many ADPH units and programs at the State and local level to coordinate projects and provide input and technical assistance on family planning. For instance, they collaborate with the Bureau of Disease Control's STD Control Division and BCL on the Title X Infertility Prevention Project, with the Department's Center for Health Statistics (CHS) on the Title X Regional Network for Data Management and Utilization Project, and the Public Health Nursing Section on Title X training activities. As well, Family Planning staff collaborate with ADPH's Offices of Women's Health and Minority Health to promote preconception health and address health disparities. Further, they collaborate with WIC concerning referrals to Family Planning Program clinics.

In October 2008 FHS's Family Planning staff collaborated with ADPH's Offices of Women's Health and Minority Health in the development of a Preconception Health Care Plan, which was submitted to Region IV's Title X Family Planning Office. The goal of this plan is to impact infant mortality through promotion of preconception planning. As part of Alabama's Preconception Health Plan, the preconception health brochure "Be Healthy, Be Ready, Be in Control" has been developed and distributed to all public health clinics for counseling and education of clients, as well as for education of the general population at health fairs etc. A web page on preconception health, including a preconception health report card, was also developed and added to the Family Planning Program section of the ADPH web site.

//2013/ Consequent to certain national meetings held in November 2011 and January 2012, ADPH is developing a state plan to address infant mortality. The November meeting was sponsored by the National Conference of State Legislatures, the Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Health Officials, National Association of County and City Health Officials, and CityMatCH. The meeting was to address how states can use limited health dollars wisely to create the health system they want. The Alabama State Team chose infant mortality and childhood obesity as areas of interest to be addressed. The January meeting was hosted by HRSA, the American Association of State and Territorial Health Officials, and AMCHP. The meeting was held to initiate or maintain networking and collaborations across and within states to reduce infant mortality. One goal of the meeting was for states to leave with a state plan to address infant mortality. Alabama attendees at the 2 meetings have united and are working together to develop and implement Alabama's state plan to address infant mortality. //2013//

//2012/ As further discussed in Section IV.F, FHS's Family Planning Program staff and SPP staff are collaborating to plan and implement the GAL Campaign, in order to raise public awareness of the importance of preconception and interconception health. //2012//

//2013/ In FY 2011, SPP spearheaded implementation of the GAL Campaign, to educate,

enlighten, and inspire women to take time out for themselves and get healthy. SPP collaborated with ADPH's Office of Women's Health and Office of Minority Health (both located in the Bureau of Professional and Support Services) to distribute GAL Campaign materials. ADPH's FOCUS Program partnered with the GAL Campaign by providing a venue for the promotion of healthy behaviors and prevention in schools and communities. The FOCUS program utilizes a youth-led approach and seeks to promote youth involvement in the planning of prevention activities. This collaboration allowed SPP to raise awareness in high schools throughout the State. As well, SPP partnered with ADPH's HIV/AIDS Prevention and Control Division (located in the Bureau of Communicable Disease) to provide materials to college students attending Historically Black Colleges and Universities. That is, SPP provided GAL Campaign materials and educational awareness items to students participating in testing programs that the HIV/AIDS Prevention and Control Division offered on site at the Historically Black Colleges and Universities. HRSA will discontinue funding for the GAL Campaign as of August 31, 2012. //2013//

In early FY 2005, the Director of FHS began devoting more time to the continuing role as Collaborative Physician for all CHD-employed nurse practitioners, all of whom work in the area of women's health. Further, in May 2005 an additional physician was hired to serve as a Collaborative Physician and direct the Bureau's Medical Branch. The role of Collaborative Physician includes ongoing review and revision of protocols used by the nurse practitioners, training of nurse practitioners, assurance that protocols are followed, provision of consultation for situations not covered by the protocols, and other activities assuring the provision of appropriate, high quality services by nurse practitioners.

/2012/ In 2010 FHS's Medical Consultant Branch implemented biannual, 2-hour satellite presentations that address the need for more continuing education for the registered nurses and nurse practitioners across the State. Recent changes in ACOG Pap smear guidelines prompted numerous updates in FHS's Pap smear guidelines and management protocols, to assure that ADPH provides patients with care that meets the most up-to-date best practice recommendations. //2012//

As part of the Bureau's responsibility to provide consultation to nurse practitioners and assure quality of services, a mandatory, 2-day training conference for CHD nurse practitioners was held in January 2005. Per informal feedback, the conference was viewed by attendees as being quite successful, pertinent, and useful. The conference has become an annual event that is geared toward presenting evidence-based information to keep the nurse practitioners informed of best practice issues. The conferences utilize speakers from Emory University, UAB, and the University of Tennessee, as well as other universities across the nation. Further, all current ADPH nurse practitioners were trained in 2008 to insert the highly effective, top-tier, long-term birth control method, Implanon(R); and the newest ADPH nurse practitioners were trained in March 2010.

/2012/ In 2010 FHS held the sixth Annual Nurse Practitioners Conference, "Striving for Excellence in Women's Health," with speakers from Washington/Seattle School of Nursing, UAB's HIV/AIDS Clinic, and the University of Tennessee. All current and new nurse practitioners coming into ADPH have been trained to insert Implanon(R). Since April 2008 well over 1,000 of these contraceptive implants have been provided to women in ADPH's Family Planning Program. //2012//

/2013/ In 2011 FHS held the seventh Annual Nurse Practitioners Conference, "Striving for Excellence in Women's Health," with speakers from the University of Tennessee and the USA. Since April 2008 approximately 3000 Implanon(R) implants have been provided to women in ADPH's Family Planning Program. ADPH continues to assure that all nurse practitioners employed by the Department are trained in the use of this contraceptive implant. //2013//

Further, as discussed in Section III.C, as part of quality assurance, FHS's Medical Branch

provides consultation to nurse practitioners (currently 46 in number) from 65 counties, via a consult template accessed on ADPH's intranet system. Another quality assurance activity, initiated in May 2002, is the 2-Day Model Clinic Rotation, which each nurse practitioner is required to complete annually. In the rotation the nurse practitioner works directly with the Collaborating Physician when seeing patients.

/2012/ In 2009 ADPH created 2 new nurse practitioner positions, Nurse Practitioner Director and Nurse Practitioner Senior, in FHS's Medical Consultant Branch. These nurse practitioner roles were expanded to interface ADPH's Central Office with the PHAs and CHDs. The goal is to have more direct interaction with the clinic nurse practitioners in order to assess, monitor, and evaluate their clinical practice.

/2013/ In 2011 ADPH added a third Nurse Practitioner Senior position, in FHS's Medical Consultant Branch. //2013//

Quality assurance audits have helped to identify issues and trends that influence protocol changes and identify training needs. Plans are being developed to enhance and automate the existing quality assurance process and the follow-up and tracking systems for abnormal findings. The consult template has undergone many improvements since its development and is also used as an education tool. //2012//

FHS staff continue to provide administrative and programmatic support to CHDs and to participate in monthly or bimonthly meetings of Area Social Work Directors and Area Administrators to share information and offer technical assistance. Additionally, WIC staff hold quarterly meetings and monthly conference calls with the Area Nutrition Directors to provide updates on policies and procedures and provide information about technical assistance.

/2012/ The meetings with Area Social Work Directors and Administrators are now held quarterly, with monthly conference calls. //2012//

/2013/ The meetings of Area Social Work Directors are no longer held quarterly, but are convened by the State Social Work Director as the need arises. //2013//

CRS COLLABORATIONS

CRS has ongoing coordination with State and federal programs that strengthen the Title V program. The placement of CRS as a division within ADRS facilitates coordination of program planning and service delivery with other divisions, including EIS, SAIL, and VRS. EIS and VRS staff members are co-located with CRS staff in most locations around the State. Implementation of a transition plan for clients from CRS to VRS for vocational guidance is a priority focus for clients for whom this is appropriate. CRS sponsors 13 early intervention programs statewide and continues active participation on the Governor's ICC, ICC subcommittees, and DCCs.

Collaborations also exist between CRS and various agencies for transition planning for CRS clients to the community and other post-secondary education opportunities in cases where the clients may not choose vocational pursuits. VRS staff continue collaborating with CRS in the ongoing development of a comprehensive statewide system of services for children and youth with TBI and in the implementation of the ADRS Continuum of Transition for Youth with Special Health Care Needs. Interagency agreements are in place for planning service delivery between ADRS and the Alabama Institute for Deaf and Blind, Head Start, the Department of Youth Services, and local education agencies for transition services.

CRS staff serve on the advisory committee for an MCHB-funded grant to ADRS-VRS to address services for persons with TBI living in rural and underserved areas. One grant objective targets children and youth. Planned activities include a series of advocacy institutes for families and consumers.

CRS is partnering with schools, child care facilities, and Head Start centers in underserved areas to provide on-site screenings for hearing loss and scoliosis. Follow up is offered through the network of CRS community-based offices should a child fail the screening.

CRS is committed to participation in many State-level collaborative planning efforts affecting CYSHCN. CRS serves on the State and local CPCs, as well as on the State Head Start Disability Advisory Committee, to provide guidance in accessing health, education, and welfare service systems. Other State-level systems development councils on which CRS participates include SPAC, RPAC, and the State Multi-Needs Child Task Force. Other key agencies involved with these councils include Medicaid, SDE, and DMH. CRS staff and families participate on a variety of interagency committees and task forces, such as Child Death Review teams, FIMR teams, Healthy People work groups, the State Improvement Grant Taskforce on Recruitment, Preparation, and Retention through SDE, the UAB Civitan International Research Center Consumer Advisory Committee, the Special Education Action Committee Advisory Group, the Olmstead Core Workgroup, the Newborn Screening Task Force, the Oral Health Coalition, the Arthritis Coalition, Individual and Family Support Councils, the Northeast Alabama Safe Kids Steering Committee, the Family to Family Health Information Council, the Alabama Respite Resource Network, a local UCP Board, and the Statewide Technology Access and Response (STAR) Advisory Committee.

As mentioned above, CRS participates in the Oral Health Coalition and on the Education and Awareness Subcommittee. The purpose of CRS's involvement with this coalition is to highlight access-to-care issues for CYSHCN whose disability may be a barrier to receiving routine and specialized dental care. This organization consists of some 31 public and private agencies and groups, with its stated purpose "to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child." After initial Robert Wood Johnson (RWJ) grant funding, the Oral Health Coalition continues project activities; develops materials about prevention and intervention for lawmakers, policy makers, and the general public; and disseminates dental awareness kits via alternative methods and funding sources. Current issues include discussions of the impact of health care reform on dental provider capacity and access to dental services. A new program was initiated over the past year to provide training to primary care providers (family practitioners and pediatricians) so they can administer fluoride varnishes for children living in underserved areas. A 2-day Statewide Dental Summit is planned for September 2010 to provide training for providers and stakeholders. CRS will participate on a panel related to resources and options for CYSHCN. CRS continues to integrate dental health initiatives for CYSHCN into the program.

CRS partners with Medicaid in various ways. Although EPSDT services are the responsibility of the primary care provider for all children under Medicaid managed care arrangements, CRS coordinates services with the medical home to ensure access to specialty care and related services through Medicaid funding for all CYSHCN served by the program. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the State, which enhances access to services for Medicaid recipients. CRS serves as the reviewer of all requests for Medicaid funding for augmentative communication devices and previously for power wheelchairs. Though CRS no longer reviews power wheelchair requests, a CRS PT assisted Medicaid during the transition between outside contracted reviewers and also provided training to the new staff. CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and served as a voice for this population in the planning for the waiver for Patient 1st. A data-sharing agreement has allowed matching of CRS enrollment data with Medicaid data to correctly identify those with coverage and also determine those with SSI coverage. CRS staff participate in Medicaid-led grants, currently including TFQ (see Section IV.C, NPM 5 for more information).

CRS is 1 of 6 State agency divisions participating in My Alabama (formerly the Camellia Project), a program, out of the Governor's Taskforce to Strengthen Alabama's Families, funded through an

Annie E. Casey Foundation grant. Phase I created an electronic resource for health and human services available in the State with criteria for eligibility. Phase II, now in process, has created an application system to populate commonly needed demographics to prevent the need for applicants to enter information in multiple places, assuming that the applicant releases the information for sharing. Also, the system will facilitate other data sharing across programs if released by applicants. The system is currently in the testing phase and has not been released to the public.

CRS has a long history of collaboration with the Alabama Easter Seal Society to enhance services for CYSHCN through community rehabilitation centers and to increase public awareness of Alabama's Special Camp for Children and Adults (Camp ASCCA), a year-round camp facility for persons with disabilities. CRS staff members volunteer their time to provide their specialized skills for various camps. Further, CRS supports camps for children with hemophilia through public awareness and information-sharing. CRS also has an extensive partnership with UCP, including employment of LPCs and promotion of public awareness concerning Camp Adventure, a camp for children and youth with disabilities.

CRS collaborates with SSA through the DDUs in Birmingham and Mobile for serving SSI beneficiaries below 16 years of age. CRS staff provide fact sheets with contact information and an annual outreach activity to SSA offices located in the various districts, focusing on the CRS program and benefits for referral.

CRS supports FVA and VOICES for Alabama's Children. CRS's SPC and the parent of a young adult with disabilities together function as the FVA Co-coordinators, home of the new Family to Family Health Information Center in Alabama. They are both actively involved with national Family Voices. CRS also supports the Alabama Governor's Youth Leadership Forum, an annual leadership and career skills training opportunity for Alabama high school youth with disabilities.

/2012/ CRS collaborations continue as above with the following changes. CRS was awarded the State Implementation Grant for Systems of Services for CYSHCN to commence on July 1, 2011. The Special Education Action Committee Advisory Group, the Olmstead Core Workgroup, and the Family to Family Information Council were discontinued. CRS now participates in the Alabama Exchange Planning Task Force. CRS staff participated in and served as presenter for the FY 2010 Alabama Dental Summit. The My Alabama project remains in the testing phase. //2012//

***/2013/ The Alabama Exchange Planning Task Force discontinued its focus group. CRS audiology staff presented at the Alabama Newborn Hearing Conference and the National Early Hearing Detection and Intervention conference. The My Alabama project remains in the testing phase. //2013//
An attachment is included in this section. III E - State Agency Coordination***

F. Health Systems Capacity Indicators

HEALTH SYSTEMS CAPACITY INDICATOR (HSCI) 3: THE PERCENT STATE CHILDRENS HEALTH INSURANCE PROGRAM (SCHIP) ENROLLEES WHOSE AGE IS LESS THAN ONE YEAR DURING THE REPORTING YEAR WHO RECEIVED AT LEAST ONE PERIODIC SCREEN.

Data Issues:

Alabama's CHIP is named "ALL Kids." In FY 2006, ALL Kids staff and MCH Epi Branch staff agreed that a standardized measure used in annual reports produced by ALL Kids would provide the best available estimate for the proportion of ALL Kids-enrolled infants who receive 1 or more well child visits. The indicator chosen is based on specifications provided by HEDIS[™] and reports well child visits in the first 15 months of life. ("HEDIS" is the Health Plan Employer Data and Information Set.) Though the Title V definition of Health Systems Capacity Indicator (HSCI) 3

pertains to the first year of life, the HEDIS-based method was chosen to estimate HSCI 3 for several reasons. First, as just stated, the HEDIS-based method has the advantage of standardization. Second, reporting well child visits through the first 15 months of life, rather than through 12 months of life, should better capture visits that are due and occur around the first birthday. Third, the Title V definition of HSCI 3 and the HEDIS specifications for well child visits in the first 15 months of life are aimed at obtaining similar information, which would presumably have similar implications for program planning. Finally, the HEDIS-based indicator is readily available.

Status:

Basically, this indicator pertains to children who reached 15 months of age during the reporting year and who were continuously enrolled in ALL Kids from 31 days of age. Of such children, 98.2% received 1 or more well child visits with a primary care provider during the reporting year. At 98.2%, this indicator was higher (better) in 2011 than in any other year during the surveillance period (2005-2011). Further, the number of ALL Kids enrollees in the appropriate age group who received such visits was higher in 2011 than any other year during the surveillance period. Trends are further discussed in the corresponding Form 17 field notes for this indicator.

Relevance to MCH Planning:

As stated in Section III.A, Alabama's CHIP is administered through ADPH's Bureau of Children's Health Insurance. As also stated there, in anticipation of the austere fiscal climate projected for the State in FY 2013, ALL Kids is halting all media-related outreach activities during FY 2012 and will research potential cost-saving measures. The percentage of infants who receive well child visits indicates ALL Kids' effectiveness in promoting its enrollees' access to well child care. Monitoring of this indicator, along with some others, will be critical as ALL Kids seeks to implement cost-saving measures without reducing the provision of recommended well child care to its enrollees.

Activities, Strategies, and Developments:

ALL Kids and FHS staff believe that, over recent years, several factors contributed to the high percentage of ALL Kids-enrolled infants who received well child visits. Key among these factors is the robust network of primary care providers who serve ALL Kids enrollees and the absence of co-pays for preventive services. Also, effective October 1, 2009, the upper income criterion for enrollment in ALL Kids increased, with 300% of FPL now being the maximum allowable household income. In response to this increase, ALL Kids staff focused on outreach and education directed toward families in the new eligibility range. As well, ALL Kids publications encouraged parents to utilize the well child visit benefits. Further, according to Alabama CHIP's FY 2010 annual report, the ALL Kids Program's ability to capture well child visit information through claims data improved circa FY 2010 (reference 13). Presumably, these measures contributed to the recent reported increase in the number of well child visits in the first 15 months of life for Alabama CHIP enrollees.

Further, as discussed under NPM 7, ADPH's Immunization Division sends vaccine pamphlets to parents of all 4-month-old infants in the State, for whom addresses are available, to remind them of the importance of vaccines. Such reminders may promote well child care for all infants, including CHIP-enrolled infants.

ALL Kids activities are further discussed under NPM 13, located in Section IV.C.

HSCIs 6A, 6B, AND 6C: THE PERCENT OF POVERTY LEVEL FOR ELIGIBILITY IN THE STATE'S MEDICAID AND SCHIP PROGRAMS

HSCI 6A: -- INFANTS (0 TO 1)

HSCI 6B: MEDICAID CHILDREN

HSCI 6C: PREGNANT WOMEN

Status:

For Medicaid eligibility, the upper limit for income eligibility as a percent of FPL is 133% for persons aged 5 years or younger, 100% for persons aged 6-18 years, and 133% for pregnant women. For persons 18 years old or younger, ALL Kids eligibility begins at the cutoff point for Medicaid eligibility and continues through 300% of FPL. That is, as a percent of the FPL, income eligibility ranges for ALL Kids are as follows: 134% through 300% of FPL for persons aged 5 years or younger and 101% through 300% of FPL for persons aged 6 through 18 years.

Medicaid eligibility income parameters have not changed for several years. However, as stated in Section III.A, in October 2009, the State Legislature increased the upper income limit for ALL Kids from 200% to 300% of FPL.

Relevance to MCH Planning:

For any program, income eligibility influences the number of persons who are eligible for services and, therefore, the resources that the program needs to serve its enrollees. Further, when the eligible income range expands, outreach is needed to inform newly eligible persons or their families about the program and their eligibility.

Activities, Strategies, and Developments:

In response to the expansion of the income-eligible range for ALL Kids that occurred in October 2009, in FY 2010 ALL Kids staff focused on outreach and education directed toward families in the new eligibility range. As well, ALL Kids publications encouraged parents to utilize the well child visit benefits. Further, the ALL Kids Program's ability to capture well child visit information through claims data has improved (reference 13). Presumably, these measures contributed to the recent reported increase in the number of well child visits in the first 15 months of life for ALL Kids enrollees (discussed under HSCI 3). However, as discussed earlier in this document, in anticipation of the austere fiscal climate projected for the State in FY 2013, ALL Kids is halting all media-related outreach activities during FY 2012 and is researching other potential cost-saving measures. Conceivably, therefore, the proportion of ALL Kids-eligible children who are not enrolled in ALL Kids could increase.

HSCI 8: THE PERCENT OF STATE SSI BENEFICIARIES LESS THAN 16 YEARS OLD RECEIVING REHABILITATIVE SERVICES FROM THE STATE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM.

Data Issues:

The denominator was provided to each state by the SSA for FY 2011. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered SSI payments as of December 2011. The file is in Characteristic Extract Record format and is 100% data. The numerator is programmatic data based on a database match between CRS and Alabama Medicaid.

Trends:

As had been the trend over time, the number of Alabama's children under 16 years old who receive SSI benefits increased in FY 2009. This number was obtained from the SSA, Supplemental Security Record. For FY 2009, there were 25,539 Alabama children under age 16 years who received SSI payments, compared to 24,772 in FY 2008. This represented a 3.1% increase statewide for FY 2009 and a 19.6% increase over the 21,360 children in FY 2001.

CRS and Alabama Medicaid maintain an interagency agreement (re-established in FY 2006) to allow matching between the respective databases to identify children enrolled in the CRS program who obtained Medicaid coverage through SSI. This allows CRS to query programmatic data to determine the numerator for this indicator. For FY 2009, the number of SSI beneficiaries under age 16 years enrolled in CRS was 3,675, representing a .66% increase over FY 2008. This

continued the trend of increases noted in FY 2008 (3.3%) and FY 2007 (7%), and reversed a trend of decline that had been evident since FY 2002. Part of this increase may have been due to better data capacity via the aforesaid data-sharing agreement with Medicaid.

For FY 2010, there were 25,648 Alabama children under age 16 years who received SSI payments, compared to 25,539 in FY 2009. This represented a .43% increase statewide for this FY and a 20% increase over the 21,360 children in FY 2001. For FY 2010, the number of SSI beneficiaries under age 16 years enrolled in CRS was 3,618, representing a 1.5% decrease relative to FY 2009. This changed the trend of increases noted in FY 2008 (3.3%) and FY 2007 (7%).

For FY 2011, there were 25,761 Alabama children under age 16 years who received SSI payments, compared to 25,648 in FY 2010. This represents a .44% increase statewide for this FY and a 21% increase over the 21,360 seen in 2001. For FY 2011, the number of SSI beneficiaries under age 16 years enrolled in CRS was 3,420, representing a decrease of 5.5% relative to 2010. This changes the trend of increases noted in FY 2008 (3.3%) and FY 2007 (7%).

Activities, Strategies, and Developments:

As discussed above, CRS and Alabama Medicaid maintain an interagency agreement that allows matching between the respective databases to identify children enrolled in the CRS program who obtained Medicaid coverage through SSI. This allows CRS to query programmatic data to determine the numerator for this indicator, to promote self-referrals in this population for this indicator. By providing informational materials and making annual contacts or in-service visits, CRS networks with local SSA offices to encourage referrals of SSI recipients less than 16 years of age to CRS. CRS received 3,085 referrals during FY 2011. Contacts are made with all children newly awarded SSI benefits with the exception of those already enrolled in CRS. During FY 2011, CRS mailed informational letters to 1,319 children (not already enrolled in CRS) who were referred by local SSA offices after new benefits had been awarded.

HSCI 9A: THE ABILITY OF STATES TO ASSURE MATERNAL AND CHILD HEALTH (MCH) PROGRAM ACCESS TO POLICY AND PROGRAM RELEVANT INFORMATION.

As indicated by its name, this indicator is relevant to development of policies and programs. Each element of HSCI 9A is discussed below, with a particular focus on the linkage of birth and Medicaid files. The parenthetical number indicates the score, per the following rating system: 1 = No, the MCH agency does not have this ability; 2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis; 3 = Yes, the MCH agency always has this ability. The parenthetical "Yes" or "No" pertains to whether the State has direct access to the database for analysis. All parenthetical scores apply to FY 2011.

Annual Linkage of Infant Birth and Infant Death Certificates (3, Yes):

CHS links these files annually and grants the MCH Epi Branch direct access to the files. Thus, the score for this element has been at 3 since this HSCI was developed.

Annual Linkage of Birth Certificates and Medicaid Eligibility or Paid Claims Files (2, Yes):

This score remains the same as it was in FY 2010, but higher than it was in FYs 2008-2009. An MOU between Medicaid and ADPH on linkage of live birth records with Medicaid claims data was signed by December 2008. Later in FY 2009, Medicaid provided a file with key elements from year 2008 Medicaid paid claims for deliveries of live-born infants. By February 2011, a master dataset of 65,348 CY 2008 live birth records, 43.0% of which linked with Medicaid delivery claims, was prepared by the MCH Epi Branch. As well, the branch prepared a technical report on the linkage and submitted it to Medicaid, requesting approval for its public release, which was granted. However, the branch plans to make several minor revisions in the terminology before distributing the report widely.

The MCH Epi Branch then studied the 64,345 CY 2008 Alabama resident births from the linked

file, to explore whether the linkage process produced operable information of public health significance that was not available from the birth certificate alone. Such exploration is indicated and feasible because Alabama's birth certificate includes an item on source of payment for delivery. Specifically, the branch explored how the method for classifying births according to source of payment for delivery affected payment-specific estimates of the prevalence of very low birth weight (VLBW). VLBW was chosen as the outcome of interest because it is a strong predictor of risk of infant death, and death records were not included in the linked birth/Medicaid file. The estimated prevalence of VLBW per the "Combined Sources Method" (which classifies the delivery as being Medicaid funded if either the linkage process or the birth certificate identify it as such) was compared to that per the "Birth Certificate Method" (which uses the birth certificate alone to ascertain source of payment).

In June 2012 the report was submitted to key ADPH administrators, some from FHS and some from CHS, for review and comment. After making any revisions indicated based on the ongoing internal review and receiving appropriate administrative approval, the MCH Epi Branch plans to submit the report to Alabama Medicaid. Per the MOU, the report cannot be further distributed without Medicaid's approval.

Work on the birth/Medicaid linkage was performed with the support of federal SSDI funds. (SSDI is administered through MCHB.) Whether Alabama live birth files for additional years will be linked with Medicaid delivery claims will depend on several factors, mainly the following: 1) key administrators' views on whether analysis of the linked files would provide otherwise unavailable, operable information of public health significance; 2) perceptions on whether study of the linked files would result in a report contributing to the methodological literature, 3) personnel resources available, and 4) competing analytic and reporting responsibilities.

Annual Linkage of Birth Certificates and WIC Eligibility Files (1, No):

By March 2008 the MCH Epi Branch's third linkage of WIC prenatal registration files to birth records was performed. Per consultation with WIC staff, linkage of birth records with WIC records is not deemed feasible for the next several years, due to the ongoing development of a new, vendor-prepared data system for WIC.

Annual Linkage of Birth Certificates and Newborn Screening Files (1, No)

Linkage of birth certificates with Neometrics(TM), the State's vendor-prepared newborn screening dataset, is not feasible at this time.

Hospital Discharge Survey for at Least 90% of in-State Discharges (1, No):

No measurable progress has occurred toward development of a hospital discharge database in Alabama, and development of one is unlikely in the short term.

Annual Birth Defects Surveillance System (1, No)

USA collects birth defects data in several counties in the State, but FHS does not receive regular reports of the findings.

Pregnancy Risk Assessment Monitoring System (PRAMS) (3, No):

CHS implements Alabama PRAMS, publishes annual reports of findings, and performs special analyses on request. The MCH Epi Branch has obtained SUDAAN software, which is recommended for analysis of PRAMS data, and plans to develop a working knowledge of the software by November 2012. By February 2013, branch staff plan to prepare a brief report on salient WIC-related findings from PRAMS. Should SSDI funds for FY 2013 be awarded, they will support these activities.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Determination of the State's priorities, performance measures, and program activities occurs in the context of the Government Performance and Results Act (GPRA, Public Law 103-62). Figure 3 of the guidance for the MCH Services Block Grant reports/applications (reference 12) depicts the Title V Block Grant Performance Measurement System. This system is to begin with needs assessment and identification of priorities and is to culminate in improved outcomes for the Title V population. As shown in Figure 2 of the aforesaid guidance, assessing needs is part of a circular process that includes: engaging stakeholders, assessing needs and identifying desired outcomes and mandates, examining strengths and capacity, selecting priorities, seeking resources, setting performance objectives, developing an action plan, allocating resources, monitoring progress for impact on outcomes, and reporting back to stakeholders. Each component of this process receives input from a preceding component and feeds into the next component. The 2 ultimate goals of needs assessment are improved outcomes for MCH populations and strengthened partnerships.

When designing, allocating resources to, and implementing programs, key ADPH and CRS staff consider the priority MCH needs identified through the most recent MCH needs assessment. ADPH or CRS supports or directly administers programs to directly address all of the 10 priority MCH needs (discussed in Section IV.B) identified through 5-year MCH needs assessments. Section IV.B describes the relationship of the priority needs, the National and State Performance Measures, and the capacity and resource capability of the State's Title V Program.

Methods used for assessing capacity during the 2009-10 Needs Assessment are detailed in the full report for that assessment. One major component of assessing capacity was the use of 2 worksheets developed by the MCH Epi Branch, who drew from 3 sources: 1) a presentation by Donna J. Petersen, ScD, MHS, entitled "MCH Needs Assessment: Capacity to Competency," made at the Federal/State Maternal and Child Health Partnership Technical Assistance Meeting on Title V 2010 Needs Assessment; 2) materials produced by the Capacity Assessment for State Title V (CAST-5) Project, a joint initiative of the John Hopkins Women's and Children's Health Policy Center and AMCHP; and 3) guidance provided by MCHB. These worksheets were used to assess capacity to address the priority MCH needs selected during the 2009-10 Needs Assessment.

Accountability for MCH Services Block Grant funds is determined in 3 ways: by 1) measuring progress toward achievement of each performance measure; 2) having budgeted and expended dollars spread over all 4 of the service levels shown in the MCH Pyramid, which are direct health care, enabling services, population-based services, and infrastructure-building services; and 3) having a positive impact on outcome measures. Sections IV.C and IV.D pertain to performance measures, Section V to dollars, and Form 12 to outcome measures.

The State Title V Program's role in actions to address each performance measure varies, but falls within 1 or more of the 3 core public health functions of assessment, policy development, and assurance. The State Title V Program's role concerning a given performance measure may, therefore, pertain to 1 or more of the 10 essential public health services, especially to: 1) monitoring health status; 2) informing and educating people about health issues; 3) mobilizing community partnerships to identify and solve health problems; 4) developing policies and plans that support individual and community health efforts; 5) linking people to needed personal health services and assuring the provision of health care when otherwise unavailable; 6) assuring a competent public health work force; and 7) evaluating accessibility of personal and population-based health services.

Services provided by the State Title V Program are intended to promote health and well-being, as well as to collectively achieve the long-term goal of having a positive effect on the 6 National

Outcome Measures in this report/application. Effects of MCH programs are often incremental, rather than dramatic, however.

OVERVIEW OF PERFORMANCE MEASURES

Sections IV.C and IV.D respectively discuss the 18 NPMs and the 7 SPMs. Performance measures are discussed in numerical order, with a focus on MCH populations served and activities by level of the MCH Pyramid. The following are described for each performance measure: key activities in FY 2011, key activities initiated in early FY 2012, and plans for the remainder of FY 2012 and for FY 2013. Where indicated and permitted by space constraints, key activities prior to FY 2011 are reported as a context for FYs 2011-2013. Specific activities are described and categorized by the 4 MCH Pyramid service levels.

When trends are discussed in the narrative or Form 11 field notes to the performance measure, they are typically based on findings that are readily available to the writer as of April 2012, which often do not include the reporting year. When currently unavailable findings become available, they will be added to Form 11 at the first opportunity, but not discussed in this narrative.

B. State Priorities

Discussion here focuses on 1) the NPMs and SPMs related to each priority need and 2) the capacity to address each priority need.

STATE PERFORMANCE MEASURES

To provide a context for relating the priorities to newly selected SPMs, the SPMs for Needs Assessment Cycle 2011-2015 are listed below:

SPM 1: The degree to which the State CSHCN Program increases access to culturally competent care coordination services for CYSHCN, including transition planning as appropriate.

SPM 2: The degree to which the State CSHCN Program promotes increased family and youth participation in policy-making.

SPM 3: The degree to which the State CSHCN Program promotes access to community-based services for CYSHCN and families.

SPM 4: Of children and youth enrolled in Alabama Medicaid's EPSDT Program, the percentage who received any dental service in the reporting year.

SPM 5: The percentage of 0-17 year-old children and youth who do not have a medical home.

SPM 6: The degree to which statewide FIMR is implemented.

SPM 7: The degree to which FHS promotes a positive youth development model.

ASSESSMENT OF CAPACITY TO ADDRESS PRIORITY NEEDS

Discussion of capacity is drawn from Section 4 of the Needs Assessment Report. Our approach to assessing capacity to address the 10 priority needs was organized around 2 grids developed by FHS's MCH Epi Branch, who drew heavily from sources cited in the Needs Assessment Report. The second grid is attached to this section. On this grid, the 10 priorities are scored across 5 domains: 1) skill sets, 2) resources/partners, 3) local networks for service delivery, 4) political will/interest, and 5) feasibility. (Shortened statements of the priorities are used on the grid.)

The highest total number of points that a priority could achieve was 60. The higher the total points, the greater the capacity to address the priority. When ranking each priority on capacity, a rank of 1 indicates that the priority had the highest number of total points and a rank of 10 that it had the lowest number of total points. (Some priorities tied for the total score, so some ranks

include a decimal.) The ranking concerns capacity to address the priority, not the importance of the priority. FHS considered public health significance, as well as the total capacity score, when selecting priorities.

RELATIONSHIP AMONG PRIORITY NEEDS, PERFORMANCE MEASURES, AND MCH CAPACITY

Priorities are organized according to the level of the MCH Pyramid to which they mainly pertain. The number assigned to each priority is an identifier, not a rank indicating its importance.

DIRECT SERVICES:

None of the selected priorities pertain mainly to provision of direct care by either ADPH or CRS. However, the purpose of several of the priorities is to assure access to needed health care, including direct services.

ENABLING SERVICES:

PRIORITY 1: Increase access to culturally competent care coordination services for CYSHCN, including transition planning as appropriate.

This priority pertains to NPM 6 (transitional services for youth with special health care needs) and to SPM 1 (access of CYSHCN to care coordination and transition planning).

Planning for this need will require special consideration of cultural-language barriers, cultural competence, and geographic differences. The total score for CRS's capacity to address this priority is 54 total points; so, of the 10 priorities, it ranks first for the MCH Program's capacity to address it.

PRIORITY 2: Promote access to a medical home and to basic health care for children, youth, and women of childbearing age.

This priority pertains to many measures: NPM 1 (follow up for disorders identified during newborn screening), NPM 3 (medical homes for CSHCN), NPM 4 (health insurance for CSHCN), NPM 7 (immunization of 19-35 month-old children), NPM 9 (dental sealants in third-grade children), NPM 11 (breast feeding), NPM 12 (newborn hearing screening), NPM 13 (health insurance for all children and youth), NPM 17 (birth of VLBW infants at perinatal centers), NPM 18 (early prenatal care), SPM 1 (care coordination services for CYSHCN), SPM 4 (dental services for EPSDT enrollees), and SPM 5 (medical homes for all children and youth).

With respect to capacity, concerning Domain 1, the requisite skills for promoting access to a medical home include knowledge about the medical home concept and health care resources available to the community, as well as the means to refer both the uninsured and underinsured for primary health care. For these skills, ADPH has moderate capacity. Concerning Domain 2--resources and partners for addressing this priority--FHS has moderate capacity to devote time to promotion of medical homes and low capacity to obtain or allocate funding. Concerning Domain 3--local networks for addressing this priority--the MCH Program's capacity is low. ADPH has a strong network of CHDs throughout the State, which are administered by PHA personnel. However, we have limited ability to redirect PHA or county staff activities without providing additional funds. Many of our partners are also facing budgetary constraints. Concerning Domain 4--the political will and interest to address this priority--the MCH Program has high capacity to garner the will among its own staff, moderate capacity to garner the will among elected officials, and low capacity to garner the will among the public, partly due to concern among officials and the public about financing access for all citizens. Concerning Domain 5, the feasibility of promoting medical homes is high for system capacity but low in the State context. The total score for our capacity to promote medical homes is 26. Of the 10 priorities, this priority ties for a rank of 8.5 for the MCH Program's capacity to address it.

POPULATION-BASED:

PRIORITY 3: Promote positive youth development to reduce high risk behaviors in adolescents.

This priority pertains to NPM 8 (teen live birth rate), NPM 10 (motor vehicle crashes), NPM 16 (suicide), and SPM 7 (positive youth development).

With respect to capacity, concerning Domain 1, required skills include the ability to identify normal stages, transitions, and tasks during adolescence; to research and discuss issues arising in adolescence; and to offer suggestions for helping adolescents build healthy coping skills. FHS's Adolescent and School Health (Adolescent Health) Program has these abilities and has high capacity to train others in the requisite skills. The program has moderate capacity to access skills from its partners. Concerning Domain 2--resources and partners for addressing this priority--the Adolescent Health Program has moderate staffing and funding capacity but low capacity to secure funds from partners. Concerning Domain 3--local networks for addressing this priority--the MCH Program has moderate capacity. CHDs have some limited capacity to address selected youth risk behaviors, especially those related to reproductive health. The MCH Program has low capacity to utilize its partners' local networks. Concerning Domain 4--the political will and interest to address this priority--the MCH Program has moderate capacity to garner the will among its own staff and low capacity to garner the will among elected officials and the public. Concerning Domain 5, the feasibility of addressing this priority is low. The total score for our capacity to promote positive youth development is 26. Of the 10 priorities, this one ties for a rank of 8.5 for the MCH Program's capacity to address it.

PRIORITY 4: Reduce the prevalence of obesity among children, youth, and women of childbearing age.

This priority pertains to NPM 14 (Body Mass Index [BMI] in 2-5 year-old WIC recipients).

With respect to capacity, concerning Domain 1, the MCH Program and its partners have high capacity in the necessary skill sets. Concerning Domain 2--resources and partners for addressing this priority--the MCH Program has moderate capacity with regard to ADPH resources and low capacity with respect to obtaining support from external funding partners. Concerning Domain 3--local networks for addressing this priority--the MCH Program has low capacity and its partners have moderate capacity. Due to funding constraints, in the CHDs, counseling about obesity is provided only for WIC participants. Concerning Domain 4--political will and interest to address this priority--the MCH Program has high capacity to garner the will among its staff and, respectively, moderate and low capacity to garner will among elected officials and the public. Concerning Domain 5, the feasibility of addressing this priority is low, due to lack of the funds and workforce to reach all the MCH Program population groups. The total score for our capacity to reduce the prevalence of obesity is 32. Of the 10 priorities, this priority ties for a rank of 5.5 for the MCH Program's capacity to address it.

PRIORITY 5: Reduce the prevalence of violent behavior, including homicide and suicide, committed by or against children, youth, and women.

This priority pertains to NPM 16 (suicide) and SPM 7 (positive youth development).

With respect to capacity to address this priority, concerning Domain 1, the requisite skill sets lie mainly in the criminal justice and judicial arenas, with notable exceptions of prevention and social marketing skills present in both the public health and mental health disciplines. With regard to these skill sets, MCH Program staff have low capacity. While ADPH staff are competent in general prevention methodology, in most cases, more training would be necessary to address violence prevention. The MCH Program has moderate capacity to access these skill sets from its external partners, but most of the partners' efforts do not focus on primary prevention. Concerning Domain 2--resources and partners to address this priority--the MCH Program has low capacity to apply ADPH resources and low capacity to obtain support from external funding partners. Concerning Domain 3--local networks for addressing this priority--the MCH Program

has low capacity to deliver violence-prevention services at the local level and moderate capacity to locate funding partners to address it locally. Concerning Domain 4--the political will and interest to address this priority--the MCH Program has low capacity to garner the will among program staff, elected officials, or the general public. As a corollary to the preceding issues, the feasibility of addressing this priority (Domain 5) is low. The total score for the MCH Program's capacity to reduce the prevalence of violent behavior is 16. Of the 10 priorities, it ranks last (tenth) for our capacity to address it.

INFRASTRUCTURE-BUILDING:

PRIORITY 6: Reduce infant mortality, especially among African Americans.

This priority pertains to NPM 17 (birth of VLBW babies at a perinatal center) and, more directly, to SPM 6 (FIMR).

With respect to capacity to address this priority, concerning Domain 1, the necessary skills include the ability to identify factors that contribute to infant mortality, collect and analyze data, and execute strategies. The MCH Program and its partners have high capacity regarding these skills. Concerning Domain 2--resources and partners for addressing this priority--the MCH Program's capacity is high with respect to time, moderate with respect to funds available, and low with respect to securing funding partners. Concerning Domain 3--local networks for addressing this priority--the MCH Program has high capacity to act through its own local networks and to utilize its partners' local networks. Concerning Domain 4--political will and interest to address this priority--the MCH Program has high capacity to garner will among its own staff, low capacity to garner will among elected officials, and moderate capacity to garner will among the general public. Concerning Domain 5, the feasibility of addressing this priority is moderate. The total score for the MCH Program's capacity to reduce infant mortality is 44. Of the 10 priorities, it ranks third for our capacity to address it.

PRIORITY 7: Increase family and youth participation in CYSHCN policy-making through support services and education/training.

This priority pertains to NPM 2 (partnership in decision making) and SPM 2 (family/youth participation in policy-making).

Planning for this need will require special consideration of cultural-language barriers and geographic differences. The total score for CRS's capacity to address this priority is 50. Therefore, of the 10 priorities, it ranks second for the capacity to address it.

PRIORITY 8: Promote access to community-based services for CYSHCN and families (including respite care, recreational opportunities, transportation, child care, and school-based services) through education, awareness, advocacy, and linking families with local resources.

This priority pertains to NPM 5 and SPM 3, both of which deal with community-based services.

Activities toward meeting this need will rely heavily on education and awareness for youth, families, and providers related to what services are available and what services are needed at the local level. It will require data dissemination from the Needs Assessment, support for and stimulation of grassroots efforts to develop local delivery systems, and advocacy and leadership training for families and youth--empowering them as agents of change in their local communities. Planning for this need will require special consideration of cultural-language barriers and geographic differences. The total score for CRS's capacity to address this priority is 36. Of the 10 priorities, it ranks fourth for the capacity to address it.

PRIORITY 9: Promote access to a dental home and to preventive and restorative dental care for children, youth, and women of childbearing age.

This priority pertains to NPM 9 (dental sealants) and SPM 4 (dental services for EPSDT enrollees).

With respect to capacity to address this priority, concerning Domain 1--the requisite skills--the MCH Program and its partners have high capacity. Concerning Domain 2--resources and partners to address this priority--the program has low capacity to give time and to finance the cost and moderate capacity to secure funds from partners. Concerning Domain 3--local networks for addressing this priority--the MCH Program has low capacity, both with respect to our own local networks and the local networks of funding partners. Concerning Domain 4--the political will and interest to address this priority--the MCH Program has high capacity to garner the will of staff, moderate capacity to garner the will of elected officials, and low capacity to garner the will of the public. Accordingly, feasibility of addressing this priority (Domain 5) is low. The total score for the MCH Program's capacity to promote dental homes is 28. Of the 10 priorities, it ranks seventh for our capacity to address it.

PRIORITY 10: Promote access to mental health services for children, youth, and women of childbearing age.

This priority directly pertains to NPM 16 (suicide). As well, assuming that medical homes, insurance coverage, and community-based services help assure access to mental health services, this priority indirectly pertains to NPM 3 (medical homes for CSHCN), NPM 4 (insurance for CSHCN), SPM 1 (care coordination for CYSHCN), SPM 3 (community-based services for CYSHCN), and SPM 5 (medical homes for all children and youth).

With respect to addressing this priority, concerning Domain 1--the requisite skills--the MCH Program has moderate capacity and its partners have high capacity. Concerning Domain 2--resources and partners to address the priority--the MCH Program has moderate capacity with respect to time and funds, but has low capacity to secure funding partners. Concerning Domain 3--local networks for addressing the priority--the MCH Program has moderate capacity. Concerning Domain 4--the political will and interest to address this priority--the MCH Program has high capacity to garner will among its own staff but low capacity to garner will among elected officials and the public. Concerning Domain 5, the feasibility of addressing this priority is low for system capacity but moderate for the State context. The total score for the MCH Program's capacity to promote access to mental health services is 32. Of the 10 priorities, it ties for a rank of 5.5 for capacity to address it.

/2012/ ACTION PLAN TO ADDRESS PRIORITY NEEDS

In FY 2011, FHS and CRS have jointly developed an action plan to address each of the preceding MCH priorities. The plan is discussed in Section II.C, and the entire plan is attached to that section. //2012//

An attachment is included in this section. IVB - State Priorities

C. National Performance Measures

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

| | | | | | |
|---|-------------|--|--|--|--|
| Numerator | 88 | 107 | 140 | 122 | 143 |
| Denominator | 88 | 107 | 140 | 122 | 143 |
| Data Source | | ADPH Newborn Screening Neometrics Database | ADPH Newborn Screening Neometrics Database | ADPH Newborn Screening Neometrics Database | ADPH Newborn Screening Neometrics Database |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2011

Data Issues and Comments:

The Alabama Department of Public Health's (ADPH's) Bureau of Clinical Laboratories (BCL) reports the number of newborn screening tests by fiscal year. Diagnoses reported pertain to calendar year 2011.

The 143 infants include 5 infants with hyperphenylalaninemia, rather than classic PKU. Depending on how high their phenylalanine levels are, some infants with hyperphenylalaninemia require dietary management.

According to BCL, in 2011, 4 infants were positively identified as having 1 of the following disorders: Very Long-chain Acyl-CoA Dehydrogenase Deficiency (VLCAD); Glutaric Acidemia; Methylmalonic Acidemia (MMA); and Carnitine Uptake Defect (CUD). These disorders had not been identified among infants screened in previous years.

Trends:

This indicator has remained at 100% in the years shown. The number of newborns who screened positive notably increased in past years, with the exception of FY 2010. This year the number of newborns who screened positive increased by 17.2%: from 122 in 2010 to 143 in 2011. The increase continues to be largely--but not totally--in the number of infants who were confirmed as having sickle cell disease.

Objectives:

Objectives have remained at 100% for several years, and will remain there unless the status of this indicator changes.

Notes - 2010

Data Issues and Comments:

The 122 infants include 2 infants with hyperphenylalaninemia, rather than classic PKU. Depending on how high their phenylalanine levels are, some infants with hyperphenylalaninemia

require dietary management.

Trends:

This indicator has remained at 100% in the years shown. The number of newborns who screened positive notably increased in past years. This year the number of newborns who screened positive decreased: from 140 in 2009 to 122 in 2010.

Objectives:

Objectives have remained at 100% for several years, and will remain there unless the status of this indicator changes.

Notes - 2009

Comments:

The 140 infants include 3 infants with hyperphenylalaninemia, rather than classic PKU. Depending on how high their phenylalanine levels are, some infants with hyperphenylalaninemia require dietary management.

Trends:

This indicator has remained at 100% in the years shown. The number who screened positive increased once again: from 107 in 2008 to 140 on 2009.

Comparing 2009 to 2008, the number of positive screens changed by 10 or more for 2 conditions. That is, the number of positive screens for congenital hypothyroidism increased by 14: from 16 positive screens in 2008 to 30 positive screens in 2009. Over the same period, the number of positive screens for cystic fibrosis increased by 15: from 7 positive screens in 2008 to 22 positive screens in 2009.

Objectives:

Objectives have remained at 100% for several years, and will remain there unless the status of this indicator changes.

a. Last Year's Accomplishments

The following activities, many continuing from previous years, occurred in FY 2011.

Direct:

NSP provided follow up to definitive diagnosis for infants who screened positive for metabolic, endocrinological, or hematological disorders. For CY 2011 the following numbers of infants were identified as having the specified conditions: hemoglobinopathies, 66; congenital adrenal hyperplasia, 5; congenital hypothyroidism, 33; and cystic fibrosis, 19.

Twenty infants were identified using tandem mass spectrometry (TMS): PKU, 5; hyperphenylalaninemia, 5; medium-chain acyl-CoA dehydrogenase deficiency (MCADD), 5; Carnitine Uptake Defect, 2; Very Long-chain Acyl-CoA Dehydrogenase Deficiency (VLCAD), 1; Glutaric Acidemia, 1; and Methylmalonic Acidemia (MMA), 1.

NSP routinely performed screening on all first and second specimens and tracked infants who did not receive an initial satisfactory screen at the birthing facility.

Tyrosinemia I was added to the NSP panel in February. With this addition, NSP was screening for 29 of the 31 disorders recommended by the ACMG and the American Academy of Pediatrics (AAP).

Specialty referral centers provided confirmatory testing and treatment to patients identified by NSP. Genetic counseling, follow-up care, and nutritional counseling were included.

Enabling:

NSP referred infants with positive results for care coordination, provided by CHD staff, when there was no physician of record listed and when appointments for repeat screens to determine a definitive diagnosis had been missed.

The Children's Hospital Pediatric Hematology Division provided regional hematology clinics in north and south-central Alabama, which enabled children diagnosed with sickle cell disease to receive consultation with a board-certified pediatric hematologist.

NSP referred all infants diagnosed with sickle cell disease or trait for education and counseling. The referrals were to 7 community-based sickle cell organizations that collectively served all Alabama counties. As well, NSP referred infants diagnosed with cystic fibrosis to 2 accredited Cystic Fibrosis Centers in the State for genetic counseling and follow up.

Population-based:

NSP used a language line to facilitate communication with Latino families about follow-up care. Newborn screening brochures were available in English and Spanish and provided to all 53 Alabama birthing hospitals.

Information for parents and healthcare providers was provided on the NSP web page, which contains a variety of information, including a newborn screening brochure and fact sheets on various genetic disorders.

Infrastructure-building:

NSP sponsored a conference for hospital-based newborn screening coordinators, pediatric staff, social workers, and laboratory technicians. The conference focused on families with children identified via newborn blood screening and discussed best practices to improve collection of specimens and reduce the rate of unsatisfactory specimens received at BCL.

In November and December, NSP convened a work group of stakeholders throughout the State to develop guidelines to implement voluntary pulse oximetry screening on all well infants in Alabama's newborn nurseries.

The NSP Advisory Committee met as needed, at least twice in the year, to provide advice to ADPH on technical and/or program issues concerning NSP.

NSP provided a grant to the UAB-affiliated Civitan-Sparks Clinics to supply medical food and formula to address the needs of families with inherited inborn errors of metabolism.

NSP managed the Alabama Voice Response System, which enables providers to obtain a facsimile copy of newborn screening results. Enrolled submitters can access the system 7 days a week.

NSP provided quarterly training to ADPH care coordinators on newborn screening policies and procedures.

NSP worked with the software vendor, Neometrics(TM), to improve ability to analyze data and perform queries for research purposes.

NSP formalized the partnership with its medical specialists through a grant that outlines the shared responsibility between ADPH and the medical specialists to provide comprehensive follow-up services, confirmatory testing and diagnosis, and patient and family education.

To ensure more accurate screening of newborns, NSP provided bi-annual hospital report cards to birthing hospital administrators to inform them of their hospital's specimen collection performance and no-input hearing rates.

NSP provided a reference manual for medical providers, with follow-up guidelines and available resources.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provide biochemical screening of newborns for mandated conditions, and, via Tandem Mass Spectrometry (TMS), screen for certain other disorders for which screening is not mandated. | X | X | X | X |
| 2. Refer infants with positive results for care coordination if there is no physician on record or appointment(s) for repeat screenings have been missed. | | X | | |
| 3. Refer families of all infants diagnosed with sickle cell disease, to 1 of 7 community-based sickle cell organizations, for education and counseling. | | X | | |
| 4. Refer infants diagnosed with cystic fibrosis to 1 of 2 accredited Cystic Fibrosis Centers in the State for genetic counseling and follow-up care. | | X | | |
| 5. Facilitate communication with Hispanic families regarding follow-up care using a language line. | | X | X | |
| 6. Manage the Alabama Voice Response System, which enables providers to obtain a facsimile copy of the newborn screening results via telephone at any time. | | | | X |
| 7. Provide funding to the Civitan-Sparks Clinics, affiliated with the University of Alabama at Birmingham, to supply medical food and formula for persons with inherited inborn errors of metabolism. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities basically continue. A recap and update follow.

Direct:

NSP continues screening for 29 of the 31 disorders recommended by the ACMG and AAP. The 2 disorders that the program is not universally screening for are Critical Congenital Heart Disease (CCHD) and Severe Combined Immunodeficiency (SCID). NSP mailed "The Hospital Guidelines for Implementing Pulse Oximetry Screening for CCHD" to all birthing facilities in March 2012. As of mid-June 2012, 37 hospitals are screening for CCHD, and NSP is consulting with other birthing hospitals to help them prepare for such screening. NSP is not screening for SCID due to the lack of an automated testing kit that is approved by the federal Food and Drug Administration.

Enabling:

NSP continues referring certain infants with positive screening results for care coordination and referring infants diagnosed with sickle cell disease/trait for education and counseling of the family. The Children's Hospital Pediatric Hematology Division continues providing regional hematology clinics.

Infrastructure-building:

Except for 1-time events or time-limited activities, NSP continues the activities described under "Last Year's Accomplishments": including meeting with the NSP Advisory Committee, managing the Alabama Voice Response System, providing quarterly training on newborn screening,

working with the software vendor, partnering with medical specialists, providing bi-annual hospital report cards, and providing a manual for medical providers.

c. Plan for the Coming Year

Cross-cutting:

Except for 1-time or time-framed events, FYs 2011 and 2012 activities, recapped under "Current Activities," will basically continue. In addition, NSP will continue educating health care providers and patients about the importance of timely screening and follow up. Further, the program will continue providing statewide training and technical assistance on newborn screening practices and policies to hospitals and healthcare providers, maintaining and updating the NSP web page, and monitoring and reviewing the addition of SCID to Alabama's newborn screening panel.

As well, NSP staff will monitor the voluntary, statewide implementation of CCHD in the 53 birthing facilities in the State and determine the appropriate method for reporting pulse oximetry screening results to the program. NSP expects that all birthing facilities will be screening for CCHD by January 2013.

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

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

| Total Births by Occurrence: | 58786 | | | | | |
|---|--|------|--|------------------------------------|--|-------|
| Reporting Year: | 2011 | | | | | |
| Type of Screening Tests: | (A) Receiving at least one Screen (1) | | (B) No. of Presumptive Positive Screens | (C) No. Confirmed Cases (2) | (D) Needing Treatment that Received Treatment (3) | |
| | No. | % | | | No. | No. |
| Phenylketonuria (Classical) | 58231 | 99.1 | 5 | 5 | 5 | 100.0 |
| Congenital Hypothyroidism (Classical) | 58231 | 99.1 | 32 | 32 | 32 | 100.0 |
| Galactosemia (Classical) | 58231 | 99.1 | 0 | 0 | 0 | |
| Sickle Cell Disease | 58231 | 99.1 | 66 | 66 | 66 | 100.0 |
| Congenital Adrenal Hyperplasia | 58231 | 99.1 | 5 | 5 | 5 | 100.0 |
| Cystic Fibrosis | 58231 | 99.1 | 19 | 19 | 19 | 100.0 |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 58231 | 99.1 | 1 | 1 | 1 | 100.0 |
| Methylmalonic Acidemia | 58231 | 99.1 | 1 | 1 | 1 | 100.0 |

| | | | | | | |
|--|-------|------|---|---|---|-------|
| Carnitine Uptake Defect | 58231 | 99.1 | 2 | 2 | 2 | 100.0 |
| Glutaric Acidemia Type I | 58231 | 99.1 | 1 | 1 | 1 | 100.0 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 58231 | 99.1 | 5 | 5 | 5 | 100.0 |

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|----------------------------------|----------------------------------|----------------------------------|------------------------------------|
| Annual Performance Objective | 70 | 59.9 | 59.9 | 59.9 | 59.9 |
| Annual Indicator | 59.9 | 59.9 | 59.9 | 59.9 | 74 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2009/2010 National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 74 | 74 | 74 | 74 | 74 |

Notes - 2011

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

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

Notes - 2010

Data Issues:

For 2007-2010, indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC in 2005-06. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey.

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

Notes - 2009

Data Issues:

See this indicator's field note to year 2010.

a. Last Year's Accomplishments

Status:

Using updated data from the National Survey of CSHCN (2009-10), 74.0% of Alabama families with CSHCN reported success for this measure, versus 70.3% of U.S. families. Per survey notes, this outcome cannot be compared to earlier versions of the survey due to changes in methodology.

Enabling:

CRS continued to employ an SPC and 9 LPCs. Vacancies existed in Huntsville and Tuscaloosa. The State hiring freeze and budget limitations have prevented the refilling of these positions.

The State Parent Advisory Committee met once in FY 2011. LPACs hosted presentations on topics such as transition, American Sign Language (ASL), Medicaid waivers, Individualized Education Plans (IEPs), Guardianship and Special Needs Trusts, SSA and parent resources.

Population-based:

CRS continued to publish the Parent Connection Newsletter, which is available in hard copy and on the ADRS web site. It is also sent to the national editors for CSHCN newsletters. A listserv was maintained for participants in the Parent to Parent Program, with 330 postings in FY 2011. LPCs presented trainings on CRS, family centered care and the parent perspective at schools, community colleges, and daycare centers. They hosted holiday events for CYSHCN and their families, including food, toys, blankets and school supply drives. Disability awareness was promoted through community health fairs.

Infrastructure-building:

The SPC provides leadership in FVA and the Family to Family Health Information Center project. CRS partnered with FVA to provide reimbursement to support youth and family participation in work groups and local and state level meetings. As a part of the FVA national data collection project, LPCs tracked services reported as lacking by families. They also provided information to families and professionals on topics such as community resources, Title V/CRS, the Parent to Parent network, and disability-specific information.

LPCs and families participated on CRS and interagency committees and task forces (refer to Section III.E), as well as many community projects and advisory groups, such as the Individual and Family Support Council, CPCs, Civitan International Research Center, a local Miracle League Board, Community Mental Health Taskforce, Community Hispanic Coalition, Coalition for the Homeless, a county Board of Education transition team, and Committee for Employment of People with Disabilities.

The SPC was involved in trainings, both as presenter and participant. She is an AMCHP Family and Youth Leadership and Health Care Financing and Legislative Committee member and is also on the Youth Involvement Task Force. She was on various interagency groups and advisory

committees including the Early Intervention and Preschool Conference Planning committee, the Youth Leadership Forum Steering Committee, the State Newborn Screening Advisory Committee, the UAB Pediatric Pulmonary Center Advisory Committee, the UAB School of Public Health MCH Leadership and Policy Advisory Committee, the Disability-Focused Emergency Response Planning group (in response to the April 2011 tornadoes), the Disabilities Leadership Coalition of Alabama, the State Implementation Grant for Systems of Services for CYSHCN Steering Committee, and the Alabama Health Exchange Planning Taskforce.

An attachment is included in this section.

An attachment is included in this section. IVC_NPM02_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Implement Alabama's 2010 Action Plan for Children and Youth with Special Health Care Needs (CYSHCN). | | | | X |
| 2. Facilitate collaboration and partnerships through Children's Rehabilitation Service's (CRS's) State and local parent advisory committees. | | X | X | X |
| 3. Facilitate collaboration and partnerships through training activities. | | X | X | |
| 4. Facilitate collaboration and partnerships through publication of a newsletter. | | | X | |
| 5. Facilitate collaboration and partnerships through employment of parent consultants. | | X | | |
| 6. Support the growth of Family Voices of Alabama (FVA), financially and philosophically, including utilization of the CRS/FVA database. | | | | X |
| 7. Include youth and families of CYSHCN as co-presenters at all training events. | | | X | |
| 8. Collaborate with FVA on activities associated with its Maternal and Child Health Bureau-funded Family to Family Health Information Center grant. | | | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities are being continued in FY 2012 with the following additions or exceptions.

Enabling:

LPC vacancies exist in Huntsville and Tuscaloosa. The State hiring freeze and budget limitations have prevented refilling these positions.

Population-based:

CRS is using an outside source to conduct a satisfaction survey to ask clients about their experiences with the services that CRS provides.

Infrastructure-building:

CRS continues to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN. The project coordinator is supervising the activities of the grant. These activities are being carried out by 2 care coordinators, who include a parent consultant. A youth consultant was recently hired to assist with some of the activities of the grant.

The SPC serves on the State Implementation Grant for Systems of Services for CYSHCN

Advisory Committee. The SPC also provided and coordinated training for the care coordinator/parent consultant working on the activities of the grant. FVA continues implementation of activities related to its MCHB-funded Family to Family Health Information Grant. CRS is assisting with in-kind support and facilitates data collection through the LPCs.

The Alabama Exchange Planning Taskforce discontinued its focus group.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013. A recap and notation of activities being newly implemented follows:

Enabling:

Family and professional collaboration in program and policy activities will be facilitated through support of families for CRS State Parent Advisory Committee and LPACs, training activities, publication of a newsletter, and employment of at least one parent consultant in each office.

CRS will have youth and parents of CYSHCN as co-presenters at all staff community trainings.

Infrastructure-building:

CRS will continue to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN. Two or three more care coordinators/parent consultants will be placed in select practice sites to carry on the activities of the grant.

CRS will continue to collaborate with FVA on activities associated with its MCHB-funded Family to Family Health Information Center grant.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| Annual Performance Objective | 60 | 50 | 50 | 50 | 50 |
| Annual Indicator | 50 | 50 | 50 | 50 | 50.7 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2009-10 National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a | | | | | |

| | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|
| 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 50.7 | 50.7 | 50.7 | 50.7 | 50.7 |

Notes - 2011

For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration (HRSA) and the U.S. Centers for Disease Control and Prevention (CDC) in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010 surveys, therefore these 2 surveys are comparable.

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

Notes - 2010

Data Issues:

For 2007-10, indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC in 2005-06. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2 surveys are not comparable for NPM 3.

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

Notes - 2009

Data Issues:

See this indicator's field note to year 2010.

a. Last Year's Accomplishments

Status:

Using updated data from the National Survey of CSHCN (2009-10), 50.7% of Alabama families with CSHCN reported success for this measure, versus 43.0% of U.S. families. Per survey notes, the 2005-06 and the 2009-10 outcomes are comparable.

Enabling:

CRS continued efforts to identify community primary care providers (PCPs) willing to accept CYSHCN as patients. Families without medical homes were helped with linkage to appropriate community PCPs. A database of PCPs of CRS enrollees was maintained to identify local providers with experience with CYSHCN to facilitate linkage. The 65% of CRS enrollees with Medicaid were provided a medical home through the Patient 1st Program. Patient 1st focuses on and provides financial incentives for physicians to provide all aspects of a medical home. CRS worked closely with Medicaid providers to receive appropriate referrals to facilitate comprehensive EPSDT services.

Infrastructure-building:

In FY 2011, CRS received the State Implementation Grant for Systems of Services for CYSHCN. One of the goals of the grant is to build medical provider capacity so that CYSHCN receive enhanced comprehensive healthcare through identified medical homes. CRS has the opportunity

to partner with Medicaid through its care networks. During Year 1 of the grant, CRS placed 1 care coordinator in a practice site within the Medicaid Care Network of Alabama, to carry out the activities of the grant.

Through the CRS data system, Children's Health and Resource Management System (CHARMS), CRS staff members created a service summary for each enrollee. This summary was printed for the enrollee's family and shared with the medical home physician to facilitate better coordination and to help streamline the system of care for CRS clients. This service summary was revised to a more comprehensive plan of care that will better capture the breadth of services received by CRS enrollees.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to implement Alabama's 2010 Action Plan for CYSHCN. | | | | X |
| 2. Feature medical home concept in newsletters and the CRS Family Guide. | | | X | |
| 3. Provide ongoing educational and CRS-related materials to enhance partnerships with primary care physicians recognized as CRS courtesy staff. | | | X | |
| 4. Identify physicians willing to accept CYSHCN and assist families at the local level with linkage to medical homes. | | | | X |
| 5. Continue to promote communication with the medical home by sending reports of clinic visits, recommendations, and service summaries to physicians. | | X | | |
| 6. Collaborate with care coordinators on medical homes through the newly awarded State Implementation Grant for Systems of Services for CYSHCN. | | | | X |
| 7. Continue to collaborate on advisory committees and work groups related to My Alabama (formerly the Camellia Project). | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Current Activities:

FY 2011 activities as described above are being continued in FY 2012 with the following additions or changes.

Infrastructure-building:

The service summary was revised to a more comprehensive plan of care for CRS enrollees. This captures breadth of services received by enrollees, identifies needs, and develops actions to be taken for both short- and long-term planning. The new electronic tool was launched for use in April 2010. Local CRS offices send hard copy reports of clinic visits, recommendations, and plans of care (at family request) to medical home providers. This facilitates better information-sharing with the medical home.

CRS enrollment forms are available on the public web site; and referrals are accepted via phone, fax, or hard copy.

CRS is in Year 1 of a 3-year State Implementation Grant for Systems of Services for CYSHCN.

Two care coordinators/parent consultants have been placed in select pediatric practice sites to carry out the activities of the grant.

CRS continues to participate on the advisory committees for " My Alabama" (formerly the Camellia Project; see NPM 5 for more information).

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this performance measure will continue.

Enabling:

CRS staff will continue to meet with community medical providers to identify PCPs willing to accept CYSHCN as patients. Partnerships will continue in FY 2013. Families of CYSHCN without medical homes will continue to be assisted at the local level with linkage to appropriate, community-based PCPs.

Infrastructure-building:

CRS will continue to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN to support a comprehensive medical home.

CRS will continue working with its partners and stakeholders to implement a State plan to ensure that Healthy People objectives related to CSHCN receiving ongoing comprehensive care through a medical home are met.

CRS will also continue working with its partners and stakeholders to implement a State action plan to ensure that Healthy People objectives related to children being screened early and continuously for special health care needs are met.

CRS offices will continue to promote communication with the medical home by sending reports of clinic visits, recommendations, and plans of care (as requested by family) to physicians. CRS will continue to facilitate referrals by maintaining enrollment forms on the public web site and accepting referrals via phone, fax, or hard copy.

CRS will continue to participate in activities pertaining to the Alabama Health Insurance Exchange.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 62 | 65 | 65 | 65 | 65 |
| Annual Indicator | 65 | 65 | 65 | 65 | 64.7 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 2005-06 | 2005-06 | 2005-06 | 2009-10 |

| | | National Survey of CSHCN |
|---|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 64.7 | 64.7 | 64.7 | 64.7 | 64.7 |

Notes - 2011

For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration (HRSA) and the U.S. Centers for Disease Control and Prevention (CDC) in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

Notes - 2010

Data Issues:

For 2007-2009, indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC in 2005-06. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for both the 2001 and the 2005-06 CSHCN survey.

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

Notes - 2009

Data Issues:

See this indicator's field note to year 2010.

a. Last Year's Accomplishments

Status:

Using updated data from the National Survey of CSHCN (2009-10), 64.7% of Alabama families with CSHCN reported success for this measure, versus 60.6% of U.S. families. Per survey notes, the same questions were used to generate the 2005-06 and 2009-10 survey results.

During FY 2011, 90.7% of CRS enrollees had insurance; 1,070 were uninsured for the entire year. The number of uninsured CRS enrollees in 2011 is a 73% decline from the 3,885 uninsured in 1997 (the first reporting year). For the most part, with the exception of FY 2007, the percentage of CRS enrollees with private insurance, SCHIP, or Medicaid coverage has steadily risen. FY 2007 data showed a decrease (83%); however, this was not a true representation of insurance status in the program and was due to a data capacity issue associated with on-site screenings for which insurance information was not gathered. The percentage of CRS enrollees with insurance was 88.5% in FY 2010, 88% in 2009, 87.5% in 2008, 88% in 2006, 85.2% in 2005, 82.3% in

2004, 83.2% in 2003, and 81.5% in 2002. The number of uninsured in the program has mostly fallen over the same years. There were 1,070 uninsured CRS enrollees in 2011, 1,408 in 2010, 1,412 in 2009, 1,463 in 2008, 1,429 in 2006, 1,705 in 2005, 2,450 in 2004, and 2,446 in 2003.

Direct:

CRS continued to participate as an ALL Kids Plus provider through Alabama's SCHIP, ALL Kids. The Plus package enhances the basic ALL Kids benefit package for CYSHCN who are served by a State-funded entity. CRS receives reimbursement to provide additional services such as audiology services, durable medical equipment, orthodontia, and therapy visits beyond the scope of the basic benefit package.

Enabling:

CRS identified children potentially eligible for Medicaid, ALL Kids, or SSI and assisted with applications.

During FY 2011, CRS paid insurance premiums for coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), the Alabama Health Insurance Plan, or ALL Kids for 279 clients whose families were unable to afford the cost.

Infrastructure-building:

CRS continued to advocate for inclusion of additional services for CYSHCN in the basic ALL Kids benefit package and for all 16 EIS-provided services as Plus-covered services. Training on enhanced services provided by CRS was given to staff from the 13 EIS programs for which CRS was the fiscal agent.

CRS continues to meet quarterly with Medicaid to address policies and issues that impact CYSHCN. CRS has begun meetings with ALL Kids as needed for similar purposes and to develop methods to assure that CSHCN who are ALL Kids enrollees are referred to CRS so they can receive the enhanced benefits of ALL Kids Plus.

CRS maintained its pharmacy fee schedule, created in 2004. All ADRS divisions use this to buy client medications. A list of covered prescription/over-the-counter medications with fees is updated weekly. Pharmacies apply to become preferred providers and agree to supply medications for the negotiated fee. This provides better use of Title V funds to meet the rising cost of medications for CYSHCN who are CRS enrollees.

CRS staff have had basic training on insurance verification and assessment of benefit packages. This assures that third-party resources are used appropriately and aids staff in discussing plan benefits with families to help them better understand and use them. The CRS Patient Accounts Manager assists as needed for complex insurance coverage and benefits issues.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to implement Alabama's 2010 Action Plan for CYSHCN. | | | | X |
| 2. Refer 100% of children with no health insurance enrolled with CRS to Supplemental Security Income (SSI), Medicaid, or Alabama's Children's Health Insurance Program (called "ALL Kids") and assist with applications as needed. | | X | | |
| 3. Identify 100% of CRS clients for whom it is appropriate to pay | | X | | |

| | | | | |
|--|--|---|---|---|
| insurance premiums and provide this service. | | | | |
| 4. Continue implementation of the CRS work plan for the Health Insurance Portability and Accountability Act (HIPAA) and provide training to new and current staff. | | | X | X |
| 5. Continue collaboration with ALL Kids to implement an expanded benefit package for CYSHCN enrolled in CRS (ALL Kids Plus) and to advocate for expanded services for all. CYSHCN enrolled in basic ALL Kids. | | X | | X |
| 6. Advocate for the unique needs of CYSHCN, especially those with more complex conditions and/or functional limitations and those with above-routine need/use of services, and for the incorporation of necessary services in basic insurance plans. | | | | X |
| 7. Meet regularly with Alabama Medicaid and as needed with ALL Kids to address policies and issues that impact CYSHCN in the State. | | X | | X |
| 8. Maintain a pharmacy fee schedule for better utilization of Title V funds in meeting the rising cost of medications for CYSHCN who are CRS enrollees. | | | | X |
| 9. Continue development of a manual and training for staff who pay bills in local offices so they may better assist families in optimizing third party resources. | | X | | X |
| 10. | | | | |

b. Current Activities

FY 2011 activities as described above are being continued in FY 2012 with the following additions or exceptions.

Enabling:

CRS continues to receive updates on the Alabama Health Insurance Exchange to promote discussion concerning CYSHCN and the implementation of the Patient Protection and Affordable Care Act (ACA).

Infrastructure-building:

Through its HIPAA Privacy Officer and HIPAA Security Officer, ADRS provides training and updates for all staff members on HIPAA regulations. Local compliance officers have been identified to serve as first point of contact for clarifications or complaints that occur in district offices. Video training is now available on demand at staff desktops. Privacy notices have been updated and are provided to all clients and families, are available in Spanish, and are posted in all field offices/clinics.

The Patient Accounts Managers have continued to update the manual used for training staff who pay bills in local offices.

CRS is monitoring the insurance status of enrollees to help them maintain coverage or apply for alternate coverage and is fully sponsoring the uninsured if a child loses insurance.

Care coordinators/parent consultants facilitating activities under the State Implementation Grant for Systems of Care for CYSHCN are assisting with the development of a fact sheet concerning insurance-related issues, how to maintain insurance, and insurance options through ACA Exchange for youth with special health care needs as they age out of current plans.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013. A recap and notation of activities being newly implemented follow.

Direct:

CRS will continue to be an ALL Kids Plus provider to offer expanded services and benefits for Alabama's CYSHCN who are eligible for the CRS Program.

Enabling:

Throughout the year, 100% of CYSHCN enrolled with CRS who have no health insurance will be referred for SSI, Medicaid, or ALL Kids consideration and will receive assistance with the application. One hundred percent of the CRS clients for whom it would be appropriate for CRS to pay for insurance premiums will be identified and afforded this service.

CRS staff will continue to participate in Alabama Department of Insurance/Health Insurance Exchanges on issues related to insurance options for CYSHCN.

Population-based:

CRS will continue collaboration with ALL Kids, Alabama's SCHIP, to include information about CRS in a packet of information for families who indicate they have a child with special health care needs at enrollment.

Infrastructure-building:

CRS will continue implementation of its work plan to address client privacy, security, and transaction issues mandated by HIPAA and will provide ongoing training related to HIPAA requirements to current and new staff members.

CRS will continue to meet quarterly with Medicaid to address policies and issues that impact CYSHCN.

CRS will advocate for the unique needs of CYSHCN, especially those with more complex conditions and/or functional limitations and those with above-routine need or use of services, and for the incorporation of necessary services in basic insurance plans.

CRS will place additional care coordinators/parent consultants in select practice sites to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN. Fact sheets on insurance-related issues, how to maintain insurance, and insurance options through the ACA Exchange for youth with special health care needs, as they relate to the health care transition component of the grant, will be provided to youth with special health care needs and their families.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|---------------------|---------------------|---------------------|-----------------------|
| Annual Performance Objective | 78 | 91.7 | 91.7 | 91.7 | 91.7 |
| Annual Indicator | 91.7 | 91.7 | 91.7 | 91.7 | 73.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 2005-06 National | 2005-06 National | 2005-06 National | 2009/2010 National |

| | | Survey of CSHCN | Survey of CSHCN | Survey of CSHCN | Survey of CSHCN |
|---|-------------|-----------------|-----------------|-----------------|-----------------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 73.5 | 73.5 | 73.5 | 73.5 | 73.5 |

Notes - 2011

For 2011, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration (HRSA) and the U.S. Centers for Disease Control and Prevention (CDC) in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the 3 rounds of the surveys are comparable.

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

Notes - 2010

Data Issues:

For 2007-2009, indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC in 2005-06. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2 surveys are not comparable for NPM 5.

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

Notes - 2009

Data Issues:

See this indicator's field note to year 2010.

a. Last Year's Accomplishments

Status:

Using updated data from the National Survey of CSHCN (2009-10), 73.5% of Alabama families with CSHCN reported success for this measure, versus 65.1% of U.S. families. Per survey notes, this outcome cannot be compared to the 2001 or the 2005-06 results due to changes in methodology.

Direct:

In FY 2011, CRS served 13,542 CYSHCN, provided 15,342 clinic visits, responded to 2,728

requests for information or referral, and furnished 103,968 encounters by physicians, dentists, and CRS staff.

To increase access in rural areas, specialty evaluation clinics such as Feeding; Augmentative Communication Technology; and Seating, Positioning, and Mobility were held in community locations outside CRS offices (homes, schools, daycare centers, and CHDs).

As a critical part of the system of care for children who fail newborn hearing screening, CRS continued to serve children through ADPH's Universal Newborn Hearing Screening (UNHS) Program. CRS audiologists provided second-level screening and offered diagnostic and intervention services via evaluations, hearing aid dispensing, and hearing aid orientation.

Population-based:

CRS presented to State SSA offices, increasing awareness to enhance the system for families. Contacts were made with children newly awarded SSI. Staff participated in local health and resource fairs and went to schools, physician offices, and community agencies to increase awareness of services for children and families.

CRS continued community-based screenings for scoliosis and hearing loss. These screenings were provided in school systems, daycare centers, and Head Start including Migrant Head Start and Even Start locations in underserved areas.

Infrastructure-building:

CRS continued to maintain and modify its electronic case management, data collection, scheduling, and billing software (CHARMS). CRS continued to develop management reports to increase data capacity and availability for reporting and decision-making.

CRS continued its data-sharing agreement with ADPH's UNHS Program to provide data on second-level hearing assessments for infants who fail initial screening. CRS created a page in CHARMS to capture these data and transmit the data electronically to ADPH.

CRS partnered with EIS to increase access to early intervention services for eligible infants and toddlers by sponsoring 12 community-based projects, serving 860 children per month in FY 2011, up from 697 per month in 2010. Receipt of ARRA funding allowed additional children to be served by programs beginning July 2009. For FY 2010, an average of 154 additional children were served per month. This funding is no longer available; however, the additional clients are still being served by the EIS program. The CRS-sponsored programs served an average of 860 children per month.

CRS participated with the UAB-MCH Collaborative on issues related to CYSHCN in communities. This group includes ADPH's FHS, UAB School of Public Health, UAB Pediatric Pulmonary Center, Leadership Education in Neurodevelopmental and Related Disabilities, Leadership Education in Pediatric Nutrition, and Leadership Education in Child Health Nursing. CRS staff provided trainings for students in these programs.

CRS staff, the UAB-MCH Collaborative, and representatives from Medicaid participated in the State Implemented Systems of Care for CYSHCN Project Advisory Committee.

CRS staff concluded its collaboration on advisory committees and work groups related to the Medicaid TFG grant.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|------------|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |

| | | | | |
|--|---|---|---|---|
| 1. Continue to implement Alabama's 2010 Action Plan for CYSHCN and expand activities to involve local communities. | | | | X |
| 2. Serve Alabama CYSHCN in their communities through local CRS offices; modify and update CRS electronic client information management system (CHARMS). | X | X | | X |
| 3. Support the Alabama Early Intervention System (EIS) by increasing access to EIS services for eligible individuals. | | X | | |
| 4. Provide CRS-related outreach to the staff in Social Security Administration offices in Alabama. | | | X | |
| 5. Work cooperatively with other agencies to support the Universal Newborn Hearing Screening Program (discussed under NPM 12) and also to support Alabama's expanded newborn screening initiatives through appropriate follow-up care. | X | | | X |
| 6. Collaborate with ongoing emergency preparedness efforts related to CYSHCN and their families (see Section III.A). | | X | X | X |
| 7. Continue participation with the UAB-Maternal and Child Health (MCH) Collaborative. | | | | X |
| 8. Promote cultural competence in the system of care for CYSHCN and their families through collaborations and partnerships. | | | | X |
| 9. Continue to implement needs assessment activities. | | | | X |
| 10. | | | | |

b. Current Activities

FY 2011 activities continue in FY 2012 with the following additions or changes.

Direct:

Feeding Clinic begins in Andalusia, the first in that office.

Population-based:

Community-based screening efforts for hearing loss and scoliosis continue.

Infrastructure-building:

CRS will continue to facilitate activities through the State Implementation Grant for Systems of Services for CYSHCN.

CRS modified its service summary to a more comprehensive plan of care. This enhanced tool covers services received, needs identified, and short- and long-range planning. A copy of the plan of care is provided to families so they may organize their records and share with providers as needed.

ADRS continues its Business Intelligence (BI) initiative. BI team goals include increasing programmatic capability to respond to the environment and addressing issues proactively. BI will enhance data-based decision-making to allow CRS to modify its programs to better meet the needs of CYSHCN and families, to maximize funding, and to operate more efficiently and effectively.

CRS, through Mississippi State University, is conducting a client satisfaction survey. The data will be used by CRS for improving services to clients, planning programs, providing feedback to staff, and identifying training needs.

CRS continues to participate in My Alabama. The web tool to host health and human service agency pre-applications and to promote information-sharing is still in pilot testing by committee members.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013. A recap and notation of activities being newly implemented follow.

Direct:

CRS will continue Feeding Clinic in Andalusia.

CYSHCN, including SSI recipients, will receive information and referral services, health and rehabilitative services, care coordination services, and enabling services arranged through local CRS offices, including assistance with referrals and applications to other agencies.

CRS will work cooperatively with other public and private agencies in Alabama to ensure access to appropriate diagnostic procedures and intervention services for all children identified with hearing impairments through UNHS. CRS will continue to provide second-level hearing screening and diagnostic and intervention services through pediatric audiology evaluations, hearing aid dispensing, and hearing aid orientation.

CRS will monitor and evaluate the statewide initiative to directly dispense hearing aids to children and youth with hearing loss and increase collaborations with VRS and VRS-Deaf/Blind Services Division.

CRS will work cooperatively with other public and private agencies to support Alabama's expanded newborn screening initiatives through appropriate follow up, care coordination, information/referral, and rehabilitation services as needed.

Population-based:

A CRS representative will make outreach efforts to every SSA office in Alabama to provide information about rehabilitation services, including care coordination, available to CYSHCN through CRS.

Infrastructure-building:

CRS will continue to work with partners and key stakeholders to provide guidance during the funding period of the State Implementation Grant for Systems of Services for CYSHCN.

CRS will work with its partners and stakeholders to implement a State plan to ensure that Healthy People objectives related to community-based service systems being organized so that families can use them easily are met.

CRS will continue to collaborate on advisory committees and work groups respectively related to the State Implementation Grant for Systems of Services for CYSHCN and to My Alabama.

CRS will support EIS by increasing access to early intervention services for eligible infants and toddlers through the sponsorship of community-based projects throughout the State.

CRS will continue to modify and update CHARMS as needed.

CRS will collaborate with ongoing emergency preparedness efforts related to CYSHCN and their families.

CRS will promote cultural competence in the system of care for CYSHCN and their families through its collaborations and partnerships.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|----------------------------------|----------------------------------|----------------------------------|------------------------------------|
| Annual Performance Objective | 10 | 38.3 | 38.3 | 38.3 | 38.3 |
| Annual Indicator | 38.3 | 38.3 | 38.3 | 38.3 | 34.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2005-06 National Survey of CSHCN | 2009/2010 National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 34.8 | 34.8 | 34.8 | 34.8 | 34.8 |

Notes - 2011

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

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

Notes - 2010

Data Issues:

For 2007-2009, indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC in 2005-06. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the

2005-06 survey may be considered baseline data.

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

Notes - 2009

Data Issues:

See this indicator's field note to year 2010.

a. Last Year's Accomplishments

Status:

Using updated data from the National Survey of CSHCN (2009-10), 34.8% of Alabama families with CSHCN reported success for this measure, versus 40.0% of U.S. families. Per survey notes, this outcome can be compared to the 2005-06 data.

Direct:

CRS staff worked individually with youth to ensure linkage to adult health care providers and community systems. Teen Transition Clinics were ongoing in Mobile, Montgomery, Birmingham, and Huntsville.

CRS continued to support staff social work positions focused on transition (developed in FYs 2008-2009). At 14-16 years of age, CRS youth are transferred to their district's Social Work Transition Specialist. These staff have expertise in all aspects of transition to help the youth and family plan for adulthood. The newly developed comprehensive plan of care is being used to identify transition plans for CRS youth.

Enabling:

CRS continued to support its State Youth Advisory Committee (YAC), comprised of youth who have leadership training through the annual Alabama Governor's Youth Leadership Forum (YLF). YAC advises CRS on policy related to services for youth and promotes a system that facilitates transition. YAC involvement and activities have been limited in 2011 due to the inability to find and hire a replacement for the CRS State Youth Consultant.

Population-based:

The ADRS web site featured a link to Youth Connection Program information.

Infrastructure-building:

In February 2005, a joint effort between CRS and VRS was established to identify challenges in the referral and transition process. The ADRS Continuum of Transition focuses on strengthening the continuum of services provided by each division. As a part of the overall strategic plan, a liaison council was formed to develop a framework for divisions to provide comprehensive, quality services to youth with disabilities. Transition liaisons were identified from both divisions for each district office, and ongoing training was provided. An electronic referral system between CRS and VRS was launched January 2006. Liaisons now have several data reports available to assist in managing their caseloads. CRS and VRS divisions in Homewood have begun quarterly case staffings for all youth turning age 16 to assure that information is transferred and to discuss referral of clients to the VRS system.

CRS collaborated with VRS, local schools, and community resources to hold Transition Information and Resource Expos or activities in all CRS districts. The events were specific to each local community but targeted youth with special health care needs, families, teachers, and local service providers. The events featured a half to a full day of speakers (including youth) who covered transition topics. They also provided networking opportunities, equipment on display, resource fairs, and information on adaptive recreational opportunities. Other transition-related events included transition fairs and local presentations on topics such as home and community-

based waivers and IEP. A new presentation series was developed by the LPC in the Birmingham area. "Soup for the Soul" is a quarterly soup lunch that features a variety of speakers focusing on transition-related issues and resources.

Healthy and Ready to Work has developed Form 13A for use by State CSHCN programs to document youth involvement. A completed version for Alabama is attached to this section.

An attachment is included in this section. IVC_NPM06_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Continue to implement Alabama's 2010 Action Plan for CYSHCN. | | | | X |
| 2. Facilitate collaboration and partnerships through support of youth on the CRS Youth Advisory Committee. | | X | | X |
| 3. Facilitate collaboration and partnerships through training activities and articles in the family newsletter. | | X | X | |
| 4. Collaborate with Vocational Rehabilitation Service to implement interdepartmental plan to promote transition and assure that all transition-age youth have a transition plan (part of comprehensive plan of care development). | | X | | X |
| 5. Have youth with special health care needs as co-presenters at all transition-related trainings. | | X | X | |
| 6. Expand transition materials and resources including public relations tools, brochures, notebooks, transition guides, etc. | | X | X | |
| 7. Collaborate with Vocational Rehabilitation Service, State Implementation Grant care coordinators/parent consultant, schools, and local community resources to hold Transition Information Expos or other activities in each district. | | X | X | X |
| 8. Assure that transition planning is sensitive to the unique needs of all CYSHCN, especially those with more complex conditions, functional limitations, and/or above-routine need or use of services. | | | | X |
| 9. Provide ongoing training and development opportunities for Social Work Transition Specialists to assure that these staff members maintain expertise with transition issues and have updated resource materials. | | X | X | |
| 10. Provide Teen Transition Clinics for CRS-enrolled youth to focus on all aspects of transition to adulthood. | | X | X | |

b. Current Activities

FY 2011 activities as outlined above continue in FY 2012 with the following additions or changes.

Direct:

The comprehensive plan of care is now being used with all CRS-enrolled children and youth. The plan covers health/medical issues, educational needs and planning, developmental and independent living skills, and future planning issues. Care coordinators update this plan annually with families and/or youth. It assists in identifying needs and short- and long-term planning for children and youth enrolled in CRS, but will specifically guide families, youth, and staff in transition to all aspects of adult life.

Enabling:

As of May 2012, there is no longer a vacancy for a State Youth Consultant. The vacancy has

been filled.

Infrastructure-building:

CRS will continue to facilitate transition activities under the State Implementation Grant for Systems of Services for CYSHCN.

Transition Resource and Information Expos continue as do local presentations and trainings about transition-related issues.

The Birmingham LPC is participating on a Community Transition Team through a county board of education in the area.

CRS is developing management reports pertaining to the electronic CRS/VRS Referral System to provide leadership with measures of effectiveness and accountability in the program.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013. A recap and notation of activities being newly implemented follow.

Enabling:

CRS will facilitate youth and professional collaboration in program and policy activities through the CRS State Youth Consultant, support of youth on the CRS State YAC, training activities, and articles in the Parent Connection Newsletter.

Population-based:

CRS will have youth with special health care needs as co-presenters at all staff and community training related to transition issues.

CRS will continue to expand transition materials and resources including public relations tools, brochures, notebooks, and transition guides.

Infrastructure-building:

CRS will continue to facilitate activities to support transition under the State Implementation Grant for Systems of Services for CYSHCN.

CRS will collaborate with VRS, schools, and the local community to hold Transition Information Expos and other activities in each district.

CRS will continue collaboration with VRS to implement the interdepartmental continuum plan to promote transition services for youth with special health care needs, including the development of a transition plan (plan of care) for all participants in the program.

CRS will assure that transition planning is sensitive to the unique needs of all CYSHCN, especially those with more complex conditions, functional limitations, and/or above-routine need or use of services.

CRS will provide ongoing training and development opportunities for Social Work Transition Specialists to assure that these staff members maintain expertise with transition issues and have updated resource materials.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| Annual Performance Objective | 86.4 | 87.7 | 89 | 80.6 | 77.3 |
| Annual Indicator | 81.9 | 78.9 | 76.3 | 74.4 | 78.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | CDC National Immunization Survey |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 77.7 | 78.1 | 78.5 | 78.9 | 79.3 |

Notes - 2011

Data Issues:

Values for all years are from the National Immunization Survey conducted by the U.S. Centers for Disease Control and Prevention (CDC). Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of ± 5.0 for Alabama in calendar year (CY) 2010. The specific CDC table used was "Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months, US, National Immunization Survey, 2010." Thus, the survey period was for the last 9 months of fiscal year (FY) 2010 and the first 3 months of FY 2011. Children in the CY 2010 survey were born between January 2007 and July 2009. The table used was made available to states on May 16, 2012 from the U.S. Health Resources and Services Administration's Maternal and Child Health Bureau regional office staff via email. This table is normally posted on CDC's website, but was not posted this year.

Status and Trends:

In FY 2010, an estimated 78.6% of 19-35 month olds in Alabama received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. During the surveillance period, FYs 2006-2011, single-year values ranged from 74.4% in 2010 to 85.3% in 2006, with a median of 78.8%.

According to CDC, coverage estimate comparisons are not recommended for years prior to 2009 because of changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. ("Hib"

refers to Haemophilus influenzae type b.) As a result, for this reporting period we will not assess trends for this performance measure. See the year 2009 and 2010 notes for previous trends.

Objectives:

Objectives through 2015 have been retained from previous years. The 2016 objective has been set at 79.3%, requiring an annual increase of 0.5% from the 2009 baseline, represented as the average of the percentage for 2008, 2009, and 2010.

Notes - 2010

Data Issues:

Values for all years are from the National Immunization Survey conducted by CDC. Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 8.1 for Alabama in FY 2010. The specific CDC table used was "Estimated Vaccine Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity and by State and Local Area--US, National Immunization Survey, Q1/2009-Q4/2009." Children in the CY 2009 survey were born between February 2006 and June 2007.

Trends:

In CY 2009, an estimated 74.4% of 19-35 month olds In Alabama received a full schedule of age appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

During the surveillance period, FYs 2005-2010, single-year values ranged from 74.4% in 2010 to 85.3% in 2006, with a median of 80.4%. After peaking at 85.3% in 2006, the estimate for this indicator declined 4 years in a row. Although this decline is not significant per comparison of 95% confidence intervals, it is cause for concern.

Per input from ADPH's Immunization Division, nationally, there were supply issues with Hib vaccine when the cohorts to whom recent estimates pertain were infants. This input is consistent with information on CDC's web site. Per this site, from 2007-2009, there were shortages of Hib vaccine or delays in distributing the vaccine. Such shortages or delays in distribution could be expected to adversely affect immunization levels as defined for NPM 7.

Objectives:

The estimate for this indicator has declined in each of the last 4 years. Further, with the exception of the year 2006, the highest value for this indicator in recent years was 82.3% in the year 2005. For these reasons, we are revising the targets for 2011-2014 downward. To revise these targets and set the year 2015 objective, the roughly estimated mean of this indicator for FYs 2008-2010 (76.5%, for the 3 rounded percentages) was considered to represent the year 2009 baseline. Targets for 2011 forward require an average annual improvement (increase) of 0.5% per year (multiplicative model).

Notes - 2009

Data Issues:

Values for all years are from the National Immunization Survey conducted by CDC. Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 6.1 for Alabama in FY 2009. The specific CDC table used was "Estimated Vaccine Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area--US, National Immunization Survey, Q1/2008-Q4/2008." Thus, the survey period was for CY 2008, or the last 9 months of FY 2008 and the first 3 months of FY 2009. As a corollary, the survey period used for the FY 2009 estimate overlaps with the survey period used for the FY 2008 estimate (Q3/2007-Q2/2008). Children in the CY 2008 survey were born between January 2005 and June 2007. The table used (Q1/2008-Q4 2008) was retrieved on March 20, 2010 from the following web address, by first clicking on "NIS-Child Data Tables—Overall" and then clicking on "Overall—Coverage

with Individual Vaccines and Vaccination Series": <http://www.cdc.gov/vaccines/stats-surv/nis/nis-2008released.htm>. (It was the most recent pertinent table that the writer could find at that time.)

Trends:

This indicator has not shown a clear trend over the years shown. As indicated by the confidence interval, this indicator can fluctuate notably from year to year, and the decline in FYs 2007 and 2008, relative to FY 2006, was not statistically significant, although it is cause for concern. (Caveat: As previously stated, the survey period used for the FY 2009 estimate included the last 9 months of FY 2008 and only the first 3 months of FY 2009.)

Objectives:

Per the Maternal and Child Health Services Block Grant FY 2004 Report/FY 2006 Application, targets set in FY 2005 required an average annual increase (improvement) of 1.5% from the FY 2004 baseline: which was greater than the average annual increase of 1.3% that had occurred from 2000 through 2004. Targets set in FY 2005 resulted in a target of 89.0% for FY 2009, which has not been approached.

We are now revising targets for FYs 2010-2014 downward. For making these revisions, the mean of the status of this indicator for the last 3 years, or 79.0%, was considered to represent the year 2008 baseline. Targets for 2010 forward require an average annual improvement (increase) of 1.0% per year multiplicative model).

a. Last Year's Accomplishments

Status and Trends:

In CY 2010 in Alabama, an estimated 78.6% of the target population was fully immunized.

See this indicator's Form 11 field notes for trends.

Cross-cutting:

The Immunization Division, located in the Department's Bureau of Communicable Disease, is basically responsible for some enabling services and for population-based and infrastructure-building services designed to promote full immunization of infants and toddlers. For several years the division has maintained a web page, which is further discussed under "Current Activities." Activities occurring in FY 2011 (unless stated otherwise) follow and, unless otherwise indicated, were carried out by the Immunization Division.

Direct:

CHD staff immunized infants and children seen in clinics.

Enabling:

Postcards continued to be sent to parents of 11-month-old CHD patients to remind parents of vaccines that will become due after the first birthday.

Population-based:

Vaccine pamphlets continued to be sent to parents of all 4-month-old infants (with available addresses) born in the State to remind parents of the importance of vaccines.

The Alabama Perinatal Hepatitis B Program continued. This program is a case management system that serves public and private HBsAg-positive maternity patients in Alabama. (HBsAg is an antigen produced by the hepatitis B virus.) In the program, the State Perinatal Hepatitis B Coordinators work closely with private medical practices and CHDs to ensure that patients are informed about hepatitis B. As well, efforts are made to identify and screen all household and sexual contacts for HBsAg and antibodies to the hepatitis B virus and to give hepatitis B vaccine if indicated. The case management system extends to the infants of HBsAg-positive patients to ensure that they receive proper biologicals at birth and at the recommended times in infancy, as well as to ensure that titers are drawn following completion of the 3-dose series of hepatitis B

vaccine.

Infrastructure-building:

Maintenance of the Immunization Provider Registry with Internet Technology (ImmPRINT) continued. This registry makes childhood vaccine histories available to all the State's vaccine providers. Many FQHCs, as well as private medical facilities, continued using ImmPRINT. (See "Current Activities" for the current number of participants.)

Operation of the Immunization Outreach Program continued. This program enables Alabama physicians to determine if their practice is meeting the Healthy People 2010 objective of having 90% of 2-year-old children appropriately vaccinated. For each participating practice, a registered nurse reviews 50 charts of children 24-35 months of age, using the Clinic Assessment Software Application provided by CDC. The review provides estimated coverage rates in the practice and gives the physician and staff feedback about office vaccination policy and procedures and how they affect vaccination completion levels.

Provision of satellite down-link sites for programs presented by CDC and administration of the Vaccines for Children (VFC) Program for the State also continued. (See "Current Activities" for a description of the VFC Program.)

Via the Public Health of Alabama County Operations Network (PHALCON), provision of educational materials required for the Immunization Program for on-site printing by CHDs continued. These materials were available in English and Spanish. Making such materials available in this way has decreased storage needs at the Central-Office and county levels.

Procedures to identify CHD Child Health patients who were 4 months of age or older and had not been vaccinated continued. The groundwork for these procedures had been laid in FY 2003, when the Immunization Division retooled a computer program, run from ImmPRINT, to identify these infants and children. Subsequently, in June 2003 immunization records in ImmPRINT were linked directly to PHALCON, allowing CHD staff to access patient vaccination history, including vaccines provided through the private sector. CHDs were then to track Child Health patients aged 4 months or older who had not been vaccinated.

As detailed under "Plan for the Coming Year," in the fall of 2010, Alabama began progressively requiring students entering certain grades to have a certificate of immunization for tetanus-diphtheria-acellular pertussis (Tdap) vaccine. In the 2010-2011 school year, this requirement applied to sixth graders.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provide immunizations to children seen in county health department (CHD) clinics. | X | | | |
| 2. Via postcards, remind parents of 11-month-old CHD patients of vaccines that will be due soon. | | X | | X |
| 3. Mail vaccine pamphlets to parents of all 4-month-old infants. | | | X | X |
| 4. Operate the Alabama Perinatal Hepatitis B Program, a case management system that serves public and private maternity patients in Alabama who test positive for an antibody to the hepatitis B virus. | | | X | X |
| 5. Maintain an electronic immunization registry (called "ImmPRINT"), to make all childhood vaccine histories available to all providers. | | | | X |
| 6. Operate the Immunization Outreach Program, which will | | | | X |

| | | | | |
|--|---|---|--|---|
| enable Alabama physicians to determine if their practice met the Healthy People 2010 objective of having 90% of 2-year-old children appropriately vaccinated. | | | | |
| 7. Administer the Vaccines for Children Program for the State. | | | | X |
| 8. Provide continuing education and materials on immunizations to CHDs. | | X | | X |
| 9. Using a file linking ImmPRINT records with the Alabama Department of Public Health's (ADPH's) patient encounter database, identify and track CHD Child Health patients aged 4 months or older who have not been vaccinated. | X | X | | X |
| 10. | | | | |

b. Current Activities

Cross-cutting:

FY 2011 activities basically continue. Additional information or updates follow.

The Alabama VFC Program, which continues from previous years, is supported by federal funds transferred from CMS to CDC and awarded to the 50 states and 11 other projects. The program supplies vaccine at no cost to public and private health care providers who enroll and agree to immunize eligible children in their practices or clinics. Any child aged 18 years or younger who meets at least 1 of the following criteria is eligible for VFC vaccine: a Medicaid enrollee, an uninsured child, or an American Indian or Alaskan Native. Further, a child having health insurance that does not cover vaccine may receive VFC vaccine from a rural health clinic or FQHC. The Alabama VFC Program has 555 provider sites.

ImmPRINT is being used by 548 private sites.

The Immunization Division continues maintaining a web page on immunization and certain diseases. For example, the page includes the childhood and adolescent immunization schedule and links to educational materials on immunization that are designed for children and youth. As well, the page includes links to CDC materials on National Immunization Awareness Month (in August) and provides information on VFC, the Perinatal Hepatitis B Program, and the Immunization Outreach Program.

Infrastructure-building:

In the 2011-2012 school year, the Tdap requirement applies to sixth and seventh graders.

c. Plan for the Coming Year

FY 2011 and 2012 activities, recapped below, will basically continue in FY 2013.

Cross-cutting:

The Immunization Division will continue maintaining a web page on immunizations.

Direct:

CHDs will continue providing immunizations to infants and children seen in clinics.

Enabling:

The Immunization Division will continue sending reminders to parents regarding immunizations that are due and the importance of vaccines.

Population-based:

The Alabama Perinatal Hepatitis B Program will continue. The Immunization Division will continue sending vaccine pamphlets to parents of all 4-month-old infants born in the State.

Infrastructure-building:

The Immunization Division will continue maintaining ImmPRINT, implementing the Immunization Outreach Program, providing satellite down-link sites for programs presented by CDC, and administering the State's VFC Program.

As stated under "Last Year's Accomplishments," Alabama is progressively requiring students entering certain grades to have a certificate of immunization for Tdap vaccine, with the ultimate goal being to require such immunization for students entering the sixth through twelfth grades. Specifically, in the fall of 2010, all students aged 11 years and older entering the sixth grade were required to have a new certificate of immunization for Tdap, because of the change from tetanus-diphtheria to Tdap vaccine. Since then, the Tdap school requirement has been escalating by one grade each school year. That is, evidence of Tdap vaccine was required for students entering the sixth and seventh grades in the 2011-2012 school year and will be required for students entering the sixth through eighth grades in the 2012-2013 school year, the sixth through ninth grades in the 2013-2014 school year, the sixth through tenth grades in the 2014-2015 school year, the sixth through eleventh grades in the 2015-2016 school year, and the sixth through twelfth grades in the 2016-2017 school year.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--------------------------|--------------------------|--------------------------|-------------|
| Annual Performance Objective | 24.8 | 24.6 | 28.2 | 27.9 | 26.8 |
| Annual Indicator | 29.1 | 26.5 | 26.2 | 22.9 | |
| Numerator | 2826 | 2562 | 2492 | 2219 | |
| Denominator | 97125 | 96661 | 95224 | 96991 | |
| Data Source | | Vital records and Census | Vital records and Census | Vital records and Census | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 24.8 | 24.7 | 24.6 | 24.4 | 24.3 |

Notes - 2011

Data Issues:

Due to the time required to receive records and edit data, final vital statistics files for 2011 are not available. The preliminary reporting-year files available when the Maternal and Child Health Services Block Grant annual reports/applications are being finalized for internal review (in June of the submission year) sometimes provide misleading estimates. Therefore, the year 2011 estimate is not provided. Instead, it will be provided in July 2013.

Births that involve Alabama residents but occur outside of the State were apparently underreported to the Alabama Department of Public Health (ADPH) in some years, most notably in 2007 and 2008. Further, key information was missing for many of the year 2008 births reported

to ADPH by a neighboring state. Though the numbers of affected births may be small, failure to account for out-of-state reporting issues could lead to overly optimistic description of trends and to overly optimistic baselines for setting future objectives. In an effort to account for the missing records and missing information, for the years 2007 and 2008, we made certain assumptions about out-of-state births involving adolescents living in Alabama. Details about these assumptions, which are based on distribution of pertinent characteristics in 2005 and/or 2006, are available upon request. Such assumptions were not necessary for subsequent years, since reporting of out-of-state events has apparently improved.

This paragraph pertains to national performance measures (NPMs) that have population-based denominators: specifically, to NPMs 8, 10, and 16. For these measures, normally the U.S. Census Bureau's population estimates are used as denominators. The Census Bureau's annual state population estimates according to race, age, sex, and origin had not been released as of March 21, 2012. At the time of this writing, only decennial census 2010 counts were available. We are using American Fact Finder's (AFF) 2010 Census Summary File 1, which consists of actual counts and basic cross tabulations of information collected from all people and housing units during the 2010 Census.

The 2010 U.S. Census count was derived from an American Fact Finder query of Alabama's total population according to sex by age. The query resulted in 16 tables (PCT 1 & PCT12A-PCT12O), with each table representing a particular race or origin.

For years past, population estimates were downloaded from a detailed, state-level spreadsheet referred to as "SCEST2009-alldata6: Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or more Races) by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2009." Population estimates from 2007 through 2009 are retained from last year's spreadsheet.

Objectives:

See this indicator's field notes for 2009 and 2010.

Notes - 2010

Data Issues:

All estimates shown are for calendar years and pertain to live births.

Data issues concerning numerators and denominators for this indicator are discussed in this indicator's year 2011 Form 11 field note.

Status and Trends:

Population estimates several years after a census may be less reliable than those that are within a few years of the previous census. As a corollary, the population estimates for the years preceding 2010 may not be comparable to the year 2010 U.S. Census count. For this reason, we are not describing trends in rates during recent years, but are instead focusing on trends in numbers of births in recent years.

In 2010, the live birth rate among 15-17 year-old Alabama females was 22.9 live births per 1,000 such females, which was 12.6% below the corresponding rate of 26.2 live births per 1,000 females in 2009. From 2005-2010, the number of live births to 15-17 year-old Alabama females ranged from 2,219 in 2010 to 2,826 in 2007, with a median of 2,527. For the last 2 years with available data, live births to Alabama 15-17 year females declined notably.

Objectives:

Objectives from 2012 forward have been set to require an average annual decline of 0.5% per year from the 2008-10 baseline of 25.2 live births per 1,000 15-17 year-old females. The status of this indicator surpassed (was better than) its objective 2 years in a row. As a result, objectives were revised downward (made more challenging). This indicator sometimes fluctuates. If the rate

remains around or below the 2010 level for 3 years in a row, objectives will again be revised downward.

Notes - 2009

Data Issues:

Data issues concerning numerators and denominators for this indicator are discussed in this indicator's year 2011 Form 11 field note.

Trends:

As mentioned in this indicator's year 2011 Form 11 field note, for analyzing trends, the number of births has been adjusted for certain years in an effort to account for missing information about out-of-state births to Alabama residents.

In 2009, the live birth rate among 15-17 year-old Alabama females was 26.2 live births per 1,000 such females, which was 1.3% below the corresponding rate in 2008. The following description concerns trends from 2000-2008, using numbers available as of April 2010.

Among 15-17 year-old Alabama females, the live birth rate declined from 33.0 live births per 1,000 such females (9,270/280,595) in 2000-02 to 28.0 live births per 1,000 (7,818/279,336) in 2003-05. The 3-year rate then declined only slightly, to reach 27.8 live births per 1,000 females (8,071/289,930) in this age group in 2006-08. Thus, the estimated live birth rate for 2006-08 was 15.7% lower than in 2000-02 and just 0.5% lower than in 2003-05. However, due to out-of-state reporting issues, whether even this very slight estimated decline in 2006-08 relative to 2003-05 actually occurred is uncertain.

For this age group of females, estimated live birth rates for individual years in the surveillance period (2000-2008) ranged from 25.3 births per 1,000 in 2005 to 36.2 births per 1,000 in 2000. Rates for overlapping 3-year periods ranged from 27.6 births per 1,000 in 2004-06 to 33.0 births per 1,000 in 2000-02.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator declined by 2.8% per year. Comparing 2006-08 to 2003-05, the indicator declined by only 0.2% per year.

Objectives:

Objectives through 2010 are retained from earlier years. Objectives from 2011-2015 require an annual decline of 0.5% from the 2007-09 baseline of 27.2 live births per 1,000 15-17 year-old females (7,880/289,458): considering that 3-year rate to be the year 2008 baseline.

a. Last Year's Accomplishments

Status and Data-Related Issues:

For the status of this indicator, see Form 11.

Note that this indicator counts only live births, not all pregnancies in the specified age group.

Historical Context:

The Alabama Abstinence-Until-Marriage Education Program (AAEP) had used federal funding for FYs 1998-2002 to provide abstinence education to youth aged 17 years and younger. AAEP's goals have been to reduce the occurrence of out-of-wedlock sexual activity and STDs by providing abstinence education to youth aged 17 years and younger. The federal funding for this program ended in FY 2003 and was not reauthorized, but Congress extended a continuing resolution that provided federal funding quarterly for FYs 2003-2007. In FY 2008, abstinence education for AAEP was not reauthorized, yet a request for proposals was published by the federal Administration for Children and Families for a 5-year grant cycle (FYs 2009-13). Alabama was awarded funding, although without reauthorization, and the program continued to operate by continuing resolution on a quarterly basis. In FY 2009, AAEP funded 7 projects that provided

abstinence education and mentoring programs in schools to approximately 42,000 youth in 40 counties.

Following the end of funding through Title V for abstinence education in June 2009, AAEP convened a study group of interested community-based agencies and partners to prepare for potential funding of evidence-based programs proven effective to prevent teen pregnancy. Overall, the group felt that a youth development approach would be the best fit for school-based programming. In the school year 2009-10, projects formerly funded under Title V were able to continue programming on a smaller scale except for those that were also receiving Community-Based Abstinence Education funding. Through follow up and continued collaboration, the former sub-grantees were able to increase infrastructure for a youth development approach to their programming. AAEP consulted with the sub-grantees as requested.

AAEP provided no direct programming in FY 2010. In anticipation of federal guidance (from DHHS's Administration for Children and Families) concerning abstinence and teen pregnancy prevention funding, FHS continued to review evidence-based programming and abstinence-based curriculum to build capacity for youth development opportunities.

FY 2011:

Unless stated otherwise, the following activities occurred in FY 2011.

Direct and Enabling:

CHD Family Planning clinics served 10,939 adolescents aged 17 years and younger in FY 2011. Services included clinical, educational, counseling, and care-coordination services.

CHD staff continued distributing 4 pamphlets to teens coming for family planning counseling sessions: the 2 pamphlets on consensual sex and Alabama law that had been developed by DHR, "20 Ways to Respond to Sexual Pressure," and "Before You Date an Older Guy."

Population-based:

The toll-free Info Connection hotline to provide educational information for teens regarding reproductive health and family planning services continued.

Infrastructure-building:

ADPH was awarded funding through Title V for Abstinence Education programming, effective August 2010, with funds becoming available February 2011. The aforesaid funding supports AAEP, so AAEP programming was resumed. Federal funding for the Alabama Personal Responsibility Education Program (APREP) was awarded April 2011.

ADPH released Requests for Proposals for both programs (AAEP and APREP) through a competitive selection process. Four community-based organizations were awarded abstinence funding (under AAEP), effective April 2011, and 3 community-based organizations were awarded APREP funding, effective July 2011. The APREP project coordinators and educators were trained on evidence-based curriculum in August 2011.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provide family planning services for teens coming to CHDs for such services. | X | X | | |
| 2. Counsel teens coming to CHDs for family planning services, regarding consensual sex and Alabama Law. | | X | | |
| 3. Operate InfoConnection, the toll-free telephone line that provides educational information for teens on reproductive health and family planning services. | | | X | X |

| | | | | |
|--|--|--|---|---|
| 4. Implement the Alabama Abstinence-Until-Marriage Program (AAEP). | | | X | X |
| 5. As part of AAEP, support 4 community-based organizations that deliver abstinence-based programming to sixth- and seventh-grade students in 22 counties. | | | X | X |
| 6. As part of APREP, support 3 community-based organizations that are to provide lessons on reducing risk and preparing for adulthood, targeting 15-19 year-old high risk youth in 3 counties. | | | X | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Direct and Enabling:

CHD Family Planning clinics continue serving teens who present there.

Cross-cutting (Population-based and Infrastructure-building):

Info Connection continues.

The 4 community-based organizations that are supported with AAEP funds continue to deliver abstinence-based education programming to sixth- and seventh-grade students in 22 Alabama counties. This programming is delivered in the context of positive youth development, utilizing high school-age teen leaders to deliver programming to middle school students. The teen leaders have received 20 hours of training and are supervised by adult instructors. It is anticipated that over 16,000 students will be impacted through this programming. AAEP projects utilize "Managing Pressures before Marriage for Preteens." Funds have been requested to continue these activities in FY 2013.

In FY 2012, the 3 community-based organizations that were funded through APREP began developing community partnerships through which the personal responsibility programming could be delivered. The projects have targeted high risk youth 15-19 years of age, in 3 counties. The projects are utilizing the evidence-based curriculum, "Reducing the Risk," plus adulthood preparation lessons taken from "Relationship Smarts Plus." The adulthood preparation programming is designed to promote successful transition to young adulthood.

c. Plan for the Coming Year

Direct and Enabling:

CHD Family Planning clinics will continue serving teens who present there.

Cross-cutting (Population-based and Infrastructure-building):

The toll-free hotline, Info Connection, will continue.

FHS will continue administering the AAEP and APREP programs with funding received through the federal Administration for Children and Families.

"Managing Pressures before Marriage for Preteens" will continue to be utilized by AAEP projects, and will be delivered utilizing the teen leader model. Training and support will be provided to assist projects in development of the teen leader program.

APREP will continue providing community-based programming to high risk youth. Additional curricula options will be offered for both evidence-based and adulthood preparation content.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Annual Performance Objective | 26.7 | 27 | 28.8 | 29.4 | 30 |
| Annual Indicator | 27.7 | 27.7 | 27.7 | 27.7 | 27.7 |
| Numerator | 2580 | 2580 | 2580 | 2580 | 2580 |
| Denominator | 9301 | 9301 | 9301 | 9301 | 9301 |
| Data Source | | ADPH Oral Health Branch Survey data |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 30.6 | 31.2 | 31.2 | 31.2 | 31.2 |

Notes - 2011

Data Issues:

Another observation-based survey on the prevalence of dental sealants was being conducted as of late FY 2011 and continues in FY 2012. The new data will not be available until FY 2013. We are using the observation-based numbers for FY 2007 as our best estimates for years in which a survey of dental sealants was not conducted.

Objectives:

In the absence of recent data, we are setting the year 2016 objective to match the year 2013 objective.

Notes - 2010

Data Issues:

Another observation-based survey on the prevalence of dental sealants is expected to be conducted in late FY 2011 and/or in FY 2012. Until then, we are using the observation-based numbers for FY 2007 as our best estimates for years in which a survey of dental sealants was not conducted.

Objectives:

In the absence of recent data, we are setting the year 2015 objective to match the year 2013 objective.

Notes - 2009

Data Issues:

Another observation-based survey on the prevalence of dental sealants is expected to be conducted in FYs 2011-12. We are using the observation-based numbers for FY 2007 as our best estimates for years in which a survey of dental sealants was not conducted.

The Oral Health Branch and the University of Alabama at Birmingham School of Dentistry partnered to conduct an observation-based, representative statewide survey of dental sealants among third-grade Alabama children from January 2006-March 2007. Jefferson County Department of Health also conducted a survey in its jurisdiction during 2006. The data from both surveys were compiled to report on this indicator. Data previously reported for 2006 were a subset of the complete study.

Trends (through FY 2007):

There has been notable improvement in this indicator. The observation-based, representative survey completed in FY 2007 found that 27.7% of third-grade Alabama children had received protective dental sealants, an improvement of 22.2% over the FY 2003 observation-based survey finding of 22.7%. The estimated annual percentage of improvement was 5.1%.

Objectives:

In the absence of recent data, we are setting the year 2014 objective to match the year 2013 objective.

a. Last Year's Accomplishments

Historical Context:

OHB and the University of Alabama School of Dentistry in Birmingham (School of Dentistry) have partnered to periodically conduct observation-based, representative statewide surveys of dental sealants among third-grade Alabama children. The last completed survey was in FYs 2006-07. Survey findings were reported according to the 9 dental districts designated by the Alabama Dental Association (ALDA). There was more than a 3-fold variance between the dental districts with the lowest and highest results. The lowest estimate of third-grade children with dental sealants was 13.2% in Dental District 2 in Central Alabama (Autauga, Chilton, Coosa, Elmore, Dallas, and Montgomery Counties), and the highest was 41.3% in Dental District 7 (Jefferson and Shelby Counties). CDC guidelines for inclusion in the National Oral Health Surveillance System, in which the State participates, recommend that states conduct surveys at least every 5 years.

In FY 2008, the Coffee County dental clinic, which had been the only Medicaid dental provider for the entire county, was scheduled to close but, instead, was outsourced to a non-profit dental organization, Sarrell Dental. Sarrell Dental also launched a new mobile dental program, targeting schools in underserved communities statewide. Also in FY 2008, the "Alabama Mobile Access to Dental Care Act" became effective. This law enabled the Board of Dental Examiners in Alabama to regulate the use of mobile dental vans and portable dental equipment. Medicaid began covering services provided through the mobile dental clinics.

FY 2011:

Direct:

ADPH staff provided dental services in 2 CHD dental clinics in Jefferson and Tuscaloosa Counties. Talladega and Coffee CHDs provided dental services in onsite clinics managed by Sarrell Dental. The 2 dental clinics managed by ADPH provided 939 dental sealants, a notable decrease from sealants provided in FY 2010 (when 2,738 sealants were provided) at these locations. Staff reductions and downsizing of the Jefferson CHD's mobile dental sealant program account for this decrease. The 2 clinics located in CHDs managed by Sarrell Dental continued to promote and provide sealants for all qualifying children accessing dental services.

The Tuscaloosa CHD dental clinic continued to collaborate with the School of Dentistry and served as a rotation site for pediatric dental residents and junior and senior dental students. OHB increased funding to support the initiative through a grant to the dental school. Preventive and

restorative dental procedures were provided, including sealant placement on each eligible child participating in the program.

Population-based:

OHB's dental health nurse coordinator provided education, screening, and outreach initiatives that included the promotion of dental sealants throughout PHA 9. She collaborated with ALL Kids area coordinators, Healthy Child Care Alabama area coordinators, and other teams to reach children through public and private schools, Head Start centers, day care centers, health fairs, and other venues. She provided 99 educational presentations to about 6,800 recipients in FY 2011.

Enabling and Infrastructure-building:

The Interim Dental Director participated in certification training sessions for CHD social workers and nurses providing Patient 1st Care Coordination. As part of the dental training, care coordinators were taught the importance of dental sealants in preventing tooth decay among at-risk children and encouraged to promote sealants through their counseling sessions with parents and children. Dental homes were also promoted through these quarterly training workshops.

The Interim Dental Director served as an ex officio member of the ALDA Board of Trustees and encouraged collaboration with ALDA members to coordinate and implement school-based sealant programs in qualifying schools statewide. A White Paper was written and distributed by an ALDA-appointed committee. One of the goals included in the paper involved partnering with ADPH dental staff to develop and provide school-based sealant projects in underserved communities.

The search for a new State Dental Director continued, but the position was not filled. The Associate Director of OHB continued serving as Interim Director of OHB. Without a dentist on staff, the OHB was limited in its capacity to provide school-based sealant projects since the Alabama Dental Practice Act requires that licensed dentists provide direct supervision for dental sealant placement.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. In collaboration with others, provide preventive and restorative dental services to certain populations of children who tend to have unmet dental needs, at permanent sites and through mobile dental programs. | X | | | X |
| 2. As part of such collaboration, rotate dental students and pediatric dental residents through a CHD dental clinic. | X | | | X |
| 3. Train care coordinators with Patient 1st (Alabama Medicaid's primary care case management program) to promote good oral health for children and their families. | | X | | X |
| 4. Collaborate with the Alabama Dental Association to encourage provision of school-based sealant programs in qualifying schools statewide. | | | | X |
| 5. In collaboration with others, conduct the Fiscal Years (FYs) 2011-12 statewide oral health needs assessment. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities basically continue in FY 2012. Some updates follow.

Population-based:

Due to budget issues, the dental health nurse coordinator was transferred from OHB to a nurse coordinator position with the Healthy Childcare Alabama Program, so the initiatives that she conducted in PHA 9 are no longer occurring there.

Infrastructure-building:

OHB is spearheading a statewide oral health needs assessment of third graders in 69 public schools, selected to represent the 9 ALDA dental districts, with about 4,800 third graders. The observation-based survey began in September 2011 and continues. Items about dental sealants on permanent molars and 3 other oral health indicators are included in the survey tool. FHS recommended that an additional grade be included; so about 5,000 kindergarten children in the same school sample are eligible for the survey. Screeners include pediatric dental residents and faculty from the School of Dentistry, public health dentists, and private volunteer dentists. Because diet and nutrition affect oral health in many ways, height and weight measurements are also being collected on participating kindergarten students and third graders.

A new dental sealant program, discussed under "Plan for the Coming Year," is being planned for implementation in FY 2013.

A new State Dental Director joined OHB in February.

c. Plan for the Coming Year

Unless previously stated otherwise, FYs 2011 and 2012 activities will continue in FY 2013. Some updates follow.

Cross-cutting (Direct and Infrastructure-building):

A new dental sealant program is being planned for implementation in FY 2013. Elements of the program will include: 1) delivering sealants to a large number of high risk children with susceptible permanent molars, 2) maximizing program efficiency, 3) re-examining children within 1 year after initial sealant placement, 4) maintaining a quality assurance system, 5) identifying children with treatment needs and assuring they receive appropriate dental care, 6) maintaining descriptive program data, and 7) assuring the program is sustainable. The program will target second- and third-grade children in an effort to seal 6-year molars as close to eruption dates as feasible. At least 10 schools will be selected from schools within the 18-county Alabama Black Belt region. SDE will provide free- and reduced-lunch program participation data for use in determining schools of greatest need. Children who qualify for dental sealants and provide evidence of parental consent will be offered free dental sealants.

OHB and the MCH Epi Branch will collaborate to analyze data collected through the FYs 2011-12 oral health needs assessment, discussed under "Current Activities." This analysis will support the translation of data into information, to enhance public health dental services and promote the nutritional health of Alabama children and youth. The goals of the analysis are to: 1) produce salient information about oral health status and nutrition from the oral health needs assessment, using 2 survey periods (FYs 2006-07 and 2011-12), and 2) use the information gained to promote dental homes for children identified as having urgent, unmet dental needs and no existing primary dentist.

Data collected through the oral health needs assessment will be used to target underserved areas of the State, promote new dental sealant projects, promote dental homes for underserved children, and inform development of policy.

Alabama continues to be well below the benchmark for providing school-based sealant programs

in at least 25% of schools with high enrollments of low-income children. Therefore, OHB will continue seeking new funding opportunities and new partnerships to increase the prevalence of dental sealants among at-risk children.

The new State Dental Director will provide guidance and support in creating new strategies, developing policy, and planning other initiatives to increase the percentage of at-risk children having sealants on permanent molars.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--------------------------|--------------------------|--------------------------|-------------|
| Annual Performance Objective | 6.2 | 6.1 | 5.2 | 5.1 | 4.6 |
| Annual Indicator | 3.7 | 4.6 | 4.6 | 4.7 | |
| Numerator | 34 | 43 | 43 | 44 | |
| Denominator | 922825 | 925961 | 934556 | 932841 | |
| Data Source | | Vital records and Census | Vital records and Census | Vital records and Census | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 4.5 | 4.5 | 4.5 | 4.5 | 4.5 |

Notes - 2011

Data Issues:

Due to the time required to receive records and edit data, final vital statistics files for 2011 are not available. The preliminary reporting-year files available when the Maternal and Child Health Services Block Grant annual reports/applications are being finalized for internal review (in June of the submission year) sometimes provide misleading estimates. Therefore, the year 2011 estimate is not provided. Instead, it will be provided in July 2013.

The 2010 U.S. Census count was derived from an American Fact Finder query of Alabama’s total population according to sex by age. The query resulted in 16 tables (PCT 1 & PCT12A-PCT12O), each table representing a particular race or origin.

For years past, population estimates were downloaded from a detailed, state-level spreadsheet referred to as “SCEST2009-alldata6: Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or more Races) by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2009.” Population estimates from 2007 through 2009 are retained from last year’s spreadsheet.

Objectives:

See this indicator’s field notes for 2010 and 2009.

Notes - 2010

Data Issues:

All estimates are for calendar years.

Vital events that involve Alabama residents but occur outside of the State were apparently underreported to the Alabama Department of Public Health in 2006-2008, causing slight underestimation of Alabama's mortality rates for those years. Though slight, such underestimation could lead to distortion of trends in mortality rates and to overly optimistic baselines for setting future objectives. Therefore, for National Performance Measure (NPM) 10, we have adjusted the number of deaths for 2006, 2007, and 2008 by: 1) computing the mean annual number of applicable deaths that occurred outside of the State for 2 time periods (2000-2005 and 2006-08); 2) subtracting the mean for the later period from that for the earlier period; and 3) for 2006, 2007, and 2008, adding the difference to the number of deaths shown in Alabama's statistical death files. In the case of NPM 10, the difference was 2 motor vehicle crash deaths per year.

Based on review of the number of applicable out-of-state deaths in 2009, such adjustment was not deemed necessary for year 2009 or 2010 deaths. The Title V Information System (TVIS) does not permit us to directly revise numbers shown for 2007, so the numerator shown on Form 11 for that year for NPM 10 does not reflect the adjustment. Also for NPM 10, the adjusted numerators shown for 2007 and 2008 do not match corresponding numbers that may have been or may soon be published in annual publications of Alabama vital statistics.

Denominator issues concerning this indicator are detailed in the year 2011 note for NPM 8.

Trends:

Population estimates several years after a census may be less reliable than those that are within a few years of the previous census. Therefore, the population estimates for the years preceding 2010 may not be comparable to the year 2010 U.S. Census count. For this reason, we are not describing trends in rates during recent years, but are instead focusing on trends in numbers of deaths.

The estimated motor vehicle crash death rate among Alabama residents 0-14 years of age has not shown a consistent trend over individual years. Among 0-14 year-old Alabama residents, the number of deaths (adjusted where necessary) due to motor vehicle crashes declined from 156 in 2005-07 to 130 in 2008-10: for an overall decline of 16.7%. From 2005-2010, deaths due to motor vehicle crashes ranged from 34 deaths in 2007 to 61 deaths in 2005 and 2006, with a median of 43.5 deaths.

Objectives:

Objectives through 2015 are retained from earlier years. Although the observed value for 2010 was much lower than its corresponding objective, it was slightly higher (by 2.5%) than in FY 2010. Thus, the objective for year 2016 has been set to match the year 2015 objective. If future observed values level off at around 4.5 or surpass (are better than) corresponding targets for 3 years in a row, objectives may be revised downward (made more challenging).

Notes - 2009

Data Issues:

Data issues concerning numerators for this indicator are discussed in this indicator's year 2010 Form 11 field note.

The U.S. Census Bureau's population estimates for persons 0-14 years of age are used as denominators through 2009. These estimates were updated on an annual basis, but TVIS does not allow us to directly change estimates for 2007. The most recent updated year 2007 population estimate for Alabama 0-14 year-olds is 928,262 persons, rather than the number shown on Form

11. Additional information about the denominators for this indicator is in the year 2011 Form 11 field note for NPM 8.

Trends:

The estimated motor vehicle crash death rate among Alabama residents 0-14 years of age has not shown a consistent trend over individual years. Comparing 2 adjacent 3-year periods, this rate declined by 35.6%: from 6.7 deaths per 100,000 (184/2,758,612) in 2004-06 to 4.3 deaths per 100,000 (120/2,795,256) in 2007-09. However, this death rate was unusually low in 2007, so future 3-year rates are likely to be higher than the rate in 2007-09. In this age group, for individual years from 2005-2009, the motor vehicle crash death rate ranged from 3.7 deaths per 100,000 persons in 2007 to 6.7 deaths per 100,000 persons in 2005, with a median of 4.6 deaths per 100,000 persons in 2008 and 2009.

Objectives:

Objectives through 2010 are retained from earlier years. Objectives from 2011-2015 were set by considering the unrounded rate for 2008-09 combined (4.6063 deaths per 100,000 when carried to 4 decimals) to be the year 2009 baseline, and then requiring a reduction of 0.5% per year. Because objectives are carried to only 1 decimal in TVIS, the year 2011 objective is the same as the year 2008 and 2009 observed values, and the objectives for 2012 onward are all 4.5 deaths per 100,000.

a. Last Year's Accomplishments

Status and Trends:

See this indicator's Form 11 note for 2010.

Historical Backdrop (Infrastructure-building):

ADPH chiefly addresses prevention of motor vehicle crash injuries through HPCD's Behavioral Health Division, which includes the Injury Prevention Branch and ACDRS. Legislation establishing ACDRS is discussed in Section III.A. ACDRS was located in FHS until FY 2011, when it was relocated to HPCD.

In FY 2006, the State Legislature passed amendments (which became law) to previous legislation on child safety restraints in motor vehicles. The amendments strengthened requirements regarding motor vehicle safety restraints for children and youth: by deleting a phrase limiting the previous legislation to children under the age of 6 years; deleting wording from the previous legislation implying that standard seat belts would constitute an adequate restraint for 4-5 year-old children; expanding the definition of "motor vehicle" under this law to include all but taxis and motor vehicles with a seating capacity of 11 or more passengers (for these excluded vehicles, every person transporting a child is responsible for assuring that the child is properly restrained); adding statements on size-appropriate restraint systems; increasing the fine for violation of the law from \$10 to \$25 for each offense, with the stipulation that the charges may be dismissed by the trial judge and no court costs shall be assessed upon proof of acquisition of an appropriate child passenger restraint; adding a point system to identify habitually negligent drivers and habitual or frequent violators; and adding a requirement that \$15 of an imposed fine shall be used to distribute vouchers for size-appropriate child passenger restraint systems to Alabama families of limited income, with said money to be distributed to the Alabama Head Injury Foundation, which administers the voucher program free of charge.

For several years the Injury Prevention Branch has conducted occupant restraint surveys at selected sites, where the sites are selected to provide a study population that resembles the statewide population. Per the report, "Alabama Observational Survey of Occupant and Child Restraint Use 2011," the estimated child (0-5 years) restraint usage in Alabama increased from 60% in 1999 to 77% in 2000. From 2002-2008, this percentage ranged from 83% in 2004 to 92% in 2005 and 2007. In more recent years, estimated child-restraint usage has been as follows: 95% (2,552/2,689) in 2009, 93% (2,844/3,054) in 2010, and 96% (4,090/4,268) in 2011. The latter 3 estimates are the highest on record for Alabama from 1981 forward. (No estimate is available

for 2002 or for years prior to 1981.)

FY 2011:

Measures that focus on teen drivers are discussed under HSI 3C.

The following population-based and infrastructure-building activities occurred in FY 2011.

As previously stated, ACDRS was administratively relocated from FHS to HPCD.

ACDRS continued reviewing all unexpected or unexplained infant and child deaths in Alabama, including those due to motor vehicle crashes, per the mandating legislation described in Section III.B. ACDRS enjoyed participation from Local Child Death Review Teams in every judicial circuit statewide and, for the third year in a row, reviewed 95% or more of all deaths qualifying for review. The State Child Death Review Team, comprised of highly qualified individuals from a variety of disciplines, continued their very active role in ACDRS policy and efforts. The Alabama graduated driver's licensure law and various passenger restraint laws continued to be operative and enforced by appropriate State authorities.

The Booster Seat Advocacy Program (initiated in FY 2006) was jointly continued by ADPH, under the leadership of the Injury Prevention Branch, and the Southeast Child Safety Institute. The purpose of this program has been to educate Alabama's citizens about the amended law on child safety restraints in motor vehicles. Other participants in the program have included the Children's Hospital Child Safety Institute (located in Birmingham) and the UAB Department of Pediatrics.

The Injury Prevention Branch maintained web pages that included information pertaining to prevention of various injuries. Currently posted information pertaining to prevention of motor vehicle-crash injuries is discussed under "Current Activities."

The annual observational survey of occupant and child restraint use was conducted.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths of children and youth. | | | X | X |
| 2. 6. [ADPH's Bureau of Health Promotion and Chronic Disease, the Southeast Child Safety Institute, and other external entities] jointly conduct the Booster Seat Advocacy Program. | | | X | X |
| 3. Maintain web pages that include information pertaining to prevention of various injuries. | | | X | X |
| 4. Conduct the annual observational survey of occupant and child restraint use. | | | | X |
| 5. [Appropriate State authorities] enforce the law concerning motor vehicle safety restraints for passengers. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Population-based and Infrastructure-building:
FY 2011 activities basically continue.

The Injury Prevention Branch's web pages include information about the following national observances: Click It or Ticket Mobilization Dates (which concern child restraints and seat belts), Child Passenger Safety Week, Drive Safely Work Week, and National Drunk and Drugged Driving Prevention Month. As well, the following documents concerning motor vehicle injuries can be accessed from the branch's web pages: "Booster Seats: Keep Alabama's Kids Safe," "Keep Alabama's Kids Safe: 4 Steps for Kids" (a brochure on protecting children by choosing the right car seat), "Buckle Up Alabama . . . It saves lives!", and "Alabama Observational Survey of Occupant and Child Restraint Use 2011."

c. Plan for the Coming Year

Population-based and Infrastructure-building:

Unless previously stated otherwise, FYs 2011 and 2012 activities will basically continue in FY 2013. To briefly recap, these include:

- 1) Review of all unexpected or unexplained deaths of infants, children, and youth.
- 2) Support of the Booster Seat Advocacy Program.
- 3) Implementation of the observational survey of occupant and child restraint usage.
- 4) Maintenance of the web page on injury prevention.
- 5) Enforcement, by appropriate State authorities, of the legislation on child safety restraints.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---|---|---|-------------|
| Annual Performance Objective | 27.1 | 28.2 | 29.4 | 27.2 | 27.2 |
| Annual Indicator | 27.0 | 25.4 | 23.6 | 29.0 | |
| Numerator | 16169 | 15135 | 13441 | 16115 | |
| Denominator | 59913 | 59508 | 56958 | 55487 | |
| Data Source | | Pregnancy Risk Assessment Monitoring System | Pregnancy Risk Assessment Monitoring System | Pregnancy Risk Assessment Monitoring System | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |

| | | | | | |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 27.3 | 27.4 | 27.5 | 27.5 | 27.5 |
|------------------------------|------|------|------|------|------|

Notes - 2011

Data Issues:

Estimates for this indicator are for calendar years and are from Pregnancy Risk Assessment Monitoring System (PRAMS) data, managed by the U.S. Centers for Disease Control and Prevention (CDC). Alabama PRAMS is a population-based mail/telephone survey of Alabama residents who recently gave birth in the State. A stratified complex sampling design is used, and numbers reported here are weighted to represent all live births occurring in Alabama to Alabama residents. Because data are based on a sample, some statistical imprecision is expected. Observations for which breastfeeding status is unknown or unreported are excluded from the denominator.

Due to time required for data management, data for a given year do not generally become available to the states until at least 16 months after the end of the data collection year. For example, PRAMS data for 2009 did not become available until May 2011. The Alabama Department of Public Health's (ADPH's) Center for Health Statistics will provide numbers from the PRAMS 2011 dataset soon after CDC provides the dataset, but numbers for 2011 are not expected to be available before April 2013.

Notes - 2010

Data Issues:

See this indicator's year 2011 Form 11 field note for the data source and for a discussion of the time frame for receiving PRAMS data.

The percentage of mothers who were breastfeeding at the time of the survey is used as a surrogate for the percentage breastfeeding at 6 months following delivery, since the survey questionnaire is sent to mothers about 2-3 months after delivery.

Status and Trends:

In 2010, about 29% of Alabama residents who had recently given birth were breastfeeding when surveyed, about 2-3 months after delivery.

From 2005-2010 (2005 and 2006 are not shown on Form 11), this indicator has ranged from 23.2% in 2005 to 29.0% in 2010, with a median of 26.2%. During this surveillance period, the indicator has not shown a consistent trend, although declines were notable each year from 2007 through 2009. The year 2010 estimate is the highest recorded for this indicator for the period 2004-2010. Compared to 2009, this indicator was notably (23.1%) higher in 2010. See the year 2009 note for previous trends.

Objectives:

Objectives through 2015 have been retained from previous years. Though the point estimate for this indicator improved in 2010, the objective for year 2016 has been set at 27.5%, to match the year 2015 objective, rather than to require a continued increase. If the status of this indicator surpasses its objective for 3 years in a row, we will consider revising targets upward to make them more challenging.

Notes - 2009

Data Issues:

See 2011 field note regarding data source and limitations.

Trends:

In 2009, about 24% of Alabama residents who had recently given birth were breastfeeding when surveyed, about 2-3 months after delivery.

From 2005-2009, this indicator has ranged from 23.2% in 2005 to 28.3% in 2006, with a median of 25.4% in 2008. During this surveillance period, the indicator has declined in the last 3 years for which estimates are shown.

Objectives:

Objectives through 2014 have been retained from previous years. Since the point estimate for this indicator worsened in 2009, the objective for year 2015 has been set at 27.5%, to match the year 2014 objective. If the point estimate for year 2010 is notably worse than that for 2009, objectives for 2012 forward may be revised downward (made less challenging) in FY 2012.

a. Last Year's Accomplishments

FY 2011:

The following activities occurred in FY 2011 unless stated otherwise.

Cross-cutting (Enabling, Population-based, and Infrastructure-building):

WIC continued to increase public awareness of the importance of breastfeeding. For example, the WIC Breastfeeding Coordinator was a speaker at several conferences promoting breastfeeding to registered dietitians and nurses in the State. As well, she provided breastfeeding information for ADPH's "Alabama's Health" newsletter each month.

The WIC Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. Presentations on breastfeeding were made at local hospitals. She served on the board of the Alabama Lactation Consultant Association, which continued to meet. Also, the coordinator served on the Alabama Breastfeeding Committee (ABC), which also continued to meet. Nurses, doctors, lactation consultants, and various other health professionals are members of ABC, which focuses on encouraging, supporting, and protecting breastfeeding in Alabama.

Expansion of the Breastfeeding Peer Counseling Program continued. Ten new sites were added in FY 2011. The new sites were in Baldwin, Morgan, Colbert, Jefferson, Calhoun, Marshall, Autauga, Elmore, Barbour, and Lauderdale Counties--bringing the total number of sites to 27.

A WIC Infant Breastfeeding Report was sent to PHA Nutrition Directors quarterly. The report provides breastfeeding initiation and duration rates for each clinic and PHA.

The Breastfeeding Resource Guide was updated for ADPH's web site. Materials were distributed to each CHD to promote Breastfeeding Awareness Month. The ABC web page remained on ADPH's web site.

SPP continued to work with the ABC to promote breastfeeding statewide. Breastfeeding Regional Taskforces were active in each perinatal region except for Region 2, whose members chose to combine with the Region 3 taskforce. The taskforces addressed specific breastfeeding needs of their regions. SPP collaborated with various agencies, businesses, and organizations to promote breastfeeding. SPP continued to collaborate with AMOD on breastfeeding promotion and education statewide. As well, SPP continued working with Medicaid to incorporate breastfeeding information into the 2 encounters that recipients of maternity care have with care coordinators.

SPP spearheaded ADPH's use of the national Text4Baby Program, discussed in Section III.E, to educate parents about important preventive health care practices for their children. Information about breastfeeding, along with other topics, is made available through this program.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Through monthly newsletters, professional meetings, and/or | | | X | X |

| | | | | |
|---|--|---|---|---|
| other appropriate media, promote public awareness of the importance of breastfeeding. | | | | |
| 2. Present breastfeeding education programs to CHD staff and, upon request, to hospitals. | | | | X |
| 3. Collaborate with the Alabama Breastfeeding Committee, the Alabama Lactation Consultant Association, the Alabama Chapter of the March of Dimes (AMOD) and, when indicated, other groups to promote breastfeeding statewide. | | | X | X |
| 4. With support from a U.S. Department of Agriculture grant, maintain and expand the Alabama Breastfeeding Peer Counseling Program. | | | X | X |
| 5. Send a quarterly infant breastfeeding report, based on WIC data, to Nutrition Directors for each of the State's 11 Public Health Areas. | | | | X |
| 6. Post the Breastfeeding Resource Guide on ADPH's web site. | | | X | X |
| 7. Convene 4 breastfeeding taskforces, which cover the State's 5 perinatal regions. | | | | X |
| 8. Work with Alabama Medicaid to incorporate breastfeeding information into the 2 encounters that recipients of maternity care have with care coordinators. | | X | | X |
| 9. Use the national Text4Baby Program to educate parents about preventive healthcare practices for their children, including information about breastfeeding as well as other topics. | | | X | |
| 10. | | | | |

b. Current Activities

FY 2011 activities are expected to continue through FY 2012. Some updates follow.

Population-based and Infrastructure-building:

The Breastfeeding Coordinator and other members of ABC participated in CDC's State Breastfeeding Coalition teleconference calls and Regional State Breastfeeding Coalition discussions.

In October 2011 the State Breastfeeding Coordinator and the State Breastfeeding Peer Counselor Coordinator attended USDA WIC Breastfeeding Peer Counseling Curriculum Update and Training.

In November 2011 the Alabama Lactation Consultant Association and the ABC held a breastfeeding conference in Birmingham, Alabama.

Nutrition Education and Breastfeeding Promotion Training for WIC staff was taped in March 2012 and will be available via teleconference for 6 months for Alabama WIC Providers.

Expansion of the Breastfeeding Peer Counseling Program continues. As of March 2012, there are 27 sites, collectively located in 18 counties, with each PHA having at least 1 site. Addition of 7 other sites is planned.

SPP continues working with Medicaid to provide breastfeeding information to their maternity program's care coordinators. Also, SPP continues working with ABC, the regional breastfeeding task forces, AMOD, and other agencies and organizations to promote breastfeeding. Text4Baby enrollment continues to be promoted by SPP, which provides Text4baby promotional materials to agencies and organizations statewide. A Text4baby link is on ADPH's web site.

c. Plan for the Coming Year

Population-based and Infrastructure-building:

FYs 2011-2012 activities are expected to continue in FY 2013. These include provision of additional training for the Breastfeeding Peer Counseling Program, training of WIC staff, convening of the Alabama Lactation Consultant Association Conference, and provision of breastfeeding education statewide. Expansion of the Peer Counseling Program will continue, contingent on funding.

SPP will continue collaborating with AMOD, ABC, breastfeeding taskforces, and other agencies throughout the State to promote breastfeeding. Breastfeeding education and awareness efforts will be included in the GAL Campaign. Text4Baby enrollment will continue to be promoted.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--|--|--|--|
| Annual Performance Objective | 95.3 | 95.4 | 95.5 | 96.2 | 96.4 |
| Annual Indicator | 94.6 | 93.9 | 96.0 | 98.4 | 99.2 |
| Numerator | 59578 | 59548 | 58846 | 60621 | 57427 |
| Denominator | 63005 | 63450 | 61317 | 61608 | 57876 |
| Data Source | | ADPH Newborn Screening Neometrics Database |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 98.6 | 98.8 | 99.1 | 99.3 | 99.6 |

Notes - 2011

The numerator was obtained from the Alabama Department of Public Health’s Newborn Screening Program’s database, Neometrics(TM).

Neometrics(TM) contained hearing screening records for an unduplicated count of 57,876 newborns. Of these, 449 had no hearing screening results reported to the program. Of the 449 not reported, 20 were due to parental refusal and 361 were due to infants dying prior to receiving

a hearing screening. Despite repeated efforts by the Universal Newborn Hearing Screening (UNHS) Program, no additional information has been obtained on the remaining 68 infants with missing records. Per the UNHS Coordinator, they were most likely tested, but after the blood spot form had been submitted. Even when the hearing screening results are subsequently entered into Neometrics(TM), they are not always appropriately captured for reporting purposes as a pre-discharge screen.

All birthing facilities are now capable of exporting screening results monthly, although some facilities are still in need of updated equipment. The program must still rely on initial results from filter paper reports from hospitals, which are not always complete. Because we cannot confirm that each of the 68 infants did receive a hearing test, the numerator may be an overestimation. These results may not be directly comparable to those of past years because a new analyst compiled the data for reporting.

Trends:

From 2007 through 2011, the estimated percentage of newborns who received hearing screening prior to hospital discharge ranged from 93.1% in 2007 to 99.2% in 2011, with a median of 96.0% in 2009. As stated above, the year 2011 estimate is not comparable to earlier estimates. Also, as detailed in this indicator's field note for 2009, our current best estimate for 2007 differs from that shown on Form 11.

Objectives:

The estimate for this indicator has improved in each of the last 3 years. For this reason, we are revising targets for 2012-2015 upward. To revise these targets and set the year 2016 objective, the mean status of this indicator for the last 3 years, of 97.9%, was considered to represent the year 2010 baseline. Targets for 2012 forward require an average improvement (increase) of 0.25% per year (multiplicative model).

Notes - 2010

Data Issues:

The data source for the numerators is referenced in the year 2011 field note.

The Neometrics(TM) database for 2010 contained 61,608 newborn hearing screening records, which were believed to be an unduplicated count. However, the aforesaid number exceeds the preliminary estimate of the number of occurrent Alabama live births in 2010 (from a file downloaded on 4/21/2011), which is 58,781 births. Further, the 61,608 records in the 2010 Neometrics(TM) database are very close to the number of occurrent Alabama live births in 2009, which was 61,317 births. For these reasons, we conjecture that the year 2010 Neometrics(TM) database may include more than 1 record for some births and/or include some out-of-state births to Alabama residents.

Nevertheless, because the file used for the preliminary estimate of Alabama occurrent live births in 2010 was incomplete, we are using the 61,608 records in the Neometrics(TM) database as the denominator for the year 2010 estimate. Of these, 987 had no hearing screening performed prior to discharge from the hospital. Of the 987 not screened, 4 were due to parental refusal.

The numerator for this estimate includes 5,488 newborns for whom no hearing screening data were entered into the database prior to discharge (a 1.6% increase over 2009). Per the UNHS Coordinator, they were most likely tested but after the blood spot form had been submitted. Even when the screening results are subsequently entered into Neometrics(TM), they are not captured for reporting purposes as a pre-discharge screen. The number of hospitals exporting screening results monthly has increased; however, we still must rely on initial results from filter paper reporting from hospitals, which is not always complete. Because we cannot confirm that each of the 5,488 did receive a hearing test, the numerator may be an overestimation.

Because the denominator for the year 2010 is from a different database than the denominators

for earlier years, the year 2010 estimate is not precisely comparable to estimates for earlier years.

Objectives:

Objectives through 2014 are retained from earlier years, and the year 2015 objective has been set to match the year 2014 objective. We are aware that the estimate for 2010 surpasses the objectives shown, but have no assurance that the status of this indicator will remain that high in future years.

Notes - 2009

Data Issues:

For reasons detailed in the Maternal and Child Health (MCH) Services Block Grant 2009 Annual Report/2011 Application, in that document, this indicator's denominators for 2007-2009 counted only occurrent, residential Alabama live births (births occurring in Alabama to Alabama residents). However, because the Neometrics(TM) database includes records for all known live births occurring in the delivery hospitals, regardless of the mother's residence, we have revised the denominators for 2008 and 2009 to count all live births occurring in Alabama, regardless of where the mother lived. The Title V Information System does not allow us to directly revise the year 2007 numbers shown on Form 11. The number of Alabama occurrent live births in 2007 was 63,995, so that our current year 2007 best estimate for this indicator is 93.1% (59,578/63,995).

As well as including all newborns who were reported as being screened, the numerator shown on Form 11 includes 5,402 newborns for whom no hearing screening data were entered into the system. These 5,402 infants are included in the numerator because—according to the UNHS Coordinator—they probably received a hearing screening before discharge, but after the blood spot form had already been submitted. Even when such hearing screening results are subsequently entered into Neometrics(TM), they are not appropriately captured for reporting purposes as a pre-discharge screen. The UNHS Coordinator anticipates a software update from Neometrics(TM) by December 2010 that will resolve this data issue. As previously stated, the number of newborns who did not have hearing screening data entered into the database in 2009 was 5,402, which is a 32.8% decline from the year 2006 number of 8,037. Because infants for whom we have no data are counted in the numerator, the percentage shown may overestimate the percentage of occurrent live births that received a hearing screening.

Objectives:

Objectives through 2009 are retained from earlier years. Objectives from 2010 forward have been revised upward.

a. Last Year's Accomplishments

Historical Context:

Alabama's Listening, Alabama's Universal Newborn Hearing Screening (UNHS) Program, was implemented in 2004. Initially the program accomplished hearing screening at all Alabama birthing hospitals on a voluntary basis. In January 2008 the Alabama State Board of Health Administrative Code was amended to make hearing loss a mandatory part of the Alabama Newborn Screening panel of tests. This information was disseminated to all hospitals via letter and made available for review on the ADPH/NSP web site. The number of birthing hospitals in Alabama declined from 59 to 54 in 2008, then further declined to 53 in FY 2011.

FY 2011:

Many activities contributed to the UNHS Program's continued success in FY 2011. Key activities follow. Unless stated otherwise, the activities were conducted by UNHS Program staff.

Cross-cutting:

ADPH's UNHS Coordinator administrated all areas of the program, including overseeing the contract audiologist and managing the audiology intern students who assist with data

management.

Enabling:

The Care Coordination Program continued providing case management services concerning newborn hearing screening for infants receiving Medicaid. There were care coordinators in all of the State's 67 counties. The care coordinators contacted parents, primary care providers, and hospitals in their county to obtain information regarding hearing screening and follow-up status. They provided this service through telephone calls, letters, and home visits.

Infrastructure-building:

Hearing screening equipment continued to be available for use as loaner equipment by hospitals when equipment was being repaired. The goal of the loaner equipment was to reduce the number of infants leaving the hospital without a hearing screening.

Six hospitals were identified as needing updated equipment to meet compliance with the program screening and reporting requirements. Grants were provided to assist these facilities in the purchase of compliant equipment, and training was provided for the utilization of the equipment and proper reporting protocols. One of those grants was terminated due to the facility's plans to discontinue the delivering of infants within 6 months of the grant award. Two outpatient sites were identified to provide outpatient repeat testing and comply with the reporting requirements.

Monthly statistical reports continued to be provided to each hospital participating in the UNHS program. These reports included the number of infants born, the number screened, the number who passed screening, the number who did not pass screening, and the number for whom screening was missed or refused. Each hospital was provided with their individual results and statewide results. Software errors were corrected so reports would be more statistically accurate. The method of delivery was changed to electronic encrypted delivery to reduce postage fees.

The UNHS Program continued to set up and train birthing facilities regarding electronic reporting methods using a secure File Transfer Protocol (FTP) server for hospitals to upload data on a monthly basis at a minimum. Training was provided to 2 additional outpatient provider sites to use a separate FTP server to upload outpatient testing results.

The UNHS Program continued its contract with Auburn University. This contract provided 2 doctoral-level audiology student assistants who worked 10 hours a week under the direction of the UNHS Coordinator. The student assistants provided data entry and follow-up assistance.

The UNHS Program continued to contract with a part-time audiologist to serve as the hospital consultant for birthing hospitals participating in UNHS. The audiologist used the above mentioned hospital reports to identify hospitals in need of assistance or hands-on training. The audiologist also initiated the set up of FTP use in 30 birthing hospitals.

The UNHS Program continued to have a nurse coordinator work .50 FTE for the program. This nurse coordinator assisted the UNHS Coordinator in providing follow up for infants who failed the initial hearing screening, infants for whom data were missing on the initial screening, and infants identified with risk factors associated with late onset hearing loss. All of these activities created a decrease in the percentage of babies for whom no test results were reported, from 13% in 2009 to 4% in 2010. Preliminary data indicate that this decrease continued with an estimate of only 2% with missing test results in 2011.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Implement the State's Universal Newborn Hearing Screening (UNHS) Program. | X | X | X | X |

| | | | | |
|--|--|---|--|---|
| 2. Provide care coordination for the UNHS Program to Medicaid-enrolled infants. | | X | | X |
| 3. When equipment belonging to a hospital participating in UNHS is being repaired, provide loaner equipment for newborn hearing screening. | | | | X |
| 4. For each participating hospital, provide monthly reports tabulating the number of newborns who had hearing screening and the results of the screenings. | | | | X |
| 5. Contract with Auburn University for 2 doctoral-level audiology students to provide data entry and follow-up assistance, on a part-time basis and under the direction of the UNHS Coordinator. | | X | | X |
| 6. Provide or assure follow up for infants who failed the initial hearing screening, for whom data were missing on the initial screening, or who had risk factors associated with late onset hearing loss. | | X | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities are basically continuing in FY 2012.

The UNHS Coordinator, along with the contract audiologist, has identified 7 hospitals in the State that could benefit from grants for new hearing screening equipment to come into compliance with the mandate for newborn hearing screening and reporting. The program is also seeking primary care physicians and outpatient audiology clinics to perform follow-up hearing screening in rural areas of need, due to lack of availability of appropriate services.

The UNHS Program is continuing to enroll birthing facilities in the use of the FTP site for reporting results on a monthly basis. Retraining is provided as staff changes occur. Training for the encrypted monthly reports is also being completed.

The UNHS Coordinator, an audiologist, is resigning in May 2012. The Children's Health Division is replacing this audiologist position with a Nurse Supervisor position, and the person filling the Nurse Supervisor position will serve as the UNHS Coordinator. The program will continue contracting with a part-time audiologist.

c. Plan for the Coming Year

As stated above, a Nurse Supervisor is expected to assume the role of UNHS Coordinator in FY 2012. The basic activities of the UNHS Program are expected to continue in FY 2013. These activities are recapped below.

Enabling:

The program will provide case management services for follow up regarding hearing screening for Alabama infants receiving Medicaid.

Infrastructure-building:

The UNHS Program will maintain a loaner inventory of hearing screening equipment for birthing facilities' use and provide monthly statistical reports.

The program will continue contracting with Auburn University for doctoral-level student assistants and contracting with a part-time audiologist as a hospital consultant.

The program staff will continue providing follow up for infants who failed or missed the initial hearing screening and infants identified with risk factors associated with late onset hearing loss.

Additionally, the program will continue to work with its database manager to allow birthing facilities the capability of automatic uploading of hearing data to linked infant records. This will reduce the number of infants for whom no results are reported, thereby reducing the number of infants lost to follow up or lost to documentation.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--|--|----------------------------------|-------------|
| Annual Performance Objective | 6.9 | 6.8 | 6.8 | 6.4 | 6.4 |
| Annual Indicator | 7.3 | 3.7 | 7.9 | 8.9 | |
| Numerator | 82000 | 41000 | 86000 | 101000 | |
| Denominator | 1123000 | 1122000 | 1090000 | 1137000 | |
| Data Source | | U.S. Census Historical Health Insurance Table HIA5 | U.S. Census Historical Health Insurance Table HIB5 | U.S. Census Insurance Table HIB5 | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 6.3 | 6.2 | 6.1 | 6.1 | 6.1 |

Notes - 2011

Data Issues:

All estimates are for calendar years.

Data Issues:

With one exception, for the annual indicators, numerators, and denominators shown on Form 11, the reference is the Health Insurance Historical Tables-HIB Series (Table HIB-5, discussed under this indicator's year 2010 form note), obtained from the U.S. Census Bureau's web site. The exception is the numerator for 2008, which is from the U.S. Census Bureau's revised Historical Health Insurance Table 5 (HIA-5) series. Per Table HIB-5, the numerator for 2008 is 42,000, rather than the 41,000 shown. (The Title V Information System [TVIS] does not permit us to directly revise Form 11 numbers for 2008 and earlier years.)

Table HIB-5 does not yet include estimates for 2011. When estimates for 2011 are provided on

the U.S. Census Bureau's web site, this report/application will be updated accordingly at the first opportunity. Table HIB-5 is based on data collected in the American Community Survey (ACS). The ACS is an ongoing nationwide survey. Single-year estimates are available for geographic units with populations of 65,000 or more. Estimates of population size are not comparable between 2009 and 2010. Estimates of percent distributions, rates, and ratios should be compared with caution.

Notes - 2010

The reference for estimates from 1999-2010 is Table HIB-5, entitled "Health Insurance Coverage Status and Type of Coverage by State—Children Under 18: 1999-2010," obtained from the U.S. Census Bureau's web site (http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html) on January 23, 2012. Because the reference rounds numbers of individuals to thousands, percentages calculated by TVIS's web-based reporting package or by the Bureau of Family Health Services sometimes differ slightly from estimates shown in U.S. Census Bureau tables. This caveat applies to all numbers shown on Form 11 for this indicator and to all discussions in this document of trends in this indicator.

Status and Trends:

This discussion of trends is based on Table HIB-5. In 2010, an estimated 8.9% of Alabama children and youth under 18 years of age were without health insurance. For the surveillance period of 1999 through 2010, this is the second highest prevalence on record for Alabama, with the highest prevalence having been 9.8% in 2002. From 2002 (inclusive) forward, the lowest estimated prevalence of non-insurance was 3.7% in 2008, and the median estimate was 7.3% in 2007. The lowest reported prevalence, 3.7% in 2008, appears to be an outlier.

Comparing 2010 to 2009, the estimated prevalence of non-insurance among Alabama children and youth increased by 12.6%: from 7.9% in 2009 (86,000/1,090,000) to 8.9% in 2010 (101,000/1,137,000).

Objectives:

Per Table HIB-5, the estimate for this indicator was worse in 2009 and 2010 than in any year from 2003-2008. Therefore, the objective for the year 2016 has been set at 6.1% to match the year 2015 objective (instead of being set below the year 2015 objective). If the estimate for the year 2011 is notably above (worse than) the objective for that year, objectives for 2013 forward may be revised upward (made less challenging) in FY 2013.

Notes - 2009

Data Issues:

See this indicator's year 2011 note.

Trends:

This discussion of trends is based on Table HIA-5, using numbers available circa April 2011. Numbers provided in Table HIA-5 often differ from those provided in Table HIB-5.

In 2009, an estimated 7.9% of Alabama children and youth under 18 years of age were without health insurance. The prevalence of 7.9% in 2009 ties with the identical estimate of 7.9% in 2003 as being the second highest prevalence on record since 2002. From 2004-2008, corresponding estimates ranged from 3.6% in 2008 to 7.4% in 2006, with a median of 6.3% in 2004.

In spite of the increase in 2009, trends show notable overall progress in this indicator over a longer term, comparing 2007-09 to 2001-03. The following combines 3-year periods, combining single-year numbers reported in Table HIA-5, in order to minimize random variation due to sampling error. Comparing 2007-09 to 2001-03, the estimated prevalence of uninsured Alabama children and youth declined by 30.0%: from 9.0% (302,000/3,372,000) in 2001-03 to 6.3% (209,000/3,335,000) in 2007-09. Further, from 1999-2009 (all years shown in Table HIA-5), the

prevalence estimate of uninsured Alabama children and youth was consistently lower than the corresponding estimate for the U.S.

Objectives:

Objectives through 2009 were retained from previous years, and the methodology for setting them has been described in earlier Maternal and Child Health Services Block Grant Reports/Applications. For example, objectives for 2007 through 2009 require an average annual decline (multiplicative model) of 1.0% per year, from the 3-year baseline for 2003-05, using Table HI-5. (Table HIA-5 was not available to the writer when these objectives were set.)

However, in FY 2010 (when the year 2009 estimate was not yet available), objectives for 2010-2013 were revised downward (made more challenging), and the objective for 2014 was set at 6.1%, the lowest 3-year value on record for this indicator in Alabama. (This estimate of 6.1% of Alabama children being uninsured occurred in 2004-06 and again in 2006-08.) The newly set objectives were challenging, since single-year estimates for this indicator had been above 7.0% in 3 of the last 5 years for which an estimate was available. Further, the status of this indicator in 2005-07 combined was 6.4%.

Currently (in FY 2011), the year 2015 objective is being set at 6.1%, the same as the year 2014 objective. If the status of this indicator fails to reach the corresponding objective 3 years in a row (that is, in 2010 and 2011, as well as in 2009), objectives for FYs 2013 onward will be made less challenging.

a. Last Year's Accomplishments

Historical Context:

Development of Alabama's CHIP, ALL Kids, is discussed in Section III.A.

As stated earlier, in October 2009 the income limit for ALL Kids eligibility increased to 300% of FPL, up from 200% of FPL. In response, in FY 2010 ALL Kids directed more targeted outreach and education toward families in the new income eligibility range. Also in FY 2010, ALL Kids initiated an outreach campaign in partnership with sports marketing groups for the 2 largest universities in Alabama. The sports marketing outreach continued in FY 2011, as discussed below.

FY 2011:

Cross-cutting:

Original federal rules about SCHIP had excluded dependents of public employees from enrollment in SCHIP. These rules changed in 2010 and, in FY 2011, Alabama received CMS approval to begin enrollment of eligible dependents of State, including public education, employees in ALL Kids. ALL Kids then conducted several outreach activities to inform affected families that their children may be eligible for ALL Kids. Information was disseminated in several ways, including a meeting with State personnel managers and public education administrators, distribution of a notice to affected State employees, articles in State employee newsletters, group meetings and individual discussions with State employees, and letters from State health employees' health plans to their members.

Population-based:

In April 2011 parts of the State were devastated by deadly tornadoes. Regional ALL Kids staff worked at disaster recovery centers placed in designated areas around the State by the Federal Emergency Management Agency, to assist families with their children's insurance needs. This work continued for several months. A state plan amendment was approved by CMS to temporarily relax renewal policies in affected counties.

ALL Kids continued partnering with sports marketing groups for the 2 largest universities in Alabama, to target all families in Alabama who may have uninsured children. Outreach packages for both schools included the sponsorship of a home game that included a pre-game tent setup to

distribute ALL Kids materials and talk with families, on-field promotions, sports radio coverage, and promotions in all print materials. Promotions also occurred during football programming and television and radio advertisements by the head football and head basketball coaches. These partnerships included the same outreach exposure during basketball, baseball, and gymnastic events. ALL Kids also received the same outreach opportunities at 2 other State universities. The collegiate sports outreach campaign was complimented with use of billboards and electronic media, including websites and radio. Also, for the first time, outreach was conducted through 1 of the State's historically Black colleges, to reach minority families via sporting events.

ALL Kids ran a 4-month campaign with Alabama's largest and fastest growing media company that provides news and information statewide. Via this campaign, over 6 million ads were delivered across the State. Other outreach targeting families included ads on movie theater screens around the State during summer and holiday seasons. Ads were also placed in parenting magazines statewide.

While ALL Kids continued efforts to reach the State's Latino population, they also focused on "special populations," to include minorities and persons in rural or isolated areas. Regional staff continued partnering with the State's Native American tribes and tribal leaders.

ALL Kids continued several other activities from previous years, including:

- 1) Provision of services by Regional Coordinators.
- 2) Participation in the "Kid Check" initiative of the Alabama Rural Action Commission, which provides health screenings through schools.
- 3) Partnership with other organizations to "teach the people who reach the people": i.e., to reach those who work directly with families.
- 4) Participation in Rapid Response events, coordinated by the State Department of Economic and Community Affairs, to provide information about health coverage programs for children to persons losing their jobs due to layoffs or plant closings.
- 5) Use of stand-alone kiosks placed in CHDs and FQHCs to provide audible instructions, in Spanish and English, about applying for Medicaid and ALL Kids online.

Infrastructure-building:

Collaboration continued with the 2 State recipients of the CHIPRA Outreach Grants, as both entities moved forward to implement outreach and evaluation.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Through ADPH's Bureau of Children's Health Insurance, administer ALL Kids. | | X | X | X |
| 2. In partnership with sports marketing groups, both in the high school and university settings, provide outreach targeting uninsured children. | | | X | X |
| 3. Collaborate with the 2 Alabama recipients of Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grants to insure that their outreach messages are consistent with ALL Kids messages. | | | | X |
| 4. Participate in the "Kid Check" initiative of the Alabama Rural Action Commission, which provides health screening through schools. | | X | X | |
| 5. Through ALL Kids Regional Coordinators, develop | | | | X |

| | | | | |
|---|--|---|---|---|
| partnerships with stakeholders around the State. | | | | |
| 6. Make combined applications for ALL Kids, SOBRA Medicaid, and Medicaid for Low Income Families available at various community locations and via the ALL Kids web page. | | | X | X |
| 7. Provide stand-alone kiosks in CHDs to provide audible instructions, in Spanish and English, enabling families to apply for coverage through the web-based application. | | X | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Cross-cutting:

As stated earlier in this document, due to the austere fiscal climate projected for FY 2013, ALL Kids is halting all media-related outreach during FY 2012 and will research all possible cost-saving measures to aid in addressing the State's projected budget deficit. At present, except for the media-related outreach, FY 2011 activities basically continue.

Population-based:

Though not discussed under "Last Year's Accomplishments" due to space constraints, ALL Kids continues to maintain a user-friendly web page that has been operational for several years. From this page, the viewer can access a variety of information, apply for ALL Kids, and maintain enrollment of their eligible children in ALL Kids. For example, the viewer can see if a child is eligible for ALL Kids, apply for ALL Kids, pay their ALL Kids premium, renew their child's coverage, find a doctor or dentist, order ALL Kids materials, and contact ALL Kids, including their Regional Coordinator. The application is a combined application for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and Plan First (the Family Planning Medicaid Waiver discussed in Section III.A).

Infrastructure-building:

To comply with CHIPRA verification of citizenship requirements, the State continued using an automated match (begun in FY 2010) of certain information from the CHIP application and from SSA files.

c. Plan for the Coming Year

Cross-cutting:

ALL Kids, along with other State programs, faces a major fiscal challenge in FY 2012. Although ALL Kids is halting all media-related outreach and researching cost-saving measures, it will continue seeking to promote access to affordable health care for children. For example, it will continue serving its enrollees as long as they remain eligible; outreaching via non-media measures as feasible, and adding eligible enrollees as resources allow. For example, the following activities are expected to continue:

1) Provision of the ALL Kids web page, which includes the combined application form discussed under "Current Activities."

2) Participation in the "Kid Check" initiative of the Alabama Rural Action Commission.

3) Distribution of combined applications for ALL Kids, SOBRA Medicaid, and Medicaid for Low Income Families at various community locations and on the ALL Kids web page.

4) Partnership with others to "teach the people who reach the people."

As well, Regional Coordinators will continue to have a presence in communities, providing support to families and ALL Kids partners.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---|---|---|-------------|
| Annual Performance Objective | 29.9 | 29.8 | 27.5 | 28.5 | 28.3 |
| Annual Indicator | 28.6 | 28.9 | 30.0 | 29.3 | |
| Numerator | 14714 | 16419 | 18172 | 19313 | |
| Denominator | 51448 | 56813 | 60572 | 65914 | |
| Data Source | | CDC Pediatric Nutrition Surveillance System | CDC Pediatric Nutrition Surveillance System | CDC Pediatric Nutrition Surveillance System | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 29 | 28.8 | 28.7 | 28.5 | 28.4 |

Notes - 2011

U.S. Centers for Disease Control and Prevention's (CDC's) Pediatric Nutrition Surveillance System (PedNSS) data for measuring the number and percentage of 2-5 year-old Alabama WIC enrollees who are obese (body mass index [BMI] at or above the 95th percentile) or overweight (BMI at or above the 85th percentile to the 95th percentile) are used to calculate this indicator.

Because the FY 2010 PedNSS data in Table 6C became available by March 2012, we expect FY 2011 data to be available by March 2013. Once 2011 PedNSS findings become available to the Bureau of Family Health Services, we will update Form 11 at the first opportunity.

Notes - 2010

The data source for this indicator is referenced in its year 2011 form note. The reference is "Table 6C, 2010 Pediatric Nutrition Surveillance, Alabama--Comparison of Growth and Anemia Indicators by Contributor, Children Aged <5 years." Per this reference, 29.3% of children, ages 2 to 5 years, had a BMI that was at or above the 85th percentile.

Trends:

The percentage of children, ages 2 to 5 years, receiving WIC with a BMI at or above the 85th percentile has not shown a consistent trend over individual years. Single year values during the surveillance period (2005-2010) for this indicator have ranged from 28.6% in 2007 to 30.9% in 2005 (not shown on Form 11), with a median of 29.1%. The average annual percent reduction

was 1.1%. Comparing the 2009 estimate of 2-5 year-old WIC enrollees whose BMI was at or above the 85th percentile to the estimate for 2010, the percentage decreased by 2.3%: from 30.0% in 2009 (18,172/60,572) to 29.3% (19,313/65,914) in 2010. Although small, any improvement in this indicator is notable.

Objectives:

Objectives through 2011 were retained from previous years. However, objectives from 2012 forward have been revised upward, to be slightly less challenging and more realistic in light of recent values for this indicator. Nevertheless, the newly set objectives are still quite challenging. Considering the percentage for 2008-2010 (29.4%, or 53,904/183,299) to represent the 2009 baseline, objectives require a decline of 0.5% per year.

Notes - 2009

Trends:

In 2009 an estimated 30.0% of Alabama children ages 2 to 5 years receiving WIC services had a BMI at or above the 85th percentile. From 2005 (not shown on Form 11) through 2009, the estimate for this indicator ranged from 28.6% in 2007 to 30.9% (9,313/30,140) in 2005, with a median of 28.9% in 2008.

Over consecutive 2-year periods, the percentages have been as follows: 28.65% in 2006-07 and 29.5% in 2008-09. Comparing 2008-09 to 2006-07, this indicator increased (worsened) by an estimated 2.9%.

Objectives:

Objectives through 2014 were retained from 2009, and the year 2015 objective was set to match that for 2014.

a. Last Year's Accomplishments

Historical Context:

Cross-cutting (Enabling, Population-based, and Infrastructure-building):

The following initiatives provide a historical context for the reporting year.

The Alabama Obesity Task Force (AOTF), which organized in FY 2004, published an AOTF State Plan in FY 2005. State WIC staff served on 2 of the AOTF subcommittees involved in implementing this plan and co-chaired 1 of the subcommittees. Another ATOF subcommittee developed the FY 2007 State Nutrition Action Plan (SNAP) for Alabama, which supported the AOTF State Plan and emphasized healthful eating and physical activity for USDA Food and Nutrition Service populations in Alabama. This subcommittee included 3 ADPH nutritionists and persons from SDE's Child Nutrition Program, the State Food Stamps program, and the Alabama Cooperative Extension System. The SNAP subcommittee was discontinued in FY 2009.

The biannual WIC Nutrition Education Plan for FY 2005-06 was implemented in all WIC clinics and focused on prevention of childhood obesity. As part of the plan, WIC clinic providers educated parents of all 1-5 year-old clients on the importance of daily physical activity and healthful eating throughout the year. FYs 2007-08 and 2009-10 Nutrition Education Plans expanded the preceding plan by focusing on prevention of obesity for the entire family and targeting breastfeeding and postpartum WIC-enrolled women as well as WIC-enrolled children. Four new educational materials that encouraged physical activity and healthful eating for families were developed for use with the FY 2007-08 education plan. The FY 2009-10 plan featured a "Mooove to 1% Low Fat and Fat Free Milk!" campaign, including posters, stickers, and a handout. As part of these plans, incentive items were distributed to WIC-enrolled clients to encourage physical activity and healthful eating. These included beach balls, Frisbees, children's books on physical activity and healthful eating, cutting boards, and pedometers.

An Overweight Risk Criteria Report was developed in FY 2004 to compute data on overweight children receiving WIC services. This report was revised in FY 2006, to include data on

overweight postpartum and breastfeeding WIC-enrolled women. Since FY 2004, the original report or the revised version has been run each year.

A new WIC Food Package Committee was formed in March 2008 and met monthly to work toward implementation of the WIC Food Packages Interim Rule by October 1, 2009. The new WIC food packages address the issue of obesity in children and adult WIC clients by offering fresh fruits and vegetables, whole grains, and milk with a lower fat content and by strengthening breastfeeding promotion and support in WIC. To finalize the new food packages in FY 2008, WIC committee members participated in the following: developing ADPH Information Technology-WIC Business Rules to update PHALCON, calculating new maximum monthly formula amounts, developing or revising over 30 WIC forms and publications related to the new food packages, planning statewide training, and developing a training DVD. Also, a Train-the-Trainer session was held to train WIC Area Nutrition Directors who, in turn, trained the WIC clinic staff. Clinic staff began educating WIC clients in late June 2009. Sesame Street kits containing a DVD, storybook, and parent's guide were given to WIC-enrolled children to promote the new, healthier food packages.

FY 2011:

The following cross-cutting activities occurred in FY 2011.

WIC clinic staff continued to educate WIC clients concerning the new WIC food packages.

Work continued on the implementation phase of the AOTF State Plan, with a member of the State WIC staff serving on the task force.

The FY 2011-12 Nutrition Education Plan was implemented in all WIC clinics, in collaboration with PHA WIC Directors. It continued to focus on obesity prevention with a new emphasis on consuming more fruits and vegetables and using the new WIC cash value voucher to buy fresh fruits and vegetables. New posters, handouts, and table tents were used to educate participants.

A new WIC Lessons web page, which provides nutrition education lessons, went live in October 2010.

The Overweight Risk Criteria Report was generated for FY 2010 and compared with previous years' data. In addition, CDC PedNSS data for FY 2009 for Alabama were used to ascertain the percentage of WIC-enrolled children aged 2-5 years who had a BMI at or above the 85th percentile.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Educate WIC clients about the new WIC food packages that promote healthier food. | | X | | X |
| 2. Maintain membership in the Alabama Obesity Task Force (AOTF), and help implement the AOTF State Plan. | | | | X |
| 3. Implement the WIC Nutrition Education Plan for all ADPH WIC clinics, focusing on prevention of obesity. | | X | | X |
| 4. As part of the WIC Nutrition Education Plan, emphasize use of the new WIC cash value voucher to buy fresh fruits and vegetables. | | X | | X |
| 5. Maintain the WIC Lessons web page, which provides nutrition education lessons. | | | X | X |

| | | | | |
|---|--|--|--|---|
| 6. Monitor the percentage of WIC-enrolled children who are overweight or at risk for becoming overweight. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities basically continue in FY 2012. Certain updates follow.

Cross-cutting (Enabling, Population-based, and Infrastructure-building):

Many of the FY 2011-12 WIC Nutrition Education Plan activities continue. These include emphasis on consuming more fruits and vegetables, use of the WIC cash value voucher to buy fresh fruits and vegetables at nutrition education visits with WIC clients targeted in the plan, and promotion of Breastfeeding Awareness Month and "Fruit & Veggies--More Matters" in ADPH WIC clinics.

The FY 2013-14 Nutrition Education Plan is currently under development. The focus on obesity prevention will continue. USDA's new MyPlate icon and messages from the 2010 Dietary Guidelines for Americans will be used to promote a healthy weight and good health among WIC-enrolled women and children.

A new lesson was added to the WIC Lessons web page. Plans are to offer web lessons in Spanish later this year. Twenty lessons on the web page are being translated into Spanish.

The Overweight Risk Criteria Report continues being generated each year and compared with previous years' data. CDC PedNSS data for FY 2010 for Alabama are being used to monitor the percentage of 2-5 year-old children on WIC who have a BMI at or above the 85th percentile.

Clinic WIC staff statewide educated WIC clients about the new FY 2012-13 WIC food packages, which, for the first time ever, include soy milk food packages.

c. Plan for the Coming Year

Cross-cutting (Enabling, Population-based, and Infrastructure-building):

AOTF will continue implementing its State plan.

The new FY 2013-14 Nutrition Education Plan will be implemented in all ADPH WIC clinics.

Additional nutrition education lessons will be added to the WIC Lessons web page.

The Overweight Risk Criteria Report will be generated to monitor FY 2012 data on the number and percentage of WIC-enrolled postpartum and breastfeeding women who are overweight and the number and percentage of WIC-enrolled children who are overweight or at risk of overweight. CDC's PedNSS data for FY 2011 for Alabama will be used to monitor the percentage of 2-5 year old WIC-enrolled children who have a BMI at or above the 85th percentile.

A new WIC Food Package Committee will begin meeting in early FY 2013 to select foods for the FY 2014-15 Alabama WIC food package and to develop the FY 2014-15 Alabama WIC Approved Foods brochure. Members of the committee will plan and assist with statewide FY 2014-15 food package training in late FY 2013.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---|---|---|-------------|
| Annual Performance Objective | 16.6 | 15.7 | 13.4 | 14.7 | 14.7 |
| Annual Indicator | 13.5 | 15.6 | 15.8 | 15.9 | |
| Numerator | 8161 | 9506 | 9242 | 8871 | |
| Denominator | 60411 | 60864 | 58394 | 55693 | |
| Data Source | | Pregnancy Risk Assessment Monitoring System | Pregnancy Risk Assessment Monitoring System | Pregnancy Risk Assessment Monitoring System | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 14.6 | 14.6 | 14.5 | 14.5 | 14.5 |

Notes - 2011

Data Issues:

Estimates for this indicator are for calendar years and are from Pregnancy Risk Assessment Monitoring System (PRAMS) data, managed by the U.S. Centers for Disease Control and Prevention (CDC). Alabama PRAMS is a population-based mail/telephone survey of Alabama residents who recently gave birth in the State. A stratified complex sampling design is used, and numbers reported here are weighted to represent all live births occurring in Alabama to Alabama residents. Because data are based on a sample, some statistical imprecision is expected. Observations for which smoking status is unknown or unreported are excluded from the denominator.

Due to time required for data management, data for a given year do not generally become available to the states until at least 16 months after the end of the data collection year. For example, PRAMS data for 2009 did not become available until May 2011. The Alabama Department of Public Health's (ADPH's) Center for Health Statistics will provide numbers from the PRAMS 2011 dataset soon after CDC provides the dataset, but numbers for 2011 are not expected to be available before April 2013.

Notes - 2010

Data Issues:

See this indicator's year 2011 Form 11 field note for the data source.

Trends:

In 2010, an estimated 15.9% of pregnant women smoked during the last 3 months of pregnancy.

During the surveillance period of 2005-2010, single-year values for this indicator ranged from 13.5% in 2007 to 18.6% in 2005 (not shown in table): indicating an average annual decline of 3.0% per year. The indicator was at 15.8% in 2 consecutive 3-year periods: 2005-07 and 2008-10. However, annual trends show slight worsening. That is, this indicator increased (worsened) slightly in 2008, 2009, and 2010.

Objectives:

The point estimate for this indicator has increased in each of the last 3 years. Further, this indicator missed (was higher than) its objective in 2009 and 2010. Objectives through 2015 have been retained from previous years, and the 2016 objective has been set to the corresponding 2015 objective. If this indicator misses its target in 2011, existing objectives from 2013 forward may be revised upward (made less challenging) in FY 2013.

Notes - 2009

Trends:

In 2009, an estimated 15.8% of pregnant women smoked during the last 3 months of pregnancy. Combining 3-year periods, the indicator improved (declined) slightly, by an estimated 12.5%: from 17.1% in 2004-06 to 15.0% in 2007-09.

Objectives:

Objectives through 2014 have been retained from previous years. The 2015 objective has been set at 14.5%, requiring an annual decline of 0.3% from the year 2007 baseline.

In April 2010, objectives for 2010 onward were revised upward (made less challenging) based on the 2006-08 baseline. We are aware that all of the objectives are lower than the estimated percentage of women who smoked during the last 3 months of pregnancy in 2009. If the status of this indicator remains above the corresponding objective 3 years in a row, we will revise the objectives upward to make them less challenging.

a. Last Year's Accomplishments

FY 2005-08 Backdrop (Infrastructure-building):

The following activities provide a backdrop for FY 2011 activities. In FY 2005, SPP wrote a strategic plan for FYs 2005-2007, 1 element of which was to decrease the percentage of women who smoke during pregnancy. SPP partnered with AMOD to provide smoking cessation counseling training for private delivering physicians' office staff statewide. Specifically, AMOD funded a grant for Regional Nurse Perinatal Coordinators (RNPCs) to recruit and train the office staff of 100 delivering physicians (20 in each of the 5 perinatal regions) so that they could provide a brief smoking cessation intervention for their pregnant patients who smoked. The evidence-based smoking cessation 5-A's model (ask, advise, assess, assist, arrange) was implemented in the training, which was provided by RNPCs in "lunch and learn" sessions.

AMOD's FY 2006 grant also provided for preconceptional counseling by SPP staff. RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model, which was used to train physicians' office staff in provision of preconceptional counseling for female patients of childbearing age. The training included information on prevention and/or discontinuation of tobacco use. PT +3 is a standardized educational method (developed several years ago by ADPH, Alabama Medicaid, and Upjohn Pharmaceuticals) with educational aids designed for those at risk of unintended pregnancy. The intent of PT +3 is to provide individualized, patient-centered counseling and education in a succinct, straightforward manner--in order to enhance the recipient's ability to hear, understand, and master a basic set of critical behaviors. The acronym stands for: 1) P = Personalize the problem; 2) T = Tackle it! (that is, set a therapeutic tone, assess current knowledge, provide the knowledge, listen for feedback, and educate again as needed); and 3) +3 = Summarize in 3 points.

In FY 2007, SPP's strategic plan changed when the State Health Officer launched several initiatives to reduce the infant mortality rate. One of the initiatives was the expansion of the

newborn screening panel.

The AMOD grant continued in FY 2008. With support from this grant, RNPCs continued providing "lunch and learn" training sessions for private delivering physicians' office staff statewide. The following numbers of providers were trained in FY 2008: 90 physicians, 553 nurses, and 192 ancillary staff. However, due to the change in SPP's strategic plan, the sessions did not focus on smoking cessation training. Instead, they focused on proper blood specimen collection and handling procedures for newborn screening.

Also in FY 2008, SPP collaborated with the Medicaid Maternity Program regarding smoking cessation for SOBRA recipients. Smoking cessation was discussed with SOBRA recipients at each encounter with the care coordinator, with referral to the Quitline if appropriate. The Quitline is a toll-free hotline that provides counseling, educational materials, and supplies to help recipients stop smoking. As well, SPP provided educational materials and other resources to organizations and agencies statewide.

One reason that SPP addresses smoking cessation is that environmental smoke is a contributing factor to SIDS and respiratory conditions during infancy. Also, if the mother continues to smoke, subsequent pregnancies may be affected.

FY 2011:

Cross-cutting (Population-based and Infrastructure-building):

The following activities occurred in FY 2011.

SPP continued partnering with ADPH's Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant women.

SPP also continued collaborating with the Medicaid Maternity Care Program regarding smoking cessation for SOBRA recipients. Smoking cessation was discussed with SOBRA recipients at each encounter with the care coordinator, with referral to Quitline if appropriate. Nicotine therapy was available for SOBRA Medicaid recipients.

SPP continued providing educational materials, including posters and brochures, about the effects of smoking on the fetus to agencies and organizations statewide.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Partner with the Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant women. | | | X | X |
| 2. Partner with the Medicaid Maternity Care Program to encourage care coordinators to discuss smoking cessation with SOBRA Medicaid recipients at each encounter and refer the client to the Quitline if appropriate. | | X | | X |
| 3. Provide educational materials and resources about smoking cessation to organizations and agencies statewide. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Cross-cutting (Population-based and Infrastructure-building):

FY 2011 activities as outlined above generally continue in FY 2012. To recap, SPP continues partnering with ADPH's Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant women, collaborating with the Medicaid Maternity Care Program about smoking cessation for SOBRA recipients, and providing educational materials statewide about the effects of smoking on the fetus.

Additionally, the GAL Campaign (discussed in Section III.E) has promoted tobacco prevention and cessation education through the production of an educational brochure. The brochures are available for agencies and organizations statewide.

c. Plan for the Coming Year

FYs 2011 and 2012 activities outlined above will generally continue in FY 2013. Certain recaps or updates follow.

Cross-cutting (Population-based and Infrastructure-building):

SPP will continue to partner with the GAL Campaign to provide educational materials and other resources to organizations and agencies statewide. As well, SPP will continue working with the Tobacco Prevention and Control Branch and with Medicaid to address smoking. Additionally, the SPP web pages will provide links to resources regarding smoking and its effects on the fetus and newborn.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--------------------------|--------------------------|--------------------------|-------------|
| Annual Performance Objective | 8.3 | 8.2 | 7.1 | 6.9 | 7 |
| Annual Indicator | 4.9 | 7.0 | 7.3 | 8.4 | |
| Numerator | 16 | 23 | 24 | 29 | |
| Denominator | 326378 | 330502 | 328967 | 343471 | |
| Data Source | | Vital records and Census | Vital records and Census | Vital records and Census | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 7 | 6.8 | 6.8 | 6.7 | 6.7 |

Notes - 2011

Data Issues:

Due to the time required to receive records and edit data, final vital statistics files for 2011 are not

yet available. The preliminary reporting-year files available when the Maternal and Child Health Services Block Grant annual reports/applications are being finalized for internal review (in June of the submission year) sometimes provide misleading estimates. Therefore, the year 2011 estimate is not provided. Instead, it will be provided in July 2013.

Objectives:

See this indicator's field notes for 2009 and 2010.

Notes - 2010

Data Issues:

All estimates are for calendar years.

For this indicator, normally the U.S. Census Bureau's population estimates for persons 15-19 years of age are used as denominators. The Census Bureau's annual state population estimates according to race, age, sex, and origin had not been released as of March 21, 2012. At that time, only decennial census 2010 counts were available. We are using American Fact Finder's (AFF) 2010 Census Summary File 1, which are actual counts and basic cross tabulations of information collected from all people and housing units during the 2010 Census.

Trends:

Population estimates several years after a census may be less reliable than those that are within a few years of the previous census. As a corollary, the population estimates for the years preceding 2010 may not be comparable to the year 2010 U.S. Census count. For this reason, we are not describing trends in rates during recent years, but are instead focusing on trends in numbers of suicide deaths.

Among 15-19 year-old Alabama residents, suicide deaths increased to 29 deaths in 2010, up from 24 deaths in 2009. This represents an overall increase of about 21% in the number of deaths between 2009 and 2010. Comparing absolute counts for 3-year periods, the number of deaths has remained fairly steady: at 73 deaths in 2005-07 and 76 deaths in 2008-10, indicating about a 4% increase between the 3-year periods.

Objectives:

The estimate for this indicator has increased in each of the last 3 years, but has not missed (been worse than) its objective for 3 years in a row. For these reasons, we are retaining targets from 2012-2015. The year 2016 objective has been set to match the 2015 objective. If this indicator misses (is worse than) its objective for 3 years in a row, we will then consider revising objectives upward to make them less challenging.

Notes - 2009

Data Issues:

The U.S. Census Bureau's population estimates for persons 15-19 years of age are used as denominators. These estimates are updated on an annual basis, but TVIS does not allow us to directly change estimates for 2007. The updated population estimate for Alabama 15-19 year-olds for 2007 is as follows, rather than as shown above: 327,732 persons.

For the following description of trends, denominators are based on population estimates available circa April 2011.

Trends:

The suicide rate among Alabama residents 15-19 years of age does not show a consistent trend. Comparing two adjacent 3-year periods, the suicide death rate among 15-19 year-olds living in Alabama declined by 29.3%: from 9.0 deaths per 100,000 (87/963,507) in 2004-06 to 6.4 deaths per 100,000 (63/987,201) in 2007-09. However, this death rate was unusually low in 2007, so future 3-year rates are likely to be higher than the rate in 2007-09. In this age group, rates for individual years from 2005-2009 ranged from 4.9 suicides per 100,000 persons in 2007 to 10.1

suicides per 100,000 persons in 2006, with a median of 7.3 suicides per 100,000 persons in 2009.

Objectives:

Objectives through 2010 are retained from earlier years. Objectives from 2011-2015 were set by considering the unrounded rate for 2008-09 combined (7.1269 deaths per 100,000 when carried to 4 decimals) to be the year 2009 baseline, and then requiring a reduction of 1.0% per year.

a. Last Year's Accomplishments

Historical Context (Infrastructure-building):

Initially, ADPH's efforts to prevent suicide were mainly carried out through the Alabama State Suicide Prevention Task Force (SPTF, which first met in March 2002) and ACDRS, both of which are discussed below. In 2010, the Alabama Suicide Prevention and Resource Coalition (ASPARC) was formed from SPTF and assumed the responsibilities of SPTF. ASPARC included representatives from several organizations: including but not limited to ADPH, DMH, UAB School of Public Health, Alabama State University, several crisis centers, SDE, Veterans Administration organizations in 4 areas of the State, and DHR.

SPTF was concerned with suicide regardless of age. The Social Work Unit in the Department's Bureau of Professional and Support Services led ADPH's involvement with this group. In FY 2003, SPTF developed a web site, hosted by ADPH and DMH, providing information about suicide and pertinent available resources. In FY 2004, SPTF completed the Alabama State Suicide Prevention Plan, and the ACDRS Director joined SPTF. In September 2004, SPTF launched a statewide media campaign to publish the toll-free number for suicide-related crisis calls.

ACDRS, created by legislation enacted in 1997, is mandated to review all unexpected deaths of children from birth through 17 years of age and was initially located in FHS. In FY 2003, ACDRS created the Infant and Child Death Investigation Task Force, in accordance with the mandating legislation's charge to develop a standardized infant and child death investigation curriculum. For several years ACDRS has maintained web pages providing information about causes of death in children and youth. In collaboration with SPTF, ACDRS developed a "Prevent Youth Suicide" educational brochure in FY 2005, as well as a Spanish translated version in FY 2006, both of which were distributed throughout the State. Initially the brochures were mass-distributed in ACDRS-branded stand-up display holders to school counselors throughout the State. Since 2006 the brochures have been stocked at ADPH's warehouse, for distribution in response to reorders and new requests. As well, a pdf file of the brochure can be downloaded from an ACDRS web page.

Several infrastructure-strengthening events concerning prevention of suicide occurred in FY 2008. In that year, SPTF hosted a 2-day coalition-building workshop (Strategic Planning for Suicide Prevention) facilitated by the Suicide Prevention Action Network USA. There were 35 attendees, the maximum enrollment, with participation from ADPH, DMH, ACDRS, other SPTF members, university counselors and professors, hospital and psychiatry representatives, high school counselors, Veterans Administration staff, and others. The purpose of the workshop was to discuss SPTF's transition to a sustainable organization with a broader scope. It was this meeting that sparked the development of new articles of incorporation and bylaws in FY 2008 (and their eventual adoption with the formation of ASPARC, which is discussed later).

Also in FY 2008, SPTF added 13 members, developed by-laws, and elected officers. As well, the newly revised State Suicide Prevention Plan was unveiled. The plan consisted of 13 strategies for reducing the frequency of suicide, which generally pertained to suicide regardless of age. One strategy, which particularly targeted youth, was to "work with state and local organizations to carry out safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention, and incorporate peer support for individuals seeking help."

In FY 2010, ASPARC was formed from the former SPTF and assumed the responsibilities of SPTF. As stated above, new articles of incorporation and bylaws were adopted with the formation of ASPARC, which applied for 501(c)(3) organizational status. ASPARC continued to meet quarterly, to promote the Alabama State Suicide Prevention Plan, and to maintain a toll-free number for suicide-related crisis calls.

FY 2011:

Population-based and Infrastructure-building:

In FY 2011, ACDRS was administratively relocated from FHS to HPCD.

ACDRS staff remained active members in ASPARC and continued distributing the "Prevent Youth Suicide" brochure. ADPH continued maintaining web pages on suicide prevention and on ACDRS.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Administer ACDRS to review unexpected deaths, including suicide, of Alabama children and youth. | | | X | X |
| 2. Maintain membership in the Alabama Suicide Prevention and Resource Coalition (ASPARC). | | | X | X |
| 3. Through ASPARC, promote and implement strategies included in the State Suicide Prevention Plan. | | | X | X |
| 4. Through ASPARC, maintain a toll-free number for suicide-related crisis calls. | | | X | X |
| 5. As part of public awareness efforts, distribute an educational brochure on prevention of suicide among youth. | | | X | |
| 6. Host and maintain web pages providing information pertaining to suicide prevention and related resources. | | | X | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Population-based and Infrastructure-building:

FY 2011 activities basically continue. ACDRS is collaborating with ASPARC on activities to address youth suicide prevention. The Director of ACDRS serves on ASPARC's Board of Directors. ACDRS continues to distribute the ACDRS-developed "Prevent Youth Suicide" brochure in both English and Spanish.

ADPH continues maintaining or linking to web pages on suicide prevention and maintaining ACDRS web pages. Information that can be obtained from the web pages on suicide prevention includes news and events concerning suicide prevention; various crisis line numbers; "Alabama Suicide Prevention 2004"; the section on suicide from the "Injury Prevention Plan of Alabama," which includes Alabama's strategy for suicide prevention; "Worried About Someone?", which lists things that an individual can do to help someone who may be at risk of suicide; and a list of ASPARC board members. According to this list, organizations or individuals having representation or membership on the board include ADPH, DMH, SDE, DHR, the Veterans Administration, 3 academic institutions providing baccalaureate and/or advanced degrees, several organizations providing crisis services, a bereavement group, a family counseling center, and a PhD-level private practitioner with a particular interest in suicide prevention and advocacy for the bereaved.

ASPARC and ACDRS are reviewing and updating both the State Suicide Prevention Plan and the "Prevent Youth Suicide" brochures.

c. Plan for the Coming Year

Population-based and Infrastructure-building:

ASPARC and ACDRS will continue efforts to prevent suicide. To briefly recap, activities that will be carried over from previous years include:

- 1) Implementation of the 13 strategies included in the State Suicide Prevention Plan.
- 2) Membership of the ACDRS Director and/or Assistant Director on ASPARC.
- 3) Maintenance of web pages on suicide and on ACDRS.
- 4) Distribution of the "Prevent Youth Suicide" brochure in English and Spanish versions.
- 5) Maintenance of a toll-free number for suicide-related crisis calls.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--|--|--|-------------|
| Annual Performance Objective | 82.3 | 83.1 | 82.1 | 83.6 | 83.7 |
| Annual Indicator | 83.5 | 82.2 | 82.1 | 85.0 | |
| Numerator | 1105 | 1076 | 953 | 967 | |
| Denominator | 1324 | 1309 | 1161 | 1138 | |
| Data Source | | Occurrent, residential live birth file | Occurrent, residential live birth file | Occurrent, residential live birth file | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 83.9 | 84.1 | 84.2 | 84.2 | 84.2 |

Notes - 2011

Data Issues:

Due to the time required to receive records and edit data, final vital statistics files for 2011 are not yet available. The preliminary reporting-year files available when the Maternal and Child Health Services Block Grant annual reports/applications are being finalized for internal review (in June of the submission year) sometimes provide misleading estimates. Therefore, the year 2011 estimate is not provided. Instead, it will be provided in July 2013.

This paragraph pertains to NPMs 17 and 18: for which both the numerators and denominators

come from statistical live birth files. Births to Alabama residents that occurred outside of the State had apparently been underreported to the ADPH for some of the years leading up to 2008. Further, key information was missing for many of the year 2008 births reported to ADPH by a neighboring state. Though the numbers of affected births may be small, failure to account for the out-of-state reporting issues may appreciably distort analyses of trends and provide misleading baselines for setting future objectives. In an effort to account for these issues, our analyses of NPMs 17 and 18 are based on occurrent events only. That is, when analyzing trends, we counted only births that occurred in Alabama to Alabama residents.

Objectives:

See this indicator's field notes for 2009 and 2010.

Notes - 2010

Data Issues:

All estimates are for calendar years and pertain to live births.

Status and Trends:

In 2010, 85.0% of very low birth weight (VLBW) occurrent, residential live births in Alabama occurred at perinatal centers, which is slightly higher (better) than any of the years shown.

For Alabama VLBW occurrent, residential live births, the percentage of births occurring at perinatal centers decreased slightly from 83.4% in 2005-2007 to 83.0% in 2008-2010: for an overall decline of 0.5% and an average annual decline of 0.2% (still comparing 3-year periods). Year-to-year trends were not consistent during the surveillance period (2005-2010). For single years during the surveillance period, the percentage of VLBW live births that occurred at a perinatal center ranged from 82.1% (953/1,161) in 2009 to 85.0% (967/1,138) in 2010 (the highest percentage recorded during the surveillance period), with a median of 83.4%.

Objectives:

Objectives through 2015 have been retained from previous years. This indicator improved slightly in 2010; however, targets have not been consistently surpassed in recent years. For this reason, we are setting the 2016 objective to match the 2015 objective. If this indicator improves in FY 2011, we will consider revising objectives upward to make them more challenging.

Notes - 2009

Trends:

In 2009 in Alabama, 82.1% of VLBW occurrent, residential live births occurred at perinatal centers. This prevalence was similar to the corresponding prevalence of 82.2% in 2008, which was slightly lower than the corresponding prevalence of 83.5% in 2007. Trends from 2000-2008 are described below.

The study population for this analysis of trends is VLBW live births that occurred in Alabama to Alabama residents, during the years 2000-2008. Among this population, the percentage of births that occurred at a perinatal center during consecutive 3-year periods was as follows: 82.6% (2,932/3,549) in 2000-02, 83.9% (2,975/3,546) in 2003-05, and 83.1% (3,195/3,847) in 2006-08.

For single years during the surveillance period, the percentage of VLBW live births that occurred at a perinatal center ranged from 80.5% (994/1,235) in 2000 to 84.9% (1,001/1,179) in 2002, with a median of 83.5% in 2007.

Trends in this indicator during the surveillance period were neither notable nor statistically significant. Specifically, statistical significance of trends in single-year percentages (over 9 years) and in 3-year percentages (over the entire 9 years and, as well, comparing 2006-08 to 2000-02 and 2006-08 to 2003-05) was assessed via Cochran-Mantel Haenszel statistics, using SAS(TM). P-values ranged from 0.3283 to 0.6383.

Objectives:

Because this indicator did not improve in 2009, the year 2015 objective was set at 84.2%, to match the year 2014 objective. If we find that this indicator notably worsened in 2010, objectives from 2012 forward will be reconsidered in FY 2012.

a. Last Year's Accomplishments

Historical Context (Infrastructure-building):

As discussed in Section III.B, the Alabama Perinatal Health Act, enacted in 1980, established the SPP and the mechanism for its operation under the direction of the State Board of Health and SPAC, with SPAC representing the RPACs. The State Committee of Public Health, which is part of the State Board of Health, typically meets on a monthly basis. Though SPAC initially met quarterly, in FY 2006 it began conducting formal business only at an annual face-to-face meeting, in order to assure the presence of a quorum.

The RPACs make recommendations to SPAC about perinatal concerns, and SPAC advises the State Health Officer on the SPP. SPP is based on the concept of regionalization of health care, a systems approach designed to ensure that pregnant women and their newborns have access to the appropriate level of care. SPP is administratively located in FHS.

By August 2002 SPP had created and filled 5 RNPC positions, 1 for each of the State's 5 perinatal regions. The RNPCs act as executive directors for the RPACs, to help the RPACs address regional perinatal issues, and serve as liaisons between SPAC and the RPACs. Activities of the RNPCs include recruiting RPAC members, working with the RPACs to revitalize the State's system of regionalized perinatal care and to develop a regional plan to address VLBW, and providing educational offerings to certain physician office groups serving Title V populations. Though some of the educational offerings do not directly pertain to whether VLBW babies are born at perinatal centers, they strengthen regional perinatal networks that influence all aspects of perinatal care.

In FYs 2008 and 2009, the RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model (explained under NPM 15), which was used to train health care professionals in the provision of preconception counseling for females of childbearing age. The focus of the preconception-counseling education was risk assessment and health promotion through medical and psychosocial interventions, which may affect whether VLBW babies are born at perinatal centers. Care for preterm infants was the focus of the infant-care education. In FY 2009, due to the redirection of their responsibilities toward FIMR, the proportion of time the RNPCs spent on these trainings was reduced to 20%. Consequently, the number of such trainings declined in 2009 relative to 2008.

FY 2011:

The following activities occurred in FY 2011.

Infrastructure-building:

Perinatal issues, including regionalization of perinatal care, were addressed by the SPP, SPAC, RPACs, and RNPCs. SPAC held its annual face-to-face meeting. Interim meetings of SPAC were held quarterly via videoconferences during which no official business was conducted.

SPP continued the statewide FIMR Program that was implemented in January 2009. The program reviewed fetal deaths that were 24 weeks gestation or greater and 500 grams or greater. In addition, staff selected for review certain infant deaths that occurred in CY 2011. Maternal and family interviews were conducted with the mothers and families who agreed to be interviewed. The RPACs served as the Case Review Teams for the FIMR Program. Community Action Teams developed and implemented plans of action to address the identified contributing factors for fetal and infant death in their communities. The SPP Director and RNPCs attended the Alabama Chapter of the AAP and ACOG meetings to encourage support of AMOD and SPP efforts. The 2009 FIMR annual report, the first FIMR annual report produced, was published.

The FIMR Program continued to be conducted by SPP staff. As well, SPP staff continued devoting 20% of their time to provision of education and training to health professionals concerning preconception health.

Each RNPC supported the Regional Perinatal Advisory Council for her assigned region. As well, each RNPC coordinated and conducted quarterly maternal-infant nurse managers' meetings in her assigned region. AMOD continued to provide supplies and educational materials for the quarterly meetings. These meetings continued building a network among perinatal providers in order to strengthen regionalization of perinatal care.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Administer the State Perinatal Program (SPP), to promote a strong system of regionalized perinatal care. | | | | X |
| 2. Convene annual meetings of the State Perinatal Advisory Council (SPAC). | | | | X |
| 3. Administer the Fetal and Infant Mortality Review (FIMR) Program, based on national FIMR guidelines, to review deaths and conduct maternal and family interviews. | | | | X |
| 4. Provide education and training to health professionals concerning preconception health. | | | | X |
| 5. Through SPP's 5 Regional Nurse Perinatal Coordinators, support SPAC and the 5 Regional Perinatal Advisory Councils. | | | | X |
| 6. As part of continued efforts to build a network among perinatal providers, conduct quarterly meetings of maternal-infant nurse managers in each perinatal region. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Infrastructure-building:

SPP continues operating under the State Board of Health and SPAC. The statewide FIMR Program continues to operate according to the national FIMR guidelines. The program is currently reviewing fetal deaths that are 24 weeks gestation or greater and 500 grams or greater, as well as selected infant deaths that occurred in CY 2011. Maternal and family interviews are being conducted.

The RPACs continue to serve as the Case Review Teams for the FIMR Program. Community Action Teams are implementing action plans based on the Case Review Teams' recommendations statewide. AMOD continues to support FIMR Program activities and to provide supplies and educational materials for the quarterly nurse managers' meetings. FIMR data are being analyzed and will be presented in an annual report.

c. Plan for the Coming Year

Infrastructure-building:

SPP activities that were conducted in FYs 2011 and 2012 will basically continue in FY 2013. These activities include: 1) the FIMR Program; 2) nurse manager quarterly meetings sponsored by AMOD; and 3) interaction of SPP staff with regional stakeholders in perinatal health to maintain and strengthen the regionalized network of perinatal care.

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

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--|--|--|-------------|
| Annual Performance Objective | 83.4 | 83.8 | 82.5 | 80.3 | 80.4 |
| Annual Indicator | 79.2 | 78.5 | 79.2 | 79.7 | |
| Numerator | 49916 | 49045 | 47855 | 46156 | |
| Denominator | 63005 | 62466 | 60396 | 57915 | |
| Data Source | | Occurrent, residential live birth file | Occurrent, residential live birth file | Occurrent, residential live birth file | |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 80.6 | 80.8 | 80.9 | 81.1 | 81.1 |

Notes - 2011

Data Issues:

Due to the time required to receive records and edit data, final vital statistics files for 2011 are not yet available. The preliminary reporting-year files available when the Maternal and Child Health Services Block Grant annual reports/applications (MCH reports/applications) are being finalized for internal review (in June of the submission year) sometimes provide misleading estimates. Therefore, the year 2011 estimate is not provided. Instead, it will be provided in July 2013.

Objectives:

See this indicator's field notes for 2009 and 2010.

Notes - 2010

Data Issues:

For all years shown, the numerator is the number reporting prenatal care as beginning during the first, second, or third month, based on the birth certificate item: "Month of Pregnancy Prenatal Care Began—First, Second, etc." Here, care received during these months is termed "early prenatal care."

For reasons discussed in the year 2011 field note for NPM 17, our analysis of NPM 18 is based on occurrent, residential events only. That is, when analyzing trends, we counted only births that occurred in Alabama to Alabama residents.

All estimates are for calendar years and pertain to live births.

Trends:

In 2010 in Alabama, 79.7% of mothers of an occurrent, residential live birth received prenatal

care beginning in the 1st trimester. Compared to 2009, this is a slight increase of 0.6%. From 2005-2010, the proportion of infants whose mother had received early prenatal care ranged from 78.5% in 2008 to 83.0% in 2005, with a median of 79.5%. See the year 2009 notes to this form for previous trends.

Objectives:

Objectives through 2015 have been retained from previous years. This indicator improved slightly in 2010 but was slightly below the target for that year. For this reason, we are setting the 2016 objective to match the 2015 objective. If the indicator begins to consistently differ from its target in the same direction, we will consider revising objectives.

Notes - 2009

Trends:

Among year 2009 live births occurring in Alabama to Alabama residents, for 79.2% of infants the mother had received early prenatal care. This prevalence is only slightly better than it had been in 2008 and the same as it had been in 2007. Trends during the years 2000-2008 are discussed below.

The study population for this analysis of trends is live births that occurred in Alabama to Alabama residents, during the years 2000-2008. Among this population, the proportion of infants whose mother had received early prenatal care during consecutive 3-year periods was as follows: 82.6% (146,396/177,341) in 2000-02, 83.6% (144,661/173,094) in 2003-05, and 79.8% (148,843/186,541) in 2006-08.

For single years during the surveillance period, the proportion of infants whose mother had received early prenatal care ranged from 78.5% (49,045/62,466) in 2008 to 84.0% (48,191/57,379) in 2004, with a median of 82.4% (50,793/61,618) in 2000. After peaking at 84.0% in 2004, this indicator declined (worsened) in each subsequent year.

The decline in this indicator during the surveillance period was statistically significant. Specifically, statistical significance of trends in single-year percentages (over 9 years) and in 3-year percentages (over the entire 9 years and, as well, comparing 2006-08 to 2000-02 and 2006-08 to 2003-05) was assessed via Cochran-Mantel-Haenszel statistics, using SAS(TM). In each case, the p-value was less than 0.0001. Comparing 2006-08 to 2003-05, this indicator declined (worsened) by 4.5%: from 83.6% in 2003-05 to 79.8% in 2006-08.

Objectives:

As has been detailed in recent MCH reports/applications, recent objectives require an annual increase of 0.2%, from a 3-year period considered to represent the year 2007 baseline. The objective for 2015 has been set to require this same rate of improvement, again from the year 2007 baseline.

a. Last Year's Accomplishments

Status and Trends:

In 2010, 79.7% of infants born alive in Alabama to Alabama residents were born to women who had received prenatal care beginning in the first trimester.

Trends in this indicator are discussed in its Form 11 notes for 2009 and 2010.

Historical Context:

Cross-cutting:

As discussed in Section III.A, by March 2005 it was determined that the private sector had the capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant women.

As also discussed in Section III.A, since initiating its current State Plan for Maternity Care, Medicaid has awarded contracts to various Primary Contractors. Under the current contracts, which became effective January 1, 2010, Medicaid contracts with 10 Primary Contractors to provide maternity services in the 14 Medicaid Districts. Effective October 2008, all Primary Contractors were encouraged by Medicaid to employ or contract with Certified Application Assistants. Effective January 2010, Medicaid began requiring the provision of these Application Assistants, who help with paperwork and conduct patient interviews. As of FY 2010, due to a State hiring freeze, the longstanding shortage of Medicaid Eligibility Workers continued, and timely Medicaid eligibility determination continued to be a challenge.

FY 2011:

Unless stated otherwise, the following occurred in FY 2011.

Direct and Enabling:

ADPH continued marginal involvement in the provision of care coordination to pregnant women. In FY 2010, 2 counties (Cullman and Mobile) provided maternity care coordination, down from 7 such counties in FY 2009.

Per Form 7, 1,631 pregnant women received Title V-funded services in CHDs in FY 2011. Because ADPH withdrew from provision of direct prenatal care in March 2005, many if not most of the services provided to pregnant women in CHD settings were presumably enabling in nature.

CHD Family Planning clients were provided information about the importance of early, continuous prenatal care.

Population-based:

FHS continued operation of a toll-free hotline that helps pregnant women access providers and provides educational materials about pregnancy.

Infrastructure-building:

The Medicaid Maternity Care Program continued. This system--mentioned under "Historical Context" and discussed in Section III.A--addressed early entry into care, referral patterns, and delivery of services.

Medicaid continued providing limited funding to doctors and hospitals for emergency delivery of women whose residence in the U.S. is not legally documented. In the absence of such coverage, due to their citizenship status, these women are not eligible for Medicaid coverage of their prenatal care.

As discussed under "Historical Context," timely determination of Medicaid eligibility has been a challenge. To address this challenge, Medicaid set up 3 Customer Service Centers to promote access to eligibility workers and allow for completion of applications by phone. The 3 centers were in Birmingham, Montgomery, and Mobile.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. In 2 counties, provide care coordination for pregnant women. | | X | | X |
| 2. Provide CHD Family Planning clients with information about the importance of early, continuous prenatal care. | | X | | X |
| 3. Operate a toll-free hotline to help women access providers and to provide educational materials about pregnancy. | | | X | |
| 4. | | | | |
| 5. | | | | |

| | | | | |
|-----|--|--|--|--|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Enabling:

Provision of information to CHD Family Planning clients about the importance of early and continuous prenatal care continues.

Population-based:

Operation of a toll-free hotline that helps pregnant women access providers and information continues.

Infrastructure-building:

Medicaid has added a Customer Service Center in Huntsville and expects to open one in Foley in FY 2012. Fourteen ADPH case managers/care coordinators who previously worked in an ADPH program for the elderly and disabled have been assigned to work in the Medicaid Customer Service Centers. These workers remain ADPH employees, but are on loan to Medicaid for an indefinite period of time.

c. Plan for the Coming Year

Direct:

As previously stated, ADPH will not provide direct prenatal care.

Enabling:

Provision of information to CHD Family Planning clients about the importance of early and continuous prenatal care will continue.

Mobile and Cullman Counties will continue subcontracting with Medicaid Primary Care Contractors to provide maternity care coordination.

Population-based:

Operation of the previously mentioned toll-free hotline will continue.

Infrastructure-building:

The Medicaid Maternity Care Program will continue.

Whether Medicaid will add Customer Service Centers is unknown at this time. With the advent of the Affordable Care Act in 2014 and the uncertainty of funding, decisions will be made about consolidation of State agencies and adjustment of services to available funding.

D. State Performance Measures

State Performance Measure 1: *The degree to which the State CSHCN Program increases access to culturally competent care coordination services for CYSHCN, including transition planning as appropriate.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------------------------------|------|------|------|------|------|
|---------------------------------------|------|------|------|------|------|

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | 7 |
| Annual Indicator | | | | 5 | 10 |
| Numerator | | | | 5 | 10 |
| Denominator | | | | 15 | 15 |
| Data Source | | | | CSHCNProgram | CSHCNProgram |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 11 | 12 | 14 | 15 | 15 |

Notes - 2011

The observed status of this indicator in 2011 comes from a measurement checklist based on CSHCN Program data. The checklist includes 5 criteria used to measure progress toward this indicator's objectives.

Notes - 2010

The observed status of this indicator in 2010 comes from a measurement checklist based on CSHCN Program data. The checklist includes 5 criteria used to measure progress toward this indicator's objectives.

This performance measure is new for the 2011-2015 Needs Assessment cycle.

a. Last Year's Accomplishments

This performance measure is new for the 2011-2015 Needs Assessment cycle.

Data Issues:

For 2011, indicator data come from a measurement checklist based on CSHCN program data. The checklist is attached.

Direct:

CRS care coordinators continued working to assure that enrolled children or youth have a comprehensive plan of care in place.

Comprehensive plans of care were completed on 4,036 of 7,457 clients.

Enabling:

CRS continued efforts to provide information regarding its Care Coordination Program to clients and their families.

8,775 clients received care coordination services, which included 2,099 new clients.

Infrastructure-building:

The report of the Care Coordination Taskforce was provided at field supervisor's meetings.

The Care Coordination Manual was completed and implemented statewide.

Care Coordination Manual training was provided to 86 nurses and social workers.

Training was evaluated using SurveyMonkey.

Of the 8 CRS districts, 7 continued to be staffed with 1 or more social work specialists who were responsible for transitioning.

Population-based:

CRS staff participated in community health fairs, resource fairs, and health screenings to identify CSHCN with hearing difficulties or scoliosis. Resource information, including CRS program

brochures, was distributed.

The Transitioning Planning Workshop was hosted by CRS and Family Voices of Alabama at 7 locations throughout the State.

An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The State CSHCN Program develops/modifies existing materials and disseminates public awareness materials on its Care Coordination Program and issues: such as cultural competence, family-centered care, medical home, and transition. | | X | | X |
| 2. These materials aid in increasing awareness and knowledge of resources available to children and youth with special health care needs (CYSHCN) and their families. | | X | | X |
| 3. The State CSHCN Program establishes and maintains a Care Coordination Taskforce to provide leadership and maintains an updated Care Coordination Manual to guide implementation of the program statewide. | | | | X |
| 4. The State CSHCN Program hosts or provides ongoing care coordination training for staff at state and local levels. | | | | X |
| 5. The CSHCN Program staff, including parent consultants, maintain a working knowledge of local resources to assist in linking and referring CYSHCN and their families to services as needed. | | X | | X |
| 6. Host or directly provide trainings and/or resource fairs for CYSHCN and their families in local communities to increase awareness and knowledge of care coordination services and other available resources. | | | X | |
| 7. Each child or youth enrolled in the State CSHCN Program is assigned to a local care coordinator (traumatic brain injury or transition care coordinator as appropriate and available). | X | | | |
| 8. Each enrolled child or youth with special health care needs has an active comprehensive plan of care in place that addresses identified needs, integration into local communities, independence, and transition planning. | X | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2012 activities described above are being continued in FY 2013 with the following exceptions or additions.

Direct:

CRS staff continue to assure that each enrolled client has a comprehensive plan of care in place.

Infrastructure-building:

CRS continues to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN.

Two care coordinators/parent consultants placed in select practice sites will continue to provide care coordination service to all CYSHCN seen at each site as part of the activities of the State Implementation Grant for Systems of Services for CYSHCN.

The Care Coordination Manual has been finalized. Care coordination training continues for new care coordinators. Updates to the manual continue.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2012.

Direct:

CRS will complete a plan of care on all enrolled clients.

Enabling:

CRS will continue to develop and/or modify materials regarding the Care Coordination Program and other related issues.

Infrastructure-building:

CRS will continue to facilitate activities under the State Implementation Grant for Systems of Services for CYSHCN to support transition planning.

CRS will develop/modify new and existing materials and disseminate public awareness materials related to the Care Coordination Program.

State Performance Measure 2: *The degree to which the State CSHCN Program promotes increased family and youth participation in policy-making.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | 8 |
| Annual Indicator | | | | 6 | 8 |
| Numerator | | | | 6 | 8 |
| Denominator | | | | 15 | 15 |
| Data Source | | | | CSHCN Progra | CSHCNProgram |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 10 | 12 | 13 | 15 | 15 |

Notes - 2011

The observed status of this indicator in 2011 comes from a measurement checklist based on CSHCN Program data. The checklist includes 5 criteria used to measure progress toward this indicator's objectives.

Notes - 2010

The observed status of this indicator in 2010 comes from a measurement checklist based on CSHCN Program data. The checklist includes 5 criteria used to measure progress toward this indicator's objectives.

This performance measure is new for the 2011-2015 Needs Assessment cycle.

a. Last Year's Accomplishments

This performance measure is new for the 2011-2015 Needs Assessment cycle.

Data Issues:

For 2011, indicator data come from a measurement checklist based on CSHCN program data. The checklist is attached.

Infrastructure-building:

A CRS parent advisory committee has met at least once in each district.

CRS continued collaborative efforts with Alabama's Family to Family Health Information Center, through local parent consultants, to provide emergency information kits to parents of CYSHCN.

The Family to Family Health Information Center's Partners in Care Summit was held. The Summit covered strengthening networks with other families and care professionals, discussed current challenges to developing quality systems of care for CYSHCN and their families in Alabama, and developed strategies to strengthen partnerships between families and professionals. Participants also gained skills and learned strategies to enhance leadership within organizations and communities.

CRS participated in a transition planning workshop for youth with disabilities and their families, which was held at several school, college, and recreation centers throughout the State.

CRS State Office Program Specialists presented at the Alabama Newborn Screening Conference, on 2nd tier follow-up screenings and hemophilia.

A youth consultant was funded through the State Implementation Grant for Systems of Services for CYSHCN.

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The CSHCN Program, in collaboration with Alabama's Family to Family Health Information Center, supports the participation of families of CYSHCN in state/local taskforces/committees, interagency meetings, and partner agency initiatives. | | | | X |
| 2. The CSHCN Program, in collaboration with Alabama's Family to Family Health Information Center, supports the participation of youth with special health care needs in the above taskforces, committees, meetings, and initiatives. | | | | X |
| 3. Such participation allows representation of the unique needs of CYSHCN and promotes a comprehensive, collaborative effort to increase their participation in policy-making. | | | | X |
| 4. The State CSHCN Program collaborates with Alabama's Family to Family Health Information Center to promote leadership development initiatives for families of CYSHCN and for youth with special health care needs. | | | | X |
| 5. The State CSHCN Program staff, including Parent Consultants, in partnership with appropriate advocacy agencies and service providers, host or directly provide training for families of CYSHCN and for youth with special health care needs. | | X | | X |
| 6. This training includes condition/disability-specific issues, | | X | | X |

| | | | | |
|--|--|---|--|---|
| special education rights, local resources, etc. to support increased knowledge and effective participation in policy-making. | | | | |
| 7. The State CSHCN Program, in collaboration with partner agencies, develops new materials, modifies existing materials, and/or disseminates resources related to the unique needs of CYSHCN, including condition/disability-specific information. | | X | | X |
| 8. Also included in the materials and resources are the core components of cultural competence, family-centered care, and care coordination to support increased knowledge and effective participation in policy-making. | | X | | X |
| 9. The CSHCN Program maintains active parent and youth advisory committees (state and local), employs parent and youth consultants, and strengthens parent to parent networks to support increased knowledge. | | | | X |
| 10. These committees, consultants, and networks also promote effective participation in policy-making by families of CYSHCN and by youth with special health care needs. | | | | X |

b. Current Activities

Infrastructure-building:

CRS will continue to facilitate activities through the State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs.

SPC, in collaboration with FVA through Alabama's Family to Family Health Information Center, provided a workshop for 80 families and professionals, as well as district staff such as care coordinators, who include nurses and social workers. Continuing education units were provided.

The CRS Parent Advisory Committee has met at least once this year.

CRS hired a youth consultant.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013. A recap and notation of activities being newly implemented follow.

Enabling:

CRS, with its partner agencies, will continue to host or directly provide training for families of CYSHCN.

CRS will continue to modify and develop materials pertinent to the unique needs of CYSHCN, to be distributed at health fairs and in clinics, schools, etc.

Infrastructure-building:

CRS will facilitate activities under the State Implementation Grant for System of Services for CYSHCN.

CRS, including the SPC, will continue to partner with FVA to coordinate trainings for CYSHCN and their families.

CRS will continue to collaborate with Alabama's Family to Family Health Information Center to provide leadership development for families of CYSHCN.

CRS will continue to develop and or modify materials and provide resources to families of CYSHCN.

CRS will continue to maintain active parent and youth advisory committees.

State Performance Measure 3: *The degree to which the State CSHCN Program promotes access to community-based services for CYSHCN and families.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | 7 |
| Annual Indicator | | | | 5 | 9 |
| Numerator | | | | 5 | 9 |
| Denominator | | | | 15 | 15 |
| Data Source | | | | CSHCNProgram | CSHCNProgram |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 10 | 11 | 13 | 15 | 15 |

Notes - 2011

For 2011-2012, indicator data from the State CSHCN Program were collected by the CSHCN staff. This performance measure is new for the 2011-2015 needs assessment cycle. A checklist measurement tool of 5 characteristics was used to measure progress toward this new objective.

Notes - 2010

For 2010-2011, indicator data from the State CSHCN Program were collected by the CSHCN staff. This performance measure is new for the 2011-2015 needs assessment cycle. A checklist measurement tool of 5 characteristics was used to measure progress toward this new objective.

a. Last Year's Accomplishments

For 2011, indicator data come from a measurement checklist based on CSHCN program data. The checklist is attached.

Infrastructure-building:

CRS staff participated in the Alabama Insurance Planning Taskforce.

CRS staff attended quarterly Medicaid meetings, MCH quarterly meetings, and the State Implementation Grant for Systems of Care for CYSHCN Advisory Committee,

CRS district staff participated in Children's Policy Council meetings held 6 times per year in all of Alabama counties.

CRS continued to provide training for families of CYSHCN. A series of transition training covering topics on community resources was held in several districts. Also, information on available resources was made available via the ADRS Facebook site. There were 685 monthly visits to the Family Voices facebook page.

CRS reviewed the 2009-2010 MCH Needs Assessment and provided district level staff with information to share with local legislatures. This was also made available on the ADRS public web site.

An attachment is included in this section. IVD_SPM3_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The State CSHCN Program staff, including Parent Consultants, participate in state and local taskforces/committees, inter-agency meetings, partner agency initiatives, and local community efforts to represent unique needs of CYSHCN. | | | | X |
| 2. Advocate for increased access to community-based services such as transportation, recreational opportunities, respite care, child care, school-based services, etc. | | X | | X |
| 3. The State CSHCN Program staff, including Parent Consultants, host or directly provide training and technical assistance for community-based organizations. | | | | X |
| 4. This training and technical assistance promote increased awareness of the unique needs of CYSHCN and their families and promote access to necessary services in local communities. | | | | X |
| 5. The State CSHCN Program staff, including Parent Consultants, host or directly provide training for families of CYSHCN and for youth with special health care needs to increase knowledge of services that may benefit them. | | | | X |
| 6. This training also allows for increased awareness of local community resources and supports and promotes effective advocacy for needed community-based services. | | | | X |
| 7. The State CSHCN Program staff, including Parent Consultants, maintain a working knowledge of local community-based resources and assist in linking or referring CYSHCN and their families to services as needed. | | X | | |
| 8. The State CSHCN Program staff, including Parent Consultants, also monitor service needs that are unable to be met in local communities and share these with appropriate policy-makers. | | | | X |
| 9. The State CSHCN Program continues to analyze the 2009-10 Needs Assessment findings to develop community-level reports and share with local policy-makers to help identify strengths, gaps, and needs for community-based services in local areas. | | | | X |
| 10. | | | | |

b. Current Activities

FY 2011 activities are being continued in FY 2012 with the following activities or exceptions.

Enabling:

CRS is currently linking families of CYSHCN affected by the recent tornadoes with available community resources.

Infrastructure-building:

CRS is facilitating activities through the State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs.

CRS participated with FVA to provide a workshop at the Family to Family Health Information Center's Partners in Care Summit. The workshop served to educate and train parents as well as health care professionals in the areas of team dynamics, health care, confidence building, and leadership. As well, the workshop brought families together to learn from each other.

CRS continues to make the 2009-10 MCH Needs Assessment Report available on ADRS's public

web site.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2013.

Enabling:

CRS will continue to link CYSHCN and their families to community-based resources.

Infrastructure-building:

CRS will participate in local taskforce/committees in an effort to meet the unique needs of CYSHCN and their families.

CRS will continue to meet with partner agencies and stakeholders to provide appropriate trainings on local community resources for CYSHCN and their families. CRS will continue to provide technical assistance to community-based organizations in order to facilitate access to services.

CRS will continue to facilitate activities through the State Implementation Grant for Systems of Services for CYSHCN: to support families and their healthcare providers through coordination and collaboration with existing agencies and organizations and provision of updated resource materials.

State Performance Measure 4: *Of children and youth enrolled in Alabama Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the percentage who received any dental service in the reporting year.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|--|--|--|--|
| Annual Performance Objective | 38.1 | 39.2 | 40.4 | 41.6 | 46.8 |
| Annual Indicator | 45.0 | 41.6 | 45.2 | 46.3 | 47.5 |
| Numerator | 226476 | 203444 | 235378 | 259193 | 279420 |
| Denominator | 503051 | 489049 | 520955 | 559430 | 588223 |
| Data Source | | CMS-416: Annual EPSDT Participation Report |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 47.3 | 47.7 | 48.2 | 48.7 | 49.2 |

Notes - 2011

The numerator and denominator for this measure come from the Alabama Medicaid Agency's (Medicaid's) "Form CMS-416: Annual EPSDT Participation Report" for Alabama, FY 2011. Per

this report, the age range is from birth through 20 years.

Status and Trends:

In FY 2011, 47.5% of Medicaid-enrolled children and youth received a dental service. Compared to FY 2010, this indicates a slight increase of 2.5%.

Comparing 3-year periods, the percentage of Alabama children and youth receiving dental services increased from 41.2% (618,395/1,501,255) in 2006-08 to 46.4% (773,991/1,668,608) in 2009-11: for an overall improvement of 12.6% and an average annual percent increase of 4.0% per year. Comparing 2011 to 2006, the average annual percent increase was 5.1%.

Trends regarding the percentage of Alabama Medicaid EPSDT enrollees who received a dental service have shown a consistent increase (improvement): from 34.0% (501,766/1,475,464) in 2003-05 to 41.2% in 2006-08 to its current 46.4% in 2009-11. Comparing estimates of 2003-05 to 2009-11, the increase represents an overall improvement of 36.4%.

Objectives:

The estimate for this indicator surpassed its objective in all of the years shown. Objectives through 2015 have been retained from previous years. The year 2016 objective has been set to require a 1.0% annual percent increase, using the 2010 baseline.

Notes - 2010

The numerator and denominator for this measure come from Medicaid's "Form CMS-416: Annual EPSDT Participation Report" for Alabama, FY 2010.

Status and Trends:

In FY 2010, 46.3% of Medicaid-enrolled children and youth received a dental service.

Over the years shown, single-year estimates for this indicator ranged from 37.0% in 2006 to 46.3% in 2010, with a median of 45.0% in 2007.

Objectives:

Using the unrounded percentage for 2010 as the baseline, objectives for 2011 forward require that this indicator increase (improve) by 1.0% per year.

Notes - 2009

The numerator and denominator for this measure come from Medicaid's "Form CMS-416: Annual EPSDT Participation Report" for Alabama, FY 2009. Per this report, the age range is from birth through 20 years.

Trends:

From 2003-2008, single-year estimates for this indicator ranged from 31.5% in 2003 to 45.2% in 2009, with a median of 37.0% in 2006. With the exception of 2008, this indicator increased (improved) every year from 2004 onward.

In 2008 the percentage of Alabama Medicaid EPSDT enrollees who received a dental service declined to 41.6%, which was 7.6% below the status (45.0%) in 2007. It is notable that, for the first time since FY 2003, the number of individuals eligible for EPSDT also declined in 2008.

Objectives:

Per the web-based Title V Information System instructions, objectives are not being updated at this time.

a. Last Year's Accomplishments

Rationale for Measure:

This measure pertains to the MCH priority need to "promote access to a dental home and to

preventive and restorative dental care for children, youth, and women of childbearing age." Oral health care is an important, but often neglected, component of total health care. Regular dental visits provide an opportunity for early diagnosis, prevention, and treatment of oral disease and conditions.

MCH Population Served: Children and youth

FY 2011:

Unless stated otherwise, the following activities occurred in FY 2011. Some of the following discussion overlaps with discussion of NPM 9, which pertains to dental sealants.

Direct:

The Jefferson and Tuscaloosa CHD dental clinics provided preventive and restorative dental services via 18,024 patient encounters at permanent sites and via mobile dental programs. Three additional CHDs provided dental services via community health center-managed dental programs. These dental clinics continued to serve at-risk children and youth who were enrolled in Medicaid or ALL Kids, as well as children with no dental insurance coverage. Sarrell Dental continued managing dental clinics at the Talladega and Coffee CHDs and opened a new dental clinic in Selma, Alabama.

Pediatric dental residents and junior and senior dental students from the School of Dentistry continued their weekly rotations through the Tuscaloosa CHD dental clinic. WIC-enrolled children continued to receive free dental screenings, and parents of WIC-enrolled children were educated regarding the importance of early and periodic dental access. Qualifying children were also provided free fluoride varnish applications.

OHB continued to support school-based dental programs as resources permitted. Free oral hygiene supplies, educational material, and other assistance were provided to these clinics as requested.

Several community health centers added dental clinics to their existing medical facilities, and 1 center added a mobile dental van to use in their community outreach activity.

Enabling, Population-based, and Infrastructure-building:

OHB staff provided dental health training presentations through quarterly Patient 1st Care Coordination Certification workshops. Care coordinators received free oral hygiene supplies and educational material to share with program recipients. Dental homes were promoted for all Medicaid-enrolled children.

Medicaid's 1st Look Program (which seeks to reduce the occurrence of early childhood caries) continued to grow. As part of this program, additional non-dental professionals were trained and certified to provide dental risk assessment, anticipatory guidance, and fluoride varnish applications to eligible Medicaid children in pediatric clinics and other programs serving children. In addition to preventing early childhood caries, a program goal is for the participating physicians and nurses to refer Medicaid-enrolled children into dental homes at an early age.

Three Alabama counties--Geneva, Greene, and Lowndes--had no active Medicaid dental providers. These are all rural counties with a combined population of over 47,000. Many families in these counties have to travel significant distances to access dental services.

For the third consecutive year, OHB partnered with ADPH's Office of Primary Care and Rural Health to recruit new dentists to underserved areas of the State. Designation of Dental Health Professional Shortage Areas (HPSAs) was updated for the State, revealing that all but 1 of Alabama's counties are Dental HPSAs, due to having low-income populations. (Shelby County and a portion of Madison County are not Dental HPSAs). A presentation was made to the School of Dentistry senior class: addressing Dental HPSAs, State and federal (National Health Service

Corps) loan repayment opportunities, and the benefits of providing dental care under Medicaid and ALL Kids.

The Interim Dental Director assumed responsibility for convening the Oral Health Coalition of Alabama and the Strategic Oral Health Team, which had previously been convened by Alabama Medicaid.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Provide oral health services in 2 county health departments (CHDs). | X | | | X |
| 2. Rotate dental students and pediatric dental residents through 1 of the above CHDs. | X | | | X |
| 3. [Three additional CHDs] provide dental services through community health center-managed dental programs. | X | | | X |
| 4. As resources permit, support school-based dental programs. | | | | X |
| 5. Provide training, oral hygiene supplies, and educational materials on oral health to CHD care coordinators. | | X | | X |
| 6. Partner with the Alabama Department of Public Health's (ADPH's) Office of Primary Care and Rural Health to increase access to dental care in Dental Health Professional Shortage Areas. | | | | X |
| 7. Convene the Oral Health Coalition of Alabama and the Strategic Oral Health Team. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

FY 2011 activities generally continue. Some updates follow.

Direct:

Sarrell Dental has opened 2 new dental clinics, located in Alex City and Tuscaloosa, Alabama. Their clinics continue to target low-income populations, including Medicaid and ALL Kids enrollees. Sarrell also provides dental screenings, education, and outreach through schools and other community programs located near their clinics. Sarrell now has 14 permanent dental clinics and 1 dental bus that travels statewide.

The School of Dentistry has added a day, funded through a HRSA Title VII Training Grant, for dental students and residents to provide services in the Tuscaloosa CHD.

Population-based and Infrastructure-building:

The previously mentioned 3 counties continue to be without active Medicaid dental providers.

The State Dental Director (who joined FHS in February 2012) and the Assistant Dental Director (who previously served as Interim Dental Director) convene the Oral Health Coalition of Alabama and the Strategic Oral Health Team. Strategies planned to energize these groups include expanding membership and updating the State Oral Health Plan to include more current goals and objectives.

Medicaid's 1st Look Program continues to grow as new non-dental providers become certified to provide oral health risk assessment and place fluoride varnish on at-risk children. Some

pediatricians and other physicians are now referring children to dental homes at a much earlier age.

c. Plan for the Coming Year

Unless previously stated otherwise, FYs 2011 and 2012 activities will basically continue in FY 2013. Some updates follow.

Direct:

Existing dental clinics operated by some CHDs, community health centers, school-based clinics, and Sarrell Dental are expected to continue. OHB will collaborate with previously mentioned stakeholders to develop strategies and seek funding opportunities for new clinic development in underserved areas of the State. The dental clinic rotation program at the Tuscaloosa CHD will continue as funding and resources permit.

Population-based and Infrastructure-building:

OHB will partner with Alabama Medicaid and with ALL Kids to promote education and awareness about oral health, enrollment of eligible children, and appropriate utilization of dental services. As resources permit, educational initiatives will continue with Head Start, CHD programs, schools, day care, and other programs serving children. Dental homes will be promoted, especially for low-income children who do not have a dental home. New dental providers will be recruited into the Medicaid and ALL Kids dental providers networks.

Periodic dental exams will continue to be promoted through all of the above initiatives, especially in programs for low-income populations. OHB will partner with programs such as Kid Check (which provides health screenings through schools), nonprofit dental programs, and private dentists in select communities to share data and expand dental services in underserved areas.

OHB will continue convening and leading the Oral Health Coalition of Alabama, in order to address oral health issues linked to access, education, awareness, data, and surveillance. The branch will promote oral health programs through new partnerships with State agencies, dental professionals, and other stakeholders. As well, OHB will continue seeking to develop oral health policy that positively impacts the oral health of Alabama residents.

State Performance Measure 5: *The percentage of 0-17 year-old children and youth who do not have a dental home.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|--|--|--|--|
| Annual Performance Objective | | | | | 43 |
| Annual Indicator | | 43.9 | 43.9 | 43.9 | 43.9 |
| Numerator | | 208788 | 208788 | 208788 | 208788 |
| Denominator | | 475600 | 475600 | 475600 | 475600 |
| Data Source | | National Survey of Children's Health, 2007 |
| Is the Data Provisional or Final? | | | | Final | Final |

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|------------------------------|------|------|------|------|------|
| Annual Performance Objective | 42.8 | 42.6 | 42.4 | 42.2 | 42 |

Notes - 2011

Data Issues:

The source for this estimate is the National Survey of Children’s Health (NSCH), 2007, which can be queried at the following web site: <http://www.nschdata.org/content/Default.aspx>. The aforesaid site is a project of the Child and Adolescent Health Measurement Initiative’s Data Resource Center for Child and Adolescent Health (Data Resource Center). The Child and Adolescent Measurement Initiative is housed at the Oregon Health and Science University. The Data Resource Center is supported via a cooperative agreement from the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. As well, the center periodically receives support from other entities for project-specific work. (The aforesaid information was retrieved from the following web address on 3/17/2011: <http://www.nschdata.org/content/AboutTheDRC.aspx>.)

The NSCH was conducted in 2003 and again in 2007. According to the Data Resource Center, NSCH 2011 is currently being conducted and findings may be released in late 2013. All estimates shown for this indicator on Form 11 are from the 2007 NSCH. We will continue using the prevalence estimate from the 2007 NSCH as our best estimate for this indicator until the next NSCH findings are made available.

The percentage shown is a weighted estimate. The denominator shown is the NSCH’s estimated number of Alabama 0-17 year-olds in 2007, after application of the sampling weights. We derived the numerator by multiplying 0.439 times the denominator.

Trends:

The 2003 NSCH also provided a prevalence estimate concerning medical homes, but the medical home items and criteria in the 2007 NSCH differed substantially from those used in the 2003 survey. The goal of changing these items and criteria for the 2007 NSCH was to align the NSCH’s medical home measure more closely with the medical home measure used in the 2005-2006 National Survey of Children with Special Health Care Needs. The year 2007 prevalence estimate for the medical home measure is discussed in this indicator’s year 2010 Form 11 field note.

Because the medical home criteria in the 2007 NSCH differed substantially from those in the 2003 NSCH, trends cannot be confidently interpreted. Therefore, the year 2003 prevalence estimate is not discussed here.

Objectives:

Where the Title V Information System requires objectives, the objective is set to require an annual decline (improvement) of 0.5%, from the year 2007 baseline. However, until another NSCH is conducted, using medical home items and criteria that are comparable to the 2007 NSCH, progress on this indicator cannot be tracked.

Notes - 2010

Data Issues:

See this indicator’s year 2011 field note. As stated there, the estimate shown is from the 2007 NSCH.

Findings:

Here, 95% confidence intervals (CIs) are shown parenthetically, following each point estimate. According to the 2007 NSCH, 43.9% (40.4-47.4%) of 0-17 year-old Alabama children and youth did not receive health care that met the survey’s definition of a medical home. This proportion

was very similar to the corresponding proportion for the U.S., which was 42.5% (CI: 41.6-43.3%).

In Alabama's 5-year needs assessment report for FYs 2009-10, the estimated prevalence of not having a medical home is discussed according to several characteristics: respectively, age, race and ethnicity, household income, insurance status, and rural versus urban residence. Highlights from that discussion follow. Assessment of statistical significance was based on comparison of 95% CIs. All the following findings pertain to Alabama children and youth and are from the 2007 NSCH.

Children and youth aged 6-17 years were significantly more likely to be without a medical home than their 0-5 year-old counterparts. That is, 33.4% (26.9-39.8%) of 0-5 year-olds, 47.7% (41.4-54.0%) of 6-11 year-olds, and 50.1% (44.8-55.4%) of 12-17 year-olds were without a medical home.

Latinos and Black non-Latinos were significantly more likely to be without a medical home than White non-Latinos were: with 58.6% (42.6-74.7%) of Latinos, 57.8% (50.7-64.9%) of Black non-Latinos, and 35.3% (31.3-39.3%) of White non-Latinos being without a medical home.

Though some comparisons between 4 income categories were not statistically significant, the lower the household income, the more likely the child did not have a medical home. Specifically, according to household income, the following percentages of children and youth did not have a medical home: 62.2% (53.8-70.6%) for incomes from 0-99% of the federal poverty level (FPL), 54.9% (47.3-62.5%) for incomes from 100-199% of the FPL, 33.8% (28.3-39.4%) for incomes from 200-399% of the FPL, and 28.8% (24.0-33.6%) for incomes at 400% of the FPL or higher.

Publicly insured children and uninsured children were significantly more likely to be without a medical home than privately insured children were: with 68.7% (54.6-82.7%) of the uninsured group, 54.2% (47.8-60.7%) of the publicly insured group, and 33.7% (29.7-37.7%) of the privately insured group not having a medical home.

The likelihood that a child lacked a medical home did not vary significantly according to rural versus urban residence.

Notes - 2009

Data Issues:

See this indicator's year 2011 field note. As stated there, the estimate shown is from the 2007 NSCH.

a. Last Year's Accomplishments

Historical Context:

The term "medical home" pertains to medical care for infants, children, and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The medical home concept was proposed by the AAP in a 1992 policy statement, which was updated in 2002. Per the AAP, a medical home is "not a building, house, or hospital, but rather an approach to providing continuous and comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day, 7 days a week, from a pediatrician or physician whom families trust" (reference 14).

The availability and nature of health insurance are important determinants of access to care. Three of the major insurers in Alabama are Medicaid, ALL Kids, and BCBS. Background on a medical home pilot study conducted by Medicaid follows.

In January 2010 Alabama Medicaid formed and convened their Medical Home Workgroup, which included representatives from ALL Kids, the Alabama Chapter of the AAP, the Alabama Academy of Family Physicians, the Medical Association of the State of Alabama, the Alabama Primary Health Care Association, the Alabama Hospital Association, the DMH, and others. FHS became

part of this workgroup in April 2010. After considering multiple models, the workgroup chose the Community Care of North Carolina Model (reference 15) as their umbrella structure for furthering and supporting medical homes.

For several years, ADPH has provided care coordination, which is one component of a medical home, under Medicaid's Patient 1st Program. Care coordination under Patient 1st is discussed in Section III.A.

FY 2011:

Crosscutting:

Of ALL Kids families sampled in FY 2011, all (40/40) reported satisfaction with availability of physicians, and 97.1% (33/34) reported satisfaction with availability of specialty physicians (reference 6).

ADPH continued providing care coordination under Medicaid's Patient 1st Program.

Infrastructure-building:

In December 2010 Alabama Medicaid released a request for proposals to establish pilot regional care networks (Care Networks) (reference 16). The geographic regions of the Care Networks were selected with stakeholder input and were to support primary medical providers, with services including quality improvement, pharmacy assistance, care management for high-risk and high-needs patients, and general medical home maturation (reference 17). Care Networks were assigned as follows, with the "Area" pertaining to Care Network areas. Area 1 (Tuscaloosa, Fayette, Pickens, Greene, Hale, and Bibb Counties) was assigned to MedNet West, Inc., Area 2 (Lee, Chambers, Tallapoosa, and Macon Counties) to Care Network of East Alabama, Inc., and Area 3 (Madison and Limestone Counties) to North Alabama Community Care, Inc. (reference 16). In May 2011 CMS provided the necessary 1915(b) waiver authority for Alabama to launch the program. Medicaid's Care Networks began circa August 2011 (reference 17). The number of Patient 1st enrollees in each Care Network area was approximately as follows: Area 1, 24,707 enrollees; Area 2, 19,561 enrollees; and Area 3, 21,835 enrollees (reference 16). (Patient 1st, Medicaid's PCCM, is discussed in Section III.A.) In addition to providing care coordination under Medicaid's Patient 1st Program, ADPH began providing care coordination upon referral from the Care Networks.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Administer ALL Kids, Alabama's Children's Health Insurance Program, which is located in ADPH's Bureau of Children's Health Insurance. | | | | X |
| 2. For ALL Kids enrollees, monitor families' satisfaction with physician availability. | | | | X |
| 3. Participate in the Medical Home Workgroup convened by Alabama Medicaid. | | | | X |
| 4. As resources permit, provide care coordination services under Alabama Medicaid's Patient 1st Program. | | | X | X |
| 5. As resources permit, provide care coordination upon referral from Alabama Medicaid's Care Networks. | | | X | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

About 40 FTE staff members working for 1 of Medicaid's 3 Care Networks have high-needs and high-risk enrollees. Further, about 135 primary medical providers are receiving enhanced payment from Medicaid to work in partnership with Care Network staff. The networks are developing initiatives around previously identified topics (high cost/high co-morbidity patients, asthma, diabetes, etc.) and topics to be defined via mutual agreement. UAB is helping Medicaid with an evaluation design for the networks. The Care Networks have hired licensed social workers or bachelor's degree-prepared nurses to provide care coordination. As well, the networks refer some clients to other organizations, including ADPH, for care coordination. ADPH has a master's degree-prepared social worker who liaises with Medicaid and the networks. The networks have made several hundred care coordination referrals to ADPH.

Medicaid is planning to establish a fourth Care Network in Mobile/Washington counties (south Alabama) and has scheduled a meeting in May 2012 with potential vendors, to identify and generate interest in these counties.

ADPH continues to provide care coordination under Medicaid's Patient 1st Program and upon referral from Medicaid's Care Networks.

c. Plan for the Coming Year

FHS will continue participating in Alabama Medicaid's Medical Home Workgroup. Contingent on sufficient resources, ADPH will continue providing care coordination under Medicaid's Patient 1st Program, as well upon referral from the Care Networks.

Evaluation of Medicaid's Care Networks will be completed in FY 2013. Key outcomes of interest for the Care Networks will include improved clinical outcomes, improved patient satisfaction, and Medicaid cost containment. Specific measures that are expected to be used include emergency department utilization for asthmatics, HbA1C measures for diabetics, inpatient hospitalization, immunization rates, and average number of office visits. However, the impact that the State's fiscal climate, discussed in Section III.A, will have on the Care Networks and on care coordination under Medicaid's Patient 1st Program is not known.

Though not discussed under "Current Activities" (due to space constraints), in FY 2012 Alabama Medicaid expects to be designated by CMS for participation in Medicaid's "Health Home" option under the ACA, which would allow for future expansion of the care network concept in Alabama. Generally, to be eligible for Health Home services, Medicaid beneficiaries must have at least 2 chronic conditions, which include asthma, diabetes, heart disease, obesity, mental condition, and substance abuse disorder; 1 chronic condition and be at risk for another; or 1 serious and persistent mental health condition (reference 18). For Alabama, however, the first criterion (2 chronic conditions) has been relaxed by CMS, so that only 1 chronic condition is required. The ACA gives the Secretary of DHHS the authority to select other chronic conditions (in addition to the previously stated ones) that may meet criteria for participation in Medicaid's Health Home program. As well, the ACA allows states to provide Health Homes services to individuals based on all of the listed chronic conditions or to target specific populations experiencing selected chronic conditions. Being designated as a participant in the Health Home program allows states a more advantageous (compared to other Medicaid programs) federal match rate of 90/10 for patients who meet the program's criteria.

ALL Kids will continue to monitor families' satisfaction with physician availability.

State Performance Measure 6: *The degree to which statewide fetal and infant mortality review (FIMR) is implemented.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | 18 |
| Annual Indicator | | | | 18 | 18 |
| Numerator | | | | 18 | 18 |
| Denominator | | | | 18 | 18 |
| Data Source | | | | FIMR Program | FIMR Program |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 18 | 18 | 18 | 18 | 18 |

Notes - 2011

Data Issues:

All scores pertain to calendar years.

The scored checklist for 2011 is attached to Section IV.D, State Performance Measure (SPM) 6, "Last Year's Accomplishments."

Components of the Total Score:

The following criteria must be met in order to achieve the maximum score of 18: 1) the presence of at least 1 infant death Case Review Team in each of the State's 5 perinatal regions, 2) the development of a statewide database framework, 3) the presence of at least 1 Community Action Team in each of the State's perinatal regions, 4) reporting by each Case Review Team to its local Community Action Team about identified community- or systems-level issues, 5) when appropriate, the addressing of identified issues through community- or systems-level actions, and 6) annual submission of data by Case Review Teams.

Trends:

In 2010 and 2011 all criteria were met. This measure received the highest score attainable, which was 18 out of 18. Therefore, the degree to which the statewide FIMR program is being implemented is currently at 100%.

Objectives:

All objectives for 2011 forward have been set at the highest possible score attainable.

Notes - 2010

Components of the Total Score:

See this indicator's year 2011 Form 11 note.

Trends:

This is a new SPM, which presents baseline data. Trends will be assessed when additional years of data become available.

Objectives:

All objectives for 2011 forward have been set at the highest possible score attainable.

a. Last Year's Accomplishments

Historical Context:

Administrative rules were written based on Code of Ala. 1975, SSSS 22-9A-21, 22-2-2(6). The rules provide administrative procedures for review of all fetal and infant deaths and for maternal and family interviews. In November 2008 administrative rules were approved for final adoption by the State Committee of Public Health. The current FIMR Program was implemented in January 2009 as a statewide initiative to address the State's high infant mortality rate, which had been 10.0 deaths per 1,000 live births in 2007. The purpose was to identify critical community strengths

and weaknesses as well as unique health and social issues associated with poor outcomes of pregnancy. Training was provided to SPP staff by the National FIMR trainers. SPP staff began collecting data on all fetal and infant deaths that occurred in CY 2009; however, due to the large number of fetal and infant deaths and the inability to review all of the deaths, the FIMR Program focused on a cohort of infant deaths for review. Neonatal deaths were chosen as the deaths that would be reviewed in 2009. SPP staff abstracted all data and conducted the maternal interview. The de-identified case summaries were presented to the Case Review Team (CRT) by SPP staff. Each RPAC assumed the role of the CRT. The RPACs met monthly, instead of quarterly, in an effort to review the large number of case summaries in a timely manner. Community Action Teams were created in each region to implement the CRT recommendations. In FY 2010, reviews focused on postneonatal deaths occurring in CY 2010.

FY 2011:

Status:

As shown on Form 11, the FIMR Program achieved a criteria-based score of 18 in FY 2011, the maximum possible score. The criteria are summarized in this indicator's Form 11 note for 2011.

Cross-cutting (Population-based and Infrastructure-building):

FIMR activities are generally infrastructure-building in nature. However, since Community Action Teams develop and implement plans of action, some of their activities may be population-based (focusing on a local population) in nature.

SPP continued to conduct FIMR activities statewide. Reviews of the CY 2010 collected cases that were not completed in FY 2010 were completed in FY 2011. As well, data were collected on fetal deaths 24 weeks gestation or greater and 500 grams or more that occurred in CY 2011. CRTs met face-to-face at least quarterly to review findings from FIMR data. Maternal and family interviews were conducted. A new Community Action Team was created in Perinatal Region 3, which makes a total of 8 active Community Action Teams. Recommendations were presented to the 8 Community Action Teams, who developed and began to implement plans. Medicaid and AMOD partnered with SPP to support FIMR activities.

An attachment is included in this section. IVD_SPM6_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Ensure presence of at least 1 infant death Case Review Team (CRT) and Community Action Team in each of the State's 5 perinatal regions. | | | | X |
| 2. [The CRTs] review infant death cases and make recommendations to the Community Action Teams about community-level or systems-level issues. | | | | X |
| 3. Based on recommendations from the CRTs, [the Community Action Teams] develop and implement community-level or systems-level plans to address infant mortality. | | | X | X |
| 4. Collect data on selected fetal and infant deaths. | | | | X |
| 5. At least quarterly, convene meetings of the CRTs to review findings from FIMR data. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Cross-cutting (Population-based and Infrastructure-building):
 FY 2011 activities are generally expected to continue through FY 2012. Recaps or updates follow.

Medicaid and AMOD continue to partner with SPP to support FIMR activities. Review of the remaining CY 2011 collected cases will be completed in FY 2012.

Concerning CY 2012 deaths, data are being collected for selected infant deaths. CRTs continue to meet face-to-face at least quarterly to review FIMR findings. Maternal and family interviews are being conducted. Recommendations will be presented to the 8 Community Action Teams, who are implementing plans to address issues identified.

c. Plan for the Coming Year

Cross-cutting (Population-based and Infrastructure-building):
 FY 2012 activities are generally expected to continue in FY 2013. Recaps and updates follow.

Review of collected cases of CY 2012 deaths that were not completed in FY 2012 will be completed in FY 2013. As well, the next cohort population to review will be determined. CRTs will continue to meet face-to-face at least quarterly to review findings from FIMR data. Maternal and family interviews will be conducted. Recommendations will be presented to the 8 Community Action Teams, who will implement plans to address issues identified. Medicaid and AMOD will continue to partner with SPP to support FIMR activities.

State Performance Measure 7: *The degree to which the Bureau of Family Health Services promotes a positive youth development model.*

Tracking Performance Measures

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

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 12 |
| Annual Indicator | | | | 12 | 13 |
| Numerator | | | | 12 | 13 |
| Denominator | | | | 15 | 15 |
| Data Source | | | | FHS Program | FHS Program |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 12 | 13 | 15 | 15 | 15 |

Notes - 2011

All scores pertain to calendar years.

The scored checklist for 2011 is attached to Section IV.D, State Performance Measure (SPM) 7, "Last Year's Accomplishments."

Components of the Total Score:

The 5 components document a system that promotes a positive youth development model to reduce high risk behaviors in adolescence.

The following criteria must be met in order to achieve the maximum score of 15: 1) the Bureau will seek grants, cooperative agreements, and other funding opportunities to implement evidence-based models of positive youth development that have demonstrated a reduction in youth risk behaviors; 2) the Bureau will promote public awareness of positive youth development principles

with its state and community partners through its newsletters, web pages, brochures, educational materials, presentations, and training sessions; 3) the Bureau will sponsor a statewide conference on adolescent health at least biannually that offers continuing education to professionals that serve youth and highlights evidence-based positive youth development models that have demonstrated a reduction in youth risk behaviors; 4) the Bureau will develop, publish, and maintain web and social media pages for adolescents and their families that promote positive youth development; and 5) the Department's Youth Advisory Council will work cooperatively to integrate positive youth development into the Department's initiatives related to tobacco usage, alcohol consumption, suicide prevention, injury prevention, and teenage pregnancy prevention.

Trends:

This measure was rated at 12 in 2010 and 13 in 2011. The year 2011 score slightly surpasses the objective for that year.

Objectives:

Objectives through 2015 have been retained from previous years. The year 2016 objective was set at 15, which is based on anticipated progress concerning the 5 criteria for this measure.

Notes - 2010

Components of the Total Score:

See this indicator's year 2011 Form 11 note.

Trends:

This is a new SPM, which presents baseline data for 2010.

Objectives:

Objectives were set based on anticipated progress concerning the 5 criteria for this measure.

a. Last Year's Accomplishments

Unless stated otherwise, the following activities occurred in FY 2011.

Infrastructure-building:

Due to funding limitations, the AHP was incorporated as a component of the Children's Health Division's newly created Teen Pregnancy Prevention Branch. The branch continued to promote positive youth development mainly through 2 programs, AAEP and APREP, which are discussed under NPM 8. As stated there, AAEP receives Title V funding for Abstinence Education. APREP is funded through Personal Responsibility Education Program (PREP) funding, administered by DHHS's Administration for Children and Families.

AAEP emphasized positive youth development through the training and utilization of teen leaders as peer role models for younger teens. APREP promoted positive youth development through the use of adulthood preparation curriculum. The Teen Pregnancy Prevention Branch provided training for sub-grantees on evidence-based curriculum. In September 2011 a reproductive health summit was provided for sub-grantees of AAEP and APREP, as well as other community organizations and providers. The Youth Advisory Council that the Teen Pregnancy Branch hosts continued to meet on a quarterly basis. Though the Adolescent Health newsletter was discontinued in April 2011 due to staffing constraints, positive youth development is highlighted on the branch's web page.

An attachment is included in this section. IVD_SPM7_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Promote positive youth development mainly through 2 programs: the Alabama Abstinence-Until-Marriage Education | | | X | X |

| | | | | |
|--|--|--|---|---|
| Program (AAEP) and the Alabama Personal Responsibility Education Program (APREP). | | | | |
| 2. As part of AAEP, emphasize positive youth development through the training and utilization of teen leaders as peer role models for younger teens. | | | X | X |
| 3. As part of APREP, promote positive youth development through the use of adult preparation curriculum. | | | X | X |
| 4. Provide training on evidence-based curriculum for sub-grantees operating under AAEP or APREP. | | | | X |
| 5. Host ADPH's Youth Advisory Council, which meets quarterly. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Infrastructure-building:

Through AAEP, the Teen Pregnancy Prevention Branch has channeled federal funding to 4 organizations to serve youth in 22 counties. Funded organizations are required to use the teen leader model to the extent possible. Technical assistance is provided to build capacity for this model and future youth development opportunities. Projects provide outreach training to parents on the influence of media on youth.

Federal funding has been channeled to 3 organizations through APREP, to provide evidence-based programming to high risk youth 15-19 years of age in 3 of the State's largest counties. Funded organizations are collaborating with other organizations to identify and reach youth most at risk of teen pregnancy or sexually transmitted infections.

The Teen Pregnancy Prevention Branch is seeking opportunities to collaborate with other evidence-based projects throughout the State, including the PREP-funded tribal organization. The branch's web page has been updated to make information about Abstinence- and PREP-funded projects available and includes information on adolescent health and positive youth development.

The branch is unable to cosponsor the annual Teen Pregnancy Prevention Conference due to scheduling conflicts with national grant meetings; but professional development training on adolescent health is being planned. The Youth Advisory Council hosted by the branch continues to meet.

c. Plan for the Coming Year

Infrastructure-building:

The Teen Pregnancy Prevention Branch will continue seeking additional funding opportunities to support positive youth development. The branch's adolescent health coordinator will provide presentations on adolescent brain development concepts and positive youth development to organizations and community partners. The branch will partner with other entities to cosponsor the annual statewide Teen Pregnancy Prevention Conference. As well, the branch will continue adding resources concerning positive youth development to its web page, as the resources become available. Additionally, the branch will continue to convene the Youth Advisory Council.

E. Health Status Indicators

HEALTH STATUS INDICATOR (HSI) 2B: THE PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 1,500 GRAMS

Status and Trends:

This indicator, which pertains to Alabama occurrent, residential live births, increased slightly: from 1.53% in 2009 to 1.54% in 2010. For single years during 2006-2010, the proportion of singleton infants who were VLBW (or less than 1,500 grams) ranged from 1.53% in 2009 to 1.66% in 2008, with a median of 1.60% in 2006. Data issues affecting this indicator are discussed under form notes concerning HSI 1A.

Relevance to MCH Planning:

VLBW is a strong predictor of infant death.

Activities, Strategies, and Developments:

SPAC and FIMR seek to promote positive pregnancy outcomes, including but not limited to optimum birth weight.

SPAC

The objectives of SPAC, some of which address risk markers for VLBW, are to:

- 1) Reduce the number of pregnancies leading to birth intervals of less than 2 years.
- 2) Decrease the percentage of women who smoke during pregnancy.
- 3) Reduce the number of pregnancies among females 17 years old and younger.
- 4) Implement public awareness and provider education activities on the importance of preconceptional health.
- 5) Increase the breastfeeding rate, both for initiation and duration, to reflect AAP guidelines and Healthy People 2010 objectives.

FIMR

FIMR informs strategies designed to positively impact pregnancy outcomes, of which birth weight is one. The main purpose of Alabama's first statewide use of the FIMR model, implemented in FY 2004, was to identify barriers that might prevent VLBW babies from being born at a perinatal center. Deaths of 61 VLBW infants who died in 2002 were reviewed. These deaths were divided into 2 groups, those born at a perinatal center and those born elsewhere. Results of the reviews were identification of issues surrounding the pregnancies, plus recommendations from the CRTs to positively impact such pregnancies and births. A brief summary of these recommendations follows.

All 5 CRTs agreed that few of the deaths of VLBW infants were preventable in terms of medical and hospital care given at delivery or, subsequently, during hospitalization. However, each team identified issues surrounding the pregnancies that could be addressed through actions or strengthening of the health care system. Salient recommendations about VLBW infants, made by the RPACs, pertained to: 1) improvement of risk assessment procedures, 2) provision of preconceptional counseling, 3) improvement of social services referrals, and 4) further strengthening of the system of regionalized perinatal care.

A statewide FIMR program that is based on the ACOG model was implemented in FY 2009. This program is discussed under SPM 6.

HSI 3A: THE DEATH RATE PER 100,000 DUE TO UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

Status and Trends:

In 2010, the estimated death rate due to unintentional injuries among Alabama residents aged 14 years and younger was 11.9 deaths per 100,000 persons in this age group.

Reported as the number of deaths due to unintentional injuries per 100,000 0-14 year olds, from 2006-2010 this estimate ranged from 11.0 deaths per 100,000 in 2008 to 13.8 deaths per 100,000 in 2006, with a median of 11.6 deaths per 100,000 in 2007. As discussed in a Form 20 field note for this indicator, the U.S. Census population count for 2010 may not be comparable to population estimates for the several preceding years. Therefore, the estimated rate for 2010 may not be comparable to estimated rates for earlier years.

Relevance to MCH Planning:

Unintentional injuries are a major cause of death and morbidity in children and youth.

Activities, Strategies, and Developments:

ADPH addresses unintentional injuries through ACDRS, the Injury Prevention Branch, and the Pharmacy Division. Brief discussion of each of these follows.

ACDRS

As discussed in Section III.A, legislation creating ACDRS was enacted in 1997 and established a mandate to review all unexpected/unexplained deaths of children in Alabama from birth through 17 years. ACDRS was located in FHS until FY 2011, when it was relocated to HPCD. ACDRS posts several pages on ADPH's web site. Information that can be obtained or linked to from these pages includes the following: a description of how medical examiners classify manner of death, detailed guidelines for local child death review teams, instructions for completing a case report, a list of State Child Death Review Team members, a list of recommendations that have been provided to the Governor, and a list of publications. Individuals and Alabama organizations having membership or representation on the State Child Death Review Team include ADPH, the Jefferson County Coroner and Medical Examiner, the Sheriff's Association, the Department of Forensic Sciences, DHR, DMH, the Department of Public Safety, the Academy of Family Physicians, the Coroner's Association, the District Attorney's Association, the Association of Chiefs of Police, the Senate Health Committee, the House Health Committee, the Medical Association, and several private citizens appointed by the Governor.

Publications produced by ACDRS over the years have addressed the following topics: teen driver safety awareness and education (discussed under HSI 3C), enhancements to the Graduated Driver's License law (also discussed under HSI 3C), prohibition of distracting electronic devices while driving, improved child passenger safety restraint requirements, improved all-terrain vehicle safety regulations, prohibition of truck bed passengers, education on safe infant bedding and practices, awareness of infant bed-sharing dangers, improved infant death scene investigations, increased use of smoke alarms and carbon monoxide detectors, improved access to health care, improved day care safety rules, and improved swimming area safety.

ACDRS successes include the following State legislation that has been passed into law: "Safe Place for Newborn's Law" (2000), Graduated Driver's License legislation (2002, enhanced in 2010), "Baby Douglas" Day Care Medication legislation (2004), and Child Passenger Safety legislation (2006). Graduated Driver's License legislation is discussed under HSI 3C and Child Passenger Safety legislation under NPM 10.

The Safe Place for Newborn's Law is intended to prevent abandonment of newborns and authorizes an "emergency medical services provider" to take possession of a child who is 72 hours or younger in age if the child is voluntarily delivered by the parent and the parent did not express an intent to return for the child. (Per the law, an emergency medical provider is a licensed hospital, per specified legislative code, that operates an emergency department.) As well, the law provides for an affirmative defense to prosecution if the parent voluntarily delivers the child in accordance with the legislation.

The Baby Douglas law was inspired by the death of a child who had apparently been given cold medication at a day care center. The law makes it a crime for workers to give medication to a child with intent to drug the child or alter the child's behavior beyond what is medically prescribed.

ACDRS is further discussed under NPM 10.

The Injury Prevention Branch

ADPH addresses injuries, regardless of age or intentionality, through HPCD's Injury Prevention Branch. This branch's web-posted material includes information about national observances such as the following: Burn Awareness Week, National Poison Prevention Week, National Safe Kids Week, National Bike Month, Recreational Water Illness and Injury Prevention Week, Home Safety Month, National ASK Day (which pertains to parents' awareness of children's access to firearms in the home), Lightening Safety Week, Fireworks Safety Months, National Fire Prevention Week, Safe Toys and Gifts Month, and National Drunk and Drugged Driving Prevention Month. As well, the branch's web-posted material includes or links to a variety of brochures or reports on such topics as fire safety, including information on the Alabama Smoke Alarm Initiative (discussed below); bicycle safety and holiday and toy-related safety; prevention of falls in children; and prevention of poisoning and drowning. (Postings on motor vehicle safety are discussed under NPM 10 and HSI 3C; those on suicide prevention are discussed under NPM 16.) Additionally, the Injury Prevention Branch's web postings include information about the Injury Advisory Council, which advises the branch. Entities initially represented on the council included the State's Department of Economic and Community Affairs, the UAB Injury Control Research Center, SDE, the State's Department of Public Safety, ADPH's Behavior Risk Factor Surveillance System Program (operated via a cooperative agreement with CDC), ADPH's CHS, and others.

According to the Injury Prevention Branch, Alabama ranks among the top 10 states in terms of fire deaths and injuries. The Alabama Smoke Alarm Initiative was created to reduce the occurrence of these events by reaching at-risk communities with fire safety education and installation of smoke alarms at no cost to homeowners. This initiative is administered by ADPH in conjunction with the State Fire Marshal's Office and is funded by CDC. Communities considered to be at risk are those with high fire fatality rates, high poverty rates, and low population density. ADPH and the State Fire Marshal's Office partner with local fire departments in high risk areas to implement the initiative. Fire departments chosen to participate agree to conduct door-to-door home visits in their respective service areas, to provide home fire safety education and install free smoke alarms. Since October 2001 the Alabama Smoke Alarm Initiative has worked with 36 fire departments in 21 Alabama counties. As of March 1, 2010, more than 8,000 smoke alarms had been installed, and it was estimated that 77 lives had been saved by the initiative.

Pharmacy Division

ADPH's Pharmacy Division, located in the Bureau of Professional and Support Services, addresses drug-related adverse outcomes in all age groups in a number of ways. For example, the division implements the PDMP: which is designed to detect diversion, abuse, and misuse of prescription medications classified as controlled substances under the Alabama Uniform Controlled Substances Act. PDMP's web postings raise awareness about the dangers and illegality of sharing prescription medications with others, including but not limited to youth. The program's home page shows sequential photos of 6 individuals (who are diverse with respect to age, sex, and race) and asks what a drug dealer looks like, saying that the answer may be surprising. PDMP is further discussed in Section II.C, since ongoing needs assessment is focusing on drug poisoning deaths in persons from 18-44 years of age.

HSI 3B: THE DEATH RATE PER 100,000 FOR UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER DUE TO MOTOR VEHICLE CRASHES

Status and Trends:

In 2010, the estimated motor vehicle crash death rate (excluding injuries known to be intentional) among Alabama residents aged 14 years and younger was 4.7 deaths per 100,000 persons in

this age group. For single years during the surveillance period of 2006-2010, this rate ranged from 3.7 deaths per 100,000 in 2007 to 6.6 deaths per 100,000 in 2006, with a mode of 4.6 deaths per 100,000 in 2008 and 2009.

Relevance to MCH Planning:

Motor vehicle crashes are a notable cause of death and morbidity in children and youth.

Activities, Strategies, and Developments:

ADPH chiefly addresses injury prevention through HPCD's Behavioral Health Division, which includes the Injury Prevention Branch and the ACDRS. Activities of the Injury Prevention Branch are discussed under HSI 3A. Activities of ACDRS are discussed in several places in this report/application. The following information pertains specifically to measures that are intended to prevent injuries caused by motor vehicle crashes. As discussed in Section III.C, ACDRS was administratively relocated from FHS to HPCD's Health Behavior Division in FY 2011.

As stated under HSI 3A, the Injury Prevention Branch's web page includes information about the following national observances: Click It or Ticket Mobilization Dates (which concerns child restraints and seat belts), Child Passenger Safety Week, and National Drunk and Drugged Driving Prevention Month. As well, the following documents concerning motor vehicle injuries are posted on the web page: "Booster Seats: Keep Alabama's Kids Safe," "2007 Child Restraint Fact Sheet," "Safety Belts: Buckle Up Alabama!", "Seat Belt Safety Activity Book," and "2008 Occupant Restraint Survey Results."

The following findings pertain to 0-5 year-old Alabama children and are based on observational surveys at selected sites, where the sites are selected to provide a study population that resembles the statewide population. According to the 2009 Occupant Restraint Survey, of the observed 0-5 year-old passengers, about 95% (2,552/2,689) were restrained: the highest level of child-restraint usage from 1981 forward. (We are not aware of any estimates for years prior to 1981.) According to the 2010 Occupant Restraint Survey, child restraint usage was at about 93% (2,844/3,054).

Key legislative events designed to reduce the occurrence of motor vehicle crash injuries in Alabama have included the Alabama Graduated License legislation, recent amendments to strengthen this graduated licensure legislation, and amendments to strengthen previous legislation concerning child safety restraints. These laws are discussed under NPM 10. Also discussed under NPM 10 is the Booster Seat Advocacy Program, which is jointly conducted by ADPH, under the leadership of the Injury Prevention Branch, and the Southeast Child Safety Institute. The purpose of this program is to educate Alabama residents about legislation concerning child safety restraints.

HSI 3C: THE DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS.

Status and Trends:

In 2010, the estimated death rate due to motor vehicle crash injuries among 15-24 year-old Alabama residents was 27.3 deaths per 100,000 persons in this age group.

Reported as the number of deaths due to motor vehicle crash injuries per 100,000 15-24 year olds, from 2006-2010 this indicator ranged from 27.3 deaths per 100,000 in 2010 to 48.3 deaths per 100,000 in 2006, with a median of 39.0 deaths per 100,000 in 2008. The indicator declined (improved) in each of the last 4 years for which data are available. As discussed in a Form 20 note for this indicator, the U.S. Census population count for 2010 may not be comparable to population estimates for the several preceding years. Nevertheless, as detailed in the Form 20 note, most of the improvement in this rate is presumably real.

Relevance to MCH Planning:

Motor vehicle crashes are a major cause of death and morbidity in youth and young adults.

Activities, Strategies, and Developments:

Various activities intended to prevent injuries due to motor vehicle crashes, with a focus on injuries occurring in childhood, are discussed under NPM 10. The following discussion focuses on issues concerning teen drivers.

Alabama's graduated driver's licensure law took effect in October 2002. Under this law, restrictions apply to 16-year-old drivers and to 17-year-old drivers who have been licensed for less than 6 months. Except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent or guardian, a licensed adult driver. Originally, restricted drivers could not have more than 4 passengers, not counting their parents, in the car.

A bill to enhance Alabama's graduated driver's license law passed and was signed into law in 2010. The changes included defining the 3 tiers of the licensing process, limiting the number of non-family passengers to 1, adding a hunting and fishing exception to the restricted driving hours, and prohibiting the use of nonessential electronic devices while driving (not in the original law). All other restrictions and exceptions of the original law remained intact.

In FY 2010, ACDRS conducted a multipronged teen driver safety campaign that included multimedia promotion, creation of a new teen driving web page (www.adph.org/teendriving), and development of an educational brochure entitled "Surviving Teen Driving." In FY 2011, ACDRS extended its teen driver safety campaign and arranged for the "Surviving Teen Driving" brochure to be placed at all driver's license testing and issuance centers throughout the State, for distribution to the general public. This brochure, which can be accessed from the aforesaid web page, highlights and discusses 3 risk factors for motor vehicle crash injuries where a teen is driving: alcohol use, lack of seat belt use, and distractions. With respect to alcohol, the brochure states that alcohol and driving never mix. With respect to seat belts, it states that seat belts are the single best prevention measure for driver safety, but that teen drivers are least likely to use them. With respect to distractions, it states that other passengers are the biggest distraction, but that new studies show the danger of distracting electronic devices.

HSI 5A: THE RATE PER 1,000 WOMEN AGED 15 THROUGH 19 YEARS WITH A REPORTED CASE OF CHLAMYDIA.

Status:

In 2011, the reported chlamydia case rate among 15-19 year-old Alabama females was 49.8 cases per 1,000 females in this age group, slightly higher than in 2010. Trends are discussed in the Form 20 notes corresponding to this indicator.

Relevance to MCH Planning:

Chlamydia (along with gonorrhea, syphilis, and HIV) is one of the most frequently reported STDs within the State (reference 19). Rates of chlamydia are highest among adolescents and young adults (reference 20). ADPH's Division of STD Prevention, located in the Bureau of Communicable Disease, is charged with identifying populations at increased risk for STDs. Further, one of the State's MCH priorities is to promote positive youth development and reduce high risk behaviors in adolescents. Reducing the prevalence of high risk sexual behaviors in adolescents should reduce the prevalence of STDs in adolescents. As well, FHS administers programs intended to collectively promote abstinence and personal responsibility in adolescents; success in these efforts should reduce the prevalence of STDs in the populations served.

Activities, Strategies, and Developments:

FHS's Children's Health Division administers AAEP and APREP, which respectively focus on promotion of abstinence in adolescents and promotion of personal responsibility in adolescents. APREP curriculum includes decision making skills, STD information, and instruction regarding

condom usage. These programs are discussed under NPM 8. Additionally, the division's Adolescent Pregnancy Prevention Branch seeks to promote a positive youth development model, as discussed under SPM 7.

Screening for chlamydia in sexually active adolescents is critical to ascertaining and reducing the prevalence of chlamydia in this population. ALL Kids' annual report for FY 2011 (reference 6) includes the following indicator: "Percentage of 16-20 year old females who were identified as sexually active and who had at least one test for Chlamydia during the measurement year." For ALL Kids, this indicator was reported as being at 21.8% (577/2,643) in FY 2010 and 32.4% (1,035/3,198) in FY 2011. (Note: For this indicator, for each year, the denominator is the number of 16-20 year-old females who were enrolled in ALL Kids and identified as being sexually active. Presumably, virtually all of those counted in the numerator and denominator were 16-18 years old, since ALL Kids does not enroll persons older than 18 years of age.)

Note that, per the preceding ALL Kids indicator, the number of 16-20 year-old ALL Kids females who were screened for chlamydia increased markedly: from 577 in FY 2010 to 1,035 in FY 2011. For any condition, changes in screening practices can cause ascertainment bias.

HSI 6: INFANTS AND CHILDREN AGED 0 THROUGH 24 YEARS ENUMERATED BY SUB-POPULATIONS OF AGE GROUP AND RACE (HSI 6A) AND HISPANIC ETHNICITY (HSI 6B)

Relevance to MCH Planning:

Awareness of overall demographic characteristics, as well as the characteristics of Title V-served populations, is relevant to the development of culturally competent services.

Background:

Census counts for the year 2010 are shown on Form 21 for HSIs 6A and 6B. However, these counts may not be comparable to Census population estimates for earlier years, mainly for 2 reasons. First, the currently available year 2010 Census numbers are counts, rather than estimates. Second, population estimates may become unreliable several years from the preceding Census count (e.g., circa 2006-2009). Therefore, the discussion below does not mention the year 2010 Census counts. Instead, it focuses on comparing 2008 to 2000 and then on comparing 2009 to 2008: first according to race (HSI 6A) and then according to ethnicity (HSI 6B). Should Census estimates for 2010 become available by early FY 2013, the MCH 2012 Report/2014 Application will include discussion of 2010 U.S. Census estimates for Alabama.

Trends According to Race, 2008 Versus 2000 (HSI 6A):

The following discussion compares Census population estimates for the year 2008 to Census population estimates for the year 2000. This discussion focuses on the total population of 0-24 year-old Alabama residents and on subgroups defined by race. In this discussion, races other than White or Black are combined into an "Other" category. The discussion below is drawn from the Needs Assessment Report, which provides somewhat more detail, including tables, on the changes discussed below.

In 2008, 1,572,695 persons from 0-24 years of age lived in Alabama: up 0.6% from the corresponding number in 2000. Among this group in 2008, 65.3% were White, 31.4% Black, and 3.3% of Other or more than 1 race. Further breaking down the "of Other or more than one race" group, of the total population of 0-24 year-old residents in 2008, 1.73% were of more than 1 race; and 0.96% were Asian, 0.54% American Indian or Native Alaskan, and 0.05% Native Hawaiian or other Pacific Islander.

Comparing 2008 to 2000, the number of 0-24 year-old Alabama residents increased, though sometimes very slightly, among the total population and among Whites, Asians, Hawaiians or Pacific Islanders, and persons of 2 or more races. The most striking increases were in the number of Asians (up by 26.1%, or by 3,129 individuals) and the number of persons who were of 2 or more races (up by 50.7%, or by 9,152 individuals). Conversely, the number of Black 0-24

year-old residents and the number of American Indian or Native Alaskan 0-24 year-old residents declined slightly. The increase in the number of 0-24 year-old Asians is credible, since a large Korean automotive manufacturer established a presence in the State early in the decade that began with the year 2000. Conjecturally, potential changes in self-reporting practices (by the head of household or the individual) may partly account for the increase in persons of 2 or more races. As a corollary, the decline in the number of individuals with a reported race of Black or of American Indian or Native Alaskan may be at least partly due to changes in reporting practices.

Trends According to Race, 2009 Versus 2008 (HSI 6A):

In 2009, 1,594,113 persons from 0-24 years of age lived in Alabama: up 1.36% from 2008. The composition of this group in 2009 was as follows: 65.4% were White, 31.1% were Black, and 3.5% were of "Other or more than one race." Further analyzing the "Other or more than one race" group, of the total population of 0-24 year-old residents in 2009, 1.82% were of more than 1 race; 1.12% were Asian; 0.51% were American Indian or Native Alaskan; and 0.06% were Native Hawaiian or other Pacific Islander.

When comparing the number of 0-24 year-old Alabama residents in 2009 to 2008, some differences were observed. The increase in the number of 0-24 year-old Asians was again notable (up 18.2%, or by 2,757 persons in 2009). With respect to slight increases in this age group in 2009, the number of White residents increased by 1.5% (or by 14,898 persons), the number of Black residents by 0.4% (or by 2,102 persons), and the number of residents who were of 1 or more races by 6.6% (or by 1,793 persons).

Trends According to Ethnicity, 2008 Versus 2000 (HSI 6B):

The following discussion compares Census population estimates for the year 2008 to Census population estimates for the year 2000. This discussion provides information concerning groups concurrently stratified by race and ethnicity, as well as on Latino residents. All discussion here pertains to 0-24 year-old Alabama residents. In this discussion, races other than White or Black are combined into an "Other" category. The discussion below is drawn from the Needs Assessment Report, which provides somewhat more detail, including tables, on the changes discussed below.

Among 0-24 year-old Alabama residents in 2008, 4.3% were Latino, up from 2.5% in 2000. Comparing 2008 to 2000, the number of Latino residents increased by 76.4%.

Stratifying concurrently by race and ethnicity, among the 1.6 million 0-24 year-old Alabama residents in 2008, 61.5% were White non-Latino (down from 63.4% in 2000), 31.1% Black non-Latino (down from 31.7% in 2000), 3.8% White Latino (up from 2.1% in 2000), and 3.1% Other non-Latino (up from 2.4% in 2000).

Comparing 0-24 year-old Alabama residents in 2008 to those in 2000, the number of White, non-Latino residents declined by 2.4 percent: from 991,137 in 2000 to 967,579 in 2008. Conversely, the number of White, Latino residents increased by 83.9%: from 32,715 in 2000 to 60,153 in 2008. Concerning the number of individual residents in this age group, compared to 2000, in 2008 there were 23,558 fewer White, non-Latino residents and 27,438 additional White, Latino residents.

Again comparing 0-24 year-old Alabama residents in 2008 to those in 2000, the number of Black, non-Latino residents declined by 1.5%: from 496,495 in 2000 to 489,112 in 2008. Concerning the number of individual residents in this age group, compared to 2000, in 2008 there were 7,383 fewer Black non-Latino residents.

Also comparing 0-24 year-old Alabama residents in 2008 to those in 2000, the number of Other, non-Latino residents increased by 27.1%: from 38,056 in 2000 to 48,373 in 2008. Concerning the number of individual residents, compared to 2000, in 2008 there were 10,317 additional Other, non-Latino residents.

Trends According to Ethnicity, 2009 Versus 2008 (HSI 6B):

Among 0-24 year-old Alabama residents in 2009, 5.1% were Latino, up 19.2% (or by 12,994 persons) from 2008. There were 80,625 Latino residents between the ages of 0-24 in Alabama in 2009.

HSI 7: LIVE BIRTHS TO WOMEN (OF ALL AGES) ENUMERATED BY MATERNAL AGE AND RACE (HSI 7A) AND ETHNICITY (HSI 7B)

Relevance to MCH Planning:

Awareness of the demographic characteristics of all live births, as well as the characteristics of Title V-served infants, is relevant to the development of culturally competent services. The following discussion compares 2008 to 2000 first, 2009 to 2008 second, and 2010 to 2009 third. Then, a brief recap of trends according to ethnicity is presented.

Live Birth Demographics in 2008 Versus 2000:

HSIs 7A and 7B enumerate year 2010 live births according to maternal age and, respectively, race and ethnicity of the mother. However, as part of the 2009-10 Needs Assessment, we combined racial groups other than White or Black into an Other-race category, concurrently classified infants according to race and ethnicity, and combined maternal ages into 3 categories. Findings from these analyses are detailed in Section 3 of the Needs Assessment Report. Highlights from these findings follow. In addition to combining racial and age groups and concurrently stratifying according to race and ethnicity, we included infants whose mother's age was not reported. Therefore, discussion here does not necessarily correspond to numbers shown on Form 21 in any of the MCH Reports/Applications.

Concurrently classifying infants by race and ethnicity, of the 64,345 infants born in 2008, 59.2% were White non-Latinos, 30.7% Black non-Latinos, 7.4% White Latinos, 1.8% non-Latinos of Other races, and 0.7% Latinos of Other races. Only 22 (0.0%) of the infants were Black Latinos, and 58 (0.1%) of the infants were of unknown race and/or ethnicity.

Due to a reporting problem concerning out-of-state births, the number of births for which maternal age was unknown increased dramatically in 2008 relative to 2000. However, even when excluding records with unknown maternal age, the percentage of live-born infants whose mother was an adolescent (here, either less than or equal to 17 years, or 18-19 years of age) did not increase in 2008 relative to 2000.

Based on maternal ethnicity and race, comparing 2008 to 2000:

- 1) The number of Latino infants increased 2.7-fold: from 1,931 infants in 2000 to 5,258 infants in 2008.
- 2) The number of non-Latino infants declined by 3.5%.
- 3) The number of White, non-Latino infants declined by 12.4%.
- 4) The number of Black, non-Latino infants declined by 3.2%.
- 5) Most of the decline in the number of Black, non-Latino infants occurred in those whose mother was 19 years of age or younger. The number of Black, non-Latino infants born to mothers aged 20 years or older declined by only 0.7%.
- 6) The number of Other, non-Latino infants increased by 69.0%: from 697 infants in 2000 to 1,178 infants in 2008.

Live Birth Demographics in 2009 Versus 2008:

The following discussion pertains to all Alabama residential live births, including those for which

maternal age was unknown. The total number of births declined by 2.9%: from 64,345 in 2008 to 62,476 in 2009. This decline occurred in all maternal age groups except the youngest (less than 15 years of age) mothers. The number of births to Black mothers and to White mothers declined: by 5.1% for White mothers and by 4.6% for Black mothers. The number of births to mothers of other races (American Indian or Native Alaskan, Asian, and Native Hawaiian or other Pacific Islander) increased by 8.4%, or 91 births: from 1,089 in 2008 to 1,180 in 2009. The number of births to mothers of other or unknown race increased 2.9 fold, or by 1,142 births: from 611 in 2008 to 1,753 in 2009.

The number of births to Latinos declined by 3.7%: from 5,258 in 2008 to 5,066 in 2009. Comparing these same years, the number of births to non-Latinos also declined, by 5.0%.

Live Birth Demographics in 2010 Versus 2009:

Again, discussion pertains to all Alabama residential live births, including those for which maternal age was unknown. The total number of births declined by 4.0%: from 62,476 in 2009 to 59,979 in 2010. This decline occurred in all maternal age groups except mothers aged 35 years and older, where the number of births increased slightly (by 0.8%). Also in 2010 relative to 2009, the number of births to Black mothers and to White mothers declined: by 1.3% for White mothers and by 3.5% for Black mothers. The number of births to mothers of other races (American Indian or Native Alaskan, Asian, and Native Hawaiian or other Pacific Islander) remained about the same (at 1,180 in 2009 and 1,186 in 2010). The number of births to mothers of other or unknown race declined by 74.3%: from 1,753 in 2009 to 450 in 2010. With respect to ethnicity, the number of births declined by 1.8% for non-Latinos and by 4.6% (or 234 births) for Latinos.

Recap of Trends According to Ethnicity, Alabama Residential Live Births:

The number of non-Latino births declined in 2008 relative to 2000, then again declined in 2009 and 2010. The number of Latino births increased in 2008 relative to 2000, then declined in 2009 and again in 2010. We conjecture that the recent decline in Latino births, and perhaps in non-Latino births as well, may be related to the economic downturn described in the Needs Assessment Report.

HSI 9A: INFANTS AND CHILDREN AGED 0 THROUGH 19 YEARS IN MISCELLANEOUS SITUATIONS OR ENROLLED IN VARIOUS STATE PROGRAMS ENUMERATED BY RACE (DEMOGRAPHICS)

Relevance to MCH Planning:

For both HSIs 9A and 9B, the situations described pertain to health care consumers' needs, and numbers served are relevant to fiscal and other issues.

Data Issues:

As detailed in Form 21 notes, multiple sources are used for HSI 9. For HSI 9 numbers reported on Form 21, therefore, several issues should be kept in mind. First, except for Census spreadsheets, the MCH Epi Branch cannot directly access the databases involved, so many indirect methods are used to estimate numbers. Second, the years for which numbers are reported vary, depending on years for which credible numbers were available when Form 21 was completed. Third, we have little information about methods underlying numbers reported to us by other State agencies. Finally, for some HSI 9 indicators, our discussion focuses on relevant information from well-documented, national databases--rather than on numbers reported on Form 21. A few indicators concerning HSI 9 are discussed below.

Selected Indicators:

Non-completion of High School

In 2011, 1.4% of Alabama public high school students dropped out of school. This is a decline compared to 2010, when this indicator was at 1.8%. Concerning race, in 2011 among groups with at least 1,000 children and youth living in Alabama, this indicator ranged from 0.4% for Asian

students to 1.5% for Black students. (The preceding percentages are based on information provided by SDE; we did not use the "All children 0 through 19" row as the denominator.)

According to Alabama's Education Report Card 2010-2011, public education in Alabama is moving in the right direction and is poised to be a national model for the college and career readiness of its students. Through some of the most challenging financial circumstances, public education in Alabama has continued to show great promise in many areas, including reading, math, and science. The success of Alabama education initiatives is lauded in national publications, research studies and, most importantly, by the teachers and students in our classrooms. The federal No Child Left Behind Act of 2001 requires public accountability reports at the school, system, and state levels that include the status of adequate yearly progress, attendance and dropout/graduation rates, student assessment data disaggregated into subgroups, and information on "highly qualified" teachers.

Juvenile Crime Rate

In 2010, the juvenile crime rate, reported on Form 21 as the number of arrests of persons aged 19 years and younger in the population of interest, was as follows: 3,795 per 100,000 for the total population of adolescents, 3,161 per 100,000 for White adolescents, and 5,048 per 100,000 for Black adolescents. For the total population of adolescents, the year 2010 rate was 21% lower than the corresponding rate in 2009 (4,795 per 100,000). The crime rate is extensively discussed in Section 3 of the 2009-10 Needs Assessment Report. There, however, the juvenile crime arrest rate focuses on adolescents 17 years of age and younger.

Household Structure

Household structure is also discussed in Section 3 of the Needs Assessment Report, where it is classified into 1 of 4 categories: 2 biological or adoptive parents, 2 parents with at least 1 step-parent, mother present but no father present, or all other family structures. Alabama children and youth were more likely to live in single-parent households than U.S. children and youth were. Per the National Survey of Children's Health, in 2007, 26.3% of 0-17 year-old Alabama residents, versus 18.7% of U.S. residents in that age group, lived in a household with the mother present but no father present.

According to American Fact Finder's (AFF) 2010 Census Summary File 1, which consists of actual counts and basic cross tabulations of information collected from all people and housing units during the 2010 Census, 28.9% of 0-17 year-old Alabama residents lived in single-parent households.

HSI 9B: INFANTS AND CHILDREN AGED 0 THROUGH 19 YEARS IN MISCELLANEOUS SITUATIONS OR ENROLLED IN VARIOUS STATE PROGRAMS ENUMERATED BY HISPANIC ETHNICITY (DEMOGRAPHICS)

This discussion mainly concerns enrollment in certain programs, according to ethnicity. (Enrollment in CHIP is not discussed because, due to methodological changes, "ever enrolled" CHIP numbers for 2011 should not be compared to those for earlier years.) Here, "children and youth" refers to 0-19 year-olds. The years for which numbers are reported vary, depending on years for which credible numbers were available when Form 21 was completed.

Latino Children and Youth:

Per Census Bureau reports, the number of Latino children and youth increased by 56.3%: from 47,194 in 2006 to 73,759 in 2010. (For reasons previously discussed, Census counts in 2010 may not be comparable to population estimates for 2006.) Comparison of certain indicators for Latino children and youth in 2011 relative to earlier years follows:

1) The number of Latino children and youth enrolled in Medicaid increased 1.8-fold: from 26,222 in 2006 to 47,851 in 2011.

2) The number of Latino children and youth enrolled for food stamps increased 2.9-fold: from

3,722 in 2006 to 10,781 in 2011.

3) In 2011, 24,225 Latino children and youth (nearly all under 5 years of age) were enrolled in WIC: an increase of 57.3% relative to 2006, when 15,401 were enrolled.

4) In 2011, the percentage of Latino children and youth enrolled in Temporary Assistance to Needy Families (TANF) decreased slightly, to 1.1% (down from 1.5% reported for 2010).

5) The percentage of Latino high school students who dropped out of school declined: from 3.4% in 2006 to 1.2% in 2011.

Non-Latino Children and Youth:

Comparing non-Latino children and youth in 2011 to those in earlier years:

1) The number of non-Latino children and youth enrolled in Medicaid increased by 12.6%: from 473,389 in 2006 to 533,235 in 2011.

2) The number of non-Latino children and youth enrolled for food stamps increased 1.6-fold: from 271,173 in 2006 to 424,964 in 2011.

3) In 2011, 158,617 non-Latino children and youth (nearly all under 5 years of age) were enrolled in WIC: an increase of 20.6% relative to 2006, when 131,536 were enrolled.

4) After declining slightly, from 2.7% in 2004 to 2.6% in 2006, the percentage of non-Latino children and youth enrolled in TANF increased to 3.1% in 2009, then again increased and was 3.4% in 2011.

5) The percentage of non-Latino high school students who dropped out of school declined: from 3.4% in 2004, to 2.4% in 2007, to 1.4% in 2011.

Recap of Changes in Miscellaneous Demographics:

Relative to 2006, enrollment in Medicaid, Food Stamps, and WIC has increased for both non-Latino and Latino children and youth. As a percent change, these increases were greater for Latinos than for non-Latinos. However, with respect to absolute numbers of children and youth enrolled, for each of these programs, the increase in the number of non-Latino enrollees exceeded the corresponding increase in the number of Latino enrollees.

The MCH 2010 Report/2012 Application also discusses enrollment in the above programs, comparing different years. For example, enrollment of non-Latino children and youth in the Food Stamp Program increased by 30% in 2009 (when 362,632 of them were enrolled) relative to 2007. Further, the percentage of non-Latino children and youth enrolled in TANF increased from 2.6% in 2006 to 3.1% in 2009. These increases, which continued in 2011 as described above, may reflect the economic downturn that is discussed in Section 3 of the Needs Assessment Report.

F. Other Program Activities

The following activities cut across the 4 levels of the MCH Service Pyramid.

Numbers shown on Form 9 for the "MCH Toll-Free" line count calls to 2 lines: Healthy Beginnings and Info Connection. Healthy Beginnings is an MCH help line, whereas Info Connection provides information on reproductive health to teens. In total, 641 calls were placed to these lines in FY 2009. Calls on both lines have decreased over the past few years due to ADPH's WIC and Family Planning Programs now having separate toll-free numbers. However, the MCH line continued to receive some calls about WIC, immunization, child health, and environmental issues. Nurses and social workers were available to answer technical questions.

/2012/ In FY 2010, a total of 1,647 calls were received on the above lines. From 2006-2010, the annual number of calls received on these 2 lines together ranged from 641 in FY 2009 to 2,362 in FY 2006, with the median being 1,647 in FY 2010. Anecdotally, factors contributing to the higher number of calls in 2010 versus 2009 included increases in calls about: 1) family planning services, since the upper age limit for services under Title X had increased to 55 years (from 44 years), 2) birth certificates, and 3) services provided by the Breast and Cervical Cancer Program. //2012//

/2013/ In FY 2011, a total of 1,309 calls were received on the above lines. //2013//

CRS maintains toll-free lines that operate during normal business hours in the CRS State Office and 15 district offices. There were 18,259 calls to these lines in FY 2009. This number is 15% lower than the 21,491 calls received in FY 2008. A statewide public awareness campaign began in May 2007, including posters with the CRS State Office toll-free number as a single point of contact. Some offices experienced increased calls shortly after the launch of the campaign; but decreases have been seen fairly consistently since FY 1997. Cell phone usage, area calling plans, and email options via the agency's public web site have contributed to the overall decline in the use of toll-free lines.

/2012/ CRS continues to maintain the above toll-free lines, with 14,333 calls to these lines in FY 2010. This number is 22% below the 18,259 calls received in FY 2009. //2012//

/2013/ CRS continues to maintain the above toll-free lines. There were 11,885 calls to CRS's toll-free lines in FY 2011. This number represents a 17% decrease over the 14,333 calls received in FY 2010. This decrease is due to the continuing increase in usage of cell phones. //2013//

The Alabama Childhood Lead Poisoning Prevention Program continues as the collaborative effort of FHS, ADPH's Bureau of Environmental Services, and Alabama Medicaid. The program's mission is to help every child in Alabama develop to his or her maximum potential by promoting a lead-free environment and a healthy lifestyle. To accomplish this mission, case management is provided for all children with a confirmed blood lead level of 10 ug/dL or higher. Environmental inspections are included in the management of blood lead levels of 15 ug/dL or higher. Universal screening of children aged 6-72 months is conducted in 7 high risk counties; remaining counties follow a targeted screening protocol, under which only children meeting certain social and medical criteria are screened. Primary prevention activities to increase awareness of lead-safe practices among parents, property owners, renovators, and child health providers are conducted statewide. In CY 2009, 38,983 children 0-21 years of age were screened for lead, with 840 (2.2%) of these being identified with elevated blood lead levels.

/2012/ In CY 2010, 40,422 children 0-21 years of age were screened for lead, with 632 (1.6%) of these being identified with elevated blood lead levels. In CY 2010, the Alabama Childhood Lead Poisoning Prevention Program purchased a new, enhanced surveillance system known as the Healthy Homes and Lead Poisoning Surveillance System. The program will operate under 2 surveillance systems until the older system is retired. The new system, which will be in a web-based format, will allow for better case management and data quality. It will greatly enhance the surveillance of screening and case management for lead poisoning in Alabama.

/2013/ In CY 2011, 41,810 children 0-21 years of age were screened for lead, with 547 (1.3%) of these being identified with elevated blood lead levels. In 2011, the Alabama Childhood Lead Poisoning Prevention Program coordinated all environmental inspections for each of the 67 counties and piloted the new surveillance system mentioned above. //2013//

In September 2010 the SPP was awarded a 3-year HRSA grant to raise public awareness of the importance of preconception and interconception health via social media. The target population is 15-44 year-old first-time mothers and parents, including fathers, throughout the State. The goals

of the campaign are to: 1) raise awareness of preconception and interconception health, 2) promote positive birth outcomes, 3) promote health across the life span, and 4) decrease infant mortality. The campaign, entitled the "GAL Campaign," was implemented statewide in January 2011. The target population will be the female the first year, the male the second year, and the male and female as parents the third year. The 5 selected messages for the first year are: 1) avoiding alcohol, tobacco and drugs, 2) being fit (with emphasis on physical activity and nutrition), 3) managing chronic diseases, 4) waiting at least 24 months between pregnancies, and 5) having a plan. Six focus groups related to the campaign will be held throughout the State. Social media outlets will include Facebook, Twitter, MySpace, expansion of FHS's preconception web page, and various other avenues. Interventions with CHD family planning clients who receive care coordination will begin in June 2011, in 2 pilot counties. A statewide initiative with family planning clients who have a negative pregnancy test will begin in July 2011. SPP staff and FHS's Family Planning Program staff are collaborating to plan and implement the campaign. //2012//

/2013/ The GAL Campaign will end August 31, 2012, due to discontinued funding by HRSA. SPP will partner with other agencies to continue raising awareness about issues that have been addressed through the campaign, by providing certain educational materials to the public that were developed under GAL. ADPH will continue supporting the GAL web page and postings about GAL on Facebook. //2013//

Enabling and Infrastructure-building:

In October 2007 FHS was awarded a 3-year supplemental Title X grant to promote optimal birth spacing. This project includes enhancing services already provided by Family Planning care coordinators. Seven counties are involved in the pilot: Randolph, Coosa, Geneva, Coffee, Dallas, Lowndes, and Choctaw. This pilot will continue through June 29, 2010.

/2012/ The pilot ended as scheduled. The study population was too small to infer whether the initiative changed behaviors in the target population; but professionals providing the information said that information on optimal birth spacing was new for many women and was well received and needed by the target population. Therefore, ADPH plans to begin providing information on optimal birth spacing to CHD Family Planning patients in all counties. //2012//

Infrastructure-building:

The SPP held Perinatal Initiatives Summits in February and November 2008. The goals of the summits were to: 1) develop a statewide plan for lowering the State's infant mortality rate and 2) involve a variety of stakeholders (State agencies, public and private health care providers, insurance providers, and other organizations and entities) in the effort to decrease infant mortality. Topics of focus included late preterm birth, preconceptional and inter-conceptional care, newborn screening, SIDS, and emergency and disaster plans for pregnant women and children.

G. Technical Assistance

ADPH

No technical assistance is requested by ADPH at this time.

/2012/ Evidence-based practice of public health requires access to a wide range of pertinent literature concerning whether particular interventions have indeed been shown, via well designed studies, to produce the desired outcomes. Accessible literature should include peer-reviewed journals and any other respected sources that report original, pertinent research and objective reviews of such research. However, FHS's access to such literature is limited, and our efforts to identify a subscription service that would provide access to a wide range of pertinent peer-reviewed literature have met with limited success. For this reason, FHS requests that MCHB either: 1) make a subscription service or services available to State Title V programs that would provide access to a wide range of pertinent peer-reviewed literature or 2) advise FHS concerning affordable subscription services that would provide such access.

A list of references cited by FHS throughout this application is attached. //2012//

//2013/ FHS requests no technical assistance at this time, but appreciates the consultation and referral provided by MCHB in late FY 2011 and early FY 2012. Based on consultation with the MCH Library at Georgetown University, consultation with UAB's Lister Hill Library, and free trials of literature citation and retrieval services offered by 2 vendors, ADPH has entered into a 1-year contract for literature citation and retrieval services provided by a particular vendor. //2013//

CRS

CRS requests technical assistance from the Catalyst Center to develop information and strategies about specific financing and health insurance options available in the State, especially for youth and young adults in transition and CYSHCN that have difficulty in obtaining coverage. Also, CRS would like guidance during the phases of implementation of health reform so that staff can effectively guide families in maximizing coverage opportunities and benefits.

//2012/ Continue as above. //2012//

***//2013/ CRS requests technical assistance from the Catalyst Center as stated above. CRS also requests technical assistance from John Snow Inc., a public health research and training institute which assists clients with building internal capacity and finding solutions to the most challenging health issues. CRS will use the technical expertise of this organization to fulfill the requirements of the State Implementation Grant for Systems of Services for CYSHCN. //2013//
An attachment is included in this section. IVG - Technical Assistance***

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

| | FY 2011 | | FY 2012 | | FY 2013 | |
|--|-----------|-----------|-----------|----------|-----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| 1. Federal Allocation <i>(Line1, Form 2)</i> | 11721312 | 11323941 | 11569686 | | 11583959 | |
| 2. Unobligated Balance <i>(Line2, Form 2)</i> | 0 | 0 | 0 | | 0 | |
| 3. State Funds <i>(Line3, Form 2)</i> | 27918090 | 28123036 | 29708097 | | 30570408 | |
| 4. Local MCH Funds <i>(Line4, Form 2)</i> | 0 | 0 | 0 | | 0 | |
| 5. Other Funds <i>(Line5, Form 2)</i> | 4556370 | 4404291 | 5895051 | | 5228235 | |
| 6. Program Income <i>(Line6, Form 2)</i> | 55300816 | 53310267 | 51901484 | | 52877241 | |
| 7. Subtotal | 99496588 | 97161535 | 99074318 | | 100259843 | |
| 8. Other Federal Funds <i>(Line10, Form 2)</i> | 188934633 | 204751273 | 189232835 | | 205049455 | |
| 9. Total <i>(Line11, Form 2)</i> | 288431221 | 301912808 | 288307153 | | 305309298 | |

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | 1156616 | 1069493 | 1784666 | | 1083935 | |
| b. Infants < 1 year old | 11055033 | 9599549 | 7792311 | | 8356075 | |

| | | | | | | |
|---|-----------|----------|-----------|--|-----------|--|
| c. Children 1 to 22 years old | 53369834 | 52359191 | 50877717 | | 53793386 | |
| d. Children with Special Healthcare Needs | 32416244 | 32413055 | 36823737 | | 35251345 | |
| e. Others | 0 | 0 | 0 | | 0 | |
| f. Administration | 1498861 | 1720247 | 1795887 | | 1775102 | |
| g. SUBTOTAL | 99496588 | 97161535 | 99074318 | | 100259843 | |
| II. Other Federal Funds (under the control of the person responsible for administration of the Title V program). | | | | | | |
| a. SPRANS | 0 | | 0 | | 0 | |
| b. SSDI | 127127 | | 97078 | | 101212 | |
| c. CISS | 142115 | | 182321 | | 130158 | |
| d. Abstinence Education | 0 | | 899668 | | 316817 | |
| e. Healthy Start | 0 | | 0 | | 0 | |
| f. EMSC | 0 | | 0 | | 0 | |
| g. WIC | 131565690 | | 133868074 | | 142965242 | |
| h. AIDS | 4616188 | | 4616188 | | 4429435 | |
| i. CDC | 0 | | 0 | | 0 | |
| j. Education | 0 | | 10165 | | 15259 | |
| k. Home Visiting | 0 | | 0 | | 0 | |
| k. Other | | | | | | |
| CRS- Hemophilia of GA | 0 | | 25953 | | 28658 | |
| CRS-State Imp Grant | 0 | | 0 | | 300000 | |
| Immunizations | 52454813 | | 48443710 | | 56704370 | |
| PREP | 0 | | 789678 | | 58304 | |
| CRS -State Imp Grant | 0 | | 300000 | | 0 | |
| Hemophilia of GA | 28700 | | 0 | | 0 | |

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|----------|----------|----------|----------|-----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Direct Health Care Services | 53761100 | 51855043 | 53169395 | | 53240660 | |
| II. Enabling Services | 19054683 | 16493158 | 16745065 | | 16891843 | |
| III. Population-Based Services | 12785357 | 13594041 | 13219373 | | 13675668 | |
| IV. Infrastructure Building Services | 13895448 | 15219293 | 15940485 | | 16451672 | |
| V. Federal-State Title V Block | 99496588 | 97161535 | 99074318 | | 100259843 | |

| | | | | | | |
|--------------------------------|--|--|--|--|--|--|
| Grant Partnership Total | | | | | | |
|--------------------------------|--|--|--|--|--|--|

A. Expenditures

ADPH

Form 3: State MCH Funding Profile

Line 3. (Other Funds)--FY 2009 Other Funds expended decreased from budget amount by 17.05% or a net of \$828,829. CRS expenditures for FY 2009 were about \$829,000 less than the budgeted amount (17%). The difference in other funds represents the difference in requested versus received dollars and includes a proration of funds specifically related to the Hemophilia program.

Line 6. (Program Income)--FY 2009 Program Income increased from the budgeted amount by 29.78% or a net of \$12.3 million. The FY 2009 budget was based on the activity/cost in 2007 and over this time period we have experienced substantial growth in the number of patients served and care coordination activities due to referrals from Medicaid and Newborn Screening. The majority of the net cumulative change can be attributed to Family Planning (\$7.5 million), Family Planning Care Coordination (\$2.5 million) and Patient 1st Care Coordination (\$2.5 million).

Form 4: Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. a. (Pregnant Women)--FY 2009 Pregnant Women Expended decreased from the budgeted amount by 45.8% or \$957,112. This rate of decline is consistent with the change in ADPH focus to withdraw from providing prenatal services. Subsequent applications will reflect only the costs associated with the Maternity Program that exists in Mobile and Cullman Counties.

Line I. b. (Infants < year old)--FY 2009 Infants < 1 year old increased from the budgeted amount by 35% or \$2.8 million. The FY 2009 budget was based on activity/cost in 2007. A better reflection of current cost/trends would be to use 2008 cost data as a comparison to 2009 which shows an increase of 8% or \$815,000. While the percentage of infants to total Child Health visits remain level its share of total Child Health costs would increase over the two year period.

Line I. c. (Children 1 to 22 years)--FY 2009 Children 1 to 22 years old increased from the budgeted amount by 40.7% or \$15 million. The FY 2009 budget was developed in 2007 using activity/cost in that year. Using the previous year 2008 cost data to compare FY 2009, the increase of 13% or \$6.5 million is a better reflection of current cost/trends. While the percentage of children 1 to 22 years Child Health visits shows a small increase, the share of total Child Health costs would rise over the period by approximately \$15 million. The primary reasons for the increased expenditures from 2007 to 2009 are driven by Patient 1st and EPSDT Care Coordination programs for children, birth to age 21 which increased 33.9%.

Line I. d. (Children with Special Healthcare Needs)--FY 2009 Children 1 to 22 years old decreased from budgeted amount by 16.7% or \$6.4 million. See CRS Narrative.

Line I. f. (Administration)--FY 2009 Administration expenditures decreased from the budgeted amount by 42.8% or \$1.1 million. The FY 2009 budget which used 2007 as a basis was overstated by a \$1.1 million CRS transfer paid using FY 2008 funds. The transfer cost for CRS was entered at \$3.8 million and the actual cost for 2007 was \$2.7 million.

Form 5: State Title V Program Budget and Expenditures by Types of Services

Line II. (Enabling Services)--FY 2009 Enabling Services expended increased from budgeted amount by \$9.2 million or 95%. Plan 1st Care Coordination which is an enabling service was excluded from this category in previous applications. This is a reclassification issue that adds \$9.8 million to expenditures. The final effects of this adjustment should narrow the differences in budgeted vs. actual for 2010.

/2012/ Form 3: State MCH Funding Profile

Line 3. (State Funds) -- FY 2010 State Funds expended decreased from the budgeted amount by -21.2% or a net of \$6.99 million. Approximately \$2.24 million of this difference resulted from an increase in earned income and the rise in actual costs in 2010. The remaining difference is due to CRS expenditures for FY 2010 which were 31.1% or \$4.75 million less than the budgeted amount (See CRS Form 3).

Form 4: Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. b. (Infants < year old) -- FY 2010 Infants < 1 year old decreased from the budgeted amount by -11.9% or \$1.236 million. The FY 2010 budget was based on activity/cost in 2008. During this period, infant live births continued to decline from 64,345 to 60,732 a total of 3,613 (5.62%) for 2008 through 2010. Current trends indicate that infants less than one year are moving to private providers and utilizing their medical home.

Line I. d. (Children with Special Healthcare Needs) -- FY 2010 Children 1 to 22 years old decreased from budgeted amount by 10.9% or \$3.95 million. See CRS Narrative.

Line I. f. (Administration) -- FY 2010 Administration expenditures increased from the budgeted amount by 33.4% or \$429,867. During FY 2008, approximately \$572,000 in costs was transferred to FY 2007, resulting in an understated budget amount for FY 2010. //2012//

/2013/ Form 4: Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. b. (Infants < year old)--FY 2011 Infants < 1 year old decreased from the budgeted amount by -13.16% or \$1.45 million. The FY 2011 budget was based on activity/cost in 2009. During this period, infants visits continued to decline from 15,573 to 13,611 a total of 1,962 (12.6%) for 2009 through 2011. Current trends indicate that infants less than one year are moving to private providers and utilizing their medical home.

Line I. f. (Administration)--FY 2011 Administration expenditures increased from the budgeted by 14.77% or \$221,386. During FY 2009, approximately \$275,648 in cost for the Fetal Infant Mortality Program was excluded from the Administrative totals. The projected FY 2011 budget number \$1,498,861 was understated in 2009. The correct actual cost increase for FY 2011 would have been 2.78% or \$49,251.

Form 5: State Title V Program Budget and Expenditures by Types of Services

Line II. (Enabling Services)--FY 2011 Enabling Services expenditures decreased from budgeted amount by -13.44% or \$2,561,525. For FY 2011, Fetal Infant Mortality Program cost in the amount of \$480,255 was reclassified from Enabling to Infrastructure Building Services. CRS accounted for 76% or \$1,950,841 of the total decrease. (See CRS Form 5 explanation.) //2013//

CRS

As per Block Grant requirements, the Budget for each reporting year was developed two years prior in the application (i.e. FY 2009 budget was developed in the FY 2007 report/FY 2009 application). CRS bases that budget on expenditures for the preceding FY and the CRS legislative budget request at that time. This method does not allow for modification later based upon third party reimbursement trends or for comparison to the actual Operations Plan for that FY. The agency's Operations Plan is built after final funding levels are set. It is a more accurate reflection of the agency's budget since it is the actual budget as opposed to a budget request. Therefore, the actual expenditures presented in the forms are a more accurate reflection of funds actually received than are the estimates represented by the budgeted amounts.

Form 3: State MCH Funding Profile

Line 3 (State Funds)--CRS expenditures for FY 2009 were about \$4.3 million less than the budgeted amount (25.8%). The difference in state funds represents the difference in requested versus received dollars and includes a proration of funds.

Line 5 (Other Funds)--CRS expenditures for FY 2009 were about \$829,000 less than the budgeted amount (17%). The difference in other funds represents the difference in requested versus received dollars and includes a proration of funds specifically related to the Hemophilia program.

Line 7 (Subtotal)--CRS expenditures for FY 2009 were about \$6.4 million less than the budgeted amount (16.7%). The significant difference in the subtotal for MCH expenditures represents the differences described above as well as smaller differences in program income and federal Block Grant dollars allocated to the CSHCN Program.

Line 9 (Total)--CRS total MCH expenditures for FY 2009 were about \$6.4 million less than the budgeted amount (16.7%). The significant difference in the subtotal for MCH expenditures represents the differences described above as well as smaller differences in program income and federal Block Grant dollars allocated to the CSHCN Program.

Form 4: Budgeted Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. d. (CSHCN)--The expended amount differs from budgeted amount by about \$6.4 million or 16.7%. The difference between FY 2009 budget and expenditures reflects the difference in requested funds versus received state and other funds and proration, as well as smaller differences in program income and federal Block Grant dollars allocated to the CSHCN Program.

Form 5: State Title V Program Budget and Expenditures by Types of Services

Lines I. thru IV.--In FY 2005, CRS revised its calculation methodology to more accurately depict percentages of the overall CSHCN budget expended per level of the MCH Pyramid. This allows CRS to develop budgets that are more in line with actual program expenditures. However, as above, the budget for FY 2009 was developed in FY 2007, which does not allow for modification based on current program expenditures. FY 2009 expenditures are a more accurate reflection of how CRS currently allocates resources by service type. Total FY 2009 actual expenditures are significantly reduced compared to budget, reflecting the overall decrease in funds available to be spent based on differences described above. A significant decrease is noted in direct, enabling, and population-based services. Although there was a decrease in expenditures for infrastructure building, the difference was not significant. The maintenance of expenditures for infrastructure building services reflects a trend of redirection of resources toward infrastructure-building services that has been seen since FY 2006 and evidenced by actual expenditures. The percent of expenditures for enabling and population-based services has remained relatively stable over that same time, even though the actual amounts were significantly reduced for FY 2009 due to budget issues as discussed above.

/2012/ As per Block Grant requirements, the Budget for each reporting year was set two years prior in the application (i.e. FY 2010 budget was set in the FY 2008 report/FY 2010 application). CRS bases that budget on expenditures for the preceding FY and the CRS legislative budget request at that time. This method does not allow for modification later based upon third party reimbursement trends or for comparison to the actual Operations Plan for that FY. The agency's Operations Plan is built after final funding levels are set. It is a more accurate reflection of the agency's budget since it is the actual budget as opposed to a budget request. Therefore, the actual expenditures presented in the forms are a more accurate reflection of funds actually received than are the estimates represented by the budgeted amounts.

Form 3: State MCH Funding Profile

Line 3 (State Funds) -- CRS expenditures for FY 2010 were about \$4.75 million less than the budgeted amount -31.1%. The difference in state funds represents the difference in requested

versus received dollars and includes a proration of funds.

Line 7 (Subtotal) -- CRS expenditures for FY 2010 were approximately \$3.95 million less than the budgeted amount -10.9%. The significant difference in the subtotal for MCH expenditures represents the differences described above as well as smaller differences in program income and federal Block Grant dollars allocated to the CSHCN Program.

Line 8 (Other Federal Funds) -- CRS expenditures for FY 2010 were about \$112,481 more than the budgeted amount -391.9%. This significant increase is a result of reimbursement dollars from insurance and for clotting factor products for the CRS Hemophilia Program.

Line 9 (Total) -- CRS total MCH expenditures for FY 2010 were approximately \$3.84 million less than the budgeted amount -10.6%. The significant difference in the subtotal for MCH expenditures represents the differences described above as well as smaller differences in program income and federal Block Grant dollars allocated to CSHCN Program.

Form 4: Budgeted Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I.d. (CSHCN) -- Expended differs from budgeted amount by about \$3.95 million or -10.9%. The difference between FY 2010 budget and expenditures reflects the difference in requested versus received state and other funds and proration, as well as smaller differences in program income and federal Block Grant dollars allocated to the CSHCN Program.

Form 5: State Title V Program Budget and Expenditures by Types of Services (Lines I. - IV.) -- In FY 2005 CRS revised its calculation methodology to more accurately depict percentages of the overall CSHCN budget expended per level of the MCH Pyramid. This allows CRS to set budgets that are more in line with actual program expenditures. However, as above, the budget for FY 2010 was set in FY 2008, which does not allow for modification based on current program expenditures. FY 2010 expenditures are a more accurate reflection of how CRS currently allocates resources by service type. Total FY 2010 actual expenditures are significantly reduced compared to budget, reflecting the overall decrease in funds available to be spent based on differences described above. A significant decrease is noted in direct, enabling, and population-based services. A slight increase was noted in expenditures for infrastructure-building services. This reflects a trend of redirection of resources toward infrastructure-building services that has been seen since FY 2006 and evidenced by actual expenditures. The percent of expenditures for enabling and population-based services decreased slightly for FY 2010 which is a reflection of the FY 2010 budget issues as discussed above. //2012//

/2013/ As per Block Grant requirements, the Budget for each reporting year was set two years prior in the application (i.e. FY 2011 budget was set in the FY 2009 report/FY 2011 application). CRS bases that budget on expenditures for the preceding FY and the CRS legislative budget request at that time. This method does not allow for modification later based upon third party reimbursement trends or for comparison to the actual Operations Plan for that FY. The agency's Operations Plan is built after final funding levels are set. It is a more accurate reflection of the agency's budget since it is the actual budget as opposed to a budget request. Therefore, the actual expenditures presented in the forms are a more accurate reflection of funds actually received than are the estimates represented by the budgeted amounts.

Form 3: State MCH Funding Profile

Line 3 (State Funds) -- CRS expenditures for FY 2011 was \$113,441 less than the budgeted amount (1.05%). The difference in state funds represents the difference in requested versus received dollars and includes a proration of funds.

Line 5 (Other Funds) -CRS expenditures for FY 2011 were about \$152,000 less than the budgeted amount (3%). The difference in other funds represents the difference in

requested versus received dollars and includes a proration of funds specifically related to the Hemophilia program.

Line 10 (Other Federal Funds) -- CRS expenditures for FY 2011 were \$1,775 more than the budgeted amount which represents income from the CRS newly awarded State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs.

Form 5: State Title V Program Budget and Expenditures by Types of Services
The budgeted funds reported each year are only an estimate. Therefore, FY 2011 expenditures are a more accurate reflection of how CRS allocates resources by service. In FY 2011, CRS expenditures on enabling services were 31.6% less than the budgeted amount. A significant decrease of 40.1% was noted in expenditures for population-based services. There was an increase in expenditures of 9.6% noted in direct services. Infrastructure-building reflects an increase in expenditures of 11.3%. This change is due to a shift in program activities and a slight change in calculation methodology which more accurately depicts percentage of overall CSHCN budget expended per level of the MCH Pyramid. Determining expenditures presents a challenge because the budget for FY 2011 was set in FY 2009, which does not allow for modification based on current program expenditure. The significant increase noted in direct services is reflective of the increased cost of services for clients who are uninsured or underinsured. The increased expenditures for infrastructure-building services reflect a trend of redirection of resources toward infrastructure-building services that has been seen since FY 2006 and evidenced by actual expenditures. The percent of expenditures for enabling and population-based has decreased even though the actual amounts were reduced for FY 2011 due to budget issues as discussed above. //2013//

B. Budget

ADPH

The State Legislature passed the 2010 General Fund budget, using funds received from the American Recovery and Reinvestment Act of 2009, which restored most government agencies to the 2009 level before the Governor's Deficit Prevention Plan reductions. The use of stimulus funds will lessen the impact of some cuts; however, State agencies may still be facing some reductions in their budgets. Title V funding for 2011 is expected to remain level and will be based on the last Notice of Grant Award for FY 2010 at \$11.721 million. We have submitted our 2011 Title X Family Planning funding application requesting \$5.67 million. Stimulus funding will expire at the end of 2010 and if the economy does not show signs of significant improvement then the State agencies could see substantial cuts in funding for 2011.

/2012/ The Alabama State Legislature passed a 2011 General Fund budget that was prorated resulting in 15% cuts for State agencies. The 2012 General Fund budget has not been finalized, however, it is expected that State agencies will receive some reduction in funding. These cuts will force agencies to further reduce expenditures including layoffs. Alabama's Title V funding for 2011 was cut \$128,428 from \$11,698,114 to \$11,569,686. It is expected that Title V funding could see further reductions for 2012. We have been notified that the 2012 Title X Family Planning Region IV allocation was reduced \$3.1 million (5.3%). The impact of this was a reduction in Alabama's current Title X allocation of \$5.770 to \$5.469 million, a total of \$301,000. It is expected that Title X funding could see further reductions. *//2012//*

/2013/ **The Alabama State Legislature passed a 2012 General Fund budget that was prorated resulting in 10.62% cut for ADPH. The 2013 General Fund budget passed and as expected, required further cuts to State agencies. ADPH received a 43.6% cut in State funding totaling \$22 million. These cuts will force agencies to further reduce expenditures and include layoffs to balance budgets. Also, Alabama voters will decide in September 2012 whether to pass a constitutional amendment to transfer \$145.8 million from the oil**

and gas trust fund to balance the General Fund budget for the next three years. The Alabama State Health Officer predicted that the State's Medicaid program would collapse and would impact the whole health care system if the voters reject the plan. State agencies would then be forced to make additional draconian cuts that would be devastating to services and staffing. Alabama's Title V MCH funding for 2011 was \$11,583,959. Title V MCH Block Grant faces an estimated 2.6% or \$17 million reduction for 2012. For FY 2012 Title X Family Planning Program received \$5.64 million, a reduction of 5.46% from FY 2011. Nationally, the 2013 Title X funding was reduced by \$5 million. //2013//

CRS

Funds spent on CYSHCN will support activities to address NPM #s 2-6 and the 3 SPMs developed by CRS. "Other funds" include funding for the EIS services to Part C-eligible infants and toddlers and the Hemophilia Program State allocation. Under "Other Federal Funds," anticipated funding is included for the MCHB Comprehensive Core Hemophilia Grant. Anticipated use of the budgeted monies is justified by the level of the pyramid.

Direct Health Services

CRS--Includes direct community-based services of specialty medical care, care coordination, and ancillary care through the CRS specialty clinic programs and information and referral services for CYSHCN who are uninsured or underinsured for needed services and supports, including SSI-eligible children 0-16 years of age.

Enabling Services

CRS--Includes care coordination, transportation reimbursements, translation services, coordination with local educational agencies and with VRS for youth transition services, a toll-free line in every district office, and parent consultant activities to assist families to advocate for their needs and to provide family support services offered through district offices.

Population-based Services

CRS--Includes State activities to screen and identify CYSHCN as early as possible and outreach to families to provide information and assistance in seeking and attaining services through multiple awareness mechanisms.

Infrastructure-building Services

CRS--This includes State-level administrative activities to support the CRS community-based service system and the continuous quality assurance process, including standards of care and outcome measures. Also included are interagency collaboration to improve and expand the service delivery system for CYSHCN, in-service training, health status surveillance and other measurement activities. At the community level, infrastructure-building services include staff, family, and youth support for local system development activities.

Other expenditures for infrastructure include maintaining the CRS electronic record and information management system to collect and analyze data, the use of information technology for public awareness and client/family education as appropriate, and the efforts toward the Healthy People 2010 objectives for CYSHCN.

ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. Until November 2008, ADPH allocated 32% of federal MCH block grant funding to CRS. At that time, ADPH notified CRS of a reduction to the minimum requirement of 30%, therefore directing about \$3.5 million to the CSHCN Program in FY 2009. This level of funding continued in FY 2010 and is expected to continue for FY 2011.

/2012/ ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. Until November 2008, ADPH allocated 32% of federal MCH block grant funding to CRS. At that time, ADPH notified CRS of a reduction to the minimum

requirement of 30%, therefore directing about \$3.5 million to the CSHCN Program in FY 2010. This level of funding continued in FY2011; however, a decrease is expected in FY 2012. //2012//

See Forms 2-5.

CRS overmatches its federal dollars through its State allocation. The actual State allocation for FY 2010 ("State Funds" Line 3, Form 3; about \$10.8 million) represents an additional decrease over the FY 2009 prorated budget amount. For 2010, in addition to the State allocation, the CRS budget includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (about \$2.4 million), a separate State allocation for the Alabama Hemophilia Program (about \$1.3 million; a decrease over the prorated FY 2009 budget), and program income from third party reimbursements (projected at about \$12.5 million). These funds, in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2010. CRS continues to receive \$28,700 from MCHB as a sub-grantee to Hemophilia of Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2010.

The FY 2011 budget is based on CRS's current budget request, modified to reflect level-funding (FY 2010 level) for the State allocation. Anticipated program income (Line 6, Form 3) has also been modified to reflect the third party reimbursement trends from FY 2009 and FY 2010.

/2012/ See Forms 2-5.

CRS overmatches its federal dollars through its State allocation. The actual State allocation for FY 2011 ("State Funds" Line 3, Form 3; about \$10.7 million) represents an additional decrease from FY 2010 prorated budgeted amount. For FY 2011, in addition to the State allocation, the CRS budget includes funds from AEIS for the provision of early intervention services to Part C-eligible infants and toddlers (about \$2.9 million), a separate State allocation for the Alabama Hemophilia Program (about \$1.2 million; which remains stable, and program income third party reimbursements (projected at about \$12.5 million). These funds, in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2011. CRS continues to receive funds from MCHB (\$25,953 for FY 2011) as a sub-grantee to Hemophilia of Georgia to provide comprehensive care to persons with hemophilia. CRS was recently awarded funding from HRSA (\$300,000) for the State Implementation Grant for Systems of Services for CYSHCN. CRS anticipates no other federal funds for special projects or grants in FY 2011.

The FY 2012 budget is based on CRS's current budget request, modified to reflect level-funding (FY 2011 level) for the State allocation. Anticipated program income (Line 6, Form 3) has also been modified to reflect the third party reimbursement trends from FY 2010 and FY 2011, and the HRSA State Implementation Grant for Systems of Services for CYSHCN (Line 10, Form 3) which shows new income from the federal source. //2012//

/2013/ ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. Until November 2008, ADPH allocated 32% of federal MCH block grant funding to CRS. At that time, ADPH notified CRS of a reduction to the minimum requirement of 30%, therefore directing about \$3.5M to the CSHCN Program in FY 2009. This level of funding continued in FY 2011 and is expected to continue for FY 2012.

CRS overmatches its federal dollars through its State allocation. The actual State allocation for FY 2011 ("State Funds" Line 3, Form 3; about \$10.7M) represents an additional decrease over the FY 2010 prorated budget amount. For 2011, in addition to the State allocation, the CRS budget includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (about \$2.8M), a separate State allocation for the Alabama Hemophilia Program (about \$1.2M; which remains stable, and program income from third party reimbursements (projected at about \$13M). These funds,

in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2012. CRS continues to receive \$28,700 from MCHB as a sub-grantee to Hemophilia of Georgia to provide comprehensive care to persons with hemophilia. CRS also receives \$300,000 from HRSA to create inclusive community based system of care for children and youth with special health care needs. CRS anticipates no other federal funds for special projects or grants in FY 2012.

The FY 2011 budget is based on CRS's current budget request, modified to reflect level-funding (FY 2011 level) for the State allocation. Anticipated program income (Line 6, Form 3) has also been modified to reflect the third party reimbursement trends from FY 2011 and FY 2012. //2013//

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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