Maternal and Child Health Services Title V Block Grant

State Narrative for Alabama

Application for 2011 Annual Report for 2009

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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.

B. Face Sheet

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

C. Assurances and Certifications

Assurances and certifications are included in Appendix A. Appendices are not submitted electronically but are on file in the Bureau of Family Health Services, Alabama Department of Public Health. Any appendix, including Appendix A, can be obtained upon request by calling, e-mailing, or faxing the Bureau of Family Health Services' Maternal and Child Health Epidemiology Branch (phone: 334.206.5333; e-mail: anita.cowden@adph.state.al.us; fax: 334.206.2914).

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Alabama Title V Program is administered by the Alabama Department of Public Health (ADPH, or Department), 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.

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," and the full report of the Needs Assessment is referred to as the "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. Some members of these groups are selected by FHS and some by the Governor of the State of Alabama (Governor). 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.

All of FHS's advisory groups serve as channels for public input regarding 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 approved for implementation. As well, the State Family Planning Advisory Committee provides community input on FHS's Family Planning Program and the program's materials. The program has 2 toll-free phone lines: 1 for women seeking resources offered through Plan First (the Family Planning Medicaid Waiver discussed in Section III.A), and 1 for teens and others who want information on family planning. Two ADPH web pages seek input on family planning.

Further, 2 key ways that FHS seeks input on MCH issues are through collaboration with the State Perinatal Advisory Council (SPAC) and Regional Perinatal Advisory Councils (RPACs). Collaboration with SPAC and RPACs is discussed in multiple places in this document (e.g., under Health Systems Indicator #2A in Section II.E).

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 e-mail 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.

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 Alabama MCH Block Grant FY 2009 Annual Report/FY 2011 Application (MCH 2009 Report/2011 Application) were reviewed by the SPC and LPCs and were made available to families in local CRS offices.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Needs Assessment Report (reference #1) is attached to Section 2. (Appendix B lists all references cited. All appendices may be obtained by calling 334-206-5943 or e-mailing anita.cowden@adph.state.al.us.) Per MCH Block Grant guidance (reference #2), this summary focuses on: 1) the newly selected MCH priority needs, 2) changes in these needs since the last 5-year needs assessment, and pertinent changes in capacity. As well, this summary includes 2 findings.

STRENGTHS AND NEEDS

Two findings from Section 3 of the Needs Assessment Report follow.

The risk of infant (under 1 year of age) death, reported as the number of deaths per 1,000 live births, increased in Alabama: from 8.7 per 1,000 in 2002-04 to 9.4 per 1,000 in 2005-07. Racial disparities in infant mortality persisted. In 2005-07, the risk of infant death was 14.2 per 1,000 among Black, non-Latino infants, versus 7.5 per 1,000 among White, non-Latino infants and 6.7 per 1,000 among Latino infants.

In general, Alabama families of CYSHCN and care providers reported greater percentages of unmet need for community-based services relative to other services. Respite, summer/after school care, and transportation tended to be the most difficult services to obtain statewide.

MCH PROGRAM CAPACITY

Section 4 of the Needs Assessment Report describes capacity to address the 10 MCH priorities that were selected by FHS and CRS. Assessment of this capacity was organized around 2 grids developed by FHS's MCH Epidemiology Branch (MCH Epi Branch), who drew from 3 sources identified in Section IV.A. On the 2nd grid (Worksheet 2), each priority is scored across 5 domains: skill sets, resources/partners, local networks for service delivery, political will/interest, and feasibility. Because this process was not included in previous 5-year needs assessments, we do not have a baseline for assessing changes in capacity as measured by Worksheet 2.

SELECTION OF PRIORITY NEEDS

The MCH priority needs that FHS and CRS selected, which are detailed in Section 5 of the Needs Assessment Report, follow (sometimes in abbreviated statements). The numbers assigned are identification numbers; they do not rank the priorities. Priorities for the FY 2011-2015 cycle are to:
1) Increase access to culturally competent care coordination services for CYSHCN, including transition planning. This priority per se was not included in the FY 2005-2010 needs assessment cycle.

2) Promote access to a medical home for children, youth, and women of childbearing age. This is a new priority.

3) Promote positive youth development to reduce high-risk behaviors in adolescents. This is a new priority.

4) Reduce the prevalence of obesity among children, youth, and women of childbearing age. This is a new priority.

5) Reduce the prevalence of violent behavior committed by or against children, youth, and women. This priority is retained from the previous needs assessment cycle.

6) Reduce infant mortality, especially among African Americans. This priority is retained from the previous cycle.

7) Increase family and youth participation in CYSHCN policy-making. This priority is similar to a priority from the previous needs assessment cycle. The purpose of the modification was to provide more of a focus on supports, education, and training.

8) Promote access to community-based services for CYSHCN and families. This priority was not included in the FY 2005-2010 needs assessment cycle.

9) Promote access to a dental home. This is a new priority.

10) Promote access to mental health services for all children, youth, and women of childbearing age. This is a new priority.

DISCONTINUED PRIORITIES

Three priorities from the previous needs assessment cycle were not retained for the FY 2011-2015 cycle. These respectively concerned: promoting education and outreach, further developing the Title V Program's data capacity, and improving the health status of CYSHCN (though CRS will continue to address the latter). Four other priorities from the previous cycle, though not retained, are generally covered by the new priorities. These four priorities respectively concerned: improving the capacity of CYSHCN to be fully integrated into their communities (covered by Priority 8), assuring primary care (covered by Priority 2), further reducing the adolescent pregnancy rate (covered by Priority 3), and reducing the prevalence of high risk behaviors in adolescents (covered by Priority 3).

CHANGES IN CAPACITY

Following the increase in the State's infant mortality rate in 2007, the State Perinatal Program (SPP), administratively located in FHS, intensified its efforts to implement fetal and infant mortality review (FIMR) statewide. In spearheading this effort, the program collaborates with the SPAC and the RPACs. Although additional nursing staff have not been added to SPP, a research analyst was added to the program's staff in FY 2010, which has enhanced the program's capacity to develop and analyze a FIMR database.

A major change in CRS's capacity is the enhancement of transition planning services in the State. All CRS districts have access to a transition specialist--a social worker who has specialized training in transition to adulthood and who serves as the primary care coordinator for youth of transition age. Also, CRS has added a Care Coordination Specialist in the State Office to focus on quality improvements within the care coordination program. CRS has enhanced its participation with the Universal Newborn Hearing Screening Program (administratively located in FHS) through electronic data-sharing related to follow-up testing for children who fail the initial newborn screening. As well, CRS has expanded its data collection and analysis capacity via an electronic medical record system. Finally, CRS has new capacity for partnership with critical organizations that provide family education, training, informational resources, and leadership development.

III. State Overview

A. Overview

Acronyms or shortened terms are listed in Appendix C, obtainable by calling 334.206.5943 or e-mailing anita.cowden@adph.state.al.us. Also, Appendix C is included in the attachment to III.A.

Key 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 reported 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 and consideration of findings from and 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 reside 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 discussed in Section III.F. Further, poverty, geographic distribution, urbanization, and socioeconomic, racial, and ethnic disparities in MCH indicators are discussed in Section 3 of 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 SPP; the Healthy Childcare Alabama Program, the Alabama Child Death Review System, 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 over the last several years. 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 concerning 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 concurrently with these programs, follows.

Medicaid Maternity Care Program

Under the Alabama Medicaid Agency's (Medicaid's, or 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.

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. (However, only Medicaid Eligibility Workers can award Medicaid eligibility.) Medicaid provides formal training to certify or update Application Assistants on a request basis. Due to a State hiring freeze, the longstanding shortage of Medicaid Eligibility Workers continues. Timely Medicaid eligibility determination continues to be a challenge, particularly in Jefferson County, due to its large and diverse population.

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. For this reason, an integrated 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 to 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 1 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, including CYSHCN, in a county 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, including CYSHCN. Under Patient 1st, though a few CHDs provided some child health services through 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 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 lst, 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 services to 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 (for example [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 that had a major impact on ADPH was that Medicaid no longer required a referral from the patient's primary medical provider in order to provide care coordination services to 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 system, which is ongoing, 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 State's 11 public health areas (PHAs, or Areas) using the CCRS system. Since implementation of CCRS, several thousand referrals have gone through the 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 assistance 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. These 101 FTEs were a substantial decline from the corresponding 133 FTEs in FY 2008. There were 25 licensed social workers or nurses providing care coordination during FY 2009, down from 30 in FY 2008.

Until the TFQ care coordination pilot ended on March 31, 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.

In FY 2010, the Medicaid match dropped from 33% to 23.46%. However, the Governor has required that ADPH turn over any savings to the State for distribution to other agencies.

Care coordination is further discussed under Health Systems Capacity Indicator (HSCI) #1 in Section III.F and under State Performance Measure (SPM) #1 in Section IV.D.

Collaboration Between CRS and Medicaid
The Medicaid Commissioner has emphasized children's issues as an agency priority. To this end, CRS has specific Medicaid staff members assigned to work with CRS's programs. Meetings between Medicaid and CRS are conducted quarterly, which has led to greater coordination and communication. 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, thus increasing access of Medicaid-enrolled CYSHCN to small therapy-provider groups. CRS credentials its staff and vendor physical, occupational, and speech therapists, as well as licensed physical therapist 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 to 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 to 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. In the past, CRS also reviewed all power wheelchair requests, but these are now contracted to a private company. A CRS physical therapist provided training for the new company and served as reviewer during the transition.

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. This waiver, called "Plan First," expanded Medicaid eligibility for family planning services for women aged 19-44 years to 133% of the 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 (SCHIP, 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 major components of the Family Planning Waiver Proposal.

Plan First is currently in its 2nd 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 of 2009, states are now allowed to use a data match with the Social Security

Administration to verify citizenship.

The State Children's Health Insurance Program

The federal 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. Discussion of the foundation follows, and is followed by a discussion of the history of Alabama's CHIP.

The Alabama Child Caring Foundation is a non-profit, publicly supported organization that is the funding mechanism for the Alabama Child Caring Program. Blue Cross and Blue Shield of Alabama (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 dollar for dollar. The mission of the Alabama Child Caring Foundation 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 the Alabama Child Caring Program.

In 1997 the State Legislature appropriated funds for Alabama's CHIP. The State Legislature also created a 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 the U.S. Department of Health and Human Services' (DHHS') HCFA and to receive the federal funds. (HCFA is now the Centers for Medicare and Medicaid Services.) 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 the passage of the State legislation, a work group had been formed and begun development of a CHIP plan for Alabama. The work group included representative 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 the 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 the FPL, began on October 1, 1998. Effective October 1, 2009, the upper income criterion for enrollment in ALL Kids increased, with 300% of the FPL now being the maximum allowable household income.

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 the Social Security Administration (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.

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, the Alabama Child Caring Program 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 the Alabama Child Caring Program are described under NPM #13.

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 through 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 in 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 the 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 providing oversight for 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 current 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 much 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 also 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 collections 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 related to this ongoing endeavor.

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 are adults with bleeding disorders. CRS provides assistance to clients with Medicare coverage to select the health plan option that best address their needs and to assist them in locating 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.

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%, whereas the nation's population had increased 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.

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.

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 the FPL, according to age, were as follows: 22.9% of persons aged 17 years or younger, 14.6% of persons aged 18-64 years, and 12.2% of persons aged 65 years or older. Corresponding percentages for the U.S. were: 18.2% of persons aged 17 years or younger, 11.8% of persons 18-64 years, and 9.8% of persons aged 65 years or older.

TRENDS IN NUMBERS OF ALABAMA TITLE V-SERVED INDIVIDUALS
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 Block Grant Services reports/applications (MCH reports/applications), and to FYs.

In most cases, the following discussion of numbers served respectively compares numbers served in 2009 to numbers served in 1997, 2004, and 2008. The year 1997 was chosen as a

referent point in order to illustrate the dramatic decline in the number of pregnant women and the number of children and youth served over the years. The years 2004 and 2008 were chosen as referent points in order to respectively illustrate changes over a 5-year and 1-year period. The "children and youth" class was served by ADPH and presumably includes some CYSHCN. The "CYSHCN" class was served by CRS.

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, by 69.9% over a 5-year period, and by 2.6% over a 1-year period. As previously discussed, ADPH has withdrawn from providing direct prenatal care. Presumably, CHDs provided care coordination, rather than direct care, to pregnant women served in 2008 and 2009.

Infants--The surveillance period for infants excludes 1997, since the method for estimating these numbers changed in 1998. 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. As detailed in notes to Form 7, the number of Title V-served infants is estimated by multiplying the number of initial screens for a given condition (as reported on Form 6) by the factor .95: which we believe provides a conservative estimate of the number served.

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 CYSHCN enrolled in the CRS program who receive direct and enabling services or families that 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 ranged from 23,441 in 1997 to 16,296 in 2009. The highest number served during that time period was 24,545 in 2000. The FY 2009 number served, 16,296, is 1.8% less than the number served in FY 2008 (16, 591), while that year showed a 1.5% increase over the FY 2007 number served (16,346). The number of CYSHCN served has been fairly stable since 2007, following a significant decrease in FY 2005 (15.6%). The FY 2005 decline 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 FY 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. This 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 personnel levels.

Others--The "others" class consists of males and females served in CHD Family Planning Program 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, by 15.3% over a 5-year period, and by 1.9% over a 1-year period.

As described above, the number of pregnant women served at CHDs has markedly declined over the years, and ADPH no longer provides direct prenatal care. As also described 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 changes in 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 numbers served, as reported above, come from Form 7. Except for the "Infants < 1 year old" class, Form 7 counts only individuals who received services in a CHD facility or a CRS facility, not individuals who were 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.

EMERGENCY PREPAREDNESS

Recent years have brought a focus on emergency preparedness. In FY 2009, ADPH made intensive efforts to prevent and track infections with the 2009 H1N1 influenza and to inform the public about this influenza. These efforts included press conferences held by the State Health Officer, vaccinations administered at CHDs, and a 2009 H1N1 Influenza web page posted by ADPH's Division of Epidemiology, which is located in ADPH's Bureau of Communicable Disease. A fuller discussion of emergency preparedness, including how ADPH and CRS are involved, is in the attachment to this section.

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 the rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN in the general child population, such as higher levels of poverty and lower educational attainment. 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 more complicated health issues. Specialists and allied health professionals with pediatric experience are mainly located in the larger urban areas, necessitating travel to access this expertise. 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. Through 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 2 tertiary-level pediatric hospitals in the State, 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.

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 during 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 significant 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 to families. With increased funding in FY 2007 and 2008, CRS was able to restore purchased services for families with annual taxable incomes up to 300% of the FPL.

With difficult economic times, the State once 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 significant 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 did provide some savings to the program. However, the FY 2010 State appropriation was set at the prorated FY 2009 level minus most of this FMAP savings. No additional cuts in services have been implemented at this time. CRS staff members have worked diligently to assure that CYSHCN and their families continue to receive high quality services in their local communities and have helped identify resources that can provide additional support. The CRS leadership team has actively sought innovative partnerships that can maximize the program and is closely monitoring staffing and budgets to assure efficiency. Continued funding challenges will certainly 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.

An attachment is included in this section.

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 occured. 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/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.

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.

Culturally Competent Care
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 #3). 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 FYs 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, the Alabama Child Death Review System, the Alabama Child Lead Poisoning Prevention Program, and FHS's Newborn Screening Program provide educational and/or outreach brochures in Spanish.

CRS promotes the provision of culturally competent care to all CYSHCN and families. The FY 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 the Alabama Child Caring Foundation 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.

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.

4) Child Death Review--Legislation creating the Alabama Child Death Review System (ACDRS) 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) SCHIP--See "Changes in 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 #4, Appendix B).

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.

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 in Appendix D and, as well, 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 e-mail 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 ADPH's Bureau of Health Promotion and Chronic Disease (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 in Appendix D:
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.

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.

An attachment is included in this section.

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.

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 94.4 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%).

In FY 2009, 229.2 FTEs were devoted to WIC. The Breast and Cervical Cancer Early Detection Program's cost-center category, which is not included in the preceding FTEs, had 15.5 FTEs in FY 2008. The Breast and Cervical Cancer Early Detection Program serves eligible 40-64 year-old women, but also provides breast cancer screening for younger women who have certain breast problems.

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.

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 with 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.

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.

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.

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 clinical care coordination programs statewide.

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 U.S. Centers for Disease Control and Prevention [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 physical therapists (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.

Key CRS senior administrative staff include the Assistant Commissioner, the State Supervisor for Professional Services, the Clinical/Policy Specialist, and the Special Programs Coordinator. Biographical information on staff in these positions follows.

Melinda Davis, MS, CCC-A, CPHL, is the Assistant Commissioner for ADRS and the Director of CRS. 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.

Julie Preskitt, MSOT, MPH, PhD, is the Special Programs Coordinator. Her experience includes high-risk follow up and provision of occupational therapy services to CYSHCN in pediatric hospital and early intervention settings. Academic credentials include undergraduate degrees in biology and occupational therapy and graduate degrees in occupational therapy, public health-MCH, and public administration/public policy.

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.

E. State Agency Coordination

Coordination of the Title V Program with entities mentioned in the Guidance (reference #2, Appendix B) 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 DDUs 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. Both FHS and CRS are involved in initiatives concerning emergency preparedness, which is briefly discussed in Section III.A and fully discussed in an attachment to that section.

CRS serves as a member of the State Newborn Hearing Screening Advisory Committee, a

subcommittee of the Alabama Newborn Screening Advisory Committee that is 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 the 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 Sections 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 #7). (NPMs and SPMs are respectively discussed in Sections IV.C and IV.D.) 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 2010, AMOD is helping to support the initiatives of SPP's FIMR Program. Also, as discussed under HSCI #5B (in Section III.F), in response to a proposal submitted by SPP in FY 2008, Medicaid has agreed to support SPP's statewide infant death review initiative with matching funds.

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 funds for purchase of contraceptives in FY 2004.) Currently, negotiations are underway to acquire

ARRA "crisis situation" funding for additional contraceptives and family planning outreach for Temporary Assistance for Needy Families (TANF)-eligible clients.

Children's Health Division staff collaborate with several entities, such as with: local child death review teams to implement ACDRS (see SPM #7), delivery hospitals to assure that newborns receive appropriate biochemical and hearing screening (see NPMs #1 and #12), CHIP and Medicaid to promote enrollment of eligible infants and children in ALL Kids and Medicaid (see NPM #13), DHR to implement the Healthy Child Care Alabama Program, DHR's work group developing a Quality Rating Improvement System for child care programs, and, as a member of the State Suicide Prevention Task Force, with various organizations to prevent suicide. The division also works closely with the Alabama Partnership for Children, DMH, DHR, EIS, and DCA through its Early Childhood Comprehensive Systems grant on the implementation of Alabama's Blueprint for Zero to Five, the State's strategic plan for early childhood systems development. Healthy Child Care Alabama (HCCA) continued its ongoing collaboration 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 continued provision of 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, which is the primary pediatric teaching hospital of the UAB School of Medicine.

In FY 2005, ACDRS teamed with the Gift of Life Foundation to fund a "Cribs for Kids" pilot program in Montgomery. This ongoing program provides safe, separate infant sleeping surfaces to families who would otherwise have none, in order to prevent sleep-related deaths. It was expanded in FY 2009 to include participants in the surrounding greater Montgomery area and a few other areas serviced by Gift of Life, but funding has not been identified to take the program statewide as originally hoped. The Jefferson County Pilot Project, started in 2009 as part of the Alabama Infant Vitality Initiative, included a new Jefferson County Cribs for Kids effort as part of its multifaceted plan, but such a program has yet to be established there.

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 ongoing 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 FY 2008 and FY 2009. However, due to lack of funds for the State match, the FY 2010 program will be reduced to 4 counties. Activities for FY 2011 are dependent on availability of funds.

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, a 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.

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.

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. As well, all current ADPH nurse practitioners were trained in 2008 to insert the highly effective, long-term birth control method Implanon, and the newest ADPH nurse practitioners were trained in March 2010.

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.

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.

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 to collaborate 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 a federal Maternal and Child Health Bureau (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 in the preceding discussion of State-level collaborations, 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.

CRS was the lead entity in planning to meet the Healthy People 2010 objectives for CYSHCN. Work groups were formed around each of the 6 objectives for CYSHCN and chaired by a colleague from outside ADRS. CRS State Office staff members served as liaisons to these groups and assisted in the facilitation of quarterly meetings addressing planning and implementation of activities and strategies to meet the objectives. Families of CYSHCN, youth, and representatives from other agencies were active participants in these work groups. Individual work group action plans, including goals and action steps, were consolidated into an overall Alabama Action Plan to meet the 2010 objectives for CYSHCN. Activities have been ongoing, and the plan was updated as steps were completed and new objectives were set. Further planning and activities will follow once new Healthy People 2020 objectives are released.

F. Health Systems Capacity Indicators

Introduction

Discussion of HSCIs follows. In most cases, discussion of trends is based on numbers available by April 2010. At that time, the final statistical birth and death files for 2009 were not available to FHS. Final statistical files may become available by August 2010. If these files become available by August 2010, the forms may be updated accordingly in September 2010. However, any updates added to the forms in September will not be discussed in the narrative.

In some cases, the Alabama 2009-10 MCH Needs Assessment Report (reference #1) is

referenced. This document can be requested by e-mailing anita.cowden@adph.state.al.us.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	83.7	79.9	62.2	53.8	48.8
Numerator	2562	2437	1906	1669	1514
Denominator	306124	305126	306432	310504	310504
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

Notes - 2009
Data Issues:
All estimates are for calendar years.

Alabama does not have a statewide hospital discharge data base, so numerators are obtained by summing numbers provided by Blue Cross and Blue Shield of Alabama (BCBS) and by the Alabama Medicaid Agency. Numerators therefore represent the number of hospital discharges of 0-4 year-old children, where the child was insured by either BCBS or Medicaid.

Several years ago, review of numbers for 2002-2004 revealed that the total reported number of BCBS and Medicaid enrollees in this age group exceeded the projected population for this age group. Therefore, the denominators are population projections or population estimates for the 0-4 year-old population, rather than the total number of Medicaid and BCBS enrollees.

Failure to capture children who are uninsured or are insured by other entities in the numerator leads to undercounting the number of asthma-related hospital discharges in this age group. Along with the use of population-based denominators, this undercounting leads to underestimating the asthma hospitalization rate. However, in the absence of a hospital discharge database and the potential for over counting Medicaid-enrolled and/or BCBS-enrolled children, estimates for this indicator are based on the best numerators and denominators available to the Bureau of Family Health Services (FHS).

Population estimates derived from a U.S. Census Bureau spreadsheet are shown as denominators for 2006 onward. However, the estimate for 2008 is used as the best estimate for 2009, since the estimated 0-4 year-old population is not readily available to FHS currently. (The year 2005 denominator shown on Form 11 is a population projection.)

Because we are now using updated population estimates and, for 2006, an updated count of hospitalizations of Medicaid-enrollees, numbers shown on Form 11 notes for 2005 and 2006 do not match our current best estimates. (The web-based Title V Information System [TVIS] does not allow us to directly change numbers for 2005 or 2006.) Our current best estimates for the rates shown on Form 11 for 2005 and 2006 are as follows: 85.3 hospitalizations per 10,000 in 2005 (2,562/300,239), and 62.6 hospitalizations per 10,000 in 2006 (1,893/302,295).

In FY 2009, communications with Medicaid staff and BCBS staff indicated that each had

experienced changes in their data systems. Due to these changes, we are not confident that the estimated hospitalization rates for later years are comparable to years through 2005 or perhaps 2006.

Trends:
Our best estimates for recent years are as follows: 62.6 per 10,000 in 2006, 62.2 per 10,000 in 2007, 53.8 per 10,000 in 2008, and 48.8 per 10,000 in 2009.

Notes - 2008
Data Issues:
See year 2009 note.

The number of hospitalizations in 2008 were provided by BCBS and Medicaid in April 2010.

Notes - 2007
Data Issues:
See year 2009 note.

Updated numbers for the number of Medicaid-funded hospitalizations in 2006 and 2007 were provided by Medicaid in April 2010. These numbers were updated in order to assure comparability of the Medicaid component of this indicator from 2006-2009, since changes in the Medicaid data system had occurred in FY 2009. However, as detailed in this indicator's year 2009 Form 17 note, TVIS does not allow us to revise Form 17 numbers for 2006.

Narrative:
Status and Trends:
The estimated hospitalization rate for asthma among 0-4 year-old Alabama residents was as follows in recent years: 62.6 per 10,000 in 2006, 62.2 per 10,000 in 2007, 53.8 per 10,000 in 2008, and 48.8 per 10,000 in 2009.

See this indicator's year 2009 Form 17 field note for data-related issues, including an explanation of why the aforesaid estimate for 2006 does not match that shown on Form 17.

Activities, Strategies, and Developments:
Ceteris paribus, appropriate medical care should decrease the hospitalization rate for persons with asthma. A Health Plan Employer Data and Information Set (HEDIS[TM])-based indicator for enrollees in ALL Kids, Alabama's CHIP, is used to monitor appropriately prescribed medication for asthma. This indicator is not monitored for preschool children but is monitored for older ALL Kids enrollees, and findings for children aged 5-9 years might correlate with appropriate medical management of preschool children with asthma. The referenced HEDIS indicator is: "the percentage of enrolled members 5-56 years of age who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year." (The numerator and denominator for this measure, including specific medications considered to be appropriate, are specified in Alabama CHIP's most recent annual report. The oldest ALL Kids enrollees are 19 years of age.) Per this measure, of 5-9 year-old ALL Kids enrollees with persistent asthma, the percentage who were appropriately prescribed medication for asthma increased (improved) from 74% (239/322) in FY 2004 to 79% (255/322) in FY 2005, and then markedly improved to 95% (225/237) in FY 2006. Subsequently, this measure increased to 96.2% (276/287) in FY 2007, increased very slightly to 96.3% (314/326) in FY 2007, and then declined slightly to 95.1% (331/348) in FY 2009 (references #5-#6).

Alabama's CHIP is extensively discussed in Section III.A, under NPM #13, and under HSCI #3.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	128.7	93.4	96.1	96.1	62.4
Numerator	48965	140863	148966	148966	101456
Denominator	38033	150811	155006	155006	162501
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

Notes - 2009
Data Issues:
Estimates are for fiscal years (FYs).

See year 2008 field note concerning methods.

Trends:
As shown, the estimated percent of Medicaid-enrolled infants dropped markedly in FY 2009 relative to FYs 2006-2008. Technically speaking, this occurred because the numerator (total screens received) dropped markedly, while the denominator (expected number of screenings) increased. This is presumably due to the change in reporting procedures, which is discussed in this indicator's year 2008 Form 17 field note. Due to competing priorities, Family Health Services has not been able to recalculate this indicator to provide an estimate that is comparable to that for FY 2007, which is also used as our best estimate for FY 2008.

Notes - 2008
Data Issues:
Numbers shown for 2005 are based on a previously used but flawed method. Though the reference for the previous method was an Alabama Medicaid Agency (Medicaid) EPSDT participation report, the line items (numerator and denominator) used from this report yielded a percentage over 100%, because of changes in eligibility during the reporting year. We have found a better way to make estimates for years through 2007 (see below), but the Title V Information System does not allow us to directly change numbers for 2005.

Per consultation with Medicaid staff, a better method of estimating this indicator for years through 2007 was identified. The source for those years continues to be Medicaid's EPSDT participation report for Alabama, now entitled "Form CMS-416: Annual EPSDT Participation Report" (the "416 Report"). However, the numerator is now the "Total Screens Received" (item 6 of the report), and the denominator is "Expected Number of Screenings" (item 5). Further, the percent yielded by the new method corresponds to the "Screening Ratio" (item 7) shown on Medicaid EPSDT participation reports. For example, in FY 2007 the screening ratio for Medicaid enrollees under 1 year of age was 0.961, which corresponds to the estimate of 96.1% that is shown above for 2007.

However, beginning with the report for 2008, Medicaid changed their interpretations of the provisions of the CMS-416 specifications. Specifically, in previous years Medicaid had counted screenings based on the age of the recipient on the date of service. However, when implementing a new data system in February 2008, Medicaid changed the methodology for counting screenings to the age that the recipient would be on September 30 (the last day) of the reporting year—regardless of the age on the date of service. Due to this change, in the 416 Report for FY 2008, many infants who are screened before their first birthday are shifted upward, into the 1-2 year-old category. For example, a baby born on September 30, 2007 and screened on November 30, 2007 (at 2 months of age) is counted as being from 1-2 years of age, because he or she would become 1 year of age on September 30, 2008. A concurrent shift does not occur in the denominator (item 5 of the 416 report). For this reason, we are using the numbers reported for FY 2007 as our best estimates for FY 2008. Medicaid subsequently provided us with detailed, complex instructions that might enable us to recalculate this indicator for 2008 in a manner that is consistent with methods previously used by Medicaid, and we will seek to do so by 2010.

Trends:
Based on items 5 and 6 of the Medicaid EPSDT participation reports through FY 2007, the estimated percentage of Medicaid infants who received a periodic screen was 90.1% in 2003, increased to 92.4% in 2004 and to 94.2% in 2005, declined slightly to 93.4% in 2006, and increased again to 96.1% in 2007.

Notes - 2007
See year 2008 field note concerning methods.

Narrative:
Status and Trends:
See this indicator's 2008 and 2009 field notes to Form 17 for data-related issues. As stated in the year 2009 note, the estimate for 2009 is not comparable to earlier estimates: for reasons discussed in the year 2008 note. Specifically, Medicaid's methodology for counting screenings, which constitute the numerator of the percentage reported on Form 17, changed in FY 2008.

Activities, Strategies, and Developments:
ADPH's activities to promote care coordination of children from birth through 9 years of age, especially EPSDT-enrolled children, may contribute to receipt of well child care for all Medicaid-enrolled infants. These activities are discussed under SPM #1, located in Section IV.D. 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 Medicaid-enrolled infants.

Health Systems Capacity Indicator 03: *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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	94.3	96.7	94.7	95.2	95.8
Numerator	82	208	213	256	298
Denominator	87	215	225	269	311
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

Notes - 2009
Data Issues:
The source document for the 2009 estimate is: Alabama's submission of the "Framework for the Annual Report of the State Children's Health Insurance Plans under Title XXI of the Social Security Act. FY 2009."

For all years shown, the surrogate used for this measure (from the above report and corresponding reports for preceding years) is entitled "Well Child Visits in the First 15 Months of Life." The numerator is the number of members who had received 1 or more well-child visits with a primary care provider during their first 15 months of life. The denominator is the number of CHIP enrollees in the appropriate age group.

Status and Trends:
From 2005-2009, this indicator ranged from 94.3% in 2005 to 96.7% in 2006, with a median of 95.2% n 2008. In 2009, 95.8% of CHIP enrollees in the appropriate age group made a well child visit to a primary provider in the first 15 months of life.

Notes - 2008
The source document for the 2008 estimate is: Alabama's submission of the "Framework for the Annual Report of the State Children's Health Insurance Plans under Title XXI of the Social Security Act. FY 2008."

Notes - 2007
The source document for the 2007 estimate is: Alabama's submission of the "Framework for the Annual Report of the State Children's Health Insurance Plans under Title XXI of the Social Security Act. FY 2007."

Narrative:
As stated elsewhere in this document, Alabama's CHIP is named "ALL Kids." In FY 2006, after considering the methodological issues involved, 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 via this consultation is based on specifications provided by HEDIS[TM], and reports well child visits in the first 15 months of life. Though aware that the Title V definition of HSCI #3 pertains to the first year of life, we have chosen the HEDIS-based method to estimate HSCI #3 for several reasons. First, as just stated, the HEDIS-based method has the advantage of standardization. Second, we believe that reporting well child visits through the first 15 months of life, rather than through 12 months of life, better captures well child 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 evaluation and planning. Finally, the HEDIS-based indicator is readily available. Further efforts to refine our previous methods are not deemed feasible, and would be unlikely to produce better information than that produced by the HEDIS-based method.

The HEDIS-based indicator that we are using is precisely defined in the Form 17 field notes for HSCI #3. 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, the percentage who received 1 or more well child visits with a primary care provider during the reporting year was 76.1% in the baseline year of 2003 (not shown); increased to

81.9% in FY 2004 (also not shown); and then ranged from 94.3% in 2005 to 96.7% in 2006. Thus, the status of this indicator in 2005 through 2009 was a notable achievement, relative to the 2003 baseline year.

Activities, Strategies, and Developments:
ALL Kids and FHS staff believe that several factors contributed to this achievement. 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. ALL Kids activities are further discussed under NPM #13, located in Section IV.C. Further, as mentioned under HSCI #2 and 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.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	78.6	76.4	74.0	74.0	
Numerator	47182	47893	46478	46085	
Denominator	60065	62686	62824	62266	
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

Notes - 2009
All estimates pertain to calendar years.

Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010. Otherwise, this estimate will be provided by July 2011.

This paragraph pertains to HSCIs #4 and #5: for which both the numerators and denominators come from statistical live birth files. Births to Alabama residents that occur outside of the State have apparently been underreported to the Alabama Department of Public Health (ADPH) in recent years. 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. In an effort to account for these issues, for years 2007 and 2008, the numbers shown on Form 17 are based on occurrent events only. That is, we counted only births that occurred in Alabama to Alabama residents. However, because TVIS does not permit us to directly revise numbers shown for 2005 and 2006, the numbers shown on Form 11 for those years include out-of-state, as well as in-state, births to Alabama residents.

Trends:
When looking at occurrent, residential births only, from 2000-2008, this indicator ranged from 74.0% in 2007 and 2008 to 78.9% in 2003, with a median of 77.4% in 2001. This indicator declined (worsened) at least slightly each year from 2004-2007, and then remained at the 2007 level in 2008. In 2008, for 74.0 percent of occurrent deliveries to 15-44 year-old Alabama residents, 74.0 percent of the mothers had received adequate or more than adequate prenatal care.

Notes - 2008
Data Issues and Trends:
See this indicator's year 2009 Form 17 note.

Notes - 2007
Data Issues:
Due to staffing changes and, presumably, slight changes in the programming for estimating the Kotelchuck Index, the current estimates for 2004 and 2005 differ slightly from those shown above. However, TVIS does not allow us to directly revise estimates for those years. Per updated estimates, of live births to 15-44 year-old Alabama residents, the percentage for whom the observed to expected prenatal visits was greater than or equal to 80% per the Kotelchuck Index was as follows: 77.6% (45,771/58,956) in 2004 and 77.6% (46,599/60,065) in 2005.

Trends:
Overall, comparing 3-year periods, this indicator declined by 1.4%: from 77.0% (139,880/181,645) in 2000-02 to 75.9% (141,810/186,745) in 2005-07. With respect to individual years, from a baseline of 76.1% in 2000, the indicator increased slightly 3 years successively, bringing it to 78.5% in 2003. However, the indicator then declined to 77.6% in 2004, where it remained in 2005. It then declined 2 successive years and was 73.9% in 2007. That is, for Alabama residential live births in 2007 to 15-44 year-old mothers, 73.9% of infants were born to mothers who had received adequate or adequate plus prenatal care per the Kotelchuck Index.

Narrative:
Status and Trends:

See this indicator's Form 17 year 2009 field note for trends and data-related issues.

In 2008, for Alabama occurrent, residential live births to 15-44 year-old mothers, 74.0% of infants were born to mothers who had received adequate or adequate plus prenatal care per the Kotelchuck Index.

Related Findings from MCH Needs Assessment Report:
Trends in the proportion of occurrent, residential live births for which the mother had received inadequate prenatal care, as measured by the Kotelchuck Index, are discussed in Section 3 of the Needs Assessment Report (reference #1), under the heading, "Certain Pregnancy-Related Indicators." In the Needs Assessment Report, findings on inadequate care are discussed and depicted in figures for the total group, 4 groups defined by race and/or ethnicity, and 3 source-of-payment groups. Selected findings from the Needs Assessment report follow. Note that these findings pertain to inadequate prenatal care, not adequate care. As well, the findings below are for live births to mothers of any age.

For the total group, the percentage of infants whose mother had received inadequate prenatal care ranged from 10.1% in 2003 to 13.9% in 2008. In this group, this percentage did not decline (improve) for 3 successive years at any point during the surveillance period. In the total group, for successive 3-year periods, the prevalence of inadequate care was 11.3% in 2000-02, 10.5% in 2003-05, and 13.1% in 2006-08. Thus, the prevalence of inadequate care was higher (worse)

in 2006-08 than in either of the other 3-year periods.

As well, for each of the 4 racial/ethnic subgroups studied (Latino; White, non-Latino; Black, non-Latino; and Other, non-Latino), proportionately more women received inadequate prenatal care in 2006-08 relative to either of the other 3-year periods studied. Latina mothers, followed by Black, non-Latina mothers, were most likely to have received inadequate prenatal care. In 2008, the percentages of infants whose mother had received inadequate prenatal care were as follows: 41.8% of Latino babies; 17.4% of Black, non-Latino babies; 9.2% of Other, non-Latino babies; and 8.3% of White, non-Latino babies.

Findings concerning trends in the prevalence of inadequate prenatal care according to source of payment are discussed under HSCI #5D.

Activities, Strategies, and Developments:
Activities to encourage early and adequate prenatal care are described under NPM #18, in Section IV.C. Briefly stated, these include: 1) education of CHD Family Planning clients on the importance of early and continuous prenatal care, 2) operation of a toll-free hotline that helps pregnant women access providers and educational materials, and 3) Medicaid's statewide implementation of their Maternity Care Program.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	88.9	88.5	89.6	91.1	93.0
Numerator	417705	442295	413797	419912	456378
Denominator	469972	499796	462044	460708	490575
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

Notes - 2009
Data Issues:
All estimates are for fiscal years.

The numerator and denominator were provided by the Alabama Medicaid Agency (Medicaid) on April 12, 2010, based on that agency's query of their data system.

Trends:
Trends from 2003-2008 are discussed in this indicator's year 2008 Form 17 field note. The indicator increased in 2009, bringing it to its highest single-year level (93.0%) during the total surveillance period (2003-2009).

At 490,575, the number enrolled in 2009 was the second-highest enrollment number during the surveillance period, when this number ranged from 449,906 in 2003 to 499,796 in 2006.

At 456,378, the number of Medicaid-eligible children who received a Medicaid-paid service in 2009 was the highest during the surveillance period. (The lowest number of such children during the surveillance period was 386,624, in 2003.)

Notes - 2008
Data Issues:
The numerator and denominator were provided by Medicaid on April 3, 2009, based on that agency's query of their data system.

Trends:
Assuming comparable methods (see field note for 2007), from a baseline of 85.9% in 2003, this indicator increased slightly in all years except 2006. Comparing 3-year periods, the indicator increased by 2.7% overall: from 87.3% (1,207,707/1,383,104) in 2003-05 to 89.7% (1,276,004/1,422,548) in 2006-08. The number of enrollees again declined in FY 2008, though not as strikingly as in 2007.

Notes - 2007
Data Issues:
The numerator and denominator were provided by Medicaid, based on that agency's query of their data system, on April 15, 2008. The numerator and denominator are notably less than those reported for 2006, but the percentage is about the same as that reported for 2006. For 2 reasons, we cannot determine whether the methods used for the 2006 and 2007 numbers were precisely comparable: A log documenting how the query was made is not available, and staff turnover has occurred. That is, the Alabama Department of Public Health (ADPH) staff member who made the request for 2006 and the Medicaid staff member who provided the requested numbers for that year are no longer with their respective agencies. However, documentation available for ADPH's corresponding request for 2006 and Medicaid's reply for 2006 were reviewed, and each agency sought to duplicate the methods used for the 2006 estimate.

Narrative:
Status and Trends:
See this indicator's Form 17 field notes for data-related issues and trends.

Activities, Strategies, and Developments:
As more fully discussed in Section III.A, over a period of several years the number of children receiving Title V-funded services in CHDs has markedly declined. Much of the decline was concurrent with implementation of Patient 1st, Medicaid's PCCM, which many believe has increased access to primary care for Medicaid recipients, including children, throughout the State. With this increased access, many Medicaid-enrolled children and youth who may otherwise have received direct health care at CHDs received their care elsewhere.

Patient 1st affects the provision of direct services and care coordination services, which are generally enabling services, to Medicaid-enrolled children. The course of Patient 1st and the parallel course of care coordination in CHD settings, therefore, are discussed in Section III.A. To briefly recap, Patient 1st was first implemented in 1988, discontinued in March 2004, and reinstated in early FY 2005.

Though providing direct care to fewer children, ADPH seeks to facilitate enrollment of Medicaid-eligible children in Medicaid (see NPM #13) and engages in activities that help promote access to care for all children. For example:
1) CHDs continue to provide direct care to some children, though far fewer than in the 1980s and early 1990s.

2) Activities to promote care coordination of children, discussed under SPM #1, promote EPSDT-enrolled children's access to health care. Social work and nurse care coordinators are available in every CHD to work with patients and families to assist in the removal of barriers to care. Care coordination services help facilitate enrollment of Medicaid-eligible children in Medicaid and help assure that Medicaid-enrolled children receive appropriate services. Care coordination services

are further discussed in Section III.A.

3) ADPH promotes universal newborn screening for metabolic and hematologic disorders and for hearing impairment. The 2 screening programs are respectively discussed under NPM #1 and NPM #12.

4) In the HCCA program, which has been in place since 1998, 9 Child Care Nurse Consultants work with child care providers, children 0-5 years of age who receive out-of-home child care, and the families of these children. These services are provided in 52 counties. Services include information on health and safety for child care providers and families of children in child care; health and safety programs for children attending child care programs; linkage of families and child care providers to community resources and services, including ALL Kids, Medicaid, EIS, and WIC; and assistance to child care providers with integration of CYSHCN into the child care environment.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	51.4	53.0	65.3	58.8	61.9
Numerator	49619	52976	64652	57679	64634
Denominator	96606	99995	99022	98055	104465
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

Notes - 2009
Data Issues:
All estimates are for fiscal years.

The source document is "Form CMS-416: Annual EPSDT Participation Report" for FY 2009, which was provided by the Alabama Medicaid Agency. The numerator is "Total Eligibles Receiving Any Dental Services" (line 12a of the report), and the denominator is "Total individuals eligible for EPSDT" (line 1 of the report).

Trends:
Trends from 2003-2008 are discussed in this indicator's year 2008 Form 17 field note. The indicator increased in 2009, bringing it to its second-highest single-year level (61.9%) during the total surveillance period (2003-2009). The highest level was 65.3%, in 2007.

At 104,465, the number of EPSDT-eligible 6-9 year-old children in 2009 was the highest number of such children during the surveillance period, (The lowest such number was 91,279, in 2003.)

At 64,634, the number of EPSDT-eligible children who received a Medicaid-paid dental service in 2009 was the second-highest during the surveillance period. The highest such number was 64,652, in 2007.

Notes - 2008

Data Issues:
The source document is "Form CMS-416: Annual EPSDT Participation Report" for FY 2008, which was provided by the Alabama Medicaid Agency. The numerator is "Total Eligibles Receiving Any Dental Services" (line 12a of the report), and the denominator is "Total individuals eligible for EPSDT" (line 1 of the report).

Trends:
From a baseline of 46.5% in 2003, this indicator increased each year through 2007, when it was notably higher than in previous years during the surveillance period. It then declined to 58.8% in 2008. Though this indicator was lower in 2008 than in 2007, the 2008 estimate was at the second-highest level for the surveillance period. Comparing 3-year periods, the percent of EPSDT-eligible children in this age group who received any dental service increased by 19.8%: from 49.3% (139,253/282,634) in 2003-05 to 59.0% (175,307/297,072) in 2006-08.

Notes - 2007
The source document is: Alabama Title XIX Annual EPSDT Participation Report, FY 2007.

Narrative:
Status and Trends:
See this indicator's Form 17 field notes. In FY 2009, 61.9% of Alabama EPSDT-eligible, 6-9 year-old children received a dental service.

Activities, Strategies, and Developments:
Issues pertaining to oral health of children are discussed under NPM #9 and SPM #2, respectively located in Sections IV.C and IV.D. To briefly summarize, measures to promote oral health of children, including but not limited to EPSDT-enrolled children, include:
1) In collaboration with others, provision of dental services to certain populations of children who tend to have unmet dental needs, including provision of oral health services in CHDs and in school-based clinics.

2) Training of care coordinators with Patient 1st, Medicaid's primary care case management program, to promote good oral health for children and their families.

3) Participation in national Children's Dental Health Month and in the national "Give Kids a Smile" campaign.

4) Promotion of the provision of dental sealants by public- and private-sector providers.

5) Provision of training and assistance to CHD staff and FHS's out-stationed staff--including care coordinators and HCCA Nurse Consultants--on ways to promote access to dental care and utilization of dental services.

The Bureau's OHB partnered with ADPH's Office of Primary Care and Rural Health, the Alabama Primary Health Care Association, and the University of Alabama School of Dentistry in Birmingham (School of Dentistry) to address dental workforce issues through strategies designed to increase access to dental care in Dental Health Professional Shortage Areas. Loan repayment opportunities, rural dental scholarship options, and National Health Service Corps Scholars programs were described through recruitment and retention presentations to freshman, sophomore, and senior dental students at the School of Dentistry. In these presentations, dentists from private rural practices provided a panel discussion to encourage students to locate in rural, underserved areas of Alabama. The benefits of becoming Medicaid and ALL Kids providers and of practicing in federally qualified health centers and underserved communities were highlighted. OHB staff became involved with the National Health Service Corps Scholars Ambassadors Program to encourage new dentists to locate in underserved areas.

During the 2009-10 Needs Assessment, the following was 1 of the 7 priority MCH needs selected by FHS: Promote access to a dental home and to preventive and restorative dental care for children, youth, and women of childbearing age.

Health Systems Capacity Indicator 08: *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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	15.1	13.6	14.5	14.7	14.4
Numerator	3591	3298	3533	3651	3675
Denominator	23845	24186	24442	24772	25539
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

Notes - 2009
The denominator was provided to each state by the Social Security Administration (SSA) for fiscal year (FY) 2009. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered Supplemental Security Income (SSI) payments as of December 2009. The file is in Characteristic Extract Record format and is 100% data. The numerator is programmatic data based on a database match between Children's Rehabilitation Service (CRS) and the Alabama Medicaid Agency (Alabama Medicaid).

Notes - 2008
The denominator was provided to each state by the SSA for FY 2008. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered SSI payments as of December 2008. 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.

Notes - 2007
The denominator was provided to each state by the SSA for FY 2007. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered SSI payments as of December 2007. 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.

Narrative:
As has 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 represents 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 0.66% increase over FY 2008. This continues the trend of increases noted in FY 2008 (3.3%) and FY 2007 (7%), and reverses a trend of decline that had been evident since FY 2002. Part of this increase may be due to better data capacity via the data-sharing agreement with Medicaid. CRS relies on the provision of informational materials and annual contacts or in-service visits to local SSA offices to encourage referrals of SSI recipients to the program. Contacts are made with all children newly awarded SSI benefits. During FY 2009, CRS mailed informational letters to 3,126 children who were referred by local SSA offices after new benefits had been awarded. CRS public awareness posters have been placed in SSA offices to promote self referrals in this population.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	11.9	9.4	10.6

Notes - 2011
Data Issues:
Estimates are for calendar year (CY) 2008 and pertain to Alabama occurrent, residential live births. Here, "Medicaid infants" pertains to those whose delivery was paid for by Medicaid, and "non-Medicaid infants" to remaining infants. As detailed in the narrative, the "non-Medicaid" group includes a typically high-risk sub-group: infants of "self paying" mothers. Therefore, the low birth weight gap between babies whose deliveries were paid for by Medicaid and babies whose deliveries were privately insured is probably wider than the gap reported for Health Systems Capacity Indicator (HSCI) #5A.

For reasons explained in the year 2009 Form 17 note to HSCI #4, the estimates shown for HSCI #5A are for occurrent events only. That is, we counted only births that occurred in Alabama to Alabama residents.

Rather than updating previous analyses of trends in this indicator, we have focused on analyzing trends in very low birth weight, according to source of payment and other issues. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report.

Narrative:
Status:
In 2008, 11.9% of Medicaid infants, 9.4% of non-Medicaid infants, and 10.6% of the total population of infants were low birth weight.

Some Issues Related to Low Birth Weight:
Low birth weight is known to be a risk factor for infant mortality. Further, the fact that babies from low-income households are at higher risk of infant death than those from higher income households has long been known. As a corollary, the higher prevalence of low birth weight among Medicaid, versus non-Medicaid, infants is presumably linked to socioeconomic status or factors linked with socioeconomic status. Moreover, the "non-Medicaid" group included in HSCI #5A includes a typically high-risk group: infants of "self paying" mothers, many of whom presumably have neither health insurance nor the means to pay for delivery. Therefore, the low

birth weight gap between babies whose deliveries were paid for by Medicaid and babies whose deliveries were privately insured is probably wider than the gap reported for HSCI #5A.

Related Findings from MCH Needs Assessment Report:
Very low birth weight (VLBW) is discussed in Section 3 of the 2009-10 MCH Needs Assessment Report (reference #1). In that report, trends in VLBW are described for 2000-2008, for the total group of occurrent, residential live singleton births and for subgroups defined by race, ethnicity, and/or source of payment for delivery. VLBW, rather than low birth weight, was chosen because VLBW is a stronger predictor of infant mortality. Concerning source of payment, in 2008, 4.2% of singleton infants born to self-paying mothers, 1.7% of singleton infants born to Medicaid-enrolled mothers, and 1.4% of singleton infants born to privately insured mothers were VLBW.

Activities, Strategies, and Developments:
FHS's overall strategy for addressing VLBW has been to maintain and develop the infrastructure for regionalized health care, seek to ascertain what interventions are most likely to reduce the frequency of VLBW, and develop strategies based on information so gathered.

Regionalization of perinatal care is discussed under NPM #17. Though NPM #17 focuses on where VLBW infants are delivered, the infrastructure-building activities included in the discussion of that measure help strengthen the State's capacity to address a variety of perinatal issues, including VLBW. For example, reducing the prevalence of VLBW remains a priority for SPAC and for each of the State's 5 RPACs. The Regional Nurse Perinatal Coordinators (RNPCs) continue to work with the RPACs to revitalize the State's system of regionalized perinatal care and to develop regional plans to address VLBW.

ADPH engages in several other initiatives that address risk markers for VLBW, including the following:
1) Activities, described under NPM #8, to reduce the occurrence of adolescent pregnancy.

2) Activities, described under NPM #18, to promote early prenatal care.

3) Provision, through WIC, of food vouchers and nutritional counseling to eligible pregnant women.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	10.8	8.3	9.5

Notes - 2011
Data Issues:
The denominator is from the CY 2008 Alabama residential live birth file, which is selected according to the residence of the mother. The numerator is from the CY 2008 Alabama residential infant death cohort file, which is selected according to the residence of the decedent.

See note to HSCI #5A for composition of the Medicaid and non-Medicaid groups. Because the non-Medicaid group includes a typically high-risk sub-group, the infant mortality gap between the Medicaid group and the privately insured group is probably wider than the gap reported for HSCI #5B.

Narrative:
Status:
In 2008, the infant mortality rate per 1,000 live births was as follows: 10.8 per 1,000 among Medicaid infants, 8.3 per 1,000 among non-Medicaid infants, and 9.5 per 1,000 among the total population of infants.

Data-Related Issues:
As stated under HSCI #5A, the fact that babies from low-income households are at higher risk of infant death than those from higher income households has long been known. As also discussed under HSCI #5A, the "non-Medicaid" group specified in HSCI #5 includes a typically high-risk group: infants of "self paying" mothers. Therefore, the infant mortality gap between babies whose deliveries were paid for by Medicaid and babies whose deliveries were privately insured is probably wider than the gap reported for HSCI #5B.

Related Findings from MCH Needs Assessment Report:
Among Alabama occurrent, residential live births in 2005-07, infants from Medicaid-covered deliveries were 1.6 times more likely to die before their first birthday than infants from privately insured deliveries were (11.0 versus 6.8 deaths per 1,000). The Medicaid versus private insurance mortality gap was especially wide during the postneonatal period. That is, in 2005-07, compared to infants from privately insured deliveries, infants from Medicaid-covered deliveries were 1.25 times more likely to die in the neonatal period and 2.6 times more likely to die in the postneonatal period. In 2005-07, 56.2 percent of infant deaths of babies from Medicaid-covered deliveries occurred in the neonatal period. As a corollary, 43.8 percent of these deaths occurred in the post-neonatal period. In contrast, just 26.8 percent of infant deaths of babies from privately insured deliveries occurred in the postneonatal period.

Activities, Strategies, and Developments:
The State's FIMR Program, which currently focuses on infant death review and is discussed under SPM #7 in Section IV.D, is one way that FHS gathers information for use in development of strategies to reduce the infant mortality rate. ADPH's FIMR Program is spearheaded by SPP. The RPACs serve as the Case Review Teams. Community Action Teams have been formed statewide. Community action plans are being implemented to address factors that are associated with fetal and infant death in various communities throughout the State. Initially, the MCH Epi Branch provided consultation. In FY 2010, a public health research analyst who mainly focuses on FIMR was added to the Bureau.

As well, ADPH's activities to promote care coordination among EPSDT-enrolled children are intended to promote wellness and reduce morbidity among all Medicaid-enrolled children, including infants. Care coordination is discussed under SPM #1, in Section IV.D.

Additionally, activities that address risk markers for VLBW, summarized under HSCI #5A, are intended to reduce the infant mortality rate.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State					

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	68.9	88	78.5

Notes - 2011
Data Issues:
Estimates are for calendar year 2008 and pertain to Alabama occurrent, residential live births.

See note to HSCI #5A for composition of the Medicaid and non-Medicaid groups. Because the non-Medicaid group includes a typically high-risk sub-group, the prenatal-care gap between the Medicaid group and the privately insured group is probably wider than the gap reported for HSCI #5C.

For reasons explained in the year 2009 Form 17 note to HSCI #4, the estimates shown for HSCI #5C are for occurrent events only. That is, we counted only births that occurred in Alabama to Alabama residents.

Rather than updating previous analyses of trends in this indicator, we have focused on analyzing trends in one indicator of prenatal care: the percentage of infants whose mother had received inadequate prenatal care as measured by the Kotelchuck Index. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report. As well, selected findings are summarized in the narrative for HSCI #5D.

Narrative:
Status:
In 2008, 68.9% of Medicaid infants, 88.0% of non-Medicaid infants, and 78.5% of the total population of infants were born to women who had received prenatal care beginning in the first trimester.

Related Findings from MCH Needs Assessment Report:
For the 2009-10 Needs Assessment, analysis of prenatal care focused on the the prevalence of inadequate care as measured by the Kotelchuck Index. Selected findings concerning inadequate care are summarized in the discussion of HSCI #5D.

Activities and Developments:
Activities to encourage early and adequate prenatal care are described under NPM #18. Briefly stated, these include: 1) education of CHD Family Planning clients on the importance of early and continuous prenatal care, 2) operation of a toll-free hotline that helps pregnant women access providers and educational materials, and 3) Medicaid's statewide implementation of its Maternity Care Program.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State					

Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	66.1	81.8	74

Notes - 2011
Data Issues:
Estimates are for CY 2008 and pertain to Alabama occurrent, residential live births to 15-44 year-old females. This age group was chosen because, several years ago, Title V Information Reporting System staff stated that the percentage reported for "All" in HSCI #5D should match that for the corresponding year for HSCI #4, which pertains to babies born to 15-44 year-old females.

See note to HSCI #5A for composition of the Medicaid and non-Medicaid groups. Because the non-Medicaid group includes a typically high-risk sub-group, the prenatal-care gap between the Medicaid group and the privately insured group is probably wider than the gap reported for HSCI #5D.

For reasons explained in the year 2009 Form 17 note to HSCI #4, the estimates shown for HSCI #5D are for occurrent events only. That is, we counted only births that occurred in Alabama to Alabama residents.

Rather than updating previous analyses of trends in this indicator, we have focused on analyzing trends in one indicator of prenatal care: the percentage of infants whose mother had received inadequate prenatal care as measured by the Kotelchuck Index. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report. As well, selected findings are summarized in the narrative for HSCI #5D.

Narrative:
Status:
In 2008, among infants born to 15-44 year-old mothers, 66.1% of Medicaid infants, 81.8% of non-Medicaid infants, and 74.0% of the total population of infants were born to women who had received adequate prenatal care.

Related Findings from MCH Needs Assessment Report:
Trends in the proportion of occurrent, residential live births for which the mother had received inadequate prenatal care, as measured by the Kotelchuck Index, are discussed in Section 3 of the 2009-10 Needs Assessment Report (reference #1). In the Needs Assessment Report, findings on inadequate care are discussed and graphically depicted for the total group, 4 groups defined by race and/or ethnicity, and 3 source-of-payment groups. Selected findings concerning source-of-payment groups follow. Note that these findings pertain to inadequate prenatal care, not adequate care. As well, the findings below are for live births to mothers of any age.

Infants of, respectively, privately insured mothers, Medicaid-enrolled mothers, and self-paying mothers were studied. As well, non-Latino babies of Medicaid-enrolled mothers were studied. Toward the end of the surveillance period (2000-2008), the trend line for Medicaid-funded deliveries of non-Latino babies notably diverged from that for the total group of Medicaid-funded deliveries.

Earlier in the decade, the prevalence of inadequate prenatal care declined for 3 or 4 successive years for the self-pay group and the non-Latino, Medicaid group. However, for all groups except the self-pay group, this indicator was significantly worse in 2006-08 combined than in 2003-05 combined. Comparing 2006-08 to 2003-05, the prevalence of inadequate prenatal care increased less for non-Latino, Medicaid-funded deliveries (where it increased by 10.0%) than for the total

group of Medicaid-funded deliveries (where it increased by 20.5%).

Of the source-of-payment groups studied, mothers whose delivery was self paid were most likely to have received inadequate prenatal care. Specifically, in 2008, mothers of 43.1% of babies from self-paid deliveries had received inadequate prenatal care. Also in 2008, 13.9% of non-Latino babies from Medicaid-funded deliveries, versus 20.1% of all babies from Medicaid-funded deliveries, were born to women who had received inadequate prenatal care.

Activities, Strategies, and Developments:
ADPH's activities to address prenatal care are described under NPM #18, located in Section IV.C, and briefly summarized under HSCI #5C.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Notes - 2011
Medicaid covers infants whose household income is at or below 133% of the federal poverty level (FPL).

Notes - 2011
In FY 2009, Alabama's Children's Health Insurance Program (CHIP) covered infants whose household income was greater than 133% of the federal poverty level (FPL), but did not exceed 200% of FPL.

However, effective October 1, 2009, the upper income criterion for enrollment in Alabama's CHIP increased, with 300% of the FPL now being the maximum allowable household income.

Narrative:
Status:
As of the end of FY 2009, Alabama's Medicaid and Alabama's CHIP household income criteria for coverage of infants, shown on Form 18 and discussed in the field notes to HSCI #6A, had not changed for several years.

However, effective October 1, 2009, the upper income criterion for enrollment in ALL Kids (Alabama's CHIP) increased, with 300% of the FPL now being the maximum allowable household income. Alabama's Medicaid income criterion remains as in FY 2009.

Activities, Strategies, and Developments:
Alabama Medicaid programs and the ALL Kids Program are discussed in Section III.A. The ALL Kids Program is also discussed under NPM #13. As discussed under NPM #13, combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation's program are available at CHDs, as well as hospitals, provider offices, many other community locations, and the ALL Kids web page. In addition, applications can be obtained by calling the ALL Kids Customer Service toll-free number, or an online application can be submitted with electronic signature.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 200 200

Notes - 2011
Medicaid has 2 age-specific income criteria for children and youth: 0-5 years inclusive and 6-18 years inclusive. For 0-5 year-olds, the upper parameter for Medicaid is 133% of the FPL. For 6-18 year-olds, the upper parameter for Medicaid is 100% of FPL.

Notes - 2011
Alabama's CHIP has 2 age-specific income criteria for children and youth: 0-5 years inclusive and 6-18 years inclusive.

In FY 2009, for 0-5 year-olds, Alabama's CHIP eligibility specified a household income greater than 133% of FPL, but not to exceed 200% of FPL. For 6-18 year-olds, Alabama's CHIP eligibility specified a household income greater than 100% of FPL, but not to exceed 200% of FPL.

However, effective October 1, 2009, the upper income criterion for enrollment in Alabama's CHIP increased, with 300% of the FPL now being the maximum allowable household income.

Narrative:
Status:
Alabama's Medicaid and CHIP household income criteria for coverage of persons aged 1-5 years and 6-18 years (inclusive) are shown on Form 18 and discussed in the field notes to HSCI #6B. As of the end of FY 2009, these criteria had not changed for several years.

However, effective October 1, 2009, the upper income criterion for enrollment in ALL Kids (Alabama's CHIP) increased, with 300% of the FPL now being the maximum allowable household income. Alabama's Medicaid income criteria remain as in FY 2009.

Activities, Strategies, and Developments:
Alabama Medicaid programs and the ALL Kids Program are discussed in Section III.A. The ALL Kids Program is also discussed under NPM #13. As discussed under HSCI #6A, applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation's program are widely available and can be submitted as a paper application or as an on-line application with an electronic signature.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Notes - 2011
For pregnant women, the upper parameter for Medicaid eligibility is 133% of the FPL.

Notes - 2011
In FY 2009, Alabama's CHIP covered pregnant females only if they were less than 19 years of age and already eligible for ALL Kids (Alabama's CHIP), with household incomes exceeding the Medicaid criterion but not exceeding 200% of the FPL.

However, effective October 1, 2009, the upper income criterion for enrollment in Alabama's CHIP increased, with 300% of the FPL now being the maximum allowable household income. Alabama's CHIP continues to cover pregnant females only if they are less than 19 years of age and already eligible for ALL Kids.

Narrative:
Status:
Alabama's Medicaid and CHIP household income criteria for coverage of pregnant women are shown on Form 18 and discussed in the field notes for HSCI #6C. As of the end of FY 2009, these criteria had not changed for several years.

However, effective October 1, 2009, the upper income criterion for enrollment in ALL Kids increased, with 300% of the FPL now being the maximum allowable household income. Alabama's Medicaid income criteria remain as in FY 2009.

ALL Kids covers pregnant females only if they are less than 19 years of age and already eligible for ALL Kids.

Activities, Strategies, and Developments:
Alabama Medicaid programs and the ALL Kids Program are discussed in Section III.A. The ALL Kids Program is also discussed under NPM #13. As discussed under HSCI #6A, applications for ALL Kids, SOBRA Medicaid, and Medicaid for Low Income Families are widely available and can be submitted as a paper application or as an on-line application with an electronic signature.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant	3	Yes

birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2011

Narrative:
Linkage of Birth and Infant Death Files:
CHS links these files annually and grants the MCH Epi Branch direct access to all vital statistics files.

Linkage of Birth Certificates and Medicaid Files:
The score of 2 applies to FY 2010 and is up from a score of 1 for FYs 2008 and 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. Competing priorities, mainly implementation of the 2009-10 Needs Assessment, have delayed work on this linkage. However, in December 2010, the MCH Epi Branch began data management tasks preliminary to linkage of year 2008 live birth records with the file provided by Medicaid. Work on this linkage has been interrupted due to competing priorities but is expected to resume by early FY 2011.

Linkage of Birth Certificates and WIC Files:
By March 2008, the third linkage of WIC prenatal registration files to birth records was performed. Per consultation with WIC staff, however, linking additional WIC files to birth records is not a priority. Further, the MCH Epi Branch does not have enough staff to routinely link birth records with both Medicaid records and WIC records. Because of the MOU with Medicaid, the branch will prioritize linkage of birth records with Medicaid records, rather than with WIC records. Accordingly, the score for this indicator is 1, down from 2 in FY 2008.

Linkage of Birth Certificates and Newborn Screening Records:
Per a reporting system begun in June 2004, if a hospital does not seem to be screening all their newborns, Newborn Screening staff can follow up on individual infants in the hospital. Findings from the system (June 2004 through circa March 2005) indicate that more than 99% of Alabama

live-born infants born in Alabama hospitals were screened before discharge. As well, Newborn Screening staff have begun mapping all unsatisfactory specimens from their Case Management database, Neometrics(TM). This new system automatically notifies Newborn Screening staff about unsatisfactory specimens, thereby facilitating more timely follow up to ensure that all infants born in Alabama hospitals receive a valid screen.

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

Birth Defects Surveillance:
The Alabama Birth Defects Surveillance System and Prevention Program, which previously covered counties in south-central or south Alabama and was spearheaded by USA, lost its funding. USA is now collecting birth defects data in several counties in the State, but the collected information is not consistently shared with ADPH.

Pregnancy Risk Assessment Monitoring System (PRAMS):
CHS implements Alabama PRAMS, publishes annual reports of findings, and performs special analyses upon request.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
Trends and Data-Related Issues:
CDC's Youth Risk Behavior Survey System's (YRBSS's) web site, which can be queried, is the source used by FHS for estimating the prevalence of tobacco use among high school students. YRBSS consists of a national school-based survey conducted every 2 years by CDC and state, territorial, and local school-based entities. The survey, which is conducted by health and education agencies, has been conducted in odd years, beginning with 1991. YRBSS data represent students in grades 9-12 in the 50 states and the District of Columbia. The National YRBSS includes both public and private schools in the sampling frame. For state-level findings, the sampling frame includes only public schools. Findings are weighted estimates based on samples of students. Each estimate therefore reflects some degree of random statistical error. Findings (point estimates and confidence intervals) and a full description of methods are obtainable from a CDC web site (references #7-#8).

In Alabama, the survey is conducted through SDE. Although Alabama participated in YRBSS during survey years from 1991-2009, the State had a response rate of less than 60% in 2007, so data for 2007 were neither weighted by CDC nor posted on CDC's web site (reference #7).

The pertinent indicator reported by YRBSS is the percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on 1 or more of the 30 days preceding participation in the survey. According to a report provided by SDE circa April 2010, among Alabama public high school students, this indicator was at the following levels in the stated years: 43.3% in 1999, 30.5% in 2001, 31.5% in 2003, 30.8% in 2005, and 27.9% in 2009. According to that report, both a "linear change" and a "quadratic change" occurred in the indicator.

The 2009 YRBSS results will be posted on CDC's web site on June 3, 2010. Therefore, at the time of this writing (May 15, 2010), FHS cannot query the web site concerning recent data.

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 #2) 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 FYs 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 the Association of Maternal and Child Health Programs; and 3) guidance provided by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. These worksheets were used to assess capacity to address the priority MCH needs selected during the FYs 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 2009, key activities initiated in early FY 2010, and plans for the remainder of FY 2010 and for FY 2011. Where indicated and permitted by space constraints, key activities prior to FY 2009 are reported as a context for FYs 2009-2011. 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 or May 2009, 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 uninsured 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), SPM #3 (positive youth development), and SPM #5 (violent behavior).

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 the 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 among 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 the will among its own staff but low capacity to garner the 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.

An attachment is included in this section.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	64	86	88	107	140

Denominator	64	86	88	107	140
Data Source				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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
All results are for calendar years (CYs).

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. However, as described in this indicator's Form 11 field note for 2008, the number of newborns who screened positive has increased notably over the years. 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.

Notes - 2008
The 107 infants include 7 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, but the number of newborns who screened positive increased notably: from 64 infants in CY 2005 (the first year that tandem mass spectrometry was used for the entire year), to 86 infants in CY 2006, to 88 infants in CY 2007, to 107 infants in CY 2008 (the first year that cystic fibrosis was included in newborn screening). This is an increase of 43 infants, only 7 of whom were identified as having cystic fibrosis. The increase continues to be largely--but not totally--in the number of infants who were confirmed as having sickle cell disease, which was as follows: 36 infants in CY 2005, 56 infants in CY 2006, 51 infants in CY 2007, and 57 infants in FY 2008. FHS will continue to monitor the number of positive screens in future years.

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

Notes - 2007
The 88 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.

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
Direct:
NSP provided timely follow up to definitive diagnosis for infants who screened positive for metabolic, endocrinological, or hematological disorders. For CY 2009 the following numbers of infants were identified as having the specified conditions: hemoglobinopathies, 62; congenital adrenal hyperplasia, 5; congenital hypothyroidism, 30; cystic fibrosis, 22; and biotinidase 1.

Twenty infants were identified using tandem mass spectrometry (TMS): PKU, 4; hyperphenylalaninemia, 3; medium-chain acyl-CoA dehydrogenase deficiency (MCADD), 6; carnitine transporter defect, 3; methylmalonic academia, 2; trifunctional protein deficiency, 1; and 3-methylbutyryl-CoA dehydrogenase deficiency, 1.

NSP routinely performed screening, including expanded TMS, on all first and second specimens. NSP follow-up activities included tracking infants who did not receive an initial satisfactory screen at the birthing facility.

Specialty referral centers provided confirmatory testing and treatment to patients identified through NSP. Genetic counseling, follow up, and nutritional counseling regarding treatment and dietary management were included.

Enabling:
NSP referred infants with positive results for care coordination services when there was no physician of record listed and when appointments for repeat screenings to determine a definitive diagnosis had been missed. These services were provided by social workers and nurses based in CHDs.

The Children's Hospital Pediatric Hematology Division (in Birmingham) 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. In addition, NSP referred all infants diagnosed with cystic fibrosis to one of two accredited Cystic Fibrosis Centers in the state for genetic counseling and follow up care.

Population-based:
NSP utilized a language line to facilitate communication with Hispanic families regarding follow-up care. Newborn screening brochures were available in English and Spanish and provided to all 54 Alabama birthing hospitals.

NSP continued to maintain its web page, which is further discussed under "Plan for the Coming Year."

Infrastructure-building:
The NSP provided a grant to UAB/Sparks Clinic 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 allows providers the ability to obtain a facsimile copy of the newborn screening results via the access number. Enrolled submitters can access 7 days a week.

NSP sponsored a conference for hospital-based newborn screening coordinators. The conference allowed discussion of best practices to improve newborn screening collection and reduce the overall rate of unsatisfactory specimens received at the BCL. The conference received support from the Alabama Hospital Association (AHA) and AMOD. Overall unsatisfactory rates fell below 10% in the months following the conference and remained below 10%.

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 of record listed 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. Monitor the Alabama Voice Response System, which enables enrolled submitters to access screening tests via telephone at any time.				X
5. Facilitate communication with Hispanic families regarding follow-up care using a language line				X
6. Provide funding to UAB/Sparks Clinic to supply medical food and formula to address the needs of families with inherited inborn errors of metabolism				X
7.				
8.				
9.				
10.				

b. Current Activities
Direct:
The Alabama NSP is screening for 28 of the 29 disorders recommended by the American College of Medical Genetics and the American Academy of Pediatrics (AAP).

All newborns diagnosed with conditions detected by NBS receive appropriate diagnostic testing and treatment.

Infrastructure-building:
NSP is working to provide a handbook to include follow-up guidelines and resources to medical providers statewide. NSP provides quarterly training to ADPH care coordinators on newborn screening policies and procedures. Educational materials for parents and providers may be found on the NSP web site.

NSP has adopted new brochures to improve and update parent information for ease of use.

The NSP Advisory Committee meets at least 2 times a year to provide advice to the ADPH on technical and/or program issues relative to the NSP.

NSP works with the software vendor, Neometrics, to improve ability to analyze data and perform queries as requested for research purposes.

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

NSP has met with the cystic fibrosis medical consultant at the UAB Cystic Fibrosis Center and discussed training opportunities for medical providers in the State to include use of the ADPH Training Network.

The unsatisfactory rate for specimens remains below 10%.

c. Plan for the Coming Year

Direct:
NSP will continue to ensure that all newborns requiring follow-up testing and referral will receive services in a timely manner. NSP staff will continue to educate health care providers and parents regarding the importance of timely screening and follow up.

BCL's Newborn Screening Section will undergo new mass spectrometer validations in order to add Tyrosinemia I to the screening panel, with implementation expected by December 2010. NSP will continue to participate in regional and national groups in order to stay abreast of the growing knowledge and developments in research of expanded newborn screening.

Infrastructure-building:
NSP will hire a nurse educator, whose primary responsibility will be to provide statewide training and technical assistance to hospitals and healthcare providers concerning newborn screening practices and policies.

NSP will develop and design an education program for hospital nurseries, neonatal intensive care units, and pediatric care providers on utilizing approved methods of newborn blood-spot screening collection, so that all providers receive standardized training.

NSP will continue to maintain and update the NSP web page. This web page contains a variety of information, including a newborn screening brochure (English and Spanish versions) and fact sheets on the following disorders: biotinidase deficiency (a version for parents and a version for professionals), congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, PKU, and sickle cell disease and related red-blood-cell disorders.

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

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:	60394					
Reporting Year:	2009					
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.	No.	%
Phenylketonuria (Classical)	62059	102.8	4	4	4	100.0
Congenital Hypothyroidism (Classical)	62059	102.8	30	30	30	100.0
Galactosemia (Classical)	62059	102.8	0	0	0	
Sickle Cell Disease	63094	104.5	62	62	62	100.0
Congenital Adrenal Hyperplasia	62059	102.8	5	5	5	100.0
Cystic Fibrosis	62059	102.8	22	22	22	100.0
Homocystinuria	62059	102.8	0	0	0	
Methylmalonic Acidemia	62059	102.8	2	2	2	100.0
Glutaric acidemia	62059	102.8	0	0	0	
Carnitine transporter defect	62059	102.8	3	3	3	100.0
2-Methylbutyryl-CoA Dehydrogenase Deficiency	62059	102.8	0	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	62059	102.8	6	6	6	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	2005	2006	2007	2008	2009
Annual Performance Objective	66.1	66.1	70	59.9	59.9
Annual Indicator	66.1	66.1	59.9	59.9	59.9
Numerator					
Denominator					
Data Source				2005-06	2005-06

				National Survey of CSHCN	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59.9	59.9	59.9	59.9	59.9

Notes - 2009
For 2007-2009, 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 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 - 2008
See this indicator's field note to year 2009 about data-related issues.

Notes - 2007
See this indicator's field note to year 2009 about data-related issues.

a. Last Year's Accomplishments
Using updated data from the National Survey of CSHCN (2005-06), 59.9% of Alabama families with CSHCN reported success for this measure, versus 57.4% of U.S. families. Per survey notes, this outcome can be compared to 2001 results. In the 2005-06 survey, 6.2% fewer Alabama families reported success for this measure than in the 2001 survey; figures for U.S. families were virtually the same. Also, 89.1% of Alabama families reported that doctors and other health care providers always or usually made them feel like a partner in their child's care. However, only 78% of families responded similarly to this question as a part of a survey for the 2009-10 needs assessment.

Enabling:
CRS continued to employ an SPC and 10 LPCs. Following resignations, vacancies existed in Birmingham, Huntsville, and Mobile. The Birmingham vacancy was filled by the former LPC for the area. Vacancies still exist in Huntsville and Mobile. The State hiring freeze and budget limitations have prevented refilling these positions.

The State Parent Advisory Committee met once in FY 2009. LPACs hosted presentations on topics such as Title V needs assessment, transition, Medicaid waivers, VRS, Individualized Education Plans (IEPs), parent resources, children with sensory problems, respite care, child care, Individual and Family Support, and SSA.

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 national editors for CSHCN newsletters. A listserv was

maintained for participants in the Parent to Parent Program, with 322 postings in FY 2009.

LPCs presented trainings on CRS, family-centered care, and the parent perspective at schools, community colleges, and daycare centers. They also hosted holiday events for CYSHCN and their families, including food, toy, and school supply drives. Disability awareness was promoted through community health fairs and SAFE Kids Car Seat Checks.

Infrastructure-building:
The SPC served as FVA State Co-coordinator and is involved with national FVA. CRS partnered with FVA to provide reimbursement to support youth and family participation in work groups and needs assessment planning. CRS contracted with FVA to assist with the 2009-10 Needs Assessment, including public awareness of surveys and support for family and youth participation in focus groups.

The Opelika LPC was named the Alabama Affiliate of the Children's Tumor Foundation and attended the national Neurofibromatosis Symposium.

The SPC and 3 LPCs participated in Parent Leadership Training conducted by Circle of Parents, a national partner of the FRIENDS National Resource Center, Altarum Institute, and the MCHB.

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 and 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, Spina Bifida Association of Alabama, Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, a county Board of Education transition team, and a local Miracle League Board.

The SPC was involved in trainings, both as presenter and participant. She is a voting delegate for the Association of Maternal and Child Health Programs (AMCHP) and was the vice-chair of the Family Leadership Caucus. She was on interagency groups and advisory committees, including the 2009-10 CRS Needs Assessment Advisory Committee, Early Intervention Conference Planning Committee, Youth Leadership Forum Steering Committee, Medicaid Buy-in subcommittee for the Ticket to Work/Medicaid Infrastructure grant, State Newborn Screening Advisory Committee, and the UAB Pediatric Pulmonary Center's State Advisory Committee. She chaired the affordability subcommittee for the Alabama Covering Kids and Families Coalition.

FVA received an MCHB-funded Family to Family Health Information Center Grant.

An attachment is included in this section.

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 (CRS) 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 CRS/Family Voices 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 2009 activities are being continued in FY 2010 with the following additions or exceptions.

Enabling:
LPC vacancies still exist in Huntsville and Mobile. The State hiring freeze and budget limitations have prevented refilling these positions.

The SPC and LPCs provided input on program activities and Needs Assessment findings. They also rated the agency on Form 13 characteristics, using a checklist modified from a tool developed by the State of Wisconsin in December 2001. The compiled findings are attached to the "Last Year's Accomplishments" section of this performance measure.

Infrastructure-building:
The Birmingham LPC serves as President of the National Costello Syndrome Family Network. The SPC serves on the Alabama's State Action Team for the National Family Support Center on Disabilities Knowledge and Involvement Network (funded through the Administration on Developmental Disabilities).

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 SPC won the 2010 Merle McPherson Family Leadership award, a national honor presented by AMCHP.

c. Plan for the Coming Year
Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2011. 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 the CRS State Parent Advisory Committee and LPACs, training activities, publication of a newsletter, and employment of at least 1 parent consultant in each office.

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

Population-based:
CRS will update and modify its family satisfaction survey.

Infrastructure-building:
CRS will continue working with its partners and stakeholders to implement a State plan to ensure that Healthy People objectives related to families of CYSHCN partnering in decision making at all levels and being satisfied with the services they receive are met.

CRS will support, financially and philosophically, the growth of FVA through the provision of leadership, the dissemination of information, and the continued utilization and analysis of data gathered through the CRS/FVA database.

CRS will 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	53.9	53.9	60	50	50
Annual Indicator	53.9	53.9	50	50	50
Numerator					
Denominator					
Data Source				2005-06 National Survey of CSHCN	2005-06 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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
For 2007-2009, 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 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 this indicator.

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 - 2008
See this indicator's field note for FY 2009 about data-related issues.

Notes - 2007
See this indicator's field note for FY 2009 about data-related issues.

a. Last Year's Accomplishments
Using updated data from the National Survey of CSHCN (2005-06), 50% of Alabama families with CSHCN reported success for this measure, versus 47.1% of U.S. families. Per survey notes, this outcome cannot be compared to 2001 results due to changes in methodology. In Alabama, 93.6% of families reported having a usual source of sick care, versus 94.3% nationally, and 97.5% of Alabama and U.S families reported having a usual source of routine preventive care. About 98% of CRS enrollees reported having a primary care provider (PCP), a figure greatly improved from the FY 1996 baseline of 62%. About 88% of families responding to a survey for the FY 2009-10 Needs Assessment indicated that their CYSHCN had a person or persons that they considered a personal doctor or nurse. Usual source of primary care was reported by 94% of youth responding to a survey for the FY 2009-10 Needs Assessment. These youth were not all CRS enrollees, so may not have had staff assistance in linking to PCPs, but the lower figure may suggest difficulties in maintaining a usual source of care as youth age.

The 2005-06 National Survey of CSHCN included baseline results for early and continuous screening for special health care needs. Overall, 62.3% of Alabama families with CSHCN reported success for this measure, versus 63.8% of U.S. families. However, about 70% of families responding to a survey for the FY 2009-10 Needs Assessment indicated that their child had been screened regularly for special needs and developmental delays. According to the national survey, Alabama CSHCN with a medical home were more likely to be screened early and continuously (65.3%) than were those without a medical home (58.8%).

Enabling:
CRS continued efforts to identify community 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 63.5% 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:
CRS continued to promote usage of a compact disc-read only memory (CD-ROM) training developed by Medicaid to provide continuing medical education to PCPs and allied health professionals related to medical homes. Medicaid provides enhanced reimbursement to PCPs who successfully complete the training. CRS and FVA contributed to this project, and CRS is listed among the materials as a resource for CYSHCN.

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. Work began on revising this service summary to a more comprehensive plan of care that will better capture the breadth of services received by CRS enrollees. CRS continued to participate in Medicaid's TFQ initiative (see NPM #5) and will determine appropriate technology that will work functionally with this effort and will further communication between CRS and medical homes.

CRS continued to participate on advisory committees and workgroups for My Alabama (formerly the Camellia Project; see NPM #5 for more information), to develop an electronic system that will facilitate information-sharing about health and human service resources in the State. This could also be accessed by medical home provider staff to help families locate resources and make

referrals. CRS will make a pre-application available electronically on the project web site.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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. Continue to facilitate referrals by maintaining enrollment forms on the public web site and accepting referrals via phone, fax, or hard copy.			X	X
7. Continue to collaborate on advisory committees and work groups related to Medicaid's grant project, Together for Quality (see National Performance Measure [NPM] #5).				X
8. Continue to collaborate on advisory committees and work groups related to My Alabama (formerly the Camellia Project).				X
9.				
10.				

b. Current Activities

FY 2009 activities as described above are being continued in FY 2010 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 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. As a part of My Alabama (formerly the Camellia Project; see NPM #5 for more information), CRS will make a pre-application available electronically on the project web site. The tool is in pilot testing as of April 2010.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2011. A recap and notation of activities being newly implemented follow.

Enabling:

CRS staff will continue to meet with community medical providers to identify PCPs willing to accept CYSHCN as patients. Partnerships will be enhanced between CRS and Alabama's PCPs

who are recognized as CRS courtesy staff physicians through the provision of ongoing educational and CRS-related public-policy awareness materials. 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 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 SHCNs 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 pursue making general application elements available electronically as a part of My Alabama, (formerly the Camellia Project; see NPM #5 for more information).

CRS will continue to collaborate on advisory committees and work groups related to Medicaid's TFQ grant (see NPM #5).

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59.7	59.7	62	65	65
Annual Indicator	59.7	59.7	65	65	65
Numerator					
Denominator					
Data Source				2005-06 National Survey of CSHCN	2005-06 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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009

For 2007-2009, 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 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 - 2008
See this indicator's field note to year 2009 about data-related issues.

Notes - 2007
See this indicator's field note to year 2009 about data-related issues.

a. Last Year's Accomplishments
Using updated data from the National Survey of CSHCN (2005-06), 65% of Alabama families with CSHCN reported success for this measure, versus 62% of U.S. families. Per survey notes, this outcome can be compared to 2001 results. Per the 2005-06 survey versus the 2001 survey, 5.4% more Alabama families and 2.4% more U.S. families reported adequate insurance. Per the 2005-2006 survey, in Alabama CSHCN managed by prescription medicines more often reported adequate insurance (71.2%) than those with above-routine need or use of medical or related services (63%) or those with functional limitations (54.2%). A similar disparity was seen nationally. In surveys for the 2009-2010 Needs Assessment, 90.5% of youth reported they had insurance and 96.3% of families stated that their CYSHCN had insurance.

During FY 2009, 88.5% of CRS enrollees had insurance; 1,412 were uninsured for the entire year. The number of uninsured CRS enrollees in 2009 is a 64% 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, CHIP, 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 87.5% in FY 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 1,463 uninsured CRS enrollees 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. 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. CRS helped its 275 ALL Kids enrollees with annual renewal as needed. CRS paid insurance premiums for coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), the Alabama Health Insurance Plan, or ALL Kids for 19 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 continued 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 received 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 and 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. 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 ALL Kids (Alabama's State Health Insurance Program) and assist with applications as needed.		X		
3. Identify 100% of CRS clients for whom it is appropriate to pay insurance premiums and provide this service.		X		
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 2009 activities as described above are being continued in FY 2010 with the following additions or exceptions.

Infrastructure-building:
Through its HIPAA Privacy Officer (a CRS staff member) 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. ADRS staff completed a HIPAA survey and results were used to identify training needs. The Privacy and Security Officers have identified video training that 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 Manager is developing a manual and training for staff who pay bills in local offices, which will include specialized information to assure that third-party resources are used effectively and to promote discussion with families about benefits packages, helping them better understand and utilize the options provided through their individual insurance plan.

CRS is monitoring the insurance status of enrollees to assist them with maintaining coverage, applying for alternate coverage, or fully sponsoring the uninsured should a child lose insurance during this economic downturn.

c. Plan for the Coming Year
Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2011. 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.

Population-based:
CRS will continue collaboration with ALL Kids to include information about CRS in a packet of information for families who indicate they have a child with special health care needs (SHCNs) at enrollment.

Infrastructure-building:
CRS will continue working with its partners and stakeholders to implement a State plan to ensure that Healthy People objectives related to families of CYSHCN having adequate public and/or private insurance to pay for the services they need are met.

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 develop a manual and training for staff who pay bills in local offices, which will include specialized information 1) to assure that third-party resources are used effectively and 2) to

promote discussion with families about benefits packages, helping them to better understand and utilize the options provided through their individual insurance plan.

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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73.7	73.7	78	91.7	91.7
Annual Indicator	73.7	73.7	91.7	91.7	91.7
Numerator					
Denominator					
Data Source				2005-06 National Survey of CSHCN	2005-06 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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91.7	91.7	91.7	91.7	91.7

Notes - 2009
For 2007-2009, 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 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 this indicator.

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 - 2008
See this indicator's field note to year 2009 about data-related issues.

Notes - 2007
See this indicator's field note to year 2009 about data-related issues.

a. Last Year's Accomplishments

Using updated data from the National Survey of CSHCN (2005-06), 91.7% of Alabama families with CSHCN reported success for this measure, versus 89.1% of U.S. families. Per survey notes, this outcome cannot be compared to 2001 results due to changes in methodology.

Direct:
In FY 2009 CRS served 16,296 CYSHCN, provided 16,057 clinic visits, responded to 3,788 requests for information or referral, and furnished 109,750 encounters by physicians, dentists, and CRS staff.

Proration and budget cuts necessitated service cuts and policy changes. CRS began purchasing secondary seating systems (manual wheelchairs) only for children who use power wheelchairs and is converting from providing brand name drugs to generic except in special approval situations.

A staff PT was added for the Tuscaloosa/Selma area, this being a first for that area. This has increased access to recommendations for PT intervention; seating, positioning, and mobility equipment; and braces and splints. A Juvenile Rheumatoid Arthritis Clinic began in Tuscaloosa.

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 served 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 all 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. A new CRS video was developed to promote CRS services.

CRS continued community-based screenings for scoliosis and hearing loss. These screenings were provided in school systems, daycare centers, and 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 continues 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 this data and transmits it electronically to ADPH.

CRS partnered with EIS to increase access to early intervention services for eligible infants and toddlers by sponsoring 13 community-based projects, serving 691 children per month in 2009, up from 687 per month in 2008. Receipt of ARRA funding allowed additional children to be served by programs beginning July 2009. For the last 3 months of FY 2009, an average of 109 additional children were served per month. Including those served via stimulus funding, the CRS-sponsored programs served an average of 718 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 participated with Medicaid's TFQ grant, aimed at increasing quality and efficiency in the Medicaid program while building an integrated health care system focused on better health outcomes and improved quality of life for recipients. Goals include: reduce duplication of service, prevent fragmented information, increase access to medical data, and improve care coordination. Medicaid is piloting a statewide electronic health information system to link Medicaid, State health agencies, providers, and private payers and to establish access to individual health information, claims, immunization records, prescription data, and lab results.

CRS continued its lead role in implementing Alabama's Healthy People 2010 Action Plan for CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 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 implement the Universal Newborn Hearing Screening Program (discussed under NPM #12) and 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. Continue to collaborate on advisory committees and work groups related to Medicaid's grant project, Together for Quality.				X
9. Promote cultural competence in the system of care for CYSHCN and their families through collaborations and partnerships.				X
10. Plan and implement needs assessment activities.				X

b. Current Activities

FY 2009 activities continue in FY 2010 with the following additions or changes.

Direct:

Pediatric Specialty Orthopedic Clinics began in Montgomery and Tuscaloosa, offering evaluations of complex orthopedic conditions.

Medical Genetics Clinics began in Mobile and Montgomery.

Population-based:

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

Infrastructure-building:
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. It is a dynamic document, updated at least yearly according to the child's health and community situation. A copy is provided to families so they may organize their records and can share with providers as needed.

ADRS has begun a Business Intelligence (BI) initiative to increase its capacity for measuring outcomes and creating predictive models. 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 continues to participate in My Alabama. As of April 2010, the web tool to host health and human service agency pre-applications and to promote information-sharing is still undergoing 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 2011. A recap and notation of activities being newly implemented follow.

Direct:
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 and 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 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 assume a lead role in implementing Alabama's Action Plan for meeting new Healthy People objectives for CYSHCN and expand activities to involve local communities.

CRS will continue to collaborate on advisory committees and work groups related to Medicaid's TFQ grant project.

CRS will continue to collaborate on advisory committees and work groups related 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	10	38.3	38.3
Annual Indicator	5.8	5.8	38.3	38.3	38.3
Numerator					
Denominator					
Data Source				2005-06 National Survey of CSHCN	2005-06 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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38.3	38.3	38.3	38.3	38.3

Notes - 2009
For 2007-2009, 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 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 this indicator, 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 - 2008
See this indicator's field note to year 2009 about data-related issues.

Notes - 2007
See this indicator's field note to year 2009 about data-related issues.

a. Last Year's Accomplishments
Using updated data from the National Survey of CSHCN (2005-06), 38.3% of Alabama families with CSHCN reported success for this measure, versus 41.2% of U.S. families. Previous Alabama estimates for this measure were not reliable and, per survey notes, this outcome cannot be compared to 2001 results due to changes in methodology. Alabama sample sizes were too small to meet reliability standards when stratified by response categories; however, national patterns indicated differences by reason for inclusion as CSHCN. CSHCN managed by prescription medicines more often reported success (49.9%) than those with above-routine need or use of medical or related services (31.6%) or those with functional limitations (29.9%). In a survey for the 2009-2010 Needs Assessment, about 44% of youth said their physician had talked with them about their health needs as they become adults, about 51% had been encouraged to take responsibility for their health needs, and 60% said they had not been given a chance to speak to the provider alone.

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 FY 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. A Care Coordination Worksheet, including transition issues, was developed and served as a template for a transition plan for CRS youth. This was a part of a larger effort that began in FY 2009 to develop a comprehensive plan of care for all CRS clients.

Enabling:
CRS continued to support its State 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 2009 due to the inability to find and hire a replacement for the CRS State Youth Consultant. Efforts were made to pursue this through grant-funding without success.

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 SHCN, families, teachers, and local service providers. The events featured 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.

The SPC co-presented "Safe Passage: transitioning CSHCN to an adult healthcare system" at the 2009 Health Care Access Conference in Birmingham.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 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, 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 2009 activities as outlined above continue in FY 2010 with the following additions or changes.

Direct:
A comprehensive plan of care has now been developed for use with all CRS-enrolled children and youth. This was released as a part of CHARMS in April 2010. 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 (including work, health care, community, and education).

Enabling:
As of April 2010, there is still a vacancy for a State Youth Consultant. Efforts are underway and it is anticipated that this position will be filled by July 2010.

Infrastructure-building:
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 2011. A recap and notation of activities being newly implemented follow.

Enabling:
CRS will facilitate youth and professional collaboration in program and policy activities through employment of a 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 SHCN 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 working with its partners and stakeholders to implement a State plan to ensure that Healthy People objectives related to transition are met.

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 SHCN, 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.8	85.1	86.4	87.7	89
Annual Indicator	82.3	85.3	81.9	78.9	76.3
Numerator					
Denominator					
Data Source				CDC National Immunization Survey	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?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80.6	81.4	82.2	83	83.9

Notes - 2009
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 + or - 6.1 for Alabama in fiscal year (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 calendar year (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-2008-released.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).

Notes - 2008
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 – 6.2 for Alabama in FY 2008. The specific CDC table used was "tab02_antigen_iap.xls," "Q3/2007-Q2/2008." Children in this survey were born between July 2004 and January 2007.

Notes - 2007
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 - 5.8 for Alabama in FY 2007. The specific CDC table used was "tab03_antigen_state.xls," "Q3/2006-Q2/2007." Children in this survey were born between July 2003 and December 2005.

a. Last Year's Accomplishments
Status and Trends:
In CY 2008 an estimated 76.3% of the target population was fully immunized. The corresponding value for the U.S. was 78.2%.

See this indicator's Form 11 field note for 2009 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 2009 (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 federally qualified health centers continued using ImmPRINT, and 712 private medical facilities in Alabama were enrolled in ImmPRINT.

Operation of the Immunization Outreach Program continued. This program enables Alabama physicians to determine if their practice is on track to meet 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. As of early FY 2009, the Immunization Division was providing vaccine and support for 560 active public and private VFC providers, compared to 566 such providers in early FY 2005, 539 providers in early FY 2006, 583 providers in early FY 2007, and 558 providers in early FY 2008.

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, since this group of infants and children are considered least likely to complete the vaccine series.

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		
3. Mail vaccine pamphlets to parents of all 4-month-old infants.			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			X	X

hepatitis B virus.				
5. Maintain an electronic immunization registry (called "ImmPRINT"), to make all childhood vaccine histories available to all providers.				X
6. Provide vaccine-level audits in federally qualified health centers and some private providers.				X
7. Operate the Immunization Outreach Program, which enables Alabama physicians to determine if their practice is on track to meet the Healthy People 2010 objective of having 90% of 2-year-old children appropriately vaccinated.				X
8. Administer the Vaccines for Children Program for the State.				X
9. Provide continuing education and materials on immunizations to CHDs.		X		X
10. 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

b. Current Activities

Cross-cutting:

FY 2009 activities basically continue. The number of sites enrolled in the VFC Program is now 560 compared to 558 sites in early FY 2008 and 568 sites in early FY 2009. The Immunization Division provides vaccine and support for all the enrollees.

The division continues maintaining a web page on immunization and certain diseases. For example, the page includes the childhood and adolescent immunization schedule, an "Immunization Page Just for Kids," and information on ImmPRINT. As well, the page includes links to CDC materials on National Infant Immunization Week (April 25 -- May 2) and National Immunization Awareness Month (in August). Further, the page provides information on VFC, the Perinatal Hepatitis B Program, and the Immunization Outreach Program.

c. Plan for the Coming Year

FY 2009 and 2010 activities, recapped below, will basically continue in FY 2011.

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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26.8	25.1	24.8	24.6	28.2
Annual Indicator	25.3	27.8	29.1	27.6	
Numerator	2486	2683	2826	2652	
Denominator	98093	96589	97125	96123	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27.9	27.6	27.3	27.1	27.1

Notes - 2009
Due to the time required to collect, edit, and manage data, final year 2009 Alabama statistical birth files are not yet available. They are expected to be available circa August 2008, and Form 11 will be updated at the first opportunity after the files have become available.

This paragraph pertains to national performance measures (NPMs) and state performance measures (SPMs) that have population-based denominators: specifically, to NPMs #8, #10, and #16 and to SPM #3. When analyzing trends in these measures, we used the U.S. Census Bureau's population estimates for denominators. These estimates are derived from a detailed, state-level spreadsheet that is referred to by the Census Bureau as "SC-EST2008-alldata6: Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and One Group with Two or more Race Groups) by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2008." The release date for the spreadsheet was May 14, 2009. In their annual releases of estimates, the Census Bureau often revises previous estimates, but the Title V Information System (TVIS) does not permit us to directly revise numbers for the denominators shown on Form 11 for 2005 and 2006. Specifically, for the population-based performance measures, the denominators shown on Form 11 for 2005 are population projections (which are less accurate than population estimates), and denominators shown for 2006 are population estimates that were available circa March 2009. Therefore, for 2005 and 2006, the single-year denominators used for our analyses of trends in population-based estimates often differ from those shown on Form 11.

This paragraph pertains to the numerators for NPM #8 (the live birth rate for 15-17 year-olds) and SPM #3 (the pregnancy rate for this age group). Births, induced abortions, and fetal deaths that involve Alabama residents but occur outside of the State have apparently been underreported to the Alabama Department of Public Health (ADPH) in recent years. 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, we made certain assumptions about out-of-state births, elective abortions, and fetal deaths 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. The numerators

shown on Form 11 for 2005 and 2006 do not reflect these assumptions, since TVIS does not permit us to directly revise them.

Notes - 2008
Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators and denominators for this indicator are discussed in this indicator's year 2009 Form 11 field note.

Trends:
As mentioned in this indicator's year 2009 Form 11 field note, for analyzing trends, the number of births has been adjusted in an effort to account for missing information about out-of-state births to Alabama residents.

Among 15-17 year-old Alabama females, the live birth rate declined (improved) 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 15.3% 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 (improved) by 2.8% per year. Comparing 2006-08 to 2003-05, the indicator declined by only 0.2% per year.

Objectives:
Objectives through 2013 were retained from earlier years. Since the objective for 2013 (27.1 live births per 1,000 females in this age group) is lower than any of the 3-year rates during the surveillance period, we set the year 2014 objective at 27.1 live births per 1,000 as well. We are aware that all the future objectives are higher (worse) than the estimate of 27.6 live births per 1,000 15-17 year-old females in 2008. However, considering the rate for 2006-08 combined and uncertainty due to out-of-state reporting issues, future objectives may prove quite challenging. If the live birth rate for this age group remains at or below the 2008 level for 3 years in a row, objectives will be revised downward.

Notes - 2007
Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators and denominators for this indicator are discussed in this indicator's year 2009 Form 11 field note. Using numerators (live births) and denominators (population estimates) that were available circa March 2009, the live birth rates per 1,000 among 15-17 year-old females were 28.9 (2,672/92,474) in 2004 and 26.3 (2,486/94,586) in 2005.

Trends:
This discussion of trends is based on numerators and denominators that were available circa March 2009.

Earlier in this decade, the live birth rate among Alabama 15-17 year-old females declined

(improved) from 36.2 live births per 1,000 such females in 2000 to 26.3 live births per 1,000 in 2005. With 1 exception, this rate declined every year during that period. (No decline occurred in 2004.) Then, however, the rate increased to 27.8 births per 1,000 in 2006 and again increased to 28.7 births per 1,000 in 2007. Comparing 3-year periods, the live birth rate among 15-17 year-old females declined from 33.1 per 1,000 (9,270/280,533) in 2000-02 to 27.6 per 1,000 (7,958/288,196) in 2005-07: for an overall decline of 16.4% and an average annual decline of 3.5%. Comparing more recent, single years, the rate declined from 31.2 per 1,000 (2,899/93,007) in 2002 to 28.7 per 1,000 in 2007: for an average annual decline of 1.6%.

Objectives:
Objectives from 2009 forward require an average annual decline of 1.0% per year from the 2005-07 baseline of 27.6 live births per 1,000 15-17 year-old females. (For setting objectives, this baseline was considered to represent the rate for 2006.) This rate of decline is less than the average annual declines described above, but the objectives are challenging nevertheless, given the increase of this indicator in 2006 and again in 2007.

a. Last Year's Accomplishments
Status and Data-Related Issues:
Because NPM #8 counts only live-born infants, rather than all pregnancies among 15-17 year-old teens, SPM #3 tracks the pregnancy rate for this age group. Trends and additional data-related issues are discussed in the Form 11 field notes for this indicator.

In 2008, the live birth rate among 15-17 year-old Alabama teens was 27.6 births per 1,000 females in this 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 2008, AAEP funded 7 projects that provided abstinence education and mentoring programs in schools to approximately 39,000 students in 39 counties.

FY 2009:
Unless stated otherwise, the following activities occurred in FY 2009.

Direct:
CHD Family Planning clinics served 12,804 adolescents aged 17 years and younger in FY 2009. Following the end of funding through Title V for abstinence education on June 30, 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. The group met bimonthly to review evidence-based programs cited by the National Campaign to Prevent Teen Pregnancy, the Healthy Teen Network, and Advocates for Youth. The evidence-based programs presented challenges for the school-based programs with some of the goals and objectives related to expanded contraception discussion and demonstration. Overall, the group felt a youth development approach would be the best fit for school-based programming.

Enabling:
CHD staff continued to distribute 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 and Infrastructure-building:
The toll-free Info Connection hotline to provide educational information for teens regarding reproductive health and family planning services continued.

AAEP activities basically continued in FY 2009, since the U.S. Congress provided funding through June 30, 2009. Classroom monitoring was completed for all sub-grantees to assure medical accuracy. AAEP's progress toward achieving the program's goals was evaluated by a new pre- and post-test survey.

During 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 provided professional development for staff, materials for use in community trainings, and informational e-mails regarding evidence-based programs and health care reform activities potentially related to the Education Funding through the Administration for Children and Families. AAEP consulted with the sub-grantees as requested.

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			
2. Counsel teens coming to CHDs for family planning services, regarding consensual sex and Alabama Law.	X	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. Utilize the web-based electronic care coordination system (CCRS) for sending referrals from ADPH to PHAs.		X		X
5. Administer the Alabama Abstinence Until Marriage Education Program (AAEP), channeling federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct and Enabling:
CHD Family Planning clinics continue to serve teens who present there. Services include clinical, educational, counseling, and care-coordination services.

In March 2010, AAEP cosponsored a statewide training event to introduce youth serving community agencies and schools potentially interested in funding opportunities to prevent teen pregnancy. The training was well attended from across the State and included presentations on the development and evaluation of evidence-based programs, the development of a Behavioral Outcomes, Determinants, and Interventions (BDI) logic model, and the importance of fidelity to programming.

In April 2010, the Office of Adolescent Health released 2 funding opportunity announcements for

replication of evidence-based programs to prevent teen pregnancy.

Population-based and Infrastructure-building:
The toll-free hotline, Info Connection, continues.

c. Plan for the Coming Year
Direct and Enabling:
CHD Family Planning clinics will continue to serve teens who present there. Services will include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:
The toll-free hotline, Info Connection, will continue. AAEP will support the application of Auburn University to implement the youth development program, Project AIM.

Abstinence education funding, approved for the proposed 5-year funding cycle, remains contingent on continuation of federal funding by Congress in FY 2010.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23.7	24.2	26.7	27	28.8
Annual Indicator	23.2	26.4	27.7	27.7	27.7
Numerator		629	2580	2580	2580
Denominator		2380	9301	9301	9301
Data Source				ADPH Oral Health Branch Survey data	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?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.4	30	30.6	31.2	31.2

Notes - 2009
Another observation-based survey on the prevalence of dental sealants is expected to be conducted in FY 2011-12. 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 is not conducted.

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

Notes - 2008

Another observation-based survey on the prevalence of dental sealants is expected to be conducted in FY 2011-12. 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 is not conducted.

Objectives:
We have set the year 2013 objective at 31.2 using the methodology described under objectives in the 2007 field note.

Notes - 2007
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:
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:
As the observed status of 27.7 in 2007 exceeds (is better than) the 2008 objective of 27.0, the objectives from 2009-2012 have been revised. However, since the data are based on a sample, the estimates may fluctuate. Using the 2007 estimate of 27.7 as a baseline, targets were set to require an annual improvement of 2.0%--a modest improvement, yet challenging given the State's historically underserved rural counties.

a. Last Year's Accomplishments
Status and Trends:
In 2007 an estimated 27.7% of third-grade Alabama children had received protective dental sealants on at least 1 permanent molar tooth.

Trends in this indicator are discussed in its Form 11 field note for 2007.

Historical Context:
OHB and the School of Dentistry have partnered to periodically conduct observation-based, representative statewide surveys of dental sealants among third-grade Alabama children. The last survey of this nature was conducted in FYs 2006-07. The 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 survey results. The lowest estimated percentage 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 estimated percentage was 41.3% in Dental District 7 (Jefferson and Shelby Counties).

The CDC guidelines for inclusion in the National Oral Health Surveillance System recommend that states conduct these surveys every 5 years. Alabama's next statewide survey of third-grade children is planned for FYs 2011-12.

In FY 2008, the Coffee County dental clinic, which had been the only Medicaid dental provider for the entire county, was scheduled to close due to funding issues. Instead of closing the clinic, however, it was outsourced to a non-profit dental organization, Sarrell Dental. Sarrell Dental guidelines include sealant placement on every qualifying client. Sarrell Dental also launched a new mobile dental program: which targeted schools in underserved communities statewide. Also

in FY 2008, the "Alabama Mobile Access to Dental Care Act" became effective. This new 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 2009:
The following activities occurred in FY 2009.

Direct:
The 3 CHD dental clinics provided 4,218 dental sealants at their permanent sites and through mobile dental programs. Sarrell Dental clinic programs provided dental sealants on all qualifying Medicaid- and ALL Kids-enrolled children through their 7 (1 of them newly opened) permanent site clinics statewide. Three school-based dental clinics also provided dental sealants on all eligible children served through their clinics. As well, dental services continued to be provided through some federally qualified health centers.

Sarrell Dental discontinued their mobile dental van program due to administrative and logistical issues. However, mobile dental van programs operated by a community health center dental program in West Alabama and a large CHD dental program in Jefferson County continued.

Enabling:
OHB staff provided Patient 1st training to CHD care coordinators, for the purpose of strongly encouraging parents of Medicaid-eligible children to access dental care and seek dental sealants as a disease-preventive measure. One PHA dental staff representative provided multi-county education, screening, and outreach initiatives that promoted sealant utilization for at-risk children.

Population-based and Infrastructure-building:
During National Children's Dental Health Month, educational material that supports sealant utilization was distributed statewide to a variety of groups including teachers, parents, health professionals, and others.

OHB continued to work with numerous internal and external programs to address dental access issues and to promote new permanent and mobile dental programs for underserved communities. All clinics continued to promote and provide dental sealants on children at risk for dental caries.

A contractual agreement with the School of Dentistry, which provides a pediatric dental consultant at .20 FTE capacity, continued. The consultant worked with OHB to address work force issues, needs assessment, policy change and development, fluoridation activity, new clinic development, funding opportunities, and numerous other issues concerning promotion of access to dental care.

The position of State Dental Director, which had become vacant in FY 2008, remained vacant. Since the person in this position serves as Director of OHB, the Associate Director of OHB served as Interim Director of OHB.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In collaboration with others, provide dental services (including application of dental sealants when indicated) to certain populations of children who tend to have unmet dental needs.	X			X
2. 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
3. Participate in national Children's Dental Health Month.			X	
4. Encourage and support efforts to use mobile dental vans to	X			X

target schools in underserved communities statewide to provide dental care, including dental sealants.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
FY 2009 activities have basically continued in FY 2010. Examples follow.

Direct:
CHD dental clinics, Sarrell Dental clinics, community health center dental clinics, mobile dental programs, and private dental offices continue to promote dental sealants and are encouraged to seal permanent molars on children soon after the 6 and 12-year molars erupt.

Sarrell Dental opened another clinic in an underserved county in North Alabama, bringing their total number of dental clinics to 8.

Enabling, Population-based, and Infrastructure-building:
Education initiatives continue that promote dental sealants to parents through CHDs, schools, day care, Head Start programs and other settings.

Oral health continues to be a high priority for FHS: as evidenced by the fact that 1 of the 7 priority MCH needs selected by FHS during the Needs Assessment concerns promotion of access to a dental home and to preventive and restorative dental care.

FHS is intensively seeking to fill the vacant State Dental Director position and expects to fill it by the end of September 2009.

c. Plan for the Coming Year
Unless previously stated otherwise, FYs 2009 and 2010 activities will continue in FY 2011. Updates follow.

Cross-cutting:
One new sealant initiative will be provided through collaboration with the School of Dentistry, pending funding approval from a Title VII Training Grant for Pediatric Dental Residents. The School of Dentistry and OHB will partner to provide a school sealant program in selected schools from the Alabama Black Belt Region. Second- and third-grade children from about 10 schools will be screened, and free sealants will be offered to those who qualify. Parental consent will be required, and the program will be expanded and sustained as funds are available. Children identified as having unmet dental needs will be referred for follow-up treatment and those without dental homes will be encouraged to establish one. The new program stems from a recent Pew Center report, "The Cost of Delay: State Dental Policies Fail One in Five Children." Alabama received an overall grade of "D" for 8 dental policy approaches. One policy addressed organized sealant programs for schools with high enrollments of low-income children. The national benchmark is to provide sealant programs for at least 25% of those qualifying schools. Alabama is currently well below the benchmark. Also, during FY 2011, OHB will partner with CHDs, the School of Dentistry, and private volunteer dentists to conduct a statewide dental survey of Alabama children. Third-grade children will be targeted and data collected will include caries experience, unmet dental needs, urgency of unmet dental needs, and sealant placement. These initiatives should increase the percentage of children with dental sealants and provide updated data for more efficient tracking of NPM #9.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.4	5.8	6.2	6.1	5.2
Annual Indicator	6.5	6.4	3.7	4.6	
Numerator	61	59	34	43	
Denominator	936034	922002	922825	925961	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.1	5	4.9	4.8	4.8

Notes - 2009
Due to the time required to receive, manage, and edit vital statistics data, final year 2009 death files are not yet available for Alabama. Our experience has shown that the incomplete, provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Vital events that involve Alabama residents but occur outside of the State have apparently been underreported to the Alabama Department of Public Health in recent years. This out-of-state reporting issue may cause slight underestimation of mortality rates for the years 2006, 2007, and 2008. Though slight, such underestimation could lead to appreciable distortion of trends in mortality rates, as well as to overly optimistic baselines for setting future objectives. Therefore, for 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 out of 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 in the age group of interest per year.

Because the Title V Information System does not permit us to directly revise numbers shown for 2005 and 2006, the numerators shown on Form 11 for those years for NPMs #10 and #16 do not reflect the adjustment. For these NPMs, 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.

Notes - 2008
Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators for this indicator are discussed in this indicator's year 2009 Form 11 field note. Data issues concerning denominators for this indicator are discussed in the year 2009 Form 11 field note to NPM #8.

Trends:
For this analysis of trends, numerators for years 2006, 2007, and 2008 have been adjusted as described in this indicator's year 2009 Form 11 field note. Among Alabama residents 14 years of age and younger, the rate of deaths due to motor vehicle crashes increased from 6.0 deaths per 100,000 (167/2,778,601) in 2000-02 to 6.3 deaths per 100,000 (173/2,748,918) in 2003-05, then declined to 5.0 deaths per 100,000 (138/2,767,839) in 2006-08. Thus, the rate for 2006-08 was 17.0% lower than in 2000-02 and 20.8% lower than in 2003-05.

Rates for individual years in the surveillance period (2000-2008) ranged from 3.7 deaths per 100,000 in 2007 to 6.8 deaths per 100,000 in 2004. Rates for overlapping 3-year periods ranged from 5.0 deaths per 100,000 in 2006-08 to 6.7 deaths per 100,000 in 2004-06.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator declined (improved) by an average of 3.1% per year. Comparing 2006-08 to 2003-05, the indicator declined by 7.5% per year.

Objectives:
Objectives through 2013 were retained from earlier years. Since the objective for 2013 (4.8 deaths per 100,000) is lower than any of the 3-year rates during the surveillance period, we set the year 2014 objective at 4.8 deaths per 100,000 as well. We are aware that all the future objectives are higher (worse) than the rate of 4.6 deaths per 100,000 in 2008. However, this rate is the second lowest during the surveillance period and this indicator may fluctuate annually. If the rate remains at or below the year 2008 level for 3 years in a row, objectives will be revised downward.

Notes - 2007
Data Issues:
Data issues concerning denominators for this indicator are discussed in the year 2009 Form 11 field note to NPM #8.

Trends:
This discussion of trends is based on numbers that were available circa April 2009. That is, they are based on then-available population estimates, and the numerators have not been adjusted to account for the out-of-state reporting issues discussed in this indicator's year 2009 Form 11 field note.

Among Alabama residents 14 years of age and younger, the rate of deaths due to motor vehicle crashes declined from 6.0 deaths per 100,000 (167/2,780,153) in 2000-02 to 5.5 deaths per 100,000 (152/2,764,216) in 2005-07: for an overall decline of 8.5% and an average annual decline of 1.8%. Rates for individual years during the surveillance period (2000-2007) ranged from 3.5 deaths per 100,000 in 2007 to 6.8 deaths per 100,000 in 2004.

Objectives:
In April 2009 objectives for 2009 onward were revised downward (made more agressive), in light of recent trends. Specifically, considering the unrounded rate for 2005-07 to be the baseline for 2006, objectives for 2009 onward require an average annual decline of 2.0%. We are aware that all of the objectives are higher (worse) than the rate of 3.5 deaths per 100,000 in 2007. However, this rate is the lowest during the surveillance period and may fluctuate annually. If the rate remains around the 2007 level for 3 years in a row, objectives will again be revised downward.

a. Last Year's Accomplishments

Status and Trends:
In 2008, among Alabama residents 14 years of age and younger, the estimated rate of deaths due to motor vehicle crashes was 4.6 deaths per 100,000 persons in this age group.

Trends in this indicator, as well as related data issues, are discussed in the indicator's Form 11 note for year 2008.

Historical Backdrop:
Key legislative events have included the Alabama graduated driver's license legislation and recent amendments to previous legislation concerning child safety restraints. Discussion of these laws follows.

The current Alabama 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. 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 or guardian, a licensed adult driver of any age.

In FY 2006, the Alabama Legislature passed key amendments to previous legislation concerning requirements for child safety restraints in motor vehicles, and these amendments were signed into law by the Governor (Section 32-5-222 of Alabama law). These amendments strengthened legislative requirements regarding motor vehicle safety restraints for children and youth and included 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 system 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 to specify 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 in order 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.

The Occupant Restraint Program, under the leadership of HPCD's Injury Prevention Division, typically conducts annual observational survey of seat belt usage in Alabama. In 2008, 88.2% of the observed 0-5 year-old passengers were restrained. Findings from this program are further discussed under HSI #3B.

FY 2009:
All of the following infrastructure-building activities occurred in FY 2009.

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 reviewed 95% or more of all deaths qualifying for review. The State Child Death Review Team, which is comprised of highly qualified individuals from a wide variety of disciplines, continued to take a very active role in ACDRS policy and efforts.

The Alabama graduated driver's licensure law and various current passenger restraint laws continued to be operative and enforced by appropriate State authorities. By the end of FY 2009, efforts to enhance these laws had not yet succeeded.

The Booster Seat Advocacy Program (initiated in FY 2006) was jointly continued by ADPH, under the leadership of HPCD's Injury Prevention Division and the Southeast Child Safety Institute. The purpose of this program has been to educate Alabama's citizens about the amended law concerning child safety restraints in motor vehicles. Other participants in the Booster Seat Advocacy Program have included the Children's Hospital Child Safety Institute (located in Birmingham) and the UAB Department of Pediatrics.

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. Through ACDRS, monitor deaths of infants, children, and youth due to motor vehicle crashes.				X
3. [Appropriate state authorities] enforce the graduated driver's license law.				X
4. [Appropriate state authorities] enforce the law concerning motor vehicle safety restraints for passengers.				X
5. [The Alabama Department of Public Health'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
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2009 activities basically continue. As well, ACDRS is developing a multipronged teen driver safety campaign.

Infrastructure-building:

After several failed previous attempts, a bill to enhance Alabama's existing 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.

c. Plan for the Coming Year

Cross-cutting:

Unless previously stated otherwise, FYs 2008 and 2009 activities will basically continue in FY 2010. To briefly recap, these include:

1) Review of all unexpected or unexplained deaths of infants, children, and youth.

2) Continuation and support of the Booster Seat Advocacy Program.

3) Continued enforcement, by appropriate State authorities, of the Alabama graduated driver's

licensure law and the amended child safety restraint laws.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		26.1	27.1	28.2	29.4
Annual Indicator	23.2	28.3	27.0	25.4	
Numerator	12835	16533	16169	15135	
Denominator	55363	58353	59913	59508	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27.2	27.2	27.3	27.4	27.5

Notes - 2009
Data Issues:
Estimates for this indicator are for calendar year 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 2004 were not available by June 2006. The Alabama Department of Public Health's (ADPH's) Center for Health Statistics will provide numbers from the PRAMS 2009 dataset soon after CDC provides the dataset, but numbers for 2009 are not expected to be available before April 2011.

Notes - 2008
Data Issues:
See this indicator's year 2009 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.

The estimate shown on Form 11 for 2005 is a preliminary estimate that was provided before the State's PRAMS report for that year was published. At this time, the Title V Information System does not allow us to directly correct the estimate for that year. The final year 2005 estimate for the percentage of mothers who were still breastfeeding at the time of the survey is 23.5%.

Trends:
From 2004-2008, this indicator has ranged from 23.2% in 2005 to 28.3% in 2006, with a median of 25.6% in 2004. At no time during the surveillance period did the indicator move in the same direction 3 years in succession.

Objectives:
Objectives through 2009 are retained from previous years. Objectives from 2010 forward have been revised downward (made less challenging) compared to previous objectives, which were unrealistic in light of the status of this indicator in recent years. To set the objectives, the combined numbers for 2006-2008 (47,837/177,774, or 26.9%) were considered to represent the year 2007 baseline. From that baseline, the newly set objectives require an annual increase (improvement) in the indicator of 0.3% per year. If the status of this indicator remains above(better than) its corresponding objective 3 years in a row, we will revise the objectives to make them more challenging.

Notes - 2007
See 2008 field note regarding data source and limitations.

Trends:
When available, confidence intervals for the following estimates are shown parenthetically. For the surveillance period 2000-2004, the weighted percentage of PRAMS mothers who were breastfeeding at the time of the survey increased slightly each year: from 20.3% (17.7-22.9) in 2000 to 25.5% (22.5-28.8) in 2004. Though the estimate then declined to 23.5% (20.6-26.6) in 2005, it increased to 28.3% (25.3-31.6) in 2006. It decreased slightly in FY 2007 to 27.0%, although it remained higher than at any time in 2000-2005. Overall, this indicator has improved by 16.3% from the estimate of 23.2% in 2003 to the estimate of 27.0% in 2007.

Objectives:
Objectives through 2010, set in FY 2006, require an average annual increase (improvement) of 4.0% per year, from the unrounded 2003 baseline of 23.2%. We are aware that the estimated prevalence for CY 2006 exceeds (is better than) objectives for 2007 and 2008. Objectives for 2011-2013 have been revised to continue an average annual improvement of 4% per year.

a. Last Year's Accomplishments
Status and Trends:
See Form 11.

FY 2009:
The following activities occurred in FY 2009 unless stated otherwise.

Population-based:
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 the Alabama's Health Newsletter each month. Breastfeeding training was held for the nurses of the Family Nurse Partnership in Montgomery.

Infrastructure-building:
The WIC Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. Presentations on breastfeeding were made at CHDs

and 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. The Breastfeeding Coordinator was a speaker at the Annual "Supporting Breastfeeding in Your Community" conference in Dothan, Alabama.

The WIC Breastfeeding Coordinator and SPP staff continued to meet with Medicaid representatives to promote breastfeeding.

USDA awarded funding to maintain and expand the Breastfeeding Peer Counselor Program. The program was expanded to include Pike, Dallas, Lee (2 sites), and Jefferson (3 sites) Counties. However, due to staff turnover, the Peer Counselor Program ended in Jefferson County. Peer Counseling Program dollars that would have been directed to Jefferson County, therefore, have been used along with other available funds to expand the program in various ways. (For example, as of September 2010, the number of Peer Counseling Program sites has expanded to 12.)

The Breastfeeding Coordinator attended USDA "Loving Support: Building Breastfeeding Competencies for Local WIC Staff" training in June 2009.

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.

The SPP worked with the ABC to promote breastfeeding statewide. The ABC was reorganized into an executive committee and 5 regional breastfeeding task forces, with all but 1 of the State's 5 perinatal regions having a task force. (Region 5 has 2 task forces, and Region 2 does not have a task force.) Each task force was to address specific needs in its region or geographic area. The SPP staff collaborated with various agencies, businesses, and organizations to promote breastfeeding.

The SPP continued to collaborate with AMOD on breastfeeding: although the reduction in funds and redirection of the responsibilities of the SPP (toward FIMR) resulted in limited breastfeeding training being provided for health care professionals relative to FY 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Through television interviews, exhibits at professional meetings, and/or other appropriate media, promote public awareness of the importance of breastfeeding.			X	
2. Present breastfeeding education programs to CHD staff and, upon request, to hospitals.				X
3. Collaborate with the Alabama Breastfeeding Coalition, the Alabama Lactation Consultant Association and, when indicated, other groups to promote breastfeeding.			X	X
4. With support from a U.S. Department of Agriculture grant, maintain and expand the Alabama Breastfeeding Peer Counselor 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. Distribute materials to each CHD to promote Breastfeeding Awareness Month.			X	X
8. With support from the Alabama Chapter of the March of Dimes, provide training on infant care counseling, which includes a component on breastfeeding, for physicians who care for infants and their staff.				X
9.				
10.				

b. Current Activities
FY 2009 activities are expected to continue through FY 2010. Some updates follow.

Population-based and Infrastructure-building:
In January 2010, the WIC Breastfeeding Coordinator and 2 representatives from ABC attended the National Conference for State Breastfeeding Coalitions.

The Alabama Lactation Consultant Association and ABC continue to meet.

The Breastfeeding Coordinator and other members of ABC participated in CDC's State Breastfeeding Coalition Teleconference calls.

The Breastfeeding Coordinator will conduct trainings for new Peer Counselors.

Nutrition Education and Breastfeeding Promotion on-demand webcast will be available for WIC staff training in June.

The Alabama Lactation Consultant Association held a breastfeeding conference planned in May 2010. The State breastfeeding coordinator continues as an active member of this organization.

Additional funding was received from USDA to expand the current Breastfeeding Peer Counseling Program. Expansion will include 1 site in each PHA. Additional expansion will be contingent on funding. Also, funds will be used to hire a State Breastfeeding Peer Counselor Coordinator.

The SPP continues to work with Medicaid to incorporate breastfeeding information into the 2 encounters recipients have with the maternity program care coordinators. As well, SPP staff continue to work and collaborate with the ABC, the breastfeeding task forces, and other agencies and organizations to promote breastfeeding.

c. Plan for the Coming Year
Population-based and Infrastructure-building:
FYs 2009-2010 activities are expected to continue in FY 2011. These include provision of additional training for the Breastfeeding Peer Counselor Program, training of WIC staff, and provision of breastfeeding education statewide. The Business Case for Breastfeeding training project is expected to continue.

The SPP will continue to collaborate with AMOD on breastfeeding. SPP staff will continue to work with the ABC, breastfeeding taskforces throughout the State, AMOD, and other agencies to promote breastfeeding.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	95.2	95.3	95.4	95.5
Annual Indicator	95.1	96.2	94.6	95.3	97.4
Numerator	56371	59764	59578	59548	58846
Denominator	59300	62100	63005	62466	60394
Data Source				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	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	96.2	96.4	96.6	96.8	97

Notes - 2009
Data Issues:
All estimates pertain to calendar years.

For reasons detailed in this indicator's Form 11 field note for the year 2007, denominators for 2007-2009 are the numbers of occurrent live births to Alabama residents. Because of the change in how denominators are counted, the estimates for 2007 onward are not precisely comparable to estimates for earlier years. The denominator for 2009 is provisional and was obtained on April 16, 2010.

The numerator was obtained from the Alabama Department of Public Health's (ADPH's) Newborn Screening Program's database, Neometrics(TM). Neometrics contained hearing screening records for an unduplicated count of 58,846 newborns. Of these, 1,120 had no hearing screening performed prior to discharge from the hospital. Of the 1,120 cases where screening was not done, 3 were due to parental refusal.

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 Universal Newborn Hearing Screening (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, they are not appropriately captured for reporting purposes as a pre-discharge screen. The UNHS Coordinator anticipates a software update from Neometrics 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.

For 2 reasons, the percentage shown may overestimate the percentage of occurrent live births that received a hearing screening. First, as previously stated, infants for whom we have no data

are counted in the numerator. Second, whereas the denominator counts only occurrent live births to Alabama residents, the screens counted include screens of births occurring in Alabama to residents of other states.

Trends:
During the years shown, with 1 exception, this estimate has remained above 95.0%. The exception is the year 2007. Combining 3 years, from 2007-2009, an estimated 95.8% of infants born in Alabama hospitals underwent hearing screening before discharge.

Objectives:
Objectives through 2009 are retained from earlier years. Objectives from 2010 forward have been revised upward. We are aware that the estimate for 2009 surpasses (is better than) the objectives for 2010 forward, but we have no assurance that the status of this indicator will remain that high in future years. If estimates for this indicator remain above the given year's objective for 3 years in a row, objectives will again be revised upward.

Notes - 2008
Data Issues:
Through 2006, the denominator for each year is the number of occurrent live births during the year. However, for reasons detailed in this indicator's Form 11 field note for the year 2007, the denominators for 2007-2009 are the number of occurrent live births to Alabama residents. The denominator shown for 2008 is now final: at 62,466, rather than at the estimate of 63,447 used for the 2008 report/2010 application. Much of the reason for the difference is that we are now excluding occurrent births to out-of-state residents from the denominator.

The numerator was obtained from the ADPH's Newborn Screening Program's database, Neometrics(TM). Neometrics contained hearing screening records for an unduplicated count of 61,924 newborns. Of these, 2,376 had no hearing screening performed prior to discharge from the hospital. Of the 2,376 who were not screened, 7 instances were due to parental refusal. Additionally, there were 5,653 newborns for whom no hearing screening data were entered into the system. As explained in this indicator's Form 11 field note for the year 2009, these infants probably received a hearing screening before discharge, but after the blood spot form had already been submitted. As previously stated, the number of newborns who did not have hearing screening data entered into the database in 2008 was 5,653, which is a 29.7% decline over the 2006 number of 8,037.

As detailed in this indicator's field note for 2009, due to the inclusion of infants for whom we have no hearing screening data in the numerator and the exclusion of occurrent births to out-of-state residents from the denominator, the percentage shown may overestimate the percentage of occurrent live births that received a hearing screening.

Objectives:
The year 2013 objective was set to match year 2012 objective of 95.7%.

Notes - 2007
The denominators for 2005 and 2006 are occurrent live births. However, denominators for 2007-2009 include only occurrent live births to Alabama residents. That is, as of April 2010, we are excluding occurrent live births to out-of-state residents from the denominator for this performance measure. Therefore, in April 2010, the denominator for 2007 was revised to be 63,005 (which excludes occurrent births to out-of state residents), rather than 63,995 (which was reported in the 2008 report/2010 application and included births to out-of-state residents). The Title V Information System (TVIS) does not allow us to change fields for the years 2005 or 2006 at this time.

We are making the above change for two reasons. First, the on-line TVIS guidance for the "Total Births by Occurrence" field on Form 6 says to report occurrent births, but only those from resident births. Since both Form 6 and National Performance Measure (NPM) #12 pertain to newborn

screening, in our view, for the reporting year, the denominator for NPM #12 should be match the corresponding number of births shown on Form 6. The second reason for excluding births to out-of-state residents is that completeness of reporting of out-of-state events may vary from year to year, and such variation could cause spurious changes in the denominator, which in turn could cause spurious changes in the estimate. Excluding out-of-state residents from the denominator prevents bias in trends that could arise from out-of-state reporting issues.

In 2008, the numerator was updated to reflect data from a new report available from Neometrics. Neometrics contained hearing screening records for an unduplicated count of 62,093 newborns. Of these, 2,515 had no hearing screening performed prior to discharge from the hospital. Of the 2,515 who were not screened, 9 instances were due to parental refusal.

Counted in the numerator are 5,203 newborns for whom no hearing screening data were entered into the system. (See year 2009 field note about the rationale for including these cases in the numerator.) Because we cannot confirm that each of the 5,203 children did receive a hearing test, the numerator may be an overestimation. Notably, the number of newborns for whom no hearing screening data were entered into the system decreased from 8,037 in 2006 to 5,203 in 2007, a 35.3% decline.

a. Last Year's Accomplishments

Historical context:
Since its inception in 2004, Alabama's Listening, Alabama's Universal Newborn Hearing Screening (UNHS) Program, accomplished hearing screening at all Alabama birthing hospitals on a voluntary basis. On January 21, 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. An additional change to the program during 2008 included a decrease in the number of birthing hospitals in Alabama from 59 to 54.

FY 2009:
In FY 2009, many activities contributed to the programs continued success. 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 the contract audiologist.

Enabling:
The Care Coordination program continued providing case management services for the UNHS Program to infants receiving Medicaid 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 to be used 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. New loaner equipment was purchased to replace outdated equipment that did not meet program requirements for exporting of data.

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 who missed or refused screening. Each hospital was provided with their individual results and statewide results. Software errors were corrected so that the reports would be more accurate.

Four regional meetings, as well as nursery site visits, were held for the purpose of updating nursery and provider staff on current requirements for UNHS and the future direction of the program.

New reporting methods were initiated in the form of redesigned filter paper forms and the secure File Transfer Protocol server for hospitals to upload data on a monthly basis at a minimum. A separate File Transfer Protocol server for providers to upload results was also created, and contact was made with 3 audiology service providers to begin using this form of data reporting.

The UNHS Program continued the contract with Auburn University. This contract provided a doctoral-level audiology student assistant who worked 10 hours a week under the direction of the UNHS Coordinator. The student assistant provided follow-up services and hospital training.

The UNHS Program continued to contract with a part-time audiologist to serve as the hospital consultant for birthing hospitals with universal newborn hearing screening programs. The audiologist used the above mentioned hospital reports to identify hospitals in need of assistance or hands-on training. The audiologist also initiated the setup of File Transfer Protocol use in 5 birthing hospitals.

The UNHS Program continued to have a nurse coordinator work .50 FTE for the program. This nurse coordinator assisted the Newborn Hearing Screening Coordinator in 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.

The UNHS Program initiated a contract with the Children's Hospital's HEAR Center. The purpose of this contract was to provide free follow-up clinics for children who failed initial hearing screens and assist in the initial phase of creating a parent peer support group for parents of hearing-impaired children.

Infrastructure-building:
The position of UNHS Coordinator, which became vacant in July 2008, was filled in December 2008. As well, an ASA was added to the UNHS staff.

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. Track infants who did not pass or did not have a hearing screening to ensure they receive appropriate follow-up services.		X		X
3. Provide care coordination for the UNHS Program to Medicaid-enrolled infants.		X		X
4. Contract with a part-time audiologist to serve as the hospital consultant for birthing hospitals participating in the UNHS Program.				X
5. When equipment belonging to a hospital participating in UNHS is being repaired, provide loaner equipment for newborn hearing screening.				X
6. For each participating hospital, provide monthly statistical reports tabulating the number of newborns who had hearing screening and the results of the screenings.				X
7. Contract with Auburn University for a doctoral-level audiology student to provide follow-up services and hospital training, on a		X		X

part-time basis and under the direction of the UNHS Coordinator.				
8. Contract with the Children's Hospital HEAR Center to provide loaner hearing aids and other equipment to children identified with hearing loss through the UNHS Program.				X
9.				
10.				

b. Current Activities
FY 2009 activities are basically being continued in FY 2010. Updates follow.

Infrastructure-building:
The UNHS Coordinator, along with the contract audiologist, identified 12 hospitals in the State that could benefit from grants for new hearing screening equipment in order to comply with the mandate for newborn hearing screening and reporting. Eleven of these hospitals have received and are using the equipment.

The program purchased hearing screening equipment for 2 pediatric practices, both located in an area where additional hearing screening services are needed, to perform follow-up hearing screening. These practices have received and begun using the equipment.

The UNHS Program is continuing to enroll birthing facilities in the use of the File Transfer Protocol site for reporting results on a monthly basis.

The program has obtained software upgrades that will enable the Neometrics database to use the data uploaded to the File Transfer Protocol server to link hearing screening test results to infants in the database and automatically populate the infant records with test results. This will reduce the manual data entry errors. Five hospitals have been identified for piloting the upgraded software as the sole source of hearing screening data reporting.

The program increased the amount of the grant to Auburn University, which paid for adding a second intern to assist in data entry and statistical analysis.

c. Plan for the Coming Year
Unless previously stated otherwise, FY 2010 activities will continue in FY 2011. To recap, these activities include the following.

Cross-cutting:
Current program staffing will be maintained.

Enabling:
Provision of case management services for follow up regarding UNHS for Alabama infants receiving Medicaid will continue.

Infrastructure-building:
The UNHS Program will continue maintaining a loaner inventory of hearing screening equipment for birthing facilities use, providing monthly statistical reports, contracting with Auburn University for doctoral-level student assistants, contracting with a part-time audiologist as a hospital consultant, 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, and contracting with the Children's Hospital's HEAR Center to provide services for rescreening, diagnosis, and loaner amplification services to children identified through the UNHS program.

Additionally, the program will add more birthing facilities to the pilot project that involves

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.5	7.3	6.9	6.8	6.8
Annual Indicator	4.5	7.4	7.3	3.7	
Numerator	49000	82000	82000	41000	
Denominator	1083000	1114000	1123000	1122000	
Data Source				U.S. Census Historical Health Insurance Table HIA5	
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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.4	6.4	6.3	6.2	6.1

Notes - 2009
The reference for estimates is the revised Historical Health Insurance Table 5 (HIA-5), obtained from the U.S. Census web site. Table HIA-5 does not yet include estimates for 2009. When estimates for 2009 are provided on the U.S. Census web site, this report/application will be updated accordingly at the first opportunity.

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, objectives for 2010-2013 have been 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 prevalence of 6.1% of Alabama children being uninsured occurred in 2004-06 and again in 2006-08.) We are aware that, at 3.7% (as shown on Form 11), the estimated status of this indicator in 2008 surpassed (was better than) any of the newly set objectives. Nevertheless, the newly set objectives are challenging, since single-year estimates for this indicator have been above 7.0% in 3 of the last 5 years for which an estimate is available. Further, the status of this indicator in 2005-07 combined was 6.4%. If the status of this indicator surpasses (is better than) the corresponding objective in 2010 and again in 2011, objectives will again be revised downward.

Notes - 2008
The reference for estimates from 1999 forward is Table HIA-5, obtained from the U.S. Census web site on March 19, 2010. Because the reference rounds numbers of individuals to thousands, percentages calculated by the Title V Information System'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.

Trends:
In the discussion that follows, the source for the prevalence of non-insurance from 1999-2008 is the Census Bureau's Table HIA-5. The source for the prevalence of non-insurance in earlier years is the Census Bureau's original Historical Health Insurance Table 5 (HI-5). In 2008, according to Table HIA-5, 3.6% of Alabama children and youth had no health insurance. This prevalence is the lowest on record for the State.

Trends show remarkable progress. The following combines 3-year periods, in order to minimize random variation due to sampling error. Comparing 2006-08 to 1999-2001, the estimated prevalence of non-insurance among Alabama children and youth declined by one-third (32.9%): from 9.1% (310,000/3,407,000) in 1999-2001 to 6.1% (205,000/3,359,000) in 2006-08. Further, from 1999-2008 (the only years shown in Table HIA-5), the prevalence of non-insurance among Alabama children and youth was lower than the corresponding prevalence for the U.S. In 2006-08 combined, 6.1% of Alabama children and youth, versus 10.8% of U.S. children and youth, were uninsured.

Extending the surveillance period indicates even more progress in Alabama. Per Table HI-5, in 1987, 22.0% of Alabama children and youth lacked health insurance, compared to 12.9% of U.S. children and youth. Comparing 2007-09 to 1987-89, the prevalence of non-insurance among Alabama children and youth declined by 68.3%: from 19.3% in 1987-89 (628,000/3,257,000, using HI-5) to 6.1% in 2006-08 (using HIA-5). (Table HI-5 does not extend beyond 2005.)

Notes - 2007
The reference for the estimate is Table HIA-5, which pertains to persons under 18 years of age, obtained from the U.S. Census web site on March 19, 2010.

a. Last Year's Accomplishments
Status and Trends:
In 2008, an estimated 3.6% of Alabama children and youth had no health insurance. This prevalence is the lowest on record for the State.

Trends in this indicator are discussed in its Form 11 field note for 2008.

Historical Context:
The development of Alabama's CHIP, called ALL Kids, is discussed in Section III.A.

FY 2009:
The number of children ever enrolled in ALL Kids during FY 2009, as reported in the 4th quarter, was 110,158 children: down 0.6% from the corresponding enrollment in FY 2008 (110,821 children, a record high).

Unless stated otherwise, the following activities occurred in FY 2009 and continued from previous years.

Cross-cutting:
ALL Kids staff attribute the continued decline in the rate of uninsured children in the State to several factors: 1) continuing collaboration among Medicaid, ALL Kids, and the Alabama Child Caring Program (a non-profit group that seeks to provide health care coverage for needy children who are not eligible for government-sponsored programs); 2) extensive partnerships with

providers, community agencies, schools, faith-based organizations, and others who help with enrollment efforts; 3) simplified application processes; and 4) effective media campaigns which included a new Sports Outreach campaign. In FY 2009, ALL Kids referred about 42,000 children to Medicaid through the joint web application and Alabama CHIP's Automated Data Integration System.

The Regional Coordinators for ALL Kids continued partnering with stakeholders to identify uninsured children. They have participated in Rapid Response events, which provide information about health coverage programs for children to persons losing their jobs due to layoffs or plant closings. One of the coordinators targets Latino communities with outreach efforts, including training of community leaders as application assistors. As well, she trained volunteers who work with seasonal migrant families. Applications and brochures were available in English and Spanish. Spanish language media efforts (radio) continued in some areas of the State with high Latino populations. The ALL Kids program continued to contract for multi-language telephone interpretation services and employs a Spanish-speaking customer service representative.

Population-based:
Combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Program were available at CHDs, hospitals, provider offices, many other community locations, and the ALL Kids web page. The electronic signature continued to be acceptable on a web-based application.

ALL Kids began piloting the Audio Visual Application Assistor Project, for which development began in FY 2007. Several kiosks where families could apply for coverage through the web-based application were placed in rural areas. Applicants with limited English proficiency, as well as those whose primary language is English, have been able to apply at these kiosks, use of which has increased steadily in most sites.

Infrastructure-building:
The ALL Kids Enrollment Unit included a SOBRA Medicaid eligibility unit placed there in FY 2002.

The ALL Kids premium collection processes included ability to accept credit card payments online or by phone, as well as payments made by postal mail. Further, the program offered families the opportunity to make partial payments.

To make the best use of its extensive partnership network, in FY 2009, ALL Kids developed the CHIP E-Blast, a short e-mail about upcoming changes in the program. This initiative allows ALL Kids to quickly get information to hundreds of partners, and response to it has been favorable.

In an effort to reach uninsured children who are eligible for free and reduced-cost lunches, in FY 2009, ALL Kids began training dietary managers to educate enrollees in the free or reduced-cost lunch program and their families about ALL Kids.

BCBS conducted a satisfaction survey in November 2008. A random sample was selected of sufficient size to achieve a 95% confidence level. Satisfaction was assessed for issues related to access to care, quality of customer service, and timeliness of claims processing. All indicators received at least a 96% satisfaction rate.

In February 2009, ALL Kids was one of 8 states to be awarded a Maximizing Enrollment for Kids grant from the RWJ Foundation. Through this project, known as Perfecting Enrollment for Alabama's Kids, ALL Kids and Medicaid will examine their enrollment, renewal, and outreach processes.

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. Through the 14 Regional Coordinators for ALL Kids, develop partnerships with stakeholders around the State to assist with the identification of uninsured children.			X	X
3. Attend Rapid Response events, providing information about health coverage programs for children to persons losing their jobs due to plant closings.		X	X	
4. Conduct outreach to the Latino community to provide information, including materials written in Spanish, about ALL Kids.			X	X
5. As part of outreach to the Latino community, identify and train Latino community leaders to serve as ALL Kids application assistors; in addition, contract for multi-language telephone interpretation services for ALL Kids.		X		X
6. Make combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation available at CHDs, at various other places, and on the ALL Kids web page.		X	X	X
7. Periodically review the ALL Kids application process, and revise as needed and feasible.				X
8. Provide several kiosks in rural areas where families with limited English proficiency can apply for coverage through the web-based application.		X	X	
9. Train dietary managers to educate enrollees in the free or reduced-cost lunch program and their families about ALL Kids.				X
10. With support from a Robert Wood Johnson Foundation grant, examine enrollment, renewal, and outreach processes, through a project known as Perfecting Enrollment for Alabama's Kids.				X

b. Current Activities
Cross-cutting:
Except for 1-time or periodic events, FY 2009 activities basically continue.

ALL Kids has implemented or is considering new measures to assure compliance with mandates of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA): for example, verification of citizenship, payment to federally qualified health centers, and mental health parity. As mentioned in Section III.A, CHIPRA 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 SSA files to meet the verification requirement. Concerning health centers, CHIPRA requires states with separate or combination CHIP programs to pay federally qualified health centers and rural health clinics using the Medicaid prospective payment system. Concerning mental health parity, CHIPRA prevents states that include mental health or substance abuse services in their CHIP plans from imposing financial requirements and treatment limitations for those benefits that are more restrictive than those for medical and surgical benefits.

As well, ALL Kids is managing an increase in the number of applications to the program. Contributing factors to this increase include the increase in the maximum allowable household income for ALL Kids enrollees to 300%, effective October 1, 2009, and possibly continuing effects of the economic downturn.

c. Plan for the Coming Year

Unless previously stated to have a shorter time frame or to be 1-time or periodic events, activities occurring in FY 2009 and FY 2010 will basically continue in FY 2011. To recap, these include the following.

Cross-cutting:
ALL Kids Regional Coordinators will continue engaging in local efforts to build partnerships in order to identify and enroll uninsured children. Staff from ALL Kids, Medicaid, and the Alabama Child Caring Program will continue collaboration to make the application process seamless. Joint applications will continue to be available around the State. Efforts to promote the use of web-based applications will continue.

Population-based:
Outreach efforts focusing on low-literacy English speaking populations, non-English speaking populations, families in rural areas, and working families with uninsured children will continue.

Infrastructure-building:
Location of a SOBRA Medicaid eligibility determination unit in the ALL Kids Enrollment Unit will continue.

ALL Kids and Medicaid will continue to implement the Perfecting Enrollment for Alabama's Kids Project.

ALL Kids will continue development and implementation of measures to assure compliance with CHIPRA.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30.1	29.9	29.8	27.5
Annual Indicator	30.9	28.7	28.6	28.9	
Numerator	9313	14300	14714	16419	
Denominator	30140	49826	51448	56813	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28.5	28.3	28.2	28	27.9

Notes - 2009
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 2008 PedNSS data in Table 6C became available by March 2010, we anticipate that FY 2009 data will be available by March 2011. Once 2009 PedNSS findings become available to the Bureau of Family Health Services, we will update Form 11 at the first opportunity.

Notes - 2008
Data Issues:
In previous PedNSS reports, a BMI for age of at least 85% but less than 95% was classified as indicating that the child was at risk for overweight, and a BMI for age of 95% or higher was classified as indicating that the child was overweight. Effective with the 2008 PedNSS report, new terminology recommended by the American Academy of Pediatrics' Expert Committee is being used. Per the new terminology, a BMI for age of at least 85% but less than 95% is classified as indicating that the child is overweight, and a BMI for age of 95% or higher is classified as indicating that the child is obese.

The estimate shown here is the percentage of 2-5 year-old WIC enrollees whose BMI was 85 percent or higher.

Trends:
During the surveillance period, 2004-2008, single-year values for this indicator have ranged from 28.6% in 2007 to 30.9% in 2005. Combining 2-year periods, the indicator declined (improved) slightly, by 6.2%: from 30.6% in 2004-05 to 28.8% in 2007-08.

Note that the denominator for this indicator increased markedly in 2006, however, and increased again in 2007 and 2008. As detailed in the State's Maternal and Child Health Services Block Grant 2007 Annual Report/2009 Application, PedNSS data for 2004 and 2005 included data for only 45 of Alabama's 67 counties. On the other hand, data from 2006 onward are from all 67 counties. Therefore, the slight improvement observed in this indicator may be due to expansion of the population to include all 67 counties--which could make the 2004-05 and 2006-08 study populations non-comparable--rather than due to a true improvement in the indicator.

Objectives:
Objectives through 2009 have been retained from previous years. However, objectives from 2010 have been revised upward, to be slightly less challenging and more realistic in light of recent values for this indicator. The newly set objectives are still quite challenging, however. Considering the percentage for 2007-08 (28.8%, or 31,133/108,261) to be the year 2008 baseline, they require a decline of 0.5% per year.

Notes - 2007
See the 2008 field note for the data source.

The reference is "Table 6C, 2007 Pediatric Nutrition Surveillance, Alabama--Comparison of Growth and Anemia Indicators by Contributor, Children Aged <5 years." Per this reference, 14.8% of the children had a BMI that had reached the 85th percentile but was less than the 95th percentile; and 13.8% of the children had a BMI at or above the 95th percentile. Adding these 2 percentages together, 28.6% of the children had a BMI at or above the 85th percentile. The numerator was estimated by multiplying the denominator by .286.

Trends:
When we began monitoring this measure in 2004, 30.4% of Alabama children, age 2 to 5 years, were observed to be overweight (BMI at or above the 95th percentile) or at risk of becoming overweight (BMI at or above the 85th percentile to the 95th percentile). In 2007, the observed value was 28.6%, which was an improvement of nearly 6%. The average annual percentage reduction was 2.0%. Although small, any improvement in this indicator is notable.

Objectives:
We are aware that the observed status in 2007 of 28.6 is less than (better than) the annual objective of 29.9. As stated in the 2006 field note, FHS had insufficient data initially for setting objectives. Although challenging, the 2009-2013 objectives have been revised to reflect a 2% annual reduction in this indicator from the baseline of 30.4% in 2004. Targets were revised through a multiplicative model using a factor of 0.98.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
Historical Context:
Cross-cutting (Enabling, Population-based, 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 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. The FY 2007-08 Nutrition Education Plan 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 education plan. 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, and pedometers.

An Overweight Risk Criteria Report was developed in FY 2004, and 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.

FY 2009:
All of the following occurred in FY 2009.

Cross-cutting:
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 SNAP subcommittee of AOTF was discontinued in FY 2009. A SNAP was not implemented in USDA food assistance programs in Alabama in FY 2009.

A biannual FY 2009-10 Nutrition Education Plan was implemented in all WIC clinics. It targeted children and breastfeeding and postpartum women enrolled in WIC. It continued the previous

plan's focus on obesity prevention for the whole family and added a new "Mooove to 1% Low Fat and Fat Free Milk!" campaign. Two new posters, a handout, and stickers were used to help educate participants. All WIC clinics participated in the Breastfeeding Awareness Campaign in August and a "Fruit & Veggies: More Matters!" campaign in September.

The Overweight Risk Criteria Report was run for FY 2008 and compared with previous years' data. In addition, CDC Pediatric Nutrition Surveillance System (PedNSS) data for FY 2007 for Alabama were used to ascertain the percentage of WIC-enrolled children aged 2-5 years who have a BMI at or above the 85th percentile.

The WIC Food Package Committee met monthly through March 2009 to finalize the new WIC food packages, develop or revise over 30 WIC forms and publications to be consistent with the new food packages, plan statewide training, and develop a training DVD. The committee provided a train-the-trainer session for WIC Area Nutrition Directors in early April using the new DVD and other materials. The Area Nutrition Directors used the DVD and materials to train clinic WIC staff statewide from mid-April to late June. Clinic staffs began educating WIC clients in late June. ADPH Information Technology-WIC Business Rules were written and new maximum monthly formula amounts were calculated to update PHALCON for the new food package implementation, which occurred on September 28, 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement and periodically update the WIC Nutrition Education Plan for all ADPH WIC clinics.		X		X
2. In the WIC Education Plan, focus on prevention of obesity in the entire family, especially targeting WIC-enrolled children and WIC-enrolled breastfeeding and postpartum women.		X		X
3. As part of the focus on preventing obesity in the family, educate WIC-enrolled women and parents of 1-5 year-old WIC enrollees about the importance of daily physical activity and healthful eating.		X		
4. Also as part of the WIC Nutrition Education Plan, develop and distribute brochures encouraging physical activity and healthful eating for families.		X		
5. Maintain membership in the Alabama Obesity Task Force.				X
6. Monitor the percentage of WIC-enrolled children who are overweight or at risk of becoming overweight.				X
7. Implement the new WIC food packages that address obesity in WIC clients				X
8.				
9.				
10.				

b. Current Activities
FY 2009 activities basically continue in FY 2010. Certain updates follow.

Cross-cutting (Enabling, Population-based, Infrastructure-building):
Healthy Habits kits containing a Sesame Street DVD, storybook, and parent's guide were given to families with children on WIC during the first quarter of FY 2010 to promote the new, healthier WIC food packages.

Clinic WIC staffs statewide continued to educate WIC clients about the new food packages as they picked up food instruments issued, using the new food packages for the first time between

October and December.

The Overweight Risk Criteria Report was run for FY 2009 and compared with previous years' data. CDC PedNSS data for FY 2008 for Alabama was also used to monitor the percentage of 2-5 year-old children on WIC who have a BMI at or above the 85th percentile.

The biannual FY 2011-12 Nutrition Education Plan is currently under development. It will target increasing fruit and vegetable consumption of WIC participants.

Many of the FY 2009-10 Nutrition Education Plan activities will continue. These include emphasis on moving to 1% low fat and fat free milk at WIC nutrition education visits of WIC participants targeted in the plan, distribution of beach balls to children as an incentive item to promote physical activity, and Breastfeeding Awareness Month and "Fruit & Veggies: More Matters!" promotions in ADPH WIC clinics.

c. Plan for the Coming Year
Cross-cutting (Enabling, Population-based, Infrastructure building):
THE AOTF will continue implementing its State plan.

The 2011-12 Nutrition Education Plan activities will be implemented in all WIC clinics.

The Overweight Risk Criteria Report will be run to monitor FY 2010 data on 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 2009 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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12.5	16.6	15.7	13.4
Annual Indicator	18.6	15.4	13.5	15.6	
Numerator	10377	9142	8161	9506	
Denominator	55912	59372	60411	60864	
Data Source				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?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14.7	14.7	14.6	14.6	14.5

Notes - 2009

Data Issues:
Estimates for this indicator are for calendar year 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 2004 were not available by June 2006. The Alabama Department of Public Health's (ADPH's) Center for Health Statistics will provide numbers from the PRAMS 2009 dataset soon after CDC provides the dataset, but numbers for 2009 are not expected to be available before April 2011.

Notes - 2008
Data Issues:
See this indicator's year 2009 Form 11 field note for the data source.

Trends:
From 2004-2008, this indicator has ranged from 13.5% in 2007 to 18.6% in 2005, with a median of 15.6% in 2008. At no time during the surveillance period did the indicator move in the same direction 3 years in succession.

Objectives:
Objectives through 2009 are retained from previous years. Objectives from 2010 forward have been revised upward (made less challenging) compared to previous objectives, which were unrealistic in light of the status of this indicator in recent years. To set the objectives, the combined numbers for 2006-2008 (26,809/180,647, or 14.8%) were considered to represent the year 2007 baseline. From that baseline, the newly set objectives require an annual decline (improvement) in the indicator of 0.3% per year. If the status of this indicator remains below (better than) its corresponding objective 3 years in a row, we will revise the objectives to make them more challenging.

Notes - 2007
See 2006 field note for data source and trends during the 1994-2005 surveillance period.

Recent trends:
In 2005 the weighted percentage of mothers who smoked in the last 3 months of the referent pregnancy was 18.6%, the highest estimate during the 1994-2007 surveillance period. During 2006 and 2007, this indicator declined (improved) to 15.4% and 13.5% respectively. The 2007 estimate of 13.5% is the second lowest weighted percentage during the surveillance period, with the lowest being 13.3% in 2003.

Objectives:
We are aware that the objective for 2007 is higher (worse than) the observed status in both 2006 and 2007. While acknowledging that this sample-based estimate can fluctuate markedly from year to year, we have revised the objectives for 2009-2013 to achieve an average annual decline (improvement) of 0.4% per a multiplicative model, using the 2007 indicator (13.5%) as the baseline. Maintaining this indicator below the 2007 baseline will be challenging and, if achieved, a notable accomplishment.

a. Last Year's Accomplishments

FY 2005-08 Backdrop (Infrastructure-building):
The following activities provide a backdrop for FY 2009 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 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. 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.

The following activities also occurred in FY 2008. The SPP partnered with the Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant teens. The SPP also collaborated with the Medicaid Maternity Program regarding smoking cessation for SOBRA recipients, in addition to providing educational materials and other resources to organizations and agencies statewide. 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 to stop smoking.

FY 2009 (Infrastructure-building):
The SPP continued to partner with the Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant teens. The SPP also collaborated with the Medicaid Maternity Program regarding smoking cessation for SOBRA recipients, in addition to providing educational materials and other resources to organizations and agencies statewide. Smoking cessation was discussed with SOBRA recipients at each encounter with the care coordinator with referral to the Quitline if appropriate.

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 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 other resources to organizations and agencies statewide.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
FY 2009 activities as outlined above generally continue in FY 2010, with the following additions or exceptions.

Infrastructure-building:
The SPP is partnering with AMOD and other agencies to provide smoking cessation-education training statewide. Underlying rationale for addressing this issue is mainly 2-fold. First, environmental smoke is a contributing factor to SIDS and respiratory conditions during infancy. Further, if the mother continues smoking, subsequent pregnancies may be affected. The SPP continues to provide educational materials including posters and brochures to agencies and organizations regarding the effects of smoking on the fetus.

SPP is partnering with the Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant teens. SPP is also collaborating with Medicaid on smoking cessation for their SOBRA Medicaid recipients. Medicaid has added smoking cessation as a requirement for care coordination with the Maternity Care Program. Smoking cessation is discussed with recipients at each encounter with the care coordinator with referral to the Quitline if appropriate. Nicotine replacement therapy is available for SOBRA Medicaid recipients.

c. Plan for the Coming Year
FYs 2009 and 2010 activities as outlined above will generally continue in FY 2010 with the following additions.

Infrastructure-building:
The SPP will continue to partner with AMOD in 2010. The SPP will continue to provide educational materials and other resources to organizations and agencies statewide. Links to information regarding smoking and its effects on the fetus and newborn will be added to SPP's web site with information for professionals and consumers. Links to smoking cessation-counseling and information for providers will also be added to SPP's web site. The SPP will continue to work with the Tobacco Prevention and Control Branch and Medicaid to address smoking.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.5	7.1	8.3	8.2	7.1
Annual Indicator	7.2	10.2	4.9	7.0	
Numerator	24	33	16	23	
Denominator	334845	324012	326378	328187	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.9	6.8	6.7	6.5	6.5

Notes - 2009
Due to the time required to receive, manage, and edit vital statistics data, final year 2009 death files are not yet available for Alabama. Our experience has shown that the incomplete, provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

As discussed in the year 2009 note to National Performance Measure (NPM) #10, out-of-state reporting issues (recent non-reporting of some deaths of Alabama residents that occur out of state) may cause slight underestimation of mortality rates for Alabama residents in 2006, 2007, and 2008. However, analysis of out-of-state suicides of 15-19 year-old Alabama residents (in 2000-2008) has not shown any effect of the out-of-state reporting issue on NPM #16. Therefore, numbers shown on Form 11 for NPM #16 are obtained directly from the statistical death files for Alabama residents.

Notes - 2008
Data Issues:
All estimates shown are for calendar years.

Data issues concerning denominators for this indicator are discussed in the year 2009 Form 11 field note to NPM #8.

Trends:
The suicide rate among Alabama residents 15-19 years of age has not shown a consistent trend during the surveillance period (2000-2008). Over consecutive 3-year periods, this rate has been as follows: 7.5 deaths per 100,000 (72/959,191) in 2000-02, 7.6 deaths per 100,000 (72/949,144) in 2003-05, and 7.4 deaths per 100,000 (72/978,477) in 2006-08. Thus, the rate for 2006-08 was 2.0% lower than in 2000-02 and 3.0% lower than in 2003-05.

Rates for individual years in the surveillance period ranged from 4.9 deaths per 100,000 in 2007 to 10.2 deaths per 100,000 in 2006. Rates for overlapping 3-year periods ranged from 7.1 deaths

per 100,000 in 2001-03 to 9.1 deaths per 100,000 in 2004-06.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator declined (improved) by 0.3% per year. Comparing 2006-08 to 2003-05, the indicator declined by 1.0% per year.

Objectives:
Objectives through 2013 were retained from earlier years. Since the objective for 2013 (6.5 deaths per 100,000) is lower than any of the 3-year rates during the surveillance period, we set the year 2014 objective at 6.5 deaths per 100,000 as well.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

The U.S. Census Bureau's population estimates for persons 15-19 years of age are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators when analyzing trends. However, the 2004 and 2005 rates shown on Form 11 for this indicator are based on the population projections for those years, because the web-based Title V Information System does not allow us to directly change estimates for 2005 and earlier years. As a corollary, the estimates shown for 2004 and 2005 are no longer our best estimates for those years. Current best estimates, reported as the number of deaths due to suicide per 100,000 population in this age group, are: for 2004, 9.5 (30/315,546); and for 2005, 7.5 (24/319,471).

Trends:
Among 15-19 year-old Alabama residents, the rate of suicide deaths showed no consistent trend over the surveillance period (2000-2007). Comparing 3-year periods, the rate remained about the same: at 7.51 deaths per 100,000 (72/958,944) in 2000-02 and 7.53 deaths per 100,000 (73/969,906) in 2005-07--for an overall increase of 0.2% and an average annual increase of 0.05%. The slight increase occurred because of the relatively high number of deaths in 2006. The lowest and highest rates for single years in the surveillance period were juxtaposed: with the lowest rate occurring in 2007 and the highest rate occurring in 2006.

Objectives:
In April 2009 objectives for 2009 onward were revised downward, based on the 2005-07 baseline. Specifically, considering the unrounded rate for 2005-07 to be the baseline for 2006, objectives for 2009 onward require an average annual decline of 2.0%. We are aware that all of the objectives are higher (worse) than the rate of 4.9 deaths per 100,000 in 2007. However, this rate is the lowest during the surveillance period (2000-2007) and may fluctuate annually. If the rate remains around the 2007 level for 3 years in a row, objectives will again be revised downward.

a. Last Year's Accomplishments
Historical Context (Infrastructure-building):
ADPH's efforts to prevent suicide were initially 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 includes representatives from several organizations: including but not limited to the ADPH, the DMH, the UAB School of Public Health, Alabama State University, several crisis centers, the SDE, Veterans Administration organizations in 4 areas of the State, and the 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 is located in the Bureau's Children's Health Division. 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 a web page 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 is available for downloading from ACRS's 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, survivors, 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 in FY 2010).

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."

FY 2009:
Population-based and Infrastructure-building:
SPTF and ACDRS continued activities to address suicide prevention. SPTF continued to meet quarterly, to promote the Alabama State Suicide Prevention Plan, and to maintain a toll-free number for suicide-related crisis calls. ACDRS staff remained active members in SPTF and continued distributing the "Prevent Youth Suicide" brochure. ADPH continued maintaining web pages on SPTF 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. With the Alabama Department of Mental Health (DMH), continue involvement in the Alabama Suicide Prevention Task Force.			X	X
3. Along with DMH and in collaboration with the Suicide Prevention Task Force, host a web page providing information pertaining to suicide prevention and related resources.			X	X
4. Along with the other members of the Suicide Prevention Task				X

Force, promote the Alabama Suicide Prevention Plan.				
5. As part of public awareness efforts, distribute an educational brochure on prevention of suicide among youth.			X	
6. Host and maintain a toll-free number for suicide-related crisis calls.				X
7.				
8.				
9.				
10.				

b. Current Activities
Cross-cutting (Population-based and Infrastructure-building):
As stated under "Historical Context" in "Last Year's Accomplishments," in FY 2010 ASPARC was formed from SPTF and assumed the responsibilities of SPTF. As also stated there, new articles of incorporation and bylaws were adopted with the formation of ASPARC, which is a 501(c)(3) organization.

ACDRS is collaborating with ASPARC in activities to address suicide prevention. ASPARC meets quarterly to maintain and promote the Alabama State Suicide Prevention Plan and to identify and promote suicide-related resources in Alabama. ACDRS staff members are active in ASPARC. In fact, the Director of ACDRS is ADPH's primary liaison with ASPARC and has assumed a broad leadership role in the organization. He has been invited to serve on ASPARC's Board of Directors, and the invitation is under consideration. ACDRS continues to distribute the ACDRS-developed "Prevent Youth Suicide" brochure in both English and Spanish.

ADPH continues maintaining web pages on ASPARC and on ACDRS.

c. Plan for the Coming Year
Cross-cutting (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, along with review of the plan and, if needed, updates to the 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 the toll-free number for suicide-related crisis calls.

As well, ASPARC and ACDRS plan to update and reprint the "Prevent Youth Suicide" brochures and seek new avenues of distribution for the updated brochures.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79.8	81.4	82.3	83.1	82.1
Annual Indicator	80.6	79.7	83.5	82.2	
Numerator	1041	1014	1105	1076	

Denominator	1291	1273	1324	1309	
Data Source				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	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	83.6	83.7	83.9	84.1	84.2

Notes - 2009
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010.

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 occur outside of the State have apparently been underreported to the Alabama Department of Public Health (ADPH) in recent years. 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. However, because TVIS does not permit us to directly revise numbers shown for 2005 and 2006, the numbers shown on Form 11 for those years include out-of-state, as well as in-state, births to Alabama residents.

Notes - 2008
Data Issues:
All estimates pertain to calendar years.

For reasons discussed in this indicator's year 2009 Form 11 field note, our analysis of NPM #17 is based on occurrent events only. That is, when analyzing trends, we counted only births that occurred in Alabama to Alabama residents. However, because TVIS does not permit us to directly revise numbers shown for 2005 and 2006, the numbers shown on Form 11 for those years include out-of-state, as well as in-state, births to Alabama residents.

Trends:
The study population for this analysis of trends is very low birth weight (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:
Objectives through 2009 are retained from earlier years. When setting objectives for subsequent years, the percentage for 2006-08 (83.1%, or 3,195/3,847) was considered to represent the year 2007 baseline. Because this indicator has not improved over the surveillance period, the objectives require only a slight improvement, of 0.2% per year, from the 3-year baseline for 2007. Nevertheless, in light of the lack of improvement during the surveillance period, the objectives are challenging.

Notes - 2007
Data Issues:
Based on consultation with the Director of the State Perinatal Program in December 2008, 2 hospitals that had previously been classified as perinatal centers were reclassified as non-perinatal centers for 1999 onward. The estimates shown on Form 11 for this indicator for 2006 and thereafter are based on the new classification system. However, numbers shown on Form 11 for 2005 are based on the previous classification system, because the web-based TVIS does not allow us to directly change the estimate for 2005. As a corollary, the estimate shown for 2005 is no longer our best estimate for that year. Instead, in 2005, 81.0% (1,046/1,291) of VLBW live-born infants were born at a perinatal center.

Trends:
For Alabama VLBW residential live births, the percentage of infants who were born at a perinatal center increased slightly, from 79.3% (2,932/3,697) in 2000-02 to 80.9% (3,165/3,912) in 2005-07: for an overall increase of 2.0% and an average annual increase of 0.4%. However, year-to-year trends were not consistent during the surveillance period (2000-2007), though the highest percentage occurred in 2007 and the lowest percentage (77.5%) occurred in 2000.

Objectives:
In April 2009 objectives for 2009 onward were revised, based on the 2005-07 baseline for the new classification system. Specifically, considering the unrounded rate for 2005-07 to be the baseline for 2006, objectives for 2009 onward require an average annual increase (improvement) of 0.5%. These objectives are challenging, given that 82.0% was the highest value for this indicator during the surveillance period (2000-2007).

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, completing annual needs assessments for their regions, 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.

FY 2009:
The following activities occurred in FY 2009 unless stated otherwise.

Infrastructure-building:
The SPP, SPAC, RPACs, and RNPCs continued addressing perinatal issues, including regionalization of perinatal care. SPAC held its annual face-to-face meeting. Interim meetings of SPAC, during which no official business was conducted, occurred quarterly via videoconference.

In January 2009 the SPP program implemented a statewide FIMR program, based on the national FIMR guidelines. The national FIMR trainers provided training to the SPP staff. The program will review neonatal deaths that occurred in 2009 and will conduct maternal and family interviews. The RPACS will serve as the Case Review Teams for the FIMR program. Formation of Community Action Teams, which are to be statewide, began. The SPP Director and the AMOD Program Director attended the Alabama Chapter of the AAP meeting to encourage support of AMOD and SPP efforts.

Due to budget constraints, 80% of SPP staff responsibilities have been redirected to the FIMR program. With the other 20% of their time, SPP staff will continue providing newborn screening training to physicians' office staff and training health professionals concerning preconceptional counseling. The RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model (explained under NPM #15), which will be used to train the health care professionals in the provision of preconceptional counseling for females of childbearing age. The focus of the preconceptional-counseling education is risk assessment and health promotion through medical and psychosocial interventions, which may affect whether VLBW babies are born at perinatal centers. Care for the preterm infant is the focus of the infant-care education. Compared to FY 2008, these trainings were fewer in number because of the redirection of SPP staff responsibilities.

AMOD continued to provide supplies and educational materials for quarterly meetings of maternal-infant nurse managers in each perinatal region. Each RNPC coordinated and conducted these meetings, which 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. Administer the Fetal Infant Mortality Review (FIMR) program, based on national FIMR guidelines, to review neonatal deaths and conduct maternal and family interviews.				X
3. Convene annual meetings of the State Perinatal Advisory Council (SPAC).				X
4. Through the Bureau of Family Health Services' 5 Regional Nurse Perinatal Coordinators, support SPAC and the 5 Regional Perinatal Advisory Councils.				X

5. In partnership with AMOD, in each perinatal region provide educational offerings for providers that collectively cover a variety of topics, including preterm birth.				X
6. Liaise with professional physician organizations, to encourage the support of the efforts of AMOD and the SPP.				X
7. Coordinate meetings of maternal-infant nurse managers in each perinatal region.				X
8.				
9.				
10.				

b. Current Activities
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 postneonatal deaths that occur in 2010. Maternal and family interviews are being conducted.

The RPACs continue to serve as the Case Review Teams for the FIMR program. Community Action Teams have been created statewide and are implementing action plans based on the Case Review Teams' recommendations. AMOD continues providing supplies and educational materials for the quarterly nurse managers meetings. The FIMR data are being analyzed and will be presented in an annual report.

c. Plan for the Coming Year
Infrastructure-building:
Activities conducted in FYs 2009 and 2010 will basically continue in FY 2011. 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87.8	83	83.4	83.8	82.5
Annual Indicator	82.5	81.2	79.2	78.5	
Numerator	49743	51115	49916	49045	
Denominator	60262	62915	63005	62466	
Data Source				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	

	2010	2011	2012	2013	2014
Annual Performance Objective	80.3	80.4	80.6	80.8	80.9

Notes - 2009
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010.

Notes - 2008
Data Issues:
All estimates pertain to calendar years. For all years shown, the numerator is the number reporting prenatal care as beginning during the 1st, 2nd, or 3rd month, based on the birth certificate item: "Month of Pregnancy Prenatal Care Began–First, Second, etc."

For reasons discussed in the year 2009 Form 11 field note for NPM #17, our analysis of NPM #18 is based on occurrent events only. That is, when analyzing trends, we counted only births that occurred in Alabama to Alabama residents. However, because TVIS does not permit us to directly revise numbers shown for 2005 and 2006, the numbers shown on Form 11 for those years include out-of-state, as well as in-state, births to Alabama residents.

Trends:
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 (1st-trimester) 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:
Objectives through 2009 are retained from earlier years. When setting objectives for subsequent years, the percentage for 2006-08 (79.8%, or 148,843/186,541) was considered to represent the year 2007 baseline. The newly set objectives require only a slight improvement, of 0.2% per year, from the 3-year baseline for 2007. Nevertheless, in light of the worsening of this indicator during each of the last 4 years of the surveillance period, the objectives are quite challenging.

Notes - 2007
Data Issues:
The data source is the residential live birth file for Alabama from 2000-2007.

Trends:
For Alabama residential live births, the percentage of infants whose mother had received prenatal

care in the 1st trimester declined from 82.6% (150,540/182,328) in 2000-02 to 81.0% (151,676/187,357) in 2005-07: for an overall decline of 1.95% and an average annual decline of 0.4%. With respect to single years, from a baseline of 82.5% in 2000, this indicator declined in 2001 and then increased 3 years in a row, bringing it to 83.7% in 2004. After then declining 3 years in a row, this indicator was at its lowest (worst) level for the surveillance period in 2007, when the mothers of 79.2% of infants had received prenatal care in the 1st trimester.

Objectives:
In April 2009 objectives for 2009 onward were revised, to require that the indicator stabilize at the 2004-06 rate of 82.5% (150,357/182,347). Given recent declines (worsening) in this indicator, an objective of stabilizing at 82.5% is quite challenging.

a. Last Year's Accomplishments
Status and Trends:
In 2008, 78.5% of infants born alive to Alabama residents were born to women who had received prenatal care beginning in the 1st trimester.

Trends in this indicator are discussed in its Form 11 note for year 2008.

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.

In FY 2005, Medicaid bid their Maternity Care Program for the new project period that began on June 1, 2005. As discussed in Section III.A, by July 2005 Medicaid Maternity Care Program contracts had been awarded in all 14 Medicaid Districts, to a total of 10 Medicaid Primary Contractors. Some contractors subcontracted with physicians, hospitals, or ADPH to provide care coordination for pregnant women and/or postpartum home visits.

FY 2009:
Unless stated otherwise, the following occurred in FY 2009.

Direct and Enabling:
ADPH continued marginal involvement in the provision of care coordination to pregnant women. In FY 2009, 7 counties provided maternity care coordination.

Per Form 7, 1,780 pregnant women received Title V-funded services in CHDs in FY 2009. 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, compliance with 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.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In some counties, provide care coordination for pregnant women.	X	X		
2. Provide clients information about the importance of early, continous prenatal care.				X
3.				
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.

ADPH is currently in the process of eliminating maternity care coordination in 5 counties, leaving only Cullman and Mobile as providers of maternity care coordination.

Population-based:
Operation of a toll-free hotline that helps pregnant women access providers and information continues.

Infrastructure-building:
Effective January 2010, Alabama Medicaid awarded contracts to 10 Primary Contractors (HealthGroup of Alabama, Quality of Life, Greater Alabama Health Network, Alabama Maternity, Inc., Gift of Life Foundation, Tombigbee Healthcare Authority, Maternity Services of District 11, Southwest Alabama Maternity Care LLC, Southeast Alabama Maternity Care Program, LLC, and USA) to provide maternity services in 14 Medicaid Districts.

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 to subcontract 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.

D. State Performance Measures

State Performance Measure 1: *Of 0-9 year-old children enrolled in Alabama Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the percentage who received care coordination in the reporting year.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		4.5	4.7	6.1	6.1
Annual Indicator	4.3	5.2	6.1	5.9	3.8
Numerator	12781	15853	18144	17760	12068
Denominator	296576	302638	297163	301532	319564
Data Source				Care Coordination program files and EPSDT Report	Care Coordination program files and EPSDT Report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.2	6.2	6.2	6.2	

Notes - 2009
Sources:
The numerator is from the Alabama Department of Public Health (ADPH) EPSDT care coordination report, and the denominator is from the Alabama Medicaid Agency's (Medicaid's) "Form CMS-416: Annual EPSDT Participation Report." The numerator and denominator are unduplicated counts.

All estimates are for fiscal years.

Trends:
From 2003-2008, single-year estimates for this indicator ranged from 3.2% in 2003 to 6.1% in 2007, with a median of 4.7% in 2004. After peaking at 6.1% in 2007, the indicator declined slightly in 2008 and then declined markedly, to 3.8%, in 2009.

Objectives:
Per the web-based Title V Information System instructions, objectives are not being updated.

Notes - 2008
Sources:
The numerator is from ADPH's EPSDT care coordination report, and the denominator is from Medicaid's "Form CMS-416: Annual EPSDT Participation Report." The numerator and

denominator are unduplicated counts.

Trends:
Comparing single-years spaced 5 years apart, this indicator improved by 85.5%: from 3.2% in 2003 to 5.9% in 2008. Comparing adjacent 3-year periods, the measure improved by 41.1%: from 4.1% in 2003-05 to 5.7% in 2006-08.

Objectives:
Since the target of 6.2% remains challenging, it was extended through the year 2013.

Notes - 2007
The numerator is from ADPH's EPSDT care coordination report, and the denominator was provided by the Alabama Medicaid Agency. The numerator and denominator are unduplicated counts.

Because observed values surpassed (were better than) the targets for 2006 and 2007, we have revised the objectives for 2008-2009 upward to 6.1%, and those for 2010-2012 upward to 6.2%. On the surface, objectives for 2008-2012 appear modest, compared to the 2007 baseline of 6.1%. However, the observed value may fluctuate and--especially without well documented historical trends--we are not confident that it will remain as high as 6.1%. Therefore, remaining at 6.1% for 2 years and achieving a status of 6.2% by 2010--as shown in the objectives--would be a notable accomplishment. If the observed value for this indicator notably increases in FY 2008, objectives will again be revised upward.

a. Last Year's Accomplishments
Rationale for Measure:
This measure pertains to the MCH priority need to assure primary care.

MCH Population Served:
Children

Status and Trends:
See this indicator's year 2009 Form 11 note for discussion of trends. The number of 0-9 year-old EPSDT enrollees who received care coordination services from ADPH declined by 32.0%: from 17,760 children in FY 2008 to 12,068 children in FY 2009. (The reason for this decline, mentioned below, was concern about the cost of providing matching dollars.) This decline in numbers receiving care coordination services, along with an increase in the number of 0-9 year-old EPSDT enrollees, accounted for the notable drop in this indicator in FY 2009. That is, ADPH provided care coordination to only 3.8% of EPSDT enrollees in FY 2009, versus 5.9% in FY 2008.

FY2009:
Enabling and Infrastructure-building:
Due to concerns about the cost of providing federally required matching dollars, ADPH provided fewer care coordination services under Patient 1st in FY 2009 relative to FY 2008: with workers focusing on providing only services for referrals received through CCRS and direct referrals from Medicaid doctors. Dental referrals and the routine assessment of children seen in CHDs for psychosocial and/or medical needs decreased in frequency. CCRS referrals continued to be limited to referrals from ADPH and from Medicaid. Patient 1st care coordination continued to be available in all 67 counties. The issue of federally required matching dollars is discussed in Section III.A.

ADPH continued to partner with Medicaid to provide care coordination for patients with asthma and diabetes, under the federally funded TFQ pilot project. FHS and Medicaid jointly provided web-based trainings concerning the project. Specific disease-related training was regularly provided to the care coordinators involved in the pilot. Responsible staff from ADPH's Central Office and from CHDs audited the program regularly, with evaluation by UAB.

Beginning Jan 1, 2009, Medicaid implemented the Dental 1st Look Program, in which primary medical providers and clinical staff are trained to perform oral assessments, provide fluoride treatments, and help find dental homes for 6-36 month-old patients. Some patients were referred by physicians to the Patient 1st care coordination program for help in locating a dental home. Effective January 2009, referrals from dentists were limited to children needing assistance obtaining specialty care and children who missed appointments and were lost to follow up during extensive treatment, e.g., root canals.

FHS's social work staff continued quarterly trainings for ADPH care coordinators and added annual social work manager trainings. Trainings focused on protocol, ethics, care for children with chronic health conditions, and documentation. FHS social work staff routinely reviewed electronic case records statewide to ensure timely, appropriate responses to referrals.

Medicaid had begun making referrals statewide on inappropriate adult emergency room use in FY 2007. In January 2009, Medicaid began sending care-coordination referrals for children with inappropriate emergency room use in Tuscaloosa County.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care Coordination Program.		X		X
2. Provide care coordination to EPSDT-eligible children and youth who are seen at county health departments (CHDs) and need the service.		X		X
3. As well, provide care coordination to patients, including children, who are directly referred by the Alabama Medicaid Agency to the Alabama Department of Public Health (ADPH) for care coordination.		X		X
4. Through partnership with Medicaid, continue to provide care coordination for patients with asthma and diabetes under the Together for Quality pilot project.		X		X
5. Administer the Dental 1st Look Program, in which primary medical providers and clinical staff perform oral assessments, provide fluoride treatments, and help find dental homes for 6-36 month-old patients.		X		X
6. Maintain the web-based Centralized Care Coordination Referral System (CCRS), for the purpose of receiving online referrals to ADPH for care coordination.				X
7. Provide quarterly training events for ADPH care coordinators.				X
8.				
9.				
10.				

b. Current Activities

Enabling and Infrastructure-building:

Unless stated otherwise above, FY 2009 activities basically continue in FY 2010. Several updates follow.

Patient 1st care coordinators are now receiving referrals from CCRS, primary medical providers, and dentists.

Growth in Patient 1st care coordination continues to create financial concerns for ADPH

regarding the federal match. Due to this concern, fewer care coordination services are being provided under Patient 1st, relative to recent years. The decrease in the match (33% in FY 2008 to 23.46% in FY 2010) is helpful, and talks with Medicaid about help with the match continue.

Medicaid's Dental 1st Look Program continued.

WIC is establishing outreach positions in PHAs. Plans are to transfer some care coordination staff into these positions.

Quality assurance positions are being created in some PHAs to monitor production and documentation of the care coordination staff.

Except for the evaluation being conducted by UAB, which will be completed by December 2010, Medicaid's 8-county TFQ asthma/diabetes care coordination pilot project ended in March 2010.

Medicaid is assessing the cost of the program in Tuscaloosa County to refer Medicaid-enrolled children with inappropriate emergency room use for care coordination, and determining whether to implement the program statewide.

Due to the previously discussed concerns about the required federal matching dollars, this performance measure is becoming inoperative, effective FY 2010.

c. Plan for the Coming Year
Enabling and Infrastructure-building:
Unless stated otherwise above, FYs 2009 and 2010 activities will basically continue in FY 2011, contingent on sufficient funding.

Care coordinators will continue receiving referrals from CCRS, primary medical providers, and dentists. CCRS referrals are expected to be stable or to show a slight increase, with the possibility of Medicaid expanding referrals for children with inappropriate emergency use to include the entire State.

The provision of care coordination under Patient 1st is expected to continue to decline gradually. Generally, care coordination staff who previously worked with the TFQ asthma/diabetes care coordination pilot project and with Patient 1st care coordination will begin working under the Plan First (family planning) care coordination program or providing outreach under the WIC Program.

UAB's evaluation of Medicaid's TFQ asthma/diabetes care coordination pilot project is to be completed by December 2010. If the evaluation is positive, Medicaid may consider initiating an asthma/diabetes care coordination program in the 8 pilot counties and expanding the program to other sites. Whether ADPH and Medicaid will be able to continue their partnership in this area, however, will depend as much on budgetary issues as on pilot evaluation.

Quarterly trainings for care coordinators and annual trainings for care coordination managers will continue, as will FHS case reviews for quality assurance. Quality assurance issues are expected to receive more attention, with PHAs being encouraged to add quality assurance staff to monitor care production and documentation.

State Performance Measure 2: *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	2005	2006	2007	2008	2009
Annual Performance Objective		37	38.1	39.2	40.4
Annual Indicator	35.9	37.0	45.0	41.6	45.2
Numerator	180089	188475	226476	203444	235378
Denominator	501766	509155	503051	489049	520955
Data Source				CMS-416: Annual EPSDT Participation Report	CMS-416: Annual EPSDT Participation Report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41.6	42.9	45	45	

Notes - 2009
Source:
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 2009. Per this report, the age range is from birth through 20 years. All estimates are for fiscal 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.

Objectives:
Per the web-based Title V Information System instructions, objectives are not being updated at this time.

Notes - 2008
Source:
The numerator and denominator for this measure come from Medicaid's "Form CMS-416: Annual EPSDT Participation Report" for Alabama, FY 2008. Per this report, the age range is from birth through 20 years.

Trends:
The percentage of Alabama Medicaid EPSDT enrollees who received a dental service increased (improved) from 34.0% (501,766/1,475,464) in 2003-05 to 41.2% (618,395/1,501,255) in 2006-08: for an overall increase of 21.1% and an average annual increase of 6.6%.

With respect to single years, in 2008 the percentage of Alabama Medicaid EPSDT enrollees who received a dental service declined to 41.6%, which was 3.4% 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:
We are aware that the observed value for 2008 surpasses the target for 2009. However, the decline of this indicator in 2008 makes future trends uncertain. Therefore, we have not changed targets for 2009-2012 and have set the target for 2013 to match the 2007 observed status of 45.0. Targets will be reconsidered in FY 2010.

Notes - 2007

This indicator improved remarkably in FY 2007, when 45% of Alabama Medicaid EPSDT enrollees received a dental service. We are aware that the observed value for 2007 surpasses the targets for the years 2007 through 2011. However, since the marked improvement in 2007 may be atypical and the percentage could decline in the future, we have retained previously set targets and set the target for 2012 to match the year 2007 observed status of 45%. If the percentage remains at around 45% or higher in FY 2008, in FY 2009 we will revise the targets upward.

a. Last Year's Accomplishments

Rationale for Measure:
This measure pertains to the MCH priority need to "assure appropriate primary care, including prenatal care, for all Title V populations--including low income, immigrant, and minority groups." 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

Status and Trends:
In FY 2009, 45.2% of children and youth (from birth through 20 years of age) enrolled in Alabama Medicaid's EPSDT Program received a dental service on 1 or more occasions (up from 41.6% in FY 2008).

Trends in this indicator are further discussed in its Form 11 note for year 2008.

FY 2009:
Unless stated otherwise, the following activities occurred in FY 2009. Some of the discussion of this indicator overlaps with discussion of NPM #9, which pertains to dental sealants.

Direct:
Two large CHD dental programs provided dental services through 29,597 encounters at permanent and mobile dental sites. Three other CHD clinics provided services through community health center-managed dental clinics on site. All of these clinics treated large numbers of Medicaid and ALL Kids children and youth. Sarrell Dental opened another dental clinic in a very rural and underserved community in Northeast Alabama, bringing their total number of dental clinics to 7. That program continued to target Medicaid-enrolled, ALL Kids-enrolled, and uninsured children and families. Sarrell Dental discontinued their mobile dental van program due to administrative and logistical issues; however 1 CHD and 1 community health center-funded program continued to provide services through mobile dental programs.

Enabling, Population-based, and Infrastructure-building:
OHB staff provided training and oral hygiene supplies to Patient 1st care coordinators, HCCA nurse consultants, and CHD staff to promote access to dental services and good oral health practices for underserved children and their families. As well, they made presentations to Head Start and HCCA staff and to parents and children served by these programs: emphasizing the importance of early, routine, and periodic dental care for children, including young children and Medicaid-enrolled children. OHB distributed thousands of educational pamphlets, toothpaste, and about 20,000 toothbrushes through schools, Head Start programs, day care centers, and other sites.

Collaborative efforts continued with the School of Dentistry, Medicaid, ALL Kids, ALDA, the Alabama Chapter of the Academy of Pediatric Dentistry (ALAPD), Sarrell Dental, and other groups to promote access to dental care for underserved children. The pediatric dental consultant from the School of Dentistry continued as a part-time staff member and assisted with a broad range of initiatives.

In January 2009, Medicaid implemented its 1st Look Program, which is designed to reduce early childhood caries by encouraging primary care physicians to perform dental risk assessments, provide anticipatory guidance, apply fluoride varnish when indicated, and refer children to a dental home by 1 year of age. Participating medical providers must first obtain certification by completing a Medicaid-approved training course.

OHB partnered with ADPH's Office of Primary Care and Rural Health, the Alabama Primary Health Care Association, and the School of Dentistry to address dental workforce issues through strategies designed to increase access to dental care in Dental Health Professional Shortage Areas. These activities are further discussed under HSCI #7B.

The state fluoridation program basically maintained a consistent level of water systems participating in the program. Eighty-three (82.9) % of Alabama's population on public water supply continued to enjoy the benefits of fluoridated water: 116 public water systems provided adjusted levels of fluoride, and 10 public water systems provided fluoride naturally. The CDC gave 77 Alabama public water systems Water Fluoridation Quality Awards for maintaining fluoride levels at optimal levels for 12 consecutive months, and OHB received a State of Excellence award from CDC. Two water systems that had discontinued fluoridation of water were visited and persuaded to resume fluoridation. These successes were achieved in the context of budget cuts, travel restriction, and limited OHB staff, with no full-time dentist on staff.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide oral health services in CHDs and in school-based clinics.	X			
2. Provide training, oral hygiene supplies, and other assistance to CHD staff, care coordinators, and Healthy Child Care Alabama nurse consultants.	X			X
3. Through the above training and provision of supplies and assistance, promote access to dental services and good oral health practices for underserved children and their families.		X	X	X
4. Promote fluoridation initiatives statewide and maintain a consistent level of water systems participating in the State's program.		X	X	X
5. Partner with multiple organizations to increase access to dental care in Dental Health Professional Shortage Areas.		X	X	X
6. Continue collaboration with Medicaid to administer the 1st Look Program to reduce early childhood caries and refer children to a dental home by 1 year of age.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct:

Sarrell Dental opened another clinic in an underserved county in North Alabama, bringing their total number of dental clinics to 8. Two new community health center dental clinics opened, 1 in North Alabama and 1 in South Alabama. Each will improve access for Medicaid and ALL Kids children and their families. CHD and community health center dental programs continue to serve these groups.

Enabling, Population-based, and Infrastructure-building:

Education and outreach initiatives continue statewide through CHDs, schools, and various public and private settings.

The Medicaid 1st Look program continues to grow as new non-dental providers of care become certified to provide risk assessment and place fluoride varnish on at-risk children. The American Academy of Pediatric Dentistry (AAPD) Head Start Dental Home initiative continues to make strides in identifying dental homes for children enrolled in Early Head Start and Head Start.

The statewide fluoridation program continues to provide fluoridated water to about 82.9% of Alabama's population. A few water systems have experienced economic concerns and are considering discontinuing fluoridation. A plan is in place to visit with these systems to encourage continuation and to collaborate with ALDA and its District Dental Society members to address the issue locally.

Recruitment and retention initiatives continue in an effort to attract new and future dentists into areas with a shortage of dental providers.

c. Plan for the Coming Year
Unless previously stated otherwise, FYs 2009 and 2010 activities will basically continue in FY 2011. Updates follow.

Direct:
New dental clinics are being considered for communities with low Medicaid and ALL Kids utilization rates for dental care. OHB and numerous partners will continue to evaluate areas of greatest need and promote provision of services in underserved communities. Recruitment and retention initiatives will continue with the School of Dentistry, and scholarship/loan repayment opportunities will be promoted to address workforce and access shortages. A new dental sealant project is planned for 10 schools in the Alabama Black Belt Region, and a statewide oral health survey is planned for 2011. Mobile dental program expansion will also be encouraged.

Enabling, Population-based, and Infrastructure-building:
Staff will continue to work with Medicaid and ALL Kids programs to promote education, awareness, enrollment of eligible children, and appropriate utilization of dental services. Education will continue with Head Start, CHD programs, schools, and other entities to encourage appropriate utilization of dental program benefits.

Periodic dental exams will continue to be promoted through all of these initiatives, particularly in programs for low-income populations.

Collaborations to address dental workforce issues will continue.

State Performance Measure 3: *The pregnancy rate (per 1,000) for adolescents aged 15-17 years.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		38.3	36.8	36.1	40.8
Annual Indicator	37.4	40.2	41.9	38.7	
Numerator	3671	3882	4074	3720	
Denominator	98093	96589	97125	96123	
Data Source				Vital records and Census	

Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40.6	40.4	40.2	40	

Notes - 2009
Data Issues:
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. The estimate will be provided by July 2011.

Notes - 2008
Data Issues:
The pregnancy rate is the number of estimated pregnancies per 1,000 females in the specified age group: where estimated pregnancies include live births, induced abortions, and estimated total fetal losses. When estimating the adolescent pregnancy rate, we sought to account for out-of-state reporting issues that have probably led to slight undercounting of adolescent pregnancies in Alabama in recent years. These reporting issues and the methods we used to account for them, as well as details about the composition of the adolescent pregnancy rate, are described in Technical Note #6 to Alabama's 2009-10 Needs Assessment Report. Due to these reporting issues, the adolescent pregnancy rates for 2006-2008 are provisional rates based on certain assumptions about missing data. Because of the assumptions involved, rates shown here may not precisely match those that may be published elsewhere.

Our current best estimate of the number of pregnancies in this age group in 2006 is 3,913 pregnancies, rather than the number shown on Form 11 for 2006. As well, our analysis of trends is based on updated population estimates. Therefore, our current best estimates for this indicator for 2005 and 2006 are as follows, rather than as shown on Form 11: 38.8 pregnancies per 1,000 (3,671/94,679) in 2005, and 40.5 pregnancies per 1,000 (3,913/96,682) in 2006. (The web-based Title V Information System[TVIS] does not permit us to directly revised estimates for 2005 and 2006.)

Trends:
As stated in the 2009-10 Needs Assessment Report, from 2000-2008, this indicator ranged from 38.7 pregnancies per 1,000 females in 2008 to 52.9 pregnancies per 1,000 females in 2000. From the 2000 baseline, in 15-17 year-old Alabama females, the pregnancy rate declined (though sometimes very slightly) every year except 2006 and 2007, when it rose each year before declining again in 2008. However, due to the out-of-state reporting issues mentioned above, actual recent pregnancy rates in this population are uncertain.

Objectives:
Per TVIS instructions, objectives are not being updated at this time.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

Data sources for the numerator are Alabama vital statistics files for, respectively, live births, fetal deaths, and abortions. The reference for each numerator is Table 27 in the "Alabama Vital Statistics " series, produced by the Alabama Department of Public Health's Center for Health Statistics.

The denominator shown on Form 11 for 2005 was derived from population projections provided by Alabama's Center for Business and Economic Research. These projections are not

comparable to population estimates. Using population estimates as denominators, the pregnancy rate per 1,000 among 15-17 year-old Alabama females in those years was 42.1 (3,893/92,474) in 2004 and 38.8 (3,671/94,586) in 2005.

Trends:
Earlier in this decade, the pregnancy rate per 1,000 among Alabama 15-17 year-old females declined (improved) from 53.0 pregnancies per 1,000 such females in 2000 to 38.8 pregnancies per 1,000 in 2005. This rate declined every year during that period. Then, however, the rate increased to 40.2 pregnancies per 1,000 in 2006 and again increased to 41.2 pregnancies per 1,000 in 2007. Comparing 3-year periods, the pregnancy rate among 15-17 year-old females declined from 48.5 per 1,000 (13,611/280,553) in 2000-02 to 40.1 per 1,000 (11,550/288,196) in 2005-07: for an overall decline of 17.4% and an average annual decline of 3.8%.

However, comparing the most recent 2-year periods, the rate rose by 0.6%: from 40.4 per 1,000 (7,564/187,060) in 2004-05 to 40.7 per 1,000 (7,879/193,610) in 2006-07.

The estimated number of pregnancies in this age group in 2007 was 3,997: about 231 more pregnancies than would have occurred if the 2007 rate had been identical to the 2005 rate of 38.8 per 1,000 (3,671/94,586).

Objectives:
Objectives from 2009 onward were revised, to require an annual decline of 0.5% from the 2007 baseline. These objectives are challenging, given the increases in this rate in 2006 and 2007.

a. Last Year's Accomplishments
MCH Population Served: Children and youth

The following discussion focuses on the rationale for SPM #3 and on the current status of this indicator, then recaps pertinent activities discussed elsewhere.

Rationale for Measure:
This measure pertains to the MCH priority need to "further reduce the adolescent pregnancy rate." Various socioeconomic disadvantages and suboptimal health outcomes, including infant mortality, have been linked with adolescent pregnancy. Though these links are not necessarily causal, some factors that predispose an adolescent to become pregnant may also place her infant at higher risk of morbidity and death. For the sake of the adolescent and her future children, therefore, prevention of adolescent pregnancy is generally desirable--to allow the adolescent more time to mature and avail herself of social, educational, and economic opportunities before assuming the responsibilities of motherhood.

Pregnancy among adolescents aged 17 years and younger is of particular concern. Though pregnancies in persons under 15 years of age are of tremendous concern, pregnancy rates are not statistically precise in this group due to small numbers in the statistical sense. Therefore, this measure focuses on teens from 15-17 years of age, as does the corresponding Healthy People 2010 objective.

NPM #8 tracks the occurrence of live births only, whereas SPM #3 captures live births, fetal deaths, and abortions. Therefore, SPM #3 is the better of the 2 measures for tracking progress in preventing teen pregnancy.

Status and Trends:
Trends in this indicator, as well as related data issues, are discussed in the indicator's Form 11 note for year 2008.

FY 2009:
Unless stated otherwise, the following activities, which are excerpted from discussion of NPM #8,

occurred in FY 2009.

Direct:
CHD Family Planning clinics served 12,804 adolescents aged 17 years and younger in FY 2009.

Enabling:
CHD family planning clients were provided information about preconceptional health and the importance of early, continuous prenatal care should they become pregnant.

CHD staff continued to distribute 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."

EPSDT-eligible teens who presented in CHD Family Planning Clinics were referred to the care coordinator after their clinical exam.

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

Activities conducted under AAEP, the State's community-based abstinence-until-marriage education program, basically continued in FY 2009, since the U.S. Congress provided funding through June 30, 2009. Classroom monitoring was completed for all sub-grantees to assure medical accuracy. AAEP's progress toward achieving the program's goals was evaluated by a new pre- and post-test survey.

Table 4b, State 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			
2. Counsel teens coming to CHDs for family planning services, regarding how to respond to pressure to engage in sexual activity.		X		X
3. Provide care coordination for teens who come to CHD Family Planning Clinics and are eligible for Alabama Medicaid's EPSDT Program.		X		X
4. Operate Info Connection, the toll-free telephone line that provides educational information for teens on reproductive health and family planning services.		X		X
5. Administer the Alabama Abstinence-Until-Marriage Education Program, channeling federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct and Enabling:
CHD Family Planning clinics continue to serve teens who present there. Services include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:
The toll-free hotline, Info Connection, continues.

c. Plan for the Coming Year
Direct and Enabling:
CHD Family Planning clinics will continue to serve teens who present there. Services will include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:
The toll-free hotline, Info Connection, will continue.

Abstinence education funding, approved for the proposed 5-year funding cycle, remains contingent on continuation of federal funding by Congress in FY 2010.

State Performance Measure 4: *The percentage of white male high school students who chewed tobacco or snuff on 1 or more of the 30 days preceding their participation in the Youth Risk Behavior Survey (YRBS).*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		29	28.7	28.4	28.1
Annual Indicator	32	32	32	27.6	27.6
Numerator					
Denominator					
Data Source				Youth Risk Behavior Survey System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27.9	27.9	27.9	27.9	

Notes - 2009
Data Issues:
The U.S. Centers for Disease Control and Prevention's (CDC's) Youth Risk Behavior Survey System's (YRBSS's) web site, which can be queried, is the source used by FHS for estimating the prevalence of tobacco use among high school students. YRBSS consists of a national school-based survey conducted every 2 years by CDC and state, territorial, and local school-based entities. The survey, which is conducted by health and education agencies, has been conducted in odd years, beginning with 1991. YRBSS data represent students in grades 9-12 in the 50 states and the District of Columbia. The National YRBSS includes both public and private schools in the sampling frame. For state-level findings, the sampling frame includes only public schools. Findings are weighted estimates based on samples of students. Each estimate therefore reflects some degree of random statistical error. Findings (point estimates and confidence intervals) and a full description of methods are obtainable from a CDC web site.

In Alabama, the survey is conducted through the State Department of Education (SDE). Although Alabama participated in YRBSS during survey years from 1991-2009, the State had a response rate of less than 60% in 2007, so data for 2007 were neither weighted by CDC nor posted on CDC's web site.

The 2009 YRBSS findings for Alabama were available on the CDC's web site as of June 3, 2010. The actual denominator for this indicator was not provided; however, the 95% confidence interval was given for interpretation of statistical significance.

Objectives:
Per web-based TVIS instructions, objectives are not being updated at this time.

Notes - 2008
Data Issues:
Year 2007 YRBSS estimates for Alabama are not available on CDC's web site. Through consultation with the Alabama Department of Public Health's Bureau of Health Promotion and Chronic Disease, in which Alabama's YRBSS is administratively located, we learned that CDC will not publish Alabama's 2007 data because they are unweighted and are not representative of all students in grades 9-12 attending public schools in Alabama. Therefore, the FY 2009 estimate, obtained in June 2010, is used as the best estimate for 2008.

Objectives:
Because no recent estimate was available when the year 2013 objective was set, it was set to match the objectives for 2011-2012.

Notes - 2007
For reasons discussed in the year 2008 note, the YRBSS-based rate for 2005 is shown as our best estimate for 2007.

a. Last Year's Accomplishments
Rationale for Measure:
This measure pertains to the State's priority MCH need to "reduce the prevalence of high risk behaviors, including those predisposing to obesity, in adolescents." Tobacco use causes many serious health problems, and chewing tobacco and snuff are not safe alternatives to cigarettes or other forms of tobacco (reference #9).

MCH Population Served: Children and youth

Status and Trends:
Per the 2009 YRBSS, 27.6% of White male Alabama public high school students had used chewing tobacco or snuff in the 30 days preceding the survey.

Historical Context:
Per the 2005 YRBSS, about 1 in 3 (32.0% of) White male Alabama public high school students had used chewing tobacco or snuff in the 30 days preceding the survey. This prevalence was 1.8 times that for their U.S. counterparts, and 2.5 times that for Black male Alabama high school students. A high rate of smokeless tobacco use among junior and senior high males and adult males was a focus in Alabama for several years. In FY 2004, smokeless tobacco and oral cancer were highlighted when a former Auburn University football star developed cancer at the base of his tongue. His admitted use of smokeless tobacco for the previous 25 years and his willingness to become a spokesperson against such use provided a unique opportunity to educate health care providers and the public on the dangers of smokeless tobacco. In FYs 2004 and 2005 collectively, statewide news releases and 3 articles written for the State's dental newsletter were distributed. Also in those years, using ADPH Alabama Cancer Registry data, an Oral Cancer Fact Sheet was developed and distributed jointly by ADPH, the Alabama Dental Association, and the School of Dentistry. In February 2005 ADPH organized an oral cancer symposium, held at the annual dental alumni association meeting. The aforesaid football star was 1 of 6 speakers, who included staff from HPCD's Tobacco Prevention Division, to address nearly 300 attendees. A month later an ADPH staff member spoke at the UAB School of Medicine Continuing Education course on oral cancer in Alabama. Through the Tobacco-Free Coalition of Alabama, the former football star spoke at a statewide youth leadership conference in Montgomery in the spring of

2005. Through FY 2007 he continued to address health care professionals, youth groups, and faith-based groups on his experience with smokeless tobacco and oral cancer. Also, with funding from HPCD's Tobacco Prevention and Control Branch, a former major league baseball player and oral cancer survivor spoke to several high school student bodies in southeast Alabama in the spring of 2007.

FY 2009:
Due to competing priorities and the absence of a full-time dentist on staff, in FY 2009 OHB was unable to actively address the use of smokeless tobacco. However, as discussed under "Current Activities" and "Plan for the Coming Year," OHB is currently collaborating with other entities on this issue.

The Tobacco Prevention and Control Branch's Youth Tobacco Prevention and Cessation Unit administered a community and public health area grant program with 26 agency grants and 11 area tobacco control coordinator grants. These grants provided LifeSkills training to 6,663 6th grade students, 199 tobacco prevention events, and 558 educational presentations to over 105,000 students recognizing Red Ribbon Week, Great American Smokeout Day, Through with Chew Week, and Kick Butts Day in 73 schools. The Youth Cessation Coordinator developed Not On Tobacco, a mini-grant program, resulting in 8 applications for cessation projects in schools. Media campaigns included 2 billboard campaigns targeting pregnant teens who smoke in 17 high-prevalence counties, a spit tobacco ad in a football magazine reaching every high school in the State, a weekly radio ad during high school football game score reviews, a cable television ad in north Alabama and Mobile targeting 12-17 year olds, a Twitter profile and Facebook fan page with 17 followers and 193 fans, and a MySpace page with 48 friends and over 1,375 hits. There were 159 teens who called the Quitline, a 64% increase since 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In partnership with external entities, raise public awareness about smokeless tobacco use: through such means as LifeSkills training, tobacco prevention events, and educational presentations to youth.			X	X
2. In partnership with external entities, raise public awareness about smokeless tobacco use: through such means as television media campaigns regarding the Quitline and a tobacco prevention MySpace, Twitter, and Facebook profile for youth.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The OHB interim director met recently with HPCD's Tobacco Prevention and Cessation staff to consider a collaborative effort to promote the tobacco program's 1-800-Quitline. Tobacco Prevention and Cessation staff want to expand their Nicotine Replacement Therapy program into dental offices. Several options have been discussed and plans are ongoing.

A new tobacco cessation program is being considered for implementation in public schools, through athletic programs, CHDs, private dental offices, and other venues to discourage spit

tobacco use among children and adolescents. Initiatives under consideration are described under "Plans for the Coming Year."

The Tobacco Prevention and Control Branch's Youth Tobacco Prevention and Cessation Unit administers a community and public health area grant program with 13 agency grants and 11 area tobacco control coordinator grants. These grants provide LifeSkills training, prevention, and educational presentations to many Alabama students.

Effective FY 2010, this SPM is no longer operative. ADPH continues efforts to reduce the occurrence of smokeless tobacco use. However, based on input obtained during the 2009-10 Needs Assessment process, a new SPM will replace this SPM. Nevertheless, overall oral health continues to be a high priority for FHS: as evidenced by the fact that 1 of the 7 priority MCH needs selected by FHS during the Needs Assessment concerns promotion of access to a dental home and to preventive and restorative dental care.

c. Plan for the Coming Year

The OHB and HPCD's Tobacco Prevention and Cessation Program are planning an educational effort that will develop, print, and distribute educational material depicting the devastating effects of oral cancer. The ALAPD is interested in participating in this statewide initiative, should it occur. Posters and other educational material would be distributed at schools, health fairs, athletic events, dental clinics, CHDs, private dental offices, and other settings.

HPCD's Tobacco Prevention and Control Branch will implement the statewide Tobacco Prevention and Cessation Taskforce's 5-year plan that was developed in April 2010.

State Performance Measure 5: *The degree to which the State CSHCN Program assures that all CYSHCN have adequate access to primary and specialty care and allied health and other related services.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2	3	14	15
Annual Indicator		1	13	14	14
Numerator		1	13	14	14
Denominator	15	15	15	15	15
Data Source				Checklist	Checklist
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	15	

Notes - 2009

This state performance measure (SPM) was created in response to FY 2004-05 needs assessment data from providers and families. It involves improving the knowledge base of health care providers in local communities related to the unique needs of CYSHCN and their families. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for

previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #5, "Last Year's Accomplishments." Please see the narrative sections for SPM #5 for more detailed information.

Notes - 2008
This state performance measure (SPM) was created in response to FY 2004-05 needs assessment data from providers and families. It involves improving the knowledge base of health care providers in local communities related to the unique needs of CYSHCN and their families. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #5, "Last Year's Accomplishments." Please see the narrative sections for SPM #5 for more detailed information.

Notes - 2007
See this indicator's field note to year 2008 about measurement and data-related issues.

a. Last Year's Accomplishments
This SPM was created in response to FY 2004-05 needs assessment data from providers and families. It involves improving the knowledge base of health care providers in local communities about the unique needs of CYSHCN and their families. See this indicator's Form 11 field note to year 2008 for a discussion of recent changes in the checklist. The scored checklist measuring progress on this performance measure is attached to this section.

Population-based:
CRS staff provided materials and training to health and professional service providers in several ways. Brochures and presentations about CYSHCN, disability-related/medical issues, and the CRS program were given statewide to medical home/primary care providers and their office staffs, local Boards of Education, school nurses, ALL Kids staff, and local DHR staff. Several CRS State Office staff presented to Alabama's AAP Chapter Champion for Universal Newborn Hearing Screening on the CRS program and FY 2009-10 Needs Assessment activities.

CRS staff provided materials and training to students and interns in the following programs: Pediatric Pulmonary Center (family-centered care, CYSHCN, and MCH Block Grant performance measurement and accountability), UAB School of Public Health's MCH Department (needs assessment for CYSHCN), UAB School of Physical Therapy (hosted student intern), University of Alabama Huntsville Special Education class (ADRS/CRS services), UAB School of Occupational Therapy, family practice residents at the University of Alabama, several State Speech-Language Pathology training programs (CYSCHN and the CRS program), and University of Southern Mississippi (supported 4th year audiology externship).

Materials on specific disabilities and special health care needs were provided in CRS offices, clinics, and parent resource rooms and at CRS public awareness displays for health fairs and conferences. Examples include materials on hearing loss, juvenile rheumatoid arthritis, epilepsy, and speech-language development. This information is also disseminated through local CRS offices.

Infrastructure-building:
CRS staff, including the SPC and LPCs, participated in the following task forces, committees,

interagency meetings, and partner agency initiatives to promote awareness of the unique needs of CYSHCN:

State: EIS Governor's Interagency Coordinating Council (ICC), EIS's District ICCs, EIS Personnel Subcommittee, State and county CPCs, District Coordinating Councils for special education and social services, Head Start Disability Council, State Multi-Needs Child Taskforce, Alabama Health Coalition, Spina Bifida Association of Alabama, Alabama Covering Kids and Families Coalition, Ticket to Work, Oral Health Coalition, Family to Family Health Information Council, Alabama Respite Resource Network, ADPH's Special Populations Taskforce, Alabama Drug-Endangered Children Taskforce, My Alabama Project, Council of Organizations Serving Deaf Alabamians, TFQ, Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, and advisory committees or groups for STAR, State Wellness, Newborn Hearing Screening, Newborn Screening, Governor's Shared Youth Vision Summit (prevent high school drop out), and UAB Pediatric Pulmonary Center.

Local: UAB/UCP Dental Advisory Committee, Regional Perinatal Advisory Committee, Child Death Review teams, FIMR teams, UAB Civitan International Research Center Consumer Advisory Committee, Homeless Care Council, Miracle League Board, Individual and Family Support Councils, Northeast Alabama Safe Kids Steering Committee, Birmingham Consumer Advisory Council, Jefferson County Board of Education Community Transition Team, and a taskforce to develop child care options for CYSHCN over age 13 in a local area.

CRS continued being a critical part of the system of care for CYSHCN in local communities and an active partner with providers, families, and other agencies to represent the unique needs of CYSHCN. Staff members, including parent consultants, were active in State and community initiatives and provided technical assistance and other resources as needed.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to host or directly provide training for health and professional service providers to CYSHCN to increase awareness of the unique needs of CYSHCN, including cultural competence, family-centered care, medical home, and care coordination.		X	X	X
2. Continue to host or directly provide training for students and interns in health professional schools to increase awareness of the unique needs of CYSHCN, including cultural competence, family-centered care, medical home, and care coordination.		X	X	X
3. Continue to develop new materials, modify existing materials, and/or disseminate resources related to the unique needs of CYSHCN, including the core components of cultural competence, family-centered care, and care coordination.			X	X
4. Continue participation in State and local task forces, committees, etc. to promote the unique needs of CYSHCN, cultural competence, family-centered care, medical home, care coordination, and available technical assistance.			X	X
5. Continue to be an active presence in local communities and provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.		X		X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
FY 2009 activities as outlined above continue in FY 2010 with the following additions or exceptions.

Population-based:
Presentations are being made to groups as listed above and also to the Greater Birmingham Homeless Coalition, University of Montevallo School of Social Work, and University of Alabama School of Music Therapy.

Most materials currently disseminated by CRS relate to specific disabilities or special health care needs, CYSHCN in general, or the CRS program. CRS would like to adapt existing materials from national sources related to medical home, cultural competence, care coordination, and family-centered care for use in Alabama. Also, CRS has expanded its care coordination program and services related to transition. Materials about these new initiatives will be developed.

ADRS has convened a task force to plan a redesign of the departmental web site. This may provide an opportunity to include information about this SPM and on topics such as transition to adult health care, disability-specific topics, and links to other resources as recommended by the State Parent Advisory Committee and Youth Advisory Committee in 2007.

c. Plan for the Coming Year
Based on findings from the 2009-2010 Needs Assessment, formal reporting for this measure will be discontinued. New SPMs have been developed to better target needs identified by youth, families, and providers. However, activities related to this measure will continue as a part of the CRS Program.

State Performance Measure 6: *The degree to which the State CSHCN Program collaborates with schools, advocacy groups, and families to enhance inclusive participation by CYSHCN in their schools and communities.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2	3	13	14
Annual Indicator		1	12	13	14
Numerator		1	12	13	14
Denominator	15	15	15	15	15
Data Source				Checklist	Checklist
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	15	

Notes - 2009
This state performance measure (SPM) was created in response to FY 2004-05 needs assessment data from providers and families. It involves providing training and promoting advocacy both for families and for schools and communities. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation

Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #6, "Last Year's Accomplishments." Please see the narrative sections for SPM #6 for more detailed information.

Notes - 2008
This state performance measure (SPM) was created in response to FY 2004-05 needs assessment data from providers and families. It involves providing training and promoting advocacy both for families and for schools and communities. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #6, "Last Year's Accomplishments." Please see the narrative sections for SPM #6 for more detailed information.

Notes - 2007
See this indicator's field note to year 2008 about measurement and data-related issues.

a. Last Year's Accomplishments
This SPM was created in response to Needs Assessment data from providers and families. It involves providing training and promoting advocacy for families, schools, and communities. See this indicator's Form 11 field note to year 2008 for a discussion of recent changes in the checklist. The scored checklist measuring progress on this performance measure is attached to this section.

Enabling:
CRS staff, including parent consultants, regularly participated in the IEP process for CYSHCN enrolled in the State CSHCN Program. In June 2008 Alabama's Disabilities Advocacy Program provided training for CRS staff on IEP development and effective participation in the IEP process.

As discussed in NPM #6, CRS has developed Social Work Transition Specialists. At age 14 to 16, CRS youth are transferred to these staff members with expertise in all aspects of transition. As a part of a general initiative to develop a comprehensive plan of care for CRS enrollees, a transition plan template was created for use with clients ages 14-21. This is a "living" document to assist CRS youth and families in preparing for adulthood, including integration in local communities.

Population-based:
The SPC provided trainings on many topics and in several venues, including a session on Family Voices and family-centered care to the UAB Pediatric Pulmonary Center trainees. LPCs presented trainings on CRS, family-centered care, disability-related issues, and the parent perspective at schools, community colleges, and daycare centers. CRS staff disseminated brochures and made presentations on CYSHCN and the CRS program to schools throughout the State. CRS LPCs, nurses, social workers, PTs, OTs, nutritionists, speech-language pathologists,

and audiologists provided technical assistance to teachers and other school personnel on disability-specific topics, the needs of CYSHCN, and inclusion in school and recreational settings. Staff PTs have also been very involved in local chapters of AMBUCS, a non-profit service organization dedicated to creating mobility and independence for people with disabilities. These chapters assist CYSHCN with obtaining AmTryke(r) therapeutic tricycles (adapted tricycles for children who are unable to use traditional bicycles). CRS staff, including LPCs, have hosted a variety of Transition Expos and Resource Fairs throughout the State. These target youth, families, community providers, and school personnel.

LPACs hosted presentations for families on topics such as Title V and needs assessment, transition, Medicaid waivers, VRS services, cardiopulmonary resuscitation, IEPs, parent resources, planning for services after school, children with sensory problems, respite care, child care, individual and family support, SSA, and CRS services.

Infrastructure-building:
CRS staff, including the SPC and LPCs, participated in the following task forces, committees, interagency meetings, and partner agency initiatives to promote a comprehensive, collaborative effort to address the participation of families and CYSHCN in their schools and communities:

State: EIS Governor's ICC, EIS's District ICCs, EIS Personnel Subcommittee, CPCs, DCCs for special education and social services, Head Start Disability Council, State Multi-Needs Child Taskforce, Spina Bifida Association of Alabama support group, Ticket to Work, Family to Family Health Information Council, Alabama Respite Resource Network, ADPH's Special Populations Taskforce, Alabama Drug-Endangered Children Taskforce, Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, and STAR Advisory Committee.

Local: UAB/UCP Dental Advisory Committee, Regional Perinatal Advisory Committee, Child Death Review teams, FIMR teams, UAB Civitan International Research Center Consumer Advisory Committee, Homeless Care Council, Miracle League Board, Individual and Family Support Councils, Northeast Alabama Safe Kids Steering Committee, and the ADRS Continuum of Transition for Youth with Special Health Care Needs.

CRS continued to be a critical part of the system of care for CYSHCN in local communities and an active partner with schools, families, and other agencies to promote inclusion of CYSHCN in schools and communities. Staff members, including parent consultants, were active in State and community initiatives and provided technical assistance and other resources as needed.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue participation in the Individualized Education Plan (IEP) process for CRS-enrolled CYSHCN.		X		
2. Continue to develop a transition plan that includes promotion of integration into local communities including school, work, and recreation for all youth enrolled in CRS.		X		
3. Continue to host or directly provide training for families including special education rights, participation in the IEP process, and advocacy for integration into school and community activities.		X	X	X
4. Continue to host or directly provide training for local educational agency staff, and provide technical assistance related to the health needs of CYSHCN and promotion of their		X	X	X

full integration into the educational and recreational setting.				
5. Continue participation in State and local task forces, committees, etc. to promote a comprehensive, collaborative effort to address the participation of families and CYSHCN in their schools and communities.				X
6. Continue training for CRS staff, including parent consultants, on school health issues for CYSHCN, participation in IEP development, and strategies to promote full integration of CYSHCN into their school environment.		X	X	
7. Continue to be an active presence in local communities and to provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.				X
8.				
9.				
10.				

b. Current Activities
FY 2009 activities as outlined above continue in FY 2010 with the following additions or exceptions.

Enabling:
The plan of care, including aspects of transition, independence, and community integration, was released for electronic usage in April 2010.

Transition Expos are ongoing in each CRS district (See NPM #6). Among other issues, participation in local community activities is discussed.

CRS TBI care coordinators work with CYSHCN and families to assist them in community and school reintegration following a head injury.

ADRS has convened a task force to plan a redesign of the departmental web site. This may provide an opportunity to include information about this SPM and on topics such as general transition issues, special education law and rights, a listing of specific disabilities and possible challenges associated with them, tips for teachers and allied health providers in working with families (family-centered care, listening, communication, etc.), tips for families in connecting with providers (expression of concerns, effective and assertive communication, etc.), and links to other resources as recommended by the State Parent and Youth Advisory Committees in 2007.

c. Plan for the Coming Year
Based on findings from the 2009-2010 Needs Assessment, formal reporting for this measure will be discontinued. New SPMs have been developed to better target needs identified by youth, families, and providers. However, activities related to this measure will continue as a part of the CRS Program.

State Performance Measure 7: *The degree to which the Bureau of Family Health Services (Bureau) collects, analyzes, and disseminates findings from data pertinent to ongoing maternal and child health (MCH) needs assessment.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6	9	14	14

Annual Indicator	5	8	14	12	15
Numerator	5	8	14	12	15
Denominator	18	18	18	18	18
Data Source				FHS Program	FHS Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14	18	18	18	

Notes - 2009
Data Issues:
All scores pertain to fiscal years.

The scored checklist for 2009 is attached to Section IV.D, State Performance Measure (SPM) #7, "Last Year's Accomplishments."

Components of the Total Score:
Item #1--The State Perinatal Program is currently implementing fetal and infant mortality review (FIMR) statewide (score = 2).

Item #2--At least 1 functional child death review team was present in each judicial circuit, and key findings have been reported to the Alabama Department of Public Health (ADPH) and others (score = 3).

Item #3--Salient findings from the 2007 National Survey of Children's Health database were reported as part of the 2009-10 Needs Assessment process (score = 3).

Item #4--The Maternal and Child Health Epidemiology Branch last produced a collaborative, data-based report on a particular issue of major importance in April 2007. Since then, their resources have been mainly devoted to the Maternal and Child Health (MCH) Services Block Grant annual reports/applications and to planning and implementing the 2009-10 Needs Assessment. The annual reports/applications and the MCH Needs Assessment Report broadly cover a wide range of issues, rather than focusing on a particular issue (score = 2).

Item #5--Along with the MCH Services Block Grant 2009 Annual Report/2011 Application, ADPH is submitting a full report of the 2009-10 MCH Needs Assessment (score = 3).

Item #6--ADPH's Bureau of Family Health Services (FHS) has not recently produced a reader-friendly needs assessment report on children and youth. However, in December 2006, the University of Alabama at Birmingham's School of Education, with guidance from FHS's Coordinator of Adolescent Health, produced a report on identifying priority adolescent needs (score = 2).

Trends:
Notable progress on this measure was made by 2007, when the score increased to 14 out of a possible 18. However, the score declined to 12 in 2008 because only 1 perinatal region had a functional FIMR program in FY 2008. In FY 2009, the score increased to 15, which surpassed the objective.

Objectives:
Per the web-based Title V Information System instructions, objectives are not being updated at this time.

Notes - 2008
Objectives:
The State Perinatal Program is currently implementing FIMR statewide. Therefore, the score for

this indicator is expected to return to 14 in 2009 or 2010 and remain there through 2011, when the objective increases to 18. Achieving a score of 18 is contingent on utilization of findings from the National Survey of Children's Health in the ongoing 5-year MCH Needs Assessment (item 3 on the checklist), production of a reader-friendly statewide needs assessment report focusing on children and youth (item 6 on the checklist), progress in FIMR (item 1 on the checklist), and maintenance of effort regarding other items on the checklist.

Notes - 2007
Objectives:
Objectives for 2008 and 2009 have been revised upward, to match the score achieved in 2007. Due to competing reporting responsibilities, further progress on the criteria for this measure is not expected until 2011, when the target is the maximum score for this indicator. Whether this maximum score will be achieved, however, depends on future staffing and budgetary resources and on emerging issues.

a. Last Year's Accomplishments
Historical Context:
Correct diagnoses of the causes of infant deaths are pertinent to MCH data capacity. One long-standing issue has been the need for application of an appropriate protocol in the diagnosis of unexplained infant deaths. In 2008, ACDRS, in conjunction with the Alabama Department of Forensic Sciences, established the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team. The ACDRS Director is a member of this 5-person team. The SUIDI Team developed a SUIDI curriculum for Alabama based on CDC research and guidelines. The SUIDI Team then trained a team to teach this curriculum throughout the State. This new Alabama SUIDI curriculum will eventually replace the course previously developed by ACDRS's Infant and Child Death Investigation Task Force, which continues to be taught at all Alabama police academies.

Criteria for SPM #7, scored for FY 2009, are attached. The total score is 15, with the maximum possible score being 18. Stated item numbers in the discussion that follows pertain to the attached checklist.

FY 2009:
The following activities occurred in FY 2009 or the years stated.

Crosscutting (Population-based and Infrastructure-building):
Concerning item #1, due to budget constraints, in January 2009, SPP implemented the statewide FIMR Program (discussed under NPM #17) with its present staff, rather than hiring new staff. Development of a web-based database and corresponding data collection began. The State's FIMR Program is based on the model developed by ACOG, with an initial focus on infant deaths. In Alabama, the RNPCs abstract data, prepare case summaries, conduct maternal interviews, and coordinate the case review teams. The case review teams make recommendations about potential ways to reduce the occurrence of infant deaths. In FY 2009, the RNPCs began establishing community action teams, in order to facilitate community participation in development of strategies to reduce infant mortality within the communities where the deaths occurred.

Concerning item #2, ACDRS continued maintaining the program's web page, which allows online submission of data from the Local Child Death Review Teams and provides information on underlying legislation, the child death review process, causes of child death, summary recommendations of the State Child Death Review Team, links to nationwide resources related to child death review, and downloadable versions of all original ACDRS publications. ACDRS also continued maintaining a comprehensive, searchable database that contains all data collected since the inception of the program. All 41 Judicial Circuits continued having Local Child Death Review Teams, with each team having a chairperson. All teams were active and, collectively, they reviewed 95% of the cases assigned to them. That completion rate is up from 64% of cases being reviewed circa 1998. In FY 2009, ACDRS adopted a new, web-based data collection system and corresponding protocols. The system was developed by the MCH National Center for

Child Death Review and the Michigan Public Health Institute, and is now used by more than half of the states.

Concerning item #3, FHS utilized the National Survey of Children's Health during the Needs Assessment process.

Item #4 concerns a data-based report on a particular MCH issue. The groundwork was begun in FY 2006, when the MCH Epi Branch organized an ADPH internal work group, the Drug Overdose Work Group, to follow up on certain findings from the 2004-05 MCH Needs Assessment. The work group held its final meeting in November 2006. In April 2007, the MCH Epi Branch produced a report, "Deaths Due to Drug-Related and Alcohol-Induced Causes, Alabama, 1999-2005: with a Focus on the 15-44 Year-Old Age Group." In November 2009, the Bureau made several data-based presentations to its MCH Needs Assessment Advisory Group.

Item #5 concerns a needs assessment report on pregnancy and infancy. The Bureau laid the groundwork for completing this task in FY 2006, by inviting SPAC to comment on draft materials to be posted on the State MCH Title V web page. In response, 1 SPAC member expressed concern about the infant mortality gap between Alabama and the U.S. In FY 2007, in collaboration with this SPAC member, the MCH Epi Branch developed an SOM on this mortality gap and prepared a background paper on the new outcome measure.

Item #6 concerns a reader-friendly needs assessment report on children and youth and is briefly discussed in this indicator's year 2009 Form 11 note.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to implement the FIMR Program, with continued development of a web-based database to collect data on infant deaths.				X
2. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths of children and youth.				X
3. Maintain the ACDRS web page, which allows online submission of data from the Local Child Death Review Teams and provides information on the child death review process, causes of child death, and recommendations of the State Child Death Review Team.			X	X
4. Periodically produce a strongly data-based, collaborative report addressing a particular MCH issue: either an emerging issue or a longstanding issue that requires focused study.				X
5. Utilize the National Survey of Children's Health for the Needs Assessment process.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Crosscutting (Population-based and Infrastructure-building):
Concerning item #1, the statewide FIMR program continues. FIMR program activities conducted in FY 2009 will basically continue in FY 2010: including data abstraction by RNPCs, maintenance of a web-based database, review of infant deaths by case review teams, and utilization of

community action teams to develop and implement strategies to reduce infant mortality in the communities where the deaths occurred. The program is continuing to review year 2009 neonatal deaths and is gathering data for review of year 2010 postneonatal deaths. In early FY 2010, a research analyst who focuses on FIMR was added to the SPP Program.

Concerning item #2, the existing ACDRS database continues to be maintained and integrated with the new system, while the old data collection system will be discontinued upon the completion and closeout of all 2007 case reviews. All eligible (per child death review legislation, discussed in Section III.B) deaths in 2008 and later years will be reviewed using the new system.

Concerning items #3 through #6, in FY 2009, the main focus of the MCH Epi Branch has been completing the 2009-10 MCH Needs Assessment and meeting reporting requirements for the 2009 Report/2011 Application.

Because FHS's MCH Needs Assessment Advisory Group (MCH Advisory Group) did not select maintenance or enhancement of data capacity as a priority need, this performance measure is being discontinued, effective FY 2010.

c. Plan for the Coming Year

Crosscutting (Population-based and Infrastructure-building):
Concerning item #1, FIMR activities conducted in FY 2010 will basically continue in FY 2011: including data abstraction by RNPCs, maintenance of a web-based database, review of deaths by case review teams, and utilization of community action teams to develop and implement strategies to reduce infant mortality within the communities where the deaths occurred.

Concerning item #2, all past ACDRS activities will basically continue in FY 2011, including: maintenance of the system's web page, maintenance of the system's database, performance of in-depth child death case reviews by local teams, and public outreach and education efforts related to strategies to prevent deaths of infants, children, and youth.

Depending on resources and competing priorities, the MCH Epi Branch will seek to produce a brief, reader-friendly report that focuses on key indicators concerning one of the federally defined Title V population groups (infants, pregnant women, and mothers; or children and youth). Information for this report would be drawn from the full 2009-10 Needs Assessment Report.

As previously stated, this performance measure will no longer be operative in FY 2011.

E. Health Status Indicators

Introduction

References are listed in Appendix B, which can be requested by e-mailing anita.cowden@adph.state.al.us.

The web-based guidance for this section suggests that HSIs be described regarding the degree to which the indicator:
1) Provides information on the State's residents.
2) Helps direct public health efforts.
3) Serves as a surveillance or monitoring tool.
4) Functions as an evaluative measure.

Information on State's Residents:
All the indicators provide information on the State's residents, but no single indicator provides a complete picture.

Direction for Public Health Efforts:
Seldom should a single indicator direct public health efforts. However, in many cases an indicator comprises part of a larger picture that suggests a direction.

Surveillance or Monitoring Tool:
Most of the HSIs are important tools, but the degree of importance varies.

Evaluative Measure:
Forces outside the control of public health professionals influence most MCH indicators. Further, rarely is a rigorous, systematic study of cause and effect feasible in a public health setting. Therefore, rarely does a single MCH indicator or a group of MCH indicators suffice for evaluation of an MCH program. Most HSIs should be viewed as descriptive measures of health status, rather than as evaluative measures per se. When going in the wrong direction, however, any given HSI can serve as a warning: indicating that the HSI or a related indicator should be prioritized for further study and collaborative consideration.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.7	10.5	10.4	10.6	
Numerator	6428	6616	6578	6631	
Denominator	60262	62915	63005	62466	
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	

Notes - 2009
Data Issues:
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years. For reasons discussed below, year 2007 and 2008 numbers shown on Form 20 for HSI #1A pertain to Alabama occurrent, residential live births. Because the web-based TVIS does not allow us to directly revise Form 20 numbers for 2006 and earlier years, numbers shown for those years pertain to all Alabama residential live births.

This paragraph pertains to Health Status Indicators (HSIs) #1A, #1B, #2A, and #2B: for which both the numerators and denominators come from statistical live birth files. Births to Alabama residents that occur outside of the State have apparently been underreported to the Alabama Department of Public Health (ADPH) in recent years. 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. In an effort to account for these issues, for the years 2007 and 2008, the numbers shown on Form 20 are based on occurrent events only. That is, we counted only births that occurred in Alabama to Alabama residents.

Trends:
Rather than updating the previous analysis of trends in this indicator, we have focused on analyzing trends in very low birth weight (VLBW) among singleton births: according to race, ethnicity, and source of payment. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report. As well, trends in VLBW for the total population of occurrent, residential singleton live births are summarized in the Form 20 year 2008 field note for HSI #2B.

Notes - 2007
Trends:
The following analysis of trends is based on all Alabama residential live births, rather than on occurrent, residential live births. Therefore, the numbers reported below for 2005-07 do not precisely coincide with the numbers shown on Form 20 for 2007, since the Form 20 year 2007 numbers have been updated and pertain only to occurrent, residential live births.

From a baseline of 9.7% in 2000, this indicator declined slightly to 9.6% in 2001 but then increased 4 years in a row: to reach 10.7% in 2005. It then declined in 2 successive years: so that, in 2007, 10.4% of infants born alive to Alabama residents weighed less than 2,500 grams. Comparing 3-year periods, the indicator increased by 7.8% overall: from 9.8% (17,813/182,328) in 2000-02 to 10.5% (19,739/187,357) in 2005-07.

The narrative for HSI #2A mentions several issues to be considered when interpreting reported trends in very low birth weight (VLBW). These potential explanations, which include but are not limited to reporting issues, apply to reported trends in low birth weight (less than 2,500 grams), as well as VLBW.

Narrative:
Status:
Among Alabama occurrent, residential live births in 2008, 10.6% were low birth weight (less than 2,500 grams). ("Alabama occurrent, residential live births" pertains to births that occurred in Alabama to Alabama residents.)

Utilization:
Low birth weight includes VLBW (less than 1,500 grams) and moderately low (1,500-2,499 grams) birth weight. Because VLBW is a much stronger predictor of infant death than moderately low birth weight is, FHS's MCH Epi Branch does not consider HSI #1A to be an especially important surveillance tool. As a corollary, though we report HSIs #1A and #1B on Form 11, we do not use either of these indicators as a key monitoring tool or evaluative measure. Accordingly, we do not use either of these measures to direct public health efforts. The following focuses on birth weight-specific risks of infant death, within more restrictive weight categories, and on approaches to addressing low birth weight.

Birth Weight-Specific Risks of Infant Death:
Low birth weight newborns are more likely than normal birth weight newborns to die during the 1st year of life. Further, within the low birth weight category, risk of infant death declines

dramatically as birth weight increases. The following birth weight-specific risks of infant death pertain to babies born in Alabama to Alabama residents (occurrent residential live births) in 2005-07. Eighty-nine (89.1) percent of babies weighing less than 500 grams at birth, and 43.1% of babies weighing 500-749 grams at birth, died during infancy. Due to their relative rarity, infant deaths in the higher birth weight categories are reported per 1,000 live births, rather than as percents. Among 750-1,499 gram newborns, 76 of every 1,000 died in infancy. Among 1,500-2,499 gram newborns, 17 of every 1,000 died in infancy. Among normal birth weight (2,500-4,249 grams) infants, 3 (3.2) of every 1,000 died in infancy.

Approaches to Addressing Low Birth Weight:
See discussion under HSIs #1B and #2B.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.7	8.5	8.6	8.7	
Numerator	5035	5176	5206	5247	
Denominator	58180	60638	60859	60327	
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	

Notes - 2009
Data Issues:
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years. For reasons discussed in the Form 20 year 2008 note to Health Status Indicator (HSI) #1A, year 2007 and 2008 numbers shown on Form 20 for HSI #1B pertain to Alabama occurrent, residential singleton live births. Because the web-based TVIS does not allow us to directly revise Form 20 numbers for 2006 and earlier years, numbers shown for those years pertain to all Alabama residential singleton live births.

Trends:
Rather than updating the previous analysis of trends in this indicator, we have focused on analyzing trends in very low birth weight (VLBW) among singleton births: according to race, ethnicity, and source of payment. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report. As well, trends in VLBW for the total population of occurrent, residential singleton live births are summarized in the Form 20 year 2008 field note for HSI #2B.

Notes - 2007
Trends:
The following analysis of trends is based on all residential singleton live births, rather than on occurrent, residential singleton live births. Therefore, the numbers reported below for 2005-07 do not precisely coincide with the numbers shown on Form 20 for 2007, since the Form 20 year 2007 numbers have been updated and pertain only to occurrent, residential singleton live births.

From a baseline of 7.9% in 2000, this indicator declined slightly to 7.8% in 2001 but then increased 4 years in a row: to reach 8.7% in 2005. In 2007, 8.6% of singleton infants born alive to Alabama residents weighed less than 2,500 grams. Comparing 3-year periods, the indicator increased by 8.9% overall: from 7.9% (13,884/176,154) in 2000-02 to 8.6% (15,517/180,819) in 2005-07.

The narrative for HSI #2A mentions several issues to be considered when interpreting reported trends in VLBW. These potential explanations, which include but are not limited to reporting issues, apply to low birth weight (less than 2,500 grams), as well as to VLBW. By focusing on singleton births, HSI #1B removes the effect of potential changes in the occurrence of multiple births. However, as discussed above, the reported prevalence of low birth weight has increased somewhat among singleton live births, as well as among the total population of live births.

Narrative:
Status:
Among Alabama occurrent, residential singleton live births in 2008, 8.7% weighed less than 2,500 grams.

Utilization:
As stated under HSI #1A, because VLBW is a much stronger predictor of infant death than moderately low birth weight is, FHS's MCH Epi Branch does not consider HSI #1A to be an especially important surveillance tool.

Approaches to Addressing Low Birth Weight:
FHS's overall strategy for addressing low birth weight has been to maintain and develop the infrastructure for regionalized health care; seek to ascertain what initiatives and services are most likely to reduce the frequency of VLBW, and develop strategies based on information so gathered. Ongoing interventions and services include:
1) CHDs' provision of family planning services with priority to low-income clients.

2) Education of CHD Family Planning clients about the importance of prenatal care. Other initiatives to promote early prenatal care are discussed under NPM #18.

3) WIC's provision of food vouchers and nutritional counseling to eligible pregnant women.

4) Initiatives, described under NPM #8, to reduce the occurrence of adolescent pregnancy.

5) Initiatives, described under NPM #15, to reduce the occurrence of smoking during pregnancy.

All of the preceding initiatives and services pertain to HSIs #1A, #2A, and #2B, as well as #1B. Further, the State seeks to address sub-optimum pregnancy outcomes, including low birth weight, through SPAC, discussed under HSI #2A and NPM #17.

Because low birth weight and gestational age at delivery are related, efforts to reduce the prevalence of prematurity pertain to low birth weight. As stated in Section III.E, 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 2010, AMOD is helping to support the initiatives of SPP's FIMR Program. Also, as discussed under

HSCI #5B (in Section III.F), in response to a proposal submitted by SPP in FY 2008, Medicaid has agreed to support SPP's statewide infant death review initiative with matching funds.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.1	2.0	2.1	2.1	
Numerator	1291	1273	1324	1309	
Denominator	60262	62915	63005	62466	
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	

Notes - 2009
Data Issues:
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years. For reasons discussed in the Form 20 year 2008 note to Health Status Indicator (HSI) #1A, year 2007 and 2008 numbers shown on Form 20 for HSI #2A pertain to Alabama occurrent, residential live births. Because the web-based TVIS does not allow us to directly revise Form 20 numbers for 2006 and earlier years, numbers shown for those years pertain to all Alabama residential live births.

Trends:
Rather than updating the previous analysis of trends in this indicator, we have focused on analyzing trends in very low birth weight (VLBW) among singleton births: according to race, ethnicity, and source of payment. Findings from these analyses are detailed in the 2009-10 Needs Assessment Report. As well, trends in VLBW for the total population of occurrent, residential singleton live births are summarized in the Form 20 year 2008 field note for HSI #2B.

Notes - 2007
Trends:
The following analysis of trends is based on all Alabama residential live births, rather than on occurrent, residential live births. Therefore, the numbers reported below for 2005-07 do not precisely coincide with the numbers shown on Form 20 for 2007, since the Form 20 year 2007 numbers have been updated and pertain only to occurrent, residential live births.

During the surveillance period (2000-2007), this indicator ranged from 1.97% in 2001 to 2.14% in 2005. Though the indicator did not show a consistent directional change from year to year, comparison of 3-year periods shows an overall increase. That is, comparing 3-year periods, the

indicator increased by 3.0% overall: from 2.03% (3,697/182,328) in 2000-02 to 2.09% (3,912/187,357) in 2005-07. In 2007, 2.10% of Alabama residential live births weighed less than 1,500 grams.

The narrative for this health status indicator mentions several hypothetical issues, which include but are not limited to reporting issues, to be considered when interpreting reported trends in very low birth weight.

Narrative:
Status:
Among infants born alive to Alabama residents in 2008, 2.10% were VLBW (less than 1,500 grams).

The degree to which this indicator's failure to decline reflects actual trends versus variation over time in reporting cannot be assessed from vital records alone. Researchers in Alabama have previously reported their perception that reporting of under 500 gram births, for which "the dividing lines between live birth, stillbirth, and spontaneous mid-trimester abortion are...often difficult to determine," had certainly increased (reference #10). Conceivably, this perceived increase in reporting of extremely low birth weight infants had actually occurred and may have continued.

Utilization:
Because VLBW is a very strong predictor of infant death, FHS considers it to be a crucial surveillance tool, though the influence of several factors on the reported prevalence of VLBW limits this indicator's use as an evaluative measure. Nevertheless, the indicator identifies a high-risk group, so may be helpful for directing public health efforts.

Several hypothetical explanations for the lack of improvement in VLBW merit consideration and data-based assessment. First, trends in multiple births, discussed in the 2009-10 MCH Needs Assessment Report, affect trends in VLBW. Second, the reporting issues described above merit consideration. Third, the possibility that advances in prenatal and perinatal care have resulted in live births of some VLBW babies who would have died before birth in the absence of such care should be considered. Finally, the possibility of unfavorable trends, or at least failure to decline, in risk markers for women giving birth should be explored. Trends in certain risk markers are discussed in the 2009-10 Needs Assessment Report.

Approaches to Addressing VLBW:
See discussion under HSIs #1B and #2B.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	1.6	1.6	1.7	
Numerator	971	987	1001	1000	
Denominator	58180	60638	60859	60327	
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	

Notes - 2009
Data Issues:
Due to the time required to receive records and edit data, final vital statistics files for 2009 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. For this reason, the year 2009 estimate is not provided. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years. For reasons discussed in the Form 20 year 2008 note to Health Status Indicator (HSI) #1A, year 2007 and 2008 numbers shown on Form 20 for HSI #2B pertain to Alabama occurrent, residential singleton live births. Because the web-based TVIS does not allow us to directly revise Form 20 numbers for 2006 and earlier years, numbers shown for those years pertain to all Alabama residential singleton live births.

Trends:
The study population for this analysis of trends is singleton live births that occurred in Alabama to Alabama residents, during the years 2000-2008. Among this population, the proportion of infants who were very low birth weight (VLBW, or less than 1,500 grams) in consecutive 3-year periods was as follows: 1.55% (2,660/171,374) in 2000-02, 1.60% (2,676/167,161) in 2003-05, and 1.63% (2,940/180,033) in 2006-08.

For single years during the surveillance period, the proportion of singleton infants who were VLBW ranged from 1.47% (837/56,778) in 2001 to 1.67% (942/56,273) in 2005, with a median of 1.60% in 2000 and 2006.

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). At the 0.05 level of significance, the trend in single-year percentages was significant ($p = 0.033$). However, trends in 3-year percentages were not significant: whether including all three 3-year percentages over the 9-year period ($p = 0.056$), comparing 2006-08 to 2000-02 ($p = 0.056$), or comparing 2006-08 to 2003-05 ($p = 0.453$).

Notes - 2007
Trends:
The following analysis of trends is based on all residential singleton live births, rather than on occurrent, residential singleton live births. Therefore, the numbers reported below for 2005-07 do not precisely coincide with the numbers shown on Form 20 for 2007, since the Form 20 year 2007 numbers have been updated and pertain only to occurrent, residential live singleton births.

During the surveillance period (2000-2007), this indicator ranged from 1.50% in 2001 to 1.67% in 2005. Though the indicator did not show a consistent directional change from year to year, comparison of 3-year periods shows an overall increase. That is, comparing 3-year periods, the indicator increased by 4.9% overall: from 1.57% (2,767/176,154) in 2000-02 to 1.65% (2,980/180,819) in 2005-07. In 2007, 1.65% of Alabama residential live singleton births weighed less than 1,500 grams.

The narrative for HSI #2A mentions several issues to be considered when interpreting reported trends in VLBW (births weighing less than 1,500 grams). These potential explanations include but

are not limited to reporting issues. By focusing on singleton births, HSI #2B removes the effect of potential changes in the occurrence of multiple births. However, as discussed above, the reported prevalence of VLBW has increased slightly among singleton live births, as well as among the total population of live births. (Trends in VLBW among all live births are discussed in the year 2007 Form11 note for HSI #2A.)

Narrative:
Status:
In 2008, 1.66% of Alabama occurrent, residential singleton live births were VLBW.

Approaches to Addressing VLBW:
In addition to the following activities, approaches discussed under HSI #1B also address VLBW.

The current 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 of VLBW Infants:
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. The deaths reviewed 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 case review teams to positively impact such pregnancies and births. A brief summary of these recommendations follows.

All 5 case review teams 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, as discussed under SPM #7.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.9	13.6	11.7	11.1	
Numerator	130	125	108	103	
Denominator	936034	922002	922825	925961	

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	

Notes - 2009

Due to time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

This paragraph concerns numerators for Health Status Indicators (HSIs) #3A, #3B, and #3C. Vital events that involve Alabama residents but occur outside of the State have apparently been underreported to the Alabama Department of Public Health in recent years. This out-of-state reporting issue may cause slight underestimation of mortality rates for the years 2006, 2007, and 2008. Though slight, such underestimation could lead to appreciable distortion of trends in mortality rates. Therefore, for HSIs #3A, #3B, and #3C, we have adjusted the number of deaths for 2006, 2007, and 2008 by: 1) computing the mean annual number of applicable deaths that occurred out of 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 HSI #3A, the difference in means was 2.67 deaths per year. Since the difference was a fraction, we added 2 deaths for 2006, 3 deaths for 2007, and 3 deaths for 2008. Because the web-based TVIS does not permit us to directly revise numbers shown for 2005 and 2006, the numerators shown on Form 20 for those years for HSIs #3A, #3B, and #3C do not reflect the adjustment. Also, for these measures, 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.

This paragraph concerns denominators for HSIs #3A, #3B, #3C, #4A, #4B, #4C, #5A, and #5B. When analyzing trends in these measures, we used the U.S. Census Bureau's population estimates for denominators. These estimates are derived from a detailed, state-level spreadsheet released in May 2009: "SC-EST2008-alldata6: Annual State Resident Population Estimates for 6 Race Groups by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2008." In their annual releases, the Census Bureau often revises previous estimates, but TVIS does not permit us to revise numbers for the denominators shown on Form 20 for 2005 and 2006. Therefore, for 2005 and 2006, the single-year denominators used for our analyses of trends in population-based estimates often differ from those shown on Form 20.

Notes - 2008

Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators and denominators for this indicator are discussed in this indicator's year 2009 Form 20 field note.

Trends:
For this analysis of trends, numerators for years 2006, 2007, and 2008 have been adjusted as described in this indicator's year 2009 Form 20 field note. The surveillance period is 2000-2008. Among 0-14 year-old Alabama residents, the single-year death rate due to unintentional injuries showed no consistent trend early in the surveillance period, but then declined in each of the last 3

years. Consecutive 3-year unintentional injury death rates in this population were: 14.7 deaths per 100,000 (408/2,778,601) in 2000-02, 13.3 deaths per 100,000 (366/2,748,918) in 2003-05, and 12.2 deaths per 100,000 (338/2,767,839) in 2006-08.

Rates for individual years in the surveillance period ranged from 11.1 deaths per 100,000 in 2008 to 16.1 deaths per 100,000 in 2001. Rates for overlapping 3-year periods ranged from 12.2 deaths per 100,000 in 2006-08 to 14.7 deaths per 100,000 in 2000-02.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator declined (improved) by 3.0% per year. Comparing 2006-08 to 2003-05, the indicator declined by 2.8% per year.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

The numerator is from statistical death files for Alabama residents. The International Classification of Diseases, Tenth Revision (ICD-10) cause-of-death codes have been used since 1999 (inclusive).

The U.S. Census Bureau's population estimates for 0-14 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators when analyzing trends. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable to population estimates. Using population estimates as denominators, the estimated death rate per 100,000 due to unintentional injuries among children aged 14 years and younger was 13.0 (119/918,475) in 2004 and 14.3 (131/916,861) in 2005. (The preceding numerator of 131 for the year 2005 is slightly higher than that shown on Form 20. The reason for this difference is that we have expanded our SAS[TM] programming criteria to capture certain unintentional injuries that were not captured in the previous programming.)

Trends:
This indicator declined (improved) in 2006 and again in 2007. In 2007 the unintentional injury death rate among Alabama children aged 14 years or younger was 11.3 deaths per 100,000 children, which was the lowest rate during the surveillance period (2000-2007).

The rate showed no consistent trend from 2000-2005, when it ranged from 12.6 deaths per 100,000 in 2003 to 16.1 deaths per 100,000 in 2001. However, comparing 3-year periods, the unintentional injury death rate among Alabama residents aged 14 years and younger declined from 14.7 (408/2,780,153) per 100,000 in 2000-02 to 13.1 (361/2,764,216) per 100,000 in 2005-07: for an average annual decline of 2.3%.

Narrative:
Status:
In 2008, the estimated death rate due to unintentional injuries among Alabama residents aged 14 years and younger was 11.1 deaths per 100,000 persons in this age group.

Preventive Approaches for Unintentional Injuries:
ADPH addresses unintentional injuries, regardless of age, through HPCD's Injury Prevention Division. This division's web page includes information about national observances such as the following: Burn Awareness Week, National Poison Prevention Week, National Youth Violence

Prevention Week, National Safe Kids Week, National Bike Month, Click It or Ticket Mobilization Dates (which concerns child restraints and seat belts), Home Safety Month, National ASK Day (which pertains to parents' awareness of children's access to firearms in the home), Fireworks Safety Month, STOP a Suicide Today Day, Child Passenger Safety Week, National Fire Prevention Week, Safe Toys and Gifts Month, and National Drunk and Drugged Driving Prevention Month. As well, the web page includes information about the Injury Advisory Council, which advises the Injury Prevention Division. Entities initially represented in 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.

FHS chiefly addresses unintentional injuries through ACDRS, discussed under NPM #10 and under SPM #7. Legislation establishing ACDRS is described in Section III.B, under "Some Statutes Pertaining to the Title V Program."

As well, ADPH's Pharmacy Division addresses drug-related adverse outcomes in all age groups in a number of ways. For example, the division implements the Prescription Drug Monitoring Program: which is designed to detect diversion, abuse, and misuse of prescription medications classified as controlled substances under the Alabama Uniform Controlled Substances Act. The division's web page raises awareness about the dangers and illegality of sharing prescription medications with others, including, but not limited to, youth. One section of the page shows sequential photos of 6 individuals (who are diverse with respect to age, sex, and race) and asks, "What does a drug dealer look like?" and says that the answer may be surprising.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.5	6.4	3.7	4.6	
Numerator	61	59	34	43	
Denominator	936034	922002	922825	925961	
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	

Notes - 2009

Due to time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Issues concerning the numerators and denominators for this indicator are discussed under the Form 20 year 2009 field note for Health Status Indicator (HSI) #3A.

Notes - 2008

Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators and denominators for this indicator are discussed in the year 2009 Form 20 field note for HSI #3A.

Trends:
For this analysis of trends, numerators for years 2006, 2007, and 2008 have been adjusted as described in HSI #3A's year 2009 Form 20 field note. In the case of this indicator, HSI #3B, the adjustment involved adding 2 deaths to the number of motor vehicle crash deaths reported in Alabama residential statistical death files (for 0-14 year-old persons) for each of the following years: 2006, 2007, and 2008.

The surveillance period is 2000-2008. Among 0-14 year-old Alabama residents, the single-year death rate due to motor vehicle crash deaths showed no consistent trend early in the surveillance period, but then declined in 3 successive years (2005, 2006, and 2007) before increasing in 2008. Consecutive 3-year motor vehicle crash death rates in this population were: 6.0 deaths per 100,000 (167/2,778,601) in 2000-02, 6.3 deaths per 100,000 (173/2,748,918) in 2003-05, and 5.0 deaths per 100,000 (138/2,767,839) in 2006-08.

Rates for individual years in the surveillance period ranged from 3.7 deaths per 100,000 in 2007 to 6.8 deaths per 100,000 in 2004. Rates for overlapping 3-year periods ranged from 5.0 deaths per 100,000 in 2006-08 to 6.7 deaths per 100,000 in 2004-06.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator declined (improved) by 3.1% per year. Comparing 2006-08 to 2003-05, the indicator declined by 7.5% per year.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

The numerator is from statistical death files for Alabama residents. The International Classification of Diseases, Tenth Revision (ICD-10) cause-of-death codes have been used since 1999 (inclusive).

The U.S. Census Bureau's population estimates for 0-14 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators when analyzing trends. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable to population estimates. Using population estimates as denominators, the estimated death rate per 100,000 for unintentional injuries among Alabama residents aged 14 years and younger due to motor vehicle crashes was 6.75 (62/918,475) in 2004 and 6.65 (61/916,861) in 2005.

Trends:
This rate did not show a consistent trend from 2000-2004: ranging from 5.4 deaths per 100,000 in 2003 to 6.8 deaths per 100,000 in 2004. The rate then declined 3 years in a row, however, to reach the lowest rate during the surveillance period in 2007. In that year, the motor vehicle crash death rate (excluding injuries known to be intentional) among Alabama children aged 14 years and younger was 3.5 deaths per 100,000 children.

Comparing 3-year periods, this rate declined from 6.0 (167/2,780,153) per 100,000 in 2000-02 to 5.5 (152/2,764,216) per 100,000 in 2005-07: for an average annual decline of 1.75%.

Narrative:
Status:
In 2008, the estimated motor vehicle crash death rate (excluding injuries known to be intentional) among Alabama residents aged 14 years and younger was 4.6 deaths per 100,000 persons in this age group.

Preventive Approaches for Motor Vehicle Crash-Related Injuries:
ADPH chiefly addresses injury prevention through HPCD's Injury Prevention Division, and FHS chiefly addresses it through ACDRS. Activities of the Injury Prevention Division 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 stated under HSI #3A, the Injury Prevention Division'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."

Per the latter report, 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 2008, 88.2% (2,458/2,788) of the observed 0-5 year-old passengers were restrained, which is about the median value of this indicator for 2002-2008. (This indicator is not available for 2001.)

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 Division, and the Southeast Child Safety Institute. The purpose of this program is to educate Alabama residents about legislation concerning child safety restraints.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	41.0	48.1	46.5	39.7	
Numerator	272	309	300	257	
Denominator	663113	641922	644621	646734	
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	

Notes - 2009
Due to time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Issues concerning the numerators and denominators for this indicator are discussed under the Form 20 year 2009 field note for Health Status Indicator (HSI) #3A.

Notes - 2008
Data Issues:
All estimates shown are for calendar years.

Data issues concerning numerators and denominators for this indicator are discussed in the year 2009 Form 20 field note for HSI #3A.

Trends:
For this analysis of trends, numerators for years 2006, 2007, and 2008 have been adjusted as described in HSI #3A's year 2009 Form 20 field note. In the case of this indicator, HSI #3C, the adjustment involved adding the following number of motor vehicle crash deaths to the number reported in Alabama residential statistical death files (for 15-24 year-old persons): 6 deaths for 2006, 5 deaths for 2007, and 5 deaths for 2008.

The surveillance period is 2000-2008. Among 15-24 year-old Alabama residents, the single-year death rate due to motor vehicle crash deaths showed no consistent trend. Consecutive 3-year motor vehicle crash death rates in this population did increase somewhat, however: from 42.3 deaths per 100,000 (809/1,910,707) in 2000-02, to 43.0 deaths per 100,000 (825/1,918,309) in 2003-05, to 45.1 deaths per 100,000 (872/1,932,757) in 2006-08.

Rates for individual years in the surveillance period ranged from 38.9 deaths per 100,000 in 2003 to 49.1 deaths per 100,000 in 2006. Rates for overlapping 3-year periods ranged from 42.0 deaths per 100,000 in 2001-03 to 46.4 deaths per 100,000 in 2004-06.

Comparing 2006-08 to 2000-02 and assuming a constant annual percent change, this indicator increased (worsened) by 1.1% per year. Comparing 2006-08 to 2003-05, the indicator increased by 1.6% per year.

To ascertain whether the above increases were an artificat introduced by adjusting for the out-of-state reporting issue, we also looked at trends in occurrent motor vehicle crash deaths in this age group. That is, we counted only deaths of Alabama residents that occurred in Alabama. Based on analysis of occurrent deaths, the motor vehicle crash death rate in 15-24 year-old Alabama residents increased by 1.4% per year: whether comparing 2006-08 to 2000-02 or to 2003-05.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

The numerators are from statistical death files for Alabama residents. The International Classification of Diseases, Tenth Revision (ICD-10) cause-of-death codes have been used since 1999 (inclusive).

The U.S. Census Bureau's population estimates for 15-24 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators when analyzing trends. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable to population estimates. Using population estimates as denominators, the estimated death rate per 100,000 from unintentional injuries due to motor vehicle crashes among 15-24 year-old Alabama residents was 47.55 (304/639,328) in 2004 and 42.5 (272/639,423) in 2005.

Trends:
This rate has not shown a consistent trend during the surveillance period: ranging from 38.8 per 100,000 in 2003 to 48.1 per 100,000 in 2006. However, in 2007 the motor vehicle crash death rate (unintentional injuries only) among 15-24 year-old Alabama residents was 45.7 deaths per 100,000 youth: the third highest rate during the surveillance period (2000-2007). Thus, 2 of the 3 highest rates during the surveillance period occurred in 2006 and 2007.

Therefore, comparing 3-year periods, this rate increased (worsened) from 42.3 (809/1,912,145) per 100,000 in 2000-02 to 45.5 (876/1,926,477) per 100,000 in 2005-07: for an average annual increase of 1.45%.

Narrative:
Status:
In 2008, the estimated motor vehicle crash death rate (excluding injuries known to be intentional) among 15-24 year-old Alabama residents was 39.7 deaths per 100,000 persons in this age group.

Preventive Approaches for Motor Vehicle Crash-Related Injuries:
Various activities intended to prevent injuries due to motor vehicle crashes are discussed under NPM #10 and HSI #3B.

The Alabama Graduated Driver's License legislation, discussed under NPM #10 and referenced under HSI #3B, is especially pertinent to the 15-24 year-old age group so is recapped here. This law took effect in October 2002. Under the law as originally passed, restrictions applied to 16-year-old drivers and to 17-year-old drivers who had been licensed for less than 6 months. Restricted drivers could not have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they could not 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.

As also discussed under NPM #10, a bill to enhance Alabama's existing 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 remained intact.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	142.7	139.4	120.3	114.4	
Numerator	1336	1285	1110	1059	
Denominator	936034	922002	922825	925961	
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	

Notes - 2009

Due to time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. (As explained in the year 2008 note for this indicator, numerators for this indicator are derived by multiplying a factor times the corresponding number of deaths.) Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008

Data Issues:

All estimates are for calendar years.

For 2000-2002 combined, Kentucky reported 3,104 numerator events for Health Status Indicator (HSI) #4A and 302 numerator events for HSI #3A. Dividing the former by the latter yields the factor 10.27815. With 1 exception, multiplying this factor times Alabama's respective numerators for HSI #3A (fatal injuries) for 2004 through 2007 yielded the numerators shown on Form 20 for HSI #4A, which are very rough estimates. (The exception is year 2005, for which the numerator should be 1,346.) For the underlying rationale for this method of estimating numerators, see form-level note entitled "Health Status Indicators (HSIs) #4A, #4B, and #4C."

Because the numerators for this indicator are derived as above, rather than computed from a database of nonfatal injuries, we do not analyze trends in this indicator.

Data issues concerning denominators for this indicator are discusse in the Form 20 year 2009 field note for HSI #3A.

Notes - 2007

Data Issues:

The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

Numerators for this indicator were derived as described in the year 2008 Form 20 field note for this indicator.

The U.S. Census Bureau's population estimates for 0-14 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable

to population estimates. Using population estimates as denominators, the roughly estimated rate per 100,000 of all nonfatal injuries among children aged 14 years and younger was 133.2 (1,223/918,475) in 2004 and 146.8 (1,346/916,861) in 2005.

Narrative:
Utilization:
Alabama does not have a database, such as a hospital inpatient database, for counting the numerator events for this indicator. Therefore, the numerator is estimated as described in the Form 20 note about HSIs #4A, #4B, and #4C and in the FY 2008 Form 20 field note for HSI #4A. Other than meeting federal reporting requirements, the only purpose served by the reported estimate for this indicator is to provide a rough, conjectural estimate of the number of Alabama residents aged 14 years and younger who sustained a nonfatal, unintentional injury during each of the years shown.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	28.3	27.8	16.0	20.2	
Numerator	265	256	148	187	
Denominator	936034	922002	922825	925961	
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	

Notes - 2009
Due to the time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. (As explained in the year 2008 note for this indicator, numerators for this indicator are derived by multiplying a factor times the corresponding number of deaths.) Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years.

For 2000-2002 combined, Kentucky reported 543 numerator events for Health Status Indicator (HSI) #4B and 125 numerator events for HSI #3B. Dividing the former by the latter yields the factor 4.34400. Multiplying this factor times Alabama's respective numerators for HSI #3B (fatal motor vehicle crash injuries) for 2004 through 2008 yielded the numerators shown on Form 20 for HSI #4B, which are very rough estimates. For the underlying rationale for this method of estimating numerators, see form-level note entitled "Health Status Indicators (HSIs) #4A, #4B, and #4C."

Because the numerators for this indicator are derived as above, rather than computed from a database of nonfatal injuries, we do not analyze trends in this indicator.

Data issues concerning denominators for this indicator are discussed in the Form 20 year 2009 field note for HSI #3A.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

Numerators for this indicator were derived as described in the year 2008 Form 20 field note for this indicator.

The U.S. Census Bureau's population estimates for 0-14 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable to population estimates. Using population estimates as denominators, the roughly estimated rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger was 29.3 (269/918,475) in 2004 and 28.9 (265/916,861) in 2005.

Narrative:
Utilization:
Alabama does not have a database, such as a hospital inpatient database, for counting the numerator events for this indicator. Therefore, the numerator is estimated as described in the Form 20 note about HSIs #4A, #4B, and #4C and in the FY 2008 Form 20 field note for HSI #4B. Other than meeting federal reporting requirements, the only purpose served by the reported estimate for this indicator is to provide a rough, conjectural estimate of the number of Alabama residents aged 14 years and younger who sustained a nonfatal, unintentional injury due to a motor vehicle crash during each of the years shown.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	176.4	207.0	200.1	170.9	
Numerator	1170	1329	1290	1105	
Denominator	663113	641922	644621	646734	
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	

Notes - 2009

Due to the time required to receive and edit vital events data, final year 2009 death files are not yet available for Alabama. (As explained in the year 2008 note for this indicator, numerators for this indicator are derived by multiplying a factor times the corresponding number of deaths.) Our experience has shown that the provisional files available at this time sometimes provide misleading results. If the final files are available by August 2010, staffing resources permit us to analyze the files, and the Title V Information System (TVIS) can be accessed in September 2010, we will provide the year 2009 estimate in September 2010. Otherwise, the estimate will be provided by July 2011.

Notes - 2008
Data Issues:
All estimates are for calendar years.

For 2000-2002 combined, Kentucky reported 2,748 numerator events for Health Status Indicator (HSI) #4C and 639 numerator events for HSI #3C. Dividing the former by the latter yields the factor 4.30047. Multiplying this factor times Alabama's respective numerators for HSI #3C (fatal injuries sustained in motor vehicle crashes) for 2004 through 2008 yielded the numerators shown on Form 20 for HSI #4C, which are very rough estimates. For the underlying rationale for this method of estimating numerators, see form-level note entitled "Health Status Indicators (HSIs) #4A, #4B, and #4C."

Because the numerators for this indicator are derived as above, rather than computed from a database of nonfatal injuries, we do not analyze trends in this indicator.

Data issues concerning denominators for this indicator are discussed in the Form 20 year 2009 field note for HSI #3A.

Notes - 2007
Data Issues:
The following information pertains to the Maternal and Child Health Services Block Grant Fiscal Year 2007 Report/Fiscal Year 2009 Application and numbers available as of September 2008.

Numerators for this indicator were derived as described in the year 2008 Form 20 field note for this indicator.

The U.S. Census Bureau's population estimates for 15-24 year-old Alabama residents are used as denominators for 2006 onward. Because population projections become unreliable a few years out from census years, we are now using population estimates as denominators. The 2006 and 2007 rates shown on Form 20 for this indicator are based on the population estimates for those years. However, the web-based TVIS does not allow us to directly change estimates for 2004 and 2005, so the numbers shown on Form 20 for those years use population projections provided by Alabama's Center for Business and Economic Research. These projections are not comparable to population estimates. Using population estimates as denominators, the roughly estimated rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15-24 years was 204.4 (1,307/639,328) in 2004 and 183.0 (1,170/639,423) in 2005.

Narrative:
Utilization:
Alabama does not have a database, such as a hospital inpatient database, for counting the numerator events for this indicator. Therefore, the numerator is estimated as described in the Form 20 note about HSIs #4A, #4B, and #4C and in the FY 2008 Form 20 field note for HSI #4C. Other than meeting federal reporting requirements, the only purpose served by the reported estimate for this indicator is to provide a rough, conjectural estimate of the number of 15-24 year-old Alabama residents who sustained a nonfatal, unintentional injury due to a motor vehicle crash during each of the years shown.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	38.1	51.7	46.7	46.8	46.7
Numerator	6231	8229	7501	7559	7550
Denominator	163488	159300	160549	161617	161617
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

Notes - 2009

Data Issues:

All estimates are for calendar years. The numerators represent cases rather than unduplicated patient counts.

Because population projections become unreliable a few years out from census years, we are now using updated population estimates as denominators when analyzing trends. However, the web-based Title V Information System does not allow us to directly change the population estimate for 2005 (which is a population projection) or 2006 (which is from an earlier U.S. Census population estimate file). Using the updated population estimates for those years does not change the rates, however. That is, using the updated denominators for 2005 and 2006, the estimated chlamydia case rate per 1,000 among 15-19 year-old Alabama females was 39.7 (6,231/156,839) in 2005 and 51.7 (8,229/159,182) in 2006. (Updated population estimates were derived from a U.S. Census Bureau spreadsheet, "SC-EST2008-alldata6-AL-ID," which includes 6 race groups.)

Because we do not have a population estimate for 2009 for 15-19 year-old Alabama females, we are using the estimate for 2008 as our best estimate for 2009.

Trends:

Ascertainment bias, discussed in the narrative, may partially account for the reported increase in 2006. From 2007 onward the rate has remained stable, at 47 cases per 1,000 females in this age group.

Notes - 2008

Trends:

The surveillance period for this discussion of trends is 2003-2008. From a baseline of 34.1 cases per 1,000 in 2003, the reported chlamydia case rate among 15-19 year-old Alabama females increased 3 years in a row, peaking at 51.7 cases per 1,000 in 2006. The rate then declined to 46.7 cases per 1,000 in 2007 and remained at about the same level in 2008. As discussed in the narrative, the reported increase in 2006 may be partly due to ascertainment bias.

Narrative:

Status:
In 2009, the reported chlamydia case rate among 15-19 year-old Alabama females was 46.7 cases per 1,000 females in this age group.

Potential for Ascertainment Bias:
According to a report published by CDC in 2007, at the national level, the increase in reported cases of chlamydia during the preceding 10 years reflected expansion of chlamydia screening activities, use of increasingly sensitive diagnostic tests, increased emphasis on case reporting from providers and laboratories, improvements in reporting systems, and, possibly, a true increase in occurrence of chlamydial infections. Many at-risk women were still not being tested, however, partly due to lack of awareness among some health care providers and to limited resources to support screening (reference #11). According to the authors, chlamydia screening and reporting in the U.S. were likely to continue to expand in response to the HEDIS annual measure concerning chlamydia screening coverage of sexually active women 16-25 years of age who receive medical care through commercial or Medicaid-managed care organizations (reference #11).

In Alabama, at least part of the increase in HSI #5A in 2006 may have been due to more frequent testing. In the fall of 2005, the State lab acquired the technology to utilize urine-based testing for chlamydia and gonorrhea, and the testing has been implemented in all CHDs. Using the amplified urine-based test dramatically increased the number of individuals tested, especially among males. Persons attending CHD Family Planning and STD clinics are now routinely screened for gonorrhea and chlamydia, and testing is more readily available at off-site locations (such as college campuses, jails, health fairs, etc.). The higher sensitivity of the test, relative to the previously used test, has also resulted in the diagnosis of more infections.

Preventive Approaches for Chlamydia:
ADPH's Division of STD Prevention, located in the Bureau of Communicable Disease, is charged with identifying populations at increased risk for STDs: in order to reduce their chances of developing an STD, transmitting an STD, and/or developing STD-related complications. Statewide disease intervention staff from this division provide STD-related screening, diagnostic, educational, treatment, partner-notification, and referral services in all of the State's counties. The Division of STD Prevention's web page provides a variety of information or links: including the National STD Hotline phone number, a brief discussion of chlamydia, a link to a list of each CHD with information for contacting each CHD, and a link to the report, "Alabama's Sexually Transmitted Diseases and HIV/AIDS 2008 Epidemiology," produced in December 2009.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	12.9	16.9	14.2	13.4	13.3
Numerator	10359	13211	11131	10486	10365
Denominator	803448	783556	781772	780095	780095
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

Notes - 2009
Data Issues:
All estimates are for calendar years. The numerators represent cases rather than unduplicated patient counts.

Because population projections become unreliable a few years out from census years, we are now using updated population estimates as denominators when analyzing trends. However, the web-based Title V Information System does not allow us to directly change the population estimate for 2005 (which is a population projection) or 2006 (which is from an earlier U.S. Census population estimate file). Using the updated population estimates yields a different estimate for 2005 than is shown on Form 20. That is, using the updated denominators for 2005 and 2006, the estimated chlamydia case rate per 1,000 among 20-44 year-old Alabama females was 13.2 (10,359/783,614) in 2005 and 16.9 (13,211/783,469) in 2006.

Because we do not have a population estimate for 2009 for 20-44 year-old Alabama females, we are using the estimate for 2008 as our best estimate for 2009.

Trends:
Ascertainment bias, discussed in the narrative, may partly account for the reported increase in 2006. In this population, after reaching 16.9 cases per 1,000 in 2006, the chlamydia case rate declined to 14.2 per 1,000 in 2007, declined again to 13.4 per 1,000 in 2008, and then remained about the same, at 13.3 per 1,000, in 2009.

Notes - 2008
Trends:
The surveillance period for this discussion of trends is 2003-2008. From a baseline of 9.1 cases per 1,000 in 2003, the reported chlamydia case rate among 20-44 year-old Alabama females increased 3 years in a row, peaking at 16.9 cases per 1,000 in 2006. The rate then declined to 14.2 cases per 1,000 in 2007 and declined again, to 13.4 cases per 1,000 in 2008. As mentioned above and further discussed in the narrative, the reported increase in 2006 may be partly due to ascertainment bias.

Narrative:
Status:
In 2009, the reported chlamydia case rate among 20-44 year-old Alabama females was 13.3 cases per 1,000 females in this age group.

Potential for Ascertainment Bias:
As more fully discussed under HSI #5A, at the national level, the earlier increase in reported chlamydial infections reflected various improvements in reporting and, possibly, a true increase in disease.

In Alabama, at least part of the reported increase in HSI #5B in 2006 may have been due to more frequent testing. As discussed under HSI #5A, in the fall of 2005, the State lab began utilizing amplified urine-based testing for chlamydia and gonorrhea, and the testing was implemented in all CHDs. With this amplified testing, persons attending CHD Family Planning and STD clinics are now routinely screened for gonorrhea and chlamydia, and testing is more readily available at off-site locations. Using the amplified test dramatically increased the number of individuals tested, especially among males. The higher sensitivity of the test, relative to the previously used test, also resulted in the diagnosis of more infections.

Preventive Approaches for Chlamydia:
ADPH's Division of STD Prevention, located in the Bureau of Communicable Disease, is charged with identifying populations at increased risk for STDs: in order to reduce their chances of

developing an STD, transmitting an STD, and/or developing STD-related complications. Some of the services provided by this division are summarized under HSI #5A.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	62655	39473	20527	414	655	42	1544	0
Children 1 through 4	247849	164552	72703	1151	2819	133	6491	0
Children 5 through 9	306980	204587	91115	1422	3021	153	6682	0
Children 10 through 14	308477	202508	96319	1525	2915	147	5063	0
Children 15 through 19	328187	209831	109665	1922	2498	152	4119	0
Children 20 through 24	318547	206781	103123	1995	3206	125	3317	0
Children 0 through 24	1572695	1027732	493452	8429	15114	752	27216	0

Notes - 2011

Narrative:
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. 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.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	58068	4587	0
Children 1 through 4	229393	18456	0
Children 5 through 9	291279	15701	0
Children 10 through 14	297492	10985	0
Children 15 through 19	319070	9117	0
Children 20 through 24	309762	8785	0
Children 0 through 24	1505064	67631	0

Notes - 2011

Narrative:
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 petains 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.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	159	53	103	1	0	0	0	2
Women 15 through 17	2518	1305	1173	8	9	0	0	23
Women 18 through 19	5890	3382	2408	23	15	0	0	62
Women 20 through 34	49008	33120	14560	142	700	10	0	476
Women 35 or older	5732	4244	1273	13	166	0	0	36
Women of all ages	63307	42104	19517	187	890	10	0	599

Notes - 2011
For each age category in this table, Non-Hawaiian "Other Asian or Pacific Islanders" are included in the count of Asians, and race pertains to that of the mother.

For all maternal age groups, the "Other and Unknown" racial category in this table includes cases where race was not reported, as well as cases where the mother's race was coded as "Other Entries" (race categories not fitting into the 5 single-race categories specified for this health status indicator) in the computerized birth records. Alabama computerized birth files do not include a multiple-race category.

Narrative:
HSIs #7A and #7B enumerate year 2008 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. As well, we analyzed birth demographics for 3 years: 2000, 2004, and 2008. Findings from these analyses are detailed in Section 3 of the Needs Assessment Report.

Highlights from the above-referenced findings follow. As stated above, we combined some racial groups, concurrently classified births according to race and ethnicity, and combined maternal ages. Additionally, our analyses included infants whose mother's age was not reported. Therefore, the following discussion does not precisely correspond to numbers shown on Form 21.

Concurrently classifying infants by race and ethnicity, of the 64,345 infants, 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 (detailed in the Needs Assessment Report) concerning out-of-state

births, the number of births for which maternal age was unknown increased dramatically. 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: either in the total population or in any of the ethnic or racial/ethnic groups studied. For example, excluding records with unknown maternal age, the percentage of all infants whose mother was 17 years of age or younger declined from 5.7% in 2000 to 4.2% in 2008; and the percentage of all infants whose mother was 18-19 years of age declined from 10.0% in 2000 to 9.2% in 2008.

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%.

3) The number of Black, non-Latino infants declined by 3.2%.

4) 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%.

5) The number of Other, non-Latino infants increased by 69.0%: from 697 infants in 2000 to 1,178 infants in 2008.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	143	16	0
Women 15 through 17	2283	235	0
Women 18 through 19	5437	450	3
Women 20 through 34	44909	4082	17
Women 35 or older	5276	453	3
Women of all ages	58048	5236	23

Notes - 2011

Narrative:
As stated under HSI #7A, as part of the Needs Assessment, we concurrently classified infants according to race and ethnicity and combined maternal ages into 3 categories. As well, we analyzed birth demographics for 3 years: 2000, 2004, and 2008. Findings from these analyses are detailed in Section 3 of the Needs Assessment Report.

As also stated in the discussion of HSI #7A, 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. (The 5,258 infants include the 22 infants whose mother's age was unknown. These 22

infants are not included in the numbers shown on Form 21.)

2) The number of non-Latino infants declined by 3.5%.

As also stated in discussion of HSI #7A, due to a reporting problem concerning out-of-state births, the number of births for which maternal age was unknown increased dramatically. However, even when excluding records with unknown maternal age, the percentage of live-born infants whose mother was an adolescent did not increase in 2008 relative to 2000. For Latino births, when excluding records with unknown maternal age: 1) The percentage of infants whose mother was 17 years of age or younger declined from 6.7% (130/1,930) in 2000 to 4.8% (251/5,236) in 2008; 2) and the percentage of infants whose mother was 18-19 years of age declined from 9.5% (183/1,930) in 2000 to 8.6% (450/5,236) in 2008.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	612	324	279	1	4	0	0	4
Children 1 through 4	91	59	27	1	2	0	0	2
Children 5 through 9	53	34	18	0	1	0	0	0
Children 10 through 14	70	41	28	1	0	0	0	0
Children 15 through 19	260	167	90	1	2	0	0	0
Children 20 through 24	441	291	142	3	3	0	0	2
Children 0 through 24	1527	916	584	7	12	0	0	8

Notes - 2011
The following note applies to all age categories reported in Health Status Indicator #8A.

Vital events that involve Alabama residents but occur outside of the State have apparently been underreported to the Alabama Department of Public Health in recent years. This out-of-state reporting issue may cause slight underestimation of the number of deaths that occurred in 2008. The data source, the year 2008 Alabama statistical death file, does not have a multiple-race category.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

Narrative:
Our analyses of deaths have focused on trends in mortality rates in 3 age groups: 1-4, 5-14, and 15-24 years. (Trends in risk of infant death are described in the Needs Assessment Report.) For each age group, discussion pertains to the total group, White non-Latinos, and Black non-Latinos. For the 1-4 and 5-14 year-old groups, numbers of deaths were small in the statistical sense among Latinos; so, in Latinos, trends are discussed only for 15-24 year-olds. For Other non-Latinos, numbers were too small to describe trends in any of the 3 age groups. Because HSIs #8A and #8B are intertwined, the narrative for them is written as a continuous discussion, rather than 2 separate discussions.

Data Issues:
Denominators for estimating mortality rates were derived from a detailed U.S. Census Bureau spreadsheet. One data problem is uncertainty about the denominator for Latinos. Substantial undercounting of Latinos, if present, would cause overestimation of mortality rates for Latinos. Further, should the number of Latinos in the population be increasingly undercounted over time, mortality rates for Latinos would be increasingly overestimated over time.

Another data problem is apparent underreporting of deaths of Alabama residents that occurred outside of the State in recent years, which could distort trends by causing ascertainment bias. In light of this problem, we used 3 different approaches to counting deaths. The first was to count all deaths of Alabama residents in the subgroup of interest, which ignores the data problem. The second was to count occurrent events only (deaths of Alabama residents that occurred in Alabama), which removes the ascertainment bias caused by out-of-state reporting issues, but often underestimates mortality rates. The third was to adjust the number of deaths for 2006-2008, by making assumptions about the number of unreported deaths of Alabama residents that occurred outside of the State in those years. The third approach seemed preferable in most, though not all, cases.

Therefore, the findings that follow (here and under HSI #8B) use adjusted mortality rates for 2006-2008, which are based on assumptions about missing records. (In cases where the unadjusted mortality rate was notably higher than the adjusted rate, it is reported parenthetically.) The surveillance period is 2000-2008, the study population is Alabama residents, and all rates are reported as the number of deaths per 100,000 persons in the stated group.

Trends: 1-4 Year-Old Children
For the total population of 1-4 year-old Alabama children, the estimated mortality rate ranged from 30.7 per 100,000 in 2007 to 44.3 per 100,000 in 2004, with a median of 41.0 per 100,000 in 2006. Successive 3-years rates were as follows: 41.7 per 100,000 in 2000-02, 40.1 per 100,000 in 2003-05, and 36.0 per 100,000 in 2006-08. The rate for 2006-08 was 13.8% lower than in 2000-02 and 10.3% lower than in 2003-05. In both White non-Latinos and Black non-Latinos, the rate declined to some degree.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	565	47	0
Children 1 through 4	84	6	1
Children 5 through 9	53	0	0

Children 10 through 14	70	0	0
Children 15 through 19	254	6	0
Children 20 through 24	411	30	0
Children 0 through 24	1437	89	1

Notes - 2011
The following note applies to all age categories reported in Health Status Indicator #8B.

Vital events that involve Alabama residents but occur outside of the State have apparently been underreported to the Alabama Department of Public Health in recent years. This out-of-state reporting issue may cause slight underestimation of the number of deaths that occurred in 2008. The data source, the year 2008 Alabama statistical death file, does not have a multiple-race category.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

See note to this indicator's "Infants 0 to 1" row.

Narrative:
The following continues the discussion that began under HSI #8A.

Trends: 5-14 Year-Old Children and Youth
For the total population of 5-14 year-old Alabama children and youth, the estimated mortality rate ranged from 20.4 deaths per 100,000 in 2007 to 25.3 deaths per 100,000 in 2001, with a median of 20.8 deaths per 100,000 in 2008. Beginning with 2002, single-year rates declined each year through 2005 in this population. Successive 3-years rates in this population were as follows: 23.6 deaths per 100,000 in 2000-02, 20.9 deaths per 100,000 in 2003-05, and 20.6 deaths per 100,000 in 2006-08. The rate for 2006-08 was 12.8% lower than in 2000-02 and 1.4% lower than in 2003-05. In White non-Latinos, the rate declined at least slightly, whether comparing 2006-08 to 2000-02 or to 2003-05. In Black non-Latinos, the rate in 2006-08 was somewhat below what it had been in 2000-02 and about the same as it had been in 2003-05.

Trends: 15-24 Year-Old Youth
For the total population of 15-24 year-old Alabama youth, the estimated mortality rate ranged from 108.5 deaths per 100,000 in 2003 to 129.0 deaths per 100,000 in 2006 and 2007, with a median of 112.3 deaths per 100,000 in 2005. In no case did the rate change in the same direction 3 or more years in a row. Successive 3-year rates were as follows: 111.4 deaths per 100,000 in 2000-02, 114.4 deaths per 100,000 in 2003-05, and 122.8 deaths per 100,000 in 2006-08. The rate for 2006-08 was 10.3% higher than in 2000-02 and 7.4% higher than in 2003-05. For White non-Latinos and Latinos, the mortality rate was higher in 2006-08 than it had been in either 2000-02 or 2003-05. On the other hand, the rate for Black non-Latinos remained about the same in successive 3-year periods.

Race- and Ethnicity-Specific Mortality Rates: 2006-08

The following pertains to the adjusted mortality rate (number of deaths per 100,000 population in the group of interest) among Alabama residents in 2006-08:
1) Among 1-4 year-old Alabama children, the mortality rate was 51.2 per 100,000 among Black non-Latinos and 30.7 per 100,000 among White non-Latinos.

2) Among 5-14 year-old children and youth, the mortality rate was 24.7 deaths per 100,000 among Black non-Latinos and 19.5 per 100,000 among White non-Latinos.

3) Among 15-24 year-old youth, the mortality rate was 213.7 deaths per 100,000 among Latinos (219.5 per 100,000 if unadjusted), 123.6 per 100,000 among Black non-Latinos, 121.9 per 100,000 among White non-Latinos, and 32.8 per 100,000 (16/48,803) among Other non-Latinos (34.8 per 100,000 if unadjusted). Thus, the estimated rate for Latinos was much higher than that for other subgroups. We have no database for assessing the degree to which undercounting of the Latino population may have accounted for the higher rate in this group relative to the other groups.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1254148	820951	390329	6434	11908	627	23899	0	2008
Percent in household headed by single parent	29.6	17.9	56.8	26.0	13.9	32.1	32.7	23.8	2005
Percent in TANF (Grant) families	3.0	1.4	6.3	9.2	0.4	1.9	0.0	0.0	2009
Number enrolled in Medicaid	540846	269154	251804	1787	3535	0	0	14566	2009
Number enrolled in SCHIP	72206	44838	24650	606	852	29	0	1231	2009
Number living in foster home care	5791	2888	2795	16	9	8	0	75	2008
Number enrolled in food stamp program	370702	155718	196859	12524	977	154	0	4470	2009
Number enrolled in WIC	162476	86614	69057	973	897	468	4467	0	2008
Rate (per 100,000) of juvenile crime arrests	5266.0	4270.0	7258.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through	1.5	1.4	1.7	1.2	0.7	0.0	0.0	1.6	2009

12)									

Notes - 2011
All Children 0 Through 19 by Race:
Numbers shown are population estimates for calendar year 2008 and are derived from a U.S. Census Bureau spreadsheet, "SC-EST2008-alldata6," which provides estimates for the year 2008 to Census population estimates for the year 2000. The spreadsheet reports 5 race groups and 1 group of persons who were of 2 or more races. The spreadsheet was downloaded from the U.S. Census Bureau web site in December 2009.

Percent in Household Headed by Single Parent by Race:
The data for the percent in household headed by single parent do not change annually as this information is only available during census years.

The estimates for this item were provided by the Center for Business and Economic Research and are based on Census Bureau data for 2000. The Title V Information System selection box for "Specific Reporting Year" does not provide "2000" as an option.

Numbers shown are for the 0-17 year group, since data are available only for this group.

Percent in TANF by Race:
Numbers for this item were derived from numbers provided by the Alabama Department of Human Resources (DHR),

As of December 31, 2009, a total of 37,516 children and youth (0-19 years of age) lived in households that received Family Assistance (TANF) in Alabama. The total number of families receiving TANF was 22,109.

The race-specific numbers of children and youth living in households receiving TANF were not provided by DHR, but the race-specific numbers of TANF households were provided. Therefore, the race-specific numbers of children and youth living in households receiving TANF were derived as follows: the total number of children and youth in TANF households (37,516) divided by the total number of households receiving TANF (22,109). The factor yielded by this method was 1.69687. For example, 6,552 White households received TANF. Multiplying 6,552 by the unrounded factor yielded 11,118, which is our estimate for the number of White children and youth living in TANF households. Using 11,118 White children and youth as the numerator and 820,951 White children and youth (from the "All children 0 through 19 row") as the denominator yields the estimate that 1.4% of White children and youth were in households receiving TANF.

The above method assumes that the ratio of the number of children and youth living in TANF households to the number of households receiving TANF is identical (1.69687) in all racial categories. We do not have the data to test the correctness of this assumption.

There were 539 Hispanic households and 75 Other households whose racial composition are unknown. As there is no denominator for the racial category of "Other and Unknown", a percentage of these individuals (an estimated numerator of 1,042) is not included.

Number Enrolled in Medicaid by Race:
Numbers for this item were provided by the Alabama Medicaid Agency and compiled from 2 special-run reports: "Alabama Medicaid FY 2009: Eligibles Less than 1 Year of Age by Race" and "Alabama Medicaid FY 2009: Eligibles Age 1 to 19 by Race".

The Medicaid reports did not include the race categories of "Native Hawaiian or Other Pacific Islander", or "More than 1 Race", so we do not know how many Medicaid-enrolled children and youth were in these racial categories.

The Medicaid reports did not classify Hispanic individuals by race; accordingly, Hispanic individuals were assumed to be White when deriving numbers by race from these reports.

Number Enrolled in SCHIP by Race:
Numbers for this item were provided by the Alabama State Children's Health Insurance Program (CHIP) and reflect enrollment in ALL Kids for December 31, 2009.

The CHIP report did not classify Hispanic individuals by race; accordingly, Hispanic individuals were assumed to be White when deriving numbers by race from this report.

CHIP enrollment is limited to eligible persons aged 18 years and younger.

Number Enrolled in Food Stamp Program by Race:
Numbers for this item were provided by DHR. Numbers provided by DHR reported here cover only 64 of Alabama's 67 counties, because the remaining counties do not participate in DHR's data system. The numbers enrolled in the Food Stamp Program as of December 31, 2009 are reported here. All numbers pertain to food stamp recipients on this date in the 64 counties for which data were available.

The report provided by DHR shows the total number of food stamp recipients according to several age categories, including 0-11 years, 12-15 years, 16-17 years, 18-20 years, and 5 categories of older age groups. The number of 18-19 year-old recipients was estimated by multipying 2/3 times the number reported for the 18-20 year-old group.

In the 64 counties, as of December 31, 2009, a total of 746,410 individuals (regardless of age) were receiving food stamps. Of these individuals, 370,704 were 0-19 years of age. Age of food stamp recipients was not reported according to race. To estimate the number of 0-19 year-old food stamp recipients who were 19 years of age or younger (370,704/746,410, or .49665) times each race-specifc number of food stamp recipients. This method assumes an identical age distribution across racial categories of food stamp recipients, and we do not have data to test the correctness of this assumption.

Number Enrolled in WIC by Race:
Numbers reported here are provided by ADPH's Bureau of Information Technology and represent an unduplicated count of WIC enrollees. Race and ethnicity are self-reported by WIC recipients. These numbers represent WIC enrollment through December 31, 2008.

Rate of Juvenile Crime Arrests by Race:
Numerators were derived from the Alabama Criminal Justice Information Center's (CJIC's) web site and represent arrests in Alabama in 2008. The aforesaid web site reports "Part I" and "Part II" arrests for all ages combined and for multiple age groups. Part I crimes pertain to more serious criminal acts, and Part II crimes to less serious offenses. Three age groups (under 18 years, 18 years, and 19 years) were summed to calculate Part I and Part II arrests for persons aged 19 years or younger. The numbers of Part I and Part II arrests in this age group were then summed to calculate the total number of arrests of persons aged 19 years or younger (32,561 arrests). Presumably, virtually all arrests in this age group involved youth whose ages were from 10 through 19 years.

CJIC's web site did not report arrests according to age and race concurrently. However, it said that: Of persons arrested for Part I offenses, 49% were White and 51% were Black; and of persons arrested for Part II offenses, 56% were White and 44% were Black. To estimate the numbers of arrests of White youth and of Black youth in the 0-19 year age group, the proportion corresponding to each of the aforesaid percentages was applied to the corresponding total number of Part I and Part II arrests of 0-19 year-old persons. For example, to estimate the number of arrests of White persons aged 0-19 years in Alabama in 2007: 0.49 was multiplied by

the number of Part I arrests in this age group, 0.56 was multiplied by the number of Part II arrests in this age group, and the 2 resulting products were summed. A corresponding procedure using factors of 0.51 (for Part I arrests) and 0.44 (for Part II arrests) was followed to estimate the number of arrests of Black 0-19 year-old youth.

While numerators were estimated as described above, denominators are population estimates for calendar year 2008 and are derived from a U.S. Census Bureau spreadsheet as described in the note to "All children 0 through 19".

As previously stated, CJIC's web site did not report arrests for juveniles according to race, which necessitated estimating race-specific numbers for White youth and for Black youth. These race-specific estimates assume that the racial distribution for arrests of youth was the same as that for arrests of all ages combined, and we do not have the data to test this assumption. Further, a few of the youths arrested may have been of a race other than White or Black. Because we have no data-based way of estimating the number of arrests of youths whose race was other than White or Black, zeroes have been entered into cells for these racial categories.

Percentage of High School Drop-Outs by Race:
Numbers for this item were provided by the Alabama State Department of Education (SDE).

Because the racial composition of Hispanics was unknown, the Hispanic group was added to the "Other and Unknown" category.

SDE did not report a category for "Native Hawaiian or Other Pacific Islander."

The enrollment data for 2009 were collected in December 2009 for the 2008-2009 school year. Dropout data for 2009 were collected in December 2009 for the 2008-2009 school year.

Number Enrolled in Foster Care by Race:
Due to the implementation of a new database, the Alabama Department of Human Resources (DHR) was unable to provide more recent data than what were previously reported in the 2008 Report/2010 Application.

Narrative:
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. Trends in numbers in enrolled in certain programs are discussed under HSI #9B, rather than here.

In 2009, 1.5% of Alabama public high school students dropped out of school. Concerning race, among groups with at least 1,000 children and youth living in Alabama, this indicator ranged from 0.7% for Asian students to 1.7% for Black students. (The percentages are based on information provided by SDE, so do not use the "All children 0 through 19" row as the denominator.)

In 2008, the juvenile crime rate, reported on Form 21 as the number of arrests of persons aged 19 years and younger per 100,000 10-19 year-old persons in the population of interest, was as follows: 5,266 per 100,000 for the total population of adolescents, 4,270 per 100,000 for White adolescents, and 7,258 per 100,000 for Black adolescents. Crime 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 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.

As well, foster care and receipt of public assistance are discussed in Section 3 of the Needs Assessment Report. Per the Census Bureau's 2006-2008 American Community Survey, 1.7% of 0-17 year-old Alabama residents were either a foster child or unrelated to the householder. According to the same survey, 23.8% of 0-17 year-old Alabama residents, versus 18.8% of U.S. residents in that age group, lived in households that had received public assistance (SSI, cash public assistance, or Food Stamp benefits) in the preceding 12 months.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1195302	58846	0	2008
Percent in household headed by single parent	29.6	25.7	0.0	2007
Percent in TANF (Grant) families	3.1	1.6	0.0	2009
Number enrolled in Medicaid	490377	42061	8408	2009
Number enrolled in SCHIP	69556	2560	90	2009
Number living in foster home care	5570	207	14	2008
Number enrolled in food stamp program	362632	8072	0	2009
Number enrolled in WIC	141286	21190	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	5266.0	2008
Percentage of high school drop-outs (grade 9 through 12)	1.5	1.6	1.4	2009

Notes - 2011
All Children 0 Through 19 by Ethnicity:
Numbers shown are population estimates for calendar year 2008 and are derived from a U.S. Census Bureau spreadsheet, "SC-EST2008-alldata6." The spreadsheet was downloaded from the U.S. Census Bureau web site in December 2009.

Percent in Household Headed by Single Parent by Ethnicity:
The data for the percent in household headed by a single parent do not change annually as this information is only available during censual years.

The estimates for this item were provided by the Center for Business and Economic Research and are based on Census Bureau data for 2000. The Title V Information System selection box for "Specific Reporting Year" does not provide "2000" as an option.

Numbers shown are for the 0-17 year age group, since data are available only for this group.

Percent in TANF (Grant) Families by Ethnicity:
Numbers for this item were derived from numbers provided by DHR.

As of December 31, 2009, a total of 37,516 children lived in households that received Family Assistance (TANF) in Alabama. The total number of households receiving Family Assistance was 22,109.

As stated in the corresponding field note for Health Status Indicator (HSI) #9A, the race-specific number of children and youth living in households receiving TANF was not provided by DHR. Similarly, the number of Hispanic children and youth living in households receiving TANF was not reported by DHR, but the number of Hispanic households (245) receiving TANF was provided. Using the rationale described in the corresponding field note for HSI #9A, by multiplying 1.69687 (using the unrounded decimal times the 539 Hispanic households), we estimated that 915 Hispanic children and youth were in households receiving food stamps. Using 915 Hispanic children and youth as the numerator and 58,846 Hispanic individuals (from the "All children 0 through 19" row of HSI #9B) as the denominator yields the estimate that 1.6% of Hispanic children and youth were in households receiving TANF.

A corresponding procedure was used to estimate the percentage of non-Hispanic children and youth who were in households receiving TANF.

The above method assumes that the ratio of the number of children and youth living in TANF households to the number of households receiving TANF is identical (1.69687) in both the Hispanic and non-Hispanic categories. We do not have the data to test the correctness of this assumption.

Number Enrolled in Medicaid by Ethnicity:
Numbers for this item were provided by the Alabama Medicaid Agency and compiled from 2 special-run reports: "Alabama Medicaid FY 2009: Eligibles Less than 1 Year of Age by Race" and "Alabama Medicaid FY 2009: Eligibles Age 1 to 19 by Race".

Number Enrolled in SCHIP by Ethnicity:
Numbers for this item were provided by the Alabama State Children's Health Insurance Program (CHIP) and reflect enrollment in ALL Kids for December 31, 2009.

The CHIP report did not classify Hispanic individuals by race; accordingly, Hispanic individuals were assumed to be White when deriving numbers by race from this report.

CHIP enrollment is limited to eligible persons aged 18 years and younger.

Number Enrolled in Food Stamp Program by Ethnicity:
Numbers for this item were provided by DHR. Numbers provided by DHR and reported here cover only 64 of Alabama's 67 counties, because the remaining counties do not participate in DHR's data system. The numbers enrolled in the Food Stamp Program as of December 31, 2009 are reported here. All numbers pertain to food stamp recipients on this date in the 64 counties for which data were available.

The report provided by DHR shows the total number of food stamp recipients according to several age categories, including 0-11 years, 12-15 years, 16-17 years, 18-20 years, and 5 categories of older age groups. The number of 18-19 year-old recipients was estimated by multiplying 2/3 times the number reported for the 18-20 year-old group.

In the 64 counties, as of December 31, 2009, a total of 746,410 individuals (regardless of age)

were receiving food stamps. Of these individuals, 370,704 were 0-19 years of age and 16,253 were identified as being of Hispanic/Latino ethnicity. We multiplied the proportion of all food stamp recipients who were 19 years of age or younger (370,704/746,410, or .49665) times the total number of food stamp recipients of Hispanic/Latino ethnicity. This method assumes an identical age distribution across food stamp recipients of Hispanic/Latino ethnicity, and we do not have data to test the correctness of this assumption.

Number Enrolled in WIC by Ethnicity:
Numbers reported here are provided by ADPH's Bureau of Information Technology and represent an unduplicated count of WIC enrollees. Race and ethnicity are self-reported by WIC recipients. These numbers represent WIC enrollment through December 31, 2008.

Rate of Juvenile Crime Arrests by Ethnicity:
As detailed in the Health Status Indicator (HSI) #9A field note for this indicator, numerators for the juvenile crime arrest rate were derived from the Alabama CJIC's web site. The aforesaid web site did not report crimes according to ethnicity, so we cannot report the juvenile crime arrest rate according to ethnicity. For this reason, the estimated juvenile crime rate for the total population of 0-19 year-old Alabama residents is placed in the "Ethnicity Not Reported" column. Because the Title V Information System does not allow blank cells in HSI #9A or #9B, a zero is placed in each of the 2 cells intended for reporting the juvenile crime arrest rate according to ethnicity. However, the actual juvenile crime arrest rates for the 2 groups--respectively Hispanic and non-Hispanic children and youth living in Alabama--are not known.

Percentage of High School Drop-Outs by Ethnicity:
Numbers for this item were provided by SDE.

The Enrollment data for 2009 were collected in December 2009 for the 2008-2009 school year. Dropout data for 2009 were collected in December 2009 for the 2008-2009 school year.

The source document provided by SDE apparently reported "Ethnicity" as a single variable, with each individual classified as being of a particular race, OR as being Hispanic, OR as being "Not Reported." For this reason, the percentage for persons whose race was not reported is shown in the "Ethnicity Not Reported" column. This percentage was based on small numbers, however (5/349, or 1.4%).

Number Enrolled in Foster Home Care by Ethnicity:
Due to the implementation of a new database, the DHR was unable to provide more recent data than what were previously reported in the 2008 Report/2010 Application.

Narrative:
This discussion mainly concerns enrollment in certain programs, according to ethnicity. Here, "children and youth" refers to 0-19 year-olds.

Latino Children and Youth:
Per Census Bureau estimates, the number of Latino children and youth increased by 49.4%: from 39,382 in 2004 to 58,846 in 2008. Comparison of certain indicators for Latino children and youth in recent years relative to 2004 follows:
1) The number enrolled in Medicaid increased 7.0-fold: from 5,984 in 2004 to 42,061 in 2009.

2) The number enrolled in CHIP increased 2.1-fold: from 1,231 in 2004 to 2,560 in 2009.

3) The number living in foster homes increased 2.1-fold: from 98 in 2004 to 207 in 2008.

4) The number enrolled for food stamps increased 2.9-fold: from 2,803 in 2004 to 8,072 in 2009.

In 2008, 21,190 Latino children and youth (nearly all under 5 years of age) were enrolled in WIC: an increase of 37.6% relative to 2006, when 15,401 were enrolled.

The percentage of Latino children and youth enrolled in TANF increased slightly, to 1.6% (from 1.1% in 2004 and 0.9% in 2006).

The percentage of Latino high school students who dropped out of school declined: from 36.0% in 2004 to 1.6% in 2009.

Non-Latino Children and Youth:
Comparing non-Latino children and youth in a recent year to those in earlier years:
1) The number enrolled in Medicaid increased by 1.7%: from 482,006 in 2004 to 490,377 in 2009.

2) The number enrolled in CHIP increased by 17.1%, from 59,424 in 2004 to 69,556 in 2009; but the number of CHIP enrollees was 17.3% lower in 2009 than in 2007.

3) The number living in foster homes increased by 1.3%: from 5,496 in 2004 to 5,570 in 2008.

4) The number enrolled for food stamps increased 2.1-fold: from 170,821 in 2004 to 362,632 in 2009. Further, the number enrolled in 2009 was an increase of 30.0% relative to 2007.

In 2008, 141,286 non-Latino children and youth (nearly all under 5 years of age) were enrolled in WIC: an increase of 7.4% relative to 2006, when 131,536 were enrolled, and an increase of 5.4% relative to 2007.

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.

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 1.5% in 2009.

Recap of Changes:
Relative to 2004 or 2006, enrollment in some publicly funded programs (Medicaid, CHIP, Food Stamps, and WIC) has increased for both non-Latinos and Latinos. As a percent change, the increases were greater for Latinos than non-Latinos. However, in terms of absolute numbers, the increased enrollment of non-Latinos in these programs is notable as well. For non-Latinos, recent increases in enrollment in the Food Stamp Program (comparing 2009 to 2007) and TANF (comparing 2009 to 2006) may reflect the economic downturn that is discussed in Section 3 of the Needs Assessment Report.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	905680
Living in urban areas	695300
Living in rural areas	558848
Living in frontier areas	0
Total - all children 0 through 19	1254148

Notes - 2011
According to the U.S. Office of Management and Budget, OMB Bulletin No. 09-01, in 2008, 28 Alabama counties were classified as metropolitan areas, which is the same as the corresponding

number in 2006. The number shown for metropolitan areas is the total number of 0-19 year-old Alabama residents in these 28 counties in 2008, as derived from a U.S. Census Bureau spreadsheet that shows estimated populations, by age and other demographic characteristics, for all U.S. counties. (The spreadsheet, downloaded on May 26, 2010 is entitled "cc-est2008-alldata-01.")

According to information provided by the University of Alabama's Center for Business and Economic Research (CBER) in 2007, age-specific numbers on urban and rural populations were compiled only for the decennial census. Also according to CBER, the urban share of the 0-19 year-old population of Alabama residents had been about 55.44% in 2000. Therefore, to estimate the number of 0-19 year-old Alabama residents in urban areas in 2008, we multiplied .5544 times the total number of 0-19 year-old Alabama residents in that year, as derived from a detailed U.S. Census Bureau spreadsheet (SC-EST2008-alldata6-AL-ID).

The number of 0-19 year-old Alabama children and youth living in rural areas was estimated by subtracting the number living in urban areas from the total number of 0-19 year-old Alabama residents.

Narrative:
The numbers shown for urban and rural residents assume that the urban share of Alabama residents aged 19 years and younger remained at the year 2000 level (about 55.44%) and that the remainder lived in rural areas. Methods are detailed in the Form 21 notes for this indicator.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4716000.0
Percent Below: 50% of poverty	6.1
100% of poverty	14.3
200% of poverty	35.0

Notes - 2011
The references for Health Status Indicator (HSI) #11 are online U.S. Census Bureau reports of the Current Population Survey, which is a joint effort between the Bureau of Labor Statistics and the Census Bureau. The Current Population Survey collects primarily labor force data about the civilian noninstitutionalized population, but also asks questions about military personnel who live in households with at least 1 other civilian adult (reference: U.S. Census Bureau. Source of the Data and Accuracy of the Estimates for Income, Poverty, and Health Insurance Coverage in the United States: 2007). Because the Current Population Survey is based on a sample, estimates are an approximation.

One of the reports used for HSI #11, part of the U.S. Census Bureau's Annual Social and Economic Supplement, is entitled "POV 46: Poverty Status by State: 2008." This report shows the "weighted person count" in thousands. Thus, the number shown on Form 21 for the "Total Population" in HSI #11 is an approximation. This approximation is shown there for the sake of internal consistency within the indicator. However, a more accurate estimate of the total population of Alabama residents in 2008 is 4,661,900 (reference: an online U.S. Census Bureau table, "DP-1. General Demographic Characteristics." Accessed on 8/14/2009 from the following address--http://factfinder.census.gov/.).

All tables used for Health Status Indicator 11 were retrieved from the U.S. Census Bureau's web site, http://www.census.gov/.

The previously referenced report on poverty status does not provide estimates concerning household incomes below 50% of the federal poverty level (FPL), and we are not aware of any reports showing this indicator for Alabama in 2008. However, in the U.S. in 2008, 42.8708% of persons with a household income below 100% of the FPL had a household income below 50% of the FPL (reference: derived from U.S. Census Bureau Table "POV01, Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2008").

Per the Census Bureau table providing state-level estimates on poverty ("POV46: Poverty Status by State: 2008", in 2008 about 675,000 Alabama residents had a household income below 100% of the FPL. For estimation purposes, we assume that 42.8708% of these (about 289,378 persons) had a household income below 50% of the FPL. In this way, we estimate that, in 2008, about 6.1% (289,378/4,716,000) of Alabama residents had a household income below 50% of the FPL. We do not have the information necessary for calculating a confidence interval for this very rough estimate.

In 2008, 14.3% of Alabama residents had a household income less than 100% of the FPL, with a 90% confidence interval of 12.3%-16.3%. (The confidence interval was derived from the standard error shown on the reference and the unrounded point estimate.) The reference is the U.S. Census Bureau's table, "POV46: Poverty Status by State: 2008," retrieved on 5/26/2010.

In 2008, 35.0% of Alabama residents had a household income less than 200% of the FPL, with a 90% confidence interval of 32.4%-37.6%. (The confidence interval was derived from the standard error shown on the reference and the unrounded point estimate.) The reference is the U.S. Census Bureau's table, "POV46: Poverty Status by State: 2008," retrieved on 5/26/2010.

Narrative:
Status and Data-Related Issues:
As stated in a Form 21 field note to this indicator, the references for HSI #11 are online U.S. Census Bureau reports of the Current Population Survey, which is based on a sample. Therefore, estimates are an approximation.

In 2008, over one-third (35.0%) of the State's population had household incomes below 200% of the FPL.

Employment and economic issues are discussed in Section 3 of the 2009-10 Needs Assessment Report. This discussion includes age-specific poverty levels, as reported in the 2006-2008 American Community Survey.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1118000.0
Percent Below: 50% of poverty	10.4
100% of poverty	23.7
200% of poverty	47.2

Notes - 2011
The references used for Health Status Indicator (HSI) #12 pertain to persons 0-17 years of age, rather than to persons 0-19 years of age.

The references for HSI #12 are online U.S. Census Bureau reports of the Current Population Survey, which is a joint effort between the Bureau of Labor Statistics and the Census Bureau. The Current Population Survey collects primarily labor force data about the civilian noninstitutionalized population, but also asks questions about military personnel who live in households with at least 1 other civilian adult (reference: U.S. Census Bureau. Source of the Data and Accuracy of the Estimates for Income, Poverty, and Health Insurance Coverage in the United States: 2007). Because the Current Population Survey is based on a sample, estimates are an approximation.

One of the reports used for HSI #12, part of the U.S. Census Bureau's Annual Social and Economic Supplement, is entitled "POV 46: Poverty Status by State: 2008." For HSI #12, the component of this table that petains to persons under 18 years of age is used. The table shows the "weighted person count" in thousands. Thus, the number shown on Form 21 for the "Total Population" in HSI #11 is an approximation of the number of Alabama residents aged 0-17 years.

All tables used for HSI #12 were retrieved from the U.S. Census Bureau's web site, http://www.census.gov/.

The previously referenced report on poverty status does not provide estimates concerning household incomes below 50% of the federal poverty level (FPL), and we are not aware of any reports showing this indicator for Alabama in 2008. However, in the U.S. in 2008, 44.6261% of 0-17 year-old persons with a household income below 100% of the FPL had a household income below 50% of the FPL (reference: derived from U.S. Census Bureau Table "POV01, "Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2008").

Per the Census Bureau table providing state-level estimates on poverty ("POV46: Poverty Status by State: 2008", in 2008 about 265,000 Alabama residents aged 0-17 years had a household income below 100% of the FPL. For estimation purposes, we assume that 44.6261% of these (about 118,259 persons) had a household income below 50% of the FPL. In this way, we estimate that, in 2008, about 10.6% (118,259/1,118,000) of 0-17 year-old Alabama residents had a household income below 50% of the FPL. We do not have the information necessary for calculating a confidence interval for this very rough estimate.

In 2008, 23.7% of 0-17 year-old Alabama residents had a household income less than 100% of the FPL, with a 90% confidence interval of 19.4%-28.0%. (The confidence interval was derived from the standard error shown on the reference and the unrounded point estimate.) The reference is the U.S. Census Bureau's table, "POV46: Poverty Status by State: 2008," retrieved on 5/26/2010.

In 2008, 47.2% of 0-17 year-old Alabama residents had a household income less than 200% of the FPL, with a 90% confidence interval of 42.1%-52.3%. (The confidence interval was derived from the standard error shown on the reference and the unrounded point estimate.) The reference is the U.S. Census Bureau's table, "POV46: Poverty Status by State: 2008," retrieved on 5/26/2010.

Narrative:
Status and Data-Related Issues:
As stated in a Form 21 field note to this indicator, the references for HSI #12 are online U.S. Census Bureau reports of the Current Population Survey, which is based on a sample. Therefore, estimates are an approximation. As also stated there, findings shown pertain to 0-17 year-old

Alabama residents, rather than 0-19 year-old Alabama residents.

Per the source used for the "100% of poverty row" for HSI #12, 23.7% of 0-17 year-old Alabama residents were living below 100% of the FPL in 2008. (The source for this row is the U.S. Census Bureau table, "POV46: Poverty Status by State: 2008.") Employment and economic issues are discussed in Section 3 of the 2009-10 Needs Assessment Report. Discussion there includes age-specific poverty levels according to the 2006-2008 American Community Survey. Per that survey, 22.9% of 0-17 year-old Alabama residents were living below the FPL. Thus, the 2 sources provide very similar estimates.

In 2008, nearly half (47.2%) of 0-17 year-old children and youth living in Alabama had household incomes below 200% of the FPL.

F. Other Program Activities

The following activities cut across levels of the MCH service pyramid.

Direct, Enabling, and Population-based:
This discussion pertains to the numbers shown on Form 9 for the "MCH Toll-Free" line, which counts 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 steadily 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 as needed.

CRS maintains toll-free lines as well, in operation during normal business hours, in the CRS State Office and 15 district offices. There were 18,259 calls to CRS's toll-free 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 e-mail options via the agency's public web site have contributed to the overall decline in the use of toll-free lines.

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, while the 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, with 840 (2.2%) of these children being identified with elevated blood lead levels.

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.

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 newborns.

G. Technical Assistance

ADPH
No technical assistance is requested by ADPH at this time.

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.

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 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11683733	11706599	11723121		11721312	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	31201723	29384544	32988189		27918090	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	4860537	4031708	4505688		4556370	
6. Program Income *(Line6, Form 2)*	41643312	54041011	47906361		55300816	
7. Subtotal	89389305	99163862	97123359		99496588	
8. Other Federal Funds *(Line10, Form 2)*	183383141	189767689	191882611		188934633	
9. Total *(Line11, Form 2)*	272772446	288931551	289005970		288431221	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2089939	1132827	1871707		1156616	
b. Infants < 1 year old	8215228	11057451	10348544		11055033	

c. Children 1 to 22 years old	37936803	53381506	47359209		53369834	
d. Children with Special Healthcare Needs	38534412	32098231	36256204		32416244	
e. Others	0	0	0		0	
f. Administration	2612923	1493847	1287695		1498861	
g. SUBTOTAL	89389305	99163862	97123359		99496588	
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	118896		67930		127127	
c. CISS	0		0		142115	
d. Abstinence Education	1064661		943608		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	130602103		137395102		131565690	
h. AIDS	3115232		6300199		4616188	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
Hemophilia of GA	0		0		28700	
Immunizations	48453549		47147072		52454813	
Hemophilia of Ga.	0		28700		0	
Hemophilia of GA.	28700		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	52607223	53621951	50719210		53761100	
II. Enabling Services	9730205	18991434	17585361		19054683	
III. Population-Based Services	13551012	12767072	14385544		12785357	
IV. Infrastructure Building Services	13500865	13783405	14433244		13895448	
V. Federal-State Title V Block Grant Partnership Total	89389305	99163862	97123359		99496588	

A. Expenditures

V. Budget Narrative
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 exist Mobile and Cullman County.

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 Heath 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 Heath 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 is 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 by16.7% 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 affects of this adjustment should narrow the differences in budgeted vs. actual for 2010.

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.

B. Budget

V. Budget Narrative
B. Budget

ADPH 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 maystill 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 FY2010 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.

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.

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.

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.

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.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

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.