



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

**State Narrative for
Alaska**

**Application for 2009
Annual Report for 2007**



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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

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The Commissioner of the Department of Health and Social Services signs the Title V application with the required Assurances and Certifications attached for reference. This information is also kept on file in the Division of Public Health, 4701 Business Park Blvd. Building J Suite 20, Anchorage, Alaska 99503-7123.

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; expires May 31, 2009.

E. Public Input

The Section of Women's, Children's and Family Health (WCFH) held two stakeholders meetings on June 5th, 2007 to review the Title V MCH Block Grant application process and solicit input related to performance measures and activities. They invited members of the focus groups used during the needs assessment process of 2005, managers of key partner programs within and outside of Alaska Division of Public Health, and parents, as well as other key stakeholders. Facilities and programs that were represented include: hospitals, federally qualified health centers, infant learning, nursing education, insurance, injury prevention, chronic disease prevention, Alaska March of Dimes, Alaska Native health, private medical practice, child protection, oral health, Governor's Council on Disabilities and Special Education, and local nonprofits that address children with special needs.

Recommendations from the groups generally served to reaffirm our current activities and plans for FY2008, as well as introducing some valuable new ideas. Feedback from attendees related to the process was overwhelmingly positive with many expressing appreciation, not only for a chance to give their input, but to learn about the MCH Block Grant itself. The facilitator submitted a report summarizing recommendations. These will be incorporated into the performance measure narratives and tables of activities.

/2009/ In April 2008 we convened the first Perinatal Advisory Committee for a half-day meeting in Anchorage. Most of the major birthing facilities, as well as Medicaid, Blue Cross, consumers and the March of the Dimes, were represented. One of the goals was to set the stage for a mutually beneficial ongoing relationship with relevant data and standards of practice as the backdrop for our efforts, as well as to review the progress made on the related performance measures and gather input on challenges, opportunities and ways to collaborate to improve performance.

Priority issues identified by the attendees included the desire to work on smoking and alcohol cessation prior to pregnancy, postpartum depression early recognition and

treatment, preconception care and improving the system for timely enrollment in the SCHIP program for pregnant women.

In addition, performance measures were discussed at the related advisory committees for newborn hearing screening, newborn metabolic screening, adolescents, and oral health. These four committees meet regularly to discuss data outcomes and provide input to program designs and interventions. In addition, feedback is solicited from physicians at the annual presentations at the Anchorage and Fairbanks Pediatric/Perinatal Grand Rounds, All Alaska Pediatric Partnership committee meetings, and specific community visits. All of these activities contribute to the ongoing work of updating our needs assessment and performance priorities

A public notice informing the general public that Alaska's Title V MCH Block Grant application is available for review was posted on the state's on-line public health notice system on July 3, 2008. In addition, members of the stakeholders groups were notified of the applications' availability for review. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

A meeting was held on June 5, 2007 for Title V MCH Block Grant stakeholders, sponsored by the Department of Health and Social Services, Division of Public Health, Section of Women's Children's and Family Health (WCFH). The purpose of the meeting was threefold:

- o to review the state's progress on national and state performance measures
- o to either reconfirm or suggest different state priorities from those developed during the initial Needs Assessment
- o to develop ideas for new activities and partnerships

Invited stakeholders represented public and private health care institutions that serve women and children. A list of the agencies is included.

The meeting was organized in two sessions. The morning session focused on perinatal and women's health issues and the afternoon session focused on children and children with special health care needs. For both sessions, Stephanie Birch, Title V Director and WCFH Section Chief, gave an overview of the Title V program and planning process. WCFH staff then presented trend data, past year's activities and current year's activities for each of the national and state performance measures highlighted during the session. (See Slides 1 and 2 in the attachment).

The attendees were divided into small discussion groups and given an assigned set of performance measures to discuss with respect to the following questions:

- ? Which performance measures do you see as the highest priorities? (Pick top 3)
- ? Are the FY 07 & 08 activities appropriate? What others should be included?
- ? What other partners might help achieve the MCH performance measures? Think in terms of both leveraging resources and non-traditional partners.

Each subgroup presented a synopsis of their discussion and suggestions to the entire group. The following national and state performance measures were chosen as a top priority by the group that took it under consideration:

- o National Performance Measures # 2, 4, 5, 8, 10, 13, 15, 16, 17, 18
- o State Performance Measures # 1, 4, 5

Ideas for new activities and partnerships developed within the subgroups were shared with the overall group.

A draft summary of the meeting is attached.

//2009// The WCFH Perinatal Advisory Committee was established and convened for the first time in April 2008. Attending were 32 health care providers from across Alaska, representing a variety of geographic areas, types of facilities, and health care professions. The purpose of the committee is the establishment a network for communication between parties about important perinatal issues, including priorities, concerns, best practices, data, and other research, the overarching goal being to improve perinatal outcomes. All of the performance measures and current data related to perinatal health were reviewed and

discussed. Priority areas were identified for the year based on the data and the status of outcomes. Plans for the Perinatal Advisory Committee are to meet 3 times a year. The most frequent input was participants wanting to learn more about CenteringPregnancy and CenteringParenting as means to provided focused education in an manner of presentation that has evidence of effectiveness. A presentation will be arranged for our next meeting in September, with the hope of garnering adequate interest and commitment to hold a 3-day workshop to implement a number of Centering programs in Alaska. A draft of the summary is attached.

In addition, advisory committees for adolescent health, family planning, newborn hearing screening, newborn metabolic screening and children with neurodevelopmental disabilities also reviewed the related performance measures to assure program activities aligned with performance targets. Additional work will be done in collaboration with the Section of Chronic Disease in the areas of smoking cessation, nutrition, obesity and school health in the coming fiscal year. //2009//

An attachment is included in this section.

III. State Overview

A. Overview

Alaska's health care system differs from most other states in that there are virtually no local health departments that function under the umbrella agency of the state health department. Two communities have locally organized health departments -- Anchorage and the North Slope Borough. In addition to these two local health departments, the entities operating in Alaska to deliver health care services include: the Department of Health and Social Services; private physicians and other health care providers; private hospitals; federally funded hospitals (military and Native); non-profit federally funded community health centers; and Native health corporations. Coordination of service delivery and systems development is an ongoing effort within the state among these entities.

In March 2003, the Department of Health and Social Services (DHSS) underwent a major reorganization that resulted in internal consolidations, name and function changes for four divisions, and the transfer of partner programs into the DHSS from other state departments. In part, the reorganization restructured the way Alaska uses Medicaid funding for programs and maximizes federal funding for state services.

The reorganization meant significant changes for MCH programs. In July 2003, the Section of Maternal, Child and Family Health (MCFH) within the Division of Public Health, the agency that administered Title V funds, was dissolved and specific programs and services within MCFH were reassigned to new or existing Divisions within DHSS. Programs formerly consolidated under MCFH that were moved to new or different divisions were: Adolescent Health (coordinator position eliminated); Children's Initiatives/Special Projects; Healthy Families Alaska; Infant Learning/Early Intervention Program; WIC/Nutrition Programs; Community and Family Nutrition; Breast and Cervical Cancer Screening; Oral Health; EPSDT; Family Planning; Genetic Screening; Newborn Metabolic Screening; Newborn Hearing Screening; Specialty Clinics; Women's Comprehensive Health Care Initiative; Denali KidCare Outreach (outreach positions eliminated in 2003); Children's Behavioral Health (coordinator position eliminated in 2003); MCH-Epi; and the Family Violence and Prevention Project. The Division of Health Care Services (formerly the Division of Medical Assistance) became the agency to administer Title V funds.

The appointment of a new Director of Public Health in June 2004, Dr. Richard Mandsager, has helped to revitalize the focus of public health and to look for opportunities to utilize the principles of quality improvement in shaping the role of public health. Dr. Mandsager had been an active participant in a variety of MCH projects and committees prior to his appointment. One of his goals in joining the administration was to reformulate an MCH section and evaluate what made the most sense in terms of transferring programs back to the Division of Public Health. The Section of Women's, Children's, and Family Health (WCFH) was created and a new section chief (Title V/CSHCN Director) was appointed.

As of July 1, 2005, some MCH programs administered by the Division of Health Care Services were transferred to the new WCFH section including Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults, Family Planning, and the Breast and Cervical Cancer program. Also transferred to WCFH were the Abstinence Grant administration from the Office of Children's Services and the MCH Epidemiology program from the Section of Epidemiology.

Former MCH programs that remain outside the Division of Public Health, despite a request to the Department's Commissioner, include WIC, Early Intervention/Infant Learning program, Healthy Families Intensive Home Visitation program, Community Nutrition and the 5-A-Day program and the Early Comprehensive Care Systems grant. These continue to be located in the Office of Children's Services. A close working relationship has been maintained between the Title V/CSHCN Director and the managers of the Early Intervention grant and the ECCS grant.

Since October of 2004, the Section Chief of Women's, Children's and Family Health (WCFH) and Title V/CSHCN Director has had a dual reporting relationship between the Division of Health Care Services and the Division of Public Health. In July 2005, the reporting relationship changed to the Division of Public Health. However, the Title V/CSHCN Director continues to work closely with the Division of Health Care Services. This enables her to offer public health policy considerations and information regarding potential outcomes when Medicaid policy was being considered. In addition, she has continued to work on regulation changes for current and new Medicaid programs including home health (regulations affecting payment methodology and streamlining processes for pregnant women and children to be considered eligible for home health care services); school based services including PT, OT, speech and language and audiology services for Medicaid eligible children; Durable Medical Equipment regulations including audiology equipment of deaf and hard of hearing children and newborn/infants with Cleft Lip/Palate disorders; and travel policies affecting CSHCN. As she is the only master's prepared nurse (with experience in perinatal, neonatal and pediatric nursing) in Medicaid, her expertise regarding clinical issues is requested on a regular basis. Finally, she is leading a special quality improvement project in collaboration with her colleagues in Medicaid and the Medicaid waiver program to improve the discharge planning and placement process for medically fragile children discharged from the state's only Level III and tribal Level II NICUs, both of which are located in Anchorage. In summary, the work conducted in collaboration with Medicaid has provided a new pathway to working toward resolving health access issues, racial disparities, and improved an understanding of tribal health delivery and its relationship to the federal Medicaid system of payment.

//2008// In October, 2006, Dr. Jay Butler M.D. was appointed as the director of public health, following the departure of Dr. Richard Mandsager. Dr. Butler was previously the Deputy Director of Science and Epidemiology. Prior to working for the AK DHSS, Dr. Butler was a CDC epidemiologist assigned to the Alaska CDC for several years and as part of his assignment had joined the Division of Public Health. His background is rich in pediatrics, internal medicine, and epidemiology and he has brought a wealth of experience in pandemic flu preparation and arctic investigations.

Attempts to move Women, Infant and Child Nutrition from the Office of Children's Services (child protection) were not supported by the Assistant Commissioner of Finance and the program was instead moved to the Division of Public Assistance to assist with outreach and the banking/voucher processes. Other proposed changes to pull back on former MCH programs will be discussed later in the document //2008//.

/2009/ In August of 2007, Beverly Wooley was named Director of Public Health. Ms. Wooley previously held the positions of Anchorage's Director of Health and Human Services and Manager of the Division of Community Services in Anchorage where she managed the WIC program, maternal-child health, immunizations and several other public health programs. Beverly got her start in public health as a registered dietician in the WIC program located in the states northernmost village, Barrow, Alaska. Dr. Jay Butler was named to a deputy commissioner level as Chief Medical Officer. The Division of Public Health reports directly to him. In May, 2008, Bill Hogan was named Acting Commissioner of the Alaska Department of Health and Social Services, following the resignation of Karleen Jackson. //2009//

Principle Characteristics of the State of Alaska

Two defining characteristics of the state are physical geography and the racial diversity of the population. Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state.

Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes two weeks before their due date. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

The 2004 population estimate is 681,507 of which 69.3% is reported as Caucasian only. The largest racial minority is composed of Alaska Native/American Indian (alone or mixed race), comprising 18.5% of the population. Other significant ethnic groups (reported alone or in combination) are Asian, 5.2%, African American, 4.2%, Pacific Islander, 0.8%, and Hispanic/Latino 3.8%.

Of the people who dwell in rural areas, 82% are Alaska Natives. However, there is a trend of people moving from rural villages to regional centers and urban areas of the state. Looking at it another way, in 2000 58% of the statewide native population lived in rural areas and 42.3% lived in five Urban Census Areas: the Municipality of Anchorage, the Matanuska-Susitna Borough, the Kenai Peninsula Borough, the Fairbanks North Star Borough and the City and Borough of Juneau. In other words, Alaska Natives made up 10.4% of the total urban population, double that of 1970 (part of the increase may be due to the fact that in the 2000 Census people were able to identify themselves as Natives of mixed race). It is predicted that the native population will be increasingly urban. More than half of all Alaska Natives may live in urban areas by 2020.

Alaska is a fairly young state, where in 2000 the median age was 32.4 years compared to 35.3 years for the entire United States. Alaska Natives are even younger, on average than the state as a whole (25.8 years). Residents age 65 or older comprised only 5.7% of the population of Alaska compared to 12.4% for the U.S. population.

Disparities

The largest differences in health trends status are between the native and non-native populations and between rural and urban populations. They are related in that the majority of people living in rural areas are natives. Four years ago, WCFH (formerly MCFH) facilitated a process for Region X states (Oregon, Washington, Idaho and Alaska) to look critically at health disparities between urban and non-urban populations. Using existing population and MCH health data, information about health care delivery systems and geographical characteristics; states were able to build a detailed picture of their MCH populations, their health status and barriers to accessing health services.

Significant improvements in the health status of natives have been made since the 1970s as a result of investments in village sanitation, housing, and access to health care services and facilities. For example, nearly 90 rural communities received new sanitation facilities between 1975 and 2003. And by 2003 health clinics staffed by local health aides were established in approximately 170 villages, up from two or three in 1974, as well as several new health centers in regional centers in western, southwestern and interior Alaska. As a result, infant mortality and rates of infectious disease declined dramatically. Nevertheless, as of 2003, 32 communities in interior and western Alaska still lacked public sanitation systems. In 23 other communities less

than 30% of households had a link to the public sanitation system. Many rural residents say clinic facilities need improvement.

Nevertheless, the research effort documented continuing disparities in Alaska between urban and non-urban populations and that Alaska Natives are at higher risk for a number of health issues. For example, the average rates for childhood mortality, teen pregnancy, fertility, mothers reporting smoking and drinking are significantly higher for those living in frontier and remote areas. The rates also indicate that fewer women in frontier and remote areas received early and adequate prenatal care.

Alaska Natives have higher rates of infant deaths among children (age 1 - 19 years), lower rates of prenatal care, higher rates of smoking during pregnancy, teen births and suicide mortality. As Natives become increasingly urban or adopt western lifestyles and diet, either by choice or not, chronic diseases such as diabetes will be of increasing concern.

Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers. Poverty is correlated with many of the health status and access disparities for non-urban populations. Higher unemployment, lower wage jobs and seasonal industries all contribute to the high poverty and near-poverty levels for non-urban populations. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities. While the state has made progress creating an infrastructure to train and recruit a culturally diverse workforce, many Alaska Natives face cultural barriers when accessing health care. WFCH supports local expertise and culturally competent care in the provision of MCH services through the training and development of parent paraprofessionals to assist parents of newly diagnosed children to navigate the system of care.

Finally, one area that requires a significant investment of resources is the range of behavioral health issues that impact MCH populations in the state. Alaska ranks among the top ten states in suicide rates for 2002, almost twice the national rate. Mental health disorders, stressful life events and substance abuse are risk factors for suicide. Children are significantly impacted by alcohol and drug abuse, especially if their mothers are abusing. A majority of families in Alaska in the child protection system have problems with alcohol or drugs. The state has recognized and responded to significant behavioral health issues facing older populations and adolescents. Recently the state has also recognized that younger populations including infants and toddlers are a population that can and does have behavioral health needs.

/2008/ In FY 2007, WCFH started a survey of women who had a live birth in 2004 and who participated in the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). The data collected from the survey will allow us to assess toddler health for the first time. Simple analysis of the data has already begun. //2008//

/2009/ The toddler survey, Alaska Childhood Understanding Behaviors Survey (CUBS), is currently in its second phase. Phase I was a two-year follow-up of PRAMS survey respondents while Phase II is a three-year follow-up. To date, CUBS response rate has been 50% or better. Analysis on Phase I weighted data is underway. Analysis on Phase II will start after one full year of data has been received. //2009//

Current State Priorities and Title V Programs

The Department of Health and Social Services has developed the following goals and strategies

for FY04-FY06 Goal #1: Establish fiscal stability to DHSS programs through federal fund maximization, prudent cost containment, and streamlined business processes. Reduce dependence on new state general funds through the following: replace \$20 million in state dollars with federal Medicaid dollars in FY04 by implementing agreements between hospitals and state-funded community programs; offset \$5 million in state dollars in FY04 with federal Medicaid dollars by investment in Alaska Native tribal health services infrastructure through cooperative agreements with the state, private health care providers, local communities and tribal programs; review business process and eliminate inefficiencies and redundancies; conduct program reviews of all DHSS programs to find options for offsetting state funds with federal funds; carry out aggressive federal agenda to lock in fair treatment of Alaska in funding formulas and policies across a diversity of federal programs; implement cost containment options to the extent feasible without disruption to essential services.

Goal #2: Expand access to cost effective quality services in underserved areas of Alaska through the following: carry out aggressive health and social services workforce development agenda in collaboration with the University, tribal health system, provider and employer organizations, and other stakeholder groups; develop integrated health services programs utilizing partnerships with the tribal health systems, the Denali Commission, the Alaska Mental Health Trust Authority, and other stakeholder groups; implement reimbursement for telehealth services; support the increased use of well-trained local residents in the delivery of a range of frontline prevention and treatment services under tribal health program auspice, for maximum federal fund benefit through Medicaid; develop juvenile substance abuse treatment capacity in rural Alaska.

Goal #3: Protect children and the public from negative effects of alcohol and substance abuse; reduce impact of illness and injury and promote self sufficiency for all Alaskans through the following: establish Performance Improvement Plan (PIP) for child protection system (DFYS); maximize available resources to assure completion of the API replacement project; to assure juvenile offenders are held accountable; to open Kenai Youth Facility promptly; to renovate Nome Youth Facility; and to achieve expedited compliance with court directed treatment and tobacco enforcement policy; develop in-state capacity for provision of appropriate behavioral health services to children and youth, utilizing financing arrangement that assures best use of federal funds whenever feasible; maximize federal resources to support environmental health, disease control, injury prevention, and Homeland Security programs in Alaska; strengthen home and community based services programs and self-sufficiency programs to achieve improvements in quality and cost effectiveness.

/2009/ goals: The acting commissioner of health recently published the 5 "Big Picture Priorities for DHSS for state fiscal year 2009. The overriding theme for future direction of the department is helping individuals and families create safe and healthy communities. The priorities outlined below span the breadth of the department and encompass the unique service-areas represented within. They include: Substance Abuse-Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/private partnerships and long-term strategies; Health and Wellness-Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease and sexually transmitted diseases. Most of this is attributable to personal choice involving diet, physical activity and tobacco use -- and is preventable. We can do a better job of screening, diagnosing and treating these conditions; Health Care Reform-Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health-care workforce, we can transform our health-care system; Long-Term Care-Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and

grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those with Alzheimer's Disease and related disorders, and promote the expansion of aging and disability resource centers; Vulnerable Alaskans-We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families. The Title V/CSHCN program will work to integrates its goals into the department's to assure continuity of services and meet our performance objectives. //2009//

The Process to Determine Alaska's MCH Priorities:

Alaska's State-Wide Title V Needs Assessment was completed in July 2005 by the Section of Women's, Children's, and Family Health (WCFH). The process of consisted of four phases completed over five months:

- Phase I consisted of topic selection and data gathering and analyses. Forty-three Fact Sheets were written on issues drawn from four focus areas: Pregnant Women and Infants, Children and Adolescents, Children with Special Health Care Needs, and Women's Health. Topics were initially selected by WCHF staff and an independent consultant and reflected those which were most critical, those that were aligned with national and current state performance measures, Healthy People Objectives, and those that were the propriety of WCFH. The fact sheets included three sections: Seriousness, Interventions and Recommendations, and Capacity. Information presented in these sections was later used in a survey to rank issues and assist in selecting priorities.
- Phase II of the prioritization process consisted of design, development, and analysis of a survey given to MCH stakeholders. A modified Hanlon-Pickett method to rank issues and integrated this into the survey design. Focus group participants were asked to read the fact sheets and answer a corresponding on-line survey for each issue.
- Phase III covered four half-day focus group meetings. Potential state performance measures and state priorities were identified. The State contracted a facilitator to lead and moderate discussions during the meetings. Survey results were presented to the groups at this time.
- Phase IV involved several meetings with the WCFH Section Chief and staff from the MCH Epidemiology Unit. The MCH Epidemiology Unit plays a critical role in the data coordination efforts for the Title V Block Grant Application, as well as being the entity at the State level that monitors and analyzes MCH data and emerging issues. Several of the data sources that are necessary for the state performance measures are directly from programs in the MCH Epidemiology Unit (i.e., PRAMS, Alaska Birth Defects Registry/FAS, Maternal Infant Mortality Review/Child Death Review, etc) and participation of those program managers were critical in defining the final version of the state priority needs and state performance measures. Also, this is the only unit within Public Health that has the capacity, expertise and ability to understand and critically evaluate and analyze MCH data, data sources, and potential data source issues.

The State intends the Needs Assessment process to be on-going throughout the five-year cycle. The structure is in place to produce yearly updates to the WCFH Fact Sheets that will be shared with the stakeholders from this process, State staff, and made widely available to the public/private health community. The MCH Epidemiology Unit within WCFH produces an annual Alaska MCH Data Book that is widely distributed throughout the State. The December 2005 edition, focused on Alaska PRAMS data.

//2008// A subsequent edition, focusing on data from the Alaska Birth Defects Registry, was published late in 2006. This was the first comprehensive presentation of data on birth defects ever published. A second edition of the original MCH Indicators Data Book will be completed in SFY08. //2008//

/2009/ Publication of the second edition of the MCH Indicators Data Book was delayed and will now be published in Fall 2008. Fact sheets developed as part of the 2005 needs assessment are currently being updated and are utilized extensively in education the public, consumer groups and the legislature on the health status and outcome data of women, children, children with special health needs, pregnant and postpartum women and infants. Other special analyses have been conducted and published by the MCH Epidemiology staff. A list of these publications are attached as part of the block grant submission. In addition, the MCH epidemiology unit was successful in recruiting a CDC CSTE fellow to conduct surveillance studies looking at health disparities of women delivering preterm and low birth weight babies. In addition, the unit was successful in attracting a CDC Public Health Preventative Health Specialist who will be working to establish a new surveillance system looking at risk factors associated with child abuse. //2009//

Meetings with stakeholders will be on-going throughout the five-year cycle, with at least one meeting per year to distribute fact sheets, discuss progress on the State priorities and activities, and any current and emerging issues that may impact the State's capacity to address identified issues.

//2008// Community stakeholders, many of who previously participated in the 5-year needs assessment, were invited to half day sessions to review and comment on the most recent outcome data related to the Title V MCH national and state performance measures and related past and future activities supporting the performance measures. One half-day session focused on perinatal and women's health measures and a second half- day session focused on child and adolescent health and children with special health care measures. Facilitated smaller group discussions produced additional focus areas for WCFH staff to concentrate on over the coming year. The participants were very engaged and enthusiastic about the work done to date and produced a number of ideas and suggestions for partners for future work. Many of the participants agreed to join the MCH advisory council, which will kick off in the fall of 2007. Subcommittees for children and youth with special health care needs will be formed, as recommended by the participants. The MCH council will act in an advisory capacity and assist in guiding the work done by WCFH staff. //2008//

/2009/ The WCFH Perinatal Advisory Committee was established and convened for the first time, the purpose of the committee is to have a means of communication between parties about important perinatal issues, including priorities, concerns, best practices, data, and other research for the purpose of improving perinatal outcomes. In addition, the committee provide valuable input into assuring that the areas we are focusing on are of importance to them and a priority measures. This is part of the ongoing process to update our needs assessment on an annual basis. Overall, response was enthusiastic and about 45 committee members were secured. Attending were 32 health care providers from across Alaska, representing a variety of geographic areas, types of facilities, and health care professions.

In April 2008 we first convened the first Perinatal Advisory Committee for a half-day meeting in Anchorage. The primary goal of this meeting was to set the stage for a mutually beneficial ongoing relationship with relevant data and standards of practice as the backdrop for our efforts.

The strategy to initiate this conversation in the context of the group was to help participants identify 'low-hanging fruit' or obvious and doable interventions in their communities or statewide and support their data and programmatic needs. After a large group presentation of background information, the group was broken into 3 smaller groups to discuss opportunities for action, data needed to proceed, and concrete first steps they would take when returning to their work. In the process of addressing the

questions posed participants unearthed a rich abundance of ideas for current and future consideration. Priority issues identified by the attendees including the desire to work on smoking and alcohol cessation prior to pregnancy, postpartum depression early recognition and treatment, preconception care and improving the system for timely enrollment in the SCHIP program for pregnant women.

Plans for the Perinatal Advisory Committee are to meet 3 times a year. Members may decide to form subcommittees to focus efforts on more narrow issues and these may meet more frequently. A recurrent request was to learn more about CenteringPregnancy and CenteringParenting and a presentation will be arranged for our next meeting in September, with the hope of garnering adequate interest and commitment to hold a 3-day workshop to implement a number of Centering programs in Alaska.

In addition, performance measures are reviewed and discussed at the related advisory committees for newborn hearing screening, newborn metabolic screening, adolescents, and oral health. These four committees meet regularly to discuss data outcomes and provide input into program designs in and interventions. In addition, ongoing feedback is solicited from physicians at the annual presentations provided at the Anchorage and Fairbanks Pediatric/Perinatal Grand Rounds, All Alaska Pediatric Partnership committee meetings, and specific community visits. All of these activities contribute to the ongoing work on updating our needs assessment and performance priorities. //2009//

Consideration of needs, priorities and competing factors can also occur at specially convened workshops. For example, in May 2006 representatives of several DHHS divisions and tribal health organizations gathered to consider how to maximize the EPSDT program to improve health outcomes of children, targeting the early childhood years of 0 -- 3. The facilitated workshop resulted in a prioritized list of strategies to pursue. The workshop was conducted by Kay Johnson Consultants and was supported by a HRSA -- MCH supported technical assistance grant.

//2009/ The work discussed in preceding paragraph was helpful in the development of the Early Comprehensive Care Systems Grant (ECCS) and the collaboration around piloting a system of continuous developmental screening as part of the ABCD Screening Academy project. In addition, work is in progress in collaboration with the Division of Behavioral Health, the Divisions of Children's Services, and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs. //2009//

Legislation

Several pieces of legislation impacting MCH populations were passed in FY 2006. A significant achievement was the passage of HB 109 relating to newborn hearing screening. This legislation requires all newborns be provided with hearing screening within 30 days of their birth, and that those identified with a positive screen or high risk factors receive a second screen or diagnostic work-up, are enrolled in early intervention and receive treatment as needed. The program requires a reporting and surveillance system for tracking all newborns and assisting them with ongoing hearing screening, diagnostic and intervention services. HB 85 allows children to carry and self-administer asthma medication at school. Previously, all asthma medications were stored in a locked container and could only be administered by the school nurse or school official. SB 22 added birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons. HB 185 requires all postsecondary students to be immunized for meningitis. The Legislature also passed resolution HCR 5 urging all communities in Alaska to offer fluoridated water.

//2008/ Several key pieces of legislation were introduced in the first year of a two year cycle, but few progressed through committee hearings. Alaska legislators were focused on passing

legislation in support of building the natural gas pipeline and developing a way to fund school districts for more than one year in advance. Bills supporting the re-establishment of the SCHIP program eligibility to its former level of 175% of poverty and removing the statutory clause preventing adjustments for cost of living received some attention passed and is currently awaiting the Governor's signature. Two other bills related to the SCHIP program propose increasing the eligibility level to 200 and 250% of poverty respectively with "buy in" options for families. In addition, one Democratic Senator has introduced a universal health care coverage bill.

Funding to develop an autism screening and evaluation program was established by a \$250K pledge from the Mental Health Trust Authority and \$250K from general fund. The Mental Health Trust Authority pledged this amount with the expectation that an additional \$250K will be added in general fund dollars as an ongoing base starting in FY 2009. The program will be operated by the Title V MCH agency and will be established in conjunction with The Children's Hospital at Providence as part of their neurodevelopmental diagnostic center.

Senate Bill 73, funding 10 additional positions in the WWAMI program, was easily passed by the legislature and was signed by the governor on March 28, 2007. WWAMI is a cooperative program between the University of Washington School of Medicine and four western states to provide access to publicly supported medical education to those states' residents. Alaska now has 20 positions in the program. One objective of WWAMI is to encourage students to learn and practice medicine in the community

Regulations supporting HB 109 -- Early Hearing, Detection and Intervention bill are near completion and will be posted for public notice in August of 2007. These regulations will become effective January 1, 2008. Regulations requiring the reporting of congenital hearing loss to the Alaska Birth Defects and FAS registry went into effect SFY07. Finally fee regulations to increase fees collected for newborn metabolic screening went into effect February 1, 2007 in support of the addition of Cystic Fibrosis screening to the already expanded metabolic screening panel //2008//.

Current and Emerging Issues

There are several emerging issues in Alaska. Emergency response planning efforts are underway at the state and local levels. The state has prepared a draft Pandemic Influenza Response Plan and a Behavioral Health Emergency Response Plan. These plans do not currently address fragile subpopulations such as CSHCN and there are only 12 pediatric intensive care beds in the state. This is a gap that will need to be addressed in the near future. /2008/ The All Alaska Pediatric Partnership (AAPP) has taken on the initiative of developing and establishing a more comprehensive disaster plan for children and youth with special health care needs, as well as pregnant women and neonates. The goal is to develop this plan in partnership with the participating hospitals and member state and local agencies who participate in the AAPP partnership within the next fiscal year. //2008//

The prevalence of overweight and obesity among Alaskan youth, based on the 2003 Alaska Youth Risk Behavior Survey, is similar to national prevalence estimates. Reducing childhood overweight and obesity has been identified as a state priority for the 2006-2010 block grant cycle. State and local systems are collaborating to address this issue. In 2004 the Anchorage School district and the AK Division of Public Health together assess the prevalence of overweight among Anchorage School District children. WCFH continues to work with school districts to monitor this health indicator.

Asthma is among the 10 leading activity limiting chronic conditions in the U.S. The rate of asthma hospitalizations among children less than 5 years of age is higher in Alaska compared to the Nation and nearly 3 times higher than the Healthy People 2010 goal. It is estimated that the prevalence of asthma is 40-90% greater for urban residents. The Alaska Asthma Coalition has implemented public awareness campaigns and worked to achieve passage of a bill allowing children to self-administer asthma medications at school. The Division of Public Health has

begun asthma surveillance.

Early intervention services are designed to meet the developmental needs of children from birth to 3 years of age who have a developmental delay (e.g. physical, emotional, communicative, cognitive, or adaptive development). In an average year in Alaska approximately 10,000 live births occur. Of these, about 10% are preterm, almost 6% have low or very low birth weight and 18% have at least one reportable birth defect. Many of these children will qualify for early intervention services. One major barrier to providing early intervention services is the difficulty in recruiting and retaining professional staff in rural communities to conduct screening. Another significant issue is the lack of services for treatment.

//2008// DHSS, in collaboration with tribal health agencies, convened a workshop in SFY 2006 to develop strategies on improving early identification through the EPSDT program. From this workshop, 4 work groups were established to address the early intervention population. They include:

- a. Medical Home: Access to an insurance support for medical homes; provision of comprehensive physical and child development services for all children (including children with special health care needs); and assessment, intervention, and referral of children with developmental, behavioral, and psycho-social problems.
- b. Mental Health and Social/Emotional: Availability of appropriate child development and mental health services to address the needs of children at risk for developing mental health problems.
- c. Early Care and Learning: Development and support of quality early care and learning services for children from birth through 8 that support children's early learning, health, and development of social competence.
- d. Family Support & Parenting Education: Availability of comprehensive family support and parent education services that address the stressors impairing the ability of families to nurture and support the healthy development of their children.

The Office of Children's Services was the recipient of the Assuring Better Child Development Screening Academy funded by the Commonwealth Fund. A core Committee was formed consisting of the Medicaid Director, Part C Program Manager, Public Health Deputy Director, Chairperson of the AAP, Alaska Chapter, and the ECCS Coordinator. Medical practices were recruited to participate as pilot sites in doing comprehensive developmental screening during well-child exams. Technical assistance and training will be provided to the pilot medical practices over the coming year. Approximately 20 key decision makers and invested professionals were invited to participate in a Stakeholder Group, which will advise the project. Service providers will be brought together to coordinate responsiveness to referrals and improve feedback to medical homes. Care coordination issues will be identified and solutions will be developed. //2008//

/2009/ Alaska is currently participating in the National Academy for State Health Policy's ABCD Screening Academy. A pilot that includes screening for autism is currently underway in two pediatric offices in Anchorage and at the Alaska Native Medical Center, a tribally owned and operated healthcare facility that provides a full range of services to eligible Alaska Natives and American Indians living in Alaska. Pilot findings will be used to expand universal screenings statewide. To date there have been tremendous increases in the use of standardized screening instruments, although information on the number of referrals is still being gathered and analyzed. A universal form for Medicaid, Part C agencies and school districts is being tested -- comments are favorable thus far. The state ABCD team is working on a handout for parents about the importance of following up on referrals from their medical practitioner, and a referral directory has been developed. The ABCD team also met with the Alaska Native Tribal Health Consortium. Although Consortium members are not yet ready to change their screening procedures, they are interested in training on the importance of identifying children early and referring them to appropriate services. The Consortium also recommended that the ABCD state team work directly with Tribal health corporations and engage pediatric providers.

The Children's Policy Team led by the Acting Commission of Health and Social Services convenes monthly to provide for the division's senior executives and their staff to report on a number of children's issues and plans for resolution. Standing agenda items include behavioral health improvements instate for adolescents, particularly in the area of residential treatment centers, progress on autism initiatives, early mental health services for children ages 0-8, and development of systems of care models with a goal towards collaboration between all of the divisions caring for children. The Divisions represented include Public Health-represented by the MCH Title V director, Juvenile Justice, Child Protection, Public Assistance, Behavioral Health, Disability Services, and Medical Assistance. The inclusion of initiatives around autism and early childhood mental health came as a result of the work done in FY07 with the EPSDT workshop technical assistance sponsored by MCHB.// 2009//

B. Agency Capacity

Alaska's state health agency, the Department of Health and Social Services (DHSS) has developed significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood, including health care services for CSHCN. Capacity building begins with recognizing two critical issues the state faces in providing comprehensive care: geographic isolation and low population density. As mentioned in Part III A, Alaska's health care system differs from most other states in that there only two locally organized health departments that function under the umbrella agency of the state health department. Collaborations and partnerships operate between state agencies as well as between the state and the private sector, the non-profit sector, local communities, other public agencies, and families.

The State's CSHCN program delivers a statewide system of services. This capacity has been built on the foundation of strong partnerships and collaboration among federal programs, the state, and Native health care systems community-based organizations. For example, the Section of Women's, Children's and Family Health (WCFH) maintains strong relationships with medical providers and other health care professionals through advisory committees for each of the specialty clinics. NBMS (Newborn Metabolic Screening) Advisory Committee, composed of statewide health providers, parents, laboratory personnel and state staff, met three times in FY05 to discuss issues including hemoglobinopathies, the addition of cystic fibrosis screening to the current screening panel, and the process of tandem mass spectrometry. A sub task force met to improve the mail out and delivery times of the screening cards that are sent from the various birthing hospitals to the lab in Portland, Oregon. Other plans include monitoring the Oregon Public Health Laboratory on their readiness to add Cystic Fibrosis (CF) screening to the current screening panel. This information will play a vital role for the state's CF Task Force in their consideration of adding this condition to the screening panel.

Another excellent example of using partnerships to expand agency capacity is the major role played by the Newborn Hearing Screening Advisory Committee. The Committee initiated the newborn hearing screening program statewide, organized advocates in a six- year effort to successfully pass mandatory hearing screening legislation in 2006, and continues to provide input in service delivery and program sustainability. Capacity is being expanded through partnership with hospitals and private providers to ensure implementation of the program including follow-up diagnostics and treatment for children who do not pass the initial screens. This newborn screening initiative has been an important and successful partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments.

Since October of 2004, the directors of the Division of Health Care Services and the Division of Public Health worked collaboratively on new capacity-expanding projects on issues such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages); recruitment of sub specialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a

quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

/2008/ It was determined that regulation changes to support foster parents who wished to open up a residential treatment home in support of caring for more than the mandatory limit of two medically fragile children were not supported by the Division of Senior and Disability Services. The focus of work is now on recruitment and training of more foster families who are willing to take care of medically fragile infants and children. //2008//

Ongoing support for the EPSDT program resulted in an expansion of services and payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. Nearly 50% of the children in Alaska are enrolled in the Medicaid program and many have special needs. Enhancing the payment methodology for schools will hopefully provide for increased funding to hire additional needed specialists and provide services for children who qualify for an Individual Education Plan (IEP). Working together, the Title V/CSHCN director and Medicaid staff developed and initiated this program in time for the new school year that started in September of 2005. In May 2006 a facilitated state leadership workshop titled "EPSDT and Title V Collaboration to Improve Child Health Outcomes" was held. Participants included staff from the divisions of Public Health, Office of Children's Services, Health Care Services, Public Assistance, and the Commissioner's Office, and representatives of tribal health agencies. Several new strategies to improving childhood outcomes through the EPSDT program were developed and will be pursued in the coming year.

/2008/ An Early Childhood Mental Health (ECMH) cross-systems working group of which the Title V MCH Director was a member, was formed to develop recommendations on mental health services. One of the outcomes of their work has been the crosswalk between diagnostic codes for young children, billing requirements, and the use of appropriate service codes to ensure services for young children. A two-day training was provided for mental health clinicians and early interventionists on this cross walk and other children's mental health training. //2008//

/2009/ The work outlined last year was helpful in the development of the Early Comprehensive Care Systems Grant (ECCS) and the collaboration around piloting a system of continuous developmental screening as part of the ABCD Screening Academy project. In addition, work is in progress in collaboration with the Division of Behavioral Health, the Divisions of Children's Services, and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs. //2009//

Regional collaborations have also been useful. The Title V/CSHCN director, newborn screening coordinator, and genetic counselor participated in the initiation of the Western States Genetic Services Collaborative, a regional project focused on expansion of genetics services, education and collaboration amongst the states. As an infrastructure building activity, the use of the Western States Collaborative Agreement funds is anticipated to be used in support of an additional part-time genetics counselor to assist with the growing clinical needs of the program and allow time to be spent in statewide planning. We will also be forming a genetics advisory committee to address issues around program planning and service delivery goals. The committee will work to design a multi-agency plan for genetic services to provide comprehensive genetic services (clinical, prenatal and disease specific) statewide, to all age groups. The committee will look at long-term feasibility of transitioning clinic services to the private sector, and short term feasibility of broadening local support by hosting clinics at regional hospitals.

/2009/ The previous goals identified with the last funding cycle continues, with a focus on improving services to be more family-centered and supportive. The collaborative is

working on standardization of data collection to achieve comparability of data across states. //2009//

The MCH-Epi (Epidemiology) Unit within WCFH provides data collection, analysis, research, and publication services to program managers for program monitoring and policy development. Significant work was accomplished in collecting, analyzing and reporting data from the Alaska Birth Defects Registry and the Fetal Alcohol Syndrome database including: publishing prevalence estimates for all major birth defects (as defined by the National Birth Defects Prevention Coalition) in the journal *Teratology*; completing a comprehensive descriptive analysis of ABDR data including trend analysis, regional distribution and prevalence of major birth defects by important demographic and birth characteristics; completing an analysis of trends in the occurrence of neural tube defects following folic acid fortification recommendations and publishing the findings in an *Epidemiology Bulletin*; and adding approximately 3,500 referrals to the FAS referrals database and conducting chart abstractions to identify a total of 92 children born between 1995 and 2002 who met surveillance criteria for FAS. Future plans are to link the birth defects databases with program databases to enable evaluation of program services. Potential collaborative projects include linkages with databases from Infant Learning Program (ILP), Women Infants and Children (WIC), Genetic and Specialty Clinics, Universal Newborn Hearing Program and Newborn Metabolic Screening Program. Other planned collaborations are to work closely with FAS prevention programs and diagnostic teams to provide surveillance data for monitoring program efforts and to expand our already strong relationship with the Division of Behavioral Health to expand distribution of surveillance findings and to begin working with agencies and communities to illustrate how our data can be used to plan and evaluate prevention efforts and policy.

The development of pediatric asthma surveillance systems was implemented under the State Systems Development Initiative (SSDI). MCH-Epi collaborated with Medicaid services and Vital Statistics to link Medicaid and birth certificate data to evaluate whether birth outcomes -- specifically low birth weight and preterm birth -- are associated with development of asthma. The analysis will be published in a peer-reviewed article (*Annals of Asthma, Allergy, and Immunology*) and was used by the non-profit Southcentral Foundation, an Alaska Native non-profit health corporation, to support current intervention policies related to asthma. MCH-Epi staff collaborated with the Anchorage School District to establish an asthma screening questionnaire for administration at enrollment and assisted with the review of regulations allowing children to self-administer asthma medications in public schools. WCFH was a finalist for a Merck Foundation grant to establish a pediatric asthma control program in the state. Finally, the MCH-Epi unit manager is Chair of the Surveillance Subcommittee of the Alaska Asthma Coalition and member of the Board of the Allergy and Asthma Foundation of America, Alaska Chapter.

/2009/ During FY 2008 the MCH-Epi Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN). The purpose of this surveillance program is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. Due to jurisdictional bounds, regulatory agency responsibility, and varying definitions, organizations that identify or respond to maltreatment generally capture only a portion of the overall picture of child maltreatment. The Alaska SCAN system relies on linking the data of these various organizations which include but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review finds, and child protect services reports. Alaska SCAN is being implemented in two main phases. Phase I covers fatalities resulting from maltreatment and Phase II will incorporate injuries resulting from maltreatment. Phase I data are collected annually by linking multiple existing data sources. These data will be analyzed descriptively and linked with additional epidemiological data tools such as the Pregnancy Risk Assessment Monitoring System (PRAMS) to identify other elusive trends. The systematic collection of information and application of standardized sensitive public health definitions promotes data consistency over time and enables individual programs to understand the impact of their interventions, target specific populations in

greatest need, implement, monitor, and evaluate scientifically based community focused initiatives, as well as advocate for resources based on reliable and consistent information.

Also in FY 2008, the The MCH-Epi Unit added a CSTE Fellow to its staff. The additional staffing capacity is being used to initiate a surveillance program for preterm birth. Birth certificate data will be analyzed. //2009//

Data provided by MCH-Epi also assisted in supporting the Medicaid staff's desire to maintain benefits including dental care for pregnant women, and staff was able to articulate more clearly the benefits of prenatal care in response to questions from legislators.

Coordination of health components and coordination of health services at the community level occurs through a mix of technical training, partnerships and direct grants to local providers. In many frontier areas, medical services are limited to a small clinic staffed by a Community Health Aide with basic training in primary, preventive and emergency medical care. Due to chronic staff shortages, unpredictable weather, and high cost of travel, villages and communities may receive a visit from an itinerant Public Health Nurse as frequently as monthly or as infrequently as bi-annually. The inability to access specialty care poses significant hardships for CSHCN. To address these challenges, a coalition of state and private agencies developed a broader definition of a medical home for Alaska CSHCN: "The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services". Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an itinerant basis or helping families access services in larger communities. As the FQHCs and community health centers before more firmly established, the Title V and CSHCN staff is working with them on developing greater competency and capacity to care for CSHCN, adolescents and prenatal women.

Specialty clinics are sponsored throughout the state since these services are not available locally. Multidisciplinary evaluations are conducted at Cleft Lip and Palate Clinics in Anchorage, Bethel and Fairbanks. Children receive consultations at the Neurodevelopment Clinics in Dillingham, Fairbanks, Juneau and Ketchikan and consultations at Neurology Clinics in Fairbanks. Additional hours for parent navigation for the CL & P clinic were offered in FY 06 to assist in families in getting their treatment plans initiated, finding funding for under insured or not insured clients if necessary and navigating the health care systems as needed. Nearly 65% of all families seen at the CL/P clinic requested assistance of the parent navigators. These paraprofessionals are provided as a result of a contract with the Stone Soup Group using Title V funds. The use of parent navigators expanded to families in SFY 2007 with newborn hearing loss and those with other special need conditions. A pilot is being considered with Medicaid services to offer parent navigation for families who have children with chronic health conditions such as diabetes, cancer and asthma in coordination with nursing case management.

//2008/ parent navigation services will be added with the expansion of the autism screening and evaluation services that will be offered at the Neurodevelopmental Center at The Children's Hospital at Providence in addition to the outreach clinics offered in smaller communities across the state. //2008//

//2009/ Grant funds were awarded to The Children's Hospital at Providence's Neurodevelopmental Center in support of expansion of diagnostic services. The expanded

program, Providence Autism Diagnostic Network, is a collaborative effort that integrates psychiatry, psychology, neurology, physical, speech, occupational therapy and parent navigation services. They have been able to develop a more efficient process for diagnosing children with autism and are working towards increasing the numbers of children seen. The second stage of this effort will be offer more screening services by some members of the team in areas outside of Anchorage. Strategies for this are in process for SFY2009. //2009//

The Newborn Metabolic Screening (NBMS) program manager continued a series of educational efforts around the state that targeted medical staff involved in the collection process. These efforts included education on proper collection techniques, transport issues, and how to reduce the number of hospital discharge refusals. These presentations often provided continuing education credits for medicine, lab and nursing. As a result of these efforts, the number of refusals at discharge fell to near zero in most communities. A brochure designed to meet a lower literacy level was developed, field tested, and distributed to prenatal providers. Brochure holders were also developed to hold both the Newborn Metabolic screening brochure and the Newborn Hearing Screening brochure and distributed widely across the state to family practice physicians, obstetrical providers, nurse midwives, direct entry midwives, public health nursing centers, and any office where prenatal patients might visit. Continuing education efforts regarding the lesser-known metabolic conditions identified through expanded testing with tandem mass spectrometry will be the focus this coming fiscal year. Education will target the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility.

Site visits were conducted by the Early Hearing Detection and Intervention (EHDI) Program Manager and the EHDI Surveillance Manager to communities implementing the screening programs to provide technical assistance and connect providers involved in the EHDI process beginning at the screening facility, through the diagnostic phase, and ending at early intervention. Screening is now performed at all birthing hospitals/communities in the State. To assist facilities with annual birthing rates of less than 50 begin newborn hearing screening, the EHDI Program purchased five portable hearing screeners and placed them in these five communities. The program purchased two additional portable screeners for placement in public health nursing centers in areas with high home/midwifery center births. Education efforts to the direct-entry midwives showed enthusiasm and willingness to send their clients to public health nurses (PHN) for hearing screening. The EHDI Program developed a video for rural Alaskan healthcare providers, termed Community Health Aide/Practitioners (CHA/Ps). The video identifies newborn hearing screening, speech and hearing developmental milestones, high risk factors for late onset and/or progressive hearing loss, and proper protocol for CHA/Ps if a hearing loss is suspected in a child. The EHDI Program Manager worked with the CHA/P Program to disseminate the video through teleconference presentations with CHA/Ps, mail outs for continuing medical units, and in-person presentations. Using footage from the video, the EHDI Program developed one radio public service announcement (PSA) and one television PSA. Using the PSAs, the EHDI Program is conducting a statewide media campaign focused on rural Alaska to stress the importance of screening newborns at birth for hearing loss. With the implementation of the web database, training for facilities that cannot send someone to Anchorage will be a major activity. The EHDI Surveillance Manager travels to those communities to provide hands on training. It is anticipated that all birthing facilities will be online and reporting through this system by fall of 2005. Tracking and follow-up activities will be enhanced with this system in an attempt to meet the National EHDI 1-3-6 goals. The Surveillance Manager will be able to perform monthly QA reports and get back to facilities in a timelier manner regarding follow-up screening and diagnostic procedures. Continued educational efforts to ensure that members of the health community are aware of hearing screening, where to go for screening, where to go for diagnostic testing, and milestones to watch for in children at risk for progressive/late onset hearing loss.

/2008/ All birthing communities have received training on data entry and the web site and are fairly current with their entry. Developing site specific systems for training when there is staff turnover continues to be a challenge, however quarterly teleconferences and offering training in

Anchorage at least yearly has assisted hospitals and communities to stay current. Linkages with the Newborn Metabolic Screening data are near completion. This will provide for ready access to viewing both sets of data and provide a web based data system to conduct surveillance and assure follow up. //2008//

//2009/ Full integration of the newborn metabolic database into the newborn hearing screening database is nearly complete and working well. Report generation is smoothing out for providers. The data integration will assist us in tracking services to all newborns offered by the MCH programs over time and hopefully will be linked with other reporting systems such as the immunization registry. The EHD staff worked with community audiologists and the contractor to redesign more user friendly audiology data entry pages in the hopes of increasing the completion rate. An agreement was finally signed between the Division of Public Health and the Office of Children's Services (child protection) to share data between the state's Infant Learning Program (early intervention) located in OCS, with the state's EHD program. //2009//

WCFH staff continues to work with communities and genetics providers from Seattle Children's Hospital and Medical Center to address problems with small clinics where cost of transportation and small population base make face-to-face service delivery time consuming and costly. Clinic days, including additional days for Metabolic Genetics Clinic, will be reassigned to hub centers, or areas of growing population need. We will also again pursue adding clinic days to Alaska Native Tribal Health Consortium in support of native clients being seen in their provider network location. In addition, the program will target underserved areas of the state through the development of educational materials for remote areas and will focus on one or more underserved areas of the state with provider information, to improve awareness of available services and internet/distance resources.

Pediatric Cardiac Clinics in Southeast Alaska were privatized in FY2005 since the number of resident in state pediatric cardiologists increased to 3 in FY 2005. The state previously contracted with Children's Hospital and Regional Medical Center (CHRMC) in Seattle to bring pediatric cardiologists to Juneau, Ketchikan and Sitka for clinics. CHRMC will continue to offer clinics in these communities through their outreach program. The contract dollars will be shifted to contract with non-profit agency (to be determined) for parent navigation services for families whose children have complex neurological issues and those with hearing loss.

Community-based services are integral to a comprehensive system of preventive and primary care services for our four primary populations: that of pregnant women and infants, women across the lifespan, children and adolescents, and children with special health care needs. One of the most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant reproductive health and immunization services to remote/frontier communities that do not have a health center. Some of the centers also offer EPSDT exams for children. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing, oversees staffing of the centers. WCFH and the Section of Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning services are offered at Public Health Centers and contraceptives purchased with MCH block grant funds support that effort. Public Health Centers and Public Health Nurses are also the state's frontline providers of prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health services, etc. Public Health Nursing is frequently contacted when following up with abnormal screens, and lab data, . The public health nurses are also critical in helping to coordinate the specialty and genetics clinics held in the regional hubs.

The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities

are available for Infant Learning Programs, WIC, Healthy Families, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities in remote and frontier areas of the state. For example, the state supports training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.

The health of newborns and young children is another capacity building effort important for the state health agency. Outreach efforts through the SCHIP program and Denali KidCare have been instrumental in enrolling pregnant women in the health insurance program so they can access needed services. The EPSDT program promotes important prenatal care and provides outreach so newborns can be enrolled in Denali KidCare soon after birth. Health information is provided on a regular basis to Medicaid/Denali KidCare recipients on well-child exams, health and safety and how to access medical care through Medicaid enrolled providers. All of these efforts require partnerships between the various state agencies administering the programs, local providers and local program administrators.

The DHSS reorganization of FY 2003, while disruptive in some ways, also afforded new opportunities for collaboration between state agencies to improve policy decision making. Staff responsible for MCH programs provided consultation and feedback in the area of Medicaid provider services including dental services, family planning, prevention and primary care services, and treatment services such as audiology, speech-language; laboratory billing and payments; regulations regarding services for children; transportation program changes; the Medicaid waiver program; medical services for CSHCN, and several others. Enhancing the Medicaid staff's understanding of how Medicaid payment policies impact public health outcomes was very rewarding. As a result, MCH program capacity in prevention and primary care services was expanded from a policy and payment perspective. The most significant challenge of the reorganization was the loss of personnel capacity to take on new public health projects or respond to new grant opportunities. With the loss of staff positions and the lack of connectivity to prior programs, such as early intervention and WIC, the ability to maximize resources, both capital and personnel, is more difficult in some areas.

Over the coming years, Alaska will be addressing significant funding issues that may affect the state's capacity to provide services to women and children. At present, 70% of the funding for WCFH is from federal grants. Over time, state general fund dollars have been redirected to other state departments. Strategic planning regarding long term funding and sustainability will be undertaken in the Fall of 2006.

/2008/ The MCH Title V Director led a work group to develop a public health logo, outreach plan and contact data base as well as an Outreach Tool kit for public health staff to use in their presentations in support of educating the public about the role of public health in communities. The executive leadership team identified this as the first step in developing an outreach plan that would look for additional funding partners //2008//.

Planned increases for staffing will be minimal due to the financial situation of the MCH programs. A perinatal nurse consultant will be hired in fiscal year FY07 to increase the capacity of work on perinatal and neonatal issues that are present in our state as well as continue to improve on things that are going well. Other staff additions include a Public Health Specialist II position and a Research Analyst I position to support the new Toddler Survey (CUBS). Finally, a half time Adolescent Health program manager will be established and funded through a reimbursable service agreement using TANF funding.

/2008/ A full time perinatal nurse consultant was hired as was a ¾ time Adolescent Health manager. The two positions supporting the Toddler Survey (CUBS) were also filled and a new

CSTE CDC fellow will be starting in mid August of 2007. Alaska is currently a finalist for assignment of a CDC Prevention Specialist. Notification will occur in August of 2007. //2008//

//2009/The four new staff positions were added. As a result several new programs were initiated, including establishment of a Perinatal Advisory Committee, creation of the Alaska Surveillance of Child Abuse and Neglect, initiation of a preterm birth surveillance program and start of an adolescent health program. In SFY09 a nurse consultant position to support school health and the EPSDT program and a new autism manager will be hired. //2009//

C. Organizational Structure

Organizational charts for the Alaska Department of Health and Social Services (DHSS), the Division of Public Health, the Section of Women's, Children's and Family Health, and the Office of Children's Services can be found under Other Supporting Documents. The WCFH Organizational Chart includes positions by program as well as job classification.

Alaska's state health agency, the DHSS, is one of 15 departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through appointed cabinet level commissioners. The DHSS organizational structure is broken down into Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS is charged with primary responsibility for MCH programs although two significant programs, the Early Intervention/Infant Learning Program and WIC, reside in the Office of Children's Services. An organizational chart for the Department is attached.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system rather is a mix of direct state, tribal or federal, local health care agencies and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. Two urban communities have locally organized health departments, the Municipality of Anchorage and the North Slope Borough. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to Alaska Natives through health clinics operated by the Indian Health Service or Alaska Native Health Corporations. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

Currently, the responsibility for some of the state's MCH Title V program and the position of Title V and CSHCN director reside in the Division of Public Health (DPH). Decisions regarding funding allocations for the FFY07 Title V grant will be made by the MCH Title V Director with input from the Director of Public Health and approval from the assistant commissioner

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:

1. Early Intervention/Infant Learning program. This program is located in the Office of Children's Services. The state general funds spent on this program provide a large portion of the state match of the Block Grant and portion of the Federal-State Partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. the Division of Public Health) and the Office of Children's Services, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.
2. Women, Infants and Children (WIC) Nutrition program. This program is located in the Office of

Children's Services. There are some state funds that support this program in the form of team nutrition grants, however the bulk of funding comes from the USDA. The WIC program and the other former MCH programs continue to collaborate on activities and participate jointly on statewide committees.

3. Maternal-Child surveillance activities. These activities are located in DPH (Division of Public Health), Section of Women's Children's and Family Health (WCFH).

4. Family Violence Prevention and Childhood Injury Prevention are located in DPH, Section of Injury Prevention and Emergency Medical Services.

5. Children's Behavioral Health is located in the Division of Behavioral Health.

6. Family Nutrition, the Early Comprehensive Care Systems (ECCS) grant, the Early Intervention Program and the Healthy Families Home Visitation program are located in the Office of Children's Services. The Title V Director and some WCFH staff actively participate in work conducted with the ECCS and Early Intervention program.

7. Primary MCH programs are located in DPH Section of WCFH. These include Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults, Family Planning, Abstinence Grant administration, Adolescent Health, and the Breast and Cervical Cancer program and Perinatal and Women's Health

The development of new working relationships in support of maintaining an MCH presence has continued to move forward despite significant staffing changes in other divisions. Ongoing efforts in this arena will continue over the coming fiscal year.

/2009/ Updates to the programs listed previously include:

1. Women, Infants and Children (WIC) Nutrition program has been relocated to the Division of Public Assistance as a result of a decision made by the Division of Finance. The MCH Title V program continues to look for ways to collaborate with the WIC program, however this has been limited to breast feeding promotion and support.

2. A school health nurse consultant position will be added in this next fiscal year. This position will provide technical assistance to school districts around the state and those who have school nurses, provide information on standards of care and disaster planning. In addition, the position will be a liaison for the EPSDT program located in the Division of Health Care Services.

No other organizational changes occurred this fiscal year//2009//.

An attachment is included in this section.

D. Other MCH Capacity

Title V MCH programs are currently implemented by three divisions within the Department of Health and Social Services: the Division of Public Health, the Office of Children's Services, and the Division of Health Care Services. These programs were all formerly within the Division of Public Health, however, a major departmental reorganization in 2003 shifted several programs and Title V oversight to other existing or new divisions. In 2005, another smaller scale but significant reorganization returned several MCH programs to a new section (Women's, Children's and Family Health) within the Division of Public Health. From 2003 to 2006 a significant number of positions were eliminated, left vacant, had a change in position description or experienced turnover.

Several MCH Programs were transferred into the new Section of WCFH in July 2005 as noted in last year's notes. The current staffing of Title V programs is as follows:

1. Division of Public Health
- 1a. Section of Women's, Children's and Family Health (49 positions):

Section Chief (Title V/CSHCN Director) - 1 position.

MCH Epidemiology Unit:

Administrative Support - 1 position (vacant) ; PRAMS - 2 positions; Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 4 positions (1 vacant and one on active duty with the Army) ; Pediatric Physician Epidemiologist - 1 position; Maternal-Infant Mortality Review/Child Death Review Committee - 1 positions; MCH Indicators Surveillance position - 1 position; MCH Epidemiologist - 1 position; Toddler Survey (CUBS)- 2 positions; Public Health Specialist -- 1 position (vacant); CDC/CSTE Fellow 1 position; CDC Prevention Specialist-1 requested

Women's and Adolescent Health Unit:

Administrative Support - 1 position; Breast and Cervical Cancer Screening program -- 9 positions; Family Planning -- 1.25 positions; Perinatal Health -- 1 position ; Health Program Manager -- 1 position (vacant); Reproductive Health Partnership

0.75 position. Adolescent Health- 1 position; Graduate Intern position-1 position

Children's Health Unit:

Administrative Support -- 1 positions; Newborn Hearing Screening - 1.5 positions; Newborn Metabolic Screening -- 1.5 positions; Genetics and Birth Defects Program - 1 position; Pediatric Specialty Clinics - 0.75 positions; Oral Health - 3.5 positions (1 in Juneau and 2.5 in Anchorage).

Section Administrative Support:

Administrative Officer: 1 position; Administrative Assistant/Supervisor: 1 position; Administrative Clerk II: 2 positions; Accounting Clerk: 1 position (vacant)

1b. Section of Injury Prevention and Emergency Medical Services (2 positions)

Alaska Family Violence Project - 2 positions; Child Injury Program - 1 position.

2. Office of Children's Services: Prevention Services (19 positions)

Unit Manager - 1 position; Administrative Support - 2 positions; Community and Family Nutrition Services - 1 position; WIC Nutrition Programs - 10 positions in Anchorage and Juneau; Early Childhood Comprehensive Systems Program - 1 position; Early Intervention/Infant Learning Program -- 4 positions; .

3. Division of Health Care Services (2 positions)

EPSDT program -- 2.5 positions; .

4. Division of Behavioral Health: 1 position

Suicide prevention support .5 position.

All of the Information Technology positions (analyst programmers, web masters, etc.), administrative assistants, accountants, and grants and contracts administrators were centralized under one Division of Financial Management services reporting to the Assistant Commissioner of DHSS. Previous to SFY05, these positions were decentralized to the divisions, sections, and programs of the department

/2009/In SFY07, additional programmatic responsibilities were incorporated into the section, most notably the Autism program. One additional position has been added for now to support the expansion of assessment and diagnostic capacity. An additional position may be considered to add screen capacity later in the year. Funding for the Autism program is coming from the Mental Health Trust Authority and General Fund dollars. This program works closely with the state's early intervention program. For SFY09, an prior position will be reclassified to handle school health issues and assure that we are meeting the EPSDT outreach and support regulations outlined in our state Medicaid plan. A total of 47 FTE's are currently budgeted for SFY09. Depending on the success of grant awards applied for, additional FTE's may be added.

1a. Division of Public Health-Section of Women's, Children's and Family Health (47 positions):

Section Chief (Title V/CSHCN Director) - 1 position.

MCH Epidemiology Unit: Administrative Support - 1 position; PRAMS -- 2.5 positions;

Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions; Pediatric Physician Epidemiologist - 1 position; Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position; MCH Indicators Surveillance position - 1 position; MCH Epidemiologist - 1 position; Toddler Survey (CUBS)- 2.5 positions; Public Health Specialist -- 1 position (vacant); CDC/CSTE Fellow 1 position; CDC Prevention Specialist-1 position

Women's and Adolescent Health Unit: Administrative Support - 1 position; Breast and Cervical Cancer Screening program -- 8.5 positions; Family Planning -- 1.25 positions; Perinatal Health -- 1 position; Reproductive Health Partnership 0.75 position. Adolescent Health- 1 position (Vacant); Intern position-1 position
Children's Health Unit: Administrative Support -- 2 position; Newborn Hearing Screening -- 2.5 positions; Newborn Metabolic Screening -- 1.5 positions; Genetics and Birth Defects Program - 1 position; Autism: 1 position; Pediatric Specialty Clinics - 0.5 positions; Oral Health - 3.5 positions (1 in Juneau and 2.5 in Anchorage); School Health/EPSDT: 1 position (Vacant).

Section Administrative Support:

Administrative Assistant II: 1 position (Vacant); Administrative Assistant: 1 position; Administrative Clerk II: 2 positions; Accounting Technician: 1 position

1b. Section of Injury Prevention and Emergency Medical Services:

Alaska Family Violence Project - 2 positions; Child Injury Program - 1 position.

2. Office of Children's Services: Early Childhood Comprehensive Systems Program - 1 position/ABCD Screening Academy/Early Childhood Behavioral Health; Early Intervention/Infant Learning Program -- 4 positions.

3. Division of Health Care Services

EPSDT program: 1.5

4. Division of Behavioral Health:

Suicide prevention support .5 position.

5. Division of Public Assistance: Prevention Services

Unit Manager - 1 position; Administrative Support - 2 positions; Community and Family Nutrition Services - 1 position; WIC Nutrition Programs - 10 positions in Anchorage and Juneau.//2009//

E. State Agency Coordination

The Section of Women's, Children's and Family Health (WCFH) intends to carry on the rich and respected collaboration with partner programs within state government, at the federal level, and within Alaskan communities that was the tradition of its predecessor, the Section of Maternal Child and Family Health. WCFH is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and, ultimately, achieving the mission of the Section.

The reorganization of DHSS in 2003, mentioned in previous sections of Part III, created many changes for the Title V program administration, patterns of work, and relationships with other divisions within DHSS during FY 2004. A lot of effort in the ensuing years went into making the organizational transition, orienting and training new staff, and maintaining services while coping with the new environment. Our current effort is focused on re-establishing and strengthening past and existing collaborations, establishing new ones, taking advantage of the program efficiencies that resulted from reorganization, and providing customer satisfaction.

Below is a description of relevant organizational relationships between the Division of Public Health, WCFH, and other DHHS divisions:

1. Office of Children's Services (OCS)-(child protection): The two divisions collaborated together with the Early Comprehensive Childhood Systems (ECCS-HRSA grant). In addition as one of six states awarded the Strengthening Families Initiative grant by the Doris Duke Charitable Foundation, WCFH staff, as representatives of Public Health, will collaborate with the Division of Public Assistance child care licensing personnel, OCS staff, private childcare resource and referral centers and early intervention programs to meet the initiatives outlined by both grants.

/2008/ This last fiscal year, OCS was awarded the ABCD (Assuring Better Child Development) Screening Academy technical assistance awarded by the Commonwealth Fund. WCFH staff will actively participate in this effort closely as the autism screening and diagnosis team gets up and running. //2008//

/2009/The ABCD Developmental Screening Project is a 15 month project that is scheduled to be completed by August 2008. The Core Committee, Stakeholder Group and pilot medical practices will use the data collected in the pilot practices as a foundation for changes in policies and practice and spreading the use of comprehensive developmental screening tool in medical homes.

The project will also provide the vehicle for exploring care coordination and family support needs. As we work with medical practitioners and referral agencies, a model for care coordination will be designed. Because our resources vary greatly in various regions of the state, this will likely be a multi-layered strategy.

Title V staff continue to work closely with the ECCS coordinator in implementing the strategies outlined in the ECCS plan. Specifically Title V staff participate in the subcommittees focused on expanding developmental screening (Goal 1; Objective 5 To develop a model of care coordination to ensure children with developmental or medical needs will be referred to appropriate services) and increasing the eligibility levels to qualify for Denali KidCare (Goal 1; Objective 6 to increase the number of eligible children enrolled in a public health insurance program). In addition, the perinatal staff participate in early screening using standardized tools for postpartum depression (Goal 1, Objective 10; To increase awareness about the importance of screening for maternal depression and other caregiver mental health issue). The DHSS Children's Policy Team chaired by the acting commissioner oversees much of the planning and implementation for children's behavioral health services. The new Interdepartmental Early Childhood Coordinating Council (IECCC) with a representation from a broader group, will become the body approving revisions to the ECCS and overseeing its progress. The MCH Title V/CSHCN Director sits on both committess. //2009//

2. Division of Senior and Disability Services (DSDS): WCFH staff are leading an effort to improve the private sector agencies responsible for coordinated care for medically fragile children discharged from the state's two main NICU's. A steering committee consisting of staff from the Section of Licensing, Office of Children's Services, Medicaid, NICU nurse managers, Durable Medical Equipment providers (DME), early intervention program and others are a part of this quality improvement process.

/2008/ Efforts to streamline processes and open up regulations for more flexible foster parenting models failed to move ahead. The steering committee did identify strategies to improve foster parent recruitment and training for children who are medically fragile. Continued work in this area. //2008//

/2009/ A review of the numbers of children required to stay in the state's two NICU's due to delays in finding medical foster homes indicated a reduced wait for placement in SFY08. Children identified and deemed eligible for the medically complex waiver program were able to find appropriate foster placement with 30-60 days and were successfully discharged. Only one child required a longer waiting period before appropriate foster

placement could be found. This is a decrease from the peak of an average of 4-6 children waiting upwards of 9-12 months in 2004-2006. //2009//

3. Divisions of Juvenile Justice, Public Assistance, OCS/Child Protection, and Health Care Services worked with WCFH staff to lead a process of improving the numbers of mandatory reports for statutory rape. An educational workshop developed in part by the Women's Health unit and presented by local law enforcement and child protection personnel was offered to nurse practitioners, school nurses and public health nurses as a pilot. The workshop received very positive reviews and thus more workshops are planned in coordination with community nursing education and public health conferences.

//2009/ Two additional workshops were conducted in rural parts of the state on mandatory reporting for sexual abuse of a minor. The workshops continue to be well received by the health care providers who participate. //2009//

4. Division of Behavioral Health: WCFH staff has participated in a Comprehensive Mental Health Systems committee to develop strategies to meet the goal of "bringing the children home" from outside behavioral health treatment facilities. Although the focus on prevention of behavioral health issues in very young children is not present currently, this effort has allowed WCFH staff to have an opportunity to insert information regarding the importance of early diagnosis and intervention during the very early years as a means to perhaps prevent a need for intervention in the teen years.

5. Federally qualified health centers (FQHC): This program was moved to the commissioner's office at the start of FY05. WCFH staff has worked with them in the past to assist with systems development of infrastructure in some of the more remote communities. WCFH staff has also worked with the FQHC staff on information regarding contraception, immunizations, and care standards for prenatal, neonatal and pediatric patients. Involvement of Medicaid staff with the WCFH staff has resulted in developing a pilot plan to provide payment for case management for adults.

//2008/ The Reproductive Health Partnership has provided training on IUD and Implanon insertion techniques and has provided reproductive products and educational materials in areas of the state where the highest rates of teen and out of wedlock pregnancy exist. In addition, TV and radio PSA's were developed in collaboration with teens from rural and remote parts of the state stressing the importance of healthy relationships and addressing the consequences of relationships where there is a large age difference. This perspective was chosen based on the recommendations from teen focus groups as a means to education and not lecture teens on the particulars of the Sexual Abuse of Minor statutes (statutory rape aspects included) . //2008//

//2009/ The Reproductive Health Partnership continues to provide health care training, supplies and educational materials to health care providers in rural Alaska. A focus on health aid training with the provision of hand outs and teaching methods has been very well received. Staff are now regular presenters at all of the health aide training sessions and their annual conference. Staff partner with public health nursing, juvenile justice center staff, and non-profits run by Alaska Native corporations in supporting not only training but also in the work with teens on health relationships. A trainer from Planned Parenthood was brought up from Outside for a train the trainer sessions in rural Alaska. Additional training opportunities will occur in July with Native Alaskan Teens in preparation for the Youth and Elders conference scheduled for October.//2009//

6. Division of Public Health: As a Section within the Division of Public Health, WCFH has had daily contact and close working relationships with Public Health Nursing, Chronic Disease Prevention & Health Promotion, Epidemiology, Injury Prevention & Emergency Medical Services (IP/EMS) the Medical Examiner's Office and the Bureau of Vital Records . Each of these sections has supported MCH through data collection and analysis, providing direct health care services, and extending prevention and treatment services for MCH populations. As a result of this work, programs located outside WCFH are including children, those with special needs, and young

families.

7. Division of Health Care Services: During the time when several Title V programs resided within the Division of Health Care Services, the Title V/ CSHCN Director established a strong collaboration with the Medicaid staff especially in areas of clinical issues and in the development of regulations that would affect the populations that the MCH programs typically served. For example, regulations around Special Medical Equipment (SME) were updated and staff who manage the programs for CSHCN were instrumental in expanding items to be covered including specialized nipples and bottles for children with Cleft Lips/Palates, digital hearing aids and assistive hearing equipment for newborns and young children are a couple of examples. Clinical staff from WCFH worked with Medicaid on provider billing issues, transportation decisions for CSHCN requiring care at the major pediatric center in Anchorage or outside of Alaska, or for children requiring EPSDT exams. Consultation and management of dental treatments, home health care regulations and payments for CSHCN and pregnant women are additional examples of MCH programs working with Medicaid.

This collaboration continues even as Title V programs were transferred back to the Division of Public Health. As an example, WCFH staff developed a proposal that is awaiting approval to work with Medicaid policy staff to develop a Medicaid state plan amendment regarding the expansion of family planning services.

One goal identified from the Five-Year Needs Assessment is better coordination of programs. One example of fulfilling this goal is the facilitated state leadership workshop titled "EPSDT and Title V Collaboration to Improve Child Health Outcomes" held in May 2006. Participants included staff from the divisions of Public Health, Office of Childrens Services, Health Care Services, Public Assistance, and the Commissioner's Office, and representatives of tribal health agencies. Several new strategies to improving childhood outcomes through the EPSDT program were developed and will be pursued in the coming year. Another example is the on-going collaboration with the Governor's Council on Developmental Disabilities.

A strong collaboration between WCFH and health care providers and agencies has been a priority. WCFH staff are active members of the All Alaska Pediatric Partnership and maintain through this organization contact with health care practitioners, hospitals, clinics and other health care organizations. The Newborn Metabolic and Newborn Hearing Screening programs have also developed strong working relationships with primary care facilities, federally qualified health centers and practitioners throughout the state. Breast and Cervical Health Check, family planning and specialty clinics also promote strong links to community-based service providers in both the private sector and the native health sector.

/2008/ in the coming year, a MCH advisory committee will be established to assist in advising the programs focused on perinatal and birth outcomes, child, and adolescent issues focused on through the Title V national and state performance measures. In addition, a subcommittee for children and adolescents will be formed to address the six specific performance measures for Title V. //2008//

/2009/ The Perinatal committee was created and met for the first time in SFY08, reviewing the work conducted as part of the needs assessment, data and progress made on the performance measures and to identify or validate priorities. A summary of their activities to date can be found in the performance measure section of the MCH Block grant application. //2009//

At the community level, grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach, and parent navigation services. WCFH staff has supported community efforts to promote and plan for the health of children and families. WCFH has also provided direct help when significant health problems have occurred in communities with limited resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives.

/2008/ The section of WCFH partners with Stone Soup group as a means to meet the outcomes

expected as part of the six national performance measures established for children with special health care needs. This organization provides for parent navigation support in a number of different ways including diagnosis specific support on a one to one manner, parents training centers (federal CMS grant), and child specific care coordination processes. Supporting their efforts financially with grants and contracts allows for a greater number of services and systems to be established in the non-profit private sector. //2008//

Other outside partners include the March of Dimes, The Association of Women's Health, Obstetric and Neonatal Nursing, AAP-Alaska chapter, families, and other non-profit organizations, such as Stone Soup, Broken Sparrow, FACE, and the YWCA. Title V funds were utilized to support the development of parent navigation training and expanding this program to communities, in collaboration with the local Family Voices chapter.

Finally, WCFH has a strong relationship with the University of Alaska, both the Anchorage (UAA) and Fairbanks (UAF) campuses. WCFH staff are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Section Chief serves on the advisory program for the UAA's MPH program in support of the program's development and future credentialing application. In addition the UAP located at the university is a close collaborator in developing programs for CSHCN especially in the area of transition from adolescents to adulthood.

F. Health Systems Capacity Indicators

Introduction

To follows is the updated report on Health Systems Capacity Indicators

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	2003	2004	2005	2006	2007
Annual Indicator	48.2	31.2	33.1	45.5	42.1
Numerator	128	91	97	123	111
Denominator	26573	29182	29286	27062	26389
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 - 2007

Source: Alaska Medicaid.

Numerator is Medicaid cases from hospitals for children less than 5 years of age with a diagnosis of asthma (ICD-9: 493-493.92) by state fiscal year (SFY). Denominator is all children under 5 years of age eligible for Medicaid services some time during the SFY reporting period.

Notes - 2006

Source: DHHS, Medicaid files

The numerator is Medicaid cases from hospitals for children less than 5 years of age with a

diagnosis of asthma (ICD-9: 493-493.92) by state fiscal year (SFY).

The denominator is all children under 5 years of age eligible for Medicaid services some time during the SFY reporting period.

Notes - 2005

Source: DHHS, Division of Health Care Services (denominator). Medicaid analysis (numerator).

The reporting year is SFY 2005.

Narrative:

In FY 2006 the indicator increased by 37% over the previous year. The methodology for measuring the indicator is based on Medicaid records, therefore the indicator is representative of the Medicaid-enrolled population.

The methodology used to calculate this indicator has changed over the years and therefore the rates may not be directly comparable. When rates for 2003 - 2005 are recalculated using the 2006 methodology, we obtain the following results: 2003 - 55.7; 2004 - 33.8; 2005 - 36.5.

In a separate study, the Maternal-Child Health Epidemiology Unit within WCFH analyzed asthma prevalence, exposure and medication use in children using a combination of Medicaid data, the Hospital Discharge database, and data from the Alaska Behavioral Risk Factor Surveillance System. The analysis was published in "Asthma in Alaska: 2006 Report". Additionally, the Division of Public Health and the Anchorage School District collaborated to introduce asthma questions into school health screening forms, although these data have not yet been analyzed. The establishment of capacity to do data analysis has come about as a result of the SSDI grant.

The Alaska Asthma Coalition has implemented public awareness campaigns and worked to achieve successful passage of a bill allowing children to self-administer asthma medications at school. The Division of Public Health sections of WCFH and Chronic disease have been able to conduct some surveillance, but it has been limited. A increment for state general funds in support of an asthma surveillance program was not supported this last fiscal year, however the Alaska Chapter of American Lung Association and the Alaska Chapter of AAFA did receive a one time allotment of capital dollars for SFY06. The utilization of medicaid claims as a result of the SSDI help make analysis of data possible. Access to medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid claims data base.

//2009/ In FY 2007, the rate of children hospitalized for asthma, among children less than five years old, decreased by 7.4%, to 42.1 per 10,000. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	83.1	83.1	86.6	88.4	86.8
Numerator	4791	4856	5234	5454	5006
Denominator	5763	5843	6041	6173	5765
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
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Notes - 2007

Data source: Division of Health Care Services

Notes - 2006

Source: Division of Health Care Services

Notes - 2005

Data Source: DHSS, Division of Health Care Services. Medicaid analysis.

Narrative:

/2008/ This measure increased from 86.6% in 2005 to 88.4% in 2006. This is the highest percentage achieved to date.

A facilitated State Leadership Workshop on EPSDT and Title V Collaboration to Improve Child Health Outcomes was convened in May 2006. Participants included representatives from nine state agencies and tribal health organizations. Several strategies were identified and prioritized to follow up in the coming year in an effort to improve the screening rate for children older than 8 years of age and address access to referral providers. In addition, updated newsletters were initiated for families with children less than two years of age. This may have had some effect. The utilization of Medicaid claims as a result of the SSDI, help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff once they have completed training on the use of the Medicaid claims database

/2009/ The Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program. In addition, a new position of School Nurse Consultant/EPSDT outreach will be added to the staff in FFY09. This position will provide technical assistance to school districts around the state and those who have school nurses, provide information on standards of care and disaster planning. In addition, the position will be a liaison for the EPSDT program located in the Division of Health Care Services. It is hoped that outreaching to school age children who are eligible for EPSDT exams will improve the number of children obtaining their well child checks. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	56.8	74.7	76.8	86.5	68.5
Numerator	54	65	63	64	61
Denominator	95	87	82	74	89
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 - 2007

Data source: Division of Health Care Services

Notes - 2006

Source: Division of Health Care Services

With the reduction in the percentage of FPL for eligibility for the SCHIP program, the number of children qualifying for this program dramatically decreased. Also corresponding with this reduction were the number of women who qualified for the SCHIP program for their pregnancy care.

Notes - 2005

Data Source: DHSS, Div. of Health Care Services. Medicaid analysis.

This measure is not particularly useful in Alaska because almost all children fall into the category covered by HSCI #2. The children who would be counted under this measure are those whose Medicaid eligibility changed, a very small number.

Narrative:

/2008/ The rate decreased from 76.8% in 2005 to 64.6% in 2006 (numerator=64, denominator=99). With the change in SCHIP eligibility (Title XXI), down to 160% of FPL, fewer children qualified. In addition, it appears more families with children qualified for family Medicaid (Title XIX) which may in part be responsible for the increase in the percentage noted with HSCI #2. This measure is not particularly useful in Alaska because almost all children fall into the category covered by HSCI #2. The children who would be counted under this measure are those whose Medicaid eligibility status changed thereby making them ineligible for Medicaid, a very small number. This data is provided directly from the Medicaid office as part of our ongoing relationships with them. The establishment of capacity to do data analysis has come about as a result of the SSDI grant.

/2009/ The rate for 2006 was incorrectly reported last year as a result of an error in counting the denominator. The corrected 2006 rate is 86.5%. The rate fell in 2007 by over 20%, to 68.5. The Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program./2009//

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	2003	2004	2005	2006	2007
Annual Indicator	75.8	71.8	72.7	70.0	
Numerator	6638	6478	7041	7108	
Denominator	8762	9022	9687	10151	
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	

Notes - 2007

Source: Alaska Bureau of Vital Statistics

The most recent data available for this indicator is CY2006. CY2007 will be available for the 2010 BG application.

Notes - 2006

Source: Alaska Bureau of Vital Statistics

The most recent data available for this indicator is CY2006. CY2007 will be available for the 2010 BG application.

Notes - 2005

Source: Alaska Bureau of Vital Statistics

The most recent data available for this indicator is CY2005. CY2006 will be available for the 2009 BG application.

Narrative:

/2008/ The indicator rose slightly from 2004 to 2005, not a statistically significant increase. There has been a gradual but significant decline in this indicator since 1995. Addressing the issue of adequacy of prenatal care and the focus on preconception care will be a primary focus the new perinatal nurse consultant hired this fiscal year. . The perinatal nurse consultant has begun focused interviews in communities with the greatest number of births to assess access to prenatal care and the community standards and attitudes around early and continuous prenatal care. In October 2006, Dr. Kotelchuck, from Boston University, was a key speaker at the annual Alaska Maternal Infant Mortality Review conference. His recommendations centered around conducting more frequent postpartum/intranatal visits to better assess postpartum depression, take advantage of teaching opportunities with combined postpartum and well baby checks and offer with follow up early contraceptive coverage to improve birth spacing and decrease unintended pregnancies. A pilot program will be designed looking at this model in the coming SFY to be trailed with one of the larger FQHC's where obstetrical and well newborn care is provided.

/2009/ The indicator fell slightly from 2005 to 2006. The perinatal nurse consultant in WCFH organized the first Perinatal Advisory Committee meeting in April, 2008. Strong interest was expressed in the CenteringPregnancy and CenteringParenting programs. It is hoped that these models will be the main topic for the next Advisory Committee meeting. In addition, reports from obstetrical providers to the MCH Title V/CSHCN director indicated their reluctance in in some practices, their policy changed to not accept any obstetrical

patients until they had proof of Medicaid coverage. This resulted in many women reportedly not receiving prenatal care until well into their second trimester. Verification of this practice will be looked for in data analyzed from birth certificates and PRAMS reporting. Processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	84.9	85.5	89.3	89.1	90.3
Numerator	67156	68734	71571	69398	65144
Denominator	79116	80417	80148	77897	72175
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 - 2007

Data Source: Division of Health Care Services.

Notes - 2006

Source: DHSS, Division of Health Care Services. Report MR-O-45FFY (Medicaid eligibles); Report MR-O-46FFY (Medicaid recipients).

/2008/ This indicator is reported on the 1 through 20 age group population for FFY 2006.

Notes - 2005

Data Source: DHSS, Division of Health Care Services. Report MR-O-45FFY (Medicaid eligibles); Report MR-O-46FFY (Medicaid recipients).

/2007/ This indicator is reported on the 1 through 20 age group population for FFY 2005.

Narrative:

/2008/ The percent of eligible children receiving Medicaid services dipped slightly from 89.3% to 89.1%. This sustains an upward trend since at least 2000. In May 2006 the state benefited from a State Leadership technical assistance workshop on ESPDT and Title V Collaboration to Improve Child Health Outcomes. One goal identified is to increase the participation rate of eligible children receiving dental services. Another goal is to increase EPSDT visits among older children. Several strategies will be pursued in the coming year. Birthday reminders were instituted for children ages 5 and up to remind parents to follow up with their medical home for an annual physical. In addition, newsletters were updated with rotating health topics that re-emphasized the importance of physical and developmental follow up as well as the types of services covered by

Medicaid. Dental utilization has improved with greater access to dentists who are taking Medicaid and the implementation of the dental health aide program in several Alaskan Native villages. The utilization of Medicaid claims as a result of the SSDI grant help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid claims data base.

/2009/The Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program./2009//

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	2003	2004	2005	2006	2007
Annual Indicator	51.9	52.0	53.6	53.1	51.6
Numerator	8652	8732	9110	9000	8376
Denominator	16679	16792	16999	16949	16235
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 - 2007

Data source: Division of Health Care Services

Notes - 2006

Source: Division of Health Care Services

Narrative:

/2008/ The percentage of EPSDT eligible children receiving dental services dipped slightly from 53.6% in 2005 to 53.1% in 2006, not a significant decrease. This is a continuation of a slow but steady upward trend since 1999. Dental services for Medicaid clients is difficult to obtain as many dentists are not accepting new Medicaid clients and the state has only 14 pediatric dental specialists. To fulfill the need for dental services for all people, the Alaska Dental Health Aide Program was developed as a specialty area under the Community Health Aide Program (CHAP) and is operated by Alaska tribal health programs. This program is authorized by federal law only for operation in Alaska. There are four categories of dental health aides, all of whom work under the direct or general supervision of a licensed dentist. The utilization of Medicaid claims as a result of the SSDI grant help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid

claims data base.

/2009/ The percentage of EPSDT eligible children receiving dental services decreased slightly from 53.1% in 2006 to 51.6% in 2007. There has been no change in the access to dental services for Medicaid enrolled children, however, the Alaska Dental health Aide Program continues successfully. A new fee structure is anticipated to go into effect for Medicaid services which will increase reimbursements to dentists caring for children and adults needing dental care. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	100	100	100	100	100
Numerator					
Denominator					
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 - 2007

All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Notes - 2006

All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Notes - 2005

All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Narrative:

In Alaska, all SSI beneficiaries less than 16 years requesting rehabilitative services from the state Medicaid waiver and Developmental Disability waiver programs are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (age 0-21) who are SSI beneficiaries. There is no change in status from the previous year.

/2009/ There is no change in eligibility for rehabilitative services from the previous year. In December, 2007, 983 children under age 16 received federally administered SSI payments.//2009//

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

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

Percent of low birth weight (< 2,500 grams)	2006	matching data files	7	4.8	5.9
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An attachment is included in this section.

Narrative:

/2008/ Low Birthweight (LBW) births in the Medicaid population decreased from 7.3% in 2004 to 6.6% in 2005 while increasing 1% in the non-Medicaid population. While the disparity between LBW Medicaid vs. non-Medicaid births in 2005 is at narrowest since 1999, the rise in LBW births in the non-Medicaid population is not a good trend. Analysis of Alaska birth certificate data indicates that from 1989 -- 2003 there was a significant increase in the proportion of moderately preterm (32 to 37 weeks gestation) and no significant change in the proportion of extremely preterm (23 to < 32 weeks gestation) births. Further analysis is needed to determine what the influencing factors are. This information and analysis will be shared with the soon to be formed MCH advisory committee. Participants of this committee will include perinatologists, neonatologists, obstetricians and family practice physicians from both rural and urban settings.

/2009/ The proportion of low birth weight births increased slightly among the Medicaid population and decreased among the non-Medicaid population, resulting in a widening of the disparity between Medicaid and non-Medicaid mothers. The Perinatal Advisory Committee expressed strong interest in new prenatal care programs. WCFH will respond by organizing educational meetings around these models. In addition, the MCH-Epi Unit initiated a preterm birth surveillance program centered around analyzing birth certificate data. //2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	9	4.1	6.7

An attachment is included in this section.

Narrative:

/2008/ Infant deaths in the Medicaid population decreased from 9.1 to 7.6 per thousand live births. The rate also fell slightly in the non-Medicaid population, thereby decreasing the disparity between the two groups. As noted in prior years, infant mortality rates are tracked in 3- or 5- year moving averages due to the small number of events. Further data analysis is needed to determine what the contributing or influencing factors are regarding this indicator. This information and analysis will be shared with the soon to be formed MCH advisory committee. Participants of this committee will include perinatologists, neonatologists, obstetricians and family practice physicians from both rural and urban settings.

/2009/ The Maternal and Child Health-Epidemiology Unit has been conducting analysis of the Alaska Maternal-Infant Mortality Review (MIMR) data. A voluntary committee of experts review all infant deaths and form consensus findings on contributors to, and causes of, infant death. For infant deaths occurring between 1992-2001, the committee fully agreed with the death certificate cause of death for 44% of the cases reviewed. The committee found that the three leading cause of death categories reviewed were

SIDS/asphyxia, preterm birth, and congenital anomalies. Findings of the MIMR were published and presented by staff. A new medical examiner who joined the state staff has experience and interest in doing more thorough autopsies and investigations of children under the age of one who die in Alaska. New protocols are in the process of being established to support this goal and assure that a correct cause of death is recorded. //2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	74.6	89	81.3

An attachment is included in this section.

Narrative:

/2008/ The percentage of pregnant women entering care in the first trimester remained approximately the same for both groups. While long term trend has been positive for both groups since 1999, the increase has been larger in the non-Medicaid group. In 2005, the disparity remains about the same, a difference of 14 percentage points.

/2009/ The percentage of women entering care in the first trimester remained approximately the same for both groups, compared to the previous year. //2009//

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	68.8	71.5	70

An attachment is included in this section.

Narrative:

/2008/ The percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) dropped slightly in the non-Medicaid populations by less than 1 percentage point and increased slightly in the Medicaid population by 2.4 percentage points. The disparity between the two groups has been narrowing steadily since 1999.

/2009/ From 2005 to 2006, the percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) dropped slightly in both groups by about the same amount. //2009//

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)	2007	162
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)	2007	162

Notes - 2009

This is a weighted average for the period spanning October 2006 through September 2007. There are few children in the 0-1 age category. Babies born to mothers enrolled in Medicaid are covered under Title XIX for the first year

Narrative:

/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this legislation into law however. In 2003 the income eligibility limits for Denali KidCare were frozen at 175% of that year's federal poverty level. In the ensuing years, inflation reduced the effective eligibility levels and approximately 2,500 beneficiaries lost coverage since 2003. This legislation would reinstate about 1,300 of the beneficiaries who lost coverage. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

/2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

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	YEAR	PERCENT OF POVERTY LEVEL Medicaid
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pregnant women.		
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	162
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 19) (Age range to) (Age range to)	2007	162

Notes - 2009

This is a weighted average for the period spanning October 2006 through September 2007.

Narrative:

/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this legislation into law however This will reinstate coverage to many of the families that lost coverage since 2003. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

/2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

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	2007	162
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	2007	

Notes - 2009

Pregnant women are not funded under Title XXI, SCHIP.

Narrative:

/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this

legislation into law however This will reinstate coverage to many of the families that lost coverage since 2003. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

//2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

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

Notes - 2009

Narrative:

Alaska's MCH data capacity is very good. There is improved access to Medicaid claims information and Medicaid pharmacy billing data for research and analysis. The Bureau of Vital Statistics is moving towards adopting an electronic birth certificate system, which will enable linkages to the universal newborn hearing screening program and the metabolic screening program in the future. The Hospital Discharge Database continues to improve collection efforts. The SSDI grant has assisted in developing data linkages in support of increasing capacity.

/2009/ The MCH-Epi Unit has utilized WIC data and linked WIC data to birth certificate data. Improvements to usage of WIC data are needed with respect to timeliness of response to data requests and the 'cleanliness' of the data itself. //2009//

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	Yes

Notes - 2009

Narrative:

The Youth Risk Behavioral Survey (YRBS) was conducted through a cooperative effort between the Section of Epidemiology and the Alaska Department of Education and Early Development, Division of Teaching and Learning Support. For the 2005 YRBS Alaska obtained a 55% overall response rate, fewer than the CDC requirement of 60%. As a result, no analyses were conducted.

For the implementation of the YRBS in Spring 2007, participating districts were contacted earlier in the academic year for obtaining active parental consent. The minimum overall response rate will be reached for the 2007 school year. Analysis of this data will be forthcoming. There are two bills before the Alaska Legislature that propose changing the consent from active to passive. This change would encourage a higher participation rate in the survey. Currently the bill has passed the House, but is being held in the Senate Rules committee by a legislator who is not in agreement with the change. Further work on exploring how to accommodate his concerns will be investigated during the summer recess.

/2009/ In 2007, the Alaska YRBS obtained an adequate response rate, yielding important survey results on tobacco use and other risk factors. You can find the results of their analysis at <http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm>.//2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Section of Women's, Children's, and Family Health (WCFH) has developed great capacity in terms of programmatic and population-based data analysis and surveillance activities for MCH-related programs. The MCH Epidemiology Unit is key to supporting the MCH Block Grant requirements and the initiatives of the Section. Their data collection, analysis and research activities provide the basis of accountability required by GPRA as well as reliable data for program evaluation, needs assessments and policy/decision making.

One of our priorities during the past three years was to make our data and findings available to the public through the Alaska MCH Data Book, Maternal and Child Health Fact Sheets and research papers. Users can query data tables on our website for leading MCH health status indicators which are updated every two years.

The Alaska WCFH Data Books are intended to serve as a reference guide for statistical and epidemiological information for use in program planning and decision-making. It provides critical data on leading health status indicators and emerging issues in maternal and child health. Data books are distributed in hard copy and are available for download from the MCH Epidemiology website. Two editions have been published -- an MCH edition in 2003 and a PRAMS edition in 2005. A new data book on findings from the Alaska Birth Defects Registry and Surveillance System was published in FY 2007 and the original 2003 data book will be updated in FY 2009.

WCFH Fact Sheets, one-page publications providing easy-to-read information from our surveillance programs, are produced in hard copy and available on our website. These were very useful in developing the 2005 Needs Assessment and state priorities and will be updated annually.

***/2009/ Seven Fact Sheets on the high priority MCH topics were updated and distributed in 2007. Additional updates will be done as data comes available. These Fact Sheets have been found to be very helpful in educating professionals and legislators on specific topics. Fact Sheets are available at:
<http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na2005.htm> //2009//***

Other research documents such as the Family Health Datalines and Epi Bulletins are produced in hard copy and available on our website.

In November 2005 WCFH successfully filled the MCH Indicators Surveillance position that had been vacant for over a year. This staff person is responsible for collecting and disseminating surveillance data, updating MCH indicators, publishing data to the website and conducting research.

A pilot survey of toddlers is being launched in FY 2006. It is a PRAMS follow-up survey that will provide population-based data on pre-school aged children in Alaska. The goal is to evaluate the association between prenatal and immediate postnatal factors with early childhood health and welfare. The survey is a response to community and staff concerns on early childhood health.

/2008/ A manager for the toddler program and a research analyst were hired to develop and administer the toddler survey name CUBS (Childhood Understanding of Behavior Survey). The first year of data collection of two year olds has been completed and analysis is underway. The next survey will be of three year olds. Alaska is only one of four states undertaking the collection of data on children three years of age regarding a number of aspects of their health and developmental status. The survey is conducted using a similar process of that used with PRAMS (Pregnancy Risk Assessment Monitoring System). The positions and expenses of this survey are supported with Title V MCH Block grant dollars. //2008//

/2009/ A research project investigating risk factors for prolonged maternal depression is underway, utilizing PRAMS data linked to Phase I CUBS data. A paper and a presentation are planned upon completion of the project. The manager of the CUBs program submitted an abstract to the 2008 AMCHP conference, but was not chosen. They will be submitting an abstract again for the 2009 conference as well as for the MCH Epidemiology conference.//2009//

/2009/ The MMIR is currently reviewing all infant deaths from calendar year 2003 and child deaths that occurred in calendar year 2004. Because this program was in hibernation during FY 03-06 due to the reorganization and dismantling of the maternal child health programs, reviews fell behind. The program manager is working hard to get up to date with reviews and committee members are volunteering more time to participate in the review process.//2009//

/2009/ To address the state priority of reducing the rate of child abuse and neglect, a new surveillance program, the Alaska Surveillance of Child Abuse & Neglect (Alaska SCAN) was created in 2007. The program resides within the MCH-Epidemiology Unit. The goal is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. The Alaska SCAN system will link data from these various organizations which include, but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review finds, and child protect services reports. This systematic collection of information and application of standardized, sensitive public health definitions promotes data consistency over time. Data from SCAN will also be used to implement, monitor, and evaluate scientifically-based, community focused initiatives, as well as advocate for resources based on reliable and consistent information. MCH-Epi Unit will produce and distribute an annual report describing the findings. A description of the program is available at this link: http://www.epi.hss.state.ak.us/bulletins/docs/b2008_06.pdf

To address the state priority of reducing the rate of post-neonatal mortality, the MCH-Epi Unit initiated a preterm birth surveillance project, managed by our new CDC CSTE (Council of State and Territorial Epidemiologists) Fellow. Tracking short- and long-term outcomes among all Alaskan preterm births would help evaluate Alaska's capacity to maximize health outcomes of these infants. Initial analysis of birth certificate data was published in an Epi Bulletin, available at this link: http://www.epi.hss.state.ak.us/bulletins/docs/b2008_12.pdf. //2009//

The MCH Epi Unit also collaborates with other divisions with DHSS and outside agencies. The unit's pediatric epidemiologist assisted the Anchorage School District to design a School Screening Questionnaire for asthma, evaluated the association between sexual activity related claims and abuse reports among teens enrolled in the Medicaid program and assisted the Healthy Families Intensive Home visitation program in their program evaluation. Finally, he assisted the Section of Epidemiology and the CDC in performing an analysis of invasive neonatal group B streptococcal disease and its relationship to adherence to management guidelines.

The Five-Year Needs Assessment was completed in FY 2006. WCFH used data and findings from the MCH Epi Unit to develop 40 Fact Sheets on a wide variety of MCH issues. The Fact Sheets included several assessments: national comparisons; estimates of severity, urgency, disparities and economic loss; interventions and recommendations; and description of capacity to address the issue. They were presented in a series of focus group meetings where needs, priorities and state performance measures were developed. Two new priorities, childhood obesity and mental health, were identified. Three state performance measures were revised, six new measures were developed and one measure remains unchanged.

B. State Priorities

WCFH assessed priority needs and State performance measures during the five-year statewide needs assessment. Focus will continue to be on prevention and early intervention services related to family violence, child abuse and neglect, young children's access to health care and reduction of unintended pregnancy. Two new priorities, childhood obesity and mental health, were identified. These expand coverage of the MCH population. MCH will rely upon the MCH EPI staff to support programs and monitor activity effectiveness through its development and implementation of data systems and analysis of relevant data.

State priorities are as follows:

1. Reduce the rate of drug use among families, primarily alcohol intake and cigarette use.

Enabling Services:

- WCFH staff work with prenatal health care providers to identify early and intervene by actively referring women who are drinking, especially during their pregnancy. WCFH plans to advocate in communities for more treatment facilities for women who have children and need a residential program. This was again vocalized as a major issue that needed work at the community MCH Title V block grant review work sessions held in May of 2007.

- WCFH staff plan to redistribute Healthy Mom/Healthy Baby Diaries which include warnings about the effects of alcohol, drugs and tobacco on unborn babies and infants. /2008/ New education materials on the effects of smoking and alcohol ingestion have been purchased and will be distributed to health care providers, tribal health centers, FQHC's, and public health centers. //2008//

/2009/This was a priority issue identified to be focused on in SFY09 by the Perinatal Advisory Committee. Partnership with the Division of Health Care Services (Medicaid) and the Division of Public Assistance will be coordinated in the areas of smoking cessation counseling and public education at public assistance offices. //2009//

Population-Based Services:

- WCFH staff collaborates with the local March of Dimes chapters as part of the preterm delivery campaign to develop smoking cessation classes with hospitals and local agencies and to develop support systems for women who are pregnant.

Infrastructure Building Services:

- WCFH Epi collects and analyzes data through its FAS Surveillance and Pregnancy Risk Assessment Monitoring activities.

- WCFH Epi produces yearly publications (Fact Sheets, MCH Data Book, and MCH Datalines) on FAS and other effects of prenatal alcohol use, prenatal smoking, drinking, and illicit drug use, post-partum smoking and drinking, and prenatal and post-partum binge drinking.

- Alaska PRAMS added questions regarding iq'mik use and commercial spit tobacco use during the prenatal period. These data have never been collected before and will be available for birth years 2004-2008.

- ***/2009/ Perinatal nurse consultant will partner with Healthy Native Babies Project, working to reduce SIDS and addressing tobacco use. //2009//***

2. Reduce the rate of child abuse and neglect.

Enabling Services:

- MCH programs addressing this issue include the Healthy Families Alaska home visiting program and the Family Violence Prevention Project.

/2008/ Title V MCH block grant funds support pilot projects at child-care centers across the state who participate in the Strengthening Families Initiative (SFI) focused on enhancing family support. The SFI is an abuse prevention framework developed by the Center for the Study for Social Policy. As one of only six states awarded this grant from the Doris Duke Charitable Foundation, this collaborative effort brings together a leadership team from child welfare, child abuse prevention, early childhood, public health as well as parents and community leaders. The Healthy Families Alaska project was discontinued. //2008//

/2009/ work continued this last year in the Strengthening Families Initiative. Funding from the MCH Title V Block grant was provided in support of additional pilots and in support of state staff to work on "spread strategies" especially within the child care center and licensed home care facilities. //2009//

Population-Based Services:

- WCFH will implement a questionnaire and distribute educational materials on Shaken Baby Syndrome and Sudden Infant Death Syndrome (SIDS). //2008// The Perinatal nurse consultant has completed training on SIDS developed specifically for Alaska native health care providers and pregnant and newly delivered mothers and fathers. She will plan to distribute brochures tailored to the regions of the state she visits as well promote and deliver the training available //2008//.

Infrastructure Building Services:

- WCFH produced fact sheets on child maltreatment, mortality, and injury. These will be updated yearly and available through the web.
- MCH trend data, Healthy People/Healthy Alaskans MCH and family planning data, and all Block Grant performance and outcome measures that are related to this priority are made available through the MCH Epi website.
- WCFH is also collaborating with the Office of Children's Services on the Early Care and Comprehensive Systems grant awarded by HRSA

/2009/

MCH-Epi Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN) to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. //2009//

3. Increase public awareness and access to health care services for children and CSHCN.
Direct Health Care Services:

- WCFH will continue to sponsor genetics clinics and pediatric specialty clinics that would not otherwise be available in Alaska.

Enabling Services:

- The Early Periodic Screening Diagnosis and Treatment (EPSDT) program developed a Medicaid benefits booklet for distribution. EPSDT initiated methods to educate foster parents to improve the level of EPSDT and Medicaid services to children in State custody.
- The EPSDT program also distributes age specific newsletters to Medicaid beneficiaries (both Title XIX, and Title XXI) that provide information on new services, the importance of immunizations and regular well child exams, and growth and development norms.
- WCFH plans to expand parent navigation services, allowing them to work with more families at specialty clinics and to work with families whose newborns are hearing impaired and have neurological issues.

/2008/ Parent navigators will travel with to outreach screening sites conducted for autism and other neurodevelopmental delays//2008//

/2009/ Parent navigators have been added to the neurodevelopmental center providing now 2.0 FTE of parent navigation services to this service area. In addition a part time parent navigator will be added to the team that travels across the state conducting outreach screening and assessment clinics. Plans are underway to train and supervise parent navigators in two to three of the larger communities to provide services in the home community and begin to increase capacity of this very valuable service. Parents are also active and sit on the Autism Alliance AdHoc committee, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), the neurodevelopmental planning committee and all of the advisory committees coordinated within the MCH Title V agency. The new Autism public health specialist will be assisting to manage the work of the parent navigator contracts. //2009//

Population-Based Services:

- MCH programs that offer services for children and CSHCN will be represented in events such as Baby Fairs, health fairs and other venues to distribute information to the public.
- The Section Chief of WCFH (the Title V/CSHCN Director) will continue to participate with the All Alaska Pediatric Partnership in the identification of pediatric sub specialists and their recruitment.

Infrastructure Building Services:

- The Section Chief of WCFH and program staff work closely with Rural Health program staff responsible for FQHCs to ensure needs of children, pregnant teens and CSHCN are considered in their delivery of services.
- The establishment of newborn hearing screening in all birthing hospitals and centers across the state improved collaboration between early intervention and audiological services.

4. Reduce the rate of unplanned and unwanted pregnancies including teen pregnancies.

Enabling Services:

- /2008/ Funding provided from the Division of Public Assistance as part of their teen pregnancy and out-of--wedlock pregnancy prevention program has provided for training in the placement of IUD's and Implanon for health care providers as well as contraceptive supplies and educational materials. The focus of these efforts has been concentrated in the areas of the state where the rates of teen and out-of-wedlock pregnancy are the highest; southwest and northern rural communities. //2008//

/2009/ The Reproductive Partnership focused this year on a train the trainer model for educating teens on healthy relationships and the importance of understanding the "power" in relationships when there is an age discrepancy. Additional public service announcements were created with a visiting trainer/educator to be played in rural Alaskan villages. Focused education of the tribal health aides on contraception education and teen relationships issues was also provided in the rural communities and at the annual Community Health Aide conference. An evaluation component was also added to the programmatic efforts to measure outcomes of teen and unintended pregnancies in the communities where the work is focused. These same activities will continue in SFY09. //2009//

- Public Health Nursing sites are provided with Title X funding and technical assistance to purchase contraceptives and supplies.
- Title V monies fund three nurse practitioner contracts for family planning services in areas of the state where access is minimal.

/2009/ The MCH Title V agency provided funding for a women's health nurse practitioner staff member to travel to areas of the state that are in most need of services as contracting in several areas of the state was not viable due to a lack of nurse practitioner availability.

In addition, the nurse practitioner works one day a week at the Municipality of Anchorage as part of an memorandum of agreement and rotates out to the women's correctional facility to provide women's health care with a focus on women who will shortly be leaving the prison. Expansion of these services is being investigated for the next state fiscal year. //2009//

Population-Based Services:

- WCFH will provide funding through a federal abstinence grant to local high schools which will enable them to conduct Postponing Sexual Involvement training to junior high and high school students. /2008/ The abstinence grant was transferred at the request of the MCH Title V program to the Office of Faith Based Services mid way through the fiscal year in an effort to more successfully recruit a possible grantee for this project. //2008//
- WCFH staff, through conferences and training opportunities, provides information for medical providers and public health professionals on contraception and the need to prevent unintended pregnancies. WCFH staff also offers continuing education opportunities on all topics related to unintended pregnancy.

• WCFH developed a statewide education campaign on teen pregnancy prevention and statutory rape prevention in collaboration with the Division of Public Assistance. Funds will be used to purchase contraceptives such as Mirena and ParaGuard IUD, NuvaRings and emergency contraception for areas of the state where availability is very minimal. Infrastructure Building Services:

- Detailed fact sheets addressing unintended pregnancy, teen pregnancy and sexual behavior, and contraception were developed and will be updated and distributed yearly.
- MCH Epi published an MCH Data Book on Birth Defects in SFY2007. .
- MCH trend data, Healthy People/Healthy Alaskans MCH and family planning data, and all Block Grant performance and outcome measures that are related to this priority are published on the MCH Epi website.
- WCFH staff collaborates with partners on the Alaska Women's Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies.

5. Increase access to dental health services for children.

Infrastructure Building Services:

- A baseline assessment of 2,300 3rd graders across the state was completed for the State's oral health plan.
- The State's Dental Officer oversees contracts with pediatric dental providers to increase access to services for children enrolled in Medicaid/SCHIP.
- The State's Dental Officer participated in the development of the tribal Dental Health Aide Program and in the development of pediatric resident itinerant rotations in Alaska.

Enabling Services:

- The Early Periodic Screening Diagnosis and Treatment (EPSDT) program distributes a Medicaid benefits booklet. EPSDT initiated methods to educate foster parents to improve the level of EPSDT and Medicaid services to children in State custody.

6. Reduce the rate of domestic violence.

Enabling Services:

- The MCH addresses these issues primarily through its Family Violence Prevention Project.
- MCH Title V block grant funds a resource center that contains materials on education and prevention of domestic violence.

Infrastructure Building Services:

- MCH Epi, PRAMS, produces publications on physical abuse around the prenatal period. An MCH Data Book on PRAMS data was published and included an analysis of partner physical

abuse during the prenatal period.

- MCH trend data, Healthy People/Healthy Alaskans MCH and family planning data, and all Block Grant performance and outcome measures that are related to this priority are published on the MCH Epi website.

/2009/The Adolescent Health Manager is an active participant in the CDC's DELTA project-focused on intimate partner and domestic violence. The MCH Title V agency has offered to provide in kind support in the form of evaluation assistance as part of DELTA's application to the RWJ grant focused on Healthy Relationships for preteens and young teens. //2009//

7. Reduce the rate of post-neonatal mortality.

Direct Health Care Services:

- Infants with identified metabolic disorders are referred to state-sponsored Genetics and/or Metabolic Clinics.

Enabling Services:

- Nutrition education information and referral to prenatal care services ensure positive birth outcomes and reduce the incidence of low birth weight among infants born to women enrolled in the WIC Program during their pregnancies.
- WCFH will redistribute Healthy Mom/Healthy Baby Diaries, a handbook for pregnant women and new mothers.
- WCFH will distribute "Never Shake a Baby" and "Back to Sleep" brochures.

Population-Based Services:

- The Newborn Metabolic Screening Program promotes education around reducing the number of hospital discharge refusals and proper collection techniques (enabling service) that has increased and kept steady the percentage of newborns that were screened to 100%. /2008/ In February of 2007, Cystic Fibrosis screening was added to the current panel of over 30 conditions screened by tandem mass spectrometry. //2008//

Infrastructure Building Services:

- Detailed fact sheets addressing infant mortality, infant injury, back to sleep, and co-sleeping were developed. /2008/ These Fact sheets are in the process of revision and will be available on the web site. //2008//
- Data from the Maternal Infant Mortality Review is provided to programs, health care providers and communities for program planning and education that focus on prevention-related activities such as the Back to Sleep and Never Shake a Baby campaigns. The state has actively engaged all of the birthing facilities to participate in the national education campaign around many of these issues.
- The MCH Epidemiology Unit publishes several fact sheets and other public health publications. /2008/ The 2003 MCH Data Book, a comprehensive examination of Alaska's MCH population is currently in revision and will be published in SFY 2008. The Alaska Birth Defects and FAS Data book was published during SFY 2007. //2008//

8. Reduce the rate of teen suicide.

Infrastructure Building Services:

- WCFH addresses this issue through its adolescent health program, promotion of Youth Developmental Assets, and collaboration with other agencies and organizations. The focus of this work was transferred to the Division of Behavioral Health. The Adolescent Health Coordinator originally in this position was replaced by a Resiliency Coordinator position. This position works to blend in the Assets Model and development of resiliency factors for teens as a means of suicide prevention. Teen suicide prevention is a priority issue in the current administration with a dedicated staff assigned to work on it. Involvement of WCFH staff has been limited.

- A new Adolescent Health Coordinator position has been created and is filled at present by a long term non-permanent employee. //2008// A new Adolescent Health manager started July 1, 2007 with WCFH. A portion of this position and its activities are funded by the MCH Title V Block Grant. //2008//
- The MCH Epidemiology Unit regularly produces fact sheets addressing suicide among this population.

9. Reduce the prevalence of childhood obesity and overweight.

Infrastructure Building Services:

- Detailed fact sheets addressing obesity, nutrition, physical activity, and diabetes were developed.
- Public Health collaborated with the Anchorage School District to conduct an analysis of the prevalence of overweight and obesity among school age children.
- WCFH staff participated in the Healthy Kids Alaska coalition which is focusing on improving the nutritional content of school breakfasts and lunches and is advocating for the removal or change in contents of the vending machines in schools across the state.
- WCFH staff is participating in the Mayor's Task Force on Obesity in Anchorage.
- WCFH continues to collaborate with the Section of Chronic Disease in their activities to assure children's needs are considered in program planning.

//2009/ The MCH Title V agency will be working collaboratively with the Section of Chronic Disease as it develops it School Health Nurse consultant position to assure that messages and education on nutrition and daily activity are incorporated in the technical assistance provided to schools. //2009//

10. Increase awareness around mental health issues in the MCH population.

Infrastructure Building Services:

- The 2003 MCH Data Book was a comprehensive examination of Alaska's MCH population.
- MCH Epidemiology has been using Medicaid claims data to examine child mental health issues and is actively exploring the possibility of using data sources other than Medicaid.
- A Future Public Health Summit topic for the Women's Health track will focus on Postpartum Depression and the unique aspects regarding women's mental health issues. //2009/

MCH Title V block grant monies assisted in supporting the development and distribution of the postpartum depression packets for providers and for women experiencing postpartum depression.

The MCH Title V Director participates on the DHSS Commissioner's Child Policy Team which is focused on improving instate access and infrastructure of behavioral health services. In addition, the MCH Title V Director is actively involved on the steering committee and subcommittees for the ECCS grant focused on behavior health training, access and financing strategies. //2009//

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	2003	2004	2005	2006	2007
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Annual Performance Objective	97.5	98.5	100	100	100
Annual Indicator	99.7	100.0	92.6	100.0	100.0
Numerator	9933	10231	25	36	44
Denominator	9959	10231	27	36	44
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

Data source: Alaska Newborn Metabolic Screening Program.

In addition, 166 hemoglobin traits were identified but not included in the denominator since no treatment is indicated for these traits. There were also 7 other infants identified with conditions that did not need treatment but which could be important for families and medical providers to know about.

Notes - 2005

100% for rapid treatment was not reached because upon re-examining two screens and testing the DNA for CPT-1, it was determined that the children had this disorder quite a while after the initial screening. 167 hemoglobin traits were also identified but not included in the denominator since no treatment was indicated for those traits.

a. Last Year's Accomplishments

The percent of infants screened in the State in CY2007 was 100%. The program manager continued with educational efforts addressing collection techniques, confirmatory testing requirements, and specimen transport time. These educational presentations often included continuing education credits. All infants identified with sickle cell disease and carnitine defects in FY 2007 were referred to the Genetics and/or Metabolic Clinics conducted by the State of Alaska. Parents of children with these disorders needed genetic counseling and advice on their child's disorder. All of the conditions diagnosed through the newborn metabolic screening program are reportable to the Alaska Birth Defects Registry, and the program manager provided the registry with this information on a quarterly basis. The number of confirmed cases of CPT-1 continued to increase and a new system for advising these families was developed and started in FY08. All infants to date have been from either western or northern Alaska. The NBMS Advisory Committee held its regular 3x/year meetings with guest speakers from the Alaska Birth Defects Registry, from the Metabolic team at Oregon Health & Science University, and from a local perinatologist on the current recommendations for screening for Down syndrome.

Cystic fibrosis was added to the screening panel as of 2/1/07.

Activities for work with the Western States & Territories Genetics Collaborative included attending an annual meeting and working on the sub-committee dealing with establishing data points for all of the regional states to collect.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continue with education and communication for providers on tandem mass spectrometry disorders.				X
2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted.				X
3. Provide community education through presentations at hospitals, birthing centers, professional organization meetings, and health fairs.			X	
4. Refer infants identified with disorders detected through the screening program to state-sponsored genetics and/or metabolic clinics.		X		
5. Provide information on reportable conditions to the Alaska Birth Defects Registry on a quarterly basis.				X
6. Convene the Newborn Metabolic Screening Advisory Committee on a three times per year basis to develop policies and review the program activities.				X
7. Continue to work with the EHDI web-based database vendor to enhance the reporting and searching function of the metabolic integration.				X
8. Initiate a task force to look at newborn screening card usage with the possibility of changing our current billing procedure.				X
9. Continue with active participation on the Western States & Territories Genetic Collaborative grant to improve access and education about genetics services in Alaska.		X		X
10. Continue collaboration with Alaska Native Tribal Health Consortium and Oregon Health & Science University to educate families and medical staff around the state regarding CPT-1.		X		X

b. Current Activities

Infants identified with CAH, fatty acid oxidation disorders, organic acidemia disorders, biotinidase, and Galactosemia are referred to the Genetics and/or Metabolics Clinics conducted by the State of Alaska. Infants identified with hypothyroidism are referred to the Alaska based pediatric endocrinology clinic and started on treatment.

More than 90 confirmed cases of a carnitine disorder called CPT-1 are found in the Alaska Native population. Biochemical geneticists from Oregon are working with Alaska physicians to try to determine the significance of this new finding. Collaboration with Alaska Native Tribal Health Consortium is underway to conduct special clinics and group counseling just for families with infants diagnosed with CPT-1.

The NBMS Advisory Committee holds its regular meetings three times per year with updates on CPT-1 at two meetings and a genetics counselor presentation on the Early Hearing, Detection, and Intervention (EHDI) program.

Ongoing educational efforts include presentations to physicians, nurses, and laboratorians at hospitals and professional organizations regarding the screening program, proper collections techniques, and proper follow-up testing of presumptive positive screens.

Database integration merging newborn hearing screening with metabolic screening into one child health record is in an initial phase.

c. Plan for the Coming Year

We anticipate the need for continuing education efforts regarding the lesser-known conditions identified through expanded testing with tandem mass spectrometry. Most important will be

education on the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility.

Once it is determined the number of infants who may be missed for a CPT-1 diagnosis through the newborn screening program, the next effort will be a mass educational intervention for providers and families. A large number of newborn screening samples will be tested through the confirmatory process for CPT-1 in an effort to determine the false negative screening percentage.

Integration of NBMS data with the software database purchased by the EHDI program will be completed through all of the phases thus enabling both program managers to run queries and reports. Birthing hospitals will be the first users of the database to have access to the metabolic screening portion of the information with other sites and providers added over time. This database will provide the means for State program staff to better track infants needing follow-up.

Ongoing work with the Western States & Territories Genetics Collaborative and other children's health programs including EHDI Program, Specialty Clinics and Genetics and Birth Defects Clinics will continue during this next year.

These are enabling and infrastructure-building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	59	61	63	61	61
Annual Indicator	57.2	57.2	57.2	57.2	51.8
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	61	61	61	61	65

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2005

/2007/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

At State-sponsored genetics clinics, patients met with board certified clinical geneticists for purposes of diagnosis, discussion of the disorder, its history, possible confirmatory testing or carrier testing, and treatment and recurrence risk to future pregnancies. Genetic counseling is non-directive. A genetic counselor was available to families prior to clinic, during the clinic appointment, and afterward. After meeting with the geneticist, parents were sent a medical report summarizing their genetics clinic visit and laboratory results. Parents were given information about national (disease specific) support groups, local parent contacts, and local support organizations. If appropriate, patients were referred to other state specialty clinics for coordination of specialty care. They were given information about Denali KidCare (state CHIP program) and non-state treatment organizations

Metabolic genetics clinics primarily serve children diagnosed with metabolic conditions on newborn screening but are also for diagnosis of suspected disorders. A nutritionist and board certified clinical biochemical geneticist, and genetic counselor worked with parents of children with metabolic conditions (PKU, galactosemia, CPT1) to assure dietary compliance and monitor monthly blood tests. The genetic counselor worked with these families to arrange formula shipments or assist them with trouble-shooting insurance reimbursements. She worked with families and the school district to assure that children receive recommended school services, including special dietary needs, psychosocial assessments, special classroom placement for hearing/vision impaired, modified physical education, and special education services.

The client evaluation form has been revised and simplified, attempting to gather more useful information for program planning, and to increase the response rate. In the past, patient response was about 10-25%. The simplified form is a self-addressed anonymous postcard that asks parents to assess their clinic appointment in terms of the information learned at clinic (understandable, useful, and the information they were looking for), and how the service was delivered. In addition, it asks parents how far they needed to travel to clinic and how long they had to wait for an appointment after referral. This allows the staff to re-schedule rural clinics based on population need.

Cleft Palate Clinics encouraged parents of CSHCN to become more involved in decision-making through the use of Stone Soup Group parent navigators. Parent navigators participated in clinics in Anchorage, Bethel, and Fairbanks. They provided clinic preparatory and follow-up services for families who requested their support as well as an opportunity to meet at clinics. They solicited feedback from families who attended state-sponsored clinics via a post-clinic survey to determine their level of satisfaction. In addition they delivered information packets to hospitals for distribution to parents of newborns with clefts. One parent navigator attended the North American Craniofacial Family Conference in Las Vegas. These services and activities were funded through a state grant using MCH block grant dollars.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to hold genetics clinics in public health centers, Children's Hospital at Providence and clinic space easily accessible to parents.		X		
2. Provide patient services for genetics clinics (referrals,		X		

scheduling, travel, medical record collection, and follow-up) by public health nurses and clinic coordinator.				
3. Update and regularly administer client/family satisfaction surveys.				X
4. Develop database for surveys to evaluate client satisfaction.				X
5. Disseminate brochure designed for parents on CPT1 to rural areas.		X		
6. Continue support of parent navigation services with MCH Block Grant funds.		X		X
7. Disseminate brochures on genetics services consortium to health care providers and parents.		X		X
8. Expand parent navigation services to include the new autism screening and evaluation clinics.		X		X
9. Continue parent involvement on MCH supported advisory committees and recruit parents for new advisory committees for adolescents and perinatal care.				X
10. Continue outreach clinics in current rural Alaskan communities and expand to new communities as financially feasible.	X	X		X

b. Current Activities

Genetic counselors working at Seattle Children's Hospital and Medical Center are included in the State of Alaska contract to provide services to Alaska families seen in the genetics clinics held six times per year around the state. A second genetic counselor accompanies the metabolic geneticist to Alaska twice each year for the metabolic clinics. The Title V MCH program personnel includes a clinic coordinator to staff the Anchorage office to coordinate the statewide clinics and provide support to families locally. The clinic coordinator schedules patients, collects medical records, arranges for travel and coordinates follow up and works with families to meet their needs at the clinic and once a diagnosis is confirmed.

Four public health centers and one rural hospital host genetics clinics in hub communities around the State. Clinics are held at the Alaska Native Medical Center once or twice a year based on the number of referrals. Feedback on how well this system achieves this performance measure is collected through post clinic parent surveys.

Parent navigator activities continue at Cleft Lip and Palate (CL/P) Clinics, as well as for families of children with hearing loss and working with the neurodevelopment center. They link families to resources and provide support as needed. Post-clinic satisfaction surveys for CL/P show that 85% of families who responded felt that services offered at clinics were excellent.

c. Plan for the Coming Year

Ongoing surveys of parents to evaluate if their needs are being met will continue in FY2009. In addition, parent navigation services will continue for Cleft Lip and Palate Clinics and children with hearing conditions. Services will expand to the neurodevelopmental and autism screening and evaluation clinics. As part of their role, parent navigators will work with parents at Cleft Lip and Palate Clinics, provide in-service training to hospital staff, make hospital visits to parents of newborns with orofacial clefts, visit parents who have a child diagnosed with a hearing loss, assure that appropriate referrals are made to state-sponsored Cleft Lip and Palate Clinics, hearing service providers and early intervention as well as facilitate parent-to-parent contact when appropriate. In response to a request from parents, they will determine whether or not it is feasible to organize social activities for cleft-affected teens where they can interact with others who share their diagnosis. One parent navigator plus a parent of a cleft-affected child will attend the North American Craniofacial Family Conference in Las Vegas. Parent navigation services for

children diagnosed with a hearing loss will continue to expand to other communities in the state as the navigator travels to areas of the state identified as having the greatest need. Educating the federally qualified health centers/community health services (FQHCs and CHCs) about their work will also be a part of the work in the coming year.

Assessment of how best to educate families and health care providers regarding CPT-1 deficiency is being developed. Discussions will be held on how to hold group sessions for families living in areas of the highest incidence. Parents will be asked how much information they need and what information is most helpful to them.

These are enabling, population-based and infrastructure-building services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	50	52	54	50	50
Annual Indicator	46.5	46.5	46.5	46.5	39.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	45	45	45	45	45

Notes - 2007

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

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2005

/2007/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

Since there are no pediatric geneticists in Alaska, DPH contracted with Seattle Children's Hospital and Regional Medical Center (CHRMC) to conduct statewide outreach clinics. The contract included services of clinical geneticists who offer diagnostic clinics for children with genetic diseases, birth defects, or persons "at risk" for genetic conditions because of ethnicity, family history or age. Metabolic geneticists and metabolic nutritionists staffed metabolic genetics clinic for medical management of children/adults with inherited metabolic conditions, particularly children identified on newborn metabolic screening.

MCH block grant funds and program receipts supported certain direct care services for children attending genetic clinics. No one was refused services due to inability to pay. A sliding fee scale was provided based on poverty guidelines and all third party payers were accepted. Patients referred to genetics clinic were required to have a medical home. The genetic counselor assisted them in obtaining a medical home if they did not have one. This was usually a primary care pediatrician, a family practice physician, or a sub-specialist knowledgeable in management of a specific genetic condition. The genetics clinic was a consultative clinic and did not provide primary care. Reports summarizing the genetics clinic evaluation, which may include recommendations for care and further testing were sent to the primary physician. Geneticists were available to primary physicians for consultation or technical assistance. The genetic counselor worked with local hospitals and CHRMC to assure that families were referred to appropriate community based genetics clinics following hospital discharge, or that families were aware and able to attend regional clinics (e.g. metabolic clinics) if a local clinic was not accessible. Finally, the geneticists and genetic counselor worked with families to locate and refer to out-of-state medical centers for care if instate resources were unavailable.

Pediatric specialty clinics worked with providers to assure that CSHCN received care within a medical home. Families that recently moved to Alaska and did not yet have a medical home for their child were encouraged to establish one. Medical homes vary from pediatricians and family practice physicians in urban areas to itinerant public health nurses and community health aides in rural areas. Since there is no craniofacial center in Alaska, the state coordinated clinics for children with facial clefts. A multidisciplinary team of health care providers offered evaluations and treatment planning. Recommendations were given to patients' parents and providers. The state also contracted with providers to offer pediatric neurodevelopmental clinics in hub communities where these services were not otherwise available. Referrals to this specialty clinic came from children's primary health care providers. Paper Trails notebooks were given to families of CSHCN to assist in managing medical records. Continuing education was provided on neurodevelopmental topics to staff at rural public health centers and to local providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand metabolic clinics to other rural locations as needed.	X			X
2. Add clinics specifically for CPT 1 in communities where newborns diagnosed with this disorder are living.	X	X		X
3. Continue financial support with Title V MCH funds for space rental for pediatric neurologist in Fairbanks clinic.				X
4. Continue parent navigation services for parents of children with cleft lip and palate and those with infants or children identified with hearing loss.		X		
5. Explore and develop a plan for expanding parent navigation services for other specialty conditions in collaboration with medical home.		X		X

6. Expand neurodevelopmental clinics/autism screening and assessment clinics to more rural communities.			X	X
7. Move clinics from public health centers to facilities in the private sector as needed.				X
8. Educate primary care providers regarding newborn hearing screening regulations and the protocol regarding infants/children identified with hearing loss				X
9.				
10.				

b. Current Activities

Genetic and metabolic clinics in Anchorage and outlying areas are undergoing evaluation regarding the number of referrals in the area to provide the optimal number of physicians and appointments to meet the needs of the communities. Genetic clinics are held at Alaska Native Medical Center (ANMC) once or twice a year based on number of Alaska Native/American Indian referrals.

Cleft lip and palate clinics continue in Anchorage and Fairbanks. Since many of the cleft-affected children from the Bethel area attend Anchorage clinics, Bethel did not host a clinic this year. The need for a Bethel clinic is being reviewed. Anchorage clinics are held at the ANMC to facilitate easy access to other services for Alaska Native children who attend the clinic.

Primary care providers are being educated about the hearing loss protocol with the new hearing regulations taking effect January 1, 2008. Children with hearing loss are referred to a parent navigator who assists the family in meeting their goals regarding hearing services and early intervention services.

Primary care providers are the primary referrals received for specialty clinics and services. If a family self-refers, work is done to identify or locate a medical home for these children. In addition, primary care providers received reports of any EPSDT exams conducted by public health nurses in rural/bush health centers. Maintaining communication with primary care providers is a goal for all providers seeing children in the state.

c. Plan for the Coming Year

Changes to program staff and reassessment of program resources will likely alter the direction of the genetics program in the near future. Eliminating rural clinics and/or replacing them with telemedicine services would be cost saving and time saving (from the clinic standpoint) if it is possible to implement. While Alaska has limited telemedicine capabilities, hospital-to-hospital facilities will improve, and may be utilized to replace in-person clinics, or for in-patient consultations. Following the example of other states, this is likely to begin for patients with established diagnoses, such as follow up for metabolic conditions and for cleft lip/palate. Educating rural physicians on follow up of abnormal newborn screening disorders, especially CPT1, will allow the primary care provider to assume some of the treatment role. Title V MCH block grant funding provides the majority of support for this effort.

The state will continue sponsoring pediatric Neurodevelopmental Clinics in Fairbanks and Juneau along with pediatric Cleft Lip and Palate Clinics in Anchorage and Fairbanks. The focus of public health nursing has shifted, and they will no longer be able to support clinics at the same level as previously. Clinics that were once held at public health centers will be moved to facilities in the private sector in some of the communities. Additional funding approved by the legislature and funding from the Alaska Mental Health Trust Authority will allow an expansion of neurodevelopmental/autism screening and assessment clinics. Continuation of Bethel Cleft Lip and Palate Clinics will be contingent on input from providers and families in the Bethel area. Finally, Title V funds will be utilized to rent clinic space for up to six days of pediatric Neurology

Clinics in Fairbanks. With all clinics, assuring services are linked with a medical home and are organized in a way that makes sense for families are central to the work conducted.

The annual Genetics clinic in Bethel will be moved from January to March due to unfavorable weather conditions during the month of January. This clinic will continue to be held at the YKHC hospital with two physicians and one genetic counselor. The State will continue to sponsor Genetics clinics in Sitka, Ketchikan, Juneau and Fairbanks in Public Health Centers. The Metabolic clinic will continue to hold clinics in Anchorage and Fairbanks and the number of days for the Anchorage clinic will be evaluated to meet the needs of the expanded newborn screening referrals.

Work will continue with the Alaska Native Tribal Health Consortium to educate families and providers regarding CPT-1 deficiency regarding what it means, how it may effect their child, and when it is necessary for medical intervention.

These services are direct health care, enabling, population-based and infrastructure building.

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	2003	2004	2005	2006	2007
Annual Performance Objective	60	60	60	60	60
Annual Indicator	58.6	58.6	58.6	58.6	62.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	70	70	70	70	70

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2005

/2007/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

Insurance information was collected and tracked for all children accessing state-sponsored CSHCN services. CSHCN program collaborated with the Denali KidCare program, which provides Medicaid coverage to many CSHCN. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provided IHS funds as payer of last resort for genetics and specialty clinics services. TriCare covered the cost of clinic visits for military dependents referred to state-sponsored clinics. More than 62% of children who attended the Cleft Palate and Neurodevelopmental Clinics were covered by Medicaid/Denali Kid Care and/or Indian Health Service. Only two percent were self-pay. In addition some CSHCN were covered by private insurance. State-sponsored genetics and specialty clinics services were provided regardless of ability to pay.

To facilitate access to hearing screening and follow up of children born out of hospital, hearing screening equipment has been placed in eight Public Health Nursing centers. This allows for hearing screening at no cost for home births, midwifery center births, or infants needing a re-screen following hospital discharge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect and track insurance information for all children accessing state-sponsored CSHCN services.				X
2. Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services.				X
3. Provide genetics and specialty clinics services regardless of ability to pay. Offer reduced fee based on income to families that self-pay.	X	X		
4. Work with the military on referrals and authorizations to include their beneficiaries in state-sponsored clinics.	X	X		
5. Bill Medicaid as appropriate for CSHCN who attend state-sponsored specialty clinics.		X		
6. Work with Division of Health Care Services to expand Medicaid coverage for nutritional supplements/supplies for children with inborn metabolic disorders.		X		
7. Continue to assure coverage for hearing aid supplies and treatment are commensurate with the Medicaid fee schedule.				X
8. Continue to provide the Hearing Aid Loaner Program to enable deaf or hard-of hearing children to obtain hearing aids if their families do not have third-party coverage for them.		X		
9. Work with the Division of Public Assistance to streamline and track their process of application review especially of new pregnant women to assure promptness and assist with acceptance by health care providers.		X		
10. Work with Medicaid staff to track the number of clients falling off Medicaid as a result of requirements enacted from DRA.				X

b. Current Activities

Last year's activities continue as outlined previously. As a result of collaboration with Medicaid, special feeding supplies for CSHCN with facial clefts are now covered. Families who attend

pediatric specialty clinics have an opportunity to meet with a parent navigator who can direct them to public insurance programs that are available to them if appropriate. This year more than 59 % of children who attended Cleft Palate and Neurodevelopmental Clinics, more than 50% of children attending the State of Alaska Genetics Clinics, and more than 36% of children attending Metabolic Clinics to date were covered by Medicaid/Denali Kid Care and/or Indian Health Service. Tricare covered 10% of children seen in Genetics Clinics and 13% in Metabolic clinics and less than 2% were self-pay with the remaining having private insurance. For CL/P clinics self-pay families were less than four percent, and the remaining families had private insurance. Data from the spring Neurodevelopmental Clinic is not in yet, but it is expected to be consistent with data from earlier clinics. The state and ANTHC signed another contract to provide payment of last resort for ANTHC beneficiaries who attend the state-sponsored clinics. The contract can be extended in on year increments for a total of five years.

c. Plan for the Coming Year

State-sponsored CSHCN clinic programs will continue collecting data regarding insurance for children who attend the clinics. A referral and TriCare authorization will be requested of military families who attend state-sponsored clinics to assure collection of some amount in support of the clinics, however, no one is denied services based on their ability to pay. Parent navigators will continue working with families who attend state-sponsored clinics and families who have an infant diagnosed with a hearing loss to assist them with the application process to public insurance programs as appropriate.

At the 2007 public review of the Title V MCH Block grant, families and health care providers shared stories of significant delays in the application process for Medicaid/Denali KidCare benefits. This delay has affected newly pregnant women in obtaining prenatal care in the first and early second trimesters as prenatal care providers are unwilling to schedule visits or see patients who do not have current benefits. Lack of access to early and continuous prenatal care could result in less than optimal outcomes. The Title V MCH director will be working with the Division of Public Assistance to investigate the timing of application completion and assist with improvements. Additional funding to hire eligibility technicians for the DPA office was approved with the FY08 and FY09 budget. The Title V MCH Director was active in testifying in support for this additional funding. In addition, the Title V MCH Director will work with staff in the Medicaid office to track the numbers of children and pregnant women affected by the requirements for citizenship and birth validation required as a result of the Deficit Reduction Act.

These are enabling and infrastructure-building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	75	75	75	75	75
Annual Indicator	73.3	73.3	73.3	73.3	85.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	90	90	90

Notes - 2007

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

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2005

/2007/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

Genetics clinics provided an infrastructure for linkages with many public and private agencies. These services included referrals for specialized medical assessment and/or medical care, psychometric testing for eligibility of special educational services, vision and hearing assessments, and local and national parent support groups. Genetics clinics met throughout Alaska in public health clinics and worked with public health nurses (PHNs) at the community level to provide clinic services, case management, and technical assistance to families and individuals. Annual reports were reviewed to assess attendance at specific clinic sites and practitioner referral patterns. This was to monitor service delivery and determine if sites were appropriate for changing population needs and access to care. Geneticists provided information, medical consultations and technical assistance to local physicians and health providers via MEDCON, telemedicine, Internet resources (<http://www.genetests.org>), and on-site continuing education presentations at grand rounds. This was particularly useful for providers in rural areas. The genetic clinic manager worked with the newborn metabolic coordinator to ensure that infants with abnormal newborn screening tests were referred to the metabolic genetics clinics for ongoing care as quickly as possible after diagnosis was made. In addition, for our non-English speaking families, professional medically trained interpreters translated the genetics session for the family. Information packets about the genetics condition were provided in their language if possible. Lending libraries of audio-visual and print materials of genetic conditions were available to families. Two state genetics clinics were held at Yukon-Kuskokwim Delta Regional Hospital and Alaska Native Medical Center, centers which offer medical care for Alaska Natives. This assured a culturally appropriate service for families, and allows the geneticists to work with the local pediatricians regarding care and follow up recommendations

Pediatric specialty clinics were held in Anchorage, Bethel, Fairbanks, Sitka, Ketchikan, and Juneau so they could be easily accessed by families throughout the state. Providers referred to community-based services as appropriate. Parent navigators who participated in state-sponsored Cleft Lip and Palate Clinics provided linkages to services, families who attended clinics were

given contact information for providers participating in clinics, and the clinic coordinator provided information about community-based services. Public health nursing became less involved in directing families to services. However Native health corporations throughout Alaska provided many services to their beneficiaries and offered case management to assure families received care they needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue contracts to deliver genetics and specialty clinics statewide.				X
2. Geneticists and other specialty providers offer information, medical consultation, and technical assistance to local health providers.				X
3. Assure culturally appropriate services by holding some clinics at Alaska Native medical care facilities.	X	X		
4. Provide professional medically-trained interpreters to translate the genetics session for non-English speaking families.		X		
5. Provide information packets about genetics conditions in other languages.		X		
6. Continue collaboration and work with the All Alaska Pediatric Partnership to identify gaps in access to pediatric specialty services and support recruitment efforts.				X
7. Expand service delivery of metabolic clinics to areas with identified capacity needs.				X
8. Continue parent navigation grant to assure families are linked to resources such as support groups, providers and financial aid programs.		X		
9. Offer a venue for health care professionals to get training at specialty clinics and genetics clinics.				X
10. Expand neurodevelopmental clinics/autism screening and assessment clinics to additional rural communities.				X

b. Current Activities

The Title V/CSHCN director and the Children's Health Unit Manager are active participants in the community coalition of hospitals and medical providers serving the pediatric population of the state. Recruitment of pediatric specialists to Alaska assists families to access services in state even if it means them traveling long distances within Alaska.

Specialty Clinics Program actively helps to build capacity for specialty services throughout Alaska. Two pediatric dentistry residents attend Anchorage Cleft Lip and Palate Clinics as part of their training. A dietician and a speech therapist observe at clinics and shadow a team member in their specialty to learn more about addressing the needs of cleft-affected children.

Two genetic counselors are working in Anchorage, one in a private hospital and one in a private perinatology practice. Although neither has had an opportunity to travel to rural areas, they receive many referrals to see patients who live in bush Alaska. . The State continues to work with partners to expand genetic and metabolic services to both urban and rural communities.

Parent navigators continue linking families to resources. The Specialty Clinics Program surveys families following Cleft Palate clinic visits. When they are asked if they can easily get services recommended at their clinic visits, 73 percent said it is "easy" or "very easy" to access them.

Alaska Native children can get all of their services at the Alaska Native Medical Center.

c. Plan for the Coming Year

The changing roles of public health nurses, who act as clinic coordinators for rural clinics, may force the relocation of those clinics. Other regional medical facilities will be approached regarding the role in hosting clinics and for financial support. These should allow services to transition to the private sector by FY 09 or FY 10 with less state support. The state Title V MCH program continues to be active in the All Alaska Pediatric Partnership which is in the process of conducting a needs assessment and strategic plan to identify and recruit for more pediatric subspecialists. Parent navigator services will continue at pediatric specialty clinics and for families with infants diagnosed with a hearing loss. Title V Block Grant funds will continue to be used to support the parent navigator role. Feedback from families via surveys confirms their role is helpful in assisting families with services and financing. Title V funds will continue to support Cleft Lip and Palate Clinics and Neurodevelopmental Clinics in remote areas of the state where these services are not otherwise available. Additional general funds approved by the legislature plus funding from the Alaska Mental Health Trust Authority will allow Neurodevelopmental Clinic/Autism screening and assessment clinics to expand to more rural communities. Parents will receive copies of providers' clinic notes and recommendations to assist them in accessing services for their children.

These services are enabling and infrastructure-building.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3	3	1.5	1.5	1.5
Annual Indicator	1.1	1.1	1.1	1.1	42.2
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	50	50	50

Notes - 2007

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

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2005

/2007/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

With limited funding, work and collaborated efforts moved forward. The Governor's Council on Disabilities and Special Education (GCDSE) worked on creation and dissemination of a Transition Tool Kit for teachers, parents, and youth to help them make decisions in the transition process. GCDSE increased connectivity among local and statewide stakeholders through the Intermediaries' work at local and state levels. This was vital for dissemination of short turn-around opportunities, leadership events, volunteer activities, and career exploration opportunities.

Intermediaries continued to work with local organizations (local government, non-profit organizations, state, and federal agencies) to improve outcomes for youth with disabilities. By connecting local organizations, Intermediaries are able to define and collaboratively approach deficits in transition services; for example, a roommate matching service was created in Anchorage based on the need for housing. Intermediaries also are instrumental in creating and sustaining community oversight teams -- teams geared towards solving individual and local infrastructure problems that impede transition.

Creation of the How Transition Works CD by the Division of Vocational Rehabilitation was completed this year. A web-based Youth Resource Map was completed by the Department of Labor and Workforce Development. GCDSE has kept transition at the forefront of youth with disabilities issues. It was highlighted in conferences and workshops about education, workforce development, community, and home based waiver opportunities, housing, etc. GCDSE worked on the Bring the Kids Home Initiative, ensuring kids with severe emotional disturbance can be served in Alaska instead of being sent out of state. Our partners, the Department of Labor and Workforce Development and the Alaska Workforce Investment Board increased availability of employment services to All Alaska Youth. GCDSE created a statewide email list for people interested in transition issues and produced two articles on youth with disabilities in transition for professional societies' magazines and newsletters.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Disability Mentoring Day activities in Fairbanks, Anchorage, Juneau, Kenai, and Sitka.				X
2. Increase connectivity among local and statewide stakeholders.				X
3. Continue Intermediaries' work with local organizations to improve outcomes for youth with disabilities.		X		
4. Distribute the How Transition Works CD		X		
5. Increase visibility of youth with disabilities within the larger				X

scope of youth employment.				
6. Continue a statewide email list for people interested in transition issues.				X
7. Further enhance navigation services for teens in transition to adulthood and investigate alternative models of access for these services that better meet their needs (such as web-camera or free cell phone numbers).		X		
8. Collaborate with the State Commission on Community Service to open up new volunteer opportunities for youth with disabilities.		X		
9. Continue the Bring the Kids Home Initiative, ensuring kids with severe emotional disturbance can be served in Alaska instead of being sent out of state.				X
10. Develop web links for teens and parents of teens to assist in accessing services.		X		

b. Current Activities

Activities from FY07 continue. An annual Special Education Conference offers workshops that include transition specific topics. Customized employment and person-centered planning are highlighted via conferences and workshops.

Creating opportunities for career/job mentoring occurs during Disability Mentoring Day. Youth Transition Coordinators continue to help youth with disabilities find and keep jobs by helping them gain knowledge and skills needed for employment. They also work with case managers to ensure housing, transportation, and other issues are addressed. The Division of Vocational Rehabilitation employs a vocational transition coordinator to help youth transition to work or education after high school. The youth liaison serves on the Workforce Investment Board's Youth Council.

A financial literacy workbook is being created to teach youth about finances in order to prevent problems with credit cards and with credit in general. Guideposts for Success are handed out at a variety of events.

GCDSE works with Stone Soup Group and other PTI's to ensure outreach to parents and youth. Work continues to improve the DD waiver waitlist for youth in transition -- currently some slots are prioritized for youth. In addition, the Adolescent Health Public Health Specialist worked with GCDSE on youth and transition issues as part of the development of adolescent health and healthy relationships training.

c. Plan for the Coming Year

GCDSE will build on successes in previous years. The youth liaison will continue working with intermediaries as they serve in different positions/roles; collaborate with partners on career guidance opportunities; and work with partner agencies to improve communication with youth, parents, and other concerned individuals through schools, PTIs, Stone Soup Group and other resources.

Collaboration with partners will continue to fund and staff Disability Mentoring Day and add another component called Career Exploration Day. GCDSE will continue to educate businesses and other entities about youth with disabilities and their potential. Membership with workforce boards and other initiatives will continue as will collaboration with MCH on issues surrounding youth with disabilities.

GCDSE is collaborating with the State Commission on Community Service to open up new volunteer opportunities for youth with disabilities.

These activities are enabling and infrastructure-building.

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	2003	2004	2005	2006	2007
Annual Performance Objective	89	91	85	85.5	86
Annual Indicator	79.7	75.3	75.4	73.5	
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	86.5	87	87	87	90

Notes - 2007

The most recent data available for this performance measure is 2006. NIS data for 2007 will be available for the 2010 BG submission

Notes - 2006

Data source: National Immunization Survey. The most recent data available for this performance measure is 2006. NIS data for 2007 will be available for the 2010 BG submission

Notes - 2005

Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series). Retrieved March 13, 2007, from http://www.cdc.gov/nip/coverage/NIS/05/tab02_antigen_iap.xls.

The most recent data available from the National Immunization Survey is for CY 2004. CY 2005 will be available for the BG FY 2008 submission

a. Last Year's Accomplishments

The WIC Program screened immunization records for DTaP immunization status and referred children for vaccinations when their records were found to be incomplete. Childcare facilities were audited by Alaska Immunization Program compliance program staff to determine adherence to state statutes for required immunizations and inform State of Alaska Childcare Licensing of compliance status.

The Alaska Immunization Program implemented an "On Time, Every Time" childhood immunization schedule that indicates the minimum age at which a child should receive a recommended immunization.

The Vaccinate Alaska Coalition conducted "I Did It By TWO!" the annual childhood immunization awareness campaign, in conjunction with the Iditarod Trail Committee and the "Race to Vaccinate."

Alaska Immunization Program staff presented immunization information at professional

conferences, public and private providers' offices, and to University of Alaska Anchorage School of Nursing nurse practitioner and RN students.

New Advisory Committee on Immunization Practice (ACIP) vaccination recommendations vaccinations were introduced for expanded age range eligibility for FluMist.

VacTrAK, the Alaska Immunization Information System, contract was awarded and was being implemented in late 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen children enrolled in WIC for DTaP immunization status and refer when needed.		X		X
2. Implement childhood immunization schedule.			X	
3. Continue to conduct annual immunization awareness campaign, "I Did It By TWO!"			X	
4. Continue to present immunization information and training to a variety of groups.			X	X
5. Audit childcare facilities, preschools, and schools for immunization compliance.				X
6. Implement VacTrAK, the Alaska Immunization Information System.				X
7. Amend the Alaska state regulations on varicella and Tdap.				X
8. Update the Alaska Recommended Childhood & Adolescent Immunization Schedule on influenza.				X
9.				
10.				

b. Current Activities

The Alaska Immunization Program continues: to provide immunization information and training; audit childcare facilities, preschools, and schools; and support the "I Did It By TWO!" childhood immunization awareness campaign.

VacTrAK, the Alaska Immunization Information System, is being implemented to be fully functional before fall of 2008. VacTrAK is a lifespan immunization information system and is designed to include immunization data from all vaccinators, public and private. New VacTrAK staff within the Alaska Immunization Program are dedicated to providing technical, training, and managerial support for VacTrAK.

The Alaska regulations are amended to reflect the ACIP recommendation that all children should receive 2 doses of varicella vaccine for kindergarten through 6th grade entry. Also, Alaska regulations are amended to require children receive Tdap, instead of Td, as the booster dose usually administered within 10 years of last tetanus containing vaccine. These new regulations become effective in July 1, 2009 for school year 2009/10.

The 2008 Alaska Recommended Childhood & Adolescent Immunization Schedule is updated to include expanded recommendations adopted by the ACIP for universal influenza for children age 6 months to age 5 years.

At this time Alaska is still a universal vaccination state which means vaccines are provided at no cost to participating providers for all children ages 0 through 18 years of age.

c. Plan for the Coming Year

Childcare facilities, preschools, and schools will continue to be audited by Alaska Immunization Program staff to assure compliance with Alaska state regulations for required childhood immunizations. Also, the Alaska Immunization Program will continue to provide immunization information and training to various groups.

The Alaska regulations require all children receive 2 doses of varicella vaccine for kindergarten through 6th grade entry and Tdap, instead of Td, as the booster. These new regulations become effective in July 1, 2009 for school year 2009/10.

The 2008 Alaska Recommended Childhood & Adolescent Immunization Schedule will be updated to include expanded recommendations adopted by the ACIP. This schedule will also be available on the Division of Public Health Web Site.

The Alaska Immunization Program will provide FluMist, live attenuated seasonal influenza nasal mist vaccine, for the first time in 2008-09. State-supplied FluMist is intended for use by children 2 years through 4 years of age.

The Alaska Immunization Program plans to partner with State of Alaska Section of Public Health Nursing to provide special infant immunization clinics and media promotion of National Infant Immunization Week at all Alaska Public Health Centers in 2009.

These are infrastructure building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	21	19	19	18	18
Annual Indicator	19.9	17.7	17.3	18.6	
Numerator	320	286	289	315	
Denominator	16060	16168	16681	16919	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	18	18	18	18	18

Notes - 2007

Source: Alaska Bureau of Vital Statistics.

CY2006 is the most recent data available for this performance measure. CY2007 will be available for the 2010 BG submission.

Notes - 2006

Source: Alaska Bureau of Vital Statistics.

CY2006 is the most recent data available for this performance measure. CY2007 will be available for the 2010 BG submission.

Notes - 2005

Source: Alaska Bureau of Vital Statistics.

CY2005 is the most recent data available for this performance measure. CY2006 will be available for the 2008 BG submission.

a. Last Year's Accomplishments

In FY07 WCFH moved administration of the Section 510 Abstinence Education grant to the State's Department of Health & Social Services Office of Faith-Based and Community Initiatives. This office has relationships with many faith- and community-based organizations and is better positioned to meet the requirements of this program.

Title V continued to fund two nurse practitioners to provide comprehensive teen reproductive health services, including encouraging abstinence, at both the Kodiak Public Health Center (PHC) and Juneau High School, Alaska's only school-based clinic. USPSTF guidelines were implemented to assure appropriate cervical screening as part of this program. Women with abnormal screening results were referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed. The WCFH Family Planning Nurse Consultant conducted clinical quality assurance reviews at each site. Service quality exceeded standards set by WCFH.

Cervical cancer screening services also continued to be funded by Title V and were available to women seeking family planning services at other public health centers, in addition to the Kodiak PHC. Women with abnormal screening results were referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

The WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY07, offering high quality, low cost family planning and related preventive health services to low income women, men, and teens in communities in the Mat-Su Valley and the lower Kenai Peninsula. FPP Title X services promoted abstinence education and parental involvement in teen contraceptive decision-making as a core part of their service delivery.

In FY07 WCFH continued an interdepartmental agreement with the Division of Public Assistance with the goal of reducing "out-of-wedlock" and teen pregnancy in Alaska. Under this agreement (named the Reproductive Health Partnership or RHP), the FPP targeted the problem of sexual abuse of minors by promoting healthy, age-appropriate relationships in Alaska's teens. "How to Talk to Your Clients about Statutory Rape and Mandatory Reporting" was presented at the Association of Women's Health, Obstetric and Neonatal Nurses in October 2006. Nationally-renowned authority in the area of adolescent sexuality, Bill Taverner, MA, presented at the 2006 Alaska Health Summit. Presentations covered: healthy teen relationships and sexuality, unintended pregnancy, sexually transmitted infections, and coercion and abuse. Also under the Division of Public Assistance agreement, a community awareness campaign was developed. Radio and television PSAs were aired statewide, with messages about the importance of age-appropriate, healthy relationships targeting teen girls younger than 16 and adult males aged 18-22.

RHP focuses efforts in rural areas where rates of births to teens are higher than the state average. Reproductive health educational materials and some contraceptives were provided at no cost to teens served by PHCs and federally qualified health centers in over 46 Alaskan communities. Skills-based trainings -- hands-on, audio conference, self-study and web-based -- were offered throughout the year. Surveys of rural health workers were conducted in order to

learn their perceptions about teens' needs for reproductive health care services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Targeted radio PSAs, recorded by Bill Taverner, air in Nome and Bethel from Jan-Dec 08 to encourage healthy relationships by offering warning signs of unhealthy relationships and tools for making healthy life decisions.			X	
2. Provide funding and clinical oversight for two nurse practitioners to provide comprehensive teen reproductive health services at the Kodiak PHC and Juneau High School.	X			
3. Maintain cervical cytology laboratory contract for PHCs and the Juneau High School clinic.	X			
4. Provide fiscal, administrative and clinical oversight to two Title X Family Planning Services grant program clinics.			X	
5. Implement educational opportunities for clinical health care providers, social workers, educators and youth advocates to promote healthy, age-appropriate relationships in Alaska's teens and other topics.				X
6. Offer professional educational opportunities on topics relevant to teen reproductive health for health care workers from areas with the highest rates of births to teens.			X	
7.				
8.				
9.				
10.				

b. Current Activities

All projects conducted in FY07 continued this year. Early results from surveys of health care workers and others living in rural areas, where rates of births to teens are more than double the statewide rate, indicate that access to comprehensive contraceptive and reproductive health services is the primary barrier to care. Educational offerings on topics relevant to teen reproductive health are being provided for health care workers from areas with the highest rates.

Additionally, in November 2007, the RHP sponsored Mr. Taverner to travel to rural communities, Nome and Bethel, to present interactive workshops on healthy relationships to the following groups: 1) health care professionals, childcare workers, psychologists/counselors, and parents/guardians; 2) groups of youth, including both peer leaders and youth convicted of minor and major crimes; 3) community-wide forums. All participants were given a copy of Mr. Taverner's "Unequal Partners" curriculum. Surveys were conducted to discover: 1) each community's perspective on the health of relationships in their community, and 2) in what forum future educational opportunities on this topic would be best embraced by the community. Surveys from adolescents and adults in both communities showed that all persons were concerned about the quality of relationships in their communities, and that there were local leaders who could assist with efforts to shape healthier communities.

c. Plan for the Coming Year

Title V will continue to fund two nurse practitioners to provide comprehensive teen reproductive health services at both the Kodiak PHC and Juneau High School. The Family Planning Nurse Consultant will conduct annual clinical service quality assurance reviews at each site.

Cervical cancer screening services will continue to be funded by Title V and remain available to women seeking family planning services at PHCs and the Juneau school clinic. Women with abnormal screening results will continue to be referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

FPP will continue to administer the Title X Family Planning Services grant serving communities in the Mat-Su Valley and the lower Kenai Peninsula. FPP Title X services will continue to promote abstinence education and parental involvement in teen contraceptive decision-making.

WCFH will continue oversight of RHP activities in FY09, including continuation of statewide public awareness efforts regarding healthy teen relationships.

Marked differences in culture between urban and rural/remote residents of the state prompted RHP to reassess its strategies for increasing community, family and teen knowledge of Alaska statutes pertaining to criminal acts of sexual abuse of minors, including sexual activity between non-peer partners where one is a young teen. In FY09, the audience of service providers who will be offered training in mandatory reporting will be broadened to include appropriate staff of the Anchorage School District. Principals, teachers, teacher's aides, substitute workers, school nurses and other school staff are all mandatory reporters who spend at least six hours each day working with and around at-risk teens. Increasing the knowledge for adults who have so much contact with at-risk youth is a critical need. WCFH will collaborate with the school district to conduct mandatory reporter trainings in conjunction with ongoing staff development programming.

Finally, RHP will strengthen its partnership with tribal leaders and work with them to promote a culturally appropriate curriculum, developed in partnership with CDC and the tribal health leaders, for use in rural/remote state regions where Alaska Native populations predominate. The curriculum will be developed using a compilation of evidence-based and nationally recognized best practices for educating communities, parents and teens about healthy choices and relationships. The activities for the coming year represent all levels of the MCH pyramid: direct health care, enabling, population-based, and infrastructure building services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	22	24	26	26	26
Annual Indicator	14.9	14.4	17.5	52.4	52.4
Numerator	3127	2966	1414	1260	1260
Denominator	20988	20598	8082	2405	2405
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
	2008	2009	2010	2011	2012
Annual Performance Objective	55	55	55	55	55

Notes - 2007

Source: 2004 Oral Health Survey, AK Oral Health Program.

/2008/ The data source has been changed. Previously we estimated this indicator from Medicaid records. We now use data from the AK Oral Health Survey - 2004 conducted by the AK Oral Health Program. Summary report available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/OHAssessment_0405.pdf

Notes - 2006

Source: 2004 Oral Health Survey, AK Oral Health Program.

/2008/ The data source has been changed. Previously we estimated this indicator from Medicaid records. We now use data from the AK Oral Health Survey - 2004 conducted by the AK Oral Health Program. Summary report available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/OHAssessment_0405.pdf

a. Last Year's Accomplishments

In state fiscal years (SFY) 2004-2005, the Oral Health Program (OHP) completed the first statewide dental assessment of third grade children using the "Basic Screening Survey" method. The dental assessment process included state baselines on dental sealants on at least one permanent first molar. The state baseline (2004) for sealant utilization in third-grade children was 52.4%; meeting the MCH Block Grant performance measure goal and Healthy People 2010 goal for dental sealant utilization with sealant utilization for racial/ethnic and third-graders reported to be enrolled in Medicaid as follows:

Dental Sealants Present:

Total (n=1,206)	52.4% (49.5, 55.3)
American Indian/Alaska Native (n=283)	67.8% (62.1, 73.3)
White (n=580)	51.0% (46.9, 55.2)
Asian (n=93)	39.8% (29.8, 50.5)
Black/African American (n=54)	29.6% (18.0, 43.6)
Hispanic/Latino (n=50)	42.0% (28.2, 56.8)
Native Hawaiian/Pacific Islander (n=21)	33.3% (14.6, 57.0)
Medicaid/Denali KidCare (n=336)	57.4% (52.0, 62.8)
American Indian/Alaska Native (n=128)	66.4% (57.5, 74.5)
White (n=99)	44.4% (45.2, 65.5)

Data has been collected on the number of unduplicated Alaska children aged 8-9 with at least one dental sealant applied to a permanent molar paid for by Medicaid. Sealants not billed to Medicaid were not available; therefore the reported sealant utilization from Medicaid claims was underestimated. The percentage of children with at least one dental sealant on at least one permanent molar for FFY1997 was as follows: 23.0%. For SFY2000-2007 it has varied from a low of 14.4% in SFY2004 to a high of 17.5% in SFY2005 and was 16.7% for SFY2007. The dental assessment information illustrated the under reporting of this method for sealant utilization with Medicaid claims. The estimate of sealant utilization from Medicaid claims for SFY2004 was 14.4% for 8-9 year olds as compared with the 52.5% of all third-graders in the sample and 57.4% of third-graders reported to be enrolled in Medicaid in the dental assessment for 2004 that had at least one sealant on at least one permanent first molar.

This past year the OHP worked with the dental association and University of Alaska to continue training on child abuse and neglect awareness and reporting requirements; implemented Medicaid adult dental preventive and enhanced restorative services (April 1, 2007); sponsored a "CSHCN Oral Health Forum" with development of a strategic plan; provided information to WIC and Head Start on American Dental Association interim guidance on use of fluoridated water with infant formula for infants whose primary food source is formula; and continued work to resume

water fluoridation in Juneau.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and promote community water fluoridation in all communities of Alaska.				X
2. Identify funding to support a statewide dental sealant coordinator.				X
3. Collaborate with 330 funded Community Health Centers to establish a dental sealant program.				X
4. Support coalition activities and the development of a comprehensive state oral health plan.				X
5. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation.	X	X	X	X
6. Maintain program web site for dental access, oral health information and coalition activity.		X		X
7. Provide technical assistance regarding ADA interim guidance on use of fluoridated water with powdered or liquid concentrate infant formula for infants whose primary food source is formula.				X
8. Prepare oral disease burden document describing oral diseases in Alaska and the impact of those diseases on the state.				X
9. Work with Commissioner's Office and Alaska Dental Action Committee to develop an evaluation plan for adult dental Medicaid services and report findings to the legislature.				X
10. Work with the Alaska Dental Access Committee to support legislation for increasing scope of practice for dental hygienists.				X

b. Current Activities

The Oral Health Program worked to provide information on water fluoridation in relation to a public vote on fluoridation in Juneau (lost vote to resume fluoridation in October 2007) and a city council vote in Fairbanks (city council voted to retain fluoridation in March 2008).

A follow-up meeting to the "CSHCN Oral Health Forum" was cosponsored by the program to identify priority recommendations and strategies for incorporation in the state oral health plan, discuss progress on topics discussed at the forum and identify information for inclusion in a parent resource manual on oral hygiene tips and information for dental access and/or dental visits.

A dental assessment of third-graders and kindergarteners (2007) was completed -- state sealant utilization for third-graders in the 2007 sample was 55.3%.

A HRSA MCHB TOHSS grant was awarded to the Oral Health Program in September 2007. Goals are to increase age one dental visits, improve oral health and dental access for CSHCN and pregnant women -- the program is working on implementation of those activities.

The state oral health plan with information on the oral disease burden in Alaska, priority recommendation of the oral health coalition and a strategic plan was completed in December 2007 and the publication was released in February 2008 -- see: <http://www.health.state.ak.us/dph/wcfh/Oralhealth/docs/Oral-Health-Plan.pdf>

c. Plan for the Coming Year

The Oral Health Program is applying for the new CDC cooperative agreement (primary funding source for the program). Planned major activities for FY09 include: work with the Coalition and stakeholders to implement recommendations of the state oral health plan; pilot a school-based/linked dental sealant program in collaboration with a community health center dental program and/or Tribal program; and continue follow-up training on the "Cavity Free Kids" curriculum for use by Head Start grantee programs. The dental sealant pilot would be in collaboration with a school in a dental-HPSA area and attempt to increase sealants in non-Native racial/ethnic minority students.

These activities are direct health care, enabling and infrastructure-building.

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	2003	2004	2005	2006	2007
Annual Performance Objective	6	5.8	5.6	5.6	5.6
Annual Indicator	6.0	6.2	6.5	5.0	
Numerator	27	28	31	24	
Denominator	447364	451114	480546	480464	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	4.5	4.5	4.5	4.5	4.5

Notes - 2007

Source: Alaska Bureau of Vital Statistics

The most recent data available for BG FY 2009 is 2004 - 2006. This indicator is reported by 3-year moving averages.

Notes - 2006

Source: Alaska Bureau of Vital Statistics

The most recent data available for BG FY 2009 is 2004 - 2006. This indicator is reported by 3-year moving averages.

Notes - 2005

Source: Alaska Bureau of Vital Statistics

The most recent data available for BG FY 2008 is 2003 - 2005. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments

Injury Surveillance and Prevention Program (ISPP) provided Child Passenger Safety (CPS) training to numerous communities across the state. Through partnering efforts, Fairbanks and Mat-Su became self-supporting for most of their CPS training needs with two CPS instructors in each area. We lost one of our Southeast CPS instructors this required us to fly in a second instructor to present the CPS technician course in Southeast.

ISPP continued to strengthen our regionalization of certified CPS technician cadre by supporting and maintaining regional CPS instructors and instructors in established community settings. ISPP has two CPS instructors in Fairbanks and two in Mat-Su, one in Kenai, one in Southeast, and seven in Anchorage. In addition, ISPP has strengthened its community-based CPS foundation. Three CPS technicians from the Anchorage Fire Department (AFD) became CPS instructors.

ISPP helped to conduct six CPS Technician certification courses and three update courses throughout the state this year. In addition, ISPP held a CPS update/support workshop to assist CPS technicians in renewing their certification.

ISPP supported CPS inspection stations housed in Anchorage and Kenai fire stations, assisting with the acquisition of supplies and equipment. ISPP continued to maintain and improve collaboration with community-based police, fire, and the medical community, Kiwanis, Safe Kids and other pro-children groups.

ISPP assisted the new Alaska CPS Board, which provides oversight of the statewide program. They have met once in FY07 and will meet four times in fiscal year 08.

ISPP worked with the Alaska Native health corporations' wellness camps; assisting statewide Safe Kids Coalitions and Chapters; and assisting with "Safe Routes to School" and "Walk to School" programs and school bus activities.

ISPP efforts helped foster support for successful new legislation requiring youth to wear bicycle helmets in Anchorage and now continued the education programming commitment to ensure helmets are available and used. ISPP education resources helped mobilize support for "Booster Seat" legislation. We were not successful.

ISPP worked to prevent TBI by evaluating and refining our programs for non-traditional motor vehicle transportation, such as snow machines and ATVs. ISPP is developed website focused on the prevention of TBI. ISPP continues to work on prevention by promoting roadway-bicycle safety awareness and related programs in conjunction with Alaska Native health corporations' wellness camps. ISPP assisted statewide Safe Kids Coalitions and Chapters in the promoting roadway-bicycle safety awareness and the use of helmets and safety activities. ISPP worked with the "Safe Routes to School" and "Walk to School" programs and school bus activities within the state.

ISPP presented at several conferences, including the Anchorage Association for the Education of Young Children. ISPP also worked with the Alaska Injury Prevention Center (AIPC) -- a non-profit organization and the Alaska Chapter of American Academy of Pediatrics (AAP) to work on preventing traumatic brain injury (TBI) in youth.

ISPP supported CPS technicians and their activities statewide by providing a monthly calendar, putting on our state website, of injury prevention activities and training opportunities. ISPP supplied a current CPS recall list and provides support for a statewide Safe Kids teleconference that is held monthly for all the Safe Kids Coalition and Chapter coordinators and a quarterly meeting for CPS instructors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Help lead the "Booster Seat Coalition" to support legislation for booster age children.				X
2. Conduct CSP inspections at each AFD station.				X
3. Conduct CSP introduction course.				X
4. Revise the "Safe Native American Program (SNAP) for CPS" to fit the new national standards.				X
5. Develop and secure national approval for a continuing education unit (CEU) webcast course.				X
6. Promote awareness on the prevention of traumatic brain injuries (TBIs) through airing of public service announcement.				X
7.				
8.				
9.				
10.				

b. Current Activities

All projects conducted in the past year were continued in current year.

The Injury Surveillance Prevention Program (ISPP) helps lead the "Booster Seat Coalition" to support legislation for booster age children. The legislation did not pass during the session, but will be reintroduced in FY09.

The Child Passenger Safety (CPS) technician course is now required in the Anchorage Fire Dept (AFD) Academy. CPS inspections are conducted at each AFD station.

ISPP conducted a CPS introduction course, a public check up event, and re-certification in Ketchikan. ISPP will help with a CPS introduction course and check off event in key locations statewide.

ISPP was invited to participate with national efforts to revise CPS curricula. The revised course criteria and standards now require nearly all to be updated prior to use. ISPP has been selected to work with five CPS instructors to revise the "Safe Native American Program (SNAP) for CPS" to fit the new standards.

ISPP developed and secured national approval for a continual education unit (CEU) webcast course. ISPP provides a library of for additional CEUs.

ISPP continues to promote awareness on the prevention of traumatic brain injuries (TBIs). In conjunction with the Denali Safety Council, ISPP procured \$10,000 worth of statewide airtime for a TBI public service announcement to encourage helmet use during recreational activities.

c. Plan for the Coming Year

ISPP plans to continue our education efforts to support legislative action to clarify our booster seat requirement. Our injury data indicates that children between four and eight years of age are prematurely being moved from child seats to seat belts. We will again work closely with our AK Office of Highway Safety and hope to again secure the support of our local American Academy of Pediatrics chapter, Alaska Automobile Dealer Association and our regional NHTSA office.

ISPP plans to continue to strengthen our CPS technician cadre by retaining and increasing the number of CPS technicians and will support all technicians who will need to be using the new CPS certification process.

Sustainability of CPS activities is most critical in southeast Alaska, and ISPP plans to work closely with AIPC, SEARHC, and DHSS public health nurse clinics on this issue. AK Injury Prevention Center has transferred their contract for CPS services in Juneau to SEARHC, providing one CPS certified technician for the area. ISPP plans to focus its efforts on at least two CPS introduction course and inspection events in Juneau. ISPP will maintain its CPS inspection stations at the community level including AFD and Kenai fire departments. ISPP will be encouraging other first responders to offer CPS inspection stations. ISPP plans to offer the new CPS Technician course at least once in key population hubs and three times in Anchorage in the coming year.

ISPP plans to support the Alaska CPS Board that provides oversight of CPS activities and will assist with sponsoring meetings including at least two face-to-face meetings and two teleconferences.

ISPP will also present a modified SNAP course in at least 4 areas of the state ISPP will teach the updated SNAP in Homer, Kodiak, Ketchikan and either Bethel or Nome.

ISPP will continue to support CPS technicians and their activities statewide through an email and web-based information. ISPP will also email a current CPS recall list to and support a statewide Safe Kids monthly teleconference with all the Safe Kids Coalition and chapter coordinators and a quarterly meeting for CPS instructors.

Since the core course for NHTSA CPS-certified technicians was revised, the NHTSA-sponsor task force selected ISPP to pilot the new CPS renewal course when it is release in late FY2008 or early FY2009

The availability of CPS services to children with special needs have been significantly neglected in Alaska, providing a dangerous environment for these clients. We plan to expand our inventory of CPS restraints for children with special needs and to secure sufficient partnership to implement a NHTSA course on "Safe Travel for All Children" for those who work with these populations. These are infrastructure building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective				60	60
Annual Indicator			52.2	14.8	
Numerator			266	1565	
Denominator			510	10605	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	70	70

Notes - 2007

2009/ Source: 2006 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Data is now given by year of birth of the children as opposed to percentage of respondents by year of respondent interview. The latest available data is for children born in 2004, collected from interviews conducted through December 2006. Data for 2004 is provisional, additional updates to 2004 data will be made by NIS in late 2008. For children born in 2004, some of the survey questions changed.

Notes - 2006

/2009/ Source: 2006 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Data is now given by year of birth of the children as opposed to percentage of respondents by year of respondent interview. The latest available data is for children born in 2004, collected from interviews conducted through December 2006. Data for 2004 is provisional, additional updates to 2004 data will be made by NIS in late 2008. For children born in 2004, some of the survey questions changed.

Notes - 2005

Data Source: Alaska WIC Program. WIC Report #345: Breast and Formula Feeding Rates, 1/1/2005 to 12/31/2005.

a. Last Year's Accomplishments

Alaska WIC's breastfeeding duration at 6 months fell to 49% from the year's previous rate of 52%. WIC received \$79,434 to continue the Using Loving Support Breastfeeding Peer Counseling Program. This program was administered by the Providence Alaska Medical Center (PAMC) WIC Program and the Armed Services YMCA WIC Program.

The University of Alaska Anchorage Competent Professional Authority Training Program facilitated the Alaska Breastfeeding Training: Breastfeeding Basics held in Anchorage and attended by 32 participants from around the state. University of Alaska Anchorage also facilitated the Alaska Breastfeeding Training and Telephone Counseling Skills which was held in Anchorage and attended by 18 participants.

The State WIC Program staff participated on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborated with the Alaska Breastfeeding Coalition (ABC) in its education initiatives. In April 2007 the WCFH Section's Epidemiology Unit presented at the annual ABC conference, sharing data from the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). Alaska WIC collected data and monitored trends through the Alaska PRAMS and Alaska WIC Management Information System.

The WCFH Perinatal Nurse Consultant promoted breastfeeding, sharing information about Baby Friendly hospital designation and consulting around breastfeeding-related issues. This position is supported by Title V funds.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain the Using Loving Support Breastfeeding Peer Counseling Program.			X	
2. Sustain the WIC breast pump loan program and support services for breastfeeding women.		X		
3. Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations.				X
4. Continue active participation with the Alaska Breastfeeding Coalition.				X
5. Continue data collection and monitoring through PRAMS and				X

Alaska WIC Management Information System.				
6. WCFH perinatal nurse consultant to provide consultation on breastfeeding issues.				X
7.				
8.				
9.				
10.				

b. Current Activities

This year Alaska WIC continues receiving funding for the Breastfeeding Peer Counseling Program, implementing it via the PAMC WIC Program and the Armed Services YMCA WIC Program, offering the Using Loving Support training. It also conducts a breast pump loan program and support services for breastfeeding women.

The State WIC Program staff continues to participate on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborate with the ABC in its education initiatives. The WCFH Section's Epidemiology Unit participated in the April 2008 ABC conference, sharing data from the Alaska PRAMS. Alaska WIC continues to collect data and monitor trends through the Alaska PRAMS and Alaska WIC Management Information System.

The WCFH Perinatal Nurse Consultant responded to requests from the legislature for information and testimony related to a bill that would make provisions for women to breastfeed at their place of employment. She also has supported breastfeeding by distributing information to hospitals on the national Mother-Friendly Childbirth Initiative.

c. Plan for the Coming Year

Next year the WIC Program will continue current year activities and a new WIC agency will take on the Breastfeeding Peer Counseling Program initiatives, along with the Armed Services YMCA WIC Program. Also, WIC is proposing an International Board Certified Lactation Consultant host a list-serve for lactation questions from WIC agencies around the state along with a monthly newsletter for training and education support for the Breastfeeding Peer Counselors. The WCFH perinatal nurse consultant will continue to address breastfeeding issues and WCFH Section's Epidemiology Unit will participate in the ABC conference, tentatively slated for spring 2009. These activities are infrastructure building, population-based, and enabling services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	55	60	92	94	96
Annual Indicator	81.1	87.3	90.5	91.8	92.5
Numerator	8081	8968	9351	9978	10092
Denominator	9959	10272	10327	10865	10916
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

	2008	2009	2010	2011	2012
Annual Performance Objective	98	100	100	100	100

Notes - 2007

Data Source: AK Bureau of Vital Statistics, AK Newborn Hearing Screening Program

Notes - 2006

Source: AK Bureau of Vital Statistics; AK Newborn Hearing Screening Program.

The numerator includes infants who were screened and born in non-hospital settings.

Some birthing facilities were late in reporting data, therefore, the indicator may be revised at a later date.

Notes - 2005

The numerator covers births in hospitals only. AK does not mandate newborn hearing screening as of FFY 05. Percentage of infants born in hospitals (n = 9770) in CY 2005 that are screened is 97.5%. Legislation passed in SFY mandating screening, to be effective Jan 1 2008.

a. Last Year's Accomplishments

Last year's focus was on enhancing screening, tracking and follow-up to meet the National EHDI 1-3-6 Goals and preparing for implementation of Alaska's legislation mandating universal newborn hearing screening. The effective date for the mandate was January 2008. Draft regulations were written, reviewed and edited by the Section of Women's, Children's and Family Health.

In CY2006, 90.4% of infants born in Alaska received newborn hearing screens. Of those receiving newborn hearing screenings, 97% were screened by one month of age.

Database training and monitoring of the EHDI database was ongoing in the last fiscal year. A total of 16 birth screen providers and 5 audiologists were brought to Anchorage for database training. Those trained either were new to the EHDI system and were never formally trained on using the database or were previously trained but were not experienced users of the database. The EHDI Program also continued to hold Database Teleconferences on a quarterly basis for quality assurance and problem solving. Preparation for integrating newborn metabolic screening results into the EHDI database was in development.

Engaging the audiology community to report diagnostic results in the database was a focus. Their engagement and cooperation in data entry was identified as a need to strengthen the link from diagnostics to intervention services for families and assist in more accurate surveillance.

The EHDI Program met throughout the year with the Part C/Early Intervention Program Manager to establish a process for receiving identifiable data on children enrolled in Early Intervention services with a diagnosed hearing loss. A data match is essential to determine the State's progress in meeting the National EHDI 1-3-6 Goals.

Two EHDI advisory committee meetings were held this year as there was not a Program Manager for five months. These meetings looked at the EHDI goals from a system prospective; case studies were presented to the committee to highlight successes, identify needs and propose solutions. An Intervention Task Force was convened to review and update the Alaska EHDI protocol with a focus on the process from diagnosis to intervention services. From this Task Force, the need for two subcommittees was identified, one specifically focused on the referral process from diagnosis to intervention services and the other to integrate infants/children identified with late onset or progressive hearing loss into the EHDI system.

The State EHDI Program implemented a contract with the Stone Soup Group in November of

2006 to provide Parent Navigation services to families of children receiving a diagnosis of hearing loss. The goal of this contract was to ensure families were connected to appropriate resources and parent-to-parent support. Plans were made for the Parent Navigator to travel to communities in various regions throughout the State to meet with EHDI stakeholders and discuss opportunities for parent support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure accurate and complete utilization of the internet-based reporting system through ongoing monitoring of data entry and training of new hospital staff, public health nurses, audiologists, early intervention staff and parent navigators.				X
2. Utilize a fax-back system with birth screeners; primary care providers to track infants in need of follow-up.				X
3. Facilitate meetings of the Diagnosis to Intervention subcommittee to review and update the Alaska EHDI protocol in accordance with the 2007 JCIH Guidelines.				X
4. Meet with subcommittees on late onset hearing loss and diagnosis to intervention to address loss to follow-up.				X
5. Monitor the data entry by the audiology community in reporting diagnostic information in the database.				X
6. Partner with the Stone Soup Group parent navigators to provide parent-to-parent support and resource information for families of children who are deaf or hard of hearing.		X		
7. Collaborate with the Early Intervention/Infant Learning Program to develop a system for identifying and tracking children with hearing loss.				X
8. Partner with the Native Health System to develop a pilot project for OAE screening in the Yukon Kuskokwim region.	X	X		X
9. Travel to rural/bush communities with implemented UNHS and assure linkages to EI, medical home and audiology.				X
10. Monitor the database for quality assurance and follow-up for children who refer on screening or are diagnosed with hearing loss.				X

b. Current Activities

House Bill 109 and accompanying regulations went into effect January 2008. Relevant information was distributed to all primary care providers, nurse midwives and direct entry midwives. A press release was distributed to radio, television and newspapers.

A memorandum of agreement was signed with Early Intervention (EI) requiring the program to provide names of children diagnosed with hearing loss enrolled in services.

The Diagnosis to Intervention subcommittee is meeting on an ongoing basis to develop a system for diagnosis to intervention services. The group is identifying areas of need and recommending solutions. The committee on progressive/late onset hearing loss is meeting to integrate those children into the EHDI protocol.

A system is in place that assists birthing hospitals track infants who missed or did not pass their newborn screen by faxing them a list of these infants. The hospitals are expected to follow up and report back by fax. This is expected to reduce the number of infants lost to follow-up.

Through advanced training on the EHDI database 23 birth screeners are increasing their ability to run reports, merges and decrease duplication of data. Twelve audiologists received training and are expected to enter diagnostic data monthly.

The EHDI Program Manager is working with staff in remote regions of the State to place otoacoustic emission (OAE) testing equipment in rural hubs for needed screening.

c. Plan for the Coming Year

Emphasis in the next year will be to increase the number of children tracked successfully through the National 1-3-6 Goals and reduce the number of children lost to follow-up/documentation.

The fax back system with birth screeners will be augmented to engage the medical home in to follow up with parents whose child has a missed screen or "refer" result.. This will hopefully increase the number of children accessing diagnostic services and decrease the number of children lost to follow-up.

Entry of diagnostic data by audiologists will assist in timely tracking of infants receiving diagnostic evaluations and will facilitate timely access to intervention services. Early Intervention (EI) will provide a name match with data entered by audiology. Follow-up by the EHDI Program will determine which children are not receiving early intervention services and why.

Parent navigation will be enhanced and a needs survey will be developed. Options for providing parent support will be explored.

The EHDI Program manager will continue to collaborate with rural community health clinics and the Alaska Native Medical Center to place OAE screening equipment in regions where children are at high risk for hearing loss.

The EHDI Advisory Committee will continue to meet three times a year to identify issues and solutions. The two sub-committees will utilize the 2007 Joint Commission on Hearing Guidelines to develop protocols for distribution to stakeholders.

These activities are enabling, population-based, and infrastructure-building.

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	2003	2004	2005	2006	2007
Annual Performance Objective	8	8	14	10	9
Annual Indicator	13.1	11.9	9.2	9.4	
Numerator	26710	23730	17880	18108	
Denominator	204240	199150	195240	192234	
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	
	2008	2009	2010	2011	2012

Annual Performance Objective	8.5	8.5	8.5	8.5	8.5
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Notes - 2007

/2009/ Estimates (numerator and denominator) based on the Census Bureau's March 2006 and 2007 Current Population Surveys. Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2005-2006). Retrieved March 3, 2008 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>. Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 205,460.

Data for 2007 will be available for the 2010 BG submission.

Notes - 2006

//2009/ Estimates (numerator and denominator) based on the Census Bureau's March 2006 and 2007 Current Population Surveys. Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2005-2006). Retrieved March 3, 2008 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>. Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 205,460.

Notes - 2005

Source: Henry Kaiser Family Foundation, State Health Facts Online, Alaska: Health Insurance Coverage of Children 0 - 18, States (2004-2005). Retrieved March 13, 2007 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>

/2008/ The most recent data available at time of the FY 2008 BG submission is based on 2004-2005 data. 2006 data will be available for 2009 BG submission.

The data, provided by the Henry Kaiser Family Foundation, is based on the American Community Census, a survey conducted by the U.S. Census Bureau in off-census years. The data for Alaska may not be accurate due to the small number of respondents.

a. Last Year's Accomplishments

In July 2007, the Denali KidCare (DKC) Federal Poverty Guidelines (FPG) were increased to 175% FPG and the 2003 monthly income amounts written into Alaska Statute were removed. Recommendations from the MCH stakeholders meetings held in June 2007 included: DKC implementing a quick review process for pregnant women, consistency among agencies and programs to help pregnant women access prenatal care early, and promoting the public message, "the first trimester matters." Stakeholders also suggested the to-be-established MCH Advisory Committee capture lack of insurance impact stories to share with finance members in the Alaska Legislature.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue partnership with the Alaska Native Tribal Health Consortium, the Southcentral Foundation and the Alaska Primary Care Association during the final year of the Robert Wood Johnson Foundation Covering Kids and Families grant.				X
2. Respond to requests for information related to Denali KidCare legislation.				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The Alaska Health Care Strategies Council's Final Report: Summary and Recommendations to the Governor included a recommendation to increase the FPG on DKC to 200% FPG - <http://www.hss.state.ak.us/hspc/> . However, the Governor and Department did not make a commitment to support or oppose the legislation to increase the FPGs during the winter 2008 Legislative Session. While the legislation passed out of the Senate and moved through the House Health Education and Social Services Committee, it was never moved to the House Floor for vote from the House Rules Committee.

The Alaska DHSS made one new investment in the Alaska's SCHIP, DKC, by adding six Division of Public Assistance staff members to the DKC Eligibility Office in Anchorage. It is hoped that this will assist in decreasing the application and renewal processing delays in the DKC Office for pregnant women and children.

The Alaska Covering Kids Coalition ceased to exist when the Robert Wood Johnson Foundation grant funding ended. The Department has no Denali KidCare outreach workers, and follows the Title XXI SCHIP State Plan with regard to outreach which includes distributing applications and maintaining a website - <http://www.hss.state.ak.us/dhcs/denalikidcare/default.htm> . The MCH Title V/CSHCN Director has also been active in Project Access, a program available in Anchorage or individuals who are under insured or have no insurance.

c. Plan for the Coming Year

Legislative bills promoting additional changes to the Title XXI-Denali Kid Care program possibly will be considered next legislative session. Changes proposed include trying again to increase the eligibility level to 200% of the FPG in one bill, increasing to 250% with co-payment and buy-in options in another, and the establishment of universal coverage in a third bill. WCFH will respond to requests from legislators for information related to proposed bills and work with the Commissioner's office in developing a supportive document using data collected and analyzed by the MCH Epidemiology staff.

The MCH Title V/CSHCN Director will focus more attention this next year in working with the Medicaid program (located in another division) and assuring that both programs are more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. In addition, joint educational sessions will be developed for health care providers around the components of EPSDT and developmental screening in support of the special efforts underway as part of the Assuring Better Child Development screening (ABCD) program. The Title V program has been very active in promoting the tenets of the ABCD program and is working on in collaboration with the Early Childhood Comprehensive Systems (ECCS) program located in another division.

Title V dollars will continue to provide gap-filling services in the area of pediatric specialties including neurodevelopmental screening services, cleft-lip and palate assessment and evaluation, neurology services, and parent navigation. Reproductive health services for young women and teens are also provided using Title V dollars. These are infrastructure building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective				22	21.5
Annual Indicator			22.1	21.7	21.6
Numerator			3787	3398	3371
Denominator			17128	15667	15579
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
	2008	2009	2010	2011	2012
Annual Performance Objective	21	20.5	20	20	20

Notes - 2007

Source: WIC program, Report #340.

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

Notes - 2006

Source: WIC Program, Report #340

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. The most recent available data is for 2005. 2006 data will be available for the 2009 BG submission.

Note that growth curves for Alaska Native children may not be the same as for caucasian children.

Notes - 2005

Data Source: WIC Program

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile, AK does not collect data on 85th %-ile.

Future objectives are based on combining separate goals for at risk for overweight and overweight children. See "The Burden of Overweight and Obesity in Alaska", April 2003, DHSS, DPH, Section of Epidemiology, Health Promotion Unit. The goals are:

- Reduce the number of low-income children at risk for overweight (percentage of children aged less than 5 years served by WIC with weight-for-height greater than or equal to 85th percentile and less than 5th percentile) to 10% by the year 2010.
- Reduce the number of low-income children who meet the criteria for overweight (percentage of children aged less than 5 years served by WIC with weight-for-height greater than or equal to 95th percentile) to 10% by the year 2010.

a. Last Year's Accomplishments

Alaska WIC rates for overweight children decreased from 21.689% to 21.638%. The indicator measured children 2-5 years of age at or above the 95 percentile. The Family Nutrition Programs 2007 Strategic Plan

http://www.hss.state.ak.us/ocs/nutri/downloads/Alaska_FNP_Strategic_Plan_3-30-06.pdf
served as a guide to incorporate an overweight prevention program goal into WIC grantees Requests for Proposals.

Last year seventeen Alaska WIC Local Agency (LA) grantees included the goal to "Reduce the Prevalence of Overweight and Obesity among Alaskan Children and Adolescents," in their Nutrition Education and Services Plans. They implemented "Playtime So Good For Me," a nutrition education theme, promoting positive family health and wellbeing by encouraging physical activity and child development through unstructured play.

"Playtime So Good For Me" was developed by Alaska WIC to provide LA grantees appropriate physical activity and nutrition education materials to deliver accurate and consistent messages to participants. LA grantees incorporated Playtime messages throughout their programs by utilizing wall posters, mini-posters, brochures, activity balls, and activity handouts. Playtime educational materials were offered to approximately 25,500 WIC participants by individual counseling contacts, mailing, on-line education, referrals, and classroom settings.

"Playtime So Good For Me" and other nutrition themes are available on the Division of Public Assistance, Family Nutrition Programs, WIC, Nutrition Education website <http://www.hss.state.ak.us/dpa/programs/nutri/WIC/default.htm>.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop, improve or adapt nutrition themes: playtime, water, Alaska fruits and veggies, family meals and breastfeeding.				X
2. Support grantees in their use of nutrition themes and the distribution of posters, brochures, and activity handouts.			X	
3. Disseminate nutrition themes via the WIC website, local agencies and State Nutrition Action Plan.				X
4. Implement and utilize Alaska WIC Nutrition Reports for quality assurance and program planning.				X
5. Identify coordinated objectives to promote healthy eating and active lifestyles.				X
6. Collaborate with the State Nutrition Action Plan (SNAP) group to disseminate nutrition themes.				X
7. Incorporate and recommend inclusion of nutrition theme materials into WIC's Nutrition Care Plans.				X
8.				
9.				
10.				

b. Current Activities

All projects conducted in the past year were continued in the current year. Also, we are implementing a new nutrition theme, "Family Meals and Breastfeeding...So Good For Me," a collaborative effort between WIC, State Nutrition Action Plan (SNAP) and the Alaska Association of WIC Coordinators Nutrition Education Committee. Operational Adjustment funds covered Evon Zerbetz' poster artwork matching the "Playtime.... So Good For Me" and the "Water, Water... So Good for Me" nutrition theme poster designs. Operational Adjustment funds also support LAs to receive 28,000 of the various nutrition theme handouts and 1750 copies of a "Family Meals Cookbook... So Good For Me" for distribution among participants. The goal is to continue to reduce overweight and obesity among Alaska WIC children.

Alaska WIC is implementing Nutrition Risk Revision 8, a new WIC dietary assessment approach identifying specific infant, children and women dietary practices and does not count amounts or types of foods eaten.

WIC continues to implement and utilize Alaska WIC Nutrition Reports for quality assurance and program planning and identify coordinated objectives to promote healthy eating and active lifestyles. It also continues to improve or adapt other nutrition themes, including water, Alaska fruits and veggies, family meals, and breastfeeding.

Alaska WIC presented at the first USDA Food and Nutrition Service Western Region Cross-Program Nutrition Education Collaboration Meeting in Sacramento, California.

c. Plan for the Coming Year

Next year Alaska WIC Local Agency grantees will continue to include the goal to "Reduce the Prevalence of Overweight and Obesity among Alaskan Children and Adolescents," in their Nutrition Education and Services Plans. LA grantees will continue to incorporate all nutrition themes in providing their clients' counseling and education.

On October 1, 2009, USDA will start implementing the New Food Packages for WIC Clients. These new food packages, tailored for each client profile including pregnant, breastfeeding, and postpartum women, breastfeeding and formula-fed infants, and children ages 1-5, will align the Food Packages to the 2005 Dietary Guidelines for Americans and the infant feeding recommendations of the American Academy of Pediatrics. The Dietary Guidelines for Americans encourage combining physical activity with good choices from every food group. It emphasizes fruits, vegetables, whole grains, and fat-free or lower fat dairy products for children over age 2 and adults. It also encourages lean meats, poultry, fish, eggs, and nuts, as well.

The New Food Package is designed to be cost neutral but plans to incorporate the addition of fruits and vegetables, fresh, frozen or canned. Soy milk and tofu will be available as milk alternatives. Whole grains such as cereals, breads, and other products will also be added. Milk, eggs, and juice will be reduced. These changes will help families to plan better more nutritious meals for their families using WIC foods. The Alaska WIC program has established an advisory group to plan the implementation of these great changes which can help lower the child obesity rate in Alaska. WCFH will partner with WIC to help disseminate the new guidelines, especially related to perinatal women and infants, and will include guidelines in revision of the Healthy Mother, Health Baby Diary.

These activities are infrastructure building, population-based, enabling, and direct health care services.

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	2003	2004	2005	2006	2007
Annual Performance Objective				15	15
Annual Indicator			16.7	14.8	
Numerator			1602	1565	
Denominator			9581	10605	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	13.5	13.5	13.5	13.5	13.5

Notes - 2007

Source: Alaska PRAMS

The latest data available is for CY 2006. 2007 data will be available for the 2010 BG submission.

Notes - 2006

Source: Alaska PRAMS

The latest data available is for CY 2006. 2007 data will be available for the 2010 BG submission.

Notes - 2005

Source: Alaska PRAMS

Data reported for FY 2007 BG is AK PRAMS 2003 data, the latest available.

a. Last Year's Accomplishments

A method of billing for smoking cessation counseling and medications was established in SFY 06 for Medicaid patients who are pregnant and those under 21 years of age. Medicaid providers who are physicians, nurse practitioners, and community health aides may bill for these services. A letter was sent to all Medicaid providers informing them of this. However, relatively few claims for reimbursement had been made according to a claims review done in SFY 08.

The Tobacco Treatment Database project was implemented in partnership with the Alaska Native Tribal Health Consortium (ANTHC), and funded by the Tobacco Program of the Chronic Disease Prevention and Health Promotion Section. This database, which captures information such as types of tobacco used, quantity, desire to quit, medications used in the past, educational encounters, and prenatal indicators, provides reports for the evaluation of counseling interventions with respect to helping any tobacco user in their smoking cessation efforts. Data is collected on all encounters with any person coming through the Alaska Native Tribal Health Care system that indicates they are a smoker.

Stand alone software is run at each of the four pilot sites as well as web-based development, to allow continuity of care throughout the Alaska Native Tribal Health system and, eventually, easy aggregation of data statewide. ANTHC has conducted further web-based development, also to facilitate aggregation of data. The project was expanded to include 5 additional grantees in varying stages of development.

The WCFH perinatal nurse consultant position was filled in 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception /interconception care, and neonatal and post-neonatal concerns. She has responsibility for tobacco cessation since it bears heavily on perinatal and neonatal outcomes, particularly prematurity/low birth weight and SIDS.

She met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. She researched patient education materials and selected "Need Help Putting Out That Cigarette?" from ACOG and Smoke-Free Families to purchase in bulk and distribute to community and public health centers statewide. The Alaska MCH Data Book-PRAMS Edition, WCFH MCH Fact Sheets, and Healthy Mother, Healthy

Baby Diary were distributed to a large number of facilities. Title V funds were used to support the purchase and distribution of materials.

In October 2006, WCFH collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and March of Dimes to hold the annual AWHONN conference and provided support to March of Dimes for the annual Alaska Health Summit. Preconception and interconception care, among other topics, were presented.

In March 2007 the perinatal nurse consultant attended a two-day train-the-trainer SIDS workshop developed by Native American Management Services, in collaboration with Alaska Native Tribal Health Consortium, with an emphasis on getting the prevention message out to Alaska Natives.

The perinatal nurse consultant promotes the Alaska QuitLine that has continued to provide service to the people of Alaska.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations from the groups were incorporated into the 2008 application and included: target younger audiences, specifically school-age; use a linked approach to tobacco and alcohol and their effects during pregnancy; use or create videos with partners that address the connection between teen pregnancy and tobacco and alcohol use; hold community forums in public places like libraries; and create a CD module for community health aides.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to expand implementation of the Tobacco Treatment Database and capacity to aggregate data.				X
2. Participate in the Alaska Tobacco Control Alliance.				X
3. Support Alaska QuitLine through education and referral.			X	
4. Support professional education opportunities.				X
5. Convene Perinatal Advisory Committee.				X
6. Collaborate with Healthy Native Babies Project to reduce SIDS, addressing tobacco use.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing activities from the past year continue. Progress continues on the Tobacco Treatment Database project, which has been expanded to a total of 9 grantees. In November Free and Clear took over The Alaska QuitLine contract from Providence. They have implemented a more intensive, new pregnant caller program. Options for increasing Medicaid reimbursement for smoking cessation counseling are being addressed in a statewide workgroup of the Alaska Tobacco Control Alliance, on which WCFH sits.

Title V funds were used to support the AWHONN conference and a perinatal and women's health track at the Alaska Health Summit. Both included a session on tobacco cessation. WCFH is participating in a project to support the city health department in a MCH indicator project, starting a perinatal listserv, and developing a flier on pregnancy and oral health.

The first Perinatal Advisory Committee meeting was held April 2008. 32 attendees from across

Alaska represented a variety of geographic areas, types of facilities, and health care professions. The importance of using data was highlighted. Members expressed interest in tobacco cessation efforts.

The perinatal nurse consultant has initiated collaboration with the Healthy Native Babies Project, and will work in three villages in Bush Alaska where the incidence of SIDS is especially high. A SIDS education/prevention flyer is being developed with input from rural Alaska residents and others.

c. Plan for the Coming Year

The Tobacco Treatment Database project will continue to work with grantees, providing orientation and training for program development and expansion, and ease of statewide data aggregation. Options for increasing reimbursement continue to be addressed in a statewide workgroup of the Alaska Tobacco Control Alliance, and the Tobacco Program will implement a program to better align services and reimbursements from Medicaid and third-party payers that will increase reimbursements and better help support the provision of services.

The perinatal nurse consultant will provide or arrange training to health care providers on tobacco cessation strategies for pregnant women using the American College of Obstetricians and Gynecologists curriculum. Also, she will explore the American Academy of Family Physicians resources for tobacco cessation materials for health care providers. The iLink technology and partnership with Public Health Nursing will be implemented to reach public health nurses and other health care providers across Alaska.

The perinatal nurse consultant again will approach Medicaid about working together on an outreach education plan to providers who care for pregnant women. She will continue to work with the Alaska Tobacco Control Alliance on options for increasing Medicaid reimbursement for smoking cessation counseling, promote smoking cessation ads that target pregnant women, and share recommendations from stakeholders and perinatal advisory committee members. Also, she will explore partnering with Anchorage School District on preconception health issues, including tobacco prevention and cessation.

Free and Clear's new contract to provide Alaska QuitLine services will allow for renewal up to a total of 3 years. An independent evaluation of the QuitLine will be done in the coming year. The perinatal nurse consultant will continue to support the QuitLine through education and referral efforts. She will explore the idea of working with the Tobacco Program to develop a rack card to promote the Alaska QuitLine's new pregnant caller program.

The Tobacco Program and WCFH Epidemiology Unit will collaborate on an in-depth analysis of BRFSS and PRAMS data related to tobacco cessation. An Oregon-based contractor has been retained to conduct the analysis. In the coming year the Tobacco Program will finalize the creation of a Cessation Grant Manager and a person will be hired.

These activities are infrastructure building, population-based, and enabling services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	25.2	23.2	30	30	30

Annual Indicator	31.0	34.3	32.6	28.5	
Numerator	49	55	53	47	
Denominator	158041	160424	162555	164729	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	27	27	27	27	27

Notes - 2007

Source: Alaska Bureau of Vital Statistics

The most recent data available for FY 2009 block grant submission is 2004 - 2006. This indicator is reported by 3-year moving averages.

Notes - 2006

Source: Alaska Bureau of Vital Statistics

The most recent data available for FY 2009 block grant submission is 2004 - 2006. This indicator is reported by 3-year moving averages.

Notes - 2005

Source: Alaska Bureau of Vital Statistics

The most recent data available for FY 2008 block grant submission is 2003 - 2005. 2006 data will be available for the 2009 BG application. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments

In Fiscal Year 2007, Behavioral Health (BH) was in its second continuation grant year of the redesigned approach and process for funding the Comprehensive Prevention & Early Intervention Services grant programs. The 25 community-based suicide prevention grantees employed prevention strategies that are designed to create a long-term impact in reducing the harmful effects of drugs and alcohol, increase resiliency and community wellness, and a reduction in suicide. The majority of grantees ran youth programs and alternative activities such as healthy recreation programs, teen centers, sports activities, mentoring, and the reestablishment of cultural activities--subsistence, beading, carving, drumming and Alaska Native and Eskimo dance. Many programs are also learning how to best employ strategic prevention planning methods with support from Behavioral Health project coordinators within their communities to build sustainable and cultural competent practices and evidence based prevention strategies. During FY07, suicide prevention grantees made 97,284 program/activity contacts.

Accomplishments for FY07 emphasized integrating suicide prevention programs with other behavioral health prevention strategies and activities. As communities were required to assess and reevaluate their programs and services on an ongoing basis, many agencies had taken a stronger focus on outcomes (vs. outputs) with a great deal of training and technical assistance provided to funded agencies. Many agencies looked to new strategies such as bringing in motivational speakers to rural areas, sending project staff to Gatekeeper suicide prevention trainings, and reintroducing cultural values as key to developing holistic practices among Alaska Native youth.

The Suicide Prevention Gatekeeper training was completed in FY06, and a process established

for developing a train-the-trainer model to have quality trainers across the state to provide training to "first responders" in every community. A staff person with Behavioral Health, Prevention and Early Intervention Services was identified in late FY07 to oversee, facilitate and coordinate the training for the coming year.

The Suicide Prevention Council also worked closely with Behavioral Health and grantee communities to assist in developing local suicide prevention plans and to increase community readiness to discuss suicide and to implement outcome-based strategies that also target other factors associated with youth suicide to include substance abuse prevention and the promotion of overall health, youth resiliency and community wellness. Outreach efforts were designed to promote gatekeeper and other training resources such as the evidence-based, Signs of Suicide (SOS) school based curriculum and to promote media campaigns.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide for community-based suicide prevention grants.				X
2. Develop a statewide mechanism for delivery of the Gatekeeper Suicide Prevention training curriculum.				X
3. Promote the use of the evidence-based youth suicide prevention program, Signs of Suicide				X
4. Participate and present at a number of statewide conferences.				X
5. Disseminate Alaska Suicide Follow-Back Study.				X
6. Write SAMHSA youth suicide prevention 3-year grant proposal.				X
7.				
8.				
9.				
10.				

b. Current Activities

FY2008 was the third and final continuation grant year for our 25 community-based suicide prevention grantees. In partnership with the Suicide Prevention Council, BH continues to develop a statewide mechanism for delivery of the Alaska Gatekeeper Suicide Prevention Training curriculum.

In addition, the Council helped to promote the use of the evidence-based youth suicide prevention program, Signs of Suicide (SOS). The SOS program was offered to school districts across the state and copies of the curriculum were purchased by the Council and a process developed to distribute these curricula to schools interested in piloting this strategy. The Council also released The Alaska Suicide Follow-Back Study in the spring of 2007 and continues to be a source of Alaska specific data for community grantees.

BH staff have participated and presented at a number of statewide conferences including the Rural Providers Conference, DARE Alaska Student Safety Summit, Public Health Nurses Conference and the Full Lives Conference. A partnership has also formed with the Alaska Council for the Arts to promote traditional Native and contemporary arts programs in rural Alaska.

BH had also written a federal grant proposal for the Alaska Youth Suicide Prevention Project. If accepted, funds would total \$500,000 per year for the next three-year Federal grant cycle.

c. Plan for the Coming Year

FY09 will reintroduce the Comprehensive, Behavioral Health, Prevention and Early Intervention Services grant program (3 year funding cycle). The focus for FY09 will be to provide more individualized training and technical assistance to improve the community planning process and increase successful outcomes for our suicide prevention grant programs. Community grantees will increase use of community planning tools such as needs/readiness assessments to better determine specific strategies that will work best for their community.

A renewed effort to train individuals statewide as trainers in the Alaska Gatekeeper Training curriculum will begin in May 2008 and into FY09. Promotion of the use of youth suicide prevention curriculums will continue in FY09 with stronger emphasis on capacity development to implement such programs in schools and other youth organizations. Further promotion of research will also identify factors associated with acculturation and youth suicide among Alaska Native youth and help to identify specific strategies associated with this population. Opportunities to apply for FY 09 grant funding will be promoted for new communities that have either lost funding or not received grant funding in the past.

BH will continue our strong partnership with the Council, focusing on statewide outreach, community readiness to address suicide at the local level, community planning for suicide prevention efforts, and increasing our department's focus on a broad suicide prevention initiative. The Council will also work with BH on developing updates revisions to the Alaska Suicide Prevention Plan to be reprinted and published in FY09. Partnership with the Alaska Council for the Arts will continue with both BH and the Council.

Contingent upon the award of the SAMHSA federally administered youth suicide prevention grant, BH will organize grant activities to further enhance capacity for regions and communities to expand, enhance and implement new programs and services. These are infrastructure building activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	65	65	78	80	82
Annual Indicator	75.3	74.8	76.8	78.0	
Numerator	67	89	73	96	
Denominator	89	119	95	123	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	84	86	86	86	90

Notes - 2007

Source: Alaska Bureau of Vital Statistics

CY 2006 is most recent data available for 2009 block grant submission.

Notes - 2006

Source: Alaska Bureau of Vital Statistics

CY 2006 is most recent data available for 2009 block grant submission.

Notes - 2005

Source: Alaska Bureau of Vital Statistics

CY 2005 is most recent data available for 2008 block grant submission. 2006 data will be available for the 2009 BG application.

a. Last Year's Accomplishments

The perinatal nurse consultant position was filled in December 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception/interconception care, and neonatal and post-neonatal concerns. The consultant met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services.

The recently revised second edition of the Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health has been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health education information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth. An analysis of the state's infant morbidity and mortality data was published in an Alaska Epidemiology Bulletin and distributed statewide.

In October 2006, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and March of Dimes to hold the annual AWHONN conference. Presenter, Milt Kotelchuck, addressed adequacy of prenatal care and interconception care. Work began to plan the October 2007 conference.

The perinatal nurse consultant provided support to March of Dimes for the annual Alaska Health Summit in December 2006. Speaker, Karla Damus, addressed prematurity, preconception health, and genetics.

The Title V director was a team member attending the AMCHP, HRSA, NGA, ASTHO jointly-sponsored meeting, "Using Health Care Dollars Wisely." Improving birth outcomes and expanding reproductive health care were given top priority. Programs around early and continuous prenatal care and interconception care were encouraged for inclusion as measures to improve outcomes. The Title V director presented data, outcomes and priorities regarding MCH priorities to the legislature. A "white paper" was crafted jointly by the team and distributed to the legislative representatives. In January 2007, the Governor of Alaska requested the formation of the Health Improvement Advisory Committee to study the health care issues in Alaska and identify solutions. The Title V director assisted with information and data during the past year.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations from the groups were incorporated into the 2008 application and included: supporting Advanced Life Support Obstetrics, neonatal stabilization, and Perinatal Continuing Education Program courses (especially in rural Alaska) and, generally, serving as a clearinghouse for perinatal professional education; creating a CD module for community health aides; and creating tobacco cessation and hypertension screening forms for statewide use, building on March of Dimes' work. During FY08, the consultant will look into implementation and/or partnering to accomplish these

recommendations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to visit health care facilities across Alaska to assess perinatal health needs and collaborate on program development.				X
2. Investigate models of care to support high risk mothers.				X
3. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, Fact Sheets, and other materials.			X	
4. Continue MCH outcome data analyses and update the MCH publications.				X
5. Participate in planning for AWHONN conference and Alaska Health Summit.				X
6. Partner with March of Dimes to solicit support for a CenteringPregnancy and Parenting workshop.				X
7. Complete oral health flier for health care providers.		X		
8. Convene Perinatal Advisory Committee on a 3x yearly basis				X
9. Establish preconception speakers bureau.				X
10. Continue dialog with Medicaid to encourage a fast track eligibility determination for pregnant women.				X

b. Current Activities

Ongoing activities from the past year continue, and included visits to Nome, Kotzebue, Kenai/Soldotna, and Bethel. The perinatal nurse consultant is continuing to put together a picture of how circumstances in various rural communities contribute to high-risk women not more often being identified and transported before delivery to Alaska's tertiary care hospital.

A number of activities address prevention of preterm birth and low birth weight. Examples include providing continuing education through professional conferences and a perinatal listserv, collaborating with the WCFH Oral Health Program to develop a flier for health care providers on pregnancy and oral health, in hopes of reducing preterm birth linked with periodontal disease. Also, the perinatal nurse consultant is participating in a project to support the city health department in an MCH indicator project which spotlights low birth weight as one of only five indicators selected.

The first Perinatal Advisory Committee meeting was held April 2008. Thirty-two attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that reduces preterm birth.

c. Plan for the Coming Year

The consultant will carry on activities that educate health care providers about low birth weight, including conferences, the listserv, and other activities such as distributing the pregnancy and oral health flier. She will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education. She will also partner with March of Dimes to evaluate the usefulness of a hypertension chart tool and promote its use or modifications, if appropriate, in hopes of increasing timely transport of pregnant women to the tertiary center.

She will continue to visit sites across Alaska, distribute WCFH-published data and other professional education materials, and explore circumstances that relate to identification and transport of high-risk pregnant women. In particular, she will visit more areas of the state that have especially high low birth weight rates in Alaska. In addition, she will work with the MCH Epidemiology staff to more thoroughly elucidate the problem, such as finding out in what location very low birth weight babies are born when they aren't born at the tertiary care hospital.

The perinatal advisory committee will continue to meet three times a year. Low birth weight and very low birth weight will be addressed later in FY09, and committee members will be surveyed about high-risk births that occur in their communities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	85	85	85
Annual Indicator	80.1	81.1	80.5	81.3	
Numerator	7693	7924	8213	8688	
Denominator	9602	9776	10197	10687	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	85	85	85	85	85

Notes - 2007

Source: Alaska Bureau of Vital Statistics.

CY 2006 is the most recent data available for the 2009 block grant submission. 2007 data will be available for the 2010 BG application.

Notes - 2006

Source: Alaska Bureau of Vital Statistics.

CY 2006 is the most recent data available for the 2009 block grant submission. 2007 data will be available for the 2010 BG application.

Notes - 2005

Source: Alaska Bureau of Vital Statistics.

CY 2005 is the most recent data available for the 2008 block grant submission. 2006 data will be available for the 2009 BG application.

a. Last Year's Accomplishments

The perinatal nurse consultant position was filled in December 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception/interconception care, and neonatal and post-neonatal concerns. The consultant met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and

collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services.

The recently revised second edition of the Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health has been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health education information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth. An analysis of the state's infant morbidity and mortality data was published in an Alaska Epidemiology Bulletin and distributed statewide.

In October 2006, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and March of Dimes to hold the annual AWHONN conference. Presenter, Milt Kotelchuck, addressed adequacy of prenatal care and interconception care. Work began to plan the October 2007 conference.

The perinatal nurse consultant provided support to March of Dimes for the annual Alaska Health Summit in December 2006. Speaker, Karla Damus, addressed prematurity, preconception health, and genetics.

The Title V director was a team member attending the AMCHP, HRSA, NGA, ASTHO jointly-sponsored meeting, "Using Health Care Dollars Wisely." Improving birth outcomes and expanding reproductive health care were given top priority. Programs around early and continuous prenatal care and interconception care were encouraged for inclusion as measures to improve outcomes. The Title V director presented data, outcomes and priorities regarding MCH priorities to the legislature. A "white paper" was crafted jointly by the team and distributed to the legislative representatives. In January 2007, the Governor of Alaska requested the formation of the Health Improvement Advisory Committee to study the health care issues in Alaska and identify solutions. The Title V director assisted with information and data during the past year.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations from the groups were incorporated into the 2008 application and included: conducting a media campaign to educate health care consumers about the crucial first trimester and importance of preconception/interconception health care; educating all pertinent health care providers about its importance and, generally, serving as a clearinghouse for perinatal professional education; soliciting a health care provider to champion the cause; considering the Centering Pregnancy model; and look for options for early prenatal visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to visit health care facilities across Alaska to assess perinatal health needs and collaborate on program development.				X
2. Investigate models of care to support high risk mothers.				X
3. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, Fact Sheets, and other materials.			X	
4. Continue MCH outcome data analyses and update the MCH publications.				X
5. Participate in planning for AWHONN conference and Alaska Health Summit.				X

6. Partner with March of Dimes to solicit support for a CenteringPregnancy and Parenting workshop.				X
7. Complete oral health flier for health care providers.				X
8. Convene Perinatal Advisory Committee.				X
9. Establish preconception speakers bureau.				X
10. Continue dialog with Medicaid to encourage a fast track eligibility determination for pregnant women.				X

b. Current Activities

Ongoing activities from the past year continue. The annual AWHONN and Alaska Health Summit conferences were supported and addressed the importance of early prenatal and, specifically, CenteringPregnancy, in one conference.

A major cause of delays in initiating prenatal care remains the time it takes for a pregnant woman to enroll in Medicaid, making it difficult for women to start prenatal care in the first trimester. The Title V MCH director is in an ongoing dialog with Medicaid, emphasizing the importance of a fast track for pregnant women, and meeting with some success.

A number of activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal listserv was started that will be used to share information about evidence-based programs and professional education opportunities.

The first Perinatal Advisory Committee meeting was held April 2008. Thirty-two attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. Members related concerns about lack of early prenatal care. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that emphasizes early prenatal care and support and reduces preterm birth. WCFH continues to investigate ways to support high risk mothers in the Anchorage area.

c. Plan for the Coming Year

The consultant will carry on activities that educate health care providers about the importance of early prenatal care. This includes continuing to visit sites across Alaska, distribute WCFH-published data and other professional education materials, support conferences, administer the perinatal listserv, and other activities. She will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education.

The Perinatal Advisory Committee will continue to meet three times a year. The October 2008 meeting will feature a teleconference with the CenteringHealthcare Institute, to present information on the CenteringPregnancy and Parenting models. If there is enough interest in implementing this model in sites across Alaska, we will look to sponsor a 3-day workshop for leaders.

WCFH will continue to work with the Division of Public Assistance to identify ways to streamline the process of eligibility determination and approval for Medicaid coverage for pregnant women. The section will also support legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women, supporting early and continuous prenatal care.

We will also continue to work with potential funders to identify possible pilot programs to improve birth outcomes that includes early prenatal care, home visitation of high risk pregnant women, and interconception care. Focused mass media attention on the value of preconception care and early and continuous prenatal care will also be investigated this coming year.

These activities are infrastructure building, population-based, and enabling.

D. State Performance Measures

State Performance Measure 1: *Percentage of mothers of newborns who say their physician or health plan would not start prenatal care as early as they wanted or they could not get an appointment as early as they wanted.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15	15
Annual Indicator		14.8	12.5	16.5	
Numerator		1471	1209	1716	
Denominator		9949	9697	10426	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	15	15	15	15	15

Notes - 2007

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2006

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2005

Source: Alaska PRAMS

a. Last Year's Accomplishments

The perinatal nurse consultant position was filled in December 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception/interconception care, and neonatal and post-neonatal concerns. The consultant met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services.

The recently revised second edition of the Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health has been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health education information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth. An analysis of the state's infant morbidity and mortality data was published in an Alaska Epidemiology Bulletin and distributed statewide.

In October 2006, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and March of Dimes to hold the annual AWHONN conference. Presenter, Milt Kotelchuck, addressed adequacy of prenatal care and interconception care. Work began to plan the October 2007 conference.

The perinatal nurse consultant provided support to March of Dimes for the annual Alaska Health Summit in December 2006. Speaker, Karla Damus, addressed prematurity, preconception health, and genetics.

The Title V director was a team member attending the AMCHP, HRSA, NGA, ASTHO jointly-sponsored meeting, "Using Health Care Dollars Wisely." Improving birth outcomes and expanding reproductive health care were given top priority. Programs around early and continuous prenatal care and interconception care were encouraged for inclusion as measures to improve outcomes. The Title V director presented data, outcomes and priorities regarding MCH priorities to the legislature. A "white paper" was crafted jointly by the team and distributed to the legislative representatives. In January 2007, the Governor of Alaska requested the formation of the Health Improvement Advisory Committee to study the health care issues in Alaska and identify solutions. The Title V director assisted with information and data during the past year.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations from the groups were incorporated into the 2008 application and included: conducting a media campaign to educate health care consumers about the crucial first trimester and importance of preconception/interconception health care; educating all pertinent health care providers about its importance and, generally, serving as a clearinghouse for perinatal professional education; soliciting a health care provider to champion the cause; considering the Centering Pregnancy model; and look for options for early prenatal visits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to visit health care facilities across Alaska to assess perinatal health needs and collaborate on program development.				X
2. Investigate models of care to support high risk mothers.				X
3. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, Fact Sheets, and other materials.			X	
4. Continue MCH outcome data analyses and update the MCH publications.				X
5. Participate in planning for AWHONN conference and Alaska Health Summit.				X
6. Partner with March of Dimes to solicit support for a CenteringPregnancy and Parenting workshop.				X
7. Complete oral health flier for health care providers.				X
8. Convene Perinatal Advisory Committee.				X
9. Establish preconception speakers bureau.				X
10.				

b. Current Activities

Ongoing activities from the past year continue. The annual AWHONN and Alaska Health Summit conferences were supported and addressed the importance of early prenatal and, specifically, CenteringPregnancy, in one conference.

A major cause of delays in initiating prenatal care remains the time it takes for a pregnant woman

to enroll in Medicaid, making it difficult for women to start prenatal care in the first trimester. The Title V MCH director is in an ongoing dialog with Medicaid, emphasizing the importance of a fast track for pregnant women, and meeting with some success.

A number of activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal listserv was started that will be used to share information about evidence-based programs and professional education opportunities.

The first Perinatal Advisory Committee meeting was held April 2008. Thirty-two attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. Members related concerns about lack of early prenatal care. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that emphasizes early prenatal care and support and reduces preterm birth. WCFH continues to investigate ways to support high risk mothers in the Anchorage area.

c. Plan for the Coming Year

The consultant will carry on activities that educate health care providers about the importance of early prenatal care. This includes continuing to visit sites across Alaska, distribute WCFH-published data and other professional education materials, support conferences, administer the perinatal listserv, and other activities. She will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education.

Specifically, in response to physicians declining to start prenatal care when requested, the consultant will work with the MCH Epidemiology staff to more thoroughly elucidate the problem, such as finding out if there are trends associated with where or among what population this is occurring.

The Perinatal Advisory Committee will continue to meet three times a year. The October 2008 meeting will feature a teleconference with the CenteringHealthcare Institute, to present information on the CenteringPregnancy and Parenting models. If there is enough interest in implementing this model in sites across Alaska, we will look to sponsor a 3-day workshop for leaders.

WCFH will continue to work with the Division of Public Assistance to identify ways to streamline the process of eligibility determination and approval for Medicaid coverage for pregnant women. The section will also support legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women, supporting early and continuous prenatal care.

We will also continue to work with potential funders to identify possible pilot programs to improve birth outcomes that includes early prenatal care, home visitation of high risk pregnant women, and interconception care. Focused mass media attention on the value of preconception care and early and continuous prenatal care will also be investigated this coming year.

These activities are infrastructure building, population-based, and enabling.

State Performance Measure 2: *Percent of women who smoked during the last 3 months of pregnancy among women who smoked 3 months prior to pregnancy and were talked to about the effects of smoking by a prenatal health care provider.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				99	99
Annual Indicator		58.5	53.8	51.5	
Numerator		1561	1283	1314	
Denominator		2667	2383	2550	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	60	60	60

Notes - 2007

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2006

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

MCH-Epi staff contributed to the following journal article:

Kim SY, England L, Dietz P, Morrow B, Perham-Hester KA. (2008) Prenatal cigarette smoking and smokeless tobacco use among Alaska Native and white women in Alaska, 1996 - 2003. *Matern Child Health J.* Springer Science+Business Media.

Notes - 2005

Source: Alaska PRAMS

a. Last Year's Accomplishments

A method of billing for smoking cessation counseling and medications was established in 2006 for Medicaid patients who are pregnant and those under 21 years of age. Medicaid providers who are physicians, nurse practitioners, and community health aides may bill for these services. A letter was sent to all Medicaid providers informing them of this. However, relatively few claims for reimbursement had been made one year later.

The Tobacco Treatment Database project was implemented in partnership with the Alaska Native Tribal Health Consortium (ANTHC), and funded by the Tobacco Program of the Chronic Disease Prevention and Health Promotion Section. This database, which captures information such as types of tobacco used, quantity, desire to quit, medications used in the past, educational encounters, and prenatal indicators, provides reports for the evaluation of counseling interventions with respect to helping any tobacco user in their smoking cessation efforts. Data is collected on all encounters with any person coming through the Alaska Native Tribal Health Care system that indicates they are a smoker.

Stand alone software is run at each of the four pilot sites as well as web-based development, to allow continuity of care throughout the Alaska Native Tribal Health system and, eventually, easy aggregation of data statewide. ANTHC has conducted further web-based development, also to facilitate aggregation of data. The project was expanded to include 5 additional grantees in varying stages of development.

The WCFH perinatal nurse consultant position was filled in 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception /interconception care, and neonatal and post-neonatal concerns. She has responsibility for tobacco cessation since it bears heavily on perinatal and neonatal outcomes, particularly

prematurity/low birth weight and SIDS.

She met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. She researched patient education materials and selected "Need Help Putting Out That Cigarette?" from ACOG and Smoke-Free Families to purchase in bulk and distribute to community and public health centers statewide. The Alaska MCH Data Book-PRAMS Edition, WCFH MCH Fact Sheets, and Healthy Mother, Healthy Baby Diary were distributed to a large number of facilities. Title V funds were used to support the purchase and distribution of materials.

In October 2006, WCFH collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and March of Dimes to hold the annual AWHONN conference and provided support to March of Dimes for the annual Alaska Health Summit. Preconception and interconception care, among other topics, were presented.

In March 2007 the perinatal nurse consultant attended a two-day train-the-trainer SIDS workshop developed by Native American Management Services, in collaboration with Alaska Native Tribal Health Consortium, with an emphasis on getting the prevention message out to Alaska Natives.

The perinatal nurse consultant promotes the Alaska QuitLine that has continued to provide service to the people of Alaska.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations from the groups were incorporated into the 2008 application and included: target younger audiences, specifically school-age; use a linked approach to tobacco and alcohol and their effects during pregnancy; use or create videos with partners that address the connection between teen pregnancy and tobacco and alcohol use; hold community forums in public places like libraries; and create a CD module for community health aides.

The percentage of women who smoked during the last three months of pregnancy among women who smoked three months prior to pregnancy and were talked to about the effects of smoking by a prenatal health care provider decreased from 58.5% in 2004 to 51.5% in 2006 (PRAMS). Although not enough to indicate a trend, this may suggest women are taking the message about the importance of quitting smoking during pregnancy more seriously or perhaps are feeling more supported in their efforts to quit smoking.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to expand implementation of the Tobacco Treatment Database and capacity to aggregate data.				X
2. Participate in the Alaska Tobacco Control Alliance.				X
3. Support Alaska QuitLine through education and referral.			X	X
4. Support professional education opportunities.				X
5. Convene Perinatal Advisory Committee				X
6. Collaborate with Healthy Native Babies Project to reduce SIDS, addressing tobacco use.				X
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing activities from the past year continue. Progress continues on the Tobacco Treatment Database project, which has been expanded to a total of 9 grantees. In November Free and Clear took over The Alaska QuitLine contract from Providence. They have implemented a more intensive, new pregnant caller program. Options for increasing Medicaid reimbursement for smoking cessation counseling are being addressed in a statewide workgroup of the Alaska Tobacco Control Alliance, on which WCFH sits.

Title V supported the AWHONN conference and a perinatal and women's health track at the Alaska Health Summit. Both included a session on tobacco cessation. WCFH is participating in a project to support the city health department in a MCH indicator project, starting a perinatal listserv, and developing a flier on pregnancy and oral health.

The first Perinatal Advisory Committee meeting was held April 2008. 32 attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. The importance of using data was highlighted. Members expressed interest in tobacco cessation efforts.

The perinatal nurse consultant has initiated collaboration with the Healthy Native Babies Project, and will work in three villages in Bush Alaska where the incidence of SIDS is especially high. A SIDS education/prevention flyer is being developed with input from rural Alaska residents and others. A focus on smoking cessation will be included in this information.

c. Plan for the Coming Year

The Tobacco Treatment Database project will continue to work with grantees, providing orientation and training for program development and expansion, and ease of statewide data aggregation. Options for increasing reimbursement continue to be addressed in a statewide workgroup of the Alaska Tobacco Control Alliance, and the Tobacco Program will implement a program to better align services and reimbursements from Medicaid and third-party payers that will increase reimbursements and better help support the provision of services.

The perinatal nurse consultant will provide or arrange training to health care providers on tobacco cessation strategies for pregnant women using the American College of Obstetricians and Gynecologists curriculum. Also, she will explore the American Academy of Family Physicians resources for tobacco cessation materials for health care providers. The iLink technology and partnership with Public Health Nursing will be implemented to reach public health nurses and other health care providers across Alaska.

The perinatal nurse consultant again will approach Medicaid about working together on an outreach education plan to providers who care for pregnant women. She will continue to work with the Alaska Tobacco Control Alliance on options for increasing Medicaid reimbursement for smoking cessation counseling, promote smoking cessation ads that target pregnant women, and share recommendations from stakeholders and perinatal advisory committee members. Also, she will explore partnering with Anchorage School District on preconception health issues, including tobacco prevention and cessation.

Free and Clear's new contract to provide Alaska QuitLine services will allow for renewal up to a total of 3 years. An independent evaluation of the QuitLine will be done in the coming year. The perinatal nurse consultant will continue to support the QuitLine through education and referral efforts.

The Tobacco Program and WCFH Epidemiology Unit will collaborate on an in-depth analysis of BRFSS and PRAMS data related to tobacco cessation. An Oregon-based contractor has been

retained to conduct the analysis. In the coming year the Tobacco Program will finalize the creation of a Cessation Grant Manager and a person will be hired.

These activities are infrastructure building, population-based, and enabling services.

State Performance Measure 3: *Percentage of children ages 10-11 who are at-risk for being overweight.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator		40.1	40.1	40.1	40.1
Numerator		6783	6783	6783	6783
Denominator		16901	16901	16901	16901
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	35	35	35	35	35

Notes - 2007

Source: National Survey of Children's Health, Alaska, 2003, Physical and Dental Health. No new information since 2003.

Notes - 2006

Source: National Survey of Children's Health, Alaska, 2003, Physical and Dental Health. Retrieved April 23, 2006 from <http://nschdata.org/anonymous/dataquery/DataQuery.aspx?control=0>.

the indicator is 40.1%. Data was based on a sample and sample sizes were too small to meet standards for reliability or precision. The relative standard error is greater than 30%. Denominator excludes unknown information. 2003 is the baseline data and is the latest available figure.

Notes - 2005

Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website. (Child Health Measures, Alaska, Physical and Dental Health, Weight Status by Age Group.) Retrieved April 23, 2006 from www.nschdata.org

According to the NSCH, the numerator represents the estimated number of children in the population after the application of sampling weights. The denominator excludes unknown information so the indicator may be an underestimate. Data was based on a sample and "caution should be used in interpreting cell sizes less than 50". The actual number of responses to the survey in the categories of 'At Risk for Overweight' and 'Overweight' were less than 50. The NSCH Survey of 2003 provides the baseline data and is the latest available statistic.

a. Last Year's Accomplishments

The Obesity Prevention and Control Program (OPC) located in the Section of Chronic Disease Prevention and Health Promotion accomplished numerous activities. They provided technical assistance to school districts and offered a two-day School Wellness Institute in September of 2007. Staff also conducted a presentation to Anchorage School District administration on Prevalence of Overweight among Anchorage Children: A Study of Anchorage School District Data: 2003-2006.

They began process of updating the Burden of Obesity in Alaska document that includes data from the Resource Patient Management System for the Alaska Native Health System and State of Alaska Public Health Nursing and the State of Alaska WIC height and weight data, and posted Youth Risk Behavior Survey report to State of Alaska web site that includes height and weight information of Alaska high school students. In addition, OCP published the Physical Activity and Nutrition Training Manual for Head Start.

OCP staff provided 56 early childhood staff and food service personnel statewide with physical activity and nutrition training. They also continued to work with Alaskan's Promotion Physical Activity to promote Safe Routes to School, walk and bike to school days.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to school districts and offered a two-day School Wellness Institute in September of 2008.				X
2. Update the Burden of Obesity in Alaska document.				X
3. Promote Working with Alaskan's Promotion Physical Activity.				X
4. Present to professional groups on the Physical Activity and Nutrition Training Initiative for Childcare providers.				X
5. Promote Walk to School Day and support efforts of Safe Routes to School Program.				X
6. Participate in the development of a grassroots community call to action conference focusing on "No Child Left Inside."				X
7. Apply for a CDC DNPAO Cooperative Agreement to fund the Alaska Obesity Prevention and Control program.				X
8.				
9.				
10.				

b. Current Activities

The OCP Program continued past year activities in providing technical assistance to school districts and offering a two-day School Wellness Institute in Anchorage in September of 2008. Thirty-five of Alaska's 54 school districts attended. They continued updating the Burden of Obesity in Alaska document, promoting Alaskan's Promotion Physical Activity, and presenting to professional groups on the Physical Activity and Nutrition Training Initiative for childcare providers. Staff provided training to 75 childcare providers in Anchorage, Fairbanks, Juneau, and the Mat-Su Valley.

In addition, OCP is promoting Walk to School Day and supporting efforts of Safe Routes to School Program statewide. Anchorage, Juneau, and Seward, among other towns, participated. In another effort they are participating in the development of a grassroots community call to action conference focusing on "No Child Left Inside."

OCP has applied for a CDC DNPAO Cooperative Agreement to fund the Alaska Obesity Prevention and Control program.

c. Plan for the Coming Year

In the coming year OCP plans to continue to promote Walk to School Day, support efforts of Safe Routes to School Program, participate in the development of "No Child Left Inside," plan and

support School Wellness Institute 2008 and 2009, and train 150 more childcare staff regarding physical activity and nutrition. OCP staff will provide training for childcare providers in Sitka, Bethel, Fairbanks, Nome, Anchorage, and on the Kenai Peninsula.

New activities for the coming year include:

- Develop fact sheets regarding childhood TV viewing time, screen time viewing time, and other childhood obesity risk factors including Childhood Understanding Behavior Survey data
- Provide supervision to MPH graduate student with an emphasis in maternal and child health to help increase Alaska's public health workforce
- Develop toolkit for employers to provide strategies to support mothers' continuing to breastfeed when returning to work
- Develop professional development opportunities for elementary school teachers on "active classroom" techniques
- Participate in the development of Coordinated School Health Model for Alaska
- Develop resources for school teachers and professionals on the persuasive intent of marketing food and beverage of low nutritional value to children and youth
- Convene Alaska DHSS to discuss the implication of rising food costs on our food safety net programs around the state, and begin planning for the predicted increase in utilization of these programs
- Promote the school breakfast program to schools as a way to reduce food insecurity, increase academic performance and prevent obesity

These activities are population-based and infrastructure building.

State Performance Measure 4: *Rate (per 1,000) of substantiated reports of harm children ages 0 through 18.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	17	17	17	17	17
Annual Indicator	21.4	20.5		15.2	14.8
Numerator	20659	19809		3113	3209
Denominator	966579	965594		205460	217105
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	12	12	12

Notes - 2007

Data source: AK Office of Children's Services

The numerator for 2006 is changed from 4543 to 3113. This corrects an error last year in the interpretation of the definition of the numerator. To reconfirm, the numerator is the 'count of children with at least one allegation substantiated'.

Notes - 2006

Source: Alaska Office of Children's Services

FY 2006 is reported as a single year whereas prior years were reported as five year moving averages. The numerator excludes 72 individuals whose birthdates were missing, some of whom might have been in this age group.

Notes - 2005

Source: Office of Children's Services

Data for the 2005 reporting year is expressed in five year averages and covers FY 2001 - 2005.

During fiscal year 2005 the Office of Children's Services was transitioning to a new data system and thus the data was collected differently during this year and was not released for reporting due to the lack of confidence that the data was accurate.

a. Last Year's Accomplishments

The Strengthening Families Initiative (FSI) produced a report outlining the changes in the early care and learning pilot programs during the first year of their involvement in the program. Additional early care and learning programs were brought into the Strengthening Families network. Orientation and technical assistance was provided and new programs joined the "Learning Network" with experienced programs.

Regional meetings were facilitated with Child Protection Services Regional Managers and the local Strengthening Families Pilot Sites. A statewide summit with Child Protection Services, pilot sites and interested early childhood programs was hosted. Local teams generated plans for improving partnerships "back home".

The Alaska Universities began embedding SFI "protective language" in early childhood and social work courses. For the first time a social work practicum student was placed in an early care and learning program.

Along with SFI Leadership team members, three state legislators attended a National Conference of State Legislators meeting on the Strengthening Families program.

Alaska was chosen to be part of a Learning Community of states sponsored by the National Alliance of Children's Trusts. This opportunity allows us to share information and resources with 19 other states implementing the Strengthening Families model of child abuse and neglect prevention. The Alaska Children's Trust Fund funded two grantees to further the Strengthening Families work.

New partners (United Way, the Office of Faith Based Initiatives, Best Beginnings- Early Learning Council) were invited to join SFI parents and two Leadership Team members at the National Strengthening Families Summit.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work toward statewide expansion of SFI model and focus on embedding this framework in state policies and systems.				X
2. Finalize criteria for programs interested in becoming a Strengthening Families early care and learning program and standardized Strengthening Families training curriculum.				X
3. Continue to support SFI programs through the "Learning Network."				X
4. Work with the Child Care Program Office to improve the provision of childcare assistance to foster parents.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SFI Leadership Team continues to work toward statewide expansion of the model and focus on embedding this framework in state policies and systems. They finalized the criteria for programs interested in becoming a Strengthening Families early care and learning program and standardized the Strengthening Families training curriculum. The Alaska Association for the Education of Young Children partnered with the SFI Leadership Team to sponsor a cross-sector "Train the Trainer" full-week event.

Support is continuing to SFI programs through the "Learning Network." Monthly conference calls and annual face-to-face meetings are provided to share information and discuss program progress. Data collection is continuing regarding the practice changes made in SFI programs. The Leadership Team is working with the early childhood professional development registry to incorporate this training into their system so that it can be tracked and applied to certification.

We are expanding our work in the child protection system. The Alaska SFI Coordinator and the Office of Children's Services Director attended a meeting with a cohort of states leading the effort to incorporate the Strengthening Families framework in their systems. Significant work has been done between the Office of Children's Services and the Child Care Program Office to improve the provision of childcare assistance to foster parents.

c. Plan for the Coming Year

The SFI Leadership Team will implement revised goals and performance targets based on the new Strategic Plan. We will continue to work toward statewide expansion of the model and focus on embedding this framework in state policies and systems. We will expand our partnerships and continue to search for additional funding. This is infrastructure building.

State Performance Measure 5: *Percentage of women who recently had a live-born infant who reported their prenatal health care provider advised them not to drink alcohol during their pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				99	99
Annual Indicator		80.3	79.5	82.6	
Numerator		7718	7629	8481	
Denominator		9615	9598	10268	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99	99	99

Notes - 2007

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2006

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2005

Source: Alaska PRAMS

a. Last Year's Accomplishments

The start of comprehensive FAS data analysis began this year. Three positions were vacant for the entire year and thus progress on completing the analysis was slower than anticipated.

The perinatal nurse consultant position was filled in December 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception/interconception care, and neonatal and post-neonatal concerns. The consultant met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. The perinatal nurse consultant has asked health care providers what information is stressed during prenatal visits. Of the providers visited, alcohol abstinence was mentioned at prenatal visits, but not generally stressed.

She is exploring the availability of culturally appropriate materials to distribute to providers' offices regarding the importance of alcohol abstinence prior to and during pregnancy. WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services.

The recently revised second edition of the Alaska MCH Data Book-PRAMS Edition and WCFH MCH Fact Sheets that address multiple issues relevant to perinatal health, including alcohol exposure, have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes FAS among health education topics on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth. An analysis of the state's infant morbidity and mortality data was published in an Alaska Epidemiology Bulletin and distributed statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant.				X
2. Continue FAS data abstraction and data cleaning in preparation for analysis and MCH Data Book publication.				X
3. Develop and distribute interim publications based on FAS data analysis.				X
4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS.				X
5. Update and continue distribution across Alaska of the WCFH MCH Fact Sheet on FAS.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Epidemiology Unit of WCFH is working on a special edition of the MCH Data Book that will feature the first comprehensive data published on FAS since the inception of the surveillance program. The data featured in this edition will represent data collected between 1996 and 2002. Staff is completing abstractions and re-abstractions on all children reported to the Alaska Birth Defects Registry as having been affected by maternal alcohol exposure with birth years 1996-2002.

A survey of prenatal health care providers' knowledge around alcohol consumption during pregnancy will be repeated during this year to measure if there has been any change.

The perinatal nurse consultant's activities from the past year are continuing. In addition, a perinatal listserv was started that will be used to share information about evidence-based programs and professional education opportunities. Also, the first Perinatal Advisory Committee meeting was held April 2008. 32 attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. The importance of using data was highlighted. WCFH continues to explore the availability of culturally appropriate materials and investigate ways to support high risk mothers in the Anchorage area and will develop materials, if needed.

c. Plan for the Coming Year

The special edition of the MCH Data Book focusing on FAS will be distributed to as many providers of obstetrical and newborn care as possible. Additional sources of funding will be sought to help support expenses associated with FAS surveillance activities. Requests for state general funds will occur if supported by the DHSS Commissioner's agenda.

The consultant will continue to visit sites across Alaska and distribute WCFH-published data and other selected materials. A revision of the Healthy Mother, Healthy Baby Diary, that includes FAS prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The Perinatal Advisory Committee will meet three times a year, once in person and twice by teleconference. The best way of sharing information through the listserv will be considered.

The perinatal nurse consultant will continue to work with March of Dimes in hopes of conducting a 3-day CenteringPregnancy and Parenting workshop to address both prenatal and interconception issues. And, she will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education Focusing on the importance of alcohol abstinence as part of this program will be included..

WCFH will continue to work with the Alaska Medicaid program and other potential funders to identify possible pilot programs to improve birth outcomes and reduce the incidence of FASD . Programs with a focus on home visitation of high risk pregnant women and newborns are being considered.

Other activities planned for the coming year include:

1. MCH Block grant will continue funding the Alaska Birth Defects Registry/FAS data surveillance program.
2. Data abstraction and data cleaning continued in preparation for comprehensive FAS analysis.
3. Develop and distribute publications based on FAS data analysis.
4. Health care provider education regarding the alcohol abstinence during pregnancy will continue including the sharing of prevalence rates of FAS and FASD.
5. Update and continue distribution of the WCFH MCH Fact Sheet on FAS across Alaska.

These are infrastructure building and population-based activities.

State Performance Measure 6: *Prevalence (per 100) of unintended pregnancies that resulted in a live birth among women who reported having a controlling partner during the 12 months prior to getting pregnant.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				35	35
Annual Indicator		52.0	51.1	69.4	
Numerator		239	191	245	
Denominator		460	374	353	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	35	35	35	35	35

Notes - 2007

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2006

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2005

Source: Alaska PRAMS

a. Last Year's Accomplishments

The Alaska Family Violence Prevention Project (AFVPP) provides technical assistance, outreach, and public education as part of its mission to improve the health of Alaska's women, infants, children, and families. In addition, the AFVPP is dedicated to improving the health of all mothers and children through its leadership for research and development of training resources, policy development, and national standards in health care and domestic violence. The AFVPP relies on its community collaboration and represents service in three areas: enabling (for outreach and health education), population-based (for injury prevention), and infrastructure-building (for policy development, planning, coordination, standards development, training, and information systems).

The Alaska Family Violence Prevention Project (AFVPP) Clearinghouse distributed screening tools, information on evidence-based strategies, posters, safety information cards, and brochures on intimate partner violence around the time of pregnancy.

The AFVPP created a reference tool of evidence-based assessment strategies for lifetime exposure to violence that was disseminated statewide to public health nurses and other service providers.

The AFVPP worked with State of Alaska, Section of Public Health Nursing to design and conduct surveys on dating violence and lifetime exposure to violence in Arctic Village and provided feedback on the results.

The AFVPP provided training on dating violence and childhood exposure to violence with youth in Fort Yukon.

The AFVPP published a paper in the Journal of Emotional Abuse on recommendations for addressing intimate partner violence during home visitation with high risk mothers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute tools and materials and provide training.		X		X
2. Provide technical assistance to State of Alaska Public Health Nursing on expanding their protocol for intimate partner violence.				X
3. Conduct training on intimate partner violence and pregnancy-related issues for newly hired public health nurses.				X
4. Provide training on dating violence to teachers and school personnel at two different high schools in Fairbanks in October 2007.				X
5. Conduct an all-day training on intimate partner violence which included pregnancy-related risks for emergency medical service providers in November 2007 and follow-up regional training.				X
6. Provide training on intimate partner violence and pregnancy-related risks at the Alaska Native Health Summit in January 2008.				X
7. Provide training on intimate partner violence and pregnancy-related risk for child protection workers in Kenai and Soldotna in February 2008.				X
8. Work with a community coalition for Prince of Wales Island to develop and implement a prevention plan for intimate partner violence				X
9.				
10.				

b. Current Activities

The AFVPP Clearinghouse continues to distribute tools and materials and provide training to youth, child protection workers, emergency medical service providers, teachers, school personnel, and others.

The AFVPP is providing technical assistance to Section of Public Health Nursing on expanding their protocol to address lifetime exposure to violence, enhance documentation practices, and provided training on evidence-based strategies to address intimate partner violence with pregnant women at their statewide conference in April 2008.

The AFVPP is serving as part of an advisory group for the Alaska Network on Domestic Violence and Sexual Assault to apply for a prevention grant on dating violence and develop a dissemination plan on primary prevention for intimate partner violence.

The AFVPP published a Compass article on the impact of intimate partner violence on children and families in the Anchorage Daily News in February 2008 and participated in a radio show on the same topic.

c. Plan for the Coming Year

The Alaska Family Violence Prevention Project (AFVPP) will continue to distribute tools and materials and provide technical assistance and training to public health and reproductive health programs.

The AFVPP will develop a Toolkit on Intimate Partner Violence and Reproductive Health that will be disseminated statewide to public health nurses and reproductive health care sites.

The AFVPP will conduct training on intimate partner violence and pregnancy-related issues for newly hired public health nurses through the PHN Training Academy which offers statewide, web-based training, and to public health nurses and clinicians at a multidisciplinary conference on child abuse prevention in November 2008 in Anchorage.

The AFVPP is working with a community coalition for Prince of Wales Island to develop and implement a prevention plan for intimate partner violence.

These activities are infrastructure building, enabling, and population-based.

State Performance Measure 7: *Percentage of women who recently had a live-born infant who reported that they always or often felt down, depressed, or hopeless since their new baby was born.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1.5	9
Annual Indicator		10.8	9.3	8.5	
Numerator		1065	914	888	
Denominator		9851	9807	10485	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	8	8	8	8	8

Notes - 2007

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2006

Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

Notes - 2005

Source: Alaska PRAMS

a. Last Year's Accomplishments

During FY07 Postpartum Support Alaska Project planning committee continued to meet. The group compiled a list of services, therapists and counselors for women with postpartum depression. A resource information sheet for health care providers was designed. Information on treatment options and new developments was gathered. Funds from the Title V MCH Block Grant supported this activity.

In December 2006 a perinatal nurse consultant was hired by WCFH. She participated in the Postpartum Support Alaska Project planning committee. Title V MCH funds support her position.

Additional funding was secured through the Providence Children's Miracle Network to pay for a part-time project coordinator. A successful hire was made in April 2007. The coordinator, or Perinatal Mood Disorder Navigator, took over the work of the planning committee and began developing a packet with materials for both health care providers and consumers.

WCFH held a stakeholders meeting in June 2007 to review the Title V MCH Block Grant application process and solicit input on performance measures and activities. Recommendations included: encouraging use statewide of a standardized screening tool, creating a central clearinghouse for postpartum depression resources, expanding beyond perinatal depression to include seasonal affective depressive disorder and other mental health issues, and considering establishment of a warm line for mental health services. Opportunities for partnering around these suggestions will be investigated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete development of educational packet.				X
2. Distribute packets to health care providers statewide.				X
3. Conduct training sessions and professional continuing education for health care providers.				X
4. Start support group.		X		
5. Provide direct counseling services.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Perinatal Mood Disorder Navigator completed development of the educational packet that includes the Edinburgh Postnatal Depression Scale. Packets were distributed to 1000 health care providers across the state. Title V dollars were used to fund printing and mail the packets.

Perinatal Mood Disorder Navigator has been training health care providers on the importance of screening every mother for depression at her prenatal and postpartum visits. Trainees include Providence nursing staff and case managers, social workers, and military health care personnel. She started a support group, fields referrals from hospital staff, and provides direct counseling services.

The WCFH continues to support the project. At the Alaska Health Summit in December 2007 Title V supported a perinatal and women's health track that included a session on postpartum depression. The recently revised second edition of the Alaska MCH Data Book-PRAMS Edition and the MCH Fact Sheet, entitled Maternal Mental Health, have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that also includes information on postpartum depression, along with other materials furnished through Title V funding, were distributed to a large number of facilities across Alaska.

Postpartum depression has also been a focus for the Early Childhood Comprehensive Systems Grant (ECCS) as part of the early behavioral/mental health identification and intervention efforts.

c. Plan for the Coming Year

Perinatal Mood Disorder Navigator will continue to conduct training sessions for health care providers and plans to expand training throughout the state. Targeted groups include: Providence Family Support Services staff and Maternity Education Center staff, and Alaska Doulas. She will also continue to facilitate the support group and provide direct counseling services.

The WCFH perinatal nurse consultant continues to support the project by facilitating professional continuing education opportunities, and distributing materials. Title V will provide funds for reproduction of educational packets at possible.

We have recommended resource allocation and organizational support for individual counseling services and hope to implement services in the coming year. We will explore developing a volunteer resource network that would provide respite to postpartum moms. Availability of counseling services as part of an expanded postpartum Medicaid benefit package will be explored as well. These are infrastructure building, enabling, and direct health care services.

State Performance Measure 8: Prevalence at birth (per 1,000) of Fetal Alcohol Spectrum Disorders (FASD).

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				5	1
Annual Indicator			1.4	19.3	19.1
Numerator			41	576	569
Denominator			29852	29852	29868
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	18	18	17	17	17

Notes - 2007

Data Source: Alaska Bureau of Vital Statistics for the number of live births.

Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

For each reporting year, prevalence is calculated for several birth cohorts, but only one cohort is shown in the table. For example, data presented for reporting year 2007 is for children born 1998- 2000, as of May 2008.

Since more children will be diagnosed as they get older, the prevalence for any specific cohort will change year to year.

For the reporting year 2008, the prevalence of FASD for children born 1999 - 2001 is 15.4 (n=462, d=29948), as of May 2008.

The average age of diagnosis for FAS is age 5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

Notes - 2006

Data Source: Alaska Bureau of Vital Statistics is the reporting source for the number of live births. Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) will be

provided based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

Starting with reporting year 2006, the methodology in measuring this indicator changed. Previously, we measured rates of FAS. In reporting year 2006 and henceforth, we shall be reporting on FASD.

Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts. Data presented in the FY 2008 block grant, for reporting year 2006, is based on an analysis performed on children born during the years 1997- 1999, as of June 2007.

For the reporting year 2007, the prevalence of FASD for children born 1998 - 2000 is 18.1 (n=542, d=29868), as of June 2007.

The average age of diagnosis for FAS is age 5-6 years. Birth cohorts who are age six in the reporting year (2007) will be included in the numerator.

Notes - 2005

Data Source: Alaska Bureau of Vital Statistics is the reporting source for the number of live births. Data on the number of children born with Fetal Alcohol Spectrum Disorders will be provided based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

Due to the small number of annual events that occur in Alaska, rates are presented in three-year moving averages. Data presented for the FY 2007 submission is based on an analysis performed on children born during the years 1997 - 1999, as of March 2006.

The average age of diagnosis for FAS is age 5-6 years. Birth cohorts who are age six in the reporting year (2006) will be included in the numerator.

a. Last Year's Accomplishments

The Alaska Birth Defects Registry (ABDR) includes FAS and FASD surveillance within its scope of activities. Two medical abstractors support these activities and both positions were vacant last year. One abstractor was hired in June 2007, and the second position was filled when the incumbent returned from military duty. The abstractors worked on abstractions and re-abstractions for all children reported to the ABDR as having been affected by maternal alcohol exposure with birth years 1995-2002. The ABDR coordinator position remained opened and duties were temporarily performed by the MCH epidemiologist. Under the ABDR, FAS surveillance activities continued using the CDC FASSNet model. Prevalence rates were calculated for FAS and FASD for birth years 1999-2001 (three year moving average).

The perinatal nurse consultant position was filled in December 2006. The focus of the work is outcomes associated with early and adequate prenatal care, preconception/interconception care, and neonatal and post-neonatal concerns. The consultant met with public and private health care providers and administrators at facilities across Alaska to bring awareness of this position and collaborate in developing the perinatal program and assessing possibilities for conducting a pilot project. The perinatal nurse consultant has asked health care providers what information is stressed during prenatal visits. Of the providers visited, alcohol abstinence was mentioned at prenatal visits, but not generally stressed.

She is exploring the availability of culturally appropriate materials to distribute to providers' offices regarding the importance of alcohol abstinence prior to and during pregnancy. WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant.				X
2. Continue FAS data abstraction and data cleaning in preparation for analysis and MCH Data Book publication.				X
3. Develop and distribute interim publications based on FAS data analysis.				X
4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS.				X
5. Update and continue distribution across Alaska of the WCFH MCH Fact Sheet on FAS.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Under the ABDR, FAS surveillance activities continue using the CDC FASSNet model. We are working on a special edition of the MCH Data Book that will feature 1995-2002 FAS data, the first comprehensive data published since the inception of the surveillance program. Computer programming staff is working on integrating the FAS and ABDR databases.

After being vacant for about two years, the ABDR coordinator position was filled. This position is responsible for ABDR oversight and FAS surveillance activities. FAS surveillance used to be a distinct program from the ABDR, with some funding allocated from our Division of Behavioral Health. That funding ended in FY06, however, FAS and FASD surveillance have continued without interruption. The new coordinator is working on re-establishing former relationships with FAS service organizations.

The perinatal nurse consultant's activities from the past year are continuing. In addition, a perinatal listserv was started that will be used to share information. Also, the first Perinatal Advisory Committee meeting was held April 2008. 32 attendees from across Alaska represented a variety of geographic areas, types of facilities, and health care professions. The importance of using data was highlighted. WCFH continues to explore the availability of culturally appropriate materials and investigate ways to support high risk mothers in the Anchorage area and will develop materials, if needed.

c. Plan for the Coming Year

The special FAS edition of the MCH Data Book and interim publications will be distributed to as many providers of obstetrical and newborn care as possible, as well as other relevant health care providers and service organizations. Findings will be presented to the major health care providers and educators especially at the community level with the hope that improvements in referral rates for at-risk populations will occur. Data may be helpful in determining the distribution of services offered to children with a diagnosis of FASD and assist in assessing where the gaps in services exist. Additional sources of funding will be sought in the coming year to help support expenses associated with diagnostic activities. Requests for state general funds will occur if supported by the DHSS Commissioner's agenda.

The consultant will continue to visit sites across Alaska and distribute WCFH-published data and

other selected materials. A revision of the Healthy Mother, Healthy Baby Diary, that includes FAS prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The Perinatal Advisory Committee will meet three times a year, once in person and twice by teleconference. The best way of sharing information through the listserv will be considered.

The perinatal nurse consultant will continue to work with March of Dimes in hopes of conducting a 3-day CenteringPregnancy and Parenting workshop to address both prenatal and interconception issues. And, she will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education. Focusing on the importance of alcohol abstinence as part of this program will be included.

WCFH will continue to work with the Alaska Medicaid program and other potential funders to identify possible pilot programs to improve birth outcomes and reduce the incidence of FASD. Programs with a focus on home visitation of high risk pregnant women and newborns are being considered.

Other activities planned for the coming year include:

1. MCH Block grant will continue funding the ABDR/FAS data surveillance program.
2. Data abstraction and data cleaning continue in preparation for comprehensive FAS analysis.
3. Develop and distribute publications based on FAS data analysis.
4. Health care provider education regarding the alcohol abstinence during pregnancy will continue including the sharing of prevalence rates of FAS and FASD.
5. Update and continue distribution of the WCFH MCH Fact Sheet on FAS across Alaska.

These are infrastructure building and population-based activities.

State Performance Measure 9: *Percentage of infants who are reported to have a Cleft Lip/Palate defect who access the Title V sponsored Cleft Lip and Palate Specialty Clinic within the first year of life.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				26	27
Annual Indicator		27.1	29.2	28.4	
Numerator		19	21	21	
Denominator		70	72	74	
Is the Data Provisional or Final?				Provisional	
	2008	2009	2010	2011	2012
Annual Performance Objective	28	29	30	30	30

Notes - 2007

Data was not been evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the

state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

Notes - 2006

Sources: 1) AK Birth Defects Registry (ABDR); 2) Alaska Cleft Lip and Palate Specialty Clinics Program

This indicator is presented in 3-year averages. The indicator for reporting year 2006 represents 2004-2006.

This indicator may be updated at a later date. Numbers change because of late reports to the Birth Defects Registry.

Notes - 2005

Source: Alaska Births Defects Registry, Birth Cohort, linked to Cleft Palate Clinic registration files. As of April 2006.

Percentages are reported in 3-year averages. Indicators for 2002-2004 and 2003-2005 are provided in the FY 2007 Block Grant submission.

/2008/ This indicator was updated on June 14, 2007. Numbers change because of late reports to the Birth Defects Registry.

a. Last Year's Accomplishments

Cleft Lip and Palate Clinics continued in Anchorage and Fairbanks. Four clinics were held in Anchorage and three in Fairbanks. Anchorage clinics were coordinated by the state Section of Women's, Children's and Family Health, and Fairbanks clinics were coordinated by the Section of Public Health Nursing. In addition a clinic was held in Bethel for the first time in two years. This was formerly an annual clinic. Because of loss of support from public health nursing in Bethel and because of the small number of patients from that area, it was decided that the clinic would be held on an as-needed basis. Several client families from the Bethel area preferred traveling to Anchorage for clinic visits because they got other health services there.

Anchorage clinics were held at the Alaska Native Medical Center (ANMC) through a Memorandum of Agreement between the state and Southcentral Foundation (SCF), an Alaska Native-owned healthcare corporation. After many years of one-year agreements, SCF and the state signed a three-year agreement that assures clinics will be held at ANMC through FY10. ANMC providers were interested in housing the clinics at their facility because approximately half of the children who received evaluations at the state-sponsored clinics were their beneficiaries. Fairbanks clinics were held at the Fairbanks Public Health Center as they have been for many years. Although Bethel Public Health Nursing was no longer able to provide staff to support the clinic, they made clinic space available at the Bethel Public Health Center. Staff traveled from Anchorage to manage the clinic.

A multidisciplinary team provided patient evaluations. Team members included an audiologist, dietitian, oral surgeon, orthodontist, otolaryngologist, pediatric dentist, pediatrician, plastic surgeon and speech pathologist. In Anchorage and Fairbanks providers from the community volunteered their time and expertise to provide patient evaluations. Bethel did not have local providers from all the specialties. In order to have all specialties available at the clinic, the state contracted with a few providers from Anchorage who traveled to Bethel to complete the team.

A parent navigator from Stone Soup Group participated in all clinics and was available to meet with families who requested her services. Her role was to link parents to resources and improve follow-through of treatment plans to assure optimal outcomes. In addition the parent navigator met with parents of newborns at hospitals before discharge and was available to work with parents of cleft-affected children as needed. She coordinated a parent-to-parent support group

and wrote a semi-annual newsletter for parents. Parent navigation services were supported by a grant to Stone Soup Group from the state. The parent navigator averaged eight hours of work per week under the grant.

In an effort to increase capacity, provider training was offered at Anchorage clinics. Pediatric dentistry residents, general dentistry residents, a dietitian and a speech pathologist observed at clinics and shadowed team members from their specialty. They gained an understanding of the special needs of children with orofacial clefts and the importance of a multidisciplinary approach to treatment. As a result of her training at the clinics, a pediatric dentist who completed her residency in Anchorage and moved to Juneau planned to heighten awareness of the needs of children with orofacial clefts among her coworkers at the Southeast Alaska Regional Health Corporation.

During FY2007 126 children received evaluations at state-sponsored Cleft Palate Clinics. Of these, 23 were new patients who were seen within the first year of life. Most newborn referrals were made by hospitals and/or physicians. In rare instances the parent of a cleft-affected newborn self-referred.

All of these activities were supported by the MCH Block Grant.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Research facilities in the private sector that could be used for state-sponsored clinics in communities where public health centers are not available.				X
2. Work with the Alaska Native Medical Center to continue renting their facility as a site for four Anchorage clinics per year.				X
3. Review need for Cleft Palate Clinic in Bethel and hold clinics as needed and work with local providers to host the clinic.				X
4. Continue grant with Stone Soup Group for parent navigation services.		X		
5. Work with public health nurses/tribal organizations to assure that families throughout the state have access to clinic services. Continue providing support to Fairbanks public health center staff and the Cleft Palate Clinic team as needed.				X
6. Continue providing support to Fairbanks public health center staff and the Cleft Palate Clinic team as needed.				X
7. Work with Birth Defects Registry to assure cleft-affected infants are referred to clinics within the first year of life.				X
8. Provide opportunities for health care professionals to acquire expertise in treating children with orofacial clefts.				X
9. Expand the numbers of hospitals parent navigation services are offered for babies born with cleft lip and palate to assure referral for parent navigation services within one month of life.				X
10.				

b. Current Activities

Activities conducted last year continue in the current year except that a Cleft Palate Clinic is not held in Bethel. Many of the children from that area are attending clinics in Anchorage.

Clinic visits are down from 126 in FY2007 to 113 in FY2008. This is due in part to a weather conditions that prevent some families from traveling to Anchorage for the clinic. The number of

new patients who are seen in the first year of life is down substantially from 23 last year to 10 this year. There are concerns that some newborns with orofacial clefts are not being referred to state-sponsored Cleft Palate Clinics. In an effort to assure that all are referred and given an opportunity to attend clinics, Specialty Clinics staff and Birth Defects Registry staff are collaborating on a system for sharing and comparing data. In addition Stone Soup Group is keeping a list of all cleft-affected newborns that are referred to them. They will share their information with the state.

The state Oral Health Program is donating a limited number of spin brushes to Cleft Palate Clinics. A pediatric dentist determines which children would most benefit from having the brushes, and those children receive a brush at their clinic visit.

c. Plan for the Coming Year

Work will continue to assure that state-sponsored Cleft Lip and Palate Clinics are easily accessible to families throughout Alaska. Clinics will be held in Anchorage and Fairbanks. A clinic will be scheduled in Bethel if there is a demonstrated need. Provider contracts will be in place in case providers need to travel to Bethel. The state will reimburse them for their expenses.

As providers retire or relinquish their positions on the team, new team members will be added. In order to assure there is capacity in the community, training of providers will continue. More than one provider from each specialty will participate in clinics throughout the year so that the responsibility can be shared. Volunteer providers will continue to make up the clinic team.

Data on newborns from the Birth Defects Registry and from Stone Soup Group will be compared with data from clinic referrals to determine if all newborns with orofacial clefts are being referred to state-sponsored clinics. Those who are not referred, will be outreached and invited to participate in clinics. If they choose not to attend clinics, they will still be eligible for parent navigator services. Visits to the major hospitals where newborns with cleft lip/palate are born will be inserviced routinely to educate nursing staff on the services available. In addition, a presentation may be done in both Anchorage and Fairbanks at the weekly pediatric grand rounds that pediatric providers attend.

These are direct health care and infrastructure-building services.

E. Health Status Indicators

Health status indicators (HSI) are disseminated to the community through the WCFH website, Fact Sheets, and Data Books. Making the data available to the public and other health researchers encourages a continual discussion of health issues promotes health delivery, health program and policy changes at the community level and enables researchers to conduct evidence-based and outcome oriented quality research. In FY 2006 two databooks were published: the Alaska Maternal and Child Health Data Book 2004: PRAMS Edition and the Alaska Maternal and Child Health Data Book 2005: Birth Defects Surveillance Edition. The 2003 Data Book, which contains most of the HSIs, will be updated and published in Fall 2006.

HSI #6, 7, 8 and 9 are enumerated by race. This illustrates that the composition of Alaska's population is distinctly different from other states in the U.S., and that there are significant disparities in the health status among the different racial groups. Many of these disparities are amongst the Alaska Native populations who also live in rural and bush communities. As a result, public health efforts continue to focus on access to care in rural and bush communities. With the number of minorities increasing in Alaska, especially in Anchorage area, efforts to conduct

outreach and develop materials that are more culturally sensitive to the Hispanic, African American, Russian Orthodox, Korean and Hmong populations has occurred. Other indicators, such as #5 and #7, specifically address issues affecting women, enumerated by age, issues of reproductive health and sexual activity, especially of young women.

HSIs serve as surveillance or monitoring tools. For example, HSI #8 A and B, deaths to infants and children, contributes to the state's surveillance of infant and child deaths (Alaska Infant Mortality Review/Child Death Review). The program was originally established in the late 1980's in response to Alaska's high infant mortality rate. A panel of experts, composed of family physicians, pediatricians, obstetricians, intensivists, neonatologists, perinatologists, nurse practitioners, and program managers, as well as representatives from the State Medical Examiner's Office and the Office of Children's Services, reviews all infant and child deaths. Analysis of the data was published in June 2006 in an Epi Report titled "Findings of the Alaska Maternal-Infant Mortality Review 1992-2001". The Epi reports are distributed widely to public health professionals and are available on the web.

HSIs can also serve as an evaluative measure. For example, HSIs # 3 - 4, deaths/injuries due to motor vehicle crashes among children, is one piece of information used to support and continue grants for the Child Passenger Safety Program. In addition HSI # 1 -- 2 are focused on low birth weight and preterm deliveries. Monitoring these rates closely has been helpful in support preterm prevention efforts and monitoring progress.

/2009/ In FY 2008, the MCH-Epidemiology Unit initiated a preterm birth surveillance program, managed by the new CSTE Fellow. Tracking short- and long-term outcomes among all Alaskan preterm births will enable us to evaluate the health system's capacity to maximize health outcomes of the children. //2009//

The WCFH Fact Sheets are based on many of the health status indicators that show current and trend data. Fact sheets are used for the development of the Needs Assessment, and annual reviews, to reconfirm or adjust MCH goals and priorities. These fact sheets have been used repeatedly with legislators and community officials to give them a snapshot definition of the problem, the data and how our state compares with the nation.

/2009/ Seven Fact Sheets addressing the state's highest priorities were updated and distributed in FY 2008. //2009//

The MCH-Epi unit conducts original research yielding new insights. Recently published articles include: 1) "The Association Between Reproductive Health-Related Medical Claims and Criminal Activity or the Experience of Abuse among Medicaid-enrolled Adolescent Females" (related to HSI #7); 2) "Trends in asthma prevalence, hospitalization risk, and inhaled corticosteroid use among Alaska Native and non-Native Medicaid recipients less than 20 years of age" (related to HSI #6, illustrating disparate health outcomes among the state's subpopulations); 3) "Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome: In Reply"; and 4) "Preterm birth in Alaska 1989-2003" (related to HSI # 1)". These articles contribute to the understanding of underlying causes and associations of preventable poor health outcomes. Information is further disseminated through public presentations, conferences, Grand Rounds, training sessions, etc.

F. Other Program Activities

Calls to the toll-free hotline is automatically directed to main telephone line at the Section of Women's, Children's and Family Health. The hotline is available within Alaska and outside of Anchorage only, in accordance with the state's policy on toll-free numbers. It is not possible to document the number of calls that are made specifically from the toll-free number. The telephone is staffed during normal business hours and a voice message option is available.**/2009/ 308 calls**

were recored for SFY08 to the hotline number. Calls are recorded and catagorized based on which program or issuesthe caller is inquiring about. This number does not include all of the calls requesting assistance for Medicaid Services, WIC, physician assistance. Approximately 50 calls per day come into the main/toll free number. //2009//

The MCH-Epidemiology Unit published numerous reports, bulletins and peer-reviewed journal articles. A partial list follows:

Perham-Hester KA, Wiens HN, Schoellhorn J. Alaska Maternal and Child Health Data Book 2004: PRAMS Edition. Anchorage, AK: Maternal and Child Health Epidemiology Unit, Section of Women's, Children's and Family Health, Division of Public Health. September 2005.

Schoellhorn KJ, Beery AL. Alaska Maternal and Child Health Data Book 2005: Birth Defects Surveillance Edition. Anchorage, AK: Maternal and Child Health Epidemiology Unit, Section of Women's, Children's and Family Health, Division of Public Health. May 2006.

Gessner BD. Reproductive health, criminal activity, and abuse among Medicaid-enrolled females age 10 to 15 years. *Obstet Gynecol*. In Print

Chimonas MA, Baggett HC, Parkinson AJ, Muth PT, Dunaway E, Gessner BD. Asymptomatic *Helicobacter pylori* Infection and Iron Deficiency are Not Associated With Decreased Growth Among Alaska Native Children Aged 7--11 Years. *Helicobacter* 2006 Jun;11(3):159-67

Gessner BD, Baggett HC, Muth PT, Dunaway E, Gold BD, Feng Z, Parkinson AJ. A Controlled, Household-Randomized, Open-Label Trial of the Effect That Treatment of *Helicobacter pylori* Infection Has on Iron Deficiency in Children in Rural Alaska *J Infect Dis*. 2006;193(4)

Epidemiology Bulletin, Recommendations and Reports. The Educational Attainment of Children with Fetal Alcohol Syndrome. Section of Epidemiology, Alaska Division of Public Health. Vol. 2, Number 3.

Baggett HC, Parkinson AJ, Muth PT, Gold BD, Gessner BD. Endemic Iron Deficiency Associated With *Helicobacter pylori* Infection Among School-Aged Children in Alaska *Pediatrics* 2006;117;396-404;

Epidemiology Bulletin. Summary Report: Reproductive Health Claims and Risk of Abuse among Medicaid-enrolled Adolescent Females. Section of Epidemiology, Alaska Division of Public Health. 2006:1

Gessner BD. Preterm birth in Alaska 1989-2003. *Electronic Newsletter: Northwest Bulletin* 2006;20:13-14

Gessner BD, Porter TJ. Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome: In Reply *Pediatrics* 2006;117;994-996

Epidemiology Bulletin, Recommendations and Reports. The Association Between Reproductive Health-Related Medical Claims and Criminal Activity or the Experience of Abuse among Medicaid-enrolled Adolescent Females. Section of Epidemiology, Alaska Division of Public Health. Vol. 10, Number 1.

Epidemiology Bulletin, Recommendations and Reports. Prevention of Perinatal Group B Streptococcal Disease: National Guidelines and a Review of Alaska Early-Onset Neonatal Cases, 2000-2004. Section of Epidemiology, Alaska Division of Public Health. Vol. 9, Number 2.

//2009/ New publications for 2008 are:

Gessner, B. D. (2008). "The effect of Alaska's home visitation program for high-risk families on trends in abuse and neglect." *Child Abuse Negl* 32(3): 317-33.

Gessner, B. D. (2008). "Lack of piped water and sewage services is associated with pediatric lower respiratory tract infection in Alaska." *J Pediatr* 152(5): 666-70.

Gessner, B. D. and M. A. Chimonas (2007). "Asthma is associated with preterm birth but not with small for gestational age status among a population-based cohort of Medicaid-enrolled children <10 years of age." *Thorax* 62(3): 231-6.

Gessner, B. D., E. R. Sedyaningsih, et al. (2008). "Vaccine-preventable haemophilus influenza type B disease burden and cost-effectiveness of infant vaccination in Indonesia." *Pediatr Infect Dis J* 27(5): 438-43.

Gessner B, Utermohle C. *Asthma in Alaska: 2006 Report. Alaska Dept. of Health and Social Services, Division of Public Health, Maternal-Child Health Epidemiology Unit. 2007.*

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. *Prenatal Smokeless Tobacco and Iq'mik Use in Alaska. Bulletin No. 28. October 10, 2007.*

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. *Preterm Birth Trends - Alaska, 1989-2006. No. 12. May 2, 2008.*

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. *Prevalence of Attention Deficit Hyperactivity Disorder among Medicaid Recipients Less Than 20 Years of Age. No. 34. November 5, 2007.*

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. *Findings of the Alaska Maternal-Infant Mortality Review 1992-2001. No. 10. June 30, 2006.*

Alaska Department of Health and Social Services, Maternal and Child Health Epidemiology. *Title V Special Series Fact Sheet, updates: Sexually Transmitted Diseases and HIV among Women in Alaska. (2:20). July 2007. Low Birthweight and Preterm Births in Alaska. (2:5). June 2007. Birth Defects among Infants and Children in Alaska. (1:11). June 2007. Prenatal Care in Alaska. (1:12). May 2007. Infant and Fetal Mortality in Alaska. (2:3). June 2007. Breastfeeding in Alaska. (2:2). May 2007. Infant and Fetal Mortality in Alaska. (2:3). June 2007.*

//2009//

G. Technical Assistance

/2006/ A request for technical assistance has been submitted requesting funds to have one or two MCH staff attend the National Network of State Adolescent Health Coordinators. This meeting will provide an opportunity to learn what other federal agencies and states are doing in the area of adolescent health and to network with other states that may have limited or no funds for adolescent health coordinators, and to provide input into future directions, i.e. the national initiative to improve adolescent health. The estimated cost for one person to travel would be \$1600 from Alaska. We feel this important to stay in touch with other states and their adolescent program and stay abreast of potential funding opportunities as no funding exists at the present time for the state of Alaska to have an adolescent health care coordinator **//2006//**.

/2007/ A request for technical assistance from the Center for cultural competence has been submitted on form 15. An assessment of our programs for meeting cultural competence could then be utilized in assessing areas of greatest need and assist Alaska's Title V program in developing a plan of improvement with measurable outcomes.//2007//

/2009/ requests for technical assistance have been submitted on form 15.

V. Budget Narrative

A. Expenditures

/2006/ As is noted on forms 3, 4, and 5 of the application, the amount of funds expended in FY04 were less than budget due to the effects of the reorganization and the absorption of many expenses especially in the personnel category by the Division of Health Care Services (a.k.a Medicaid). A significant portion of General funds were supplanted with federal and state match dollars specifically.

As a result of the reorganization of DHSS, programs that had been part of the Section of Maternal, Child and Family Health were distributed to 5 divisions and a significant portion of general fund dollars and Medicaid school base funding went away. As a result, many positions were lost and programs were either cut, absorbed into other programs or were stopped. Specifically funding for Adolescent health, pregnancy prevention, MIMR, family nutrition, and injury prevention was lost. In addition with the distribution of programs to divisions other than where the Title V/CSHCN director is, the oversight of other federal grant programs and state G.F. was eliminated which affected the changes in reported expenditures.

With the reorganization that has gone into effect for FY06, many of the MCH program are being reformulated into the Section of Women's, Children's and Family Health and staff in those programs have been transferred back into the Division of Public Health. With that change comes a financial management team that is much more accustomed to working with federal grants and detailed reporting using ledger codes and other accounting structures related to grant management//2006//.

/2007/ Spending for FY05 occurred closer to budget for FY05 as noted on forms 3, 4, and 5 and was closer to amounts experienced prior to the reorganization in FY03. Categorical spending was much greater in the pregnant women level than anticipated due improved tracking and increase of expenditures from state funds in this arena. This is also true of funding for Children 1-22 years of age. Costs for administration were substantially reduced as the Division of Health Care services absorbed the major administrative costs as part of their budget including, rent, utilities, administrative support, human resources, and I.T. support. Spending in direct services decreased from expected budgeted levels as clinics were reorganized and smaller communities where very few patients attended were absorbed into larger hub communities to gain greater efficiency and reduce the cost of services. In addition, the elimination of an expensive clinic for cardiology went into effect in FY05 as the private sector has adequate resources and infrastructure to serve the southeast part of the state. These changes resulted in a shift of funding to infrastructure building and population-based services. //2007//

/2009/ Spending in FY07 was less than budgeted due to programmatic changes that occurred with the EPSDT program and the use of state general fund dollars for outreach and meeting the intent of the Title V legislation regarding EPSDT. This change specifically affected spending particularly in the areas of pregnant women, infants less than 1 year and children 1-22 years of age. MCH Block grant funds continue to provide a significant base of support for these populations with half of all dollars spent collectively designated for infrastructure services. Administrative costs were close to budget and reflected costs associated with moving into a new location //2009//.

B. Budget

/2006/ Form 2 outlines our proposed budget for the coming federal fiscal year. For FY06, children's preventative and primary care comprise a minimum of 30% of the anticipated federal allocation. CSHCN reflects 33% of the federal allocation and includes expenditures for spending

in the areas of direct services for pediatric specialty clinics to increase access to services and parent navigation (family care coordination). Administrative expenditures are budget to be no more than the allotted 10% of the budget.

Of note is that support from federal dollars has become the primary base of support and acts as either secondary or primary dollars for infrastructure or population-building services. The amount of general fund support has markedly decreased overtime and has been supplanted by Medicaid dollars in some cases or support has been eliminated altogether as outlined in the report on expenditures.

Budget priorities for FFY06 are focused on the new state performance measures identified as part of the 5 year Title V needs assessment and the national performance measures. This will include adding a new position to focus on perinatal and neonatal issues in support of primary and preventive care in the perinatal period. The current Title V/CSHCN director was originally hired to develop this program, but due to changes in structure and priorities over the last couple of years, roles have changed and it is not possible to add this to the work load of the director position. In addition, with the loss of federal and state general funds for the mandated morbidity and mortality review committee and the Alaska birth defects registry, the MCH Title V block grant will be covering the costs of these very important programs. Finally, dollars from the Title V block grant will be distributed to other divisions and sections that support some of the MCH priorities //2006//

/2007/ Form 2 outlines our proposed budget for the coming federal fiscal year. For FY07, children's preventative and primary care comprise a minimum of 33% of the anticipated federal allocation. CSHCN reflects 33% of the federal allocation and includes expenditures for spending in the areas of direct services for pediatric specialty clinics to increase access to services and parent navigation (family care coordination). Administrative expenditures are budget to be no more than the allotted 10% of the budget

Federal and State efforts:

The State of Alaska MCH Title V program utilizes both Title V funds and state dollars in support of pregnant women, infants less than 1, and children/adolescents (ages 1 to 22 years). Programs that benefits the population of Children with Special health care needs and thus meet the Title V requirement of over 30% included the Genetics, Birth Defects and Metabolic program, the pediatric specialty clinics including neurodevelopmental, spina bifida and cerebral palsy clinic, neurology clinic and the cleft lip and palate clinic. These clinics are offered in 6-8 communities across the state throughout the year in order to meet many of the national performance measures for CSHCN (organization of services for CSHCN, etc...). Title V funds are also used in combination with other federal grants to offer parent navigation services to families with a special needs child in an effort to navigate resources and payment options and achieve optimal program support of their child. These services have been primarily funded with the support of Title V dollars in the last couple of years with some support of Medicaid funding for travel of clients to rural hub communities or urban locations. With the re-organization of the maternal child health programs a second time beginning with SFY 06, funding will be available from receipts collected at some of the clinics and Medicaid fees billed for others again to support the clinics. Because the clinic administration and contracts were moved to the Division of Health Care services from SFY03 through SFY05, billed receipts were absorbed by the Division overall. Finally, Title V funds support the FAS and Birth Defects registry and surveillance program

Funding for preventative and primary care of children through outreach services for the EPSDT program, contraceptive services and supplies for adolescent through public health nursing centers, immunization education support, additional funding support for the Early Childhood and Care System Grant (ECCS), child abuse prevention efforts, domestic violence prevention, injury prevention efforts, maternal child surveillance including supporting the maternal morbidity and mortality surveillance committee, Pregnancy Risk Assessment and Monitoring program, a new Toddlers survey program.

Support for pregnant women and infants less than a year of age by Title V MCH Block grant provides supportive funding for programs such as the newborn metabolic screening, Back to Sleep prevention campaign, education regarding alcohol use and FAS, and SIDS and co-sleeping, MCH surveillance and epidemiology efforts, postpartum depression screening and education, smoking cessation efforts for pregnant women and preterm delivery and low birth weight prevention supports and child abuse prevention through intensive home visitation. Additional work will be forthcoming as a new perinatal nurse consultant position is hired supported by Title V funds.

A match in funds comes from a variety of sources including the state general fund match for Medicaid services for children and pregnant women, state funds for Early intervention, Women, Infant and Child nutrition program, and Team nutrition grants. In addition, there are state funds for child abuse prevention, fetal alcohol spectrum prevention, and pregnancy prevention.

Other federal grants are braided together with the Title V program to enhance program impact. These include CDC grants for the Pregnancy Risk Assessment Monitoring Program (PRAMS), Oral Health, Early Hearing, Detection and Intervention program (EHDI), and the Breast and Cervical Cancer Health Check program. Federal grants from HRSA include, SSDI, Abstinence Education, Oral Health, Universal Newborn Hearing Screening, Title X and a portion of Western States Genetics Collaborative.

Finally, with the reorganization of the most of the MCH programs back into the Division of Public Health, collection of fees and billing of Medicaid can resume which will provide for approximately an additional 100,000 in funding in SFY06 and 07. //2007//

//2009/ The budget for FFY2009 is anticipated to be similar to that submitted for FY08 with reductions in expenditures for pregnant women and children ages newborn to 22 years. Programs have been combined and streamlined since the re-emergence of the MCH program to provide for greater flexibility and cross trained staff. Staff has been been supportive of managing more than program and appreciate the exposure to programs and the training that comes with this exposure. In addition, less direct services are being offered than had been in the past. Training to health care providers and linkages with FQHC's and 330 clinics are ongoing to take advantage of the programs they offer and their requirements for case management and their focus on prevention and health promotion. The Title V program consistently looks for ways to braid and blend funding for new and existing programs to assure an ongoing plan for sustainability. A new position of School Health Nurse consultant will come on board in SFY09. This position will provide technical assistance to school districts around the state and those who have school nurses, provide information on standards of care and disaster planning. In addition, the position will be a liaison for the EPSDT program located in the Division of Health Care Services. //2009//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.